

RFP 2020HCA5, Attachment 1: Draft Sample IMC Contract

		Washington Apple Health – Integrated Managed Care Contract		HCA Contract Number: «Contract» Resulting from Solicitation Number (If applicable): «Procurement_s»	
THIS AMENDMENT is between the Washington State Health Care Authority, hereinafter referred to as "HCA," and the party whose name appears below, hereinafter referred to as the "Contractor."					
CONTRACTOR NAME «Organization_Name»			WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) «UBI»		
CONTRACTOR ADDRESS «Mailing_AddressSt_Address» «City», «State» «Zip_Code»					
CONTRACTOR CONTACT «Contact_Fname» «Contact_LName»		CONTRACTOR TELEPHONE «PhoneNo»		CONTRACTOR E-MAIL ADDRESS «EmailAddress»	
HCA PROGRAM Managed Care Program			HCA DIVISION/SECTION Medicaid Program Operations and Integrity		
HCA CONTACT NAME AND TITLE Johnny Shults, Section Supervisor			HCA CONTACT ADDRESS PO Box 45530 Olympia, WA 98504-5502		
HCA CONTACT TELEPHONE (360) 725-0480			HCA CONTACT E-MAIL ADDRESS johnny.shults@hca.wa.gov		
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				CFDA NUMBER(S) 93.778	
CONTRACT START DATE January 1, 2020				CONTRACT END DATE December 31, 2020	
PRIOR MAXIMUM CONTRACT AMOUNT N/A		AMOUNT OF INCREASE OR DECREASE N/A		TOTAL MAXIMUM CONTRACT AMOUNT Per Member Per Month	
PURPOSE OF CONTRACT: Integrated Managed Care (AH-IMC) Services to Apple Health					
ATTACHMENTS/EXHIBITS. When the box below is marked with an X, the following Exhibits/Attachments are attached and are incorporated into this Contract by reference: <input checked="" type="checkbox"/> Exhibit(s) (specify): Exhibit A, IMC Rates; Exhibit A, BHSO Rates; Exhibit B, [intentionally left blank]; Exhibit C, [intentionally left blank]; Exhibit D, Value-Based Purchasing; Exhibit E, Challenge Pool Value-Based Purchasing Incentives; Exhibit F, Instructions for Medical Loss Ratio (MLR) Reporting; Exhibit G, Data Use, Security and Confidentiality; Exhibit H, Health Homes; Exhibit I, Service Areas; Exhibit J, RAC Codes; Exhibit K, [intentionally left blank]; and Exhibit L, Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs). <input checked="" type="checkbox"/> Attachment(s) (specify): Attachment 1, [intentionally left blank]; Attachment 2, 2020 HEDIS® Performance Measures; Attachment 3, [intentionally left blank]; Attachment 4, Oral Health Connections Pilot; Attachment 5, ABCD Program, Attachment 6, RFP 15-008 – Apple Health – Integrated Managed Care – Southwest Region (incorporated by reference, available upon request); Attachment 7, Contractors Response to RFP 15-008 – Apple Health – Integrated Managed Care – Southwest Region (incorporated by reference, available upon request); Attachment 8, RFP 1812 – Apple Health – Integrated Managed Care – North Central Region (incorporated by reference, available upon request); Attachment 9, Contractors Response to RFP 1812 – Apple Health – Integrated Managed Care –North Central Region (incorporated by reference, available upon request); Attachment 10, RFP 2567, 2019/Integrated Managed Care RFP (incorporated by reference, available upon request); and Attachment 11, Contractors Response to RFP 2567 – 2019/2020 Integrated Managed Care RFP (incorporated by reference, available upon request)					
The terms and conditions of this Contract are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise, regarding the subject matter of this Contract. The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract shall be binding on HCA only upon signature by HCA.					
CONTRACTOR SIGNATURE		PRINTED NAME AND TITLE		DATE SIGNED	
HCA SIGNATURE		PRINTED NAME AND TITLE		DATE SIGNED	

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Exhibits

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Exhibit F	Instructions for Medical Loss Ratio (MLR) Reporting
Exhibit G	Data Use, Security and Confidentiality
Exhibit H	Health Homes
Exhibit I	Service Areas
Exhibit J	RAC Codes
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Exhibit L	Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs)

Attachments

Attachment 1	<i>[Intentionally left blank]</i>
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Attachment 2	2020 HEDIS® Performance Measures
Attachment 3	<i>[Intentionally left blank]</i>
Attachment 4	Oral Health Connections Pilot Project
Attachment 5	ABCD Program
Attachment 6	RFP 15-008 – Apple Health – Integrated Managed Care – Southwest Region (incorporated by reference, available upon request).
Attachment 7	Contractor’s Response to RFP 15-008 – Apple Health – Integrated Managed Care Southwest Region (incorporated by reference, available upon request).
Attachment 8	RFP 1812 – Apple Health – Integrated Managed Care – North Central Region (incorporated by reference, available upon request).
Attachment 9	Contractor’s Response to RFP 1812 – Apple Health – Integrated Managed Care –North Central Region (incorporated by reference, available upon request).
Attachment 10	RFP 2567 – 2019/2020 Integrated Managed Care RFP (incorporated by reference, available upon request).
Attachment 11	Contractor’s Response to RFP 2567 – 2019/2020 Integrated Managed Care RFP (incorporated by reference, available upon request).

1. DEFINITIONS

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

1.1 Access

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

1.2 Access to Baby and Child Dentistry (ABCD)

“Access to Baby and Child Dentistry (ABCD)” means a program to increase access to dental services for Medicaid-eligible clients age 5 and younger. See Attachment 5, ABCD Program.

1.3 Accountable Community of Health (ACH)

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

1.4 Actuarially Sound Capitation Rates

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

1.5 Acute Withdrawal Management

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

1.6 Administrative Day

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

1.7 Administrative Hearing

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

1.8 Advance Directive

“Advance Directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to

the provision of health care when an individual is incapacitated (WAC 182-501-0125, 42 C.F.R. § 438.3, 438.10, 422.128, and 489.100).

1.9 Adverse Benefit Determination

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

- 1.9.1 The denial or limited authorization of a requested service, including determinations based on the type or level of service; requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- 1.9.2 The reduction, suspension, or termination of a previously authorized service;
- 1.9.3 The denial, in whole or in part, of payment for a service;
- 1.9.4 The denial of request for “good cause” designation that would preclude usual third-party liability procedures;
- 1.9.5 The failure to provide services or act in a timely manner as required herein, including failure to issue an authorization or denial within required timeframes;
- 1.9.6 The failure of the Contractor to act within the timeframes for resolution and notification of appeals and grievances;
- 1.9.7 The denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities; and
- 1.9.8 For a rural area resident with only one Managed Care Organization (MCO) available, the denial of an Enrollee's request under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside the Contractor's network; or, for a plan's denial of coverage by an out-of-network provider when the in-network providers do not have the needed training, experience, and specialization, or do not provide the service the Enrollee seeks, when receiving all care in-network would subject the Enrollee to unnecessary risk, or when other circumstances warrant out-of-network treatment.

1.10 All Payer Claims (APC) Database

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

1.11 Allegation of Fraud

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

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

- 1.11.1 Fraud hotline complaints;
- 1.11.2 Claims data mining;
- 1.11.3 Referral of potential fraud received from the Contractor; and
- 1.11.4 Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

1.12 Alternative Benefit Plan (ABP)

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

1.13 American Indian/Alaska Native (AI/AN)

“American Indian/Alaska Native (AI/AN)” means any individual defined at 25 USC § 1603(13), § 1603(28), or § 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

- 1.13.1 Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is descendant, in the first or second degree, of any such member;
- 1.13.2 Is an Eskimo or Aleut or other Alaska Native;
- 1.13.3 Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- 1.13.4 Is determined to be an Indian under regulations issued by the Secretary.

The term AI/AN also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.14 American Society of Addiction Medicine (ASAM)

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

1.15 American Society of Addiction Medicine (ASAM) Criteria

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

1.16 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).

1.17 Appeal

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

1.18 Appeal Process

“Appeal Process” means the Contractor’s procedures for reviewing an Adverse Benefit Determination.

1.19 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:

- 1.19.1 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;
- 1.19.2 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;
- 1.19.3 Acquisition or modification of equipment or devices; and
- 1.19.4 Other similar services and actions.

1.20 Behavioral Health

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

1.21 Behavioral Health Agency

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

1.22 Behavioral Health Assessment System (BHAS)

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

1.23 Behavioral Health Administrative Services Organization (BH-ASO)

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

1.24 Behavioral Health Data Systems (BHDS)

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

1.25 Behavioral Health Services Only (BHSO)

“Behavioral Health Services Only (BHSO)” means those Enrollees who receive only behavioral health benefits through this Contract and the companion non-Medicaid Contract.

1.26 Behavioral Health Supplemental Transaction (BHST)

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

1.27 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.

1.28 Business Associate Agreement

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

1.29 Business Day

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

1.30 Capacity Threshold

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

1.31 Care Coordination

“Care Coordination” means an Enrollee’s healthcare needs are coordinated with the assistance of a Care Coordinator. The Care Coordinator provides information to the Enrollee and the Enrollee’s caregivers, and works with the Enrollee to ensure that the Enrollee receives the most appropriate treatment, while ensuring that health care is not duplicated.

1.32 Care Coordination Organization (CCO)

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

1.33 Care Coordinator (CC)

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

- 1.33.1 A Registered Nurse, Social Worker, Mental Health Professional or Substance Use Disorder Professional (SUDP) employed by the Contractor or primary care provider or Behavioral Health agency; and/or
- 1.33.2 Individuals or groups of licensed professionals, or paraprofessional individuals working under their licenses, located or coordinated by the primary care

provider/clinic/Behavioral Health agency.

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

1.34 Caregiver Activation Measure (CAM)

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

1.35 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:

- 1.35.1 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;
- 1.35.2 Utilization of evidence-based practices in screening and intervention;
- 1.35.3 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;
- 1.35.4 Ready access to integrated behavioral and physical health services; and
- 1.35.5 Use of appropriate community resources to support individual Enrollees, families and caregivers in managing care.

1.36 Care Manager (CM)

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

1.37 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.

1.38 Certified Electronic Health Record

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

1.39 Certified Electronic Health Record Technology (CEHRT)

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

1.40 Certified Peer Counselor (CPC)

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

1.41 Certified Substance Use Disorder Professional (SUDP)

“Certified Substance Use Disorder Professional (SUDP)” means an individual who is certified according to RCW 18.205.020 and the certification requirements of WAC 246-811-030 to provide substance use disorder (SUD) counseling.

1.42 Child and Family Team (CFT)

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

1.43 Child Study and Treatment Center (CSTC)

“Child Study and Treatment Center (CSTC)” means the Department of Social and Health Services’ child psychiatric hospital.

1.44 Children’s Behavioral Health Measures of Statewide Performance (CBH-MSP)

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

1.45 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.

1.46 Children’s Long Term Inpatient Program (CLIP)

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

1.47 Children’s Long Term Inpatient Programs Administration (CLIP Administration)

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

1.48 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:

- 1.48.1 Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act;
- 1.48.2 Eligible for Medicaid under Section 1902(e) (3) of the Act;
- 1.48.3 In foster care or other out-of-home placement;
- 1.48.4 Receiving foster care or adoption assistance; and/or
- 1.48.5 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.

1.49 Chronic Condition

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

1.50 Chronic Disease Self-Management Education (CDSME)

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

1.51 Clinical Data Repository (CDR)

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

1.52 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.

1.53 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)).

1.54 Community Behavioral Health Advisory (CBHA) Board

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

1.55 Community Health Workers (CHW)

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

1.56 Community Mental Health Agency (CMHA)

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

1.57 Comparable Coverage

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

1.58 Complex Case Management (CCM)

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

1.59 Comprehensive Assessment Report and Evaluation (CARE)

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

1.60 Concurrent Review

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

1.61 Confidential Information

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

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

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

1.63 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Database

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

1.64 Continuity of Care

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

1.65 Continuity of Care Document (CCD)

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

1.66 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.

1.67 Contract Year

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

1.68 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.

1.69 Contracted Services

“Contracted Services” means Covered Services that are to be provided by the Contractor under the terms of this Contract and as outlined in the Medicaid State Plan.

1.70 Copayment

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

1.71 Covered Services

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

1.72 Credible Allegation of Fraud

“Credible Allegation of Fraud” means an allegation of fraud, which has been verified by HCA, has indicia of reliability and HCA has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. (42 C.F.R. § 455.2).

1.73 Crisis Services

“Crisis Services” means evaluation and treatment of mental health crisis to all Medicaid-enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis Services shall be available on a 24-hour basis. Crisis Services are

intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation. Services are provided by or under the supervision of a Mental Health Professional. Crisis Services have been expanded to include evaluation and treatment for clients experiencing a crisis, related to a SUD.

1.74 Day Support

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

1.75 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.

1.76 Department of Children, Youth and Families (DCYF)

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

1.77 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:

- 1.77.1 Aging and Long-Term Support Administration is responsible for providing a safe home, community, and nursing facility array of long-term supports for Washington citizens.
- 1.77.2 Developmental Disabilities Administration is responsible for providing a safe, high-quality array of home, community, and facility-based residential services and employment support for Washington citizens with disabilities.
- 1.77.3 Behavioral Health Administration (BHA) is responsible for providing mental health services in state psychiatric hospitals.

1.78 Designated Crisis Responder (DCR)

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

1.79 Division of Behavioral Health and Recovery (DBHR)

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

1.80 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.

1.81 Duplicate Coverage

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

1.82 Durable Medical Equipment (DME)

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

- 1.82.1 Can withstand repeated use;
- 1.82.2 Is primarily and customarily used to serve a medical purpose;
- 1.82.3 Generally is not useful for a person in the absence of illness or injury; and
- 1.82.4 Is appropriate for use in the Client’s place of residence.

1.83 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 21, as defined in Section 1905(r) of the Social Security Act (SSA), codified in 42 C.F.R. § 441.50-441.62, and chapter 182-534 WAC and described in HCA EPSDT and Provider Billing Guide.

1.84 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.

1.85 Emergency Care for Behavioral Health Condition

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

1.86 Emergency Department Information Exchange™ (EDIE)

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

1.87 Emergency Fill

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

1.88 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)).

1.89 Emergency Medical Transportation

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

1.90 Emergency Room Care

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

1.91 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)).

1.92 Encounter Data Reporting Guide

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

1.93 Encrypt

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

1.94 Enrollee

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

1.95 Essential Behavioral Health Administrative Functions

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

1.96 Evaluation and Treatment

“Evaluation and Treatment” means services provided in freestanding inpatient residential (non-hospital/non-Institution for Mental Disease (IMD)) facilities licensed and certified by the Department of Health to provide medically necessary evaluation and treatment to the Medicaid-enrolled individual who would otherwise meet hospital admission criteria.

At a minimum, services include evaluation, stabilization, and treatment provided by or under the direction of licensed psychiatrists, nurses, and other Mental Health Professionals, and discharge planning to ensure continuity of mental health care. Treatment may include nursing care, individual and family therapy, milieu therapy,

psycho-educational groups, and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder or co-occurring substance use disorder. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow him/her to be managed at a lesser level of care. This service does not include cost from room and board. HCA shall authorize exceptions for involuntary length of stay beyond a fourteen (14) day commitment.

1.97 Evaluation and Treatment Facility

"Evaluation and Treatment Facility" means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a behavioral health disorder, and which is licensed or certified as such by the department". (RCW 71.05.020).

1.98 Evidence-Based Practices

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

1.99 Exception to Rule (ETR)

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

1.100 Excluded Benefit

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

1.101 External Entities (EE)

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

1.102 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).

1.103 External Quality Review Report (EQRR)

"External Quality Review Report (EQRR)" means a detailed technical report that describes the manner in which the data from all activities described in External Quality

Review provisions of Section 7.8 and conducted in accordance with 42 C.F.R. § 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness, and access to the care furnished by the Contractor.

1.104 Facility

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

1.105 Family Connect

“Family Connect” means enrolling a family member into the same Apple Health - Integrated Managed Care plan that other family members are enrolled in.

1.106 Family Treatment

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

1.107 Federally Qualified Health Center (FQHC)

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

1.108 First Responders

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

1.109 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).

1.110 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).

1.111 Geo-Coding

“Geo-Coding” is a process involving the use of tools and software to convert location addresses into coordinates for analysis. Geocoded locations of patients, populations, providers, and other services can be potentially coupled with other data sources to inform and enhance clinical and administrative decision making.

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

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

1.113 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.

1.114 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).

1.115 Grievance Process

“Grievance Process” means the procedure for addressing Enrollees’ Grievances (42 C.F.R. § 438.400(b)).

1.116 Group Treatment Services

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

1.117 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.

1.118 Habilitative Services

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

1.119 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.

1.120 Health Care Plan (Plan)

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

1.121 Health Care Professional

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

1.122 Health Care Provider (HCP)

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

1.123 Health Care Services

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

1.124 Health Care Settings (HCS)

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

1.125 Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

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

1.127 Health Information Technology (HIT)

“Health Information Technology” means the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making. Certified HIT (including certified EHR technology (CEHRT)) are systems that meet the technological capability, functionality, and security requirements adopted by the U.S. Department of Health and Human Services. Certification gives providers and

patients confidence that the Health IT products and systems they use are secure and can work with other systems to share information (interoperability). The Health IT Certification Program is a voluntary program established by the Office of the National Coordinator for Health IT (ONC) to provide for the certification of health IT standards, implementation specifications and certification criteria adopted by the Secretary. The ONC Health IT Certification Program supports the availability of certified health IT for its encouraged and required use under federal, state and private programs.

1.128 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.

1.129 Health Technology Assessment (HTA)

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

1.130 Home Health Care

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

1.131 Hospice Services

“Hospice Services” means services associated with an Enrollee’s terminal illness and related conditions.

1.132 Hospital Safety Net Assessment Fund (Safety Net)

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

1.133 Hospitalization

“Hospitalization” means an admission to a hospital for treatment.

1.134 Hospital Outpatient Care

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

1.135 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.

1.136 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.

1.137 Individual Service Plan (ISP)

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

1.138 Individuals with Intellectual or Developmental Disability (I/DD)

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

1.139 Individual with Special Health Care Needs

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

1.139.1 Has a biologic, psychological, or cognitive basis;

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

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

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

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

1.140 Individual Treatment Services

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

1.141 Inpatient/Residential Substance Use Treatment Services

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

1.141.1 Intensive inpatient services;

- 1.141.2 Recovery house treatment services;
- 1.141.3 Long-term residential treatment services; and
- 1.141.4 Youth residential services.

1.142 Intake Evaluation

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

1.143 Intensive Inpatient Residential Services

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

1.144 Intensive Outpatient Treatment

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

1.145 Interdisciplinary Care Conferences (ICCs)

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

1.146 Interoperable Health IT

“Interoperable Health IT” means technology that enables the secure exchange of electronic health information with, and use of electronic health information from, other health IT without special effort on the part of the user. It also allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable state or federal law and prevents information blocking.

1.147 Institute for Mental Disease (IMD)

“IMD or Institute for Mental Disease” means, per P.L. 100-360, an institution for mental diseases as a hospital, nursing Facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is an IMD if its overall character is that of a Facility established and maintained primarily for the care and treatment of Individuals with mental diseases.

1.148 Involuntary Treatment Act (ITA)

“Involuntary Treatment Act (ITA)” allows Individuals to be committed by court order to a facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of Individuals with a behavioral health disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to seventy-

two (72) hours, but, if necessary, Individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days (RCW 71.05.180, RCW 71.05.230, RCW 71.05.240 and RCW 71.05.290).

1.149 Involuntary Treatment Act Services

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

1.150 Large Rural Geographic Area

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

1.151 Less Restrictive Alternative Treatment

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

1.152 Level of Care Guidelines

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

1.153 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 according to WAC 182-501-0169.

1.154 Limited English Proficient (LEP)

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

1.155 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.

1.156 Local IHCP Provider

“Local IHCP Provider” means an IHCP Provider with a Facility in the Contractor’s Regional Service Area or with a client residing in the Contractor’s Regional Service Area.

1.157 Local Tribe

“Local Tribe” means a federally recognized tribe that has all or part of its Contract Health Service Delivery Areas (as established by 42.C.F.R. 136.22 and is updated from time to time within the Federal Register) within the Contractor’s Regional Service Area.

1.158 Managed Care

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

1.159 Managed Care Organization (MCO)

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

1.160 Marketing

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

1.161 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)).

1.162 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.

1.163 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).

1.164 Medicaid Fraud Control Division (MFCD)

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

1.165 Medicaid State Plan

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

1.166 Medically Necessary Services

“Medically Necessary Services” means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Enrollee that endanger life, or cause suffering of pain, or result in an

illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Enrollee requesting the service. For the purpose of this Contract, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

1.167 Medical Loss Ratio (MLR)

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

1.168 Medication Assisted Treatment (MAT)

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

1.169 Medication Management

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

1.170 Medication Monitoring

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

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

1.171 Mental Health Advance Directive

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

1.172 Mental Health Parity

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

1.173 Mental Health Professional

"Mental Health Professional" means:

- 1.173.1 A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;
- 1.173.2 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;
- 1.173.3 A person with a master's degree or further advanced degree in counseling or one of the behavioral sciences from an accredited college or university. Such persons shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional; or

1.174 National Committee for Quality Assurance (NCQA)

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

1.175 National Correct Coding Initiative (NCCI)

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

1.176 Natural Supports

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

1.177 Network

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

1.178 Network Adequacy

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

1.179 Neurodevelopmental Centers

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

1.180 New Individual

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

1.181 Non-Participating Provider

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

1.182 Non-Quantitative Treatment Limits (NQTL)

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

1.183 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.

1.184 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.

1.185 Opiate Substitution Treatment Program (OSTP)

“Opiate Substitution Treatment Program (OSTP)” means a designated program that dispenses approved medication as specified in 21 C.F.R Part 291, for opioid treatment programs in accordance with WAC 246-341-1000.

1.186 Oral Health Connections Pilot

“Oral Health Connection Pilot” means a project to integrate oral-systemic health care in two predetermined populations, in three select counties in anticipation of influencing health outcomes and controlling chronic disease. Adults with diabetes and pregnant women (not including Dual Eligible Clients) located in Cowlitz, Thurston or Spokane counties are those that qualify for this pilot. See Attachment 4, Oral Health Connections Pilot Project.

1.187 Outcomes

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

1.188 Outpatient Treatment for Substance Use Disorder

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

1.189 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.

1.190 Parent Patient Activation Measure (PPAM)

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

1.191 Participating Rebate Eligible Manufacturer

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

1.192 Participating Provider

“Participating Provider” means a person, medical or behavioral 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.

1.193 Partnership Access Line (PAL)

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

1.194 Patient Activation Measure (PAM)

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

- 1.194.1 Measure activation and behaviors that underlie activation including ability to self-manage, collaborate with providers, maintain function, prevent decline and access appropriate and high quality health care;
- 1.194.2 Target tools and resources commensurate with the Enrollee’s level of activation; and
- 1.194.3 Provide insight into how to improve unhealthy behaviors, and grow and sustain healthy behaviors to lower medical costs and improve health.

1.195 Patient Days of Care

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

1.196 Patient Health Questionnaire (PHQ-9)

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

1.197 Peer Support

“Peer Support” means services provided by certified peer counselors to Medicaid-enrolled individuals under the consultation, facilitation, or supervision of a Mental Health Professional or SUDP who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Clients actively participate in decision-making and the operation of the programmatic supports.

1.198 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.

1.199 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.

1.200 Physician Incentive Plan

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

1.201 Physician’s Orders for Life Sustaining Treatment (POLST)

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

1.202 Physician Services

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

1.203 Plan Reconnect

“Plan Reconnect” means an individual who has regained eligibility for Apple Health - Integrated Managed Care and who was enrolled in an Apple Health contractor (Apple Health Managed Care or Apple Health - Integrated Managed Care) within the six (6) months immediately preceding reenrollment.

1.204 Population Health Management Systems (PHMS)

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

and claims data) can be captured, analyzed, and shared to support VBP models and care delivery redesign.

1.205 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.

1.206 Post-Stabilization Services

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

1.207 Potential Enrollee

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

1.208 Predictive Risk Intelligence System (PRISM)

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

1.209 Premium

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

1.210 Prescription Drug

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

1.211 Prescription Drug Coverage

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

1.212 Primary Care Provider (PCP)

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

1.213 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.

1.214 Primary Point of Contact

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

1.215 Prior Authorization

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

1.216 Program Integrity

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

1.217 Promising Practice

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

1.218 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).

1.219 Provider Access Payment (PAP) Program

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

1.220 ProviderOne

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

1.221 Provider Performance Profile (PPP)

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

1.222 Psychological Assessment

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

1.223 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.

1.224 Quantitative Treatment Limitations (QTL)

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

1.225 Recovery

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

1.226 Regional Service Area (RSA)

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

1.227 Regulation

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

1.228 Rehabilitation Case Management

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

1.229 Rehabilitation Services

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

1.230 Research-Based Practice

“Research-Based Practice” means a program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained

desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes but does not meet the full criteria for evidence-based. (Washington State Institute for Public Policy (WSIPP) 3/2015).

1.231 Residential Mental Health Services

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

1.232 Resilience

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

1.233 Revised Code of Washington (RCW)

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

1.234 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.

1.235 Rural Area

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

1.236 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

“Screening, Brief Intervention, and Referral to Treatment (SBIRT)” means a comprehensive, evidenced-based public health practice designed to identify through screening, adolescents and adults who are at risk for or have some level of SUD that can lead to illness, injury, or other long-term morbidity or mortality. If a person is found to be at risk of harm from their use, they receive several Brief Interventions to reduce their risk

or if necessary, a referral for further evaluation for treatment. SBIRT services are provided in a wide variety of medical and community health care settings.

1.237 Second Opinion Network (SON)

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

1.238 Secure Withdrawal Management and Stabilization Facility

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

1.239 Secured Area

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

1.240 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.

1.241 Service Encounter Reporting Instructions (SERI)

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

1.242 Single Case Agreement

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

1.243 Special Population Evaluation

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

1.244 Specialist

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

1.245 Stabilization Services

“Stabilization Services” means services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person’s own home, or another home-like setting, or a setting that provides safety for the individual

and the Mental Health Professional. Stabilization Services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to Crisis Services; and b) other individuals determined by a Mental Health Professional to need additional Stabilization Services. Stabilization Services may be provided prior to an Intake Evaluation for mental health services.

1.246 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.

1.247 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.

1.248 Substance Use Disorder (SUD)

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

1.249 Substantial Financial Risk

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

- 1.249.1 Withholds greater than 25 percent of total potential payments; or
- 1.249.2 Withholds less than 25 percent of total potential payments but the physician or Physician Group is potentially liable for more than 25 percent of total potential payments; or
- 1.249.3 Bonuses greater than 33 percent of total potential payments, less the bonus; or
- 1.249.4 Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of total potential payments; or
- 1.249.5 Capitation arrangements if the difference between the minimum and maximum possible payments is more than 25 percent of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the Contract.

1.250 SUPPORT for Patients and Communities Act (SUPPORT Act)

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

1.251 System for Award Management (SAM)

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

1.252 Therapeutic Psychoeducation

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

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

1.253 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.

1.254 Transitional Age Youth (TAY)

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

1.255 Transitional Healthcare Services (THS)

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

1.256 Transport

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

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

1.256.2 Is accomplished other than via a Trusted System.

1.257 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.

1.258 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.

1.259 Urgent Care

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

1.260 Urgent Medical Condition

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

1.261 Validation

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

1.262 Washington Administrative Code (WAC)

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

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

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

1.264 Washington Apple Health Foster Care (AH-IFC)

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

1.265 Washington Healthplanfinder (HPF)

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

1.266 Washington State Children’s System of Care

“Washington State Children’s System of Care” means Washington State’s efforts to develop a systematic approach to serving children and Youth with needs for intensive,

behavioral health home, and community-based services, including recovery support services.

1.267 Washington State Institute for Public Policy (WSIPP)

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

1.268 Wraparound with Intensive Services (WISe)

“Wraparound with Intensive Services (WISe)” means a range of services that are individualized, intensive, coordinated, comprehensive, culturally competent, and provided in the home and community. The WISe Program serves children and youth under the age of 21 who are experiencing mental health symptoms that are causing severe disruptions in behavior and/or interfering with their functioning in family, school, or with peers requiring: a) the involvement of the mental health system and other child-serving systems and supports; b) intensive care collaboration; and c) ongoing intervention to stabilize the youth and family in order to prevent more restrictive or institutional placement.

1.269 Young Adult

“Young Adult” means a person from age 18 through age 20.

1.270 Youth

“Youth” means, in general terms, a person from age 13 through age 17. Specific programs may assign a different age range for Youth. Early Periodic Screening Diagnosis and Treatment (EPSDT) defines youth as an individual up to age 21.

2 GENERAL TERMS AND CONDITIONS

2.1 Amendment

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

- 2.1.1 Any amendment shall be in writing and shall be signed by a Contractor's authorized officer and an authorized representative of HCA. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.
- 2.1.2 HCA reserves the right to issue unilateral amendments that provide corrective or clarifying information.
- 2.1.3 The Contractor shall submit all feedback or questions to HCA at contracts@hca.wa.gov.
- 2.1.4 The Contractor shall submit written feedback within the expressed deadline provided to the Contractor upon receipt of any amendments. HCA is not obligated to accept Contractor feedback after the written deadline provided by HCA.
- 2.1.5 The Contractor shall return all signed amendments within the written deadline provided by HCA Contracts Office.

2.2 Assignment

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

2.3 Billing Limitations

- 2.3.1 HCA shall pay the Contractor only for services provided in accordance with this Contract.
- 2.3.2 HCA shall not pay any claims for payment for services submitted more than twelve (12) months after the calendar month in which the services were performed.
- 2.3.3 The Contractor must waive the timeliness rule for processing a claim and prior authorization requirements when HCA program integrity or MFCD activities result in recoupment of an improperly paid claim HCA paid but should have been paid by the Contractor:
 - 2.3.3.1 The Contractor shall pay for Medically Necessary Services submitted beyond the standard claims payment timeframes in these circumstances. If the Contractor is unable to systematically identify and waive the timeliness rules in this scenario, it is acceptable for the Contractor to address the waiver of the timeliness rule within its provider payment dispute processes.
 - 2.3.3.2 The servicing provider must submit a claim to the Contractor within one hundred twenty (120) calendar days from HCA's notification of improper payment. The Contractor must have in place a process to administer these claims.
 - 2.3.3.3 If the Contractor is unable to waive the timeliness rule to process an

improperly paid claim identified by HCA, HCA may at any time request a refund from the Contractor of the improperly paid claim.

2.4 Compliance with Applicable Law

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

- 2.4.1 Title XIX and Title XXI of the Social Security Act;
- 2.4.2 Title VI of the Civil Rights Act of 1964;
- 2.4.3 Title IX of the Education Amendments of 1972, regarding any education programs and activities;
- 2.4.4 The Age Discrimination Act of 1975;
- 2.4.5 The Rehabilitation Act of 1973;
- 2.4.6 The Budget Deficit Reduction Act of 2005;
- 2.4.7 The Washington Medicaid False Claims Act and Federal False Claims Act (FCA);
- 2.4.8 The Anti-Kickback Statute 42 U.S.C. § 1320a-7b;
- 2.4.9 The Health Insurance Portability and Accountability Act (HIPAA);
- 2.4.10 The American Recovery and Reinvestment Act (ARRA);
- 2.4.11 The Patient Protection and Affordable Care Act (PPACA or ACA);
- 2.4.12 The Health Care and Education Reconciliation Act;
- 2.4.13 The Public Assistance Act, Title 74 RCW;
- 2.4.14 The Mental Health Parity and Addiction Equity Act (MHPAEA) and final rule;
- 2.4.15 The 21st Century Cures Act;
- 2.4.16 Federal 1915(b) Mental Health Waiver, Medicaid State Plan or any successors;
- 2.4.17 42 C.F.R. § 438;
- 2.4.18 45 C.F.R. 96 Block Grants;
- 2.4.19 45 C.F.R. 96.126 Capacity of Treatment for Intravenous Substance Abusers who Receive Services under Block Grant funding;
- 2.4.20 Chapter 70.02 RCW and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews;
- 2.4.21 Chapter 71.05 RCW Mental Illness;
- 2.4.22 Chapter 71.24 RCW Community Mental Health Services Act;
- 2.4.23 Chapter 71.34 RCW Mental Health Services for Minors;

- 2.4.24 Chapter 74.09 RCW Medical Care;
- 2.4.25 Community Mental Health and Involuntary Treatment Programs;
- 2.4.26 Behavioral Health Services Administrative Requirements;
- 2.4.27 Outpatient Mental Health Services;
- 2.4.28 Substance Use Disorder Services;
- 2.4.29 Chapter 43.20A RCW Department of Social and Health Services;
- 2.4.30 Senate Bill 6312 (Chapter 225, Laws of 2014) State Purchasing of Mental Health and SUD Treatment Services;
- 2.4.31 All federal and state professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including, but not limited to:
 - 2.4.31.1 All applicable standards, orders, or requirements issued under Section 306 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 C.F.R. Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to HCA, DHHS, and the EPA.
 - 2.4.31.2 Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.
 - 2.4.31.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
 - 2.4.31.4 Those specified in Title 18 RCW for professional licensing.
- 2.4.32 Industrial Insurance – Title 51 RCW;
- 2.4.33 Reporting of abuse as required by RCW 26.44.030 and chapter 74.34 RCW;
- 2.4.34 Federal Drug and Alcohol Confidentiality Laws in 42 C.F.R. Part 2;
- 2.4.35 EEO Provisions;
- 2.4.36 Copeland Anti-Kickback Act;
- 2.4.37 Davis-Bacon Act;
- 2.4.38 Byrd Anti-Lobbying Amendment;
- 2.4.39 All federal and state nondiscrimination laws and regulations;
- 2.4.40 Americans with Disabilities Act of 1990, as amended: The Contractor shall make reasonable accommodation for Enrollees with disabilities, in accordance with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit Enrollees with disabilities from obtaining contracted services;
- 2.4.41 The Contractor shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State

Plan; and

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

2.5 Covenant Against Contingent Fees

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

2.6 Data Use, Security, and Confidentiality

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

2.7 Debarment Certification

The Contractor, by signature to this Contract, certifies that the Contractor is not presently debarred, suspended, proposed for Debarment, declared ineligible or voluntarily excluded in any Washington state or federal department or agency from participating in transactions (debarred). The Contractor shall immediately notify HCA if, during the term of this Contract, the Contractor becomes debarred. HCA may immediately terminate this Contract by providing Contractor written notice in accordance with Subsection 2.39 of this Contract if the Contractor becomes debarred during the term hereof.

2.8 Defense of Legal Actions

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

2.9 Disputes

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

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

2.9.1.1 The disputed issue(s).

2.9.1.2 An explanation of the positions of the parties.

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

2.9.2 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).

- 2.9.3 The Director, in his or her sole discretion, shall determine a time for the parties to present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's discretion. The Director shall provide written notice of the time, format, and location of the conference. The conference is informal in nature and is not governed in any way by the Administrative Procedure Act, chapter 34.05 RCW.
- 2.9.4 The Director shall consider all of the information provided at the conference and shall issue a written decision on the disputed issue(s) within thirty (30) calendar days after the conclusion of the conference. However, the Director retains the option of taking up to an additional sixty (60) calendar days to consider the disputed issue(s) or taking additional steps to attempt to resolve them. If the Director determines, in his or her sole discretion, that an additional period of up to sixty (60) calendar days is needed for review, he or she shall notify the Contractor, in writing, of the delay and the anticipated completion date before the initial thirty-day period expires.
- 2.9.4.1 The Director, at his or her sole discretion, may appoint a designee to represent him or her at the dispute conference. If the Director does appoint a designee to represent him or her at the dispute conference, the Director shall retain all final decision-making authority regarding the disputed issue(s). Under no circumstances shall the Director's designee have any authority to issue a final decision on the disputed issue(s).
- 2.9.5 The parties hereby agree that this dispute process shall precede any judicial or quasi-judicial proceeding and is the sole administrative remedy under this Contract.
- 2.9.6 Disputes regarding Overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Section. Disputes regarding other recoveries sought by the MFCD are governed by the authorities, laws and regulations under which the MFCD operates.

2.10 Force Majeure

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

2.11 Governing Law and Venue

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

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

2.12 Independent Contractor

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

2.13 Insolvency

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

- 2.13.1 The state of Washington and Enrollees shall not be, in any manner, liable for the debts and obligations of the Contractor (42 C.F.R. § 438.106(a) and 438.116(a) (1)).
- 2.13.2 In accordance with the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge Enrollees for Contracted services (42 C.F.R. § 438.106(b)(1)).
- 2.13.3 The Contractor shall, in accordance with RCW 48.44.055 or RCW 48.46.245, provide for the Continuity of Care for Enrollees.
- 2.13.4 The Contractor shall cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

2.14 Inspection

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

- 2.14.1 The Contractor and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring or evaluation identified in this Section. If the requesting agency asks for copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or a shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency (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)).

2.15 Insurance

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

- 2.15.1 Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. The state of Washington, HCA, its elected and appointed officials, agents, and employees shall be named as additional insured's expressly for, and limited to, Contractor's services provided under this Contract.
- 2.15.2 Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000.
- 2.15.3 Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The state of Washington and HCA shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.
- 2.15.4 Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.
- 2.15.5 Subcontractors: The Contractor shall ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for subcontractors, to HCA if requested.
- 2.15.6 Separation of Insured's: All insurance Commercial General Liability policies shall contain a "separation of insured's" provision.
- 2.15.7 Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the state of Washington, with a "Best's Reports" rating of A-, Class VII or better. Any exception must be approved by HCA. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.
- 2.15.8 Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accordance with the Notices section of the General Terms and Conditions, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.
- 2.15.9 Material Changes: The Contractor shall give HCA, in accordance with the Notices section of the General Terms and Conditions, forty-five (45) calendar days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give HCA ten (10) calendar days advance notice of cancellation.

- 2.15.10 General: By requiring insurance, the state of Washington and HCA do not represent that the coverage and limits specified shall be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the state and HCA in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.
- 2.15.11 The Contractor may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers and Evidence of Coverage provisions of this Section if self-insured. In the event the Contractor is self-insured, the Contractor must send to HCA by the third Wednesday of January in each contract year, a signed written document, which certifies that the Contractor is self-insured, carries coverage adequate to meet the requirements of this Section, shall treat HCA as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA.
- 2.15.12 Privacy Breach Response Coverage. For the term of this Contract and three (3) years following its termination Contractor shall maintain insurance to cover costs incurred in connection with a security incident, privacy Breach, or potential compromise of Data including:
- 2.15.12.1 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).
 - 2.15.12.2 Notification and call center services for individuals affected by a security incident, or privacy Breach.
 - 2.15.12.3 Breach resolution and mitigation services for individuals affected by a security incident, or privacy Breach, including fraud prevention, credit monitoring and identity theft assistance.
 - 2.15.12.4 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).

2.16 Records

- 2.16.1 The Contractor and its subcontractors shall maintain all financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.
- 2.16.2 All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of ten (10) years after final payment is made under this Contract. However, when an inspection, audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of ten (10) years following resolution of such action (42 C.F.R. § 438.3(h)).

- 2.16.3 The Contractor and the Contractor's subcontractors shall 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.
- 2.16.4 The Contractor acknowledges HCA is subject to the Public Records Act (chapter 42.56 RCW). This Contract shall 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.

2.17 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.

2.18 Contractors Located Outside of the United States

The Contractor assures HCA that it is not located outside the United States. The Contractor shall not include in its encounter data reporting to 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)).

2.19 Notification of Organizational Changes

The Contractor shall provide HCA with ninety (90) calendar days' prior written notice of any change in the Contractor's ownership or legal status. The Contractor shall provide HCA written notice of any changes to the Contractor's key personnel within seven (7) business days including, but not limited to, the Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, HCA government relations contact, HCA Account Executive, Compliance Officer, Medical Director, behavioral health Medical Director, and behavioral health Clinical Director. The Contractor shall provide HCA with an interim contact person that will be performing the key personnel member's duties and a written plan for replacing key personnel, including expected timelines. If key personnel will not be available for work under the Contract for a continuous period exceeding thirty (30) business days, or are no longer working full-time in the key position, the Contractor shall notify HCA within seven (7) business days after the date of notification of the change.

2.20 Order of Precedence

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

- 2.20.1 Federal statutes and regulations applicable to the services provided under this Contract;
- 2.20.2 State of Washington statutes and regulations applicable to the services provided under this Contract;
- 2.20.3 Applicable state of Washington statutes and regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers;
- 2.20.4 General Terms and Conditions of this Contract;

- 2.20.5 Attachment 6 – RFP 15-008 – Apple Health Integrated Managed Care – Southwest Region (incorporated by reference, available upon request);
- 2.20.6 Attachment 7 – Contractor's Response to RFP 15-008 – Apple Health Integrated managed Care – Southwest Region (incorporated by reference, available upon request);
- 2.20.7 Attachment 8 – RFP 1812 – Apple Health – Integrated Managed Care – North Central Region (incorporated by reference, available upon request);
- 2.20.8 Attachment 9– Contractor's Response to RFP 1812 – Apple Health – Integrated Managed Care –North Central Region (incorporated by reference, available upon request);
- 2.20.9 Attachment 10 – RFP 2567 – 2019/2020 Integrated Managed Care (incorporated by reference, available upon request);
- 2.20.10 Attachment 11 – Contractor's Response to RFP 2567 – 2019/2020 Integrated Managed Care (incorporated by reference, available upon request);
- 2.20.11 Any other term and condition of this Contract and exhibits; and
- 2.20.12 Any other material incorporated herein by reference.

2.21 Severability

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

2.22 Survivability

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

- 2.22.1 Cover hospitalized Enrollees until discharge consistent with this Contract.
- 2.22.2 Submit all data and reports required in this Contract.
- 2.22.3 Provide access to records required in accordance with the Inspection provisions of this Section.
- 2.22.4 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.
- 2.22.5 Repay any Overpayments within sixty (60) calendar days of discovery by the Contractor or its subcontractors of the overpayment, or within sixty (60) calendar days of notification by HCA, MFCD, or other law enforcement agency, (42 U.S.C. 1320a-7k(d)) and that:
 - 2.22.5.1 Pertain to services provided at any time during the term of this Contract; and
 - 2.22.5.2 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

2.22.5.3 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.

2.22.6 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.

2.23 Waiver

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

2.24 Contractor Certification Regarding Ethics

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

2.25 Health and Safety

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

2.26 Indemnification and Hold Harmless

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

2.26.2 If the federal government issues a written notice of disallowance or recoupment of any federal funds associated with Subsection 5.34 of this Contract, then HCA and the Contractor will cooperate with each other in attempting to obtain a resolution that reduces the financial risks to Washington. The Contractor will be held harmless for any disallowance or recoupment of MQIP funds associated

with this Contract, including any payments made after December 1, 2019.

- 2.26.3 If HCA receives a notice from the federal government that would require repayment of any federal funds associated with Subsection 5.34 of this Contract, HCA will notify the Contractor in writing within five (5) business days. Within the following five (5) business days, HCA may request the Contractor designate in writing an individual to participate in a Repayment Resolution Conference (RRC). As part of the RRC process, the Contractor will provide any reasonable assistance HCA may request, including but not limited to (i) retrieval of relevant documents in its own possession as well as in the possession of its providers or subcontractors and (ii) participation in discussions with representatives of federal officials, state officials, subcontractors, and providers. HCA shall invite representatives from the Governor's office, including the OFM, to participate in the RRC. The Governor's office will have sole authority to decide how the state's liability for the recoupment or disallowance is repaid; provided, however, that the Contractor will be held harmless from and against any obligation to recoup or repay MQIP funds associated with this Contract. The authority applies only to the state's liability and does not negate the hold harmless provision in 2.26.2.

2.27 Industrial Insurance Coverage

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

2.28 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.

2.29 Notices

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

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

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

- 2.29.2 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

- 2.29.3 Notices shall be effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage.
- 2.29.4 Either party may at any time change its address for notification purposes by mailing a notice in accordance with this Section, stating the change and setting for the new address, which shall be effective on the tenth (10th) day following the effective date of such notice unless a later date is specified.

2.30 Notice of Overpayment

- 2.30.1 A Notice of Overpayment to the Contractor will be issued if HCA determines an overpayment has been made.
- 2.30.2 The Contractor may contest a Notice of Overpayment by requesting an adjudicative proceeding. The request for an adjudicative proceeding must:
 - 2.30.2.1 Comply with all of the instructions contained in the Notice of Overpayment, in accordance with RCW 41.05A.170(1);
 - 2.30.2.2 Be received by HCA within twenty-eight (28) calendar days of service receipt of the Notice of Overpayment by the Contractor, in accordance with RCW 41.05A.170(3);
 - 2.30.2.3 Be sent to HCA by certified mail (return receipt), to the location specified in the Notice of Overpayment;
 - 2.30.2.4 Include a statement and supporting documentation as to why the Contractor thinks the Notice of Overpayment is incorrect; and
 - 2.30.2.5 Include a copy of the Notice of Overpayment.
- 2.30.3 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.
- 2.30.4 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.
- 2.30.5 Nothing in this Contract limits HCA's ability to recover Overpayments under applicable law.

2.31 Proprietary Data or Trade Secrets

- 2.31.1 Except as required by law, regulation, or court order, data identified by the Contractor, as proprietary trade secret information, including paid amount information as described in subsection 5.14.3, shall be kept strictly confidential, unless the Contractor provides prior written consent of disclosure to specific parties. Any release or disclosure of data shall include the Contractor's interpretation.
- 2.31.2 The Contractor shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. If HCA anticipates releasing data that is identified as proprietary or trade secrets, HCA will notify the Contractor upon receipt of any request under the Public Records Act (chapter 42.56 RCW) or otherwise for data or Claims Data identified by the Contractor as proprietary trade secret information and will not release any such information until five (5) business days after it has notified the Contractor of the receipt of such request. If the Contractor files legal proceedings within the aforementioned five (5) business day period in an attempt to prevent disclosure of the data, HCA agrees not to disclose the information unless it is ordered to do so by a court, the Contractor dismisses its lawsuit, or the Contractor agrees that the data may be released.
- 2.31.3 Nothing in this Section shall prevent HCA from filing its own lawsuit or joining any other lawsuit in an attempt to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will promptly notify the Contractor of the filing of any such lawsuit.
- 2.31.4 Notwithstanding other requirements in this Section, nothing in this Contract prohibits HCA from making the following types of disclosures:
 - 2.31.4.1 Disclosures required by law, including disclosures in the course of:
 - 2.31.4.1.1 Litigation, with an appropriate court order;
 - 2.31.4.1.1.1 HCA will provide the Contractor with notice and opportunity to file legal proceedings in accordance with subsection 2.31.2.
 - 2.31.4.1.2 Oversight review or audits, including reviews by the State Auditor's Office (SAO), the Office of the Inspector General (OIG), or CMS; or
 - 2.31.4.1.3 Medicaid Fraud Control Division (MFCD) review or investigation.
 - 2.31.4.2 Disclosures of information that is not directly identifiable by MCO, including disclosures:
 - 2.31.4.2.1 In response to request from the Legislature or Governor's Office; and
 - 2.31.4.2.2 Washington State Institutional Review Board (WSIRB) approved research projects.
 - 2.31.4.3 Disclosures to contractors working on behalf of HCA, to the minimum extent necessary for the performance of services. HCA will use best efforts to ensure continued confidential treatment of

Contractor's disclosed proprietary information or trade secrets.

2.31.4.4 Disclosures of aggregated information; and

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

2.32 Ownership of Material

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

2.33 Solvency

- 2.33.1 The Contractor shall have a Certificate of Registration as a Health Maintenance Organization (HMO), Health Care Service Contractor (HCSC) or Life and Disability Insurance Carrier, from the Washington State Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of chapters 48.21, 48.21A, 48.44 or 48.46 RCW, as amended.
- 2.33.2 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.
- 2.33.3 The Contractor shall deliver to HCA copies of any financial reports prepared at the request of the OIC or National Association of Insurance Commissioners (NAIC) per the HCSC required filing checklist for financial reports. The Contractor's routine quarterly and annual statements submitted to the OIC and NAIC are exempt from this requirement. The Contractor shall also deliver copies of related documents, reports and correspondence (including, but not limited to, Risk-Based Capital (RBC) calculations and Management's Discussion and Analysis), at the same time the Contractor submits them to the OIC or NAIC.
- 2.33.4 The Contractor shall notify HCA within ten (10) business days after the end of any month in which the Contractor's net worth (capital and/or surplus) reaches a level representing two or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Contract or which may otherwise materially affect the relationship of the parties under this Contract.
- 2.33.5 The Contractor shall notify HCA within 24 hours after any action by the OIC that may affect the relationship of the parties under this Contract.
- 2.33.6 The Contractor shall notify HCA if the OIC requires enhanced reporting requirements within fourteen (14) calendar days after the Contractor's notification by the OIC. The Contractor agrees that HCA may, at any time, access any financial reports submitted to the OIC in accordance with any enhanced reporting requirements and consult with OIC staff concerning information contained therein.

2.34 Conflict of Interest Safeguards

The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public contracting (42 C.F.R. § 438.3(f)(2)).

2.35 Reservation of Rights and Remedies

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

2.36 Termination by Default

2.36.1 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.

2.36.2 Termination by HCA. HCA may terminate this Contract if HCA determines:

- 2.36.2.1 The Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106(a).
- 2.36.2.2 The Contractor failed to timely submit accurate information required under 42 C.F.R. § 455, Subpart E (42 C.F.R. § 455.416(d)).
- 2.36.2.3 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)).
- 2.36.2.4 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)).
- 2.36.2.5 One of the Contractor's owners did not cooperate with any

screening methods required under 42 C.F.R. § 455, Subpart E.

- 2.36.2.6 One of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years (42 C.F.R. § 455.416(b)).
- 2.36.2.7 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)).
- 2.36.2.8 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)).
- 2.36.2.9 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)).
- 2.36.2.10 The Contractor has falsified any information provided on its application (42 C.F.R. § 455.416(g)).

2.37 Termination for Convenience

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

2.38 Termination due to Federal Impact

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

2.39 Terminations: Pre-termination Processes

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

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

- 2.39.1 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.

- 2.39.2 If the Contractor disagrees with a HCA decision to terminate this Contract and the dispute process is not successful, HCA shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 C.F.R. § 438.708. HCA shall:
- 2.39.2.1 Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;
 - 2.39.2.2 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
 - 2.39.2.3 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.

2.40 Savings

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

2.41 Termination - Information on Outstanding Claims

In the event this Contract is terminated, the Contractor shall provide HCA, within 365 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.

2.42 Administrative Simplification

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

- 2.42.1 To maximize understanding, communication, and administrative economy among all Managed Care Contractors, their Subcontractors, governmental entities, and Enrollees, Contractor shall use and follow the most recent updated versions of:
- 2.42.1.1 Current Procedural Terminology (CPT)
 - 2.42.1.2 International Classification of Diseases (ICD)
 - 2.42.1.3 Healthcare Common Procedure Coding System (HCPCS)
 - 2.42.1.4 CMS Relative Value Units (RVUs)
 - 2.42.1.5 CMS billing instructions and rules
 - 2.42.1.6 The Diagnostic and Statistical Manual of Mental Disorders
 - 2.42.1.7 NCPDP Telecommunication Standard D.O.
 - 2.42.1.8 Medi-Span® Master Drug Data Base or other nationally recognized

drug database with approval by HCA.

- 2.42.2 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.
- 2.42.3 HCA will share the non-public Medicaid NCCI edit files received from CMS with the Contractor, when available.
 - 2.42.3.1 The Contractor will not:
 - 2.42.3.1.1 Disclose, publish, or share with any party not involved in the implementation of the quarterly state Medicaid NCCI methodologies covered by this Contract, the non-public Medicaid NCCI edit files;
 - 2.42.3.1.2 Use any non-public information from the non-public Medicaid NCCI edit files for any business purposes unrelated to the implementation of the Medicaid NCCI methodologies in the state;
 - 2.42.3.1.3 Implement new, revised, or deleted non-public Medicaid NCCI edits prior to the first calendar day of the quarter;
 - 2.42.3.1.4 Allow use of new, revised, or deleted Medicaid NCCI edits by reviewers in non-Medicaid programs prior to the posting of the public Medicaid NCCI edit files on the Medicaid NCCI webpage (www.medicaid.gov);
 - 2.42.3.1.5 Release to the public any non-public Medicaid NCCI edit files, at any time; and
 - 2.42.3.1.6 Use the non-public Medicaid NCCI edit files for any non-Medicaid purpose, at any time.
 - 2.42.3.2 Contractor and their Subcontractors may disclose only non-confidential information that is also available to the general public about the Medicaid NCCI edit files on the Medicaid NCCI webpage.
 - 2.42.3.3 HCA will impose sanctions in accordance with the Sanctions section of this Contract, up to and including termination of this Contract, for violations of this section.
- 2.42.4 In lieu of the most recent versions, Contractor may request an exception. HCA's consent thereto will not be unreasonably withheld.
- 2.42.5 Drug database requirements are specific to values used as reference file in adjudication of pharmacy claims and storage of pharmacy claim data. Drug databases used for other purposes are not subject to this requirement and do not require approval.
- 2.42.6 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 HCA. Marketing materials include any items developed by the Contractor for distribution to Enrollees or potential Enrollees that are intended to provide information about the Contractor's benefit administration, including:
 - 3.1.1.1 Print media;
 - 3.1.1.2 Websites; and
 - 3.1.1.3 Electronic Media (Television/Radio/Internet/Social Media).
- 3.1.2 Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information (42 C.F.R. § 438.104(b)(2)).
- 3.1.3 Marketing materials must be distributed in all service areas the Contractor serves (42 C.F.R. § 438.104(b) (1) (ii)).
- 3.1.4 Marketing material must not contain an invitation, implied or implicit, for an Enrollee to change from one AH-IMC MCO to the Contractor, or imply that the Contractor's benefits are substantially different from any other AH-IMC MCO. 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 primary 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 shall 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 shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment (42 C.F.R. § 438.104(b) (1) (v)).
- 3.1.9 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 shall not make any assertion or statement, whether written or oral, in marketing materials that the Contractor is endorsed by CMS, the federal or state government or similar entity (42 C.F.R. § 438.104(b) (2) (ii)).

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

3.2 Information Requirements for Enrollees and Potential Enrollees

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

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

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

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

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

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

- 3.2.4 The Contractor may develop supplemental materials specific to the Contractor's programs, in addition to the Managed Care handbooks that are sent to newly enrolled and assigned Enrollees. The supplemental, plan-specific, material shall be incorporated into the Managed Care handbook templates as instructed by HCA. The supplemental, plan-specific, materials will include mandatory materials such as NCQA-required materials and the annual notices that the Contractor is required to send to Enrollees.

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

- 3.2.5 The Contractor shall include with all written materials a tagline and information on how the Enrollee can request Auxiliary Aids and Services including the

provision of information in an alternative language and format that is understandable to the Enrollee. If the Enrollee requests the tagline in large print, the Contractor shall provide it to the Enrollee in either paper form or electronically within five (5) business days.

- 3.2.6 The Contractor shall submit branding materials developed by the Contractor that specifically mentions Medicaid, AH-FIMC, or the specific benefits provided under this Contract for review and approval. No such materials shall be disseminated to Enrollees, Potential Enrollees, providers or other members of the public without HCA's approval.
- 3.2.7 The Contractor shall submit Enrollee information developed by the Contractor that specifically mentions AH-IMC or the specific benefits provided under this Contract at least thirty (30) calendar days prior to distribution for review and approval, including any Enrollee materials regarding Utilization Management activities that are developed by the Contractor or its delegates. All other Enrollee materials shall be submitted as informational. HCA may waive the thirty day requirement if, in HCA's sole judgment, it is in the best interest of HCA and its clients to do so.
- 3.2.8 The Contractor shall notify all new AH-IMC Health Home-eligible Enrollees of their eligibility for the Health Home program. The notice shall include all of the following:
 - 3.2.8.1 A description of the benefits of the program;
 - 3.2.8.2 Confirmation that program participation is voluntary and not a condition for the Enrollee's receipt of any other covered service;
 - 3.2.8.3 Information about how to file Grievances and appeals;
 - 3.2.8.4 A statement that a participant has the right to change Care Coordination providers and the procedure for doing so; and
 - 3.2.8.5 How to obtain more information about the program.
- 3.2.9 The Contractor shall notify all known pregnant Enrollees about their eligibility to participate and receive Maternity Support Services (MSS) through HCA First Steps program.
 - 3.2.9.1 The Contractor must use HCA MSS informational letter template to notify these Enrollees. HCA will provide the template to the Contractor. No later than the twentieth of each month, the Contractor shall submit to HCA a list of all Enrollees who are newly identified within the preceding month as pregnant or are within sixty (60) calendar days postpartum. The Contractor shall submit the list to HCA using HCA First Steps Maternity Support Services report template. HCA will provide the Support Services report template to the Contractor.
- 3.2.10 The Contractor shall communicate changes to state or federal law to Enrollees no more than ninety (90) calendar days after the effective date of the change and Enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of HCA, the change is significant in regard to the Enrollees' quality of or access to care, which may include changes to: enrollment rights, Grievance and hearing procedures, benefits, authorizations or coverage of Emergency Services. HCA shall notify the Contractor in writing of

any significant change (42 C.F.R. § 438.10(f)(4)).

- 3.2.11 The Contractor shall create a link on the front page of its website for providers and Enrollees that directs said providers and Enrollees to a behavioral health website. The behavioral health website shall:
 - 3.2.11.1 Contain information on how to access behavioral health services;
 - 3.2.11.2 Connect to the provider directory that displays a current list of contracted behavioral health agencies, specifying those which are contracted to serve children and youth;
 - 3.2.11.3 Inform the Enrollee about Ombuds services and how to access these services;
 - 3.2.11.4 Include information on how to contact the Contractor should the provider or Enrollee have difficulty accessing such care; and
 - 3.2.11.5 Include information about the behavioral health resource line (chapter 74.09 RCW).
- 3.2.12 The Contractor will have a written process for development, review, and approval of all marketing and Enrollee information including those provided by a third party. This process shall be provided to HCA upon request. It must include the names of the approving source for all internal and third party documents. All documents must be approved by the Contractor as meeting all contract terms, and federal, state, and local laws prior to submission to HCA.

3.3 **Equal Access for Enrollees and Potential Enrollees with Communication Barriers**

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

3.3.1 Oral Information

- 3.3.1.1 The Contractor shall ensure interpreter services are provided free of charge for Enrollees and Potential Enrollees with a primary language other than English or those who are Deaf, DeafBlind, or Hard of Hearing. This includes oral interpretation, Sign Language (SL), and the use of Auxiliary Aids and Services as defined in this Contract (42 C.F.R. § 438.10(d)(4)). Interpreter services, provided by certified interpreters, shall be provided for all interactions between such Enrollees or Potential Enrollees and the Contractor or any of its providers including, but not limited to:
 - 3.3.1.1.1 Customer service,
 - 3.3.1.1.2 All interactions with any provider for any covered service,
 - 3.3.1.1.3 Emergency Services, and
 - 3.3.1.1.4 All steps necessary to file Grievances and Appeals including requests for Independent Review of Contractor decisions (RCW 48.43.535 and chapter 284-43 WAC).
- 3.3.1.2 The Contractor is responsible for payment for interpreter services for Contractor administrative matters, including, but not limited to,

handling Enrollee Grievances and Appeals.

- 3.3.1.3 HCA is responsible for payment of interpreter services provided when the interpreter service is requested through, authorized, and provided by 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 Enrollee-specific written materials through Auxiliary Aids and Services in a manner that takes into consideration the special needs of Enrollees and Potential Enrollees (42 C.F.R. § 438.10(d)(1) and 438.10(d)(6)(iii)). For the purposes of this subsection, the Enrollee's preferred language may not be the same as their primary language. The Contractor must translate materials into the Enrollee's preferred language.

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

3.3.2.1.2 The Contractor shall include with all written material a 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 If 5 percent or 1,000, whichever is less of the Contractor's Enrollees speak a language other than English, generally available materials, including the Contractor's handbook must be translated into that language.

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

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

- 3.3.2.1.4.2 Providing the material in an audio format in the Enrollee's or Potential Enrollee's preferred language.
 - 3.3.2.1.4.3 Having an interpreter read the material to the Enrollee or Potential Enrollee in the Enrollee's preferred language.
 - 3.3.2.1.4.4 Making the materials available via Auxiliary Aids and Services, or a format acceptable to the Enrollee or Potential Enrollee. The Contractor shall document the Enrollee's or Potential Enrollee's acceptance of the material in an alternative medium or format (42 C.F.R. § 438.10(d)(1)(ii)).
 - 3.3.2.1.4.5 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 shall ensure that all written information provided to Enrollees or Potential Enrollees is: accurate, not misleading, comprehensible to its intended audience, designed to provide the greatest degree of understanding, written at the sixth (6th) grade reading level, provided in a font size no smaller than 12 point, and fulfills other requirements of the Contract as may be applicable to the materials (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 (6th) grade reading level or the Enrollees' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth (6th) grade reading level must be in writing.
- 3.3.2.4 Educational materials about topics such as preventative services or other information used by the Contractor for health promotion efforts must be submitted to HCA within thirty (30) calendar days of use, but do not require HCA approval as long as they do not specifically mention AH-IMC 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 Enrollee-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved

materials in final form.

3.3.2.7 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 such as flu clinics;
- 3.4.1.4 Initial health screening (IHS);
- 3.4.1.5 Surveys;
- 3.4.1.6 Appointment reminders/immunizations/well child appointments; and
- 3.4.1.7 Notification of new programs or assistance offered.
- 3.4.2 Under no circumstances will the Contractor use automated calls for Care Coordination activities, behavioral health-related calls or prescription verifications.
- 3.4.3 The Contractor shall ensure that if this service is provided by a third party, that either a subcontract or a Business Associate Agreement is in place and is submitted to HCA for review.

3.5 Medication Information

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

- 3.5.1 If provided electronically, the information must be provided on the Contractor's website in a place that is prominent and readily accessible, in a machine readable file and format that can be retained and printed.
- 3.5.2 Information must be consistent with content and language requirements.
- 3.5.3 The Contractor shall notify Enrollees that the information is available in paper form without charge, upon request. If an Enrollee requests the information in paper form, the Contractor must provide the information to the Enrollee within five (5) business days.

3.6 Conscience Clause

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

4 ENROLLMENT

4.1 Regional Service Areas (RSA)

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

- 4.1.1 The Contractor's RSAs are identified in Exhibit I, AH-IMC Regional Service Area.

4.2 RSA Changes

- 4.2.1 The Contractor must offer services to all clients within the boundaries of the RSA covered by this Contract.
- 4.2.2 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's RSA, HCA shall alter the RSA zip code numbers or the boundaries of the RSA with input from the affected contractors, and input from the ACH.
- 4.2.3 HCA shall determine, with input from the local ACH, which zip codes fall within each RSA.
- 4.2.4 HCA will use the Enrollee's residential zip code to determine whether an Enrollee resides within a RSA.

4.3 Eligible Client Groups

HCA shall determine Medicaid eligibility for enrollment under this Contract. HCA will provide the Contractor a list of Recipient Aid Categories (RACs) that are eligible to enroll in Apple Health – Integrated Managed Care (AH-IMC) to receive either full scope benefits or Behavioral Health Services Only under BHSO enrollment type. Enrollees in the following eligibility groups shown on Exhibit J, RAC Codes, at the time of enrollment are eligible for enrollment under this Contract. Enrollment in this program is voluntary, except where CMS has approved federal authority allowing the state to mandate enrollment.

- 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 (Apple Health Medicaid Expansion (AHAC)).
- 4.3.3 Children, from birth through 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 who are not eligible for Medicare.
- 4.3.7 Breast and Cervical Cancer Treatment, Categorically Needy Program.
- 4.3.8 Categorically Needy Program, Long-Term Care.

4.4 Behavioral Health Services Only (BHSO)

- 4.4.1 RACs enrolled in BHSO are listed in Exhibit J.

4.5 Client Notification

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

4.6 Exemption from Enrollment

An Enrollee may request exemption from enrollment from AH-FIMC (full scope benefits) for cause at any time. Each request for exemption will be reviewed by HCA pursuant to chapter 182-538 WAC. Exempted Enrollees will be enrolled into the BHSO plan for BH services. 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.

- 4.6.1 If the Contractor receives an exemption request from an Enrollee or Potential Enrollee, the Contractor shall forward the request to the Medical Assistance Customer Service Center (MACSC) within two (2) business days of receipt of the request.

4.7 Enrollment Period

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

4.8 Enrollment Process

- 4.8.1 Eligible clients may choose an AH-IMC plan through the Medicaid plan selection process. All eligible family members will be enrolled to the same AH-IMC Managed Care contractor.
- 4.8.2 The HCA will assign the clients who do not make a AH-IMC plan selection. All eligible family members will be assigned to the same AH-IMC Managed Care contractor in accordance with the Assignment of Enrollees provisions of this Contract.
- 4.8.3 The HCA will assign clients eligible for the BHSO.
- 4.8.4 An Enrollee may change his or her MCO (FIMC/BHSO), with or without cause, at any time. The effective date of the change in MCO shall be consistent with HCA's established enrollment timelines.
- 4.8.5 The Enrollee, the Enrollee's representative or responsible parent or guardian must notify HCA if they want to choose another MCO.
- 4.8.6 The HCA will attempt to enroll all family members with the same AH – AH-IMC Managed Care plan unless the following occurs:
 - 4.8.6.1 A family member is placed into the Patient Review and Coordination (PRC) program by the Contractor or HCA. The PRC placed family member shall follow the enrollment requirements described in the PRC provisions of this Contract. The remaining family members shall be enrolled with a single AH-IMC Managed Care plan of their choice.
 - 4.8.6.2 The HCA grants an exception because the family members have conflicting medical needs that cannot be met by a single AH-IMC

Managed Care contractor.

4.9 Effective Date of Enrollment

- 4.9.1 Except for a newborn whose mother is enrolled in an AH-IMC MCO, HCA shall enroll all newly eligible Medicaid clients subject to this Contract into AH-IMC effective the first day of the month, if both the date of initial Medicaid eligibility and the managed care enrollment take place in the current month. A newborn whose mother already is enrolled in an Apple Health MCO will be enrolled with that MCO as of the date of birth.
- 4.9.2 The Contractor is responsible for payment, medical necessity determinations and service authorizations for all services provided on and after the effective date of enrollment.
- 4.9.3 No retroactive coverage is provided under this Contract, except as described in this Section or by mutual, written agreement by the parties.

4.10 Newborns Effective Date of Enrollment

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

- 4.10.1 Retrospectively for the month(s) in which the first twenty-one (21) days of life occur, effective when the newborn is reported to HCA.
- 4.10.2 If the newborn does not receive a separate client identifier from HCA, the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) days of life occur.
- 4.10.3 If the mother's enrollment is ended before the newborn receives a separate client identifier from HCA, the newborn's enrollment shall end the last day of the month in which the twenty-first (21st) day of life occurs or when the mother's enrollment ends, whichever is sooner, except as provided in the provisions of Subsection 16.7, Enrollee in Facility at Termination of Enrollment of this Contract.
- 4.10.4 A newborn whose mother is enrolled with the Contractor when the baby is born and the newborn is placed in foster care during the month of birth, the newborn is enrolled with the Contractor for the month of birth. The newborn will be enrolled with the Apple Health Foster Care (AHFC) program effective the first of the month that follows placement. Subject to the terms in Subsection 16.4, Enrollee in Facility at Enrollment: Medical Conditions, the MCO with which a newborn was enrolled at birth is responsible for hospital costs until the newborn is discharged from the birth hospitalization.
- 4.10.5 A newborn, whose mother is not covered by Apple Health or any comparable coverage, and the newborn is determined eligible in the month of birth for Apple Health Medicaid prior to discharge from their initial birth hospitalization shall be enrolled according to HCA enrollment rules. The Contractor will be responsible for hospital costs for the newborn starting from the month of enrollment.

4.11 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.

- 4.11.1 Data files will be sent to the Contractor at intervals specified within HCA 834

Benefit Enrollment and Maintenance Companion Guide, published by HCA and incorporated by reference into this Contract.

- 4.11.2 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).
- 4.11.3 The data file will be transferred per specifications defined within HCA Companion Guides.
- 4.11.4 The Contractor shall have ten (10) calendar days from the receipt of the data files to notify HCA in writing of the refusal of an application for enrollment or any discrepancy regarding HCA's proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by HCA. The effective date of enrollment specified by HCA shall be considered accepted by the Contractor and shall be binding if the notice is not timely or HCA does not agree with the reasons stated in the notice. Subject to HCA approval, the Contractor may refuse to accept an Enrollee for the following reasons:
 - 4.11.4.1 HCA has enrolled the Enrollee with the Contractor in a RSA where the Contractor is not contracted.
 - 4.11.4.2 Enrollee is not eligible for enrollment under the terms of this Contract.

4.12 Termination of Enrollment

4.12.1 Voluntary Termination of Enrollment

- 4.12.1.1 Except where CMS has approved federal authority allowing the state to mandate enrollment, enrollment in this program is voluntary. Enrollees may request termination of enrollment by submitting a written request to terminate enrollment to HCA or by calling HCA toll-free customer service number (42 C.F.R. § 438.56(d)(1)(i)). If the Contractor receives a termination request from an Enrollee, the Contractor shall direct the Enrollee to contact HCA.
- 4.12.1.2 Termination requests that are approved will be consistent with the provisions outlined in Subsection 4.6 Exemption from Enrollment.
- 4.12.1.3 For the purposes of this Section, the following are cause for disenrollment (42 C.F.R. § 438.56(d)(2)):
 - 4.12.1.3.1 The Enrollee moves out of the Contractor's RSA;
 - 4.12.1.3.2 The Contractor does not, because of moral or religious objections, deliver the service the Enrollee seeks;
 - 4.12.1.3.3 The Enrollee needs related services (for example, birth and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Enrollee's Primary Care Provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; and

- 4.12.1.3.4 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.
 - 4.12.1.4 Enrollees denied disenrollment for cause or a plan change may request an appeal of the decision through a state hearing.
 - 4.12.1.5 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.
- 4.12.2 Involuntary Termination of Enrollment Initiated by HCA for Ineligibility.
 - 4.12.2.1 The enrollment of any Enrollee under this Contract shall be terminated if the Enrollee becomes ineligible for enrollment due to a change in eligibility status.
- 4.12.3 When an Enrollee's enrollment is terminated for ineligibility, the termination shall be effective:
 - 4.12.3.1 The first day of the month following the month in which the enrollment termination is processed by HCA if it is processed on or before HCA cut-off date for enrollment or the Contractor is informed by HCA of the enrollment termination prior to the first day of the month following the month in which it is processed by HCA.
 - 4.12.3.2 Effective the first day of the second month following the month in which the enrollment termination is processed if it is processed after HCA cut-off date for enrollment and the Contractor is not informed by HCA of the enrollment termination prior to the first day of the month following the month in which it is processed by HCA.
- 4.12.4 Newborns placed in foster care before discharge from their initial birth hospitalization shall be terminated from enrollment in Apple Health Integrated Managed Care (AH-IMC) and enrolled in the Apple Health Integrated Foster Care (AH-IFC) effective the first of the month that follows placement in foster care. Subject to the terms in Subsection 16.4, Enrollee in Facility at Enrollment: Medical Conditions, the Contractor is responsible for hospital costs until the newborn is discharged from the birth hospitalization.
- 4.12.5 The foster care newborn will be automatically enrolled in the Integrated Foster Care MCO.
- 4.12.6 Involuntary Termination Initiated by the Contractor from AH-IMC
 - 4.12.6.1 To request involuntary termination of enrollment of an Enrollee, the Contractor shall send written notice to HCA at hcaintegratedmcquestions@hca.wa.gov.
 - 4.12.6.1.1 HCA shall review each involuntary termination request on a case-by-case basis. The Contractor shall be notified in writing of an approval or disapproval of the involuntary termination request within thirty (30) business days of HCA's receipt of

such notice and the documentation required to substantiate the request. HCA shall approve the request for involuntary termination of the Enrollee when the Contractor has substantiated in writing any of the following (42 C.F.R. § 438.56(b)(1)):

- 4.12.6.1.1.1 The Enrollee purposely puts the safety or property of the Contractor, or the Contractor's staff, providers, patients, or visitors at risk, and the Contractor's attempts to address this behavior with reasonable accommodations of any disability of the Enrollee have not been successful; and continued enrollment would seriously impair the Contractor's ability to furnish services to the Enrollee or any other Enrollees;
- 4.12.6.1.1.2 The Enrollee engages in intentional misconduct, including refusing without good cause to provide information to the Contractor about third party insurance coverage; or
- 4.12.6.1.1.3 The Enrollee received written notice from the Contractor of its intent to request the Enrollee's termination of enrollment, unless the requirement for notification has been waived by HCA because the Enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the Enrollee shall include the Enrollee's right to use the Contractor's Grievance Process to review the request to end the Enrollee's enrollment.
- 4.12.6.2 The Contractor shall continue to provide services to the Enrollee until HCA has notified the Contractor in writing that enrollment is terminated.
- 4.12.6.3 HCA will not terminate enrollment and the Contractor may not request disenrollment of an Enrollee solely due to a request based on an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or behavioral health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b) (2)).
- 4.12.6.4 The Contractor shall have in place, and provide upon HCA's request, written methods by which it assures it does not request

disenrollment for reasons other than those permitted under this Contract (42.C.F.R. § 438.56(b)(3)).

- 4.12.7 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.
- 4.12.8 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:
 - 4.12.8.1 When the Enrollee is hospitalized or in another inpatient Facility covered by this Contract at termination of enrollment and continued payment is required in accordance with the provisions of this Contract.
 - 4.12.8.2 For the provision of information and assistance to transition the Enrollee's care with another provider.
 - 4.12.8.3 As necessary to satisfy the results of an appeal or hearing.
- 4.12.9 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 4.12.6 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 shall pay a monthly premium for each Medicaid Enrollee in full consideration of the work to be performed by the Contractor under this Contract. HCA will only pay monthly premium payments for Medicaid Enrollees in the eligible client groups detailed in Subsection 4.3 of this Contract. HCA shall pay the Contractor, on or before the fifteenth (15th) calendar day of the month based on HCA list of Enrollees whose enrollment is ongoing or effective on the first day of said calendar month. 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 capitation rates are identified and developed, and payment is made in accordance with 42 C.F.R. § 438.3(c). Supporting rate documentation demonstrates that the rate development process meets requirements of 42 C.F.R. Part 438 and generally accepted actuarial principles and practices. Rates are based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at 42 C.F.R. § 457.10.

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

$$\text{Premium Payment} = \text{Capitation Rate (at the region, program, age/gender cell level)} \times \text{Risk Adjustment Factor} \times \text{Withhold Factor}$$

The BHSO Enrollees will be divided into the following categories for calculation of the monthly premium payment:

- a. Non-Disabled Child;
- b. Disabled Child;
- c. Non-Disabled Adult;
- d. Disabled Adult; and
- e. Newly Eligible.

There are no additional risk or withhold factors used to derive the premium payment amount for BHSO rate category.

Additional premium payments include Delivery Case Payment Rates, and Wraparound with Intensive Services (WiSe), as described in Subsections 5.7 and 5.9 of this Contract.

- 5.2.1 The premium payment formula 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), Apple Health 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 initially be the same for all contractors, but may vary based on ACA related taxes and/or fees.

- 5.2.2 The Age/Sex Adjustment factors are established by HCA and will vary between the AH Family, SCHIP, AHBD, COPES, DDA, and AHAC populations. The age/sex factors will be the same for all contractors.
- 5.2.3 The Risk Adjustment Factors will be established by HCA for the AH Family Adult, AH Family Child, SCHIP, AHBD, COPES, DDA, and AHAC populations to reflect differences in the relative health status of the populations enrolled with the Contractors. The Risk Adjustment Factors are calculated by geographical region and by Contractor.
- 5.2.4 The Withhold Factor is intended to hold back a percentage amount, as identified in Exhibit D, Value-Based Purchasing, of the capitation payments excluding any administrative, WSHIP, Safety Net, PAP, IMD, or FQHC/RHC enhancement funding. A calculated portion of the amount withheld from the monthly premium payment will be released upon demonstrated improvement towards the quality measure benchmarks and physician incentive agreements defined in Exhibit D, Value-Based Purchasing.
- 5.2.5 HCA shall automatically generate newborn premiums upon enrollment of the newborn. For newborns whose premiums HCA does not automatically generate, the Contractor shall submit a premium payment request to HCA within 365 calendar days of the date of birth. HCA shall pay within sixty (60) calendar days of receipt of the premium payment request.
- 5.2.6 HCA shall make a full monthly payment to the Contractor for the month in which an Enrollee's enrollment is terminated except as otherwise provided in this Contract.
- 5.2.7 The Contractor shall be responsible for contracted services provided to the Enrollee in any month for which HCA paid the Contractor for the Enrollee's care under the terms of this Contract.
- 5.3 **Annual Fee on Health Insurance Providers**
 - 5.3.1 The Contractor is subject to a fee (the "Annual Fee") imposed by the federal government under Section 9010 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (124 Stat. 1029 (2010)) (collectively, "PPACA"), unless specifically exempt under federal law.
 - 5.3.2 If the Contractor is responsible for payment of a percentage of the Annual Fee for all health insurance providers, the Contractor's obligation is determined by the ratio of the Contractor's net written premiums for the preceding year compared to the total net written premiums of all covered entities subject to the Annual Fee for the same year.
 - 5.3.3 The amount of the Annual Fee attributable to the Contractor and attributable specifically to the Contractor's premiums under this Contract ("Contractor's Allocated Fee") could affect the actuarial soundness of the premiums received by the Contractor from HCA for the contract year during which the Annual Fee is assessed.
 - 5.3.4 A dollar amount reflecting the Contractor's Allocated Fee, which shall also include an adjustment for the impact of non-deductibility of the Annual Fee for federal and state tax purposes, including income and excise taxes

("Contractor's Adjusted Fee"), shall be payable to the Contractor under this Contract, unless the Contractor is exempt from the Annual Fee under federal law.

- 5.3.5 HCA shall consult with the Contractor and determine an estimated amount of the Contractor's Adjusted Fee based on the pro rata share of the preliminary notice of the fee amount, as transmitted by the United States Internal Revenue Service to the Contractor, attributable to the Contractor's net written premiums under this Contract.
- 5.3.6 Capitation payments for the period to which the tax applies will be retroactively adjusted to account for this fee. The net aggregate change in capitation payments for the period based on the retroactive rate change will be paid to the Contractor.
- 5.3.7 HCA shall make a good-faith effort to make the estimated payment to the Contractor thirty (30) calendar days before the deadline for payment by the Contractor.
- 5.3.8 The adjustment shall be reconciled, no later than ninety (90) calendar days following the receipt of the final notice of the fee from the United States Internal Revenue Service, through a retroactive adjustment to the capitation rates for the applicable period and an additional payment to the Contractor, or a refund from the Contractor, as applicable, once the complete data is available to calculate the Contractor's Adjusted Fee.
- 5.3.9 The Contractor agrees not to pursue any legal action whatsoever against HCA or its officers, employees, or agents with respect to the amount of the Contractor's Allocated Fee or Contractor's Adjusted Fee.

5.4 Medical Loss Ratio (MLR) Report

- 5.4.1 In accordance with 42 C.F.R. § 438.8, MCOs must report a Medical Loss Ratio (MLR) calculation to HCA on an annual basis.
 - 5.4.1.1 Using the instructions provided in Exhibit F, Instructions for MLR Reporting, and in accordance with 42 C.F.R. § 438.8, the Contractor shall complete the MLR reporting template available in MC-Track for the MLR reporting year beginning January 1, 2019, and submit to HCA no later than May 31, 2020.

5.5 Gain Share Program

- 5.5.1 MCOs must report MLR experience calculated in accordance with 42 C.F.R. § 438.8. Any settlements which result from the gain share program calculation will be limited such that the Contractor's minimum MLR will not be less than 85 percent when the settlement amount is included in the MLR calculation.
- 5.5.2 HCA will perform gain share calculations on an annual basis for the Integrated Managed Care (AH-IMC) AH Family Adult, AH Family Child, SCHIP, AHBD, COPES, DDA and AHAC populations. The Behavioral Health Services Only (BHSO) is not eligible for gain sharing. Separate calculations of Gain Sharing are done for each population due to differences in assumed administrative loads included in the rates for each program. Upon completion of the separate calculations, the results for the seven populations will be aggregated to determine any net Gain Share payment. Gain Sharing is calculated separately for each Contractor.

- 5.5.3 The following methods will be used to calculate the Gain Share components:
- 5.5.3.1 Total Revenue is the sum of all Pre-Tax Capitation Rates including the results of the HIRP settlement in Subsection 5.8 below and Delivery Case Rate Payments. Total Revenue also assumes full recovery by the Contractor of Value-Based Purchasing withheld funds, regardless of whether those funds were actually recovered under the capitation withhold arrangement described in Exhibit D. Pre-tax capitation rates means that the AH-PDL payments, Health Insurer Fee and Premium Tax related revenue will be excluded from this (Gain Share) computation.
 - 5.5.3.2 Total Net Revenue is equal to Total Revenue, net of any Safety Net, PAP, and WSHIP components of the capitation revenue.
 - 5.5.3.3 Revenue for Health Care Expenses is defined as the Total Net Revenue less an assumed administrative load. [(Revenue-supplemental payments) x (1- administrative load)] Actual administrative expenses will not be included in the computation. The administrative load varies by population and rate period. The assumed administrative load is shown on Exhibit A.
 - 5.5.3.4 Net Health Care Expenses will be based on the actual medical service expenses incurred during the contract year less any reimbursements from third-party reimbursements (including but not limited to pharmacy rebates, overpayment recoveries from providers, net reinsurance costs or third-party liability offsets) and less supplemental payments plus direct Medical Management costs as defined by NAIC and GAAP guidelines and excluding any overhead allocations. Upon request by HCA, the Contractor will report its health care expenses for the year with any adjustments and run out claims as specified in the request from HCA. The template for providing the data and due date for the report will be included in the request from HCA.
 - 5.5.3.5 Contractor's Gain/Loss will be calculated for each population using the following formula: **Revenue for Health Care Expenses - Net Health Care Expenses** (based on the actual incurred expenses for health care) = **Net Gain/Loss** (for the health care services provided by population).
 - 5.5.3.6 The net gain/loss divided by the Total Net Revenue will provide a percentage of the gain/loss, which will be compared to the gain sharing thresholds established by HCA.
- 5.5.4 Under the Gain Share Program, HCA will share in a significant excess of the Total Net Revenue for Health Care Expenses over the Net Health Care Expenses experienced by the Contractor as defined in subsection 5.5.5 of this Contract. Six (6) months following the end of the calendar year, using the financial reports provided by the Contractor, a simple profit and loss statement will be developed for the health services portion for each of the seven populations.
- 5.5.5 After aggregating the results for all seven populations, if the Contractor experiences gain exceeding 3 percent, HCA will share equally in the gain

between 3 percent and 5 percent. HCA will recover all gains exceeding 5 percent. The Contractor will only be required to reimburse HCA if it experiences an actual gain above 3 percent.

5.6 Recoupments

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

5.6.1.1 With Duplicate Coverage as defined in this Contract.

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

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

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

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

5.6.1.6 Who is residing in an Institute for Mental Disease (IMD) for more than fifteen (15) calendar days within a single calendar month, and whose primary admission is not SUD.

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

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

5.6.2.1 Shall void the invalid encounters;

5.6.2.2 May recoup payments made to providers.

5.6.2.2.1 If the Contractor recoups said payments:

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

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

5.6.2.2.1.3 The Contractor's providers may submit appropriate claims for payment to HCA through its FFS program, with the Contractor's

notice of recoupment, if the Enrollee was eligible for covered services.

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

5.7 **Delivery Case Rate Payment**

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

HCA shall not pay the Delivery Case Rate payment for Enrollees who have comparable Third Party Insurance coverage.

5.8 **High-Cost Infant Risk Pool (HIRP)**

High-cost infant hospital claims for AH Family Child Enrollees will be included in a High-Cost Infant Risk Pool (HIRP) effective January 1, 2020.

5.8.1 **HRIP Funding Development.**

- 5.8.1.1 Base experience data used in the development of the monthly managed care capitation rates for the AH-IMC program will include HIRP cases. HIRP experience will remain in the monthly capitation rate benefit cost and paid to Contractor.
- 5.8.1.2 Total funding included in HIRP will be based on a per-member per-month (PMPM) amount, developed as a subset of the monthly capitation rates for AH Family Child infants under age 1, multiplied by infant member months within these rate cells. The HIRP will be developed and distributed on a statewide basis, however the PMPM will vary by region based on historical experience.
- 5.8.1.3 Using the identification criteria outlined below, a PMPM amount for qualifying high-cost infant cases will be developed as part of the annual capitation rate development analysis. For the CY2020 HIRP, the PMPM amount will be based on CY2018 experience data with adjustments applied for projection to CY2020. No adjustment will be made to reflect provider reimbursement assumptions that vary from historical MCO experience.

5.8.2 **HIRP Experience Identification. Qualifying infant hospital costs will be identified based on the following criteria.**

- 5.8.2.1 Infants must be enrolled in the Integrated Managed Care Medicaid program in the AH Family Child eligibility category effective the date of birth or in the month within which the hospital admission occurred in order for hospital claims to be considered in the HIRP distribution. Infants who incur hospital claims but do not become enrolled in AH Family Child Integrated Managed Care under the

terms of this Contract will not qualify for inclusion in HIRP, even if their claims are covered by Medicaid.

5.8.2.2 Infant hospital claims must be tied to an enrolled infant Client ID meeting the covered population criteria and must be accepted as a complete encounter into HCA's ProviderOne, meeting the treatment identification rules below. Professional or ancillary claims, defined as any service billed separately from the inpatient stay, will be excluded from the HIRP or settlement calculation.

5.8.2.3 Qualifying encounters, accepted into ProviderOne, must be assigned one of the following All Patients Refined Diagnosis Related Groups (APR-DRG) codes: 583, 588, 589, 591, 593, 609, or 630 at any severity of illness (SOI); and, when they have a level 4 SOI, 602, 607, 611, 631, or 633.

5.8.3 HIRP Settlement.

5.8.3.1 Distribution of the HIRP funding will be calculated concurrent with the annual Gain Share calculation, in the final quarter of the calendar year following the Contract year, with encounter data submitted and accepted into ProviderOne by September 30 of the calculation year.

5.8.3.2 The funding within the HIRP will be distributed to each AH-IMC contracted MCO based upon a percentage of the pool attributed to each MCO that will be determined by repricing all eligible encounters to HCA's FFS reimbursement rates. An assumption for Incurred But Not Paid (IBNP) will be allowed.

5.8.3.3 Using the repriced claims data, the percentage of the HIRP attributed to each MCO will be the total repriced claim cost for each MCO as a percentage of the total repriced claims across all MCOs during the year. These percentages will be applied to the total HIRP amount, as described in the HIRP Development Section, above. The initial distribution amount will not exceed the total amount of an MCO's actual payments for qualifying claims during the Contract year.

5.8.3.4 To the extent that excess funds remain in the HIRP after the initial distribution, the remaining funds will be distributed based on repriced hospital inpatient expenses for infants under age 1 for all other (non-HIRP) accepted inpatient hospital encounters, excluding behavioral health and nursing facility claims.

5.9 WISE payment

5.9.1 A separate case rate payment will be made monthly for individuals in the WISE program as defined in this Contract and further described in Section 17.1.16 of this Contract.

5.10 Targeted Service Enhancements

The per member per month premium amounts established by HCA will include additional funding for targeted services for the Hospital Safety Net (Safety Net). The Provider Access Payment (PAP) is a directed payment.

- 5.10.1 Provider Access Payment (PAP) Program – State Directed Payment methodology
 - 5.10.1.1 The PAP program was developed to provide additional funding to critical professional providers. HCA will base the proposed minimum fee schedule payments on the Average Commercial Rate (ACR), with appropriate trending factors.
 - 5.10.1.2 On a quarterly basis, HCA will do a retrospective review of the providers accepted professional encounter data to compare managed care payments versus the ACR at the service line level. HCA will aggregate, by provider, the total difference between the managed care payment and the ACR. HCA will pay the Contractor the total amount of the total difference for the PAP eligible providers.
 - 5.10.1.2.1 On a quarterly basis, the Contractor shall pay the participating providers, the specific directed payment amounts as provided by HCA based on the providers individual utilization.
 - 5.10.1.3 On a yearly basis, PAP payments for the calendar year will be reconciled with mature encounter data to ensure participating providers PAP payments do not exceed the programs allowable amounts. HCA will calculate and provide to the Contractor, the specific directed payment amounts to be provided to the PAP participating providers.
 - 5.10.1.3.1 On a yearly basis, the Contractor will pay the participating providers, the yearly reconciliation-specific directed payment amounts per provider as provided by HCA.
- 5.10.2 PAP program – ongoing adjustments pre-directed payment methodology.
 - 5.10.2.1 Ongoing adjustments to the PAP per member per month premium paid amounts from periods prior to PAP becoming a state directed payment will continue as adjustments to those premium transactions for periods as they occur.
 - 5.10.2.2 On a monthly basis, HCA will calculate and provide to the Contractor, the specific PAP amounts, for each managed care plan, to be passed on to the PAP participating providers.
 - 5.10.2.3 HCA's calculation of the distribution percentages by participating provider ending December 31, 2019, will be extended until the adjustments of prior periods cease. The percentages and clinics are listed below:
 - 5.10.2.3.1 0.2836 – Children's University Medical Group (CUMG)
 - 5.10.2.3.2 0.0098 – Harborview Medical Center (HMC)
 - 5.10.2.3.3 0.0015 – University of Washington Medical Center (UWMC)
 - 5.10.2.3.4 0.5106 – University of Washington Physicians

(UWP)

5.10.2.3.5 0.1359 – Valley Medical Center (VMC)

5.10.2.3.6 0.0549 – Northwest Hospital (NWH)

5.10.2.3.7 0.0037 – University of Washington School of Dentistry (SOD)

5.10.2.4 On no less than a quarterly basis, the Contractor shall pay the monthly reported amounts provided by HCA, subsection 5.10.2.2. The Contractor shall distribute the reported amounts to the participating providers in accordance with the established percentages in subsection 5.10.2.3.

5.10.3 Hospital Safety Net (Safety Net)

5.10.3.1 The Safety Net is an assessment on certain Washington hospitals, which will be used to augment funding from all other sources and thereby support additional payment to hospitals for Medicaid services specified in chapter 74.60 RCW.

5.10.3.2 Managed care capitation payments for each fiscal year shall be adjusted in a manner consistent with federal contracting requirements to the Contractor by an amount at least equal to the amount available from the fund after deducting disbursements authorized by RCW 74.60.020(4)(c) through (f) and payments required by RCW 74.60.080 through 74.60.120. These Safety Net payments are a per-member-per-month add on to the monthly capitation payment paid by HCA.

5.10.3.3 If the federal government determines that total payments to the Contractor exceeds what is permitted under applicable Medicaid laws and regulations, payments must be reduced to levels that meet such requirements.

5.10.3.3.1 In the event that the Contractor is legally obligated to repay amounts distributed to hospitals to the state or federal government, the Contractor may recoup the amount it is obligated to repay under the Medicaid program from individual hospitals by not more than the amount of overpayment each hospital received from the Contractor.

5.10.3.4 Payments to the MCOs shall be determined by HCA based on each organization's enrollment relative to the anticipated total enrollment in each program for the fiscal year in question, the anticipated utilization of hospital services by an organizations Medicaid enrollees, and such other factors as are reasonable and appropriate. These payments are a per-member-per-month add on to the monthly capitation payment paid by HCA.

5.10.3.5 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.

5.10.3.5.1 Safety Net payments, under RCW 74.60.130, do not

reduce the amounts that otherwise would be paid to the Contractor, provided that such payments are consistent with actuarial soundness certification and enrollment.

- 5.10.3.6 On a monthly basis, for each MCO, HCA will calculate, and communicate, the Safety Net amounts to be paid, aggregated by participating provider.
- 5.10.3.7 Before making payments, HCA requires Medicaid MCOs to comply with the following requirements:
 - 5.10.3.7.1 All payments to MCOs must be expended for hospital services provided by Washington hospitals, which includes psychiatric and rehabilitation hospitals, in a manner consistent with the purposes and provisions of chapter 74.60 RCW, and must be equal to all increased capitation payments under chapter 74.60.130 RCW received by the MCO, consistent with actuarial certification and enrollment, less an allowance for any estimated premium taxes the organization is required to pay under Title 48 RCW associated with the payments under RCW 74.60.
 - 5.10.3.7.2 MCOs shall expend the increased capitation payments in a manner consistent with the purposes of chapter 74.60 RCW, with the expenditures by the MCOs to be made before the end of the quarter in which the funds are received from HCA.
- 5.10.3.8 No hospital or MCO may use the payments under RCW 74.60.130 to gain advantage in negotiations.
- 5.10.3.9 No hospital has a claim or cause of action against a managed care organization for monetary compensation based on the amount of payments under RCW 74.60.130(5).
- 5.10.3.10 If funds cannot be used to pay for services in accordance with chapter 74.60 RCW, the MCOs must return the funds to HCA which shall return them to the Safety Net assessment fund.

5.11 Excluded Drugs

- 5.11.1 The prescription drugs included in the table in subsection 17.4.5.16.5 are excluded from the premium payments described in subsection 5.2.1 of this Contract for the AH Family Adult, AH Family Child, Apple Health State Children's Health Insurance Program (SCHIP), Apple Health Blind Disabled (AHBD), Apple Health Community Options Program Entry System (COPES), Developmental Disability Administration (DDA) and Apple Health Adult Coverage (AHAC) populations when not administered in an inpatient setting.

5.12 Apple Health Preferred Drug List Payment

- 5.12.1 The cost of all outpatient pharmacy products included on the National Council for Prescription Drug Programs (NCPDP) Batch submission form, including prescription drugs on the AH-PDL described in subsection 17.3.3.1.1 of this

Contract, have been excluded from the premium payments described in subsection 5.2.1 of this Contract for the AH Family Adult, AH Family Child, Apple Health State Children's Health Insurance Program (SCHIP), Apple Health Blind Disabled (AHBD), Apple Health Community Options Program Entry System (COPES), Developmental Disability Administration (DDA) and Apple Health Adult Coverage (AHAC) populations.

- 5.12.2 The Contractor shall continue to administer the outpatient prescription drug program and submit paid encounters for pharmacy products in the National Council for Prescription Drug Programs (NCPDP) Batch format as required in Subsection 5.13.
- 5.12.3 HCA shall reimburse the Contractor for the expenditures for outpatient prescription drugs.
 - 5.12.3.1 The Contractor shall be reimbursed for qualifying accepted National Council for Prescription Drug Programs (NCPDP) pharmacy encounters including an administrative fee of \$1.50 by generating a Service Based Enhancement (SBE) payment beginning July 1, 2019. During the first full week of each month from February 2018 through July 2018, HCA will extract the encounter data submitted by the Contractor during the prior month with dates of service on or after January 1, 2018, for paid claims for drugs on the AH-PDL. Starting in August 2018, the data extract will include all outpatient pharmacy products included on the National Council for Prescription Drug Programs (NCPDP) Batch submission form with dates of service on or after on or after July 1, 2018. As of July 1, 2019 dates of service, the data extract will only include encounters submitted January 1, 2018 to June 30, 2019. This manual data extract and process will account for encounters that have had a business status change and have not been paid.
 - 5.12.3.2 The encounter data files will be provided to the Contractor via HCA Secure File Transfer (SFT) sites for the encounters submitted by the Contractor. HCA will send notification to the Contractor via e-mail when the files have been posted to the SFT sites.
 - 5.12.3.3 The Contractor shall review the data files provided within five business days of the date they receive notification of their availability. If the Contractor identifies any discrepancies between the Contractor's records and the data provided, the discrepancies shall be reported to HCA by the close of business on the fifth day.
 - 5.12.3.4 If adjustments are made to the data files, HCA will provide a final version of the data files to the Contractor within five business days.
 - 5.12.3.5 HCA will initiate payment via ProviderOne Gross Adjustment to the Contractor for the total paid amount in each final version of the encounter plus the applicable administrative fee within five (5) business days of the finalization of the encounter.

5.13 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 the underlying data related to the change. The Contractor will have thirty (30) calendar days to review and comment on the underlying data provided by HCA prior to HCA's implementation of the rate change. At the explicit written approval of HCA and CMS, the Contractor can elect to make a lump sum or similar arrangement for payment in lieu of modifications to the rate.

5.14 Encounter Data

5.14.1 For purposes of this Subsection:

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

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

5.14.1.3 "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.

5.14.1.4 "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.

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

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

5.14.2.2 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:

5.14.2.2.1 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;

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

Contractor;

5.14.2.2.3 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

5.14.2.2.4 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.

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

5.14.3 The Contractor must report the paid date, paid unit, and paid amount for each encounter. The "paid amount" data is considered the Contractor's proprietary information and is protected from public disclosure under RCW 42.56.270(11). Paid amount shall not be utilized in the consideration of a Contractor's assignment percentage and may only be disclosed as described in Section 2.31, Proprietary Data or Trade Secrets.

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

5.14.5 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:

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

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

5.14.5.3 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.

5.14.6 The Contractor shall submit a signed Monthly Certification Letter, a template is available through MC-Track. This letter must include a list of all submitted encounter data files and is due within five business days from the end of each month. The purpose of this letter is to certify that, based on the best information, knowledge, and belief, the data, documentation, and information submitted is accurate, complete, and truthful in accordance with 42 C.F.R. § 438.606 and this Contract.

- 5.14.7 The Contractor must validate the accuracy and completeness of all encounter data for physical health care services compared to the year-to-date general ledger of paid claims for the health care services. Encounters for behavioral health (mental health and SUD) services shall not be subject to reconciliation requirements in this Section for the first eighteen (18) months after implementation only when the Contractor is not already contracted for AH-IMC in another RSA. The reconciliation requirements in this Section will apply to behavioral health encounters starting in the nineteenth (19th) month after program implementation for any Contractor.
- 5.14.7.1 Within sixty (60) calendar days of the end of each calendar quarter, the Contractor shall provide aggregate totals of all encounter data submitted and accepted within required timing in subsection 5.14.2.2 of this Section during that quarter using the Apple Health - Integrated Managed Care Quarterly Encounter/General Ledger Reconciliation (Form D), available through MC-Track, and shall reconcile the cumulative encounter data submitted and accepted for the quarter and Contract year with the general ledger paid claims for the quarter. The Contractor shall provide justification for any discrepancies. HCA will approve or reject the discrepancy justifications and notify the Contractor of the decision 120 calendar days of the end of each calendar quarter.
- 5.14.7.2 The Contractor's encounter data submitted and accepted on Form D will be validated against submitted and accepted data captured within HCA's ProviderOne System and must be within 1 percent of what HCA captured.
- 5.14.7.2.1 If the Contractor's encounter data submitted and accepted on Form D is not within 1 percent of the submitted and accepted encounter data captured within HCA's ProviderOne System, HCA will provide the Contractor a list of ProviderOne TCNs and associated Contractor's Transaction Reference Numbers. The Contractor must explain the difference in the encounter data provided by HCA with the encounter data submitted and accepted on Form D for that quarter. HCA will approve or reject the Contractor's explanation. If approved, the reconciliation process will use the submitted and accepted encounter data on the Contractor's Form D. If rejected, the reconciliation process will use the submitted and accepted encounter data captured within HCA's ProviderOne System.
- 5.14.7.3 Following the completion of the quarterly validation process described in subsections 5.14.7.1 through 5.14.7.2 of this Section, HCA may charge the Contractor \$25,000 for nonperformance if the Contractor fails to demonstrate that the encounter data submitted and accepted within required timing reconciles to the general ledger amounts within 1 percent. HCA shall notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next

batch payment to the Contractor.

- 5.14.8 HCA collects and uses this data for many reasons such as: Audits, investigations, identifications of improper payments and other Program Integrity activities, federal reporting (42 C.F.R. § 438.242(b)(1)), rate setting and risk adjustment, service verification, Managed Care quality improvement program, utilization patterns and access to care; HCA hospital rate setting; pharmacy rebates and research studies. Pharmacy encounters submitted by the Contractor that are rejected due to the pharmacy provider not being enrolled with HCA as a Medicaid provider will not be included in the data used for setting the rates for January 1, 2021 amendment to this Contract.
- 5.14.9 Additional detail can be found in the Encounter Data Reporting Guide and Service Encounter Reporting Instructions (SERI) Guide published by HCA and incorporated by reference into this Contract:
 - 5.14.9.1 HCA may change the Encounter Data Reporting Guide and SERI Guide with ninety (90) calendar days' written notice to the Contractor. The SERI Guide can be found at:
<https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri>.
 - 5.14.9.2 The Encounter Data Reporting Guide and SERI Guide may be changed with less than ninety (90) calendar days' notice by mutual agreement of the Contractor and HCA.
 - 5.14.9.3 The Contractor shall, upon receipt of such notice from HCA, provide notice of changes to subcontractors.

5.15 Retroactive Premium Payments for Enrollee Categorical Changes

Enrollees may have retroactive changes in their eligibility category. With the exception of the Recoupment categories listed in Subsection 5.6, such changes will only affect premium payments prospectively.

5.16 Renegotiation of or Changes in Rates

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

5.17 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.

5.18 Provider Payment Reform

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

5.19 Experience Data Reporting

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

shall be provided directly to an actuary designated by HCA. The designated actuary will determine the timing, content, format and medium for such information. HCA requires this information in order to be able to set actuarially sound Managed Care rates.

5.20 Payments to Hospitals

5.20.1 Payments must be made to hospitals subject to the Hospital Safety Net Assessment in accord with chapter 74.60 RCW as follows:

5.20.1.1 HCA will provide information to the Contractor to facilitate its payments to the hospitals subject to the Hospital Safety Net Assessment.

5.20.2 The Contractor will pay all hospitals for services delivered under the Inpatient and Outpatient service categories at rates no less than those published by HCA for its FFS program, including the Administrative Day rate which is applicable through the date of discharge, regardless of the level of service being provided.

5.20.3 Fourteen-Day Readmission Review Program

5.20.3.1 The Contractor shall conduct review of inpatient admissions that occur within fourteen (14) calendar days of a prior inpatient admission to determine if that readmission is medically necessary. Readmission deemed not medically necessary shall not be reimbursed.

5.20.3.2 The Contractor shall conduct post-pay review of inpatient admissions that occur within fourteen (14) calendar days of a prior inpatient admission to determine if that readmission was potentially preventable. The readmission must be clinically related to the prior admission and avoidable.

5.20.3.2.1 The Contractor shall consider a readmission to be avoidable if there is a reasonable expectation it could have been prevented by the provider through one or more of the following actions:

5.20.3.2.1.1 Providing quality care in the prior admission. A specific quality concern, identified and documented during the first admission which then resulted in the readmission, must be identified;

5.20.3.2.1.2 Completing adequate discharge planning with the prior admission;

5.20.3.2.1.3 Implementing adequate post-discharge follow-up of the prior admission; or

5.20.3.2.1.4 Coordinating between inpatient and outpatient health care teams to provide required care post discharge of the prior admission.

5.20.3.3 The Contractor shall not classify a readmission as avoidable or

within the provider's ability to affect, if the readmission is:

- 5.20.3.3.1 At a Critical Access Hospital (CAH);
- 5.20.3.3.2 Unrelated to conditions or care from the prior admission;
- 5.20.3.3.3 A planned readmission or necessary for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, burn therapy, dialysis, or other planned inpatient treatment documented in the record or as indicated using patient discharge status "81"-planned readmission;
- 5.20.3.3.4 A planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same case;
- 5.20.3.3.5 A same-day planned admission to a different hospital unit for continuing care (can include mental health/SUD transfers, rehab transfers, etc. which may be technically coded as discharge/admission for billing reasons);
- 5.20.3.3.6 An admission for required treatments for cancer including treatment-related toxicities, or care for advanced-stage cancer;
- 5.20.3.3.7 End of life and hospice care;
- 5.20.3.3.8 Obstetrical readmissions for birth after an antepartum admission;
- 5.20.3.3.9 Admissions with a primary diagnosis of mental health or SUD issue;
- 5.20.3.3.10 Neonatal readmissions;
- 5.20.3.3.11 Transplant readmissions within 180 days of transplant;
- 5.20.3.3.12 Readmissions when the index admission occurred in a different hospital system;
- 5.20.3.3.13 To complete care for an Enrollee who left Against Medical Advice from a prior admission;
- 5.20.3.3.14 Due to Enrollee non-adherence despite appropriate discharge planning and supports. This also includes cases where the recommended discharge plan was refused by the Enrollee, and a less appropriate alternative plan was made to accommodate Enrollee preferences; this must be clearly documented in the record; or
- 5.20.3.3.15 Because the Contractor did not fulfill its responsibility for post discharge services that would have prevented the readmission.

- 5.20.3.4 The Contractor shall work with its providers to assure they understand their role and take the following actions to prevent the occurrence of a readmission within fourteen (14) calendar days of a prior admission:
 - 5.20.3.4.1 Create a discharge summary including summary of diagnoses, care provided, medication list, and follow up plan;
 - 5.20.3.4.2 Determine the Enrollee's needs to support a safe discharge and write orders accordingly;
 - 5.20.3.4.3 Ensure the discharge summary is sent to the PCP or follow-up provider;
 - 5.20.3.4.4 Provide all required prescriptions and educate the Enrollee about appropriate use of the medication(s);
 - 5.20.3.4.5 Provide written discharge instructions, accompanied by an explanation, to the Client and family/guardian;
 - 5.20.3.4.6 Provide appropriate contact telephone numbers to Enrollee or family/guardian to call for discharge related questions; and
 - 5.20.3.4.7 Document clearly in a readable format the content of discussion with the Contractor (call, fax, etc.).
- 5.20.3.5 The Contractor shall share responsibility with its providers to successfully manage the discharge to prevent a readmission. The Contractor shall coordinate with the provider to remove any barriers the provider may face in implementing the discharge plan and the elements of care.
- 5.20.3.6 In addition to the services required in the Transitional Services section of this Contract, the Contractor shall:
 - 5.20.3.6.1 Resolve any barriers to implementing ordered services;
 - 5.20.3.6.2 Ensure a follow-up appointment is scheduled according to the discharge instructions (typically seven (7) calendar days);
 - 5.20.3.6.3 Educate the Enrollee about the importance of attending the follow-up appointment, and provide assistance to the Enrollee in getting to the appointment, including helping with transportation arrangements;
 - 5.20.3.6.4 Assure implementation of DME or non-durable supply orders, and the Enrollee is given appropriate education on use;
 - 5.20.3.6.5 Assess the need for and arrange, as indicated, an in-home safety assessment with appropriate follow up as needed;
 - 5.20.3.6.6 Assess and address relevant financial and social

- needs of the Enrollee;
- 5.20.3.6.7 Respond timely to implement any changes required in the discharge plan to sustain a successful discharge; and
- 5.20.3.6.8 Provide case management services, as needed, to prevent readmission.
- 5.20.3.7 If a readmission occurs because of the Contractor's failure to fulfill its responsibilities, or a component of its shared responsibilities, the Contractor shall not deny payment for the readmission.
- 5.20.3.8 The Contractor shall use the template letters created with HCA to support this program.
- 5.20.3.9 The Contractor must provide a first and second level re-review to the hospital or physician if the Contractor has deemed the provider failed to provide the level of care described above and was responsible for the readmission.
 - 5.20.3.9.1 After exhausting the Contractor's first and second level re-review process, the hospital may request HCA to conduct a review if a dispute between the Contractor and the provider still exists about payment and assignment of responsibility. The Contractor shall appeal to HCA for a "Potentially Preventable" case review when the Contractor and the hospital or attending physician are unable to agree on assignment of responsibility for the readmission and the provider continues to dispute the Contractor's determination.
 - 5.20.3.9.2 The Contractor and the hospital or attending physician will each present a written summary of their position and supporting clinical documentation to HCA. The Contractor shall collect the information and request submitted by the hospital or physician as well as the Contractor's information to HCA within fourteen (14) calendar days of the hospital's request. HCA shall convene an internal panel to review the documents and make a final assignment of responsibility.
- 5.20.3.10 The Contractor shall respond within fourteen (14) calendar days to any request from HCA for readmission review information and data required in response to a concern for a pattern of inappropriate adjudication presented to HCA by a hospital.
- 5.20.3.11 The Contractor shall submit a quarterly report, due thirty (30) days after the end of each quarter (April, July, October) with a comprehensive annual report for the previous year, by January 31 of each year. The report must include:
 - 5.20.3.11.1 Total number of patients readmitted to any hospital within fourteen (14) days of discharge from a prior

- hospitalization (regardless of preventability);
- 5.20.3.11.2 Number of readmissions reviewed by the Contractor for determination of Provider Potentially Preventable Readmission (PPPR) status;
- 5.20.3.11.3 Number of readmissions identified as PPPR with recoupment requested from the hospital;
- 5.20.3.11.4 For each readmission identified in subsection 5.20.3.11.3 above:
 - 5.20.3.11.4.1 Recouped amount;
 - 5.20.3.11.4.2 Hospital;
 - 5.20.3.11.4.3 Primary and secondary diagnosis of admission; and
 - 5.20.3.11.4.4 Rationale for denial (brief narrative description of what criteria were used to determine that the readmission was preventable and how the case met these criteria).
- 5.20.3.11.5 Number of cases contested by hospitals, how these were handled, and outcome of dispute; and
- 5.20.3.11.6 Estimated Contractor staffing time for PPPR process.
- 5.20.4 Treatment of Inpatient Hospital Claims for Certified Public Expenditure (CPE) Hospitals.
 - 5.20.4.1 Because HCA can leverage additional federal funds for FFS inpatient claims at CPE facilities, these expenditures were carved out of the premium payments for the blind and disabled populations moved from FFS to Apple Health Managed Care beginning July 1, 2012. HCA will separately identify the Enrollees subject to the carve-out. If an Enrollee's eligibility category changes to AHBD while he or she is an inpatient at a CPE hospital:
 - 5.20.4.1.1 The Contractor is responsible for the claim when the AHBD eligibility does not cover the entire hospitalization.
 - 5.20.4.1.2 HCA is responsible for the inpatient claim when the Enrollee's AHBD eligibility covers the entire hospitalization.
 - 5.20.4.2 While premiums are net of CPE inpatient hospital claims, the Contractor does remain at risk for these FFS claims if they exceed expectations. CPE inpatient hospital expenditure benchmarks will be computed on a per-member-per month (PMPM) basis, and will vary by category, age, gender and region.
 - 5.20.4.3 After the end of each calendar year, HCA will compute aggregate CPE hospital FFS expenditures attributable to the Contractor, based upon actual enrollment. Actual CPE hospital expenditures

for all Contractor enrolled member months will be compared to the Contractor specific benchmarks that take into account changes in utilization and risk. If actual expenditures exceed the established benchmarks, the Contractor will reimburse HCA for the amount of the excess. HCA will not make payments to any MCO if expenditures are below benchmark amounts.

5.20.4.4 The following is a list of CPE Hospitals:

- 5.20.4.4.1 University of Washington Medical Center
- 5.20.4.4.2 Harborview Medical Center
- 5.20.4.4.3 Cascade Valley Hospital
- 5.20.4.4.4 Evergreen Hospital and Medical Center
- 5.20.4.4.5 Kennewick General Hospital
- 5.20.4.4.6 Olympic Medical Center
- 5.20.4.4.7 Samaritan Hospital – Moses Lake
- 5.20.4.4.8 Skagit County Hospital District #2 – Island
- 5.20.4.4.9 Skagit Valley Hospital
- 5.20.4.4.10 Valley General Hospital – Monroe
- 5.20.4.4.11 Valley Medical Center – Renton

5.20.4.5 The Contractor shall authorize inpatient services at CPE hospitals. HCA shall honor the Contractor's authorizations for the Contractor's provision of services related to inpatient claims.

5.20.4.6 The Contractor shall conduct quarterly audits of CPE hospital payments to confirm Contractor authorization of CPE hospital stays. The Contractor shall provide a quarterly report to HCA of all CPE hospital stays not authorized by the Contractor, including the recommended payment amount of CPE hospital recoupments. The Contractor shall submit its quarterly reports to HCA within thirty (30) business days of receiving the quarterly payment reports from HCA.

5.21 Non-Hospital Payments

- 5.21.1 Payment to Freestanding Birthing or Childbirth Centers. The Contractor will pay all Freestanding Birthing or Childbirth Centers licensed by the Department of Health a facility fee at a rate no less than those published by HCA for its FFS Planned Home Births and Births in Birthing Center program.
- 5.21.2 Payments for Secure Withdrawal Management Services. The Contractor will pay all Secure Withdrawal Management and Stabilization Facilities licensed and certified by Department of Health (DOH) as defined in section 1.237 of this Contract a facility fee at a rate no less than those published by HCA for its FFS SUD program.
- 5.21.3 Bi-Directional Behavioral Health Services. The Contractor will pay providers that provide Behavioral Health services to patients in primary care settings at a rate no less than those published by HCA for its FFS Mental Health and Psychology Services.

5.22 Payment for Services by Non-Participating Providers

- 5.22.1 The Contractor shall limit payment for Emergency Services furnished by any provider who does not have a contract with the Contractor to the amount that would be paid for the services if they were provided under HCA's, Medicaid FFS program (Deficit Reduction Act of 2005, Public Law No. 109-171, Section 6085).
- 5.22.2 Except as provided herein for Emergency Services, the Contractor shall coordinate with and pay a Non-Participating Provider that provides a service to Enrollees under this Contract no more than the lowest amount paid for that service under the Contractor's contracts with similar providers in the State. For the purposes of this subsection, "contracts with similar providers in the State" means the Contractor's contracts with similar providers to provide services under the Managed Care program when the payment is for services received by a Managed Care Enrollee.
- 5.22.3 The Contractor shall track and record all payments to Participating Providers and Non-Participating Providers in a manner that allows for the reporting to HCA the number, amount, and percentage of claims paid to Participating Providers and Non-Participating Providers separately. The Contractor shall identify the type of providers and subspecialty according to specifications provided by HCA. The Contractor shall also track, document and report to HCA any known attempt by Non-Participating Providers to balance bill Enrollees.
- 5.22.4 The Contractor shall provide annual reports to HCA for the preceding state fiscal year (SFY) July 1 through June 30. The reports shall indicate the proportion of services provided by the Contractor's Participating Providers and Non-Participating Providers, by county, and including hospital-based physician services in a format provided by HCA. Contractor shall submit the report to HCA no later than August 15 of each year, or as required by HCA.

5.23 Data Certification Requirements

Any information and/or data required by this Contract and submitted to HCA shall be certified by the Contractor as follows (42 C.F.R. § 438.242(b)(1) and (2) and § 438.600 through § 438.606):

- 5.23.1 Source of certification: The information and/or data shall be certified by one of the following:
 - 5.23.1.1 The Contractor's Chief Executive Officer.
 - 5.23.1.2 The Contractor's Chief Financial Officer.
 - 5.23.1.3 An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.
- 5.23.2 Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.
- 5.23.3 Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.
- 5.23.4 Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

- 5.23.5 HCA will identify the specific data that requires certification.
- 5.23.6 Certification applies to Medicaid and file submissions.
- 5.23.7 The Contractor must provide training and technical assistance to Subcontractors in order to ensure compliance with provisions of this Contract.

5.24 Sanctions

- 5.24.1 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).
- 5.24.2 HCA shall notify the Contractor of any default in writing, and shall allow a cure period of up to thirty (30) calendar days, depending on the nature of the default. If the Contractor does not cure the default within the prescribed period, HCA may withhold payment, assignments, or re-enrollments from the end of the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.
 - 5.24.2.1 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.
 - 5.24.2.2 HCA, CMS, or the Office of the Inspector General (OIG) may impose intermediate sanctions in accordance 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, against the Contractor for:
 - 5.24.2.2.1 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.
 - 5.24.2.2.2 Imposing on Enrollee's premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.
 - 5.24.2.2.3 Acting to discriminate against Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll an Enrollee, except as permitted under law or under this Contract, or any practice that would reasonably be expected to discourage enrollment by Enrollees whose medical condition or history indicates probable need for substantial future medical services.
 - 5.24.2.2.4 Misrepresenting or falsifying information that it furnishes to CMS or HCA. For any program integrity-related noncompliance violation, HCA may

- not allow a cure period before imposing an intermediate sanction.
- 5.24.2.2.5 Misrepresenting or falsifying information that it furnishes to Enrollee, Potential Enrollee, or any of its Subcontractors.
- 5.24.2.2.6 Failing to comply with the requirements for physician incentive plans.
- 5.24.2.2.7 Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by HCA or that contain false or materially misleading information.
- 5.24.2.2.8 Violating any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, and any implemented regulations.
- 5.24.2.3 HCA may base its determinations regarding Contractor conduct on findings from onsite surveys, Enrollee or other complaints, financial status, or any other source.
 - 5.24.2.3.1 Civil monetary sanctions in the following amounts:
 - 5.24.2.3.1.1 A maximum of \$25,000 for each determination of failure to provide services; distribution of marketing materials that have not been approved by HCA, or that contain false or misleading information, misrepresentation or false statements to Enrollees, Potential Enrollees or healthcare providers; failure to comply with Physician Incentive Plan requirements; or marketing violations.
 - 5.24.2.3.1.2 A maximum of \$100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or HCA.
 - 5.24.2.3.1.3 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.
 - 5.24.2.3.1.4 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.

- 5.24.2.3.2 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 accordance with RCW 48.44.033 or other applicable law.
- 5.24.2.3.3 Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. HCA shall notify current Enrollees of the sanctions and that they may terminate enrollment at any time.
- 5.24.2.3.4 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.

5.25 Payment to FQHCs/RHCs

- 5.25.1 HCA will pay to the Contractor a lump sum monthly amount intended to provide funding to supplement the Contractor's payment to each of its contracted Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC) to ensure that each FQHC/RHC receives its entire, specific encounter rate for each qualifying encounter. This monthly amount to be paid to the Contractor in a lump sum and subsequently disbursed to each FQHC/RHC as directed by HCA is called an enhancement payment.
 - 5.25.1.1 The lump sum payment to the Contractor for its contracted FQHC/RHC will continue to be based on a prior month's client assignments. The total amount of enhancement payment to be made to each Contractor will be based on the Contractor's correct and timely reporting and submission of client assignment roster files to HCA on a monthly basis. For purposes of this Section, the "client assignment roster file" is the electronic file submitted monthly by the Contractor to HCA that is intended to identify the FQHC/RHC to which a Managed Care client has been assigned by the Contractor. The client assignment roster file is specific to client assignment and the resulting per-client enhancement payment only, and it is a separate and distinct process from encounter claim submission. It is this per-client enhancement payment, or capitation payment, that is aggregated by FQHC/RHC and paid to the Contractor for disbursement to the individual FQHC/RHC. The amount due to each FQHC/RHC will be provided to the Contractor by HCA.
 - 5.25.1.1.1 The Contractor shall submit its client assignment roster files to HCA no later than the 15th of the month for the current month of enrollment. HCA will pay to the Contractor a lump sum enhancement payment in the following month. Without exception, any client assignment roster file data received after

the 15th of the month will be included in the next payment cycle for HCA's payment to the Contractor.

5.25.1.1.2 Incorrectly submitted client assignment roster files and/or data records within the client assignment roster files will not be included in any payment to the Contractor and must be corrected and re-submitted by the Contractor to HCA before payment is made. Corrected client assignment roster files received after the 15th of the current month will be included in the following month's cycle for payment purposes. Retroactive enrollment and disenrollment shall follow the same timeline and procedure and will be processed no differently than client assignment roster files for the current month.

5.25.1.1.3 Using correctly submitted client assignment roster files, HCA will base the total enhancement payment due to the Contractor on the number of successfully loaded client records multiplied by the specific enhancement rate of each contracted FQHC/RHC. Thus, payment due to each Contractor will be the aggregated amount of all capitation payments for each contracted FQHC/RHC.

5.25.1.1.4 The Contractor shall submit the final roster updates for the previous calendar year by June 15 of the current year. This final roster submission is to include all retro enrollments and disenrollments for the previous calendar year.

5.25.1.2 HCA will provide the Contractor with the monthly enhancement payment funds separately from the monthly premium payments.

5.25.1.2.1 These supplemental payments will include the load for the 2 percent premium tax as shown on Exhibit A, Rates, AHFQHC and A-AHRHC of this contract. The premium tax is retained by the Contractor and is not paid to the FQHC/RHC.

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

5.25.2 The FQHC/RHC is entitled to its specific, full encounter rate for each qualifying encounter as outlined in the Medicaid State Plan and in accordance with Section 1902(bb) of the Social Security Act (42 USC § 1396a(bb)). The full encounter rate shall be at least equal to the Prospective Payment System (PPS) rate specific to each FQHC/RHC and applies to FQHC/RHC reimbursed under the Alternative Payment Methodology (APM) rate methodology and to FQHC/RHC reimbursed under the PPS rate methodology. The encounter rates and enhancement rates for each contracted FQHC/RHC will be provided by HCA to the Contractor on a quarterly basis or sooner if any changes or

corrections are needed. The rate files will be published to this location (<http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides>), according to the following schedule: January 1, April 1, July 1 and October 1. Any changes that occur during the quarter will be included in the next file and will specify the effective date of the change.

5.25.3 To ensure that each FQHC/RHC receives its entire encounter rate for each qualifying encounter, the Contractor shall pay each contracted FQHC/RHC in one (1) of the ways described below:

- 5.25.3.1 Under the first payment method, the Contractor shall pay the specific monthly enhancement payment amount provided by HCA to the FQHC/RHC in addition to payment of claims for services made at standard rates paid to the FQHC/RHC by the Contractor. The Contractor shall ensure the entire amount of the enhancement payment is passed to each FQHC/RHC as prescribed by HCA within thirty (30) calendar days of the Contractor's receipt of the enhancement payment from HCA; or
- 5.25.3.2 Under the second payment method, the Contractor shall pay the specific monthly enhancement payment amount provided by HCA to the FQHC/RHC in addition to any monthly capitation rates for services. The Contractor shall ensure the entire amount of the enhancement payment is passed to each FQHC/RHC as prescribed by HCA within thirty (30) calendar days of the Contractor's receipt of the enhancement payment from HCA.
- 5.25.3.3 Within the third payment method, for participating RHCs only, the Contractor shall pay the clinic their full encounter rate for encounter-eligible RHC services. HCA will notify the Contractor of participating RHC NPIs.

Dates to Service	RHC Encounter Payment Method
January 1, 2018 to December 31, 2019	The Contractor will not pass the enhancement through to the clinics. MCOs will use the enhancement funds received from HCA for the sole purpose of paying RHCs for the T1015 portion of encounter eligible claims.
January 1, 2020 to current	The Contractor shall, no longer receive monthly enhancements for pass through to RHCs and will instead be reimbursed for the T1015 portion of encounter eligible claims via a service based enhancement (SBE) payment. This SBE payment will be generated through ProviderOne after the Contractor submits claims for eligible encounters.

5.25.3.4 The Contractor must ensure that all encounter-eligible services as defined in HCA's "Rural Health Clinic Billing Guide" are paid at the RHC encounter rates to participating RHCs. RHCs encounter rates are published quarterly and are available at: <https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides>. The Contractor shall make changes or correction to any systems or processes as

needed to comply with HCAs guidelines for billing RHC encounter claims.

- 5.25.4 For all RHCs under the payment method described in subsection 5.25.3.3 HCA will perform an annual reconciliation with the Contractor. Reconciliations will ensure that each participating RHC received its full encounter rate for each qualifying claim and that MCOs are not put at risk for, or have any right to, the T1015 portion of the claim. Reconciliations will be conducted in the second half of the calendar year following the calendar year for which enhancements were made.
- 5.25.4.1 Claims included in RHC encounter reconciliations between the Contractor and HCA will include:
- 5.25.4.1.1 An eligible RHC encounter service as outlined in the RHC Billing Guide (found at: <https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides#>);
- 5.25.4.1.2 A T1015 procedure code; and
- 5.25.4.1.3 A certified RHC Billing NPI (participating NPIs will be shared by HCA with MCOs at least annually).
- 5.25.4.2 HCA will base reconciliation findings on the Contractor's timely submission of encounter data, as specified in Subsection 5.13 of this Contract. Actual payment amounts will be used for each RHC reconciliation, except for the RHCs that receive payment from the Contractor under a capitated model. Reconciliation for the RHCs that are capitated will utilize a FFS equivalency methodology.
- 5.25.4.3 For any underpayment in which the Contractor did not receive sufficient payments for the T1015 portion of encounter eligible claims in the previous year, HCA shall pay the Contractor the amount due. For any overpayment in which the MCO received more than sufficient payment for the T1015 portion of encounter eligible claims in the previous year, HCA shall recoup the amount due from the Contractor.
- 5.25.4.4 Following HCA's notification of reconciliation results, the Contractor shall have thirty (30) calendar days to review and respond to the outcome and provide justification for any discrepancies or findings. The Contractor will address any findings outlined by HCA including any instances in which an RHC was not paid appropriately. Following the review period, the Contractor shall make these payments to the FQHC/RHC as designated by HCA within the next thirty (30) calendar days.
- 5.25.5 For RHCs participating in the payment methodology described in subsection 5.25.3.3. The Contractor shall provide the following deliverables.
- 5.25.5.1 The Contractor shall submit a completed RHC T1015 99405 Error File to MC-Track with dates of service in the previous calendar year (January 1 through December 31) by June 15 of each year. The first report is due June 15, 2021. The purpose of this error file is to inform HCA of the negative T1015 amounts which will be used

during the reconciliation process to ensure the Contractor is paid appropriately.

- 5.25.6 The Contractor shall ensure RHCs participating in the payment method described in subsection 5.25.3.3 receive their full encounter payment for global maternity visits.
- 5.25.7 The Contractor shall ensure it has sufficiently trained staff to handle calls and/or inquiries from providers regarding the reimbursement process and client assignment.
- 5.25.8 By June 15, 2020 and each year thereafter, the Contractor shall submit to HCA the FQHC/RHC Paid Amount report indicating the total amount paid, excluding bonuses and quality performance payments, for services provided during the previous calendar year for each FQHC and those RHCs identified by HCA.

5.26 FQHCs Mental Health Encounters

- 5.26.1 Federally-Qualified Health Centers. The Contractor is required to contract with at least one (1) Federally-Qualified Health Center (FQHC) in their service area if any FQHC makes such a request.

5.27 Payment of Physician Services for Trauma Care

The Contractor shall pay physician services an enhancement for severe trauma care. If all criteria are met, the trauma enhancement must be at least 275 percent of the Contractor's standard rate for the service.

- 5.27.1 To qualify for the trauma care enhancement, a service must meet all of the following criteria:
 - 5.27.1.1 The service must be provided by a physician or clinician;
 - 5.27.1.2 The service must be hospital-based, with a billed place of service 21, 22, 23, 24, 51, 52, or 56;
 - 5.27.1.3 The service must be provided in a Department of Health designated or recognized trauma service center; and
 - 5.27.1.4 The provider has indicated that the injury severity score (ISS) criteria has been met by billing with modifier ST in any position. The ISS must be:
 - 5.27.1.4.1 Thirteen (13) or greater for clients age 15 and older;
 - 5.27.1.4.2 Nine (9) or greater for clients younger than age 15; or
 - 5.27.1.4.3 Zero or greater when the service is provided at a Level I, II, or III trauma service center when the trauma case is received as a transfer from another Facility.
- 5.27.2 Rehabilitation and surgical services provided within six (6) months of the date of an injury that meets all criteria in subsection 5.27.1 may also receive the enhancement rate if all of the following criteria are met:
 - 5.27.2.1 The follow-up procedures are directly related to the qualifying traumatic injury;
 - 5.27.2.2 The follow-up procedures were planned during the initial acute

episode of care, i.e. the inpatient stay; and

5.27.2.3 The plan for the follow-up procedure(s) is clearly documented in the medical record of the client's initial hospitalization for the traumatic injury.

5.27.3 Exemptions. The following services are never subject to trauma care enhancements:

5.27.3.1 Laboratory and pathology services; or

5.27.3.2 Technical component (TC) only charges

5.28 Payment to Freestanding Birthing or Childbirth Centers

The Contractor will pay all Freestanding Birthing or Childbirth Centers licensed by the Department of Health a facility fee at a rate no less than those published by HCA for its FFS Planned Home Births and Births in Birthing Center program.

5.29 Nonpayment for Provider Preventable Conditions

The Contractor shall comply with WAC 182-502-0022, on Provider Preventable Conditions (PPCs) – Payment Policy. The Contractor shall deny or recover payments to healthcare professionals and inpatient hospitals for care related to the treatment of the consequences of Healthcare Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC), also known as Serious Adverse Events.

5.29.1 The Contractor shall require all providers to report PPC associated with claims for payment or Enrollee treatments for which payment would otherwise be made. (42 C.F.R § 434.6(a)(12).

5.30 Billing for Services Provided by Residents

The Contractor shall allow teaching physicians to submit claims for primary care services provided by interns and residents under supervision of the teaching physician as described in HCA's Physician's Billing Guide.

5.31 Enrollees Receiving Mental Health Treatment in an Institute for Mental Disease (IMD)

5.31.1 Federal funds may not be used to cover the cost of care for an Enrollee when the Enrollee resides in an IMD for mental health services for sixteen (16) calendar days or more, within a single calendar month (herein referred to IMC long-stay). As of July 1, 2018, this process is not applicable to IMD stays for treatment of SUD.

5.31.2 HCA will recoup the premium payment for each IMD long-stay month of service.

5.31.3 By September 1 of each year, HCA will provide a report to the Contractor of all IMD long-stay months of service that occurred during the previous state fiscal year.

5.31.3.1 HCA will post the reports and instructions to the Contractor's Secure File Transfer (SFT) site during the reconciliation period.

5.31.3.2 The Contractor will have thirty (30) calendar days following the posting date to review and comment on the underlying data provided by HCA.

5.31.3.3 HCA will recover the premium payment for identified IMD long-stays within ten (10) business days from resolution of any discrepancies

identified.

- 5.31.4 Once HCA recoups a premium payment for an Enrollee in accordance with this Section, the Contractor must update the records to reflect the correct funding source for any payments made for Covered Services on behalf of the Enrollee during the impacted month of service. The Contractor shall ensure the updated records to be provided to HCA's contracted actuaries for the purposed of rate development.
- 5.31.5 Instructions for reimbursement of claims paid on behalf of these Enrollees is outlined in the Contractor's wraparound contracts.

5.32 Payment for Supervision of Behavioral Health Providers

- 5.32.1 The Contractor acknowledges that the capitation rate paid by HCA for BHA services includes funding, as an administrative component, which is intended to reimburse licensed behavioral health practitioners for their time supervising unlicensed practitioners. The Contractor will convey to the providers in their contracts the inclusion of this service.

5.33 Challenge Pool Value-Based Purchasing Incentives

The Contractor is eligible to receive annual Challenge Pool funds for timely reporting of data under Exhibit D, Value-Based Purchasing in this Contract, for demonstrating achievement in adopting Alternative Payment Methodologies in its contracts with providers, and for high performance on quality metrics defined by HCA. The conditions under which the Contractor may earn these funds are defined in Exhibit E, Challenge Pool Value-Based Purchasing Incentives.

5.34 Medicaid Quality Improvement Program (MQIP)

- 5.34.1 If HCA implements a Medicaid Quality Improvement Program (MQIP) in accordance with 42 C.F.R. § 438.6(b)(2), the Contractor will be eligible to receive MQIP for the achievement of certain detailed milestones aligned with HCA's Quality Strategy. MQIP payments will be separate from and in addition to the capitation payments made to Contractor under this Contract and will be specifically identified as the MQIP payment in any distribution to the Contractor. MQIP is not premium revenue and will not be considered as such for purposes of calculating Contractor's Medical Loss Ratio or premium tax liability. Eligibility to participate in the MQIP is not linked to whether Contractor is a public or private entity or whether the Contractor has provided an intergovernmental transfer to HCA.
- 5.34.2 To qualify for MQIP in each Contract Year, the Contractor must first have an approved project proposal and implementation plan in place. If the Contractor has an approved project proposal and implementation plan in place from a prior contract period, the Contractor is eligible to receive MQIP payments by meeting the requirements described in subsection 5.34.3. If the Contractor does not have an approved project proposal and implementation plan in place from a prior contract period, the Contractor is eligible to receive MQIP payment if the Contractor develops a project proposal and implementation plan that is subsequently approved by HCA. The proposal must identify the high-level approach, benefits, and potential challenges associated with implementing the project, and the implementation plan must describe the key tasks and activities required for successful implementation, expected outcomes/deliverables, and anticipated timeline for completion. The proposal and implementation plan

deadlines will be included in the MQIP Milestone Performance and Reporting timeline, and will align with the goals and objectives outlined in HCA Medicaid Quality Strategy.

- 5.34.3 After receiving an MQIP payment for meeting the first milestone described above, the Contractor will be eligible to receive additional MQIP payments by submitting status reports identifying accomplishments, challenges, and risk mitigation strategies the Contractor used during the assessed performance period. An updated implementation plan describing the status of, or changes to, each task or activity must accompany all status reports. The timeline for submission of all milestones, including status reports, will be outlined in the MQIP Milestone Performance and Reporting timeline available online at: <https://www.hca.wa.gov/assets/program/mqip-metrics-milestones.pdf> After The incentive arrangement for completed milestones and activities will be available only for each contract year identified by HCA, and the Contractor's total MQIP payment will be measured based on performance during the current contract year. The MQIP will not be renewed automatically, but HCA may include the MQIP or similar arrangements in subsequent contract years. HCA will notify Contractor ninety (90) calendar days prior to the start of the contract year whether the MQIP program will be in effect for that contract year.
- 5.34.4 In no event will MQIP exceed 5 percent of total capitation revenue that the Contractor receives during the contract year.

5.35 Primary Care Expenditure Report

- 5.35.1 HCA will develop the Primary Care Expenditure report utilizing input from HCA's Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) program medical carriers, and Medicaid Managed Care Organizations.
- 5.35.2 The Contractor shall complete HCA's Primary Care Expenditure report annually, by the last business day of July. The reporting period is January 1 through December 31. The report is available through MC-Track.

6 ACCESS TO CARE AND PROVIDER NETWORK

6.1 Network Capacity

- 6.1.1 The Contractor shall maintain and monitor an appropriate and adequate provider network, supported by written agreements, sufficient to provide adequate access to all services covered under the Contract for all Enrollees, including those with limited English proficiency or physical or mental disabilities (42 C.F.R. § 438.206(b) (1)).
- 6.1.2 On a quarterly basis, no later than the 15th of the month following the last day of the quarter, the Contractor shall provide documentation of its provider network, including critical provider types and all contracted specialty providers. This report shall provide evidence that the Contractor has adequate provider capacity to deliver services that meet the timeliness standards described in Subsection 6.11 to all Enrollees and shall ensure sufficient choice and number of community health centers (FQHCs/RHCs) and/or private providers to allow Enrollees a choice of service systems or clinics. The report shall include information regarding the Contractor's maintenance, monitoring and analysis of the network. The quarterly reports shall include a one page narrative describing the contracting activities in border communities and service areas.
- 6.1.3 The Contractor shall have written policies and procedures for selection and retention of network providers that, at a minimum, meet the requirements of 42 C.F.R. § 438.214.
- 6.1.4 In addition to the quarterly reports required under this Subsection, the Contractor shall also submit updated provider network information within ten (10) business days when requested by HCA or in the following circumstances:
 - 6.1.4.1 At the time it enters into a Contract with HCA;
 - 6.1.4.2 At any time there has been a change in the Contractor's network or operations that, in the sole judgment of HCA, would materially affect capacity 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 with the Contractor.
- 6.1.5 Provider network information will be reviewed by HCA for:
 - 6.1.5.1 Completeness and accuracy;
 - 6.1.5.2 The need for HCA provision of technical assistance;
 - 6.1.5.3 Removal of providers who no longer contract with the Contractor; and
 - 6.1.5.4 The effect that the change(s) in the provider network will have on the network's compliance with the requirements of this Section.
- 6.1.6 The Contractor shall provide contracted services through Non-Participating Providers, at a cost to the Enrollee that is no greater than if the contracted services were provided by Participating Providers, if its network of Participating Providers is insufficient to meet the medical needs of Enrollees in a manner consistent with this Contract. The Contractor shall adequately and timely cover

these services out of network for as long as the Contractor's network is inadequate to provide them (42 C.F.R. § 438.206(b)(4)). This provision shall not be construed to require the Contractor to cover such services without authorization except as required for Emergency Services.

- 6.1.7 To the extent necessary to comply with the provider network adequacy and distance standards required under this Contract, the Contractor shall offer contracts to providers in bordering states. The Contractor's provider contracts with providers in bordering states must ensure access to necessary care, including inpatient and outpatient services and must coordinate with Oregon and Idaho providers to explore opportunities for reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective.
- 6.1.8 Inaccurate or Incomplete Submissions: For each quarterly network submission that is not submitted in HCA-developed format as described in the submission Data Definitions that accompany the contract submission documents, HCA may charge the Contractor \$5,000 for nonperformance. HCA shall notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.
 - 6.1.8.1 If the submission must be returned to the Contractor for corrections, and the submission contained errors that reflect a material loss of providers in a service area, the Contractor's assignments shall be suspended for that service area. Suspension of assignments shall continue until the quarter in which the Contractor submits an accurate submission for that service area.
- 6.1.9 Late Submissions: For each quarterly network submission that is not submitted by the due date and does not have written approval from HCA prior to the due date for the late submission, HCA may charge the Contractor \$1,000 for the first day, and \$100 per day thereafter for non-performance. HCA will notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.
- 6.1.10 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network of providers in any contracted service area including all critical provider types: Primary Care Providers, Hospitals, Pharmacy, Behavioral Health providers, Obstetrician/Gynecologist, and Pediatrician and high volume specialties identified by the Contractor, for two (2) consecutive quarters, and after notification following the first (1st) quarter, HCA reserves the right to immediately terminate the Contractor's services for that service area.
- 6.1.11 The Contractor shall update and maintain the Contractor's provider manual to include all relevant information regarding behavioral health services and requirements.
- 6.1.12 The Contractor shall maintain an online provider directory that meets the requirements listed below and include information about available interpreter services, communication, and other language assistance services. Information must be provided for each of the provider types covered under this Contract: physicians, including specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers as appropriate. The Contractor shall make all information in the online provider directory available on the Contractor's website in a machine readable file and format as specified by the Secretary. The

Contractor shall also make copies of all provider information in the online provider directory available to Enrollees in paper form upon request. The online provider directory must meet the following requirements:

- 6.1.12.1 Maintain a link on the front page of the Contractor's website that immediately links users to the Contractor's online, searchable provider directory.
- 6.1.12.2 Include a list of all clinics and primary and specialty providers, including behavioral health providers for Medicaid, their street addresses, telephone numbers, and URLs, as available.
- 6.1.12.3 Includes the providers' names, locations, telephone numbers and for behavioral health providers, service types, clinical specialty and areas of expertise.
- 6.1.12.4 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.
- 6.1.12.5 Includes a description of each primary and specialty provider's languages spoken, including American Sign Language, and if appropriate, a brief description of the provider's skills or experiences that would support the cultural or linguistic needs of its Enrollees, e.g., "served in Peace Corps, Tanzania, speaks fluent Swahili," and whether the provider has completed cultural competence training.
- 6.1.12.6 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.
- 6.1.12.7 Indicates whether each primary and specialty provider, including behavioral health providers (BHPs), are accepting new patients. Pediatric BHPs must be listed separately from adult BHPs.
 - 6.1.12.7.1 Search capability to locate providers contracted to provide mental health services to children and youth who are accepting new patients (chapter 74.09 RCW).
- 6.1.12.8 Include a list of hospitals, pharmacies, and DME providers.
- 6.1.12.9 Include Behavioral Health crisis contacts.
- 6.1.12.10 Include a specific description of any telemedicine services available from a listed provider and at what facilities.
- 6.1.12.11 Update the online 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)).
 - 6.1.12.11.1 If the Contractor chooses to provide paper provider directories, they must be updated monthly.

- 6.1.12.12 The online provider directory shall be available to providers, Enrollees, family members, and other community stakeholders.
- 6.1.12.13 The Contractor shall have in place a process for Enrollees, Potential Enrollees, and other individuals to identify and report potential inaccurate, incomplete, or misleading information in the Contractor's online directory. The Contractor shall provide a dedicated email address and either a form on the website or a telephone number so that errors can be reported directly through the website. Errors must be corrected within ten (10) business days.
- 6.1.12.14 Contractor program staff shall provide assistance to Enrollees and Potential Enrollees in conducting provider searches based on office or facility location, clinical specialty, provider discipline, provider capacity, and available languages.

6.2 Behavioral Health Network Analysis

- 6.2.1 The Contractor shall incorporate the following requirements when developing its behavioral health network. The Contractor shall offer and maintain contracts to licensed facilities and entities as listed in subsection 6.2.1.3 as well as individual licensed health care professionals. The Contractor shall:
 - 6.2.1.1 Have sufficient behavioral health providers in its network to allow Enrollees a choice of behavioral health providers.
 - 6.2.1.2 Contract with licensed behavioral health providers. Licensed behavioral health providers include, but are not limited to, Health Care Professionals, licensed agencies or clinics, or non-licensed professionals operating under an agency-affiliated license.
 - 6.2.1.3 Establish and maintain contracts with providers determined by HCA to be Essential Behavioral Health Providers (EBHP). The current list of Essential Behavioral Health Providers includes, but is not limited to:
 - 6.2.1.3.1 Certified residential treatment providers;
 - 6.2.1.3.2 Licensed Community MH Agencies;
 - 6.2.1.3.3 Certified SUD provider Agencies;
 - 6.2.1.3.4 DOH-certified medication assisted treatment (e.g. buprenorphine) providers;
 - 6.2.1.3.5 Certified opiate substitution providers (Methadone Treatment programs);
 - 6.2.1.3.6 Licensed and certified free-standing facilities, hospitals, or psychiatric inpatient facilities that provide Evaluation and Treatment services, including Freestanding Evaluation and Treatment Facilities;
 - 6.2.1.3.7 Licensed and certified detox facilities (for acute and subacute), including Secure Withdrawal Management and Stabilization Facilities;
 - 6.2.1.3.8 Licensed and certified residential treatment facility to provide crisis stabilization services;

- 6.2.1.3.9 DBHR-Recognized Wraparound and Intensive Services (WISe) provider; and
- 6.2.1.3.10 DBHR-Recognized Program for Assertive Community Treatment (PACT) provider for the provision of outpatient behavioral health services, as outlined in subsection 17.1.15, excluding day support and high intensity.
- 6.2.1.4 Establish and maintain contracts with office-based Opioid treatment qualifying providers that have obtained a waiver under the Drug Addiction Treatment Act of 2000 to practice medication-assisted opioid addiction therapy.
- 6.2.1.5 Ensure sufficient provider capacity to meet the statewide need for WISe services. Continue work with the independent workforce development collaborative to ensure compliance with the WISe workforce development plan.
- 6.2.1.6 Provide evaluations and/or medically necessary behavioral health services in the Enrollee's residence, when the Enrollee's health care needs require an onsite service, including Enrollees who have been discharged from a state hospital or similar treatment facility to a placement such as an adult family home, assisted living facility, or Skilled Nursing Facility.
- 6.2.1.7 Collaborate with HCA to use data to inform the development of:
 - 6.2.1.7.1 Community-based alternatives for crisis stabilization, such as mobile crisis or crisis residential and respite beds; and
 - 6.2.1.7.2 Community-based, recovery-oriented services and research- and Evidence-based Practices including, but not limited to certified Peer Support specialists.
- 6.2.1.8 Contract with an adequate number of behavioral health provider agencies that offer urgent and non-urgent same day, evening, and weekend services.

6.3 Service Delivery Network

In establishing, maintaining, monitoring and reporting of its network, the Contractor must consider the following (42 C.F.R. § 438.206(b)):

- 6.3.1 Expected enrollment for each service area in which the Contractor offers services under this Contract.
- 6.3.2 Adequate access to all services covered under this Contract.
- 6.3.3 The expected utilization of services, taking into consideration the characteristics and health care needs of the population represented by the Contractor's Enrollees and Potential Enrollees.
 - 6.3.3.1 The Contractor shall consider expected utilization by children, Transitional Age Youth (TAY), adults, and older adults with behavioral health conditions based upon national and State

prevalence data.

- 6.3.4 The number and types (in terms of licensure training, experience and specialization) of providers required to furnish the contracted services.
 - 6.3.4.1 This shall include behavioral health providers by provider type.
- 6.3.5 The number of network providers who are not accepting new Enrollees or who have placed a limit, or given the Contractor notice of the intent to limit their acceptance of Enrollees.
- 6.3.6 The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees or Potential Enrollees, and whether the location provides physical access for the Contractor's Enrollees with disabilities.
- 6.3.7 The cultural, racial/ethnic composition and language needs of Enrollees and the ability of network providers to communicate with limited English proficient enrollees in their preferred language.
- 6.3.8 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.
- 6.3.9 The availability of triage lines or screening systems, as well as the use of telemedicine, e-visit, and other evolving and innovative technological solutions.
- 6.3.10 With respect to a behavioral health network, the anticipated needs of special populations including, but not limited to:
 - 6.3.10.1 TAY with behavioral health needs;
 - 6.3.10.2 Children and Youth with Serious Emotional Disturbances;
 - 6.3.10.3 Adults with Serious Mental Illness;
 - 6.3.10.4 Adults and TAY identified with first episode psychosis;
 - 6.3.10.5 Cross-system involved children and Youth;
 - 6.3.10.6 Individuals with co-occurring behavioral health conditions;
 - 6.3.10.7 Individuals with behavioral health/Individuals with Developmental Disabilities in need of behavioral health services;
 - 6.3.10.8 Individuals with a MH condition or a SUD and co-occurring chronic physical health condition;
 - 6.3.10.9 Individuals with a SUD in need of medication-assisted treatment;
 - 6.3.10.10 Homeless individuals;
 - 6.3.10.11 Individuals transitioning from state operated psychiatric facilities and other inpatient and residential settings;
 - 6.3.10.12 Individuals with behavioral health conditions transitioning from jail/prison/courts;
 - 6.3.10.13 Individuals in permanent supported housing or other types of community housing; and
 - 6.3.10.14 Individuals who self-identify as having specialized cultural, ethnic, linguistic, disability, Pregnant and Parenting Women, or age related

needs.

6.4 Unavailable Detention Facilities Records

6.4.1 The Contractor shall coordinate with the Behavioral Health Administrative Service Organization (BH-ASO) to engage an Enrollee in appropriate treatment services following a notification from a Designated Crisis Responder (DCR) that an Enrollee met ITA detention criteria and there were no beds available in an Evaluation and Treatment Facility, Secure Withdrawal Management and Stabilization facility, psychiatric unit, or under a single bed certification, and the DCR was not able to arrange for a less restrictive alternative for the Enrollee.

6.4.1.1 The Contractor shall develop a plan for engaging the Enrollee in appropriate treatment services for which the person is eligible.

6.4.1.2 The Contractor shall report to HCA within seven (7) calendar days of receiving the notification from HCA, the plan and attempts made to engage the person in treatment, including involuntary treatment.

6.5 Hours of Operation for Network Providers

The Contractor must require that network providers offer hours of operation for Enrollees that are no less than the hours of operation offered to any other patient (42 C.F.R. § 438.206(c)(1)(iii)).

6.6 24/7 Availability

The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week, 365 days a year basis by a toll-free telephone number. These services may be provided directly by the Contractor or may be delegated to subcontractors (42 C.F.R. § 438.206(c) (1) (iii)).

6.6.1 Medical and behavioral health advice for Enrollees from licensed Health Care Professionals.

6.6.2 Triage concerning the emergent, urgent or routine nature of medical and behavioral health conditions by licensed Health Care Professionals.

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

6.6.4 The toll-free line staff must be able to make a warm handoff to the regional crisis line.

6.6.5 The Contractor shall either cover emergency fills without authorization, or guarantee authorization and payment after the fact for any emergency fill dispensed by a contracted pharmacy.

6.6.5.1 The Contractor shall post the Emergency Fill policy on its website to be visible and easy to access for providers.

6.7 Customer Service

The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8:00 a.m. to 5:00 p.m., Pacific Time, Monday through Friday, year round and shall provide customer service on all dates that are recognized as 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. A single toll-free number shall be provided at the expense of the Contractor.

- 6.7.1 The Contractor shall report by December 1 of each year its scheduled non-business days for the upcoming calendar year.
- 6.7.2 The Contractor must notify HCA five (5) business days in advance of any non-scheduled closure during scheduled business days, except in the case when advanced notification is not possible due to emergency conditions.
- 6.7.3 The Contractor and its subcontracted pharmacy benefit manager, provider help desks, authorization lines, and Enrollee customer service centers, if any, shall comply with the following customer service performance standards:
 - 6.7.3.1 Telephone abandonment rate – standard is less than 5 percent.
 - 6.7.3.2 Telephone response time - average speed of answer within thirty (30) seconds.
- 6.7.4 The Contractor shall staff its call center with a sufficient number of trained customer service representatives to answer the phones. Staff shall be able to access information regarding behavioral health service requirements and benefits; facilitate navigation of the eligibility systems to access Medicaid benefits and state only and federal block grant services; refer for needed behavioral health services; distinguish between a benefit inquiry, third party insurance issue, Appeal or Grievance; and resolve and triage Grievances and Appeals.
- 6.7.5 The Contractor shall submit its customer service policies and procedures to HCA for review at least ninety (90) calendar days before implementation. Customer service policies and procedures shall address the following:
 - 6.7.5.1 Information on the array of Medicaid covered benefits behavioral health services including where and how to access them.
 - 6.7.5.2 Authorization requirements.
 - 6.7.5.3 Requirements for responding promptly to family members and supporting linkages to other service systems including, but not limited to: state only and federal block grant funded behavioral health services, law enforcement, criminal justice system, social services.
 - 6.7.5.4 Assisting and triaging Enrollees, who may be in crisis, with access to qualified clinicians, without placing the Enrollee on hold. The qualified clinician shall assess the crisis and warm transfer the call to the BH-ASO or its designated crisis provider(s), call 911, refer the individual for services, refer the individual to his or her provider, or resolve the crisis over the telephone as appropriate.
- 6.7.6 The Contractor shall train customer service representatives on revised behavioral health policies and procedures. The training shall incorporate the State's vision, mission, system goals, and operating principals for behavioral health Managed Care programs and services.

6.8 Timely Access to Care

The Contractor shall have contracts in place with all subcontractors that meet state standards for access, taking into account the urgency of the need for services (42 C.F.R. § 438.206(b) and (c)). The Contractor shall ensure:

- 6.8.1 Network providers offer access comparable to that offered to commercial Enrollees or, if the Contractor serves only Medicaid Enrollees, comparable to Medicaid FFS.
- 6.8.2 Mechanisms are established to ensure compliance by providers.
- 6.8.3 Providers are monitored regularly to determine compliance.
- 6.8.4 Corrective action is initiated and documented if there is a failure to comply.

6.9 **Appointment Standards**

The Contractor shall comply with appointment standards that are no longer than the following (42 C.F.R. § 438.206(c) (1) (i)). Nothing in this Section prohibits the Contractor from conducting assessments in alternate settings, such as the Enrollee's home or within an institutional setting:

- 6.9.1 Transitional healthcare services by a Primary Care Provider shall be available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a SUD treatment program.
- 6.9.2 Transitional healthcare services by a home care nurse, a home care Mental Health Professional or other behavioral health professional within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health care, if ordered by the Enrollee's Primary Care Provider or as part of the discharge plan.
- 6.9.3 Non-symptomatic (i.e., preventive care) office visits shall be available from the Enrollee's PCP or another provider within thirty (30) calendar days. A non-symptomatic visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.
- 6.9.4 Non-urgent, symptomatic (i.e., routine care) office visits, shall be available from the Enrollee's PCP or another provider within ten (10) calendar days, including behavioral health services from a behavioral health provider. A non-urgent, symptomatic visit is associated with the presentation of medical signs not requiring immediate attention.
- 6.9.5 Urgent, symptomatic office visits shall be available from the Enrollee's primary care, behavioral health or another provider within 24 hours. An urgent, symptomatic visit is associated with the presentation of medical or behavioral health signs that require immediate attention, but are not emergent.
- 6.9.6 Emergency care shall be available 24 hours per day, seven (7) days per week.
- 6.9.7 Second opinion appointments 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.
- 6.9.8 Failure to meet appointment standards may, at HCA's sole discretion, result in withholding of payments, assignments and/or re-enrollments as described in the Sanctions subsection of this Contract.

6.10 **Provider Database**

The Contractor shall have, maintain and provide to HCA upon request an up-to-date database of its provider network. In populating its database, the Contractor shall obtain the following information: the identity, location, languages spoken (when this information is supplied by the provider), qualifications, practice restrictions, and availability of all current contracted providers, including specialty providers (42 C.F.R. § 438.242(b)(1)).

6.11 Provider Network - Distance and Drive Time Standards

6.11.1 The Contractor's network of providers shall meet the distance and drive time standards in this subsection in every service area. HCA will designate a zip code in a service area as urban or non-urban for purposes of measurement. HCA will provide to the Contractor a list of service areas, zip codes and their designation. The Contractor's ability to receive enrollment and/or assignment is based on the assignment provisions in this Contract. "Rural area" is defined as any area other than "urban area" as defined in 42 C.F.R. § 412.62(f)(1)(ii).

6.11.2 Distance Standards

6.11.2.1 PCP

6.11.2.1.1 Urban: 2 within 10 miles.

6.11.2.1.2 Non-urban: 1 within 25 miles.

6.11.2.2 Obstetrics

6.11.2.2.1 Urban: 2 within 10 miles.

6.11.2.2.2 Non-urban: 1 within 25 miles.

6.11.2.3 Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

6.11.2.3.1 Urban: 2 within 10 miles.

6.11.2.3.2 Non-urban: 1 within 25 miles.

6.11.2.4 Hospital

6.11.2.4.1 Urban/Non-urban: 1 within 25 miles.

6.11.2.5 Pharmacy

6.11.2.5.1 Urban: 1 within 10 miles.

6.11.2.5.2 Non-urban: 1 within 25 miles.

6.11.2.6 Mental Health Professionals and SUDPs

6.11.2.6.1 Urban/non-urban: 1 within 25 miles.

6.11.3 Drive Time Standards

The Contractor must ensure that when Enrollees travel to service sites, the drive time to the closest provider of the service the Enrollee is seeking is within a standard of not more than:

6.11.3.1 In Urban Areas, service sites are accessible by public transportation with the total trip, including transfers, not to exceed ninety minutes each way;

6.11.3.2 In Rural Areas, a thirty-minute drive from the Enrollee's primary

residence to the service site; and

- 6.11.3.3 In Large Rural Geographic Areas, a ninety-minute drive from the Enrollee's primary residence to the service site.

These travel standards do not apply under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

- 6.11.4 HCA may, at its sole discretion, grant exceptions to the distance and drive time standards. HCA's approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as HCA may require supporting the request. If the closest provider of the type subject to the standards in this Section is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest provider may be a provider not participating with the Contractor.

6.12 Assignment of Enrollees

- 6.12.1 HCA has the sole and exclusive right to determine the methodology and procedures by which Enrollees are assigned to the Contractor or reassigned to any other Apple Health - Integrated Managed Care contractors (MCOs).
- 6.12.2 HCA may adjust the methodology or procedures at any time during the term of this Contract if, in its sole discretion, it determines that any such adjustment would be in the best interests of HCA or Enrollees.
- 6.12.3 HCA will count New Individuals, Family Connects, and Plan Reconnects as part of an MCO's enrollment in all service areas.
- 6.12.4 Reassignment of Enrollees
 - 6.12.4.1 HCA may, at its sole discretion, reassign Enrollees to the Contractor and an individual may choose to voluntarily enroll with the Contractor if the Contractor is eligible to receive enrollment in the individual's service area, consistent with this Subsection.
- 6.12.5 Assignment of New Individuals
 - 6.12.5.1 The number of New Individuals assigned to the Contractor and to all other MCOs depends on (a) the number of MCOs eligible to receive assignments in a service area; (b) the number of New Individuals eligible for assignment in a service area; and (c) the performance of the Contractor and all other MCOs on the Clinical Performance Measures and the Administrative Measures described in this Section.
 - 6.12.5.2 HCA will assign New Individuals to an eligible 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.
- 6.12.6 Service area assignment process:
 - 6.12.6.1 HCA, in its sole discretion, shall determine whether the Contractor's

provider network meets the required capacity.

- 6.12.6.1.1 To receive New Individual assignments and voluntary enrollments in a service area, the Contractor must attain a Capacity Threshold as described in this Subsection.
- 6.12.6.1.2 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.
 - 6.12.6.1.2.1 Upon HCA's request, the Contractor shall provide a list of current Enrollees and their assigned PCP.
 - 6.12.6.1.2.2 The Contractor shall assist HCA in the orderly transition of Enrollees to another MCO, consistent with the Care Coordination and Transitional Healthcare Services provisions of this Contract.
- 6.12.6.1.3 HCA recognizes that a full complement of critical provider types may not be available in a service area; therefore, HCA may, at its sole discretion, make exceptions to network adequacy standards to provide coverage for that service area.
- 6.12.6.1.4 The levels of service area participation are described in the following table:

Capacity Threshold			Assignment of New Individuals and/or Voluntary Enrollment	Family Connects or Plan Reconnects
80% or more in all six provider types			Assignment and voluntary enrollment	Yes
Between 60% to 80% in any critical provider types			No assignment; voluntary enrollment only	Yes
Below 60% in any of the critical provider types.			No assignment or voluntary enrollment	None

- 6.12.6.2 Enrollments for each month covered by this Contract will be set by HCA based on the performances of the Contractor and all other MCOs under the Clinical Performance Measures and the

Administrative Measure described in this Section.

6.12.6.3 HCA will calculate the Contractor's assignment percentages of New Individuals for January and July of each contract year based on a normed and weighted average of two Clinical Performance measures and one Administrative measure.

6.12.6.3.1 Clinical Performance Measures: The Contractor's reported HEDIS® Clinical Performance measures for the previous contract year.

6.12.6.3.1.1 Childhood Immunization Combo 10 Status.

6.12.6.3.1.2 Comprehensive diabetes care: retinal eye exam.

6.12.6.3.2 Administrative Measure (Initial Health Screen): The Contractor shall submit quarterly reports of its performance on completing (IHS) on all New Individual, Family Connect, and Plan Reconnect Enrollees. Assignments will be based on the September and March submissions as described in Subsection 6.12.7.

6.12.7 Administrative Measure (Initial Health Screen (IHS)) calculation:

6.12.7.1 The Contractor shall calculate and report its performance on completing IHS on all New Individual, Family Connect and Plan Reconnect Enrollees on a quarterly basis.

6.12.7.2 To calculate the quarterly screening performance:

6.12.7.2.1 The numerator is the total number of New Individuals, Family Connects, and Plan Reconnects that have received an IHS.

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

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

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

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

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

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

6.13 Distance Standards for High Volume Specialty Care Providers

The Contractor shall establish, analyze and meet measurable 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 Cardiologists, Dermatologists, Oncologists, Ophthalmologists, Orthopedic Surgeons, General Surgery, Gastroenterologists, Pulmonologists, Neurologists, Endocrinologists, Otolaryngologists, behavioral health professionals with prescribing authority and Specialists in Physical Medicine Rehabilitation.

The Contractor shall ensure pediatric specialists are noted on 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 Care Providers.

6.14 Contracts with Mental Health Professionals

The Contractor shall contract with behavioral health providers, to ensure that Enrollees have access to the provider that most appropriately meets their mental health needs.

6.15 Standards for the Ratio of Primary Care and Specialty Providers to Enrollees

The Contractor shall establish and meet measurable standards for the ratio of both PCPs and high volume Specialty Care Providers to Enrollees. The Contractor shall analyze performance against standards at minimum, annually.

6.16 Access to Specialty Care

- 6.16.1 The Contractor shall provide all medically necessary specialty care for Enrollees in a service area. If an Enrollee needs specialty care from a type of specialist who is not available within the Contractor's provider network, or who is not available to provide the medically necessary services required by the Enrollee within the timeframe described in this Contract, the Contractor shall arrange for the necessary services with the nearest qualified specialist outside the Contractor's provider network, who is willing to see the Enrollee.
- 6.16.2 The Contractor shall maintain, and make readily available to providers, up-to-date information on the Contractor's available network of specialty providers and shall provide any required assistance to providers in obtaining timely referral to specialty care.

6.17 Enrollees Residing in Rural Areas

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

- 6.17.1 The Enrollee must have a choice of two (2) Primary Care Providers when there is a single plan in the area (42 C.F.R. § 438.52(b)(2)(i));
- 6.17.2 The Enrollee may seek care from a Non-Participating Provider when the service or type of provider (in terms of training, experience and specialization) is not available within the Contractor's network or when the service or type of provider is available in the Contractor's network, but an appointment with a participating provider cannot be scheduled to provide the service within the time frames listed in Subsection 6.8 of this Contract (42 C.F.R. § 438.52(b)(2)(ii)(A));
- 6.17.3 The Enrollee may seek a service from a Non-Participating Provider when Enrollee's Primary Care Provider or other provider determines that the Enrollee needs related services that would subject the individual to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available from a Participating Provider. (42 C.F.R. § 438.52(b)(2)(ii)(D)); and
- 6.17.4 The Enrollee may seek a service from a Non-Participating Provider when the state determines that circumstances warrant out-of-network treatment. (42 C.F.R. § 438.52(b)(2)(ii)(E)).

6.18 Order of Acceptance

- 6.18.1 The Contractor shall provide care to all Enrollees who voluntarily choose the Contractor and all Enrollees assigned by HCA.
- 6.18.2 Enrollees will be accepted in the order in which they apply.
- 6.18.3 HCA shall enroll all 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.

- 6.18.4 HCA may suspend voluntary enrollment and/or assignments in any service area if, in its sole judgment, the Contractor's network is not adequate to meet the requirements of Section 6.11 Provider Network – Distance and Drive Time Standards, and Section 6.12 Assignment of Enrollees. The Contractor shall submit any information HCA requires to make a final decision on the suspension within thirty (30) calendar days of the Contractor's receipt of the request for information.
- 6.18.5 The Contractor may request in writing that HCA suspend voluntary enrollment and/or assignments in any service area. HCA will approve the temporary suspension when, in the sole judgment of HCA, it is in the best interest of HCA and/or its clients. The Contractor shall submit any information HCA requires to make a final decision on this request.
- 6.18.6 The Contractor shall accept clients who are enrolled by HCA in accordance with this Contract and chapter 182-538 WAC.
- 6.18.7 No eligible client shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, the existence of a pre-existing physical or behavioral condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 C.F.R. § 438.3(d)).

6.19 Provider Network Changes

- 6.19.1 The Contractor shall give HCA a minimum of ninety (90) calendar days' prior written notice, in accordance with the Notices provisions of the General Terms and Conditions Section of this Contract, of the loss of a Material Provider.
- 6.19.2 The Contractor shall make a good faith effort to provide written notification to Enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 C.F.R. § 438.10(f)(5)). Enrollee notices shall have prior approval of HCA. If the Contractor fails to notify affected Enrollees of a provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected Enrollees to continue to receive services from the terminating provider, at the Enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies Enrollees or the Enrollee's effective date of enrollment with another plan.
- 6.19.3 HCA reserves the right to reduce the premium to recover any expenses incurred by HCA as a result of the withdrawal of a material subcontractor from a service area. This reimbursable expense shall be in addition to any other provisions of this Contract.
- 6.19.4 HCA reserves the right to impose Sanctions, in accordance with the Sanctions subsection of this Contract, if the Contractor was notified by the terminating provider in a timely manner and does not comply with the notification requirements of this Section.
 - 6.19.4.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor shall provide documentation of

the date of notification along with the notice of loss of a Material Provider.

6.20 Network Submissions for Washington Healthplanfinder

The Contractor shall maintain provider network data. The Contractor shall submit provider network data to the Health Benefit Exchange (HBE) in a format specified by HBE. The provider network data will support Enrollee plan selection and will include a provider directory. In addition to the provider network data and directory, the Contractor shall submit to public reporting of performance measure data such as HEDIS® and CAHPS® results. The data will be used by Enrollees to select an Apple Health - Integrated Managed Care Contractor. HBE will develop a detailed implementation schedule to include specific dates for Contractor submission of information. In addition, the Contractor may be required to participate in testing of provider network and directory functionality. The provider network and directory submissions required under this subsection are in addition to and do not supersede or replace any other provider network or provider directory submissions or reports due to HCA under this Contract.

6.21 Enrollee PCP Assignment Files

6.21.1 As part of HCA's ongoing efforts to improve population health management activities, the Contractor shall send current Enrollee PCP assignment files to HCA on a monthly basis, or upon request by HCA. The Contractor shall send assignment files by the 15th of each month for the current month through Secure File Transfer (SFT) and Pretty Good Privacy (PGP) encryption protocols. Assignment files must include, at a minimum:

- 6.21.1.1 ProviderOne Client ID number;
- 6.21.1.2 Primary Care Provider (PCP) name;
- 6.21.1.3 PCP National Provider Identifier (NPI); and
- 6.21.1.4 PCP assignment effective date.

6.22 Geo-coding Workgroup

6.22.1 The Contractor shall participate in a workgroup when convened by HCA to identify and prioritize opportunities to implement geo-coding for use by Medicaid beneficiaries, network providers, and the Contractor. The workgroup shall consider how to address regional provider and service needs and the benefits of a statewide geo-coding infrastructure.

6.22.2 The Workgroup shall, in collaboration with HCA, shall consider the availability of needed tools for, and feasibility and value of implementing geo-coding to enhance clinical and administrative decision making for and service delivery to targeted populations (e.g., persons with SUD/Opioid Use Disorder (OUD)). The Workgroup shall take into account the location of:

- 6.22.2.1 physical and behavioral health providers;
- 6.22.2.2 ancillary providers (e.g., pharmacy);
- 6.22.2.3 social services; and
- 6.22.2.4 other services needed to address the needs of the targeted population.

7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1 Quality Assessment and Performance Improvement (QAPI) Program

- 7.1.1 The Contractor shall have and maintain one quality assessment and performance improvement (QAPI) program for all services it furnishes to its Enrollees that meets the provisions of 42 C.F.R. § 438.330.
 - 7.1.1.1 The Contractor shall define its QAPI program structure and processes and assign responsibility to appropriate individuals.
 - 7.1.1.2 The QAPI program structure shall include the following elements:
 - 7.1.1.2.1 Assessment of the quality of care received by Enrollees, as measured by HEDIS® and other quality performance measures;
 - 7.1.1.2.2 Goals and interventions to improve the quality of care received, including primary care and behavioral health bi-directional clinical integration;
 - 7.1.1.2.3 Assessment of health equity, including identification of health disparities;
 - 7.1.1.2.4 Service to a culturally and linguistically diverse membership;
 - 7.1.1.2.5 Service to members with complex health issues and special health care needs;
 - 7.1.1.2.6 Patient safety initiatives and tracking of the critical incident management system;
 - 7.1.1.2.7 Inclusion of Enrollee voice and experience, which may include consumer surveys, grievances, and feedback from Ombuds process;
 - 7.1.1.2.8 Inclusion of provider voice and experience, which may include feedback through involvement in Contractor committees, provider complaints, provider appeals and surveys;
 - 7.1.1.2.9 Involvement of designated physician in the QI program, including involvement of designated behavioral health care provider;
 - 7.1.1.2.10 A quality improvement committee that oversees the quality functions of the Contractor. The Quality Improvement Committee will:
 - 7.1.1.2.10.1 Include practicing provider participation;
 - 7.1.1.2.10.2 Analyze and evaluate the results of QI activities including annual review of the results of performance measures, utilization data, and performance improvement;

- 7.1.1.2.10.3 Institute actions to address performance deficiencies, including policy recommendations; and
- 7.1.1.2.10.4 Ensure appropriate follow-up.
- 7.1.1.2.11 A written QAPI program description shall include the following:
 - 7.1.1.2.11.1 A listing of all quality-related committee(s);
 - 7.1.1.2.11.2 Descriptions of committee responsibilities and oversight;
 - 7.1.1.2.11.3 Contractor staff and practicing provider committee participant titles;
 - 7.1.1.2.11.4 Meeting frequency;
 - 7.1.1.2.11.5 Maintenance of meeting minutes, signed and dated reflecting decisions made by each committee, as appropriate;
 - 7.1.1.2.11.6 All contractually required elements of the QAPI program structure as outlined above;
 - 7.1.1.2.11.7 Proposed methods to meet the requirements under the Contract to evaluate and report performance measure results in a manner that distinguishes individuals who have indicators of need of mental health and/or SUD treatment;
 - 7.1.1.2.11.8 Processes for monitoring, aggregating, and presenting information regarding physical and behavioral health providers or provider groups with at least 1,000 Enrollees, performance in a Provider Performance (PPP) format that encourages self-correction and includes, but is not limited to performance relative to:
 - 7.1.1.2.11.8.1 Adherence to applicable EBPs and practice guidelines;
 - 7.1.1.2.11.8.2 Appointment access standards; and
 - 7.1.1.2.11.8.3 Utilization and quality metrics such as readmissions, average

- length of stay, and transitional health care services to ambulatory services.
- 7.1.1.2.11.9 Compliance with all quality management requirements as stipulated by the T.R. v. Quigley and Teeter Settlement Agreement.
- 7.1.1.2.12 A sufficient number of physical health and behavioral health staff members to completely implement all QAPI program requirements on a timely basis.
- 7.1.1.2.13 The Contractor shall participate in the single RSA Community Behavioral Health Advisory Board (CBHA).
- 7.1.1.2.14 The CBHA shall, at minimum, advise on the need for establishing a behavioral health Quality Management (QM) sub-committee. If the Community Advisory Board recommends a behavioral health QM subcommittee, the subcommittee shall:
 - 7.1.1.2.14.1 Include, in an advisory capacity, Enrollees, family members, certified peer specialists, and provider representatives.
 - 7.1.1.2.14.2 Maintain records of meetings documenting attendance by Enrollees, family members, and providers, as well as committee's findings, recommendations, and actions.
 - 7.1.1.2.14.3 Include mechanisms to solicit feedback and recommendations from a CBHA and key stakeholders to improve quality of care and Enrollee outcomes.
 - 7.1.1.2.14.4 Provide quality improvement feedback to the CBHA, key stakeholders, and other interested parties defined by HCA. The Contractor shall document the activities and provide to HCA upon request.
- 7.1.1.2.15 An annual quality work plan is due March 1. The work plan shall contain:
 - 7.1.1.2.15.1 Goals and objectives for the year, including objectives for patient

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| | safety, serving a geographically, culturally and linguistically diverse membership, individuals with special health care needs, health equity, and health care utilization; |
| 7.1.1.2.15.2 | Timeframe to complete each activity; |
| 7.1.1.2.15.3 | Identification of a responsible person for each activity; |
| 7.1.1.2.15.4 | Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs as defined in HCA's Quality Strategy; and |
| 7.1.1.2.15.5 | Monitoring plans to assure implementation of the work plan, including at least quarterly documentation of the status of said goals and objectives. |
| 7.1.1.2.16 | An annual written QAPI Program Evaluation due July 15, of the overall reporting of the effectiveness of the Contractor's QAPI program. (42 C.F.R. § 438.330(c)(2)(i) and (ii)). The report shall reflect on required QI program structure and activities in the Work Plan and shall include at minimum: |
| 7.1.1.2.16.1 | Analysis of and actions taken to improve health equity. |
| 7.1.1.2.16.2 | Inclusion of consumer voice. |
| 7.1.1.2.16.3 | Contractually required HEDIS® performance measure and utilization data pictorially displayed using charts and graphs, trended over time and compared against the Medicaid NCQA 90th percentile and Washington State average. Both clinical and non-clinical performance measures must be trended and evaluated in the MCO report. |
| 7.1.1.2.16.4 | Accompanying written analysis of performance, including data comparisons to the Medicaid NCQA 90th percentile and Washington State average. |
| 7.1.1.2.16.5 | Findings on quality and utilization measures and completed or |

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

- 7.1.1.2.16.5.1 Preventable hospitalizations, including readmissions;
- 7.1.1.2.16.5.2 Avoidable emergency department visits;
- 7.1.1.2.16.5.3 EPSDT or well-child care;
- 7.1.1.2.16.5.4 Childhood and adolescent immunizations;
- 7.1.1.2.16.5.5 Mental health treatment penetration;
- 7.1.1.2.16.5.6 Children and Adult Access to Primary Care;
- 7.1.1.2.16.5.7 Prenatal and postpartum care; and
- 7.1.1.2.16.5.8 Comprehensive Diabetes Care.
- 7.1.1.2.16.6 An evaluation of the impact of interventions, including any planned follow-up actions or interventions.
- 7.1.1.2.16.7 A written assessment of the success of contractually required performance improvement projects.

- 7.1.2 Upon request, the Contractor shall make available to providers, Enrollees, or HCA, the QAPI program description, and information on the Contractor's progress towards meeting its quality plans and goals.
- 7.1.3 The Contractor shall provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities shall include evidence of:
 - 7.1.3.1 A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity.
 - 7.1.3.2 Evaluation of the delegated organization prior to delegation.
 - 7.1.3.3 An annual evaluation of the delegated entity.
 - 7.1.3.4 Evaluation of regular delegated entity reports.
 - 7.1.3.5 Follow-up on issues out of compliance with delegated agreement or

HCA contract specifications.

7.2 Performance Improvement Projects

- 7.2.1 The Contractor shall have an ongoing program of performance improvement projects (PIPs) that focus on clinical and non-clinical areas. PIPs identified by the Contractor are subject to review and approval of HCA including, but not limited to area of focus, design and implementation, and evaluation methodologies. The Contractor shall conduct the following PIPs:
 - 7.2.1.1 One clinical PIP piloting a behavioral health intervention for adults that is an evidence-based, research-based or Promising Practice recognized by the Washington State Institute for Public Policy (WSIPP). (See current WSIPP Report: Inventory (and Updated Inventory report) of Evidence-based, Research-based, and Promising Practices: Prevention and Intervention Services for Adult Behavioral Health; <http://www.wsipp.wa.gov/Reports>). This PIP must be designed for both BHSO and AH-IMC Enrollees or the Contractor may choose two separate adult WSIPP PIPs which are applicable to these populations;
 - 7.2.1.2 One clinical PIP piloting a behavioral health intervention for children found in the current WSIPP Reports: Inventory (and Updated Inventory report) of Evidence-based, Research-based, and Promising Practices for Prevention and Intervention Services for Children and Juveniles in the Child Welfare, Juvenile Justice, and Mental Health Systems <http://www.wsipp.wa.gov/Reports>. This PIP must be applicable to AH-IMC Enrollees;
 - 7.2.1.3 One clinical PIP, conducted in partnership between the Department of Health and the Contractor, which will be a statewide PIP on improving well-child visit rates in infants, young children, and adolescents described in this Contract. This PIP must be applicable to AH-IMC Enrollees; and
 - 7.2.1.4 One non-clinical PIP of the Contractor's own choosing. This PIP must be designed for both BHSO and AH-IMC Enrollees or the Contractor may choose two non-clinical PIPs which are applicable to these populations.
- 7.2.2 Each PIP shall be designed to achieve significant improvement, sustained over time, in health outcomes and Enrollee satisfaction and shall include the following elements:
 - 7.2.2.1 Measurement of performance using objective quality indicators.
 - 7.2.2.2 Implementation of interventions to achieve improvement in the access to and quality of care.
 - 7.2.2.3 Evaluation of the effectiveness of the interventions based on the performance measures.
 - 7.2.2.4 Planning and initiation of activities for increasing or sustaining improvement.
- 7.2.3 The Contractor shall report the status and results of all required clinical and non-clinical performance improvement projects to HCA. (42. C.F.R. §

438.330(c)(3)).

- 7.2.3.1 The Contractor must annually submit current year PIP proposals to HCA no later than March 15.
- 7.2.3.2 Each completed project shall be documented on a PIP Worksheet found in the CMS protocol entitled "Conducting Performance Improvement Projects".
- 7.2.4 The Contractor shall collaborate with peer Medicaid Managed Care Organizations, DOH and other entities as appropriate to conduct one non-clinical statewide PIP to improve well-child visit rates in infants, young children and adolescents. This group shall be called the Collaborative PIP Workgroup and shall perform the following work:
 - 7.2.4.1 Appoint a workgroup coordinator to assist DOH with developing meeting agenda topics, writing quarterly reports, and serving as a managed care subject matter expert. The coordinator position shall be rotated among participating MCOs.
 - 7.2.4.2 Provide adequate funding, resources and staff to plan, execute and evaluate the PIP.
 - 7.2.4.3 Coordinate with existing state efforts such as the DOH Pediatric Transforming Clinical Practice Improvement Initiative to improve well-child visit rates
 - 7.2.4.4 Set an improvement goal for the next year's HEDIS® for the following HEDIS® well-child visit measures:
 - 7.2.4.4.1 Well-Child Visits in the first fifteen (15) months of life (W15);
 - 7.2.4.4.2 Well-Child Visits in the third, fourth, fifth and sixth years of life (W34); and
 - 7.2.4.4.3 Adolescent Well-Care Visits (AWC).
 - 7.2.4.5 Define the target populations and scope of the PIP.
 - 7.2.4.6 Define intervention(s) used in the PIP. Interventions shall be robust and innovative in nature, intended to increase the number of children receiving well-child visits and to educate and assist providers.
 - 7.2.4.7 Evaluate the success of interventions to improve well-child visit rates by the workgroup set goal in the three child measures using available Contractor Well-Child Visit data.
 - 7.2.4.8 Submit quarterly progress reports on the status of the Collaborative PIP Workgroup activities. Reports shall be submitted to HCA on the third Friday of the month following the end of the quarter in January; April; July; and October.
 - 7.2.4.9 Submit a PIP Worksheet annually, upon request, to HCA.
- 7.2.5 The Contractor shall provide financial support to the DOH to conduct the ongoing Collaborative PIP Workgroup, Health Care Disparity Workgroup and other quality improvement efforts, as described in the following manner:

- 7.2.5.1 The Contractor shall make semi-annual payments, due to DOH no later than the last business day of June and December, based on total Apple Health MCO enrollment as of December 1 of the previous year.
 - 7.2.5.1.1 If the Contractor's combined statewide Medicaid managed care enrollment is less than 25,000, the Contractor shall make two payments of \$25,000 each to support the PIP.
 - 7.2.5.1.2 If the Contractor's combined statewide Medicaid managed care enrollment is 25,000 or more but less than 100,000, the Contractor shall make two payments of \$50,000 each to support the PIP.
 - 7.2.5.1.3 If the Contractor's combined statewide Medicaid managed care enrollment is 100,000 or greater, the Contractor shall make two payments of \$100,000 each to support the PIP.
- 7.2.6 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 Integrated Patient Record/Clinical Data Repository

- 7.3.1 The Contractor shall collaborate with peer AH MCOs, HCA, and at the direction of HCA, the State HIE to design, establish and maintain a longitudinal integrated patient record for all Apple Health-Managed Care Enrollees assigned to Contractor.
- 7.3.2 The integrated patient record will be housed in a Clinical Data Repository (CDR) using a service connected to the State HIE and set up by HCA. HCA will invest in the technical infrastructure necessary to set up, prepare, and source the CDR with patient demographic and other relevant services data for all Enrollees.
- 7.3.3 The integrated patient record has the capacity to bring together physical, dental, behavioral health, and social service data currently stored in disparate provider EHR systems and other state and local data sources across the health care delivery system. HCA encourages transmission of interoperable documents to enable the efficient reuse of content by providers and others.
- 7.3.4 The CDR will connect and leverage the power of information and federal, State, and private investments in EHR technology to enable Care Coordination and increased communication among providers across multiple disciplines and organizations. This effort will provide access to data sets that are not broadly available to authorized clinicians, care teams, communities, plans, and purchasers that can be used to improve care.
- 7.3.5 The Contractor shall appoint a representative to provide input into the design and evaluation of the integrated patient record maintained in the CDR.
- 7.3.6 The Contractor shall pay the operational costs to maintain an integrated health record for each of its Enrollees as billed by the State HIE in two installments each year no later than January 31 and July 1.
 - 7.3.6.1 The Contractor shall pay a percentage of the operational costs to

- maintain an integrated health record for current and past Enrollees. The cost shall not exceed \$1.02 per year per covered life.
- 7.3.6.2 HCA will use the most current Managed Care Market Share report, or other agreed upon total population report, to report the Contractor's total percentage of Enrollees to the State HIE.
- 7.3.6.3 The State HIE will use the percentage of market share, multiplied by the total covered lives in the CDR, multiplied by a rate not to exceed \$1.02 per covered life to determine the Contractor's invoice. The State HIE will bill the Contractor for the maintenance of integrated health records each year on or around January 31, and July 1.
- 7.3.6.4 The Contractor shall pay the State HIE in full by the due date indicated on the billings.
- 7.3.6.5 If the Contractor fails to pay the State HIE within thirty (30) calendar days of the due date on the billing, HCA will withhold the amount due from the next available scheduled monthly AH-IMC premium payment to the Contractor.
- 7.3.6.6 Costs to the Contractor to connect to the HIE to access data are the responsibility of the Contractor.
- 7.3.6.7 Costs to the subcontractors to program EHR systems or connect to the HIE are the responsibility of individual entities.
- 7.3.7 The Contractor shall coordinate with HCA and the state HIE efforts to facilitate readiness activities intended to prepare for the secure exchange of high value health information among subcontractors identified by HCA through participation in communication and readiness activities organized by HCA and HIE.
- 7.3.8 The Contractor shall require subcontracted providers with certified EHR systems submit automated exports of standard CCD/CCDA, or subsequent ONC-specified standard healthcare transactions, as specified by HCA and consistent with the design of the integrated patient record, from their EHR to the CDR via the HIE each time an Enrollee is seen. The Contractor will include contract language reflecting these expectations during contract activities with subcontractors.
- 7.3.9 The Contractor shall participate in quality measurement activities related to the CDR.
- 7.3.9.1 When a subcontracted provider is required to participate in the CDR per subsection 7.3.8 above, the Contractor will require a clinical document to be submitted for a minimum of 80 percent of submitted claims and that a minimum of 85 percent of documents submitted by the subcontracted provider be error free.
- 7.3.9.2 The Contractor will provide a Provider Compliance report semi-annually to HCA by April 1 and October 1 detailing provider compliance with subsections 7.3.8 and 7.3.9.1 above for the prior six month period.
- 7.3.10 The Contractor shall participate in business process improvement activities

related to the CDR.

7.3.10.1 The Contractor will review care coordination processes that require the use of clinical documentation (e.g., creation, use and/or transmission of discharge summaries, care plans, medication lists, chart notes) and determine the opportunities and challenges for subcontracted providers to submit this data to the CDR.

7.3.10.2 The Contractor will provide a CDR - Care Coordination and Recommendation report annually to HCA by July 1 detailing how CDR data is being used to support care coordination, and provide recommendations for improvements to CDR services to enhance usability, including recommendations for expanding CDR content.

7.3.11 The Contractor shall participate in workgroups related to enhancing the use of and participation in CDR activities.

7.4 Washington Rural Health Access Preservation (WRHAP) Pilot

7.4.1 The Contractor shall make pay-for-performance payments to Critical Access Hospitals participating in the Washington Rural Health Access Preservation (WRHAP) Pilot created by the Legislature (Substitute House Bill 1520) (2017), upon the achievement by the hospitals of specified benchmarks on quality measures. The amounts and frequency of the payments shall be no less than the minimums specified below. Additional funds have been appropriated by the Legislature as part of the WRHAP Pilot to help the participating hospitals transition to a new payment methodology and will not extend beyond the anticipated 3-year pilot period. The total amount of additional funds available for the period of January 1, 2020 through June 30, 2020 to support this performance improvement initiative is \$1,417,000. Each of the 13 participating hospitals, if it achieves all of the specified benchmarks, will need to receive a total of no less than \$109,000 from all of the MCOs with which it has contracts in order to successfully implement the service changes needed to achieve the benchmarks. In order to accomplish this, the Contractor shall pay each hospital with which it has contracts amounts greater than or equal to the amounts listed in subsection 7.4.1.3 if and when the hospital achieves the specified quality benchmarks.

7.4.1.1 List of participating hospitals and service regions:

WRHAP CAHs	Public Hospital District	Region
Cascade Medical Center	Chelan County PHD #1	R1-North Central
Columbia Basin Hospital	Grant County PHD #3	R1-North Central
Dayton/Columbia County Health System	Columbia County PHD	R9-Greater Columbia
East Adams Rural Healthcare	Adams County PHD #2	R11-Spokane
Ferry County Memorial	Ferry County PHD #1	R11-Spokane
Forks Community Hospital	Clallam County PHD #1	R9-Salish
Garfield Co. Public	Garfield County PHD	R9-Greater Columbia
Mid-Valley	Okanogan County PHD #3	R11-Spokane
Morton General	Lewis County PHD #1	R15-Great Rivers
Odessa Memorial	Lincoln County PHD #1	R11-Spokane
Willapa Harbor	Pacific County PHD #2	R15-Great Rivers

North Valley	Okanogan County PHD #3	R11-Spokane
Three River	Okanogan-Douglas Counties PHD #1	R11-Spokane & R1-North Central

7.4.1.2 The Contractor shall contract with each participating Hospital District to make pay-for-performance payments based on the quality measures and benchmarks described in subsections 7.4.1.2.1, 7.4.1.2.2, 7.4.1.2.3, and 7.4.1.2.4. Each participating Hospital District (Participant) has selected previously whether the payments will be made for its work on either (a) Behavioral Health services or (b) Care Coordination services. Effective January 1, 2020, in addition to one of the selected measures described in subsections 7.4.1.2.1 and 7.4.1.2.2, each participating hospital will select either the Anti-depressant Medication Management (NCQA HEDIS®) or the Potentially Avoidable Emergency Department (ED) Use (Washington Health Alliance) measure described in subsections 7.4.1.2.3 and 7.4.1.2.4. The Participant shall continue to collect data for the initial quality measures (outlined in subsections 7.4.1.2.2 and 7.4.1.2.3) using an EHR, registry, or manually collected data. The Participant shall receive outcome data from HCA for quality measures (outlined in subsections 7.4.1.2.3 and 7.4.1.2.4) using Medicaid claims data. When the Participant achieves one of the specified benchmarks, it must receive a payment equal to or greater than the applicable amount specified in subsection 7.4.1.3 in addition to any other payments to which it may be entitled. The following are the quality measures and the benchmarks to be achieved during this contract period:

7.4.1.2.1 If the Participant indicates that the majority of the continued services delivered will be behavioral health services (including psychiatric collaborative care services), the Participant submits a report on the behavioral health quality measure (Patients Screened for Clinical Depression and Follow-Up Plan - NQF 0418/MIPS 134) for a three month period that shows that the Participant has met the benchmark for that period. To receive a percentage of the quality performance payment, the participant must meet the minimum performance target rate of 53 percent of total Medicaid clinic patients for each three-month period. To receive the full quality performance payment for the quarter, the Participant must meet the performance target increase of 3 percent above the minimum of 53 percent: 56 percent for the first three-month period and 59 percent for the second three-month period. The first three-month period begins January 1, 2020 and ends March 31, 2020. The second three-month period begins April 1, 2020 and ends June 30, 2020. The measure shall be calculated by the Participant as follows:

7.4.1.2.1.1 **Numerator:** Number of Enrollees screened for depression on the date of the visit using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen that includes either a referral to a practitioner who is qualified to diagnose and treat depression, a pharmacological intervention, or another documented intervention.

7.4.1.2.1.2 **Denominator:** Number of Enrollees who visit the Participant's Rural Health Clinic or primary care clinic during the performance period. If there is no RHC or primary care clinic, the focus will be Enrollees who visit the Participant's Emergency Department. Enrollees with an active diagnosis of depression or bipolar disorder, who refuse to participate, or are in an urgent or emergent situation where time is of the essence and delaying treatment would jeopardize the patient's health status, or have limitations on functional capacity or motivation to improve that may impact the accuracy of results of standardized assessment tools are excluded from the program.

7.4.1.2.2 If the Participant indicates that the majority of the continued services delivered will be chronic care management or care coordination services (other than psychiatric collaborative care management services), the Participant submits a report on the care coordination quality measure (percent of residents with phone contact or face-to-face visit within seven (7) calendar days of ED or hospital discharge) that shows the Participant has met the benchmark for that period. To receive a percentage of the quality performance payments, the participant must meet the minimum performance target rate of 40 percent of patients for each three-month period. To receive the full quarterly performance payment for the quarter, the participant must meet the performance target increase of 5 percent above the minimum of 40 percent: 45 percent for the first three-month period and 50 percent for the second three-month period. The first three-month period

begins January 1, 2020 and ends March 31, 2020. The second three-month period begins April 1, 2020 and ends June 30, 2020. The measure shall be calculated by the Participant as follows:

7.4.1.2.2.1 **Numerator:** Number of Enrollees with a phone contact or face-to-face visit with the care coordinator or a primary care provider within seven (7) calendar days following discharge from the ED or the hospital where the Enrollee was admitted following the ED visit. For a contact to have occurred: (1) A phone or face-to-face visit within seven calendar days of ED or hospital discharge must occur OR, (2) an attempted contact where the first attempt is initiated within the first 48 to 72 hours of discharge and there are a minimum three daily attempts within the seven days following discharge.

7.4.1.2.2.2 **Denominator:** Number of Enrollees who (1) visit the Emergency Department operated by the Public Hospital District, and (2) are discharged alive to their homes following the ED visit or following a hospital admission resulting from the ED visit during the performance period (calendar quarter).

7.4.1.2.3 If the Participant indicates they elect the Anti-Depressant Medication Management (NCAQ HEDIS®) outcome measure the performance expectation is a 10 percent improvement in anti-depressant medication treatment adherence; closing the gap between baseline rate and the HEDIS® 90th percentile national benchmarks. For example, if baseline performance is 76 percent, the improvement target is set at 77.68 ($76.0 + 1.68$) percent, based on the metric absolute benchmark of 92.80 (90th percentile). The baseline for the selected measure will be state fiscal year (SFY) 2018 and will be compared to performance year SFY 2020 (July 2019 through June 2020). Performance will be determined during calendar year (CY) Quarter 3 of 2020. Payment based on performance improvement will be dispersed in CY Quarter 4 of 2020 (by December 2020). Measure definition: The percentage of Medicaid beneficiaries 18 years of age

and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an anti-depressant medication treatment. Two sub-metrics are reported: (1) Effective Acute Phase Treatment: The percentage of Medicaid beneficiaries who remained on an antidepressant medication for at least 84 days (12 weeks); and (2) Effective Continuation Phase Treatment: The percentage of Medicaid beneficiaries who remained on an anti-depressant medication for at least 180 days (6 months).

7.4.1.2.3.1 **Numerator:** (1) Number of individuals from the denominator population who remained on anti-depression medications for 84 days or more, over a 114 day period from the initial start of therapy; and (2) Number of individuals from the denominator population who remained on anti-depression medications for 180 days or more, over a 231 day period from the initial start of therapy.

7.4.1.2.3.2 **Denominator:** Eligible population age 18 years and older, who had a diagnosis of major depression and were newly treated with antidepressant medication, during the measurement time period.

7.4.1.2.4 If the Participant indicates that they elect the Potentially Avoidable ED Use (Washington Health Alliance) outcome measure, the performance expectation is a reduction of 1 percent of potentially avoidable ED use during the performance period. The baseline for the selected measure will be SFY 2018, and will be compared to performance year SFY 2020 (July 2019 through June 2020). Performance will be determined during CY Quarter 3 of 2020. Payment based on performance improvement will be dispersed in CY Quarter 4 of 2020 (by December 2020).

7.4.1.2.4.1 **Measure definition:** The Percentage of patient visits to an emergency department for conditions that could have been managed in a primary care or in another non-acute setting.

7.4.1.2.4.2 **Numerator:** The number of patient (ages 1+) visits to an emergency

department for conditions that could have been managed in a primary care or in another non-acute setting.

7.4.1.2.4.3

Denominator: The number of all outpatient visits to an emergency department for Medicaid clients age 1 or older.

- 7.4.1.3 The Contractor shall award a pay-for-performance payment to a Participant as soon as possible after they submit a report showing that they have achieved one of the benchmarks specified in subsection 7.4.1.2. The minimum amount to be paid to each Participant for each benchmark is listed below and is based on the number of MCOs the hospital has contracted with in the region. The Contractor has the discretion to make additional payments for higher performance on the quality measures and to make additional payments more frequently than quarterly.

WRHAP CAHs	* Quarter 1 CY 2020 Minimum Rate	* Quarter 2 CY 2020 Minimum Rate
Cascade Medical Center	\$18,167	\$18,167
Columbia Basin Hospital	\$18,167	\$18,167
Dayton/Columbia County Health	\$13,625	\$13,625
East Adams Rural Healthcare	\$18,167	\$18,167
Ferry Community Hospital	\$18,167	\$18,167
Forks Community Hospital	\$10,900	\$10,900
Garfield County Public	\$13,625	\$13,625
Mid-Valley	\$18,167	\$18,167
Morton General	\$10,900	\$10,900
Odessa Memorial	\$18,167	\$18,167
Willapa Harbor	\$10,900	\$10,900
North Valley	\$18,167	\$18,167
Three River	\$18,167	\$18,167
*Rates are based on the 2019 contract arrangements between CAHs and MCOs and may be subject to change to reflect contractual arrangement for the remaining 2019 contract and the 2020 contract period. If changes occur, HCA will communicate them directly with the Contractor in writing.		

- 7.4.1.4 The Contractor shall submit to HCA a written quarterly WRHAP status report due forty-five (45) calendar days after the end of each quarter, on the performance improvement project (including copies of documentation received from the hospital demonstrating successful completion of the measures) and proof of payment to the hospital. Capitation payments for the period to which these payments apply will be retroactively adjusted by HCA annually, no later than June 30 following the year the Contractor submitted the WRHAP report.

7.5 Performance Measures

- 7.5.1 The Contractor shall include the AH-IMC population in its annual submission to NCQA of NCQA and HCA required HEDIS® measures according to directions provided by HCA's designated EQRO.
- 7.5.2 The Contractor shall report AH-IMC required HEDIS® measures using the current year HEDIS® Technical Specifications and official corrections published by NCQA, to NCQA and HCA annually, unless directed otherwise in writing by HCA. The Contractor shall use administrative and hybrid data collection methods, specified in the current HEDIS® Technical Specifications and required by HCA (42 C.F.R. § 438.240(b)(2)).
- 7.5.3 The Contractor shall collect and report no more than ten regional measures as "early warning indicators" following specifications provided by HCA. This shall include, but not be limited to behavioral health measures for children and adults.
- 7.5.4 Attachment 2, HEDIS® Performance Measures is the list of HCA required HEDIS® performance measures to be submitted to NCQA and HCA. If "Hybrid" is noted in the "Notes" column of Attachment 2, the Contractor is contractually required to report using this methodology. If the Contractor is unable to report using this methodology, the Contractor is required to notify HCA within five (5) business days with the reason.
- 7.5.5 In addition to reporting all required HEDIS® data to NCQA, the Contractor will publicly report performance measure data including MCO name through the Quality Compass reporting mechanism, whether public reporting is required or not by NCQA.
- 7.5.6 No later than the date in June of each year as specified by the audit team, AH-IMC required HEDIS® measures shall be submitted electronically to HCA's contracted EQRO according to instructions provided by HCA or HCA's designated EQRO.
- 7.5.7 The following performance measures shall be produced by HCA, in partnership with the DSHS/Research and Data Analysis Division (RDA), and delivered to the Contractor in reporting year 2020; for the data collection period January 1, 2019 through December 31, 2019. Populations included are all eligible Apple Health enrolled populations.
 - 7.5.7.1 Substance Use Disorder Treatment Penetration;
 - 7.5.7.2 Substance Use Disorder treatment initiation and engagement (Washington Circle version);
 - 7.5.7.3 Mental Health Treatment Penetration – Broad Definition;
 - 7.5.7.4 Thirty (30) day psychiatric inpatient readmissions;
 - 7.5.7.5 Number of Nulliparous Transverse Singleton Vertex (NTSV) C-Sections (cesarean births); and
 - 7.5.7.6 The proportion of person-months receiving long-term services and supports (LTSS) associated with receipt of in home- and community-based settings during the measurement year.
- 7.5.8 BHSO Performance Measures: The following performance measures shall be produced by HCA, in partnership with the DSHS/Research and Data Analysis

Division (RDA), and delivered to the Contractor annually reflecting performance in the prior calendar year data collection period. The measures will include only BHSO members. Performance measure validation will be performed annually.

7.5.8.1 Substance Use Disorder Treatment Penetration (Total).

7.5.8.2 Mental Health Treatment Penetration – Broad Definition (Total).

7.5.9 The Contractor shall submit raw HEDIS® data to HCA electronically, no later than June 30 of each year. The Contractor shall submit the Raw HEDIS®/Member Level Data according to specifications provided by HCA.

7.5.10 AH-IMC Performance Measure: No later than June 30 of each year, the following AH-IMC-specific measure shall be submitted to HCA. The Contractor shall calculate this additional HEDIS® measure using the administrative method only for all eligible Enrollees covered under this Contract and calculated separately for each of the Contractor's Regional Service Areas.

7.5.10.1 Ambulatory Care (AMB).

7.5.11 All HEDIS® measures including the CAHPS® sample frame, shall be audited by a designated certified HEDIS® Compliance Auditor, a licensed organization in accord with methods and timelines described in the current HEDIS® Compliance Audit™ Standards, Policies and Procedures and the Centers for Medicare and Medicaid Services (CMS) Validating Performance Measures Protocol found at <https://www.medicaid.gov/medicaid/quality-of-care/index.html>. HCA will fund and the designated EQRO will conduct the audit.

7.5.12 The Contractor shall cooperate with HCA's designated EQRO to validate the Contractor's HEDIS® performance measures and CAHPS® sample frame.

7.5.12.1 Data collected and the methods employed for HEDIS® validation may be supplemented by indicators and/or processes published in the CMS Validating Performance Measures protocol identified by HCA designated EQRO.

7.5.13 The Contractor shall create, maintain, and collect separate and unique data fields for Enrollee self-reported demographic data to the Contractor. At minimum, the following data fields shall be maintained by the Contractor: Enrollee name, address, email address, and ethnicity, race, and language markers.

7.5.14 The Contractor shall rotate HEDIS® measures only with HCA's advance written approval. The Contractor may request approval to rotate measures by making a written request to HCA MC Programs mailbox. Any measures rotated by the Contractor without written permission from HCA shall be subject to the sanctions language described in this Contract.

7.5.15 Health Care Disparities Workgroup. The Contractor shall collaborate with peer MCOs and the DOH to form a Health Care Disparities Workgroup aimed at reducing disparities in one performance measure. The Health Care Disparities Workgroup shall consult with community experts and organizations as appropriate to disaggregate data on at least one performance measure and examine the data for racial/ethnic disparities. The Workgroup shall implement interventions aimed at reducing health care disparities in the selected measure. The Health Care Disparities Workgroup shall perform the following work:

- 7.5.15.1 Appoint a Workgroup coordinator to assist DOH with developing meeting agenda topics, writing quarterly reports, and serving as a managed care subject matter expert. The coordinator position shall be rotated among participating managed care organizations.
- 7.5.15.2 Collect and examine data on ethnicity, race, and language markers as provided by HCA on all Enrollees and augmented by MCOs.
- 7.5.15.3 Cooperate with the Department of Health to complete the analysis of one performance measure no later than June 30.
- 7.5.15.4 Define interventions to address observed disparities.
- 7.5.15.5 Implement defined interventions aimed at addressing disparities.
- 7.5.15.6 Evaluate the effectiveness of interventions to reduce health care disparities.
- 7.5.15.7 Provide adequate funding, resources, and staff to plan, execute, and evaluate the project.
- 7.5.15.8 Submit quarterly progress reports providing an update on the status of the Health Care Disparity Workgroup activities. Reports shall be submitted to HCA quarterly on the third Friday of the month of January, April, July and October.
- 7.5.16 The following performance measure shall be produced by HCA and delivered to the Contractor quarterly starting July 1, 2020 for the data period of January 1, 2020 through March 30, 2020 and quarterly thereafter.
 - 7.5.16.1 Medicaid beneficiaries, age 5 and younger, who received a topical fluoride application by a professional (non-dental medical provider) during any medical visit.
- 7.5.17 WISE Performance Measures. The Contractor will meet or exceed each MCO's proportion of the state's WISE capacity and intensity agreements within the T.R. v. Birch and Strange Settlement Agreement to support statewide compliance. HCA will monitor performance monthly using Contractor self-reported WISE performance measures within the WISE Plan Progress Report. Research and Data Analysis (RDA) will validate the WISE performance measures on a quarterly and annually basis. Reporting of the WISE Service Intensity will be in collaboration with peer MCOs as agreed upon by HCA, the Contractor, and MCO peers.
 - 7.5.17.1 MCO-specific WISE Regional Caseload Targets. The Contractor will meet or exceed 85 percent of the Contractor's caseload target by RSA as determined by the RDA for the number of children and youth served by WISE in the month (referred to as capacity within the Settlement). HCA will provide the MCO-specific WISE Regional Caseload Targets by the end of March and October each year.
 - 7.5.17.2 WISE Service Intensity. The Contractor must maintain WISE Service Intensity at a monthly average of 10.5 hours for children and youth participating in WISE for each contracted RSA. No subcontracted provider will have a monthly average below nine hours.

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

- 7.6.1 The Contractor shall conduct a CAHPS® survey of Apple Health Enrollees for the annual HEDIS® audit. In even-numbered years, the Contractor shall conduct a CAHPS® Adult survey, and in odd-numbered years a CAHPS® Child with Chronic Conditions survey.
- 7.6.1.1 The Contractor shall contract with an NCQA-certified HEDIS® survey vendor qualified to administer the CAHPS® survey and conduct the survey according to NCQA protocol. The Contractor shall submit the following information to HCA's designated EQRO:
- 7.6.1.1.1 Contractor CAHPS® survey staff member contact, CAHPS® vendor name, and CAHPS® primary vendor contact annually by January.
- 7.6.1.1.2 Timeline for implementation of vendor tasks upon request.
- 7.6.1.2 The Contractor shall ensure the survey sample frame consists of all Apple Health members 18 to 64 years of age with Washington State addresses for the Adult Survey, and members 17 years and younger for the Child Survey. In administering the CAHPS®, the Contractor shall:
- 7.6.1.2.1 Submit the eligible sample frame file(s) for certification by HCA designated EQRO, a Certified HEDIS® Auditor, by the second Friday in January, or the date otherwise specified by the audit team.
- 7.6.1.2.2 Receive written notice of the sample frame file(s) compliance audit certification from HCA designated EQRO by the January deadline listed in the NCQA HEDIS® Audit timeline.
- 7.6.1.2.3 HCA EQRO shall review each MCOs questionnaire format, questions, and question placement, using the most recent HEDIS® version of the Medicaid CAHPS® survey (currently 5.0H), plus approved supplemental questions as determined by HCA.
- 7.6.1.2.4 HCA will add supplemental questions to the Contractor's survey as determined by HCA and approved by NCQA.
- 7.6.1.2.5 Conduct the mixed methodology (two questionnaires and two reminder postcards with telephone follow-up of at least three telephone attempts) for CAHPS® survey administration.
- 7.6.1.2.6 Submit a copy of the final NCQA data submission report to HCA designated EQRO by the date in June each year as specified by HCA or HCA designated EQRO.
- 7.6.1.2.7 Submit a copy of the Washington State Medicaid response data set according to current year NCQA/CAHPS® standards to HCA designated EQRO by the date in June each year as specified by

HCA or HCA designated EQRO.

7.6.1.3 The HCA requires the Contractor to submit its CAHPS® data to the CAHPS® Database by the submission deadline set by the CAHPS® Database.

7.6.2 The Contractor shall notify HCA in writing if the Contractor cannot conduct the CAHPS® survey because of limited total enrollment or sample size. The written statement shall provide enrollment and sample size data to support the Contractor's inability to meet the requirement.

7.7 NCQA Accreditation

7.7.1 The Contractor shall have and maintain NCQA accreditation at a level of "accredited" or better.

7.7.2 The Contractor shall provide HCA with the results of the Contractor's NCQA accreditation reviews within thirty (30) calendar days of the finalized review, including accreditation status, survey type, level of accreditations, results of the review, HEDIS® and CAHPS® summary level data, recommended actions or improvements, corrective action plans and summaries of findings and expiration date of the accreditation (42 C.F.R. § 438.332(b)).

7.7.3 The Contractor shall notify HCA of the date of its NCQA site visit within fifteen (15) calendar days of confirmation of the site visit by NCQA. The Contractor shall provide HCA with all written materials submitted to NCQA for purposes of the NCQA audit and allow HCA representative(s) to participate in the NCQA audit activities, including the site visit.

7.7.4 Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of the final NCQA report and may result in termination of the contract in accordance with the terms and conditions set forth in this Contract.

7.7.5 If the Contractor fails to obtain accreditation at a level of "accredited" or better within the timeframe described in this subsection or if the Contractor fails to maintain accreditation thereafter, the Contractor shall be considered in breach of this Contract. HCA shall terminate the Contract in accordance with the Termination by Default Subsection of this Contract.

7.8 External Quality Review

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

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

7.8.2.1 Performance improvement projects.

7.8.2.2 Performance measures.

7.8.2.3 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 (3) year period.

7.8.3 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.

- 7.8.4 The Contractor shall submit reports, findings, and other results obtained from a Medicare or private accreditation review (e.g., CMS, NCQA, eValue8, URAC, etc.) if requested by HCA. HCA may, at its sole discretion, use the accreditation review results in lieu of an assessment of compliance with any federal or state standards and the review conducted by HCA of those standards.
- 7.8.5 The Contractor shall submit to annual monitoring reviews by HCA and EQRO. The monitoring review process uses standards developed by HCA and methods and data collection tools and methods found in the CMS EQR Managed Care Organization Protocol and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by Medicaid MCOs (42 C.F.R. § 438.358).
- 7.8.6 The Contractor shall, during an HCA annual monitoring review of the Contractor's compliance with contract standards or upon request by HCA or its EQRO Contractor(s), provide evidence of how external quality review findings, agency audits and contract monitoring activities, Enrollee Grievances, HEDIS® and CAHPS® results are used to identify and correct problems and to improve care and services to Enrollees.
- 7.8.7 The Contractor will provide data requested by the EQRO for purposes of completing the External Quality Review Report Annual (EQRAR). 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.
- 7.8.8 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.
- 7.8.9 If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to HCA. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with HCA and Washington State Department of Health (DOH) as needed to reduce duplicated work for both the Contractor and the State.

7.9 Provider Complaints and Appeals

- 7.9.1 The Contractor shall have a system in place to process, track, and record provider complaints and appeals. The Contractor shall accept, record, and process provider complaints forwarded by HCA. The Contractor's provider complaint and appeal process should include a quality improvement process. The Contractor shall provide a Provider Complaints and Appeals Report on provider complaint and appeal data to HCA quarterly. The report is due by the last business day of the month following the end of the quarter. (42 C.F.R. §

438.66(c)(3)).

7.10 Collaboration with Developmental Disabilities Administration (DDA)

- 7.10.1 The Contractor shall participate in quarterly comprehensive reviews to assess the overall quality of care and services for individuals with developmental disabilities living in the community, in accordance with the Allen et al. vs. Western State Hospital settlement agreement. The Enrollees chosen for review are enrolled with DDA and have recently been involved in behavioral health inpatient or outpatient services, including but not limited to hospitalization at Eastern State or Western State hospitals. The Contractor shall:
 - 7.10.1.1 Identify a single point of contact and work directly with regional DDA representatives in coordinating and conducting these reviews.
 - 7.10.1.2 The Contractor representative and a regional DDA designee will be the lead staff for the reviews. The lead staff will coordinate and participate in the reviews, and prepare and submit the final reports from the reviews to DSHS and HCA Internal Oversight Review Team (IORT) contacts.
 - 7.10.1.3 Develop an analysis of quality of care and services based on the results of the review. Identify opportunities or recommendations for improvement. Include short-term and long-term actions and goals to be used to improve the quality of care for the selected Enrollees, as well as to make improvements to the system as a whole.
 - 7.10.1.4 Ensure the submission of the review to the identified DSHS and HCA IORT contacts no later than the last calendar day of the quarter in which the review was conducted.

7.11 Critical Incident Management System

- 7.11.1 The Contractor shall establish a Critical Incident Management System consistent with all applicable laws and shall include policies and procedures for identification of incidents, reporting protocols and oversight responsibilities. The Contractor shall designate a Critical Incident Manager responsible for administering the Incident Management System and ensuring compliance with the requirements of this Section.
- 7.11.2 Individual Critical Incident Reporting
 - 7.11.2.1 The Contractor shall submit an individual Critical Incident report for the following incidents that occur:
 - 7.11.2.1.1 To an Enrollee, and occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider.
 - 7.11.2.1.1.1 Abuse, neglect, or sexual/financial exploitation; and
 - 7.11.2.1.1.2 Death.
 - 7.11.2.1.2 By an Enrollee, with a behavioral health diagnosis; or history of behavioral health treatment within the

previous 365 days. Acts allegedly committed, to include:

7.11.2.1.2.1 Homicide or attempted homicide;

7.11.2.1.2.2 Arson;

7.11.2.1.2.3 Assault or action resulting in serious bodily harm which has the potential to cause prolonged disability or death;

7.11.2.1.2.4 Kidnapping; and

7.11.2.1.2.5 Sexual assault.

7.11.2.1.3 Unauthorized leave from a behavioral health facility during an involuntary detention.

7.11.2.1.4 Any event involving an Enrollee that has attracted, or is likely to attract media coverage. (Contractor shall include the link to the source of the media, as available).

7.11.2.2 The Contractor shall report critical incidents within one business day of becoming aware of the incident and shall report incidents that have occurred within the last thirty (30) calendar days, with the exception of incidents that have resulted in or are likely to attract media coverage. Media related incidents should be reported to HCA as soon as possible, not to exceed one business day.

7.11.2.2.1 The Contractor shall enter the initial report, follow-up, and actions taken into HCA Incident Reporting System <https://fortress.wa.gov/hca/ics/>, using the report template within the system.

7.11.2.2.2 If the system is unavailable the Contractor shall report Critical Incidents to HCAMCPrograms@hca.wa.gov.

7.11.2.2.2.1 HCA may ask for additional information as required for further research and reporting.

7.11.3 Population Based Reporting

7.11.3.1 The Contractor shall submit a semi-annual report of all Critical Incidents tracked during the previous six (6) months. The report shall include an analysis of the following incidents:

7.11.3.1.1 Incidents reported through HCA Incident Reporting System;

7.11.3.1.2 Incidents posing a credible threat to Enrollee safety;

7.11.3.1.3 Suicide and attempted suicide; and

7.11.3.1.4 Poisonings/overdoses unintentional or intention unknown.

- 7.11.3.2 The following shall be addressed in the analysis:
 - 7.11.3.2.1 How the incident reporting program has been structured and operationalized;
 - 7.11.3.2.2 The number and types of critical incidents and comparisons over time;
 - 7.11.3.2.3 Trends found in the population (i.e. regional differences, demographic groups, vulnerable populations, other as defined by Contractor);
 - 7.11.3.2.4 Actions taken by the Contractor to reduce incidents based on the analysis, and other actions taken and why;
 - 7.11.3.2.5 The Contractor's evaluation of how effective their critical incident program has been over the reporting period and changes that will be made, as needed.
- 7.11.3.3 The report shall be submitted as a Word document and is due no later than the last business day of January and July for the prior six (6) month period. The January report shall reflect incidents that occurred July through December and the July report shall reflect incidents that occurred January through June.
- 7.11.3.4 The Contractor shall also include a data file of all Critical Incidents from which the analysis is made using a template provided by HCA.

7.12 Mental Health Evidence-Based Practices (EBPs)

- 7.12.1 The Contractor shall cooperate and collaborate with HCA on the collection of data related to mental health EBPs. Contractor actions shall include, but are not limited to all of the following:
 - 7.12.1.1 Participation in planning meetings;
 - 7.12.1.2 Developing methods to collect and use data, including electronic health information; and
 - 7.12.1.3 Reporting of data on the uptake in use of EBPs over time to satisfy HCA requirements and state law.
- 7.12.2 The Contractor shall require the reporting of E/RBPs to Enrollees under 18 years of age by a qualified medical provider through SERI as outlined in the [Evidence-Based Practice Reporting Guides](#) and submit to HCA a quarterly report that details how the Contractor required the reporting the delivery of mental health Evidence/Research Based Practices (E/RBPs) provided to Clients under the age of 18 years old by a qualified medical provider. The quarterly reports are due to HCA the last business day of January, April, July, and October. The report shall include the following data information:
 - 7.12.2.1 The number of children receiving E/RBP services;
 - 7.12.2.2 The number of mental health encounters using these services;
 - 7.12.2.3 The percentage of mental health encounters using these services;
 - 7.12.2.4 Instructional information provided to authorized mental health providers on how to report E/RBPs through SERI. Authorized

provider types identified in SERI to provide individual group or family treat; and

- 7.12.2.5 Action steps taken with authorized mental health providers not reporting E/RBPs.

7.13 Evidence-Based, Research-Based and Promising Practices

The Contractor will promote the use of research and Evidence-Based Practices, with a particular focus on increasing these practices for children and Youth receiving mental health treatment services as identified through legislative mandates. This includes:

- 7.13.1 Ensuring providers participate in approved E/RBPs trainings as outlined in the [Evidence-Based Practice Reporting Guides](#) or as approved by the Evidence-Based Practice Institute.
- 7.13.2 Submitting an annual plan to HCA via MC-Track outlining how the Contractor is supporting medical providers reporting under the E/RBPs benchmark set by HCA to increase the use of culturally appropriate E/RBPs. The E/RBP Use and Reporting Support plan is due annually on the last day of March.

7.14 Home Health/Private Duty Nursing Services

On a quarterly basis, the Contractor shall submit to HCA a utilization review report of all Enrollees for whom Private Duty Nursing or Home Health services were requested. The report shall be due on the last business day of the month: in June when reporting for January-March; in September for April-June; in December for July-September; and in March for October-December. The report shall include:

- 7.14.1 Enrollee name;
- 7.14.2 Enrollee date of birth;
- 7.14.3 ProviderOne ID
- 7.14.4 Type of Service (Private Duty Nursing or Home Health);
- 7.14.5 Name of Provider;
- 7.14.6 Provider NPI;
- 7.14.7 Date request for services received;
- 7.14.8 Number of units requested, indicated days of fifteen (15) minute increments;
- 7.14.9 Number of units approved;
- 7.14.10 Number of units paid; and
- 7.14.11 Date decision was made.

7.15 Practice Guidelines

- 7.15.1 The Contractor shall adopt physical and behavioral health practice guidelines known to be effective in improving health outcomes. Practice guidelines shall meet the following requirements (42 C.F.R. § 438.236):

- 7.15.1.1 Are based upon the following:
 - 7.15.1.1.1 Valid and reliable clinical scientific evidence;
 - 7.15.1.1.2 In the absence of scientific evidence, on professional standards; or

- 7.15.1.1.3 In the absence of scientific evidence and professional standards, a consensus of Health Care Professionals in the particular field.
- 7.15.2 The Contractor shall develop guidelines based on the United States Preventive Services Task Force (USPSTF) as the primary source. The Contractor may adopt guidelines developed by recognized sources that develop or promote evidence-based clinical practice guidelines such as voluntary health organizations, National Institute of Health Centers, or the Substance Abuse and Mental Health Services Administration (SAMHSA). If the Contractor does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines. The guidelines shall:
 - 7.15.2.1 Be age appropriate to address the special needs or considerations that are driven by age.
 - 7.15.2.2 Consider the needs of Enrollees and support client and family involvement in care plans.
 - 7.15.2.3 Be adopted in consultation with contracting Health Care Professionals within the state of Washington, or, when applicable, are adopted in consultation with the behavioral health professionals in the Contractor's contracted network.
 - 7.15.2.4 Be reviewed and updated at least every two (2) years and more often if national guidelines change during that time.
 - 7.15.2.5 Be disseminated to all affected providers and, upon request, to HCA, Enrollees and Potential Enrollees (42 C.F.R. § 438.236(c)).
 - 7.15.2.6 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.
- 7.15.3 Be the basis for and are consistent with decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply (42 C.F.R. § 438.236(d)).
- 7.15.4 The Contractor shall develop health promotion and preventive care educational materials for Enrollees using both print and electronic media. In developing these materials, the Contractor shall:
 - 7.15.4.1 Conduct outreach to Enrollees to promote timely access to preventive care according to Contractor-established preventive care guidelines.
 - 7.15.4.2 Report on preventive care utilization through required performance measure reporting.
 - 7.15.4.3 In collaboration with peer Managed Care organizations, disaggregate data on at least one (1) preventive care measure and examine the data for racial/ethnic disparities.
 - 7.15.4.4 In collaboration with peer Managed Care Organizations, target interventions with known disparities in preventive care utilization

and measure the impact of the interventions on utilization patterns.

7.15.4.5 Prepare and disseminate all such materials consistently with the requirements of Subsections 3.2 and 3.3.

7.15.5 The Contractor shall include the behavioral health medical director in the evaluation of medications and other emerging technologies for the treatment of behavioral health conditions and related decisions. The Contractor shall also have a child psychiatrist available for consultation related to medications and other emerging technologies for the treatment of behavioral health conditions in children and adolescents.

7.16 Health Information Systems

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

7.16.1 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.

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

7.16.2.1 Verifying the accuracy and timeliness of reported data;

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

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

7.16.3 The Contractor shall make all collected data available to HCA and CMS upon request.

7.16.4 Establish and maintain protocols to support timely and accurate data exchange with any subcontractor that will perform any delegated behavioral health function under this Contract.

7.16.5 Establish and maintain web-based portals with appropriate security features that allow referrals, requests for prior authorizations, claims submission, and claims status updates for behavioral health services.

7.16.6 Have information systems that enable paperless submission, automated processing, and status updates for prior authorization and other UM related requests.

7.16.7 Establish and maintain data driven approaches to monitor requirements, by eligibility group when appropriate, including behavioral health network adequacy, crisis plans, mental health advance directives, and behavioral health specific reporting requirements for UM, QM, and financial management as well as administrative and clinical performance metrics.

7.16.8 Maintain behavioral health content on a website that meets the following minimum requirements:

7.16.8.1 Public and secure access via multi-level portals (such as providers and Enrollees) for providing web-based training, standard reporting,

and data access as needed for the effective management and evaluation of the performance of the contract and the service delivery system as described under this Contract.

- 7.16.8.2 The Contractor shall organize the website to allow for easy access of information by Enrollees, family members, network providers, stakeholders, and the general public in compliance with the Americans with Disabilities Act. The Contractor shall include on its website, at a minimum, the following information or links:
 - 7.16.8.2.1 Hours of operations for the Contractor.
 - 7.16.8.2.2 How to access behavioral health services, including crisis contact information and toll-free crisis telephone numbers.
 - 7.16.8.2.3 Telecommunications device for the deaf/text telephone numbers.
 - 7.16.8.2.4 Information on the right to choose a qualified behavioral health service provider.
 - 7.16.8.2.5 An overview of the range of behavioral health services being provided.
 - 7.16.8.2.6 Access to behavioral health-medical integration tools and supports to support provider integration initiatives.
 - 7.16.8.2.7 Access to information for Transitional Age Youth.
 - 7.16.8.2.8 A library for providers and Enrollees that provides comprehensive information and practical recommendations related to mental illness, SUD and recovery, life events, and daily living skills.
 - 7.16.8.2.9 Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for Enrollees receiving behavioral health services, family members, providers, and stakeholders to become involved.
 - 7.16.8.2.10 Information regarding advocacy organizations, including how Enrollees and other family members may access advocacy services.
 - 7.16.8.2.11 Opportunities, including surveys, for behavioral health Enrollees, family members, network providers, and other stakeholders to provide satisfaction/complaint feedback.

7.17 Clinical Data Repository

- 7.17.1 HCA shall develop and the Contractor shall publish guidelines for participation in the CDR, along with the contacts and resources to support provider organizations through the readiness activities.
- 7.17.2 The Contractor shall require that the subcontracted physical health provider organizations sends clinical information to the CDR after providing services to

Apple Health Enrollees.

- 7.17.3 The Contractor shall support and encourage subcontracted behavioral health provider organizations send clinical information to the CDR after providing services to Apple Health Enrollees. Support may include, but is not limited to, providing technical assistance resources to providers.
- 7.17.4 Clinical information submitted to the CDR should be provided as a care summary using the C-CDA standard or other applicable transaction as specified by HCA.
- 7.17.5 If a provider does not have an EHR certified to the 2014 or 2015 certification standards, these requirements do not apply.
- 7.17.6 If a provider holds itself out as a SUD treatment provider under 42 C.F.R. Part 2, these requirements do not apply.

7.18 Data Submission to Collective Medical Technologies (CMT)

The Contractor shall submit enrollment, encounter and provider data to Collective Medical Technologies on a monthly basis. The data will be used to improve the ability of Emergency Room physicians to make informed decisions about Enrollees, improve care coordination and ensure Enrollee safety. HCA will provide a list of required data elements to ensure consistency.

The Contractor shall maintain a record of submission and record any errors or issues that occur during submission.

- 7.18.1 The Contractor will report to HCA in a form and manner to be determined by HCA, within five (5) calendar days of any issues that prevent or delay submission of data to CMT. The report will include any actions the Contractor will take to resolve the issue including any requests for HCA assistance.
- 7.18.2 The Contractor will provide a summary report for each calendar year to HCA within thirty (30) business days upon request showing confirmation of submission and any errors that occurred by month.

7.19 Required Reporting for Behavioral Health Services

- 7.19.1 The Contractor must comply with behavioral health reporting requirements, including SERI. Beginning October 1, 2020, the Contractor must begin reporting of behavioral health supplemental transactions using the Behavioral Health Supplemental Transaction Guide. This first report must include data going back to January 1, 2020. A test batch must be sent no later than September 1, 2020. Reporting includes encounters and behavioral health supplemental transactions documenting services paid for by the Contractor and delivered to Enrollees during a specified reporting period.
- 7.19.2 Behavioral Health Supplemental Transaction Data Submission and Error Correction.
 - 7.19.2.1 The Contractor must submit behavioral health supplemental transactions about Enrollees to the Behavioral Health Data System within thirty (30) calendar days of collection or receipt from subcontracted providers.
 - 7.19.2.2 Upon receipt of data submitted, the Behavioral Health Data System

generates error reports. The Contractor must have documented policies and procedures to assure that data submitted and rejected due to errors are corrected and resubmitted within thirty (30) calendar days.

7.19.2.3 The Contractor must implement changes documented in any updated version of the Behavioral Health Supplemental Transaction Guide within 120 calendar days from the date published.

7.19.2.3.1 In the event that shorter timelines for implementation of changes under this Section are required or necessitated by either a court order or agreement resulting from a lawsuit or legislative action, HCA will provide notice of the impending changes and specification for the changes as soon as they are available. The Contractor will implement the changes required by the timeline established in the court order, legal agreement, or legislative action.

7.19.2.4 The Contractor must send at least one test batch of data containing the required changes. The test batch must be received no later than fifteen (15) calendar days prior to the implementation date.

7.19.2.4.1 The test batch must include 100 transactions that include information effected by the change.

7.19.2.4.2 The processed test batch must result in at least 80 percent successfully posted transactions or an additional test batch is required.

7.19.2.5 The Contractor must respond to requests from HCA for behavioral health information not previously reported in a timeframe determined by HCA that will allow for a timely response to inquiries from CMS, SAMHSA, the legislature, and other parties.

7.19.3 The Contractor's disclosure of individually identifiable information is authorized by law, including 42 C.F.R. § 2.53, authorizing disclosure of patient records for purposes of Medicaid evaluation.

7.20 Technical Assistance

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

7.21 Annual Diabetes Report

7.21.1 The Contractor shall prepare an annual report on the prevalence of diabetes and utilization of diabetes education services among Contractor Enrollees. The report is due each year no later than the last business day of December and shall include data from the first business day of October of the previous calendar year through the last business day of September of the current calendar year.

7.21.2 The Annual Diabetes Report shall be no more than four (4) pages in length, excluding attachments, and shall describe:

7.21.2.1 The total number of Contractor Enrollees with Type 1 and Type 2

diabetes.

- 7.21.2.2 The number of Contractor Enrollees with Type 1 and Type 2 diabetes in the following age groupings:
 - 7.21.2.2.1 Ages less than 18 years of age;
 - 7.21.2.2.2 Ages 18-64 years of age; and
 - 7.21.2.2.3 Ages greater than 65 years of age.
- 7.21.2.3 The gender distribution of Enrollees with Type 1 and Type 2 diabetes.
- 7.21.2.4 The geographic distribution of Enrollees with Type 1 and Type 2 diabetes using the Enrollee's county of residence, rolled up into the *Healthier Washington* regional map found at: <http://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach>.
- 7.21.2.5 The total number of Enrollees with a diagnosis of Type 1 and Type 2 diabetes who received a diabetes education encounter.
- 7.21.2.6 The proportion of Enrollees with a diagnosis of diabetes Type 1 and Type 2 diabetes who received a diabetes education encounter.
- 7.21.2.7 A narrative description of how:
 - 7.21.2.7.1 Enrollees are referred to diabetes education, and a description of any role that the plan plays in these referrals.
 - 7.21.2.7.2 Diabetes education is promoted to Enrollees including links to Diabetes educational materials.
 - 7.21.2.7.3 Diabetes education providers enroll with the Contractor if interested in joining the Contractor's network of providers.
- 7.21.2.8 A list of:
 - 7.21.2.8.1 Available Diabetes education providers including, name of diabetes educator, physical address, zip code, county and *Healthier Washington* region.
 - 7.21.2.8.2 Any potential gaps in the network of diabetes educators, and measures the Contractor may take to address gaps in network providers.

7.22 Value-Based Purchasing: Paying for Value Survey

- 7.22.1 Each year the Contractor will complete all portions of HCA's annual Paying for Value Survey located in MC-Track, as appropriate based on the Contractor's non-Apple Health contracting in Washington State. The Contractor's survey response is due at the end of the month following HCA's release of the survey (e.g. survey is released July 1, 2019, Contractor's response is due August 31, 2019).

8 POLICIES AND PROCEDURES

The Contractor shall develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of this Contract. The Contractor shall submit policies and procedures to HCA for review and approval in accordance with Subsection 8.2 of this Section, Assessment of Policies and Procedures.

8.1 Contractor's Policies and Procedures:

The Contractor's Policies and Procedures shall:

- 8.1.1 Direct and guide the Contractor's employees, Subcontractors, and any non-contracted providers' compliance with all applicable federal, State, and contractual requirements;
- 8.1.2 Fully articulate the Contractor's understanding of the requirements;
- 8.1.3 Have an effective training plan related to the requirements and maintain records of the number of staff participating in training, including evidence of assessment of participant knowledge and satisfaction with the training;
- 8.1.4 Have an effective training plan related to the requirements and maintain records of the number of providers who participate in training, including satisfaction with the training; and
- 8.1.5 Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.

8.2 Assessment of Policies and Procedures

- 8.2.1 The Contractor shall provide a list of its policies and procedures related to this Contract to HCA. The format for the list will be provided by HCA. The Contractor shall complete and submit the list no later than June 30, 2019; and in response to corrective action, any time there is a new policy and procedure or a change to an existing policy and procedure. The Contractor shall also submit copies of policies and procedures upon request by HCA.

9 SUBCONTRACTS

9.1 Contractor Remains Legally Responsible

Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract. However, no subcontract, or other agreement delegating any authority or performance of obligations under this Contract, shall terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any subcontractor (42 C.F.R. § 434.6(c) and 438.230(b)).

9.1.1 Beginning January 1, 2020, the Contractor will submit to HCA for approval an HCA Self-Assessment form and any templates for an individual or entity to perform any duties or obligations that the Contractor is required to perform. Templates will also be submitted any time there is a substantive change to the template. The HCA Self-Assessment form and templates will be submitted to hcamcprograms@hca.wa.gov. This includes each of the following, as applicable:

- 9.1.1.1 Agreement;
- 9.1.1.2 Contract;
- 9.1.1.3 Statement of Work;
- 9.1.1.4 Amendment(s); and
- 9.1.1.5 Exhibits.

9.1.2 Rates or payment amounts may be redacted from the contract template.

9.1.3 A subcontract will not take effect prior to HCA's review and written approval of the template. If HCA does not provide approval or denial within forty-five (45) calendar days, the Contractor may move forward with executing the subcontract.

9.1.4 Approval or denial shall be provided within forty-five (45) calendar days of the Contractor's submission to HCA. When denied, HCA will provide the deficiencies identified in the template in need of correction.

9.2 Solvency Requirements for Subcontractors

For any Subcontractor at financial risk, as defined in the Substantial Financial Risk provision, or of the Risk provision found in the Definitions Section of this Contract, the Contractor shall establish, enforce and monitor solvency requirements that provide assurance of the Subcontractor's ability to meet its obligations.

9.3 Provider Nondiscrimination

9.3.1 The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold (42 C.F.R. § 438.12(a)(1)).

9.3.2 If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision (42 C.F.R. § 438.12(a)(1)).

9.3.3 The Contractor's policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk

populations or specialize in conditions that require costly treatment (42 C.F.R. § 438.214(c)).

9.3.4 Consistent with the Contractor's responsibilities to the Enrollees, this Section may not be construed to require the Contractor to:

9.3.4.1 Contract with providers beyond the number necessary to meet the needs of its Enrollees (42 C.F.R. § 438.12(b)(1)).

9.3.4.2 Preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty (42 C.F.R. § 438.12(b)(2)).

9.3.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs (42 C.F.R. § 438.12(b)(3)).

9.4 Required Provisions

Subcontracts shall be in writing and be consistent with the provisions of 42 C.F.R. § 434.6, § 438.230 and § 438.214, as applicable. All subcontracts shall contain applicable provisions contained in Subsections 9.5 and 9.6 of this Contract and the following provisions:

9.4.1 Identification of the parties of the subcontract and their legal basis for operation in the state of Washington.

9.4.2 A process for monitoring the subcontractor's performance and a periodic schedule for formally evaluating performance, consistent with industry standards or state managed care laws and regulations.

9.4.3 Procedures and specific criteria for terminating the subcontract and for any other remedies the Contractor provides if HCA or the Contractor determines that the subcontractor has not performed satisfactorily (42 C.F.R. §438.230(c)(1)(iii)).

9.4.4 Identification of the services to be performed and reports to be provided by the Subcontractor and which of those services may be subcontracted by the Subcontractor. If the Contractor allows the subcontractor to further subcontract, all subcontractor requirements contained in this Contract must be propagated downward into any other lower tiered subcontracts.

9.4.5 Reimbursement rates and procedures for services provided under the subcontract, including the use of the Contractor's own fee schedule for services provided by essential behavioral health providers.

9.4.6 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.

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

- 9.4.8 The Contractor and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring, or evaluation identified in subsection 9.4.7. If the requesting agency asks for copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency. (42 C.F.R. § 455.21(a)(2); 42 C.F.R. § 431.107(b)(2)). The right for the parties named above to audit, access, and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law. (42 C.F.R. § 438.3(h)).
- 9.4.9 The requirement to completely and accurately report encounter data and behavioral health supplemental transactions, and to certify the accuracy and completeness of all data submitted to the Contractor. The Contractor shall ensure that all Subcontractors required to report encounter data and behavioral health supplemental transactions have the capacity to submit all HCA required data to enable the Contractor to meet the reporting requirements in the Encounter Data Guide and Behavioral Health Supplemental Transaction Data Guide published by HCA.
- 9.4.10 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved program integrity policies and procedures.
- 9.4.11 No assignment of a subcontract shall take effect without HCA's written agreement.
- 9.4.12 The Subcontractor shall comply with the applicable state and federal statutes, rules, and regulations including, but not limited to, the laws identified in Subsection 2.4 of this Contract, 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).
- 9.4.13 Subcontracts shall set forth and require the Subcontractor to comply with any term or condition of this Contract that is applicable to the services to be performed under the subcontract (42 C.F.R. § 438.6).
- 9.4.14 The Contractor shall provide the following information regarding the Grievance and Appeal System to all Subcontractors (42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(1)):
- 9.4.14.1 The toll-free numbers to file oral Grievances and Appeals.
 - 9.4.14.2 The availability of assistance in filing a Grievance or Appeal, including informing the Enrollee about Ombuds services and how to access these services.
 - 9.4.14.3 The Enrollee's right to request continuation of Medicaid benefits during an appeal or hearing and, if the Contractor's Adverse Benefit Determination is upheld, that the Enrollee may be responsible to pay for the cost of the benefits received for the first sixty (60) calendar days after the appeal or hearing request was received.
 - 9.4.14.4 The Enrollee's right to file Grievances and Appeals and their

requirements and timeframes for filing.

- 9.4.14.5 The Enrollee's right to a hearing, how to obtain a hearing, and representation rules at a hearing.
- 9.4.14.6 The Subcontractor may file a Grievance or request an adjudicative proceeding on behalf of an Enrollee in accordance with subsection 13.2.1.
- 9.4.15 The process for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.
- 9.4.16 A process to identify deficiencies and take corrective action for both the Contractor and Subcontractor.
- 9.4.17 The process whereby the Subcontractor evaluates and ensures that services furnished to individuals with special health care needs are appropriate to the Enrollee's needs.
- 9.4.18 Prior to delegation, the Contractor shall evaluate any prospective Subcontractor's ability to perform the activities for which that Subcontractor is contracting, including the Subcontractor's ability to perform delegated activities described in the subcontracting document.
- 9.4.19 The requirement to refer potential allegations of fraud to HCA and the MFCD as described in Subsection 12.6 of this Contract. (42 C.F.R § 455.23).
- 9.4.20 An exception request process for underpaid pharmacy claims must be available online for pharmacies on both the Contractor's website and the PBM's website. The process may require the pharmacy to provide an invoice documenting the actual acquisition cost of the medication and reasons why the product was not available for purchase at the reimbursement rate set by the PBM.

9.5 Health Care Provider Subcontracts

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

- 9.5.1 A quality improvement system consistent with the Contractor's obligations under Subsections 7.1, 7.2, and 7.5, tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this Contract.
- 9.5.2 A statement that primary care and specialty care provider subcontractors shall cooperate with Quality Assessment and Performance Improvement (QAPI) activities required by Section 7 of this Contract.
- 9.5.3 A means to keep records necessary to adequately document services provided to Enrollees for all delegated activities including QAPI, Utilization Management, Enrollee Rights and Responsibilities, Health Homes, and Credentialing and Re-credentialing.
- 9.5.4 A requirement that the Subcontractor shall comply with chapter 71.32 RCW (Mental Health Advance Directives).
- 9.5.5 Delegated activities are documented and agreed upon between Contractor and Subcontractor. The document must include:

- 9.5.5.1 Assigned responsibilities.
- 9.5.5.2 Delegated activities.
- 9.5.5.3 A mechanism for evaluation.
- 9.5.5.4 Corrective action policy and procedure.
- 9.5.6 Information about Enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.
- 9.5.7 An agreement that applicable Subcontractors will receive payment for the supervision of behavioral health providers whose license or certification restricts them to working under supervision, effective with the next provider contracting period.
- 9.5.8 The Subcontractor accepts payment from the Contractor as payment in full. The Subcontractor shall not request payment from HCA or any Enrollee for contracted services performed under the subcontract, and shall comply with WAC 182-502-0160 requirements applicable to providers.
- 9.5.9 The Subcontractor agrees to hold harmless HCA and its employees, and all Enrollees served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors (42 C.F.R. § 438.230(b)(2)).
- 9.5.10 If the subcontract includes physician or behavioral health services, provisions for compliance with the Performance Improvement Project (PIP) requirements stated in this Contract.
- 9.5.11 If the subcontract includes physician services, provisions that inform the provider of any state determined appeal rights to challenge the failure of the Contractor to cover a service (42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(1)(xi)).
- 9.5.12 A ninety (90) day termination notice provision.
- 9.5.13 A specific termination provision for termination with short notice when a Subcontractor is excluded from participation in the Medicaid program.
- 9.5.14 The Subcontractor agrees to comply with all relevant provisions of this Contract, including, but not limited to, the appointment wait time standards and the obligation to report accurately the information required for the Contractor's provider directory and any changes thereto. The subcontract must provide for regular monitoring of timely access and corrective action if the Subcontractor fails to comply with the appointment wait time standards (42 C.F.R. § 438.206(c)(1)).
- 9.5.15 A provision that informs the provider of a reasonably accessible on-line location of the policies and procedures listed in Section 8 of this Contract.
- 9.5.16 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. Formal review must be completed no less than once every three (3) years and must identify deficiencies or areas

for improvement and provide for corrective action (42 C.F.R. § 438.230(b)).

- 9.5.16.1 Upon request by HCA, the Contractor will provide a copy of the monitoring policy, process and any results of identified health care providers.
- 9.5.17 The Contractor shall document and confirm in writing all Single Case Agreements with providers. The agreement shall include:
 - 9.5.17.1 The description of the services;
 - 9.5.17.2 The authorization period for the services, including the begin date and the end date for approved services;
 - 9.5.17.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other plan documents that define payment; and
 - 9.5.17.4 Any other specifics of the negotiated rate.
- 9.5.18 The Contractor must supply documentation to the Subcontractor no later than five (5) business days following the signing of the agreement. Updates to the Single Case Agreement, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).
- 9.5.19 The Contractor shall maintain a record of the Single Case Agreements for a period of six (6) years.
- 9.5.20 The Contractor shall provide a copy of the Health Care Provider subcontract template and any contract samples upon request by HCA.
- 9.5.21 The Contractor shall include Exhibit L, Medicaid and CHIP Managed Care Addendum for IHCPs, in every subcontract with an IHCP.
- 9.6 **Health Care Provider Subcontracts Delegating Administrative Functions**
 - 9.6.1 Subcontracts that delegate administrative functions under the terms of this Contract shall include the following additional provisions:
 - 9.6.1.1 For those Subcontractors at financial risk, that the Subcontractor shall maintain the Contractor's solvency requirements throughout the term of the Contract.
 - 9.6.1.2 Clear descriptions of any administrative functions delegated by the Contractor in the subcontract. Administrative functions are any obligations of the Contractor under this Contract other than the direct provision of services to Enrollees and include, but are not limited to, utilization/medical management, claims processing, behavioral health supplemental transactions processing. Enrollee Grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.
 - 9.6.1.3 How frequently and by what means the Contractor will monitor compliance with solvency requirements and subcontractor performance related to any administrative function delegated in the subcontract.
 - 9.6.1.4 Provisions for revoking delegation or imposing sanctions if the

Subcontractor's performance is inadequate (42 C.F.R. § 438.230(c)(1)(iii)).

9.6.1.5 Whether referrals for Enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.

9.6.1.6 Prior to delegation, an evaluation of the Subcontractors ability to successfully perform and meet the requirements of this Contract for any delegated administrative function.

9.6.2 The Contractor shall submit a report of all current delegated entities, activities delegated and the number of Enrollees assigned or serviced by the delegated entity to HCA by March 1 of each year applicable to this Contract and upon request by HCA.

9.7 Administrative Functions with Subcontractors and Subsidiaries

9.7.1 Essential Behavioral Health Administrative Functions may be subcontracted for a period of time as determined by HCA and the Contractor. The Contractor shall achieve full integration of Essential Behavioral Health Administrative Functions according to a timeline agreed upon with HCA. No Subcontractor shall terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any Subcontractor.

9.7.2 Behavioral Health Subcontracts must require Subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the activity to be performed under this Contract.

9.7.2.1 Subcontracts must require Subcontractors to notify the Contractor in the event of a change in status of any required license or certification.

9.7.3 GAIN-SS

9.7.3.1 Subcontracts for the provision of behavioral health services must require the use of the GAIN-SS and assessment process that includes use of the quadrant placement. In addition, the Subcontract must contain terms requiring corrective action if the Integrated Co-Occurring Disorder Screening and Assessment process is not implemented and maintained throughout the contract period of performance.

9.7.3.2 If the results of the GAIN-SS are indicative of the presence of a co-occurring disorder, this information must be considered in the development of the treatment plan including appropriate referrals.

9.8 Health Homes

The Contractor shall provide health home services as a qualified health home lead organization, or may delegate the Health Home services by contracting with other qualified Health Home lead organizations, to deliver health home services for Enrollees meeting the eligibility criteria for the Health Home program. The Contractor shall subcontract with community based Care Coordination Organizations sufficient in quantity and type and may also provide Health Home services as a Care Coordination Organization.

Network adequacy for a Care Coordination Organization (CCO) network will be determined by evidence of signed subcontracts with at least five of the CCOs described below. Two of the five subcontracts must be with an organization that provides mental health services and an organization that provides long-term services and supports. The Contractor must assign at least 35 percent of their Health Home Enrollee population to the subcontracted CCO when providing Health Home services in each coverage area.

The following CCOs meet the requirement for “sufficiency” of a Health Home network:

- 9.8.1 Federally Qualified Health Centers
- 9.8.2 Area Agencies on Aging
- 9.8.3 Rural Health Clinics
- 9.8.4 Community Mental Health Agencies
- 9.8.5 Mental Health clinics or counseling services
- 9.8.6 Substance Use Disorder Treatment Agencies or counseling services
- 9.8.7 Hospitals
- 9.8.8 Medical or specialty clinics
- 9.8.9 Pediatric clinics
- 9.8.10 Social Service organizations

9.9 Home Health Providers

The Contractor may not subcontract with a home health agency unless the home health agency is in compliance with the surety bond requirements of federal law (Section 4708(d) of the Balanced Budget Act of 1997 and 42 C.F.R. § 441.16).

9.10 Physician Incentive Plans

Physician Incentive Plans, as defined herein, are subject to the conditions set forth in this Section and in federal regulations (42 C.F.R. § 438.6, 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210). The Contractor shall provide written notification to HCA on an annual basis (due March 1) that its physician’s incentive plans, if any, comply with federal regulations.

- 9.10.1 Prohibited Payments: The Contractor shall make no payment to a physician or Physician Group, directly or indirectly, under a Physician Incentive Plan as an inducement to reduce or limit Medically Necessary Services provided to an individual Enrollee.
- 9.10.2 Disclosure Requirements: Risk sharing arrangements in subcontracts with physicians or Physician Groups are subject to review and approval by HCA. Prior to entering into, modifying, or extending the risk sharing arrangement in a subcontract at any tier, the Contractor shall provide the following information about its Physician Incentive Plan, and the Physician Incentive Plans of its Subcontractors to HCA:
 - 9.10.2.1 A description of the incentive plan including whether the incentive plan includes referral services.
 - 9.10.2.2 If the incentive plan includes referral services, the information provided to HCA shall include:
 - 9.10.2.2.1 The type of incentive plan (e.g., withhold, bonus, capitation).

- 9.10.2.2.2 For incentive plans involving withholds or bonuses, the percent that is withheld or paid as a bonus.
 - 9.10.2.2.3 Proof that stop-loss protection meets the requirements identified within the provisions of this Section, including the amount and type of stop-loss protection.
 - 9.10.2.2.4 The panel size and, if commercial members and Enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or Physician Group's panel may be pooled provided the terms of risk for the pooled Enrollees and commercial members are comparable, and the incentive payments are not calculated separately for pooled Enrollees. Commercial members include military members.
- 9.10.3 If the Contractor, or any Subcontractor, places a physician or Physician Group at Substantial Financial Risk, the Contractor shall assure that all physicians and Physician Groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or Physician Group.
- 9.10.3.1 If aggregate stop-loss protection is provided, it must cover 90 percent of the costs of referral services that exceed 25 percent of maximum potential payments under the subcontract.
 - 9.10.3.2 If stop-loss protection is based on a per-member limit, it must cover 90 percent of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.
 - 9.10.3.2.1 1,000 members or fewer, the threshold is \$3,000 for professional services and \$10,000 for institutional services, or \$6,000 for combined services.
 - 9.10.3.2.2 1,001 - 5,000 members, the threshold is \$10,000 for professional services and \$40,000 for institutional services, or \$30,000 for combined services.
 - 9.10.3.2.3 5,001 - 8,000 members, the threshold is \$15,000 for professional services and \$60,000 for institutional services, or \$40,000 for combined services.
 - 9.10.3.2.4 8,001 - 10,000 members, the threshold is \$20,000 for professional services and \$100,000 for institutional services, or \$75,000 for combined services.
 - 9.10.3.2.5 10,001 - 25,000 members, the threshold is \$25,000 for professional services and \$200,000 for institutional services, or \$150,000 for combined services.
 - 9.10.3.2.6 25,001 members or more, there is no risk threshold.

- 9.10.3.3 The Contractor shall provide the following information regarding its Physician Incentive Plans to any Enrollee who requests it:
 - 9.10.3.3.1 Whether the Contractor uses a Physician Incentive Plan that affects the use of referral services;
 - 9.10.3.3.2 The type of incentive arrangement; and
 - 9.10.3.3.3 Whether stop-loss protection is provided.

9.11 Provider Education

The Contractor will maintain records of the number and type of providers and support staff participating in provider education, including evidence of assessment of participant satisfaction from the training process.

- 9.11.1 The Contractor shall keep Participating Providers informed about:
 - 9.11.1.1 Covered Services for Enrollees served under this Contract.
 - 9.11.1.2 Coordination of care requirements.
 - 9.11.1.3 HCA and the Contractor's policies and procedures as related to this Contract.
 - 9.11.1.4 Health Homes.
 - 9.11.1.5 HCA First Steps Program - Maternity Support Services (MSS). The Contractor shall notify providers about HCA's First Steps Program, MSS, using HCA's MSS informational letter template that includes HCA First Steps Program website and Provider Directory.
 - 9.11.1.6 Interpretation of data from the Quality Improvement program.
 - 9.11.1.7 Practice guidelines as described in the provisions of this Contract.
 - 9.11.1.8 Behavioral health services through the Contractor. The Contractor shall provide a link to the provider directory annually to all Primary Care Providers, including its contracted mental health and children's mental health professionals. The Contractor shall provide the link to its Primary Care Providers no later than January 31.
 - 9.11.1.9 Behavioral Health resource line (chapter 74.09 RCW).
 - 9.11.1.10 The information required for UM decision making, procedure coding and submitting claims. The Contractor shall inform behavioral health network providers in writing regarding these requirements.
 - 9.11.1.11 Contractor care management staff for assistance in care transitions and care management activity.
 - 9.11.1.12 Program Integrity requirements.
 - 9.11.1.13 DSHS long-term care services, including availability of home and community based care (chapter 388-106 WAC).
 - 9.11.1.14 DSHS developmental disability services including community-based care (WAC 388-823 to -850).
 - 9.11.1.15 DCYF services for children and families, including, but not limited to, DCYF-contracted home visiting, Early Support for Infants and Toddlers (ESIT), Early Childhood Intervention and Prevention

Services (ECLIPSE), and Early Childhood and Education Assistance Program (ECEAP) and Head Start programs using the informational letter template jointly developed by DCYF and HCA.

- 9.11.1.16 Perinatal Psychiatry Consultation Line (PAL for Moms) offered through University of Washington Medicine.
- 9.11.1.17 Educational opportunities for Primary Care Providers, such as those produced by the Washington State Department of Health Collaborative, the Washington State Medical Association or the Washington State Hospital Association, etc. The Contractor shall offer continuing medical and clinical education, including when network providers complete attendance requirements for contractually required training.
- 9.11.1.18 The Contractor, in collaboration with HCA, shall keep providers (including physical health, behavioral health, tribal health care providers) informed of and provide technical assistance on:
 - 9.11.1.18.1 Health IT and interoperable health information exchange at the state and federal levels;
 - 9.11.1.18.2 Current and anticipated health information exchange and use via the CDR; and
 - 9.11.1.18.3 Information about Certified EHR Technology and Certified Health IT available through the ONC.
- 9.11.2 The Contractor shall develop and deliver ongoing training for network providers. The training objective is to strengthen the knowledge, skill and expertise of all parties to improve integrated care delivery as it relates to outreach and engagement, screening and assessment, appropriate referral and delivery of person-centered, recovery-oriented care. Training shall go beyond concepts to address how to incorporate guidelines and principles into daily practice. This shall include offering technical assistance and support tools regarding coordinated care practices defined in Section 14 of this Contract. The training program shall meet the following minimum requirements:
 - 9.11.2.1 Training shall be accessible to network providers at alternate times and days of the week. A schedule of training shall be available on the Contractor's website and updated as needed but at least annually.
 - 9.11.2.2 Training for behavioral health network providers shall address the following requirements:
 - 9.11.2.2.1 The application of evidence-based, research-based, Promising Practices related to the assessment and treatment of behavioral health conditions, including those from the Bree Collaborative.
 - 9.11.2.2.2 Incorporation of Recovery and Resilience principles in service provision as well as policies and procedures.
 - 9.11.2.2.3 Screening, identification and referral for treatment for medical conditions and risk factors commonly

occurring in individuals with severe and persistent behavioral health. For individuals on medication, screening includes review of Enrollee medical and medication history, and for individuals on psychotropic medication, vital signs, weight, and BMI. Screening tools used with children and Youth shall be developmentally age-appropriate.

9.11.2.2.4 Subcontracts must require Subcontractors to participate in training when requested by HCA. Requests for HCA to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to targeted Subcontractor staff.

9.11.2.2.5 Annually, all community behavioral health employees who work directly with Enrollees must be provided with training on safety and violence prevention topics described in RCW 49.19.030.

9.11.2.3 The Contractor shall ensure all of its contracted Primary Care Providers are offered training related to all of the following:

9.11.2.3.1 Screening for behavioral health conditions using developmentally, age appropriate screening tools.

9.11.2.3.2 Brief Intervention and Referral to Treatment for Enrollees aged 13 years and older.

9.11.2.3.3 The application of evidence-based, research-based and Promising Practices (including those from the Bree Collaborative) for behavioral health conditions commonly occurring in primary care.

9.11.2.3.4 Identification of individuals with First Episode Psychosis (FEP) and referral to appropriate FEP services.

9.11.2.4 Behavioral health and medical providers shall be offered training on effective approaches to managing individuals with co-occurring conditions including individuals with behavioral health and co-occurring medical conditions or co-occurring intellectual and developmental disabilities. Training shall address the following requirements:

9.11.2.4.1 Care Coordination requirements as defined in Section 14, including, but not limited to creating and maintaining a shared care plan;

9.11.2.4.2 Collaborative care or similar research-based models for Care Coordination;

9.11.2.4.3 Discharge planning for Enrollees transitioning from the hospital to the community; and

9.11.2.4.4 Accurate diagnosis and appropriate treatment for individuals with I/DD.

- 9.11.2.5 Enrollees, family members and other caregivers are involved in the planning, development and delivery of trainings specific to delivery of behavioral health services and behavioral health-medical integration initiatives.
- 9.11.2.6 Cultural competency shall be incorporated into provider training specific to delivery of behavioral health services and behavioral health-medical integration initiatives.
- 9.11.3 The Contractor shall maintain records of the number and type of providers and support staff participating in provider education, including evidence of assessment of participant satisfaction from the training process.

9.12 Claims Payment Standards

- 9.12.1 The Contractor shall meet the timeliness of payment standards specified for Medicaid FFS in Section 1902(a)(37) of the Social Security Act, 42 C.F.R. § 447.46 and specified for health carriers in WAC 284-170-431. These standards shall also be applicable to State-only and federal block grant fund payments. To be compliant with payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, 95 percent of clean claims within thirty (30) calendar days of receipt, 95 percent of all claims within sixty (60) calendar days of receipt and 99 percent of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.
 - 9.12.1.1 A claim is a bill for services, a line item of service or all services for one (1) Enrollee within a bill.
 - 9.12.1.2 A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.
 - 9.12.1.3 The date of receipt is the date the Contractor receives the claim from the provider.
 - 9.12.1.4 The date of payment is the date of the check or other form of payment.
- 9.12.2 The Contractor shall support both hardcopy and electronic submission of claims and encounters for all claim types (hospital and professional services).
- 9.12.3 The Contractor must support hardcopy and electronic submission of claim inquiry forms, and adjustment claims and encounters.
- 9.12.4 The Contractor shall educate and support Behavioral Health Providers about the requirement to submit HIPAA-compliant encounters.
 - 9.12.4.1 The Contractor shall work with BH Providers to resolve encounters or claims not approved on initial submission, identify and resolve errors in encounter submission before they become widespread and systemic, and address other billing issues discovered during the first 180 days of the Contract.
 - 9.12.4.2 The Contractor shall ensure timely payment to BH providers for services delivered to enrollees when a mental health or SUD provider cannot submit HIPAA-compliant encounters or electronic

claims.

- 9.12.4.3 The Contractor shall produce and provide monthly reports to contracted BH providers to assist with claims management that includes numbers of accepted claims or encounters vs. those that are not accepted on initial submission, and error rates by types of errors.
- 9.12.5 The Contractor shall update its claims and encounter system to support additional behavioral health services, provider types and provider specialties for rendering providers that will be added under the Apple Health - Integrated Managed Care program.
- 9.12.6 The Contractor shall allow providers 365 calendar days to submit claims for services provided under this Contract unless the provider has agreed or agrees to a shorter timely filing timeframe in their contract with the Contractor.
- 9.12.7 The Contractor shall produce and submit to HCA a quarterly claims denial analysis report. The report is due the 15th of the month following the end of the quarter. The report shall include the following data:
 - 9.12.7.1 Total number of:
 - 9.12.7.1.1 Approved claims for which there was at least one denied line; and
 - 9.12.7.1.2 Completely denied claims.
 - 9.12.7.2 Total number of claims adjudicated in the reporting claim.
 - 9.12.7.3 Total number of behavioral health claims denied by claim line.
 - 9.12.7.4 Summary by reason and type of claims denied.
 - 9.12.7.5 The total number of denied claims divided by the total number of claims.
 - 9.12.7.6 For each of the five network billing providers with the highest number of total denied claims, the number of total denied claims expressed as a ratio to all claims adjudicated.
 - 9.12.7.7 Total number of:
 - 9.12.7.7.1 Behavioral Health claims received, that were not approved upon initial submission.
 - 9.12.7.7.2 The total number of rejected/non-clean behavioral health claims, divided by the total number of claims submitted.
 - 9.12.7.7.3 The top five reasons for behavioral health claims being rejected upon initial submission.
- 9.12.8 The report shall include a narrative, including the action steps planned to address:
 - 9.12.8.1 The top five (5) reasons for denial, including provider education to the five network billing providers with the highest number of total denied claims. Provider education must address root causes of

denied claims and actions to address them.

9.12.8.2 Claims denied in error by the Contractor.

9.13 Federally Qualified Health Centers / Rural Health Clinics Report

The Contractor shall provide HCA with information related to subcontracted Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), as required by HCA Federally Qualified Health Center and Rural Health Center Billing Guides, published by HCA and incorporated by reference into this Contract.

9.14 Screening and Enrollment of Providers

- 9.14.1 The Contractor shall ensure that all network providers are enrolled with the state as Medicaid providers consistent with federal disclosure, screening and enrollment requirements.
- 9.14.2 HCA shall screen, enroll and periodically revalidate all network providers as Medicaid providers, in accordance with Part 455, Subparts B and E of chapter 42 C.F.R.
- 9.14.3 The Contractor may execute network provider agreements, pending the outcome of screening, enrollment and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from HCA that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and must notify affected Enrollees.

9.15 Provider Credentialing

The Contractor's policies and procedures shall be in writing and meet NCQA requirements related to the credentialing and re-credentialing of Health Care Professionals who have signed contracts or participation agreements with the Contractor. The Contractor shall ensure and demonstrate compliance with the requirements described in this Contract (42 C.F.R. § 438.214).

- 9.15.1 The Contractor's policies and procedures related to the credentialing and recredentialing of Health Care Professionals shall ensure compliance with the following requirements described in this Section.
 - 9.15.1.1 The Contractor's medical director or other designated physician shall have direct responsibility for and participation in the credentialing program.
 - 9.15.1.2 The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.
- 9.15.2 The Contractor's credentialing and recredentialing program shall include:
 - 9.15.2.1 Identification of the type of providers credentialed and recredentialed, including but not limited to, acute, primary, behavioral, SUD and LTSS providers, as appropriate (42 C.F.R. § 438.214(b)).
 - 9.15.2.2 Specification of the verification sources used to make credentialing and recredentialing decisions, including any evidence of provider sanctions.
 - 9.15.2.3 A process for provisional credentialing that affirms that:
 - 9.15.2.3.1 The practitioner may not be held in a provisional

- status for more than sixty (60) calendar days; and
- 9.15.2.3.2 The provisional status will only be granted one (1) time and only for providers applying for credentialing the first time.
- 9.15.2.3.3 Provisional credentialing shall include an assessment of:
 - 9.15.2.3.3.1 Primary source verification of a current, valid license to practice;
 - 9.15.2.3.3.2 Primary source verification of the past five (5) years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Databank query; and
 - 9.15.2.3.3.3 A current signed application with attestation.
- 9.15.2.4 Prohibition against employment or contracting with providers excluded from participation in federal health care programs under federal law and as described in the Excluded Individuals and Entities provisions of this Contract.
- 9.15.2.5 A detailed description of the Contractor's process for delegation of credentialing and recredentialing.
- 9.15.2.6 Verification of provider compliance with all Program Integrity requirements in this Contract.
- 9.15.3 The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials shall include communication of the provider's rights to:
 - 9.15.3.1 Review materials.
 - 9.15.3.2 Correct incorrect or erroneous information.
 - 9.15.3.3 Be informed of their credentialing status.
- 9.15.4 The Contractor's process for notifying providers within fifteen (15) calendar days of the credentialing committee's decision.
- 9.15.5 An appeal process for providers for quality reasons and reporting of quality issues to the appropriate authority and in accord with the Program Integrity requirements of this Contract.
- 9.15.6 The Contractor's process to ensure confidentiality.
- 9.15.7 The Contractor's process to ensure listings in provider directories for Enrollees are consistent with credentialing file content, including education, training, certification and specialty designation.
- 9.15.8 The Contractor's process for recredentialing providers at minimum every thirty-six (36) months through information verified from primary sources, unless otherwise indicated.
- 9.15.9 The Contractor's process to ensure that offices of all Health Care Professionals

meet office site standards established by the Contractor.

- 9.15.10 The Contractor's system for monitoring sanctions, limitations on licensure, complaints and quality issues or information from identified adverse events and provide evidence of action, as appropriate based on defined methods or criteria. (42 C.F.R. § 455.101).
- 9.15.11 The Contractor's process and criteria for assessing and reassessing organizational providers.
- 9.15.12 The criteria used by the Contractor to credential and recredential practitioners shall include (42 C.F.R. § 438.214(b)):
 - 9.15.12.1 Evidence of a current valid license or certification to practice;
 - 9.15.12.2 A valid DEA or CDS certificate if applicable;
 - 9.15.12.3 Evidence of appropriate education and training;
 - 9.15.12.4 Board certification if applicable;
 - 9.15.12.5 Evaluation of work history;
 - 9.15.12.6 A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider; and
 - 9.15.12.7 A signed, dated attestation statement from the provider that addresses:
 - 9.15.12.7.1 The lack of present illegal drug use;
 - 9.15.12.7.2 A history of loss of license and criminal or felony convictions;
 - 9.15.12.7.3 A history of loss or limitation of privileges or disciplinary activity;
 - 9.15.12.7.4 Current malpractice coverage;
 - 9.15.12.7.5 Any reason(s) for inability to perform the essential functions of the position with or without accommodation; and
 - 9.15.12.7.6 Accuracy and completeness of the application.
 - 9.15.12.8 Verification of the: National Provider Identifier, the provider's enrollment as a Washington Medicaid provider, and the Social Security Administration's death master file.
- 9.15.13 The Contractor shall ensure that subcontracted providers defined as "high categorical risk" in 42 C.F.R. § 424.518, are enrolled through the Medicare system, which requires a criminal background check as part of the enrollment process. Using <https://www.medicare.gov> or an enrollment verification letter from Medicare issued after March 23, 2011, the Contractor shall ensure that providers defined as "high categorical risk" are enrolled through the Medicare system. The Contractor shall document use of the Medicare.gov website when using it to verify the subcontracted provider's status. The Contractor shall ensure that contracted providers defined as "high categorical risk" revalidate their Medicare enrollment every five (5) years in compliance with 42 C.F.R. § 424.515.

- 9.15.13.1 If a “high categorical risk” subcontracted provider is not enrolled in the Medicare system and delivers a service that is not commonly delivered to a Medicare covered subscriber, e.g. someone under 21 years of age, the above requirement to submit a letter from Medicare as part of the Contractor’s credentialing process is waived. However, the provider must successfully complete the Contractor’s credentialing process, which could include a background check.
- 9.15.14 The Contractor shall terminate any provider where HCA or Medicare has taken any action to revoke the provider’s privileges for cause, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. For cause may include, but is not limited to, Fraud; integrity; or quality (42 C.F.R. § 455.101).
- 9.15.15 The Contractor shall notify HCA in accord with the Notices section of this Contract, within three (3) business days of receipt of information relating to disciplinary action against the accreditation, certification, license and/or registration of the Contractor, an employee, Subcontractor or Subcontractor employee.
- 9.15.16 The Contractor shall require providers defined as “high categorical risk” for potential Fraud as defined in 42 C.F.R. § 424.518 to be enrolled and screened by Medicare.
- 9.15.17 The Contractor’s policies and procedures shall be consistent with 42 C.F.R. § 438.12, and the process shall ensure the Contractor does not discriminate against particular Health Care Professionals that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination.
- 9.16 **Behavioral Health Administrative Service Organization (BH-ASO)**
 - 9.16.1 The Contractor shall contract with HCA’s selected Behavioral Health Administrative Services Organization (BH-ASO) for the administration of Crisis and Ombuds Services.
 - 9.16.2 The Contractor shall reimburse the BH-ASO for behavioral health Crisis and Ombuds Services delivered to individuals enrolled in the Contractor’s AH-IMC plan. The reimbursement shall be upon receipt of a valid claim per the requirements for timely accurate claims payment under this Contract or a monthly sub-capitation.
 - 9.16.3 In order to ensure the current level of crisis funding for the Regional Service Area is sustained for the initial two (2) years of the contract, the following provisions shall be met:
 - 9.16.3.1 Any sub-capitation arrangement with the BH-ASO shall be reviewed and approved by HCA.
 - 9.16.3.2 The Contractor shall participate in a semi-annual financial reconciliation process related to predicted versus actual Crisis Services utilization.
 - 9.16.4 The Contractor shall submit complete and accurate encounter data related to the provision of Crisis Services under this Contract in formats prescribed by HCA.

- 9.16.5 The Contractor shall enter into a subcontract with the BH-ASO to evaluate and monitor the performance of the crisis system and develop corrective action where needed.
- 9.16.6 The subcontract with the BH-ASO shall contain the following provisions.
 - 9.16.6.1 Crisis Services shall be available 24 hours per day, seven (7) days per week, 365 days per year. This shall include availability of a 24/7 regional crisis hotline that provides screening and referral to a network of local providers, and availability of a 24/7 mobile crisis outreach team. Individuals will be able to access Crisis Services without full completion of Intake Evaluations and/or other screening and assessment processes. MCOs shall make it a requirement for behavioral health providers to be the first contact for their assigned member to allow for an attempt at prevention or early intervention strategies to be implemented prior to Crisis Services being contacted.
 - 9.16.6.2 The BH-ASO shall collaborate with the Contractor to develop and implement strategies to coordinate care with community behavioral health providers for individuals with a history of frequent crisis system utilization, or those enrolled in high intensity programs such as WISE and PACT. Coordination of care strategies will seek to reduce utilization of Crisis Services by promoting relapse/crisis prevention planning and early intervention and outreach that addresses the development and incorporation of wellness recovery action plans and Mental Health Advance Directives in treatment planning consistent with requirements in Section 14 of this Contract.
 - 9.16.6.3 The BH-ASO shall collaborate with the Contractor to support data exchange between the Contractor, the BH-ASO, and with community behavioral health providers, consistent with the requirements under this Contract including, but not limited to eligibility interfaces, exchange of claims and encounter data, sharing of care plans, crisis plans, critical incidents, and mental health Advance Directives, and other relevant information necessary to coordinate service delivery in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.
 - 9.16.6.4 The Contractor shall make provisions for the BH-ASO to access crisis plans and individual service plans on a 24/7 basis for Clients receiving BH services.
 - 9.16.6.5 The BH-ASO shall participate in a semi-annual financial reconciliation process as directed by HCA.
- 9.16.7 The Contractor shall either cover Emergency Fills without authorization, or guarantee authorization and payment after the fact for any Emergency Fill dispensed by a contracted pharmacy.

10 ENROLLEE RIGHTS AND PROTECTIONS

10.1 General Requirements

- 10.1.1 The Contractor shall comply with any applicable federal and state laws that pertain to Enrollee rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to Enrollees (WAC 182-503-0100; and 42 C.F.R. § 438.100(a)(2)).
- 10.1.2 The Contractor shall have in place written policies that guarantee each Enrollee the following rights (42 C.F.R. § 438.100):
 - 10.1.2.1 Receive information on Apple Health Managed Care in general and the Contractor's Apple Health program in particular, including information about how to contact the person or entity designated as primarily responsible for coordinating the services accessed by the Enrollee.
 - 10.1.2.2 To be treated with respect and with consideration for their dignity and privacy (42 C.F.R. § 438.100(b)(2)(ii)).
 - 10.1.2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's ability to understand (42 C.F.R. § 438.100(b)(2)(iii)).
 - 10.1.2.4 To participate in decisions regarding their health care, including the right to refuse treatment (42 C.F.R. § 438.100(b)(2)(iv)).
 - 10.1.2.5 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 C.F.R. § 438.100(b)(2)(v)).
 - 10.1.2.6 To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. § 164 (42 C.F.R. § 438.100(b)(2)(vi)).
 - 10.1.2.7 Each Enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its Subcontractors treat the Enrollee (42 C.F.R. § 438.100(c)).
 - 10.1.2.8 To choose a behavioral Health Care Provider.
- 10.1.3 The Contractor shall require a criminal history background check through the Washington State Patrol for employees and volunteers of the Contractor who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults.

10.2 Cultural Considerations

- 10.2.1 The Contractor shall promote access to and delivery of services that are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. (42 C.F.R. § 438.206(c)(2)).
- 10.2.2 The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are

responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

10.2.3 At a minimum, the Contractor shall:

- 10.2.3.1 Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis (CLAS Standard 4);
- 10.2.3.2 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (CLAS Standard 5);
- 10.2.3.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (CLAS Standard 6);
- 10.2.3.4 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (CLAS Standard 7);
- 10.2.3.5 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (CLAS 8);
- 10.2.3.6 Establish culturally and linguistically appropriate goals (CLAS Standard 9);
- 10.2.3.7 Conduct ongoing assessments of the organization's CLAS, related activities and integrate CLAS, related measures into measurement and continuous quality improvement activities (CLAS Standard 10);
- 10.2.3.8 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery (CLAS 11); and
- 10.2.3.9 Create conflict and Grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints (CLAS 14).

10.3 Advance Directives and Physician Orders for Life Sustaining Treatment (POLST)

- 10.3.1 The Contractor shall meet the requirements of WAC 182-501-0125, 42 C.F.R. § 438.3, 438.10, 422.128, 489.100 and 489 Subpart I as described in this Section.
- 10.3.2 The Contractor's Advance Directive policies and procedures shall be disseminated to all affected providers, Enrollees, HCA, and, upon request, Potential Enrollees.
 - 10.3.2.1 The Contractor shall develop policies and procedures to address Physician Orders for Life Sustaining Treatment (POLST) and ensure that they are distributed in the same manner as those governing Advance Directives.
 - 10.3.2.2 The Contractor's policies and procedures respecting the implementation of advance directives and POLST rights shall be included in the Enrollee handbook at a location designated in its

template by HCA, and shall be featured on the Contractor's website in the member/enrollee section.

- 10.3.3 The Contractor's written policies respecting the implementation of Advance Directive POLST rights shall include a clear and precise statement of limitation if the Contractor cannot implement an Advance Directive as a matter of conscience (42 C.F.R. § 422.128). At a minimum, this statement must do the following:
 - 10.3.3.1 Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.
 - 10.3.3.2 Identify the state legal authority permitting such objection.
 - 10.3.3.3 Describe the range of medical conditions or procedures affected by the conscience objection.
- 10.3.4 If an Enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an Advance Directive or received a POLST, the Contractor may give Advance Directive information to the Enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated Enrollee or to a surrogate or other concerned persons in accordance with state law. The Contractor is not relieved of its obligation to provide this information to the Enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.
- 10.3.5 The Contractor must require and ensure that the Enrollee's medical record documents, in a prominent part, whether or not the individual has executed an Advance Directive or received a POLST.
- 10.3.6 The Contractor shall not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an Advance Directive or received a POLST.
- 10.3.7 The Contractor shall ensure compliance with requirements of state and federal law (whether statutory or recognized by the courts of the State) regarding Advance Directives or POLSTs.
- 10.3.8 The Contractor shall provide education to staff concerning its policies and procedures on Advance Directives or POLSTs.
- 10.3.9 The Contractor shall provide community education regarding Advance Directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an Advance Directive, emphasizing that an Advance Directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state and federal law concerning Advance Directives. The Contractor shall document its community education efforts (42 C.F.R. § 438.6(i)(3)).
- 10.3.10 The Contractor is not required to provide care that conflicts with an Advance Directive; and is not required to implement an Advance Directive if, as a matter

of conscience, the Contractor cannot implement an Advance Directive and state law allows the Contractor or any Subcontractor providing services under this Contract to conscientiously object.

- 10.3.11 The Contractor shall inform Enrollees that they may file a Grievance with the Contractor if the Enrollee is dissatisfied with the Contractor's Advance Directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform Enrollees that they may file a Grievance with the Washington State Department of Health if they believe the Contractor is non-compliant with Advance Directive and POLST requirements.

10.4 Mental Health Advance Directive

- 10.4.1 The Contractor shall maintain a written Mental Health Advance Directive (MHAD) policy and procedure that respects individuals' Advance Directive for behavioral health care. Policy and procedures must comply with chapter 71.32 RCW.
- 10.4.2 The Contractor shall inform all Enrollees who present for mental health services of their right to a Mental Health Advance Directive, and shall provide technical assistance to those who express an interest in developing and maintaining a Mental Health Advance Directive.
- 10.4.3 The Contractor shall maintain current copies of any Mental Health Advance Directive in the Enrollee's record.
- 10.4.4 The Contractor shall inform Enrollees that complaints concerning noncompliance with a MHAD should be referred to the Department of Health by calling 1-360-236-2620.

10.5 Enrollee Choice of PCP/Behavioral Health Provider

- 10.5.1 The Contractor must implement procedures to ensure each Enrollee has a source of primary care appropriate to their needs (42 C.F.R. § 438.208(b)(1)).
- 10.5.2 The Contractor shall allow, to the extent possible and appropriate, each new Enrollee to choose a participating PCP (42 C.F.R. § 438.3(l)) or behavioral health professional.
- 10.5.3 The Contractor shall offer each Enrollee a choice of providers for medically necessary behavioral health services.
- 10.5.4 In the case of newborns, the parent shall choose the newborn's PCP.
- 10.5.5 In the case of American Indian/Alaska Native (AI/AN) Enrollees, the Enrollee may choose a tribal clinic as his or her PCP, whether or not the tribal clinic is a network provider.
- 10.5.6 If the Enrollee does not make a choice at the time of enrollment, the Contractor shall assign the Enrollee to a PCP or clinic, within reasonable proximity to the Enrollee's home, no later than fifteen (15) business days after coverage begins.
- 10.5.7 Contractor shall provide a list of assigned Enrollees to PCP upon request by the PCP or by HCA.
- 10.5.8 The Contractor shall allow an Enrollee to change PCP or clinic at any time with the change becoming effective no later than the beginning of the month following the Enrollee's request for the change (WAC 182-538-060 and WAC 284-170-360).

- 10.5.9 The Contractor may limit an Enrollee's ability to change PCPs in accord with the Patient Review and Coordination provisions of this Contract.

10.6 Prohibition on Enrollee Charges for Covered Services

- 10.6.1 Under no circumstances shall the Contractor, or any providers used to deliver services under the terms of this Contract, including Non-Participating Providers, charge Enrollees for Covered Services (SSA 1932(b)(6), SSA 1128B(d)(1), 42 C.F.R. § 438.106 and WAC 182-502-0160).
- 10.6.2 Prior to authorizing services with Non-Participating Providers, the Contractor shall assure that Non-Participating Providers fully understand and accept the prohibition against balance billing Enrollees.
- 10.6.3 The Contractor shall require providers to report when an Enrollee is charged for services. The Contractor shall maintain a central record of the charged amount, Enrollee's agreement to pay, if any, and actions taken regarding the billing by the Contractor. The Contractor shall be prepared at any time to report to HCA any and all instances where an Enrollee is charged for services, whether or not those charges are appropriate.
- 10.6.4 If an Enrollee has paid inappropriate charges, the Contractor will make every effort to have the provider repay the Enrollee the inappropriate amount. If the Contractor's efforts to have the provider repay the Enrollee fail, the Contractor will repay the Enrollee the inappropriately charged amount.
- 10.6.4.1 Reimbursement to Enrollees who submit claims for Covered Services provided by Non-Participating Providers under the terms of this Contract shall be made consistent with subsection 5.22 of this Contract.
- 10.6.5 The Contractor shall have a separate and specific policy and procedure that fully articulates how the Contractor will protect Enrollees from being billed for contracted services.
- 10.6.6 The Contractor shall coordinate benefits with other insurers in a manner that does not result in any payment by or charges to the Enrollee for Covered Services including other insurer's copayments and coinsurance.
- 10.6.7 The Contractor is not required to reimburse Enrollees for the cost of services that are not covered under the terms of this Contract or if the Enrollee did not follow requirements for self-referral under the terms of this Contract.

10.7 Provider/Enrollee Communication

The Contractor may not prohibit, or otherwise restrict, a Health Care Professional acting within their lawful scope of practice from advising or advocating on behalf of an Enrollee who is their patient, for the following (42 C.F.R. § 438.102(a)(1)(i)):

- 10.7.1 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)).
- 10.7.2 Any information the Enrollee needs in order to decide among all relevant treatment options (42 C.F.R. § 438.102(a)(1)(ii)).
- 10.7.3 The risks, benefits, and consequences of treatment or non-treatment (42 C.F.R. § 438.102(a)(1)(iii)).

- 10.7.4 The Enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions (42 C.F.R. § 438.102(a)(1)(iv)).

10.8 Enrollee Self-Determination

The Contractor shall ensure that all providers, obtain informed consent prior to treatment from Enrollees, or persons authorized to consent on behalf of an Enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (chapter 70.122 RCW) and state and federal Medicaid rules concerning Advance Directives (WAC 182-501-0125 and 42 C.F.R. § 438.3(j)), and, when appropriate, inform Enrollees of their right to make anatomical gifts (chapter 68.64 RCW).

10.9 Women's Health Care Services

The Contractor must provide female Enrollees with direct access to a women's health practitioners within the Contractor's network for covered care necessary to provide women's routine and preventive health care services. This includes prescriptions for pharmaceutical or medical supplies ordered by a directly accessed women's health care practitioner, and which are in the practitioner's scope of practice in accord with the provisions of WAC 284-170-350 and 42 C.F.R. § 438.206(b)(2).

10.10 Maternity Newborn Length of Stay

The Contractor shall ensure that hospital delivery maternity care is provided in accordance with RCW 48.43.115.

10.11 Enrollment Not Discriminatory

- 10.11.1 The Contractor will not discriminate against Enrollees due to an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, diminished mental capacity, uncooperative or disruptive behavior resulting from their special needs or treatable behavioral health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b)(2)).
- 10.11.2 No eligible person shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, including the existence of a pre-existing physical or behavioral health condition, functional impairment, pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 C.F.R. § 438.3(d)).
- 10.11.3 The Contractor will not exclude from participation in any health program or activity, deny benefits to, or discriminate against Enrollees or those eligible to enroll on the basis of race, color, or national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any sensory, behavioral health or physical disability, or the use of a trained guide dog or service animal by a person with a disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any sensory, mental or physical disability, or the use of a trained guide dog or service animal by a person with a disability (42 C.F.R. § 438.3(d)(4) and 42 U.S.C. 18116).

11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 Utilization Management General Requirements

The Contractor shall follow the Utilization Management (UM) requirements described in this Section and educate UM staff in the application of UM protocols, and communicating the criteria used in making UM decisions. UM protocols shall recognize and respect the cultural needs of diverse populations.

11.1.1 Drug Utilization Review (DUR) Program

- 11.1.1.1 The Contractor shall operate a drug utilization review program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K.
- 11.1.1.2 The Contractor shall provide a detailed description of its drug utilization review program by December 31 of each calendar year for the prior federal fiscal year (October 1 through September 30). The first report is due no later than December 31, 2018.
- 11.1.1.3 Contractor must provide a DUR Program to assure that prescriptions are appropriate, Medically Necessary and not likely to result in adverse medical outcomes, and to enhance the quality of patient care by educating prescribers, pharmacists, and Enrollees.

11.1.2 Prospective Drug Utilization Review (Pro-DUR)

- 11.1.2.1 Contractor must provide for a review of drug therapy before each prescription is filled or delivered to a member at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, drug refill too soon and clinical abuse/misuse.

11.1.3 Retrospective Drug Utilization Review (Retro-DUR)

- 11.1.3.1 Contractor must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, and abuse such as gross overuse, excessive filling or inappropriate or medically unnecessary care among physicians, pharmacists and members.
- 11.1.3.2 Contractor shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.
- 11.1.3.3 Contractor shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing

practices.

- 11.1.4 The Contractor shall demonstrate that all UM staff making service authorization decisions have been trained and are competent in working with the specific area of service for which they have authorization and management responsibility, including, but not limited to, co-occurring MH and SUDs, co-occurring behavioral health and medical diagnoses, and co-occurring behavioral health and I/DD, and that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health or long-term services and supports needs (42 C.F.R 438.210(b)(3)).
- 11.1.5 The Contractor's policies and procedures related to UM shall comply with, and require the compliance of Subcontractors with delegated authority for Utilization Management, the requirements described in this Section.
- 11.1.6 The Contractor shall have and maintain a Utilization Management Program (UMP) description for the physical and behavioral health services it furnishes its Enrollees (WAC 284-43-2000(2)). The UMP description shall include:
 - 11.1.6.1 The definition of the Contractor's UMP structure and assignment of responsibility for UMP activities to appropriate individuals.
 - 11.1.6.2 Identification of a designated physician responsible for program implementation, oversight and evaluation, and evidence of the physician and a behavioral health practitioner's involvement in program development and implementation.
 - 11.1.6.3 Identification of the type of personnel responsible for each level of UM decision-making.
 - 11.1.6.4 The use of board-certified consultants to assist in making medical necessity determinations.
 - 11.1.6.5 Assurance that a physician, doctoral level psychologist, certified addiction medicine specialist or pharmacist, as appropriate, reviews any behavioral health denial based on medical necessity.
 - 11.1.6.6 A written description of all UM-related committee(s).
 - 11.1.6.7 Descriptions of committee responsibilities.
 - 11.1.6.8 Description of committee participant titles, including UM Subcontractor, Sub-contractor representatives, and practicing providers.
 - 11.1.6.9 Meeting frequency.
 - 11.1.6.10 Maintenance of signed meeting minutes reflecting decisions made by each committee, as appropriate.
 - 11.1.6.11 Behavioral healthcare benefits to include at a minimum:
 - 11.1.6.11.1 Benefit structure and description;
 - 11.1.6.11.2 Triage and referral procedures and protocols, if any, (i.e., clearly describe how Enrollees access behavioral healthcare services);

- 11.1.6.11.3 UM activities and staff roles and responsibilities;
- 11.1.6.11.4 Coordination activities with the behavioral healthcare system, including Ombuds;
- 11.1.6.11.5 Monitoring and oversight of the behavioral health program; and
- 11.1.6.11.6 Strategies to foster integration of physical health and behavioral health.
- 11.1.6.12 Annual evaluation and update of the UMP.
- 11.1.6.13 Annually upon request, the Contractor shall submit to HCA for approval a UMP description that incorporates and accommodates initiatives requested by HCA when there are changes to the UMP approved by the Contractor and HCA.
- 11.1.7 The Contractor shall monitor each Enrollee's needs and appropriately refer Enrollees for Care Coordination or Intensive Care Management services consistent with Section 14 of this Contract.
- 11.1.8 The Contractor shall document use and periodic review of written clinical decision-making criteria based on clinical evidence, including policies and procedures for appropriate application of the criteria (WAC 284-43-2000(2)).
- 11.1.9 The Contractor shall have written policies for applying UMP decision-making criteria based on individual Enrollee needs, such as age, comorbidities, complications and psychosocial and home environment characteristics, where applicable; and the availability of services in the local delivery system.
- 11.1.10 The Contractor shall have mechanisms for providers and Enrollees on how they can obtain the UM decision-making criteria upon request, including UM Adverse Benefit Determination (denial) determination letter template language reflecting the same (WAC 284-43-2000(2)).
- 11.1.11 The Contractor shall have mechanisms for at least annual assessment of inter-rater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions for both physical and behavioral health.
- 11.1.12 The Contractor shall maintain a list of all behavioral health services requiring prior authorization by the Contractor and submit to HCA annually on January 31, each year. The Contractor shall also publish this list on their website.
- 11.1.13 The Contractor shall maintain written job descriptions of all Contractor UM staff. Contractor staff that review denials of care based on medical necessity shall have job descriptions that describe required education, training or professional experience in medical or clinical practice and evidence of a current, non-restricted license, including HIPAA training compliance.
- 11.1.14 The Contractor shall have mechanisms to verify that claimed services were actually provided.
- 11.1.15 The Contractor shall require authorization decisions for behavioral health services are made by Washington licensed behavioral health professionals except when there is no Washington resources for specialty review. Contractor staff described in this subsection shall review any behavioral health Adverse Benefit Determination (denial) based on medical necessity, including any

decision to authorize a service in an amount, duration or scope that is less than requested.

- 11.1.15.1 A physician board-certified or board-eligible in Psychiatry or Child Psychiatry;
- 11.1.15.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry or by ASAM;
- 11.1.15.3 A licensed, doctoral level psychologist; or
- 11.1.15.4 A pharmacist, as appropriate.
- 11.1.16 The Contractor shall have behavioral health professionals with Utilization Management experience working in a behavioral health Managed Care setting or Washington State behavioral health clinical settings on staff. These staff must include individuals who are Certified SUDPs or have three (3) years of experience in an SUD setting.
- 11.1.17 The Contractor must designate at least one (1) Children's Care Manager who oversees behavioral health services requested for Enrollees under age 21 that is a Children's Mental Health Specialist or who is supervised by a Children's Mental Health Specialist.
- 11.1.18 The Contractor shall have Utilization Management staff who have experience and expertise in working with one (1) or more of the following populations:
 - 11.1.18.1 Children, Transitional Age Youth, adults and older adults with behavioral health needs;
 - 11.1.18.2 High risk groups such as individuals with behavioral health conditions with or without co-occurring SUD;
 - 11.1.18.3 Co-occurring behavioral health and chronic medical conditions or I/DD;
 - 11.1.18.4 Individuals involved with multiple service systems;
 - 11.1.18.5 Individuals with a SUD in need of medication-assisted treatment;
 - 11.1.18.6 High risk groups, such as individuals involved in the juvenile justice and criminal justice systems; and
 - 11.1.18.7 Individuals who are homeless.
- 11.1.19 The Contractor shall have a sufficient number of behavioral health clinical peer reviewers available to conduct denial and appeal reviews or to provide clinical consultation on psychological testing, complex case review and other treatment needs.
- 11.1.20 The Contractor shall ensure that any physical or behavioral health clinical peer reviewer who is subcontracted or works in a service center other than the Contractor's Washington State service center shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center, to include participation in initial orientation and at least annual training on Washington State specific benefits, protocols and initiatives.
- 11.1.21 The Contractor shall ensure that any behavioral health Adverse Benefit Determinations must be peer-to-peer — that is, the credential of the licensed clinician making the decision to authorize service in an amount, duration or

scope that is less than requested must be at least equal to that of the recommending clinician. In addition:

- 11.1.21.1 A physician board-certified or board-eligible in Psychiatry must review all inpatient level of care Adverse Benefit Determinations (full or partial denials, terminations and reductions) for psychiatric treatment.
- 11.1.21.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry or by ASAM, must review all inpatient level of care Adverse Benefit Determinations (full or partial denials, terminations, and reductions) for SUD treatment.
- 11.1.22 The Contractor shall ensure documentation of timelines for Appeals shall be in accordance with the Appeal Process provisions of the Grievance and Appeal System Section of this Contract.
- 11.1.23 The Contractor shall implement the coverage decisions of the Health Technology Clinical Committee (HTCC) (chapter 182-55 WAC) as directed by HCA (See Health Technology Assessment (HTA) resources: <http://www.hca.wa.gov/about-hca/health-technology-assessment>).
- 11.1.24 Prior Authorization Administrative Simplification Workgroup. The Contractor shall participate in the statewide Prior Authorization Administrative Simplification Workgroup convened by the OIC (RCW 48.165.030). The Contractor will abide by best practice recommendations agreed to by the Prior Authorization Administrative Simplification Workgroup unless otherwise directed by HCA.
- 11.1.25 Opioid Crisis Engagement. The Contractor's Medical Director or representative shall participate in the Washington HCA Managed Care Medical Director's meeting to collaborate on approaches to the opioid crisis. Contractor activities developed in collaboration with peer managed care organizations and HCA medical directors to address this health and safety concern may include, but are not limited to: Identification and management of Enrollees taking high-dose opioids for non-cancer pain; prescriber and Enrollee education about the risk of using high dose opioids, including the provision of opioid dosing guidelines to the prescriber, use of naloxone, requesting second opinions from a pain management specialist, preauthorization of opioid medication, negotiating taper plans with the prescriber resulting in safer dosing levels and referrals to mental health services and/or SUD programs for assessment.
- 11.1.26 The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee (42 C.F.R. § 438.210(e)).
- 11.1.27 The Contractor shall not penalize or threaten a provider or facility with a reduction in future payment or termination of Participating Provider or participating facility status because the provider or facility disputes the Contractor's determination with respect to coverage or payment for health care service.
- 11.1.28 The Contractor shall develop and implement UM protocols, including policies and procedures and Level of Care Guidelines for behavioral health services that are specific to Washington State Levels of Care, consistent with HCA's medical necessity criteria and comply with federal and state parity requirements.

- 11.1.29 The Contractor shall establish criteria for, and document and monitor consistent application of Medical Necessity criteria and Level of Care Guidelines to include:
- 11.1.29.1 UM protocols and guidelines as well as any subsequent modifications to the protocols and guidelines for behavioral health levels of care shall be submitted to HCA for prior review and approval.
 - 11.1.29.2 The Contractor's Level of Care Guidelines must include criteria for authorization of inpatient behavioral health care at a community hospital and extensions to community hospital episodes of care.
 - 11.1.29.3 The Contractor shall establish protocols for discharge planning during initial and continued stay reviews that addresses:
 - 11.1.29.3.1 Treatment availability and community supports necessary for recovery including, but not limited to: housing, financial support, medical care, transportation, employment and/or educational concerns, and social supports.
 - 11.1.29.3.2 Barriers to access to and/or engagement with post-discharge ambulatory appointments, including Medication Management and other interventions.
 - 11.1.29.3.3 Procedures for Concurrent Review, if applicable for Enrollees requiring extended inpatient care due to poor response to treatment and/or placement limitations.
 - 11.1.29.3.4 Corrective action expectations for ambulatory providers who do not follow-up on Enrollees discharged from inpatient settings as per the transitional health care services timeframes defined in Section 14 of this Contract.

11.2 Prescription Drug Authorization Decisions and Timeframes

- 11.2.1 Contractor must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Outpatient Drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will, apply, regardless of whether the Covered Outpatient Drug is provided as an outpatient drug benefit or as a "medical benefit" incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).
- 11.2.2 Contractor must respond to a prior authorization request for a covered outpatient drug or over-the-counter drug by telephone or other telecommunication device within 24 hours of the request. Authorization Determinations for Covered Out Patient Drugs or Over-the-Counter Drugs: Consistent with Section 1927(d)(5) of the Social Security Act, all authorization determinations for prescriptions or over-the-counter drugs must be made no later than the following business day after receipt of the request for service

unless additional information is required. Any additional information needed must be requested by the close of business on the first day following the initial request for authorization and determinations must be made no later than close of business on the first business day after receipt of the additional information. If the provider does not respond to the Contractor's request for additional information within three (3) business days of the request the Contractor must make a decision based on the information at hand.

- 11.2.3 Contractor shall have in place a mechanism to allow automated approval of prior authorization criteria based on situation specific codes or values submitted via point-of-sale by the dispensing pharmacy. Overrides of prior authorization criteria may be based on values submitted in either the prior authorization or diagnosis fields.
- 11.2.4 Contractor shall have a process for providing an emergency drug supply to Enrollees when a delay in authorization would interrupt a drug therapy that must be continuous or when the delay would pose a threat to the Enrollee's health and safety. The drug supply provided must be sufficient to bridge the time until an authorization determination is made.
- 11.2.5 Contractor shall have a process for authorization after the fact of an emergency fill as defined in this Contract when an emergency fill of a medication is dispensed according to the professional judgment of the dispensing pharmacist not to exceed thirty (30) calendar days' supply. The authorization for the prescription must match the drug quantity and days supplied as dispensed by the pharmacist.

11.3 Medical Necessity Determination

The Contractor shall collect all information necessary to make medical necessity determinations (42 C.F.R § 456.111 and 456.211). The Contractor shall determine which services are medically necessary, according to the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding Appeals, hearings and independent review.

11.4 Authorization of Services

- 11.4.1 The Contractor shall follow the authorization of services requirements described in this Section. The Contractor shall not have or implement authorization policies that inhibit Enrollees from obtaining medically necessary contracted services and supplies. For example, inpatient admissions for deliveries or home births should not require prior authorization because there is not a question of medical necessity associated with a delivery. It is reasonable to require notification of admissions for delivery or of a home delivery to support Concurrent Review activities or Case Management.
- 11.4.2 Authorizations for contracted services and supplies that are needed on an ongoing basis shall not be required any more frequently than every six (6) months. Services and supplies needed on an ongoing basis include, but are not limited to, insulin pens, incontinence supplies, ongoing medications or medications for Chronic Conditions.
- 11.4.3 The Contractor's policies and procedures related to authorization and post-service review of services shall include compliance with 42 C.F.R. § 438.210, WAC 284-43-2000(6)(b), chapters 182-538 and 182-550 WAC, WAC 182-501-

0160 and -0169, and require compliance of Subcontractors with delegated authority for authorization of services with the requirements described in this Section, and shall include a definition of “service authorization” that includes an Enrollee’s request for services.

- 11.4.4 The Contractor shall provide education and ongoing guidance and training to Enrollees and providers about its UM protocols and Level of Care Guidelines, including admission, continued stay, and discharge criteria.
- 11.4.5 The Contractor shall consult with the requesting provider when appropriate (42 C.F.R. § 438.210(b)(2)(ii)).
- 11.4.6 The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a Health Care Professional who has appropriate expertise in addressing the Enrollee's medical or behavioral health condition or long-term services and supports (42 C.F.R. § 438.210(b)(3)).
 - 11.4.6.1 In denying services, the Contractor will only deny a service as non-covered if HCA has determined that the service is non-covered under the FFS program. For services that are excluded from this Contract, but are covered by HCA, the Contractor’s denial will include directions to the Enrollee about how to obtain the services through HCA and will direct the Enrollee to those services and coordinate receipt of those services.

11.5 Timeframes for Authorization Decisions

- 11.5.1 The Contractor shall provide for the following timeframes for authorization decisions and notices:
 - 11.5.1.1 Denial of Payment that may result in Payment Liability: The authorization decision and notice is provided for the Enrollee, at the time of any Adverse Benefit Determination affecting the claim.
 - 11.5.1.2 Termination, Suspension, or Reduction of Previously Authorized Services: The authorization decision and notice is provided ten (10) calendar days prior to such termination, suspension, or reduction, except in the following circumstances:
 - 11.5.1.2.1 The Enrollee dies;
 - 11.5.1.2.2 The Contractor has a signed written Enrollee statement requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that termination, reduction, or suspension of services is the result of supplying this information);
 - 11.5.1.2.3 The Enrollee is admitted to an institution where he or she is ineligible for services;
 - 11.5.1.2.4 The Enrollee’s address is unknown and mail directed to him or her has no forwarding address;
 - 11.5.1.2.5 The Enrollee has moved out of the Contractor’s service area past the end of the month for which a premium was paid;

- 11.5.1.2.6 The Enrollee's PCP prescribes the change in the level of medical care;
 - 11.5.1.2.7 An adverse determination regarding the preadmission screening for nursing facility was made; or
 - 11.5.1.2.8 The safety or health of individuals in the nursing facility would be endangered, the Enrollee's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Enrollee's urgent medical needs, or an Enrollee has not resided in the nursing facility for thirty (30) calendar days (applies only to Adverse Benefit Determinations for nursing facility transfers).
- 11.5.1.3 Standard authorizations for Health Care Services determinations: The authorization decisions are to be made and notices are to be provided as expeditiously as the Enrollee's health condition requires (42 C.F.R. § 438.210(d)(1)). The Contractor must make a decision to approve, deny, or request additional information from the provider within five (5) calendar days of the original receipt of the request. If additional information is required and requested, the Contractor must give the provider five (5) calendar days to submit the information and then approve or deny the request within four (4) calendar days of the receipt of the additional information (WAC 284-43-2050).
- 11.5.1.3.1 A possible extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances (42 C.F.R. § 438.210(d)(1)):
- 11.5.1.3.1.1 The Enrollee or the provider requests an extension; or
 - 11.5.1.3.1.2 The Contractor justifies and documents a need for additional information and how the extension is in the Enrollee's interest.
- 11.5.1.3.2 If the Contractor extends the timeframe past fourteen (14) calendar days of the receipt of the request for service:
- 11.5.1.3.2.1 The Contractor shall provide the Enrollee written notice within three (3) business days of the Contractor's decision to extend the timeframe. The notice shall include the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a

grievance if he or she disagrees with that decision.

11.5.1.3.2.2 The Contractor shall issue and carry out its determination as expeditiously as the Enrollee's health condition requires, and no later than the date the extension expires (42 C.F.R. § 438.404(c)(4)).

11.5.1.3.3 For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an Adverse Benefit Determination), authorization decisions are to be made and Notices of Adverse Benefit Determinations are to be provided no later than the date that the timeframes expire (42 C.F.R. § 438.404(c)(5)).

11.5.1.4 Expedited Authorization Decisions: For cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires.

11.5.1.4.1 The Contractor will make the decision within two (2) calendar days if the information provided is sufficient; or request additional information within one (1) calendar day, if the information provided is not sufficient to approve or deny the request. The Contractor must give the provider two (2) calendar days to submit the requested information and then approve or deny the request within two (2) calendar days of the receipt of the additional information.

11.5.1.4.2 The Contractor may extend the expedited time period by up to ten (10) calendar days under the following circumstances (42 C.F.R. § 438.210(d)(2)(ii)):

11.5.1.4.2.1 The Enrollee requests the extension; or

11.5.1.4.2.2 The Contractor justifies and documents a need for additional information and how the extension is in the Enrollee's interest.

11.5.1.5 Concurrent Review Authorizations: The Contractor must make its determination within one (1) business day of receipt of the request for authorization.

11.5.1.5.1 Requests to extend concurrent care review authorization determinations may be extended to

- within three (3) business days of the request of the authorization, if the Contractor has made at least one (1) attempt to obtain needed clinical information within the initial one (1) business day after the request for authorization of additional days or services.
 - 11.5.1.5.2 Notification of the Concurrent Review determination shall be made within one (1) business day of the Contractor's decision.
 - 11.5.1.5.3 Expedited appeal timeframes apply to Concurrent Review requests.
 - 11.5.1.6 Post-service Authorizations: For post-service authorizations, including pharmacy post-service authorizations, the Contractor must make its determination within thirty (30) calendar days of receipt of the authorization request.
 - 11.5.1.6.1 The Contractor shall notify the Enrollee in writing and the requesting provider either orally or in writing within three (3) business days of the Contractor's determination.
 - 11.5.1.6.2 Standard appeal timeframes apply to post-service denials.
 - 11.5.1.6.3 When post-service authorizations are approved, they become effective the date the service was first administered.
 - 11.5.1.7 Verified Enrollee Fraud: The Contractor shall give notice at least five (5) calendar days before the effective date when the Adverse Benefit Determination is a termination, suspension, or reduction of previously authorized Medicaid-Covered Services when Enrollee Fraud has been verified.
 - 11.5.1.8 For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an Adverse Benefit Determination), authorization decisions are to be made and Notices of Adverse Benefit Determinations are to be provided no later than the date that the timeframes expire (42 C.F.R. § 438.404(c)(5)).
 - 11.5.1.9 Extenuating Circumstances: When extenuating circumstances are identified, consistent with *Best Practice Recommendation for Extenuating Circumstances around Pre-Authorization and Admission Notification*, and the provider is not able to request a pre-authorization prior to treating the Enrollee or provide timely notification to the Contractor of the Enrollee's admission, the Contractor shall allow claims and related appeals to process as if a pre-authorization had been requested or admission notification had been submitted within the time period (WAC 284-43-2060).

11.6 Notification of Coverage and Authorization Determinations

- 11.6.1 For all Adverse Benefit Determinations, the Contractor must notify the Enrollee

in writing and the 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. The Contractor must use an HCA-developed template for Skilled Nursing-related Adverse Benefit Determinations.

- 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 shall send the written notice no later than seventy two (72) hours after receipt of the request for service.
- 11.6.1.2 Adverse Authorization Decisions involving a WISe screening. The Contractor must notify the Enrollee in writing of the decision to deny WISe services if a Children and Adolescent Needs and Strengths screen is provided and WISe services are not offered.
- 11.6.1.3 The Contractor shall notify the requesting provider and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the following requirements (42 C.F.R. § 438.210(c) and 438.404):
 - 11.6.1.3.1 The notice to the Enrollee shall meet the requirements of the, Information Requirements for Enrollees and Potential Enrollees of this Contract to ensure ease of understanding.
 - 11.6.1.3.2 For all authorization decisions, the notice shall be mailed as expeditiously as the Enrollee's health condition requires and within three (3) business days of the Contractor's decision.
 - 11.6.1.3.3 The notice to the Enrollee and provider shall explain the following (42 C.F.R. § 438.404(b)(1-3)(5-7)):
 - 11.6.1.3.3.1 The Adverse Benefit Determination the Contractor has taken or intends to take.
 - 11.6.1.3.3.2 The reasons for the Adverse Benefit Determination, in easily understood language, including citation to the Washington Administrative Code rules or any Contractor guidelines, protocols, or other criteria that were the basis of the decision.
 - 11.6.1.3.3.3 If applicable the notice must include information about alternative covered services/treatment which may be seen as a viable treatment option in lieu of denied services.

- 11.6.1.3.3.4 The Enrollee and providers right to request and receive free of charge a copy of the rule, guideline, protocol or other criterion that was the basis for the decision.
- 11.6.1.3.3.5 A statement whether or not an Enrollee has any liability for payment.
- 11.6.1.3.3.6 A toll-free telephone number to call if the Enrollee is billed for services.
- 11.6.1.3.3.7 The Enrollee's or the provider's right to file an appeal and any deadlines applicable to the process.
- 11.6.1.3.3.8 If services are denied as non-covered, inform Enrollees how to access the Exception to Rule (ETR) process including, but not limited to, the fact that an Enrollee may appeal an Adverse Benefit Determination affecting his or her services and simultaneously request an ETR to obtain the services that are the subject of the appeal, and that requesting an ETR does not affect any deadlines applicable to the appeal process.
- 11.6.1.3.3.9 If services are denied or authorized in a more limited scope, amount or duration than requested because they would exceed the established limit on the scope, amount or duration of the requested service, inform Enrollees how to access the Limitation Extension (LE) process including, but not limited to, the fact that an Enrollee may appeal an Adverse Benefit Determination affecting his or her services and simultaneously request an LE to obtain the services that are the subject of the appeal, and that requesting an LE does not affect any deadlines applicable to the appeal process.
- 11.6.1.3.3.10 The procedures for exercising the Enrollee's rights.

- 11.6.1.3.3.11 The circumstances under which expedited resolution is available and how to request it.
- 11.6.1.3.3.12 The Enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay for these services.
- 11.6.1.3.3.13 The Enrollee's right to receive the Contractor's or regional Ombuds' assistance with filing the appeal.
- 11.6.1.3.3.14 The Enrollee's right to equal access to services for Enrollees and potential Enrollees with communications barriers and disabilities.
- 11.6.1.4 Untimely Service Authorization Decisions: When the Contractor does not reach service authorization decisions within the timeframes for either, standard or expedited service authorizations it is considered a denial and thus, an Adverse Benefit Determination. The Contractor shall issue a formal Notice of Adverse Benefit Determination to the Enrollee, including the Enrollee's right to an Appeal. See 42 C.F.R. § 438.404(c)(5).
- 11.6.1.5 UM Authorization Turnaround Time Compliance Report: The Contractor will send quarterly a report to HCA by the last day of the month following the quarter that shall include:
 - 11.6.1.5.1 Monthly UM authorization determination data that demonstrates timeliness compliance rates separated into Standard, Pharmacy, Expedited, Concurrent Review, and Post-service timelines, including:
 - 11.6.1.5.1.1 Percentage compliance, including those in which the timeline is extended appropriately;
 - 11.6.1.5.1.2 Specific numbers of authorization determinations meeting contractual timeframes and the numbers of those that did not; and
 - 11.6.1.5.1.3 For those authorization determinations that did not meet contractual timeframes, the range of time to complete the authorization determinations.
 - 11.6.1.5.2 If UM authorization turnaround time compliance is below 90 percent in any month during the quarter for

any of the authorization categories specified in this Contract, the report shall also include a narrative description of the Contractor's efforts before and after notification to HCA to address the problem.

11.7 Experimental and Investigational Services for Managed Care Enrollees

- 11.7.1 In determining whether a service that the Contractor considers experimental or investigational is medically necessary for an individual Enrollee, the Contractor must have and follow policies and procedures that mirror the process for HCA's medical necessity determinations for its FFS program described in WAC 182-501-0165, including the option to approve an investigational or experimental service when there is:
 - 11.7.1.1 A humanitarian device exemption for the requested service or device from the Food and Drug Administration (FDA); or
 - 11.7.1.2 A local Institutional Review Board (IRB) protocol addressing issues of efficacy and safety of the requested service that satisfies both HCA and the requesting provider.
- 11.7.2 Medical necessity decisions are to be made by a qualified healthcare professional and must be made for an individual Enrollee based on that Enrollee's health condition. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to HCA upon request.
- 11.7.3 Criteria to determine whether an experimental or investigational service is medically necessary shall be no more stringent for Medicaid Enrollees than that applied to any other Enrollees.
- 11.7.4 An Adverse Benefit Determination made by the Contractor shall be subject to Appeal through the Contractor's Appeal process, hearing, and independent review process in accordance with the Grievance and Appeal System Section of this Contract.

11.8 Compliance with Office of the Insurance Commissioner Regulations

The Contractor shall comply with all Office of the Insurance Commissioner (OIC) regulations regarding utilization management and authorization of services unless those regulations are in direct conflict with federal regulations. Where it is necessary to harmonize federal and state regulations, HCA will direct such harmonization. If an OIC regulation changes during the Period of Performance of this Contract, HCA will determine whether and when to apply the regulation.

12 PROGRAM INTEGRITY

12.1 General Requirements

- 12.1.1 The Contractor shall have and comply with policies and procedures that guide and require the Contractor and the Contractor's officers, employees, agents and Subcontractors to comply with the requirements of this Section. (42 C.F.R. § 438.608).
- 12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts and provider application, credentialing and recredentialing processes.
- 12.1.3 The following are relevant citations for Program Integrity compliance. The

Contractor is expected to be familiar with, comply with, and require compliance with all regulations related to Program Integrity whether or not those regulations are listed below:

- 12.1.3.1 Section 1902(a)(68) of the Social Security Act;
- 12.1.3.2 42 C.F.R. § 438.608;
- 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.
- 12.1.4 The Contractor shall ensure compliance with the Program Integrity provisions of this Contract, including proper payments to providers or Subcontractors and methods for detection and prevention of Fraud, Waste, and Abuse.
- 12.1.5 The Contractor shall have a staff person dedicated to working collaboratively with HCA on Program Integrity issues, and with MFCD on fraud and abuse investigation issues. This will include the following:
 - 12.1.5.1 Participation in MCO-specific, quarterly Program Integrity meetings with HCA. Discussion at these meetings shall include but not be limited to case development and monitoring.
 - 12.1.5.2 Participation in a bi-annual Contractor-wide forum to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned.
 - 12.1.5.3 Quality control and review of encounter data submitted to HCA.
 - 12.1.5.4 Participation in meetings with MFCD and HCA, as determined by MFCD, HCA, and the Contractor.
- 12.1.6 The Contractor must have and sustain adequate staffing resources in the Contractor's Program Integrity and Special Investigation Units who are dedicated to identifying fraud, waste, and abuse in Washington Apple Health and Integrated Care programs.
 - 12.1.6.1 Staffing configuration should include all staff with appropriate education and expertise to conduct federal, state, and contract required program integrity activities that:
 - 12.1.6.1.1 Prevent, detect, investigate fraud, waste and abuse;
 - 12.1.6.1.2 Refer potential provider fraud to both HCA and MFCD; and
 - 12.1.6.1.3 Produce cost avoidance savings or post-payment recoveries of improper payments.
 - 12.1.6.2 Adequate staffing is defined as minimum one (1) full-time equivalent (FTE) dedicated to Washington Medicaid for every 50,000 Enrollees in all Washington Apple Health programs.
- 12.1.7 When the Contractor or the state identifies an overpayment, pursuant to Section 1128J(d) of the Social Security Act, the funds must be recovered by and returned to the state or the Contractor. For the purposes of this subsection,

“overpayment” means a payment from the Contractor to a provider or subcontractor to which the provider or subcontractor is not legally entitled.

- 12.1.7.1 To maintain compliance with Section 1128J(d) of the Social Security Act, overpayments that are not recovered by or returned to the Contractor within sixty (60) calendar days from the date they were identified and known by the provider or subcontractor and the Contractor, may be recovered by HCA.

12.2 Disclosure by Managed Care Organization: Information on Ownership and Control

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

- 12.2.1.1 The identification of any person or corporation with a direct, indirect or combined direct/indirect ownership interest of 5 percent or more of the Contractor’s equity (or, in the case of a Subcontractor’s disclosure, 5 percent or more of the subcontractor’s equity);

- 12.2.1.2 The identification of any person or corporation with an ownership interest of 5 percent or more of any mortgage, deed of trust, note or other obligation secured by the Contractor if that interest equals at least 5 percent of the value of the Contractor’s assets (or, in the case of a subcontractor’s disclosure, a corresponding obligation secured by the Subcontractor equal to 5 percent of the Subcontractor’s assets);

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

- 12.2.2 The disclosures must include the following:

- 12.2.2.1 The name, address, and financial statement(s) of any person (individual or corporation) that has 5 percent or more ownership or control interest in the Contractor.

- 12.2.2.2 The name and address of any person (individual or corporation) that has 5 percent or more ownership or control interest in any of the Contractor’s subcontractors.

- 12.2.2.3 Indicate whether the individual/entity with an ownership or control interest is related to any other Contractor’s employee such as a spouse, parent, child, or siblings; or is related to one of the Contractor’s officers, directors or other owners.

- 12.2.2.4 Indicate whether the individual/entity with an ownership or control interest owns 5 percent or greater in any other organizations.

- 12.2.2.5 The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box

address.

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

12.2.2.7 Other tax identification number (in the case of a corporation) with an ownership or control interest in the Managed Care Organization or its Subcontractor.

12.2.3 The Contractor must terminate or deny network participation if a provider, or any person with 5 percent or greater direct or indirect ownership interest fails to submit sets of fingerprints in a form and manner to be determined by HCA, within thirty (30) calendar days when requested by HCA or any authorized federal agency.

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

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

12.2.4.2 When the Contractor executes the Contract with HCA.

12.2.4.3 Upon renewal or extension of the Contract.

12.2.4.4 Within thirty-five (35) calendar days after any change in ownership of the Contractor. The Contractor shall report the change on HCA Medicaid Provider Disclosure Statement Form HCA-09-048.

12.2.4.5 Upon request by HCA.

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

12.3.1 The Contractor shall include the following provisions in its written agreements with all Subcontractors:

12.3.1.1 Requiring the Subcontractor to disclose to the 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 (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. (42 C.F.R. § 455.104(b)(1)(i)).

12.3.1.3 If the Subcontractor is a corporate entity, the disclosure must include primary business address, every business location, and P.O. Box address (42 C.F.R. § 455.104(b)(1)(i)).

12.3.1.4 If the Subcontractor has corporate ownership, the tax identification number of the corporate owner(s) (42 C.F.R. § 455.104(b)(1)(iii)).

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

12.3.1.6 If the Subcontractor has a 5 percent ownership interest in any of its Subcontractors, the tax identification number of the

Subcontractor(s) (42 C.F.R. § 455.104(b)(1)(iii)).

- 12.3.1.7 Whether any person with an ownership or control interest in the Subcontractor 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 (42 C.F.R. § 455.104(b)(2)).
- 12.3.1.8 If the Subcontractor has a 5 percent ownership interest in any of its Subcontractors, whether any person with an ownership or control interest in such Subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the Subcontractor (42 C.F.R. § 455.104(b)(2)).
- 12.3.1.9 Whether any person with an ownership or control interest in the Subcontractor also has an ownership or control interest in any Managed Care entity (42 C.F.R. § 455.104(b)(3)).
- 12.3.2 Upon request, the Contractor and the Contractor's Subcontractors shall furnish to HCA, within thirty-five (35) calendar days of the request, full and complete business transaction information as follows:
 - 12.3.2.1 The ownership of any Subcontractor with whom the Contractor or Subcontractor has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the request (42 C.F.R. § 455.105(b)(1)).
 - 12.3.2.2 Any significant business transactions between the Contractor or Subcontractor and any wholly owned supplier, or between the Contractor and any Subcontractor, during the five (5) year period ending on the date of the request (42 C.F.R. § 455.105(b)(2)).
- 12.3.3 Upon request, the Contractor and the Contractor's Subcontractors shall furnish to the Washington Secretary of State, the Secretary of the US Department of Health and Human Services, the Inspector General of the US Department of Health and Human Services, the Washington State Auditor, the Comptroller of the Currency, and HCA a description of the transaction identified under 42 C.F.R. § 455.105 between the Contractor and the other party of interest within thirty-five (35) calendar days of the request, including the following transactions 42 C.F.R. § 438.50(c)(1):
 - 12.3.3.1 A description of transactions between the Contractor and a party in interest (as defined in Section 1318(b) of the Public Health Service Act), including the following:
 - 12.3.3.1.1 Any sale or exchange, or leasing of any property between the Contractor and such a party.
 - 12.3.3.1.2 Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party but not including salaries paid to employees for services provided in the normal course of their employment.
 - 12.3.3.1.3 Any lending of money or other extension of credit between the Contractor and such a party. (1903(m)(4)(B); 42 C.F.R. § 438.50(c)(1)).

12.4 Information on Persons Convicted of Crimes

The Contractor shall include the following provisions in its written agreements with all Subcontractors and providers who are not individual practitioners or a group of practitioners:

- 12.4.1 Requiring the Subcontractor/provider to investigate and disclose to the MCO, at contract execution or renewal, and upon request by the MCO of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs and who is (42 C.F.R. 455.106(a)):
 - 12.4.1.1 A person who has an ownership or control interest in the Subcontractor or provider (42 C.F.R. § 455.106(a)(1)).
 - 12.4.1.2 An agent or person who has been delegated the authority to obligate or act on behalf of the subcontractor or provider (42 C.F.R. § 455.101; 42 C.F.R. § 455.106(a)(1)).
 - 12.4.1.3 An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the subcontractor or provider (42 C.F.R. § 455.101; 42 C.F.R. § 455.106(a)(2)).

12.5 Fraud, Waste and Abuse (FWA)

- 12.5.1 The Contractor, or the Contractor's subcontractor delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between HCA and the Contractor, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse. (42 C.F.R. § 438.608(a)). The arrangements or procedures must include the following:
 - 12.5.1.1 A compliance program that includes, at a minimum, all of the following elements:
 - 12.5.1.1.1 Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements.
 - 12.5.1.1.2 Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the contract and who directly reports to the Chief Executive Officer (CEO) and the Board of Directors.
 - 12.5.1.1.3 Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract.

- 12.5.1.1.4 System for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under this Contract.
- 12.5.1.1.5 Effective lines of communication between the Compliance Officer and the Contractor's staff and subcontractors.
- 12.5.1.1.6 Enforcement of standards through well-publicized disciplinary guidelines.
- 12.5.1.1.7 Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract.
- 12.5.1.1.8 Ensure it maintains up-to-date program integrity policies and procedures relative to any contract modifications to ensure all program integrity functions are adequately addressed.
- 12.5.1.2 Provision for prompt reporting of all overpayments identified and recovered, specifying the overpayments due to potential fraud, to HCA. (42 C.F.R § 438.608(a)(2)).
- 12.5.1.3 Provision for notification to HCA when the Contractor receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor. (42 C.F.R § 438.608(a)(4)).
- 12.5.1.4 Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Enrollees and the application of such verification processes on a regular basis. (42 C.F.R § 438.608(a)(5)).
 - 12.5.1.4.1 The Contractor may use explanation of benefits (EOB) for such verification only if the Contractor suppresses EOBs that would be a violation of Enrollee confidentiality requirements for women's healthcare, family planning, sexually transmitted diseases, and behavioral health services (42 C.F.R. § 455.20).
 - 12.5.1.4.2 Results of the verification and any action(s) taken must be available upon HCA's request.

- 12.5.1.5 Written policies for all employees of the Contractor that provide detailed information about the False Claims Act, including protections for whistleblowers, as described in Section 1902(a)(68) of the Social Security Act, 42 C.F.R § 438.608(a)(6), and the Washington false claims statutes, chapters 74.66 RCW and RCW 74.09.210, including information about rights of employees to be protected as whistleblowers, and the criminal statutes found in chapter 74.09.230- .280 RCW.
- 12.5.1.6 Provision for prompt referral of any potential fraud, waste, or abuse the Contractor identifies to HCA Program Integrity and potential fraud to the MFCD pursuant to Subsection 12.6. (42 C.F.R § 438.608(a)(7)).
- 12.5.1.7 Provision for the Contractor's suspension of payments to a network provider for which HCA determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 and pursuant to Subsection 12.6. (42 C.F.R § 438.608(a)(8)).
- 12.5.1.8 Provision for prompt response to detected offenses, and for development of corrective action initiatives.
- 12.5.1.9 Provision for notification of the Contractor's program integrity activities when requested by HCA or MFCD to prevent duplication of activities.
- 12.5.2 The Contractor and its subcontractors shall:
 - 12.5.2.1 Provide written disclosure of any prohibited affiliation in accordance with 42 C.F.R. § 438.610; 42 C.F.R. § 455.106; and 42 C.F.R § 438.608(c)(1) to HCA;
 - 12.5.2.2 Provide written disclosures of information on ownership and control as indicated under Subsection 12.3 (42 C.F.R. § 455.104; 42 C.F.R. § 455.105; and 42 C.F.R § 438.608(c)(2)); and
 - 12.5.2.3 Report to HCA within sixty (60) calendar days when it has identified capitation payments or other payment amounts received are in excess to the amounts specified in this Contract. (42 C.F.R. § 438.608(c)(3)).
- 12.5.3 The Contractor must audit their providers and subcontractors to detect and identify fraud, waste, and abuse.
 - 12.5.3.1 Identified improper payments must be reported to HCA on the monthly Program Integrity Report.
 - 12.5.3.2 Identified improper payments must be recovered by the Contractor in accordance with Section 1128J(d) of the Social Security Act.
 - 12.5.3.3 HCA will monitor the Contractor's activities through the Monthly Program Integrity Report.
- 12.5.4 Treatment of recoveries made by the Contractor of overpayments to the providers. (42 C.F.R. § 438.608(d)).
 - 12.5.4.1 The Contractor and its subcontractors shall:
 - 12.5.4.1.1 Have internal policies and procedures for the

documentation, retention, and recovery of all overpayments, specifically for the recovery of overpayments due to fraud, waste, or abuse.

12.5.4.1.2 Report the identification and recovery of all overpayments as required in subsection 12.9.

12.5.4.2 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.

12.5.4.3 The Contractor shall have a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment within sixty (60) calendar days, and to notify the Contractor in writing of the reason for the overpayment.

12.5.4.4 The Contractor shall report at least annually to HCA, or as required in the Contract, on their recoveries of overpayments. See Subsection 12.9, Reporting.

12.5.5 When the Contractor conducts an audit of a Contractor's provider or subcontractor, the Contractor must:

12.5.5.1 Provide a thirty (30) day notice to a provider or subcontractor prior to an onsite audit, unless there is evidence of danger to public health and safety or fraudulent activities.

12.5.5.2 Make reasonable efforts to avoid auditing a provider or subcontractor claim that is or has already undergone an audit, review or investigation by the Contractor, HCA, MFCD, or another governmental or law enforcement entity.

12.5.5.3 Allow a provider or subcontractor, at their request, to submit records requested as a result of an audit in electronic format, including compact disc, digital versatile disc, or other electronic formats deemed appropriate by the Contractor, or by facsimile transmission.

12.5.5.4 Extrapolate only when there is a sustained high level of payment error or when documented provider or subcontractor educational intervention has failed to correct the level of payment error.

12.5.5.5 Issue draft or preliminary findings within one-hundred twenty (120) calendar days from receipt of all provider or subcontractor information required to conduct the audit.

12.5.5.6 Provide a detailed explanation in writing to a provider or subcontractor for any adverse determination that would result in partial or full recoupment of a payment to the provider or subcontractor. The written notification shall, at a minimum, include the following:

12.5.5.6.1 The reason for the adverse determination;

12.5.5.6.2 The specific criteria on which the adverse determination was based;

12.5.5.6.3 An explanation of the provider's appeal rights; and

12.5.5.6.4 If applicable, the appropriate procedure to submit a

claim adjustment.

- 12.5.5.7 Ensure any appeal process is completed before recouping overpayments.
- 12.5.5.8 Offer a provider or subcontractor with an adverse determination the option of repaying the amount owed according to a negotiated repayment plan of up to twelve months.
- 12.5.5.9 In any appeal by a health care provider, employ or contract with a medical or dental professional who practices within the same specialty, is board-certified, and experienced in the treatment, billing, and coding procedures used by the provider being audited to make findings and determinations.
- 12.5.5.10 Provide educational and training programs annually for providers. The training topics must include a summary of audit results, a description of common issues, problems and mistakes identified through audits and reviews, and opportunities for improvement.
- 12.5.5.11 In the event of an audit of a provider or subcontractor who is no longer in the Contractor's network, include a description of the claim with patient name, date of service and procedure.
- 12.5.5.12 Provide HCA with a courtesy copies of all letters sent to the provider or subcontractor being audited through MC-Track.
- 12.5.5.13 Consistent with the requirements in 42 C.F.R. § 438.4, HCA will utilize the information and documentation collected in Subsection 12.5 of this Contract for setting actuarially sound capitation rates for each Contractor.
- 12.5.6 The Contractor must provide HCA a detailed list of current and past program integrity activities initiated and completed by the Contractor upon HCA's or MFCD's request.
- 12.5.7 HCA may conduct independent or collaborative audits, investigations, and clinical reviews of the Contractors providers and subcontractors at any time. HCA will coordinate with the Contractor to ensure the same claim is not audited or reviewed.
- 12.5.8 In an effort to identify fraud, waste, and abuse, HCA will:
 - 12.5.8.1 Conduct proactive data mining of the Contractor's data; and
 - 12.5.8.2 Conduct audits of the Contractor's provider and subcontractor.
- 12.6 Referring of Allegations of Potential Fraud and Invoking Provider Payment Suspensions**

The Contractor shall establish policies and procedures for referring all identified allegations of potential fraud to HCA and MFCD, and for provider payment suspensions. When HCA notifies the Contractor that a credible allegation of fraud exists, the Contractor shall follow the provisions for payment suspension contained in this Section. (42 C.F.R § 455.23).

 - 12.6.1 When the Contractor has concluded that an allegation of potential fraud exists, the Contractor shall make a Fraud referral to MFCD and HCA within five (5) business days of the determination. The referral must be submitted to HCA

through MC-Track and emailed to MFCUreferrals@atg.wa.gov. The Contractor shall report using the WA Fraud Referral Form.

- 12.6.2 When HCA determines the Contractor's referral of potential fraud is a credible allegation of fraud, HCA shall notify the Contractor's compliance officers in writing.
 - 12.6.2.1 To suspend provider payments, in full, in part, or if a good cause exception exists to not suspend. (42 C.F.R § 438.608(a)(8)).
 - 12.6.2.1.1 Unless otherwise notified by HCA to suspend payment, the Contractor shall not suspend payment of any provider(s) identified in the referral.
 - 12.6.2.2 Whether MFCD, or other law enforcement agency, accepts or declines the referral.
 - 12.6.2.2.1 If MFCD, or other law enforcement agency accepts the referral, the Contractor must "stand-down" and follow the requirements in the Investigation subsection of this Section.
 - 12.6.2.2.2 If HCA, MFCD, or other law enforcement agency decline to investigate the potential fraud referral, the Contractor may proceed with its own investigation and comply with the reporting requirements contained in Section 12.
- 12.6.3 Upon receipt of payment suspension notification from HCA, the Contractor shall send notice of the decision to suspend program payments to the provider within five (5) calendar days of HCA's notification to suspend payment, unless the MCFD or other law enforcement agency requests a temporary withhold of the notice.
- 12.6.4 The notice of payment suspension must include or address all of the following (42 C.F.R. § 455.23(2)):
 - 12.6.4.1 State that payments are being suspended in accordance with this provision;
 - 12.6.4.2 Set forth the general allegations identified by HCA. The notice should not disclose any specific information concerning an ongoing investigation;
 - 12.6.4.3 State that the suspension is for a temporary period and cite suspension will be lifted when notified by HCA that it is no longer in place;
 - 12.6.4.4 Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and
 - 12.6.4.5 Where applicable and appropriate, inform the provider of any Appeal rights available to this provider, along with the provider's right to submit written evidence for consideration by the Contractor.
- 12.6.5 All suspension of payment actions under this Section will be temporary and will not continue after either of the following:
 - 12.6.5.1 The Contractor is notified by HCA, MFCD, or other law enforcement

- agency that there is insufficient evidence of Fraud by the provider;
or
- 12.6.5.2 The Contractor is notified by HCA, MFCD, or other law enforcement agency that the legal proceedings related to the provider's alleged Fraud are completed.
- 12.6.6 The Contractor must document in writing the termination of a payment suspension and issue a notice of the termination to the provider and send a copy to HCA.
- 12.6.7 HCA may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a Credible Allegation of Fraud if any of the following are applicable:
 - 12.6.7.1 MFCD or other law enforcement agency have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
 - 12.6.7.2 Other available remedies are available to the Contractor, after HCA approves the remedies as more effective or timely to protect Medicaid funds.
 - 12.6.7.3 HCA determines, based upon the submission of written evidence by the Contractor, individual or entity that is the subject of the payment suspension, there is no longer a Credible Allegation of Fraud and that the suspension should be removed. HCA shall review evidence submitted by the Contractor or provider. The Contractor may include a recommendation to HCA. HCA shall direct the Contractor to continue, reduce, or remove the payment suspension within thirty (30) calendar days of having received the evidence.
 - 12.6.7.4 Enrollee access to items or services would be jeopardized by a payment suspension because of either of the following:
 - 12.6.7.4.1 An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
 - 12.6.7.4.2 The individual or entity serves a large number of Enrollees within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.
 - 12.6.7.5 MFCD or law enforcement agency declines to certify that a matter continues to be under investigation.
 - 12.6.7.6 HCA determines that payment suspension is not in the best interests of the Medicaid program.
- 12.6.8 The Contractor shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:
 - 12.6.8.1 Details of payment suspensions that were imposed in whole or in

part; and

- 12.6.8.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.
- 12.6.9 If the Contractor fails to suspend payments to an entity or individual for whom there is a pending investigation of a Credible Allegation of Fraud without good cause, and HCA directed the Contractor to suspend payments, HCA may impose sanctions in accordance with the Sanctions Subsection of this Contract.
- 12.6.10 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery belongs exclusively to the state of Washington and the Contractor and any involved subcontractor have no claim to any portion of such recovery.
- 12.6.11 Furthermore, the Contractor is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the state of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the Contractor or subcontractor has or may have against any entity or individual that directly or indirectly receives funds under this Contract including, but not limited to, any Health Care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products or services.
- 12.6.12 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.
- 12.6.13 For the purposes of this Section, "subrogation" means the right of any state of Washington government entity or local law enforcement to stand in the place of a Contractor or client in the collection against a third party.

12.7 Investigations

- 12.7.1 The Contractor must cooperate with all state and federal agencies that investigate Fraud, waste and abuse.
- 12.7.2 The Contractor must suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable state or federal agency.
 - 12.7.2.1 If MFCD, or other law enforcement agency accepts a fraud referral from the Contractor, the Contractor must "stand-down". For the purpose of this Subsection, "stand-down" means the Contractor must not:
 - 12.7.2.1.1 Proceed with any further investigation, audit, or other program integrity activity until notified otherwise by HCA, MFCD, or other law enforcement agency.
 - 12.7.2.1.2 Notify the provider or subcontractor in any way about the acceptance of the referral by MFCD or other law enforcement agency.
 - 12.7.2.1.3 Seek to recover or identify any overpayment identified in the Contractor's investigation, audit, or

- other program integrity activity.
- 12.7.2.1.4 Suspend payments until directed by HCA.
- 12.7.2.1.5 Deny any claims for a provider or subcontractor, who the Contractor referred for potential fraud, and MFCD or other law enforcement agency accepted the referral.
- 12.7.2.1.6 Terminate the provider due to any reason identified in the Contractor's investigation.
- 12.7.2.1.7 Invoke any other action that may tip off the provider or related parties to the existence of a possible investigation based on the Contractor's referral to MFCD or other law enforcement agency.
- 12.7.3 The Contractor must 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 must comply with directives resulting from state or federal agency investigations.
- 12.7.5 The Contractor shall request a refund from a third-party payer, provider or subcontractor when an investigation indicates that such a refund is due. These refunds must be reported to HCA as overpayments in the monthly Program Integrity Report.

12.8 Excluded Individuals and Entities

The Contractor and its subcontractors are prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction, or on the prescription of an excluded person. The Contractor shall notify the suppliers of the excluded individual and allow the suppliers a fifteen (15) day grace period from the notification to stop all prescription fills (Social Security Act (SSA) Section 1903(i)(2); 42 C.F.R. § 455.104, § 455.106, and § 1001.1901(b)).

- 12.8.1 The Contractor shall monitor for excluded individuals and entities by:
 - 12.8.1.1 Screening Contractor and Subcontractor individuals and entities with an ownership or control interest during the initial provider application, credentialing and recredentialing processes, and prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract and payable by a federal health care program.
 - 12.8.1.2 Screening individuals during the initial provider application, credentialing and recredentialing process and before entering into a contractual or other relationship where the individual would benefit directly or indirectly from funds received under this Contract or payable by a federal health care program.
 - 12.8.1.3 Screening, the LEIE and SAM lists monthly by the 15th of each month for all Contractor and Subcontractor individuals and entities

with an ownership or control interest, and individuals defined as affiliates in the Federal Acquisition Regulation, of an individual that is debarred, suspended, or otherwise excluded from participating in procurement activities, and individuals that would benefit from funds received under this Contract for newly added excluded individuals and entities (42 C.F.R. § 438.610(a) and (b), SMD letter 2/20/98).

- 12.8.2 The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of exclusion. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.
- 12.8.3 The Contractor shall immediately terminate any employment, contractual and control relationships with any excluded individual or entity discovered during its provider screening processes, including the provider application, credentialing and recredentialing, and shall report these individuals and entities within five (5) business days of discovery.
- 12.8.4 Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees (SSA Section 1128A (a)(6) and 42 C.F.R. § 1003.102(a)(2)).
- 12.8.5 An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA Section 1126(b), and 42 C.F.R. § 455.104(a).
- 12.8.6 In addition, if HCA notifies the Contractor that an individual or entity is excluded from participation by HCA, the Contractor shall terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately (WAC 182-502-0030).
- 12.8.7 The HCA will validate that the Contractor is conducting all screenings required by this Section during its annual monitoring review.

12.9 Reporting

- 12.9.1 All Program Integrity notification and reporting to HCA shall be in accordance with the provisions of the General Terms and Conditions of this Contract unless otherwise specified herein.
- 12.9.2 All Program Integrity notification and reports shall be submitted through the MC-Track application unless otherwise instructed in this Section and/or within the notification form or report templates. See table below of the listing of notification forms and reports and their respective due dates:

DELIVERABLES	FREQUENCY	DUE DATE
Annual Program Integrity Plan for WA State	Annual	March 1 of each calendar year
Records	On Request, or while On-site	By the date specified in HCA's record request or while onsite
Program Integrity Report	Monthly	Thirty (30) calendar days after the end of the reporting month

DELIVERABLES	FREQUENCY	DUE DATE
PIR001 – Annual Program Integrity Report for WA State	Annual	March 1 of each calendar year
HCA Medicaid Provider Disclosure Statement Form HCA-09-048	Ad Hoc	Within thirty-five (35) calendar days of an owner change
WA Excluded Individual Reporting Form	Ad Hoc	Within five (5) business days from the date of discovery
WA Fraud Referral Form	Ad Hoc	Within five (5) business days from the date of determining an allegation of potential fraud exists

12.9.3 On a monthly basis, the Contractor shall use the Program Integrity Reporting Form to report the following:

12.9.3.1 Allegations of provider and subcontractor fraud received and reviewed by the Contractor.

12.9.3.2 Program Integrity Activities and all required notifications found in Section 12.5.

12.9.3.3 Provider Termination Report to include but not limited to:

12.9.3.3.1 Termination for convenience;

12.9.3.3.2 Provider self-termination;

12.9.3.3.3 Terminations due to:

12.9.3.3.3.1 Sanction;

12.9.3.3.3.2 Invalid Licenses;

12.9.3.3.3.3 Services or Billing Errors;

12.9.3.3.3.4 Re-credentialing Errors;

12.9.3.3.3.5 Data Mining;

12.9.3.3.3.6 Investigation; or

12.9.3.3.3.7 Any other related program integrity involuntary terminations.

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

12.9.4.1 A completed Annual Program Integrity Report containing details of the improper payments identified, overpayments recovered, and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report shall include a report of all provider and service-specific program integrity activities such as, but not limited to: algorithms, data analytics, clinical reviews, audits, investigations, authorization denials, payment edits and audits, provider credentialing outcomes and terminations, and COB/TPL identification outcomes.

12.9.5 The Contractor is responsible for investigating Enrollee fraud, waste and abuse. If the Contractor suspects Client/member/Enrollee Fraud:

- 12.9.5.1 The Contractor shall notify and submit all associated information of any alleged or investigated cases in which the Contractor believes there is a serious likelihood of Enrollee fraud to HCA Office of Medicaid Eligibility and Policy (OMEP) by:
 - 12.9.5.1.1 Sending an email to WAEligibilityfraud@hca.wa.gov; or
 - 12.9.5.1.2 Calling the Office of Medicaid Eligibility and Policy at 360-725-0934 and leave a detailed voice mail message; or
 - 12.9.5.1.3 Mailing a written referral to:

Health Care Authority
Attention: OMEP
P.O. Box 45534
Olympia, WA 98504-5534

Or
 - 12.9.5.1.4 Faxing the written complaint to Attention Washington Apple Health Eligibility Fraud at 360-725-1158.
- 12.9.6 Any excluded individuals and entities discovered in the screening described in the Fraud, Waste and Abuse Subsection of this Contract, including the provider application, credentialing and recredentialing processes, must be reported to HCA within five (5) business days of discovery. The identified excluded individual/entities shall be reported using the WA Excluded Individual Reporting Form.
- 12.9.7 The Contractor shall investigate and disclose to HCA, within five (5) calendar days of Contractor's discovery or upon request from HCA, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) services program since the inception of those programs and:
 - 12.9.7.1 Who is an agent or person who has been delegated the authority to obligate or act on behalf of the Contractor; or
 - 12.9.7.2 Any person entering into a provider or subcontractor agreement with the Contractor, or
 - 12.9.7.3 Any person who has ownership or control interest in a provider or subcontractor, or
 - 12.9.7.4 Is an agent or managing employee of the provider or subcontractor.
- 12.9.8 The Contractor and any person entering into a provider or subcontractor agreement, or a person who has ownership or control interest in a provider or subcontractor, or is an agent or managing employee of the provider or subcontractor shall, on a monthly basis, check the LEIE and SAM database to identify any excluded individuals/entities. Documentation shall be kept validating the review of the databases and provided to HCA upon request.
- 12.9.9 The Contractor shall submit to HCA via MC-Track or ProviderOne help ticket all payment and enrollment inquiries to include but not limited to Newborn retro-

enrollment, Service Base Enhancement (DCR, WISe, etc.), regular premium payments and other demographic changes that may impact eligibility (DOD, Address, etc.). Please refer to the Payment Assistant Request section of the Encounter Data Reporting Guide.

- 12.9.10 The Contractor shall submit an Annual Program Integrity Plan of activities the Contractor plans for the upcoming year. The Plan shall include all provider, service, and subcontractor specific program integrity activities such as, but not limited to: algorithms, data analytics, clinical reviews, audits, investigations planned, services requiring authorization, prepayment services or providers, payment edits and audits, provider credentialing, and COB/TPL identification.

12.10 Access to Records, and 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, federal agencies, including but not limited to: CMS, Government Accountability Office, Office of Management and Budget, Office of the Inspector General, Comptroller General, and their designees, to access, inspect and audit any records or documents of the Contractor or its subcontractors, at any time and shall permit inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, at any time.
- 12.10.2 The Contractor and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring, or evaluation identified in subsection 12.10.1. If the requesting agency requests copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency. (42 C.F.R. § 455.21(a)(2); 42 C.F.R. § 431.107(b)(2)). The right for the parties named above to audit, access, and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law. (42 C.F.R. § 438.3(h)).
- 12.10.3 A record, in this Section, includes, but is not limited to:
- 12.10.3.1 Medical records;
 - 12.10.3.2 Billing records;
 - 12.10.3.3 Financial records;
 - 12.10.3.4 Any record related to services rendered, quality, appropriateness, and timeliness of service;
 - 12.10.3.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and
 - 12.10.3.6 Any record of a Contractor-paid claim or encounter, or a Contractor-denied claim or encounter.
- 12.10.4 Upon request, the Contractor, its provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the

premises to reasonably accommodate HCA, MFCD or other state or federal agency.

- 12.10.5 HCA will conduct, or contract for the conduct of, periodic audits of the Contractor no less frequently than once every three (3) years of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each Contractor. (42 C.F.R. 438.602(e)).

12.11 Affiliations with Debarred or Suspended Persons

Pursuant to Section 1932(d)(1)(A) of the SSA (42 U.S.C. § 1396u-2(d)(1)(A)):

- 12.11.1 The Contractor shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5 percent of the Contractor's equity who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.
- 12.11.2 The Contractor shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5 percent of the Contractor's equity who is affiliated with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.
- 12.11.3 The Contractor shall not have an employment, consulting, or any other contractual agreement with a debarred or suspended person or entity for the provision of items or services that are significant and material to this Contract.
- 12.11.4 The Contractor shall agree and certify it does not employ or contract, directly or indirectly, with:
- 12.11.4.1 Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U.S.C. § 1320a-7) or 1128A (42 U.S.C. § 1320a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;
- 12.11.4.2 Any individual or entity discharged or suspended from doing business with HCA; or
- 12.11.4.3 Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

12.12 Transparency

- 12.12.1 HCA shall post on its website, as required by 42 C.F.R. § 438.10(c)(3), the following documents and reports:

12.12.1.1 The Contract;

12.12.1.2 The data at 42 C.F.R. § 438.604(a)(5) which HCA certifies that the Contractor has complied with the contract requirements for

availability and accessibility of services, including adequacy of the provider network, as set forth in 42 C.F.R. § 438.206;

12.12.1.3 The name and title of individuals included in 42 C.F.R. § 438.604(a)(6) to confirm ownership and control of the Contractor, described in 42 C.F.R. § 455.104, and subcontractors as governed by 42 C.F.R. § 438.230; and

12.12.1.4 The results of any audits, under 42 C.F.R. 438.602(e), of the accuracy, truthfulness, and completeness of the encounter and financial data submitted and certified by the Contractor.

12.12.2 In accordance with RCW 74.09.195, HCA will post performance metrics and outcomes on its website.

12.13 Liquidated Damages for Failure to Report Recoveries

12.13.1 If the Contractor fails to report or inaccurately reports overpayments identified and recovered in its monthly Program Integrity Report, HCA will be entitled to impose monetary damages in the form of liquidated damages.

12.13.2 In the event that HCA determines that liquidated damages will be imposed in accordance with this Section, the Contractor shall be notified in writing, in a Notice of Damages.

12.13.3 HCA may assess liquidated damages against the Contractor regardless of whether the failure to report or accurately report is the fault of the Contractor (including the subcontractor, network providers, agents, and/or consultants), provided that HCA itself, MFCD or other state or federal agency did not materially cause or contribute to the Contractor's failure to report or accurately report.

12.13.4 Nothing in this Section shall be construed to limit the authority of the HCA to investigate, audit, or otherwise obtain recoveries from a network provider, non-network provider, Contractor, subcontractor, or third party.

12.13.5 The liquidated damages specified in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HCA's projected financial loss and/or damage to the program resulting from the Contractor's nonperformance, including financial loss as a result of audit, investigation or review delays. Accordingly, in the event the Contractor fails to perform in accordance with this Contract, HCA may assess liquidated damages as provided in this Section.

12.13.6 The amount of the liquidated damages that HCA may assess in accordance with this Section is an amount equal to twice the amount that was not reported or was inaccurately reported.

12.13.7 Nothing in this Section shall be construed to limit the authority of HCA to sanction the Contractor, without a cure period, for non-performance of conducting program integrity activities as required in this Contract or in federal regulations.

13 GRIEVANCE AND APPEAL SYSTEM

13.1 General Requirements

The Contractor shall have a Grievance and Appeal System which complies with the requirements of 42 C.F.R. § 438 Subpart F and chapters 182-538, 182-526, and 284-43 WAC, insofar as those WACs are not in conflict with 42 C.F.R. § 438 Subpart F. The Grievance and Appeal System includes a Grievance Process, a single level of appeal, access to the state's administrative hearing process, and access to independent review through the Contractor. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

- 13.1.1 The Contractor shall have policies and procedures addressing the Grievance and Appeal System, which comply with the requirements of this Contract. HCA must approve, in writing, all Grievance and Appeal System policies and procedures and related notices to Enrollees regarding the Grievance and Appeal System.
- 13.1.2 The Contractor is an independent party and is responsible for its own representation in any administrative hearing, independent review, review by the Board of Appeals, and subsequent judicial proceedings.
- 13.1.3 The Contractor shall provide information on the covered person's right to obtain a second opinion (WAC 284-43-4020(2)(h)).
- 13.1.4 The Contractor shall inform Enrollees about Ombuds services including how to access these services, and provide Enrollees any reasonable assistance necessary in completing forms and other procedural steps for Grievances and Appeals (42 C.F.R. § 438.406(a) and WAC 284-43-4020(2)(d)). Enrollees may also use the free and confidential regional Ombuds services for assistance with Grievances and Appeals.
- 13.1.5 The Contractor shall cooperate with any representative authorized in writing by the Enrollee (WAC 284-43-4020(2)(e), and 42 C.F.R. § 438.402(c)(1)(ii)).
- 13.1.6 The Contractor shall consider all information submitted by the Enrollee or representative (WAC 284-43-4020(2)(f)).
- 13.1.7 The Contractor shall acknowledge receipt of each Grievance, either orally or in writing, within two (2) business days.
- 13.1.8 The Contractor shall acknowledge in writing the receipt of each Appeal. The Contractor shall provide the written notice to both the Enrollee and requesting provider within five (5) calendar days of receipt of the Appeal (42 C.F.R. § 438.406(b)(1)).
- 13.1.9 The Contractor shall ensure that decision makers on Grievances and Appeals were not involved in previous levels of review or decision-making, nor were they a subordinate or direct report of any such individual (42 C.F.R. § 438.406(a)(3)(i) and WAC 284-43-4040(4)).
- 13.1.10 A physician, doctoral level psychologist, certified addiction medicine specialist, or pharmacist, as appropriate, shall review any behavioral health Appeal of care based on medical necessity.
- 13.1.11 Decisions regarding Grievances and Appeals shall be made by individuals with clinical expertise in treating the Enrollee's condition or disease if any of the

following apply (42 C.F.R. § 438.406(b)(2)):

- 13.1.11.1 If the Enrollee is appealing an Adverse Benefit Determination concerning medical necessity, including any decision to not authorize the service in an amount, duration or scope less than requested.
- 13.1.11.2 If an Enrollee Grievance concerns a denial of expedited resolution of an Appeal.
- 13.1.11.3 If the Grievance or Appeal involves any clinical issues.
- 13.1.12 With respect to any decisions described in subsection 13.1.10 that involve behavioral health, the Contractor shall ensure that the individuals making such decisions:
 - 13.1.12.1 Have clinical expertise in treating the Enrollee's condition or disease that is age appropriate when clinically indicated (e.g., a pediatric psychiatrist for a child Enrollee).
 - 13.1.12.2 Are physician board-certified or board-eligible in Psychiatry or Child Psychiatry if the Grievance or Appeal is related to inpatient level of care denials for psychiatric treatment.
 - 13.1.12.3 Are physician board-certified or board-eligible in Addiction Medicine, a Sub-specialty in Addiction Psychiatry or by ASAM, if the Grievance or Appeal is related to inpatient level of care denials for SUD treatment.
 - 13.1.12.4 Are one (1) or more of the following, as appropriate, if a clinical Grievance or Appeal is not related to inpatient level of care denials for psychiatric or SUD treatment:
 - 13.1.12.4.1 Physicians board-certified or board-eligible in Psychiatry, Addiction Medicine or a sub-specialty in Addiction Psychiatry or by ASAM;
 - 13.1.12.4.2 Licensed, doctoral level psychologists; or
 - 13.1.12.4.3 Pharmacists.

13.2 Grievance Process

The following requirements are specific to the Grievance Process:

- 13.2.1 An Enrollee or the Enrollee's authorized representative may file a grievance with the Contractor at any time. Only an Enrollee or the Enrollee's authorized representative may file a Grievance with the Contractor; a provider may not file a Grievance on behalf of an Enrollee (42 C.F.R. § 438.402(c)) unless the provider is acting on behalf of the Enrollee and with the Enrollee's written consent.
- 13.2.2 Enrollee Grievances must be filed with the Contractor, not with HCA. HCA will forward any Grievance received by HCA to the Contractor for resolution.
- 13.2.3 The Contractor shall accept, document, record, and process Grievances forwarded by HCA or DSHS.
- 13.2.4 The Contractor shall provide a written response to HCA within three (3) business days to any constituent grievance, unless HCA requests an expedited

response. For the purpose of this subsection, “constituent grievance” means a complaint or request for information from any state or federal elected official or any state or federal agency director or designee.

- 13.2.5 The Contractor shall investigate and resolve all Grievances whether received orally or in writing. The Contractor shall not require an Enrollee or his/her authorized representative to provide written follow-up for a Grievance the Contractor received orally (WAC 182-538-110(3)).
- 13.2.6 The Contractor shall complete the resolution of a Grievance and notice to the affected parties as expeditiously as the Enrollee’s health condition requires, but no later than forty-five (45) calendar days from receipt of the Grievance. The Contractor may extend the timeframe for processing a grievance by up to fourteen (14) calendar days if the enrollee requests the extension. For any extension not requested by an Enrollee, the Contractor must document that there is need for additional information and that the delay is in the Enrollee’s best interest and give the Enrollee prompt oral notice of the delay.
 - 13.2.6.1 If the Contractor extends the timeline for a grievance not at the request of the Enrollee, it must give the Enrollee written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision. 42 C.F.R. § 438.408(c)(2)(ii); and 42 C.F.R. § 438.408(b)(1).
- 13.2.7 The Contractor must notify Enrollees of the resolution of Grievances within five (5) business days of determination. The notification may be orally or in writing for Grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing, must be easily understood and meet all Enrollee communications requirements in Subsection 3.2.
- 13.2.8 Enrollees do not have the right to a hearing in regard to the resolution of a Grievance, except to address the Contractor’s failure to adhere to the notice and timing requirements for grievances (WAC 182-538-110(4)).

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, informing the Enrollee within five (5) calendar days of receipt of the provider’s request, that an Appeal has been made on the Enrollee’s behalf, and then asking if the Enrollee would like to continue the Appeal. The Contractor shall have made at least three (3) attempts to contact the Enrollee on three (3) different business days, at three (3) different times during the day, without success, prior to dismissing the provider-initiated appeal request.
 - 13.3.1.2 If the Enrollee wants to continue the Appeal, the MCO shall obtain from the Enrollee a written consent for the Appeal. If the Enrollee

does not wish to continue the Appeal, the MCO shall formally dismiss the Appeal, in writing, with appropriate Enrollee Appeal rights and by delivering a copy of the dismissal to the provider as well as the Enrollee.

- 13.3.1.3 For expedited Appeals, the Contractor may bypass the requirement for Enrollee written consent and obtain Enrollee oral consent. The Enrollee's oral consent shall be documented in the Contractor's UMP records.
- 13.3.2 If HCA receives a request to Appeal an Adverse Benefit Determination of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the Enrollee.
- 13.3.3 For Appeals of standard service authorization decisions, an Enrollee, or a provider acting on behalf of the Enrollee, must file an Appeal, either orally or in writing, within sixty (60) calendar days of the date on the Contractor's Notice of Adverse Benefit Determination. This also applies to an Enrollee's request for an expedited Appeal (42 C.F.R. § 438.402(c)(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 (42 C.F.R. § 438.402(c)(3)(ii)); 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. The Contractor shall outreach and coordinate as needed to assist the Enrollee in submitting a written, signed Appeal.
 - 13.3.5.1 If the Enrollee does not provide a written, signed Appeal within ten (10) calendar days of a standard oral Appeal request, the Contractor shall notify the Enrollee, in writing, of the need for the written Appeal, unless the Enrollee's sixty (60) 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.
 - 13.3.5.2 During the Appeal process, the Contractor shall proactively engage the Enrollee offering alternative treatment or pathway of care steps, care coordination, or explaining the continuation of benefits to support meeting medically necessary care.
- 13.3.6 The Appeal process shall provide the Enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this

sufficiently in advance of the resolution timeframe for appeals in the case of expedited resolution (42 C.F.R. § 438.406(b)(5) and § 438.408(b) and (c)).

- 13.3.7 The Appeal process shall provide the Enrollee and the Enrollee's representative copies of the Enrollee's case file, including medical records, other documents and records relied on, or generated by the Contractor (or at the direction of the Contractor) in connection with the Appeal of the Adverse Benefit Determination. This information must be provided upon request by either the Enrollee or the Enrollee's representative and free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. § 438.406(b)(5) and 42 C.F.R. § 438.408(b) and (c).
- 13.3.8 The Appeal process shall include as parties to the Appeal, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate (42 C.F.R. § 438.406(b)(6)).
- 13.3.9 In any Appeal of an Adverse Benefit Determination by a Subcontractor, the Contractor or its Subcontractor shall apply the Contractor's own clinical practice guidelines, standards, protocols, or other criteria that pertain to authorizing specific services.
- 13.3.10 The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within the following timeframes (42 C.F.R. § 438.408):
 - 13.3.10.1 For standard resolution of Appeals and for Appeals for termination, suspension, or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the Appeal, unless the Contractor notifies the Enrollee that an extension is necessary to complete the Appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for Appeal. For any extension not requested by an Enrollee, the Contractor shall resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.
 - 13.3.10.2 The Enrollee may request an extension in the timeframe for processing an appeal for up to fourteen (14) calendar days. For any extension not requested by an Enrollee, the Contractor must document how the delay is in the Enrollee's best interest and make reasonable efforts to provide oral notice of the delay.
 - 13.3.10.2.1 The Contractor must follow up the oral notification within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.
- 13.3.11 The Contractor shall provide notice of resolution of the Appeal in a language and format, which may be understood by the Enrollee. The notice of the resolution of the Appeal shall:
 - 13.3.11.1 Be in writing and sent to the Enrollee and the requesting provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice (42 C.F.R. §

438.408(d)).

- 13.3.11.2 Include the date completed and reasons for the determination in easily understood language (42 C.F.R. § 438.408(e)).
- 13.3.11.3 Include a written statement of the clinical rationale for the decision, including how the requesting provider or Enrollee may obtain the UMP clinical review or decision-making criteria.
- 13.3.11.4 For Appeals not resolved wholly in favor of the Enrollee (42 C.F.R. § 438.408(e)(2)):
 - 13.3.11.4.1 Include information on the Enrollee's right to request a hearing and 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 in accordance with RCW 74.09.741, if the hearing decision upholds the Contractor's Adverse Benefit Determination.

13.4 Expedited Appeal Process

- 13.4.1 The Contractor shall establish and maintain an expedited Appeal review process for Appeals when the Contractor determines or a provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain, or regain maximum function (42 C.F.R. § 438.410(a)).
- 13.4.2 The Enrollee may file an expedited Appeal either orally or in writing. No additional Enrollee follow-up is required.
- 13.4.3 The Contractor shall resolve each appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within the following timeframes (42 C.F.R. § 438.408(b)(2)-(3)):
 - 13.4.3.1 For expedited resolution of appeals or appeals of mental health drug authorization decisions, including notice to the affected parties, the Contractor shall make a decision within seventy-two (72) hours after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice of the decision.
 - 13.4.3.2 The Enrollee may request an extension in the timeframe for processing an appeal for up to fourteen (14) calendar days. For any extension not requested by an Enrollee, the Contractor must document how the delay is in the Enrollee's best interest and make reasonable efforts to provide oral notice of the delay. If the Contractor extends the timeline for processing an expedited appeal not at the request of the enrollee, it must resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
 - 13.4.3.2.1 The Contractor must follow up the oral notification

within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

- 13.4.4 The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an Enrollee's Appeal (42 C.F.R. § 438.410(b)).
- 13.4.5 If the Contractor denies a request for expedited resolution of an Appeal, it shall transfer the Appeal to the timeframe for standard resolution and make reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of denial (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 shall provide to HCA and the Enrollee, upon request, and within three (3) business days, and for expedited Appeals, within one (1) business day, all Contractor-held documentation related to the Appeal, including but not limited to, any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.
- 13.5.4 When medical necessity is an issue, the Contractor's medical director or designee shall review all cases where a hearing is requested and any related Appeals and the outcome of any independent review.
- 13.5.5 The Enrollee must exhaust Appeal rights prior to filing a request for a hearing with HCA. If the Contractor fails to adhere to the appeal notice and timing requirements, the Enrollee is deemed to have exhausted the appeal process and may initiate a hearing (42 C.F.R. § 438.408(c)(3)).
- 13.5.6 The Contractor will be bound by the final order, whether or not the final order

upholds the Contractor's decision. Implementation of the final order shall not be the basis for termination of enrollment by the Contractor.

13.5.7 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.

13.5.8 The hearings process shall include as parties to the hearing, the Contractor, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate and HCA.

13.6 Independent Review

After exhausting both the Contractor's Appeal process and the Administrative Hearing, the Enrollee has the right to request an independent review in accordance with RCW 48.43.535 and chapter 182-538 WAC.

The MCO will advise 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 accordance with chapter 182-526 WAC. Notice of this right shall be included in the Initial Order from the Administrative Hearing.

13.8 Continuation of Services

13.8.1 The Contractor shall continue the Enrollee's services if all of the following apply (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 Determination 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 HCA Board of Appeals (BOA), reverses a decision to deny, limit, or delay services that were not provided while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date the Contractor receives notice reversing the determination (42 C.F.R. § 438.424(a)).

13.9.2 If the final order of OAH or HCA Board of Appeals, or an IRO reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the Appeal was pending, the Contractor shall pay for those services (42 C.F.R. § 438.424(b)).

13.10 Recording and Reporting Adverse Benefit Determinations, Grievances, Appeals and Independent Reviews

The Contractor shall maintain records of all Adverse Benefit Determinations, Grievances, Appeals and independent reviews.

13.10.1 The records shall include Adverse Benefit Determinations, Grievances and Appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of responding to such Adverse Benefit Determinations, Grievances, Appeals, and independent reviews.

13.10.2 The Contractor shall provide a report of all Adverse Benefit Determinations, Grievances, Appeals and independent reviews to HCA in accordance with the Grievance and Appeal System Reporting Requirements published by HCA.

13.10.2.1 The Contractor will separately track, trend and report behavioral health Adverse Benefit Determinations, Grievances, Appeals, and independent reviews.

13.10.2.2 The Contractor will separately track, trend and report Grievances, Appeals, and independent reviews for children/youth referred to WISE.

13.10.3 The Contractor is responsible for maintenance of records for and reporting of any Grievance, Adverse Benefit Determinations, and Appeals handled by delegated entities.

- 13.10.4 Delegated Adverse Benefit Determinations, Grievances, and Appeals are to be integrated into the Contractor's report.
- 13.10.5 Data shall be reported 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 shall be specified by HCA and shall be in accordance with the Grievance and Appeal System Reporting Requirements published by HCA.
- 13.10.7 Reporting of Adverse Benefit Determinations shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers unless the Enrollee is liable for payment in accordance with WAC 182-502-0160 and the provisions of this Contract.
- 13.10.8 The Contractor shall provide information to HCA regarding denial of payment to providers upon request.
- 13.10.9 Reporting of Grievances shall include all expressions of Enrollee dissatisfaction not related to an Adverse Benefit Determination. All Grievances are to be recorded and counted whether the Grievance is remedied by the Contractor immediately or through its Grievance and quality of care service procedures.

14 CARE COORDINATION

14.1 Continuity of Care

The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute physical or behavioral health condition, including children receiving WISE services and TAY who have a current care plan. The Contractor shall ensure medically necessary care for Enrollees is not interrupted and transitions from one setting or level of care to another are promoted for six months after the implementation of this Contract. The Contractor shall honor service authorizations made by other systems such as FFS and Apple Health Managed Care Organizations (42 C.F.R. § 438.208). After the initial six months of the contract, the continuity of care period shall be no less than ninety (90) days for all new Enrollees.

- 14.1.1 When changes occur in the Contractor's provider network or service areas, the Contractor shall comply with the notification requirements identified in the Service Area and Provider Network Changes provisions in this Contract.
- 14.1.2 The Contractor shall make a good faith effort to preserve Enrollee provider relationships, including relationships through transitions.
- 14.1.3 Where preservation of provider relationships is not possible and reasonable, the Contractor shall assist the Enrollee to transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the Enrollee's physical and behavioral health condition requires.
- 14.1.4 The Contractor shall allow Enrollees to continue to receive care from non-participating providers with whom an Enrollee has a documented established relationship. The Contractor shall take the following steps:
 - 14.1.4.1 The Contractor must make a good faith effort to subcontract with the established non-participating provider.
 - 14.1.4.2 If transition is necessary, the Contractor shall facilitate collaboration between the established non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care.
 - 14.1.4.3 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.
 - 14.1.4.4 Pay the non-participating provider indefinitely if it chooses when the non-participating provider accepts payment rates the Contractor has established.
 - 14.1.4.5 Apply utilization management decision-making standards to non-participating providers that are no more stringent than standards for participating providers.
- 14.1.5 Unless required in this Contract to provide longer continuation of a prescribed medication, the Contractor shall allow new Enrollees to fill prescriptions written prior to enrollment until the first of the following occurs:
 - 14.1.5.1 The Enrollee's prescription expires. If the Enrollee's prescription expires before evaluation by a participating provider, the Contractor

shall facilitate a primary care visit and shall not deny the prescription. For the purposes of this subsection, a prescription expires when the date by which a prescribed refills for the prescription passes or when the last fill on the prescription has been made by a pharmacy and the Enrollee has used the medications for that fill.

14.1.5.2 A participating provider examines the Enrollee to determine the continued need for the prescription, and if necessary, appropriate changes are made that do not threaten the health of the Enrollee.

14.1.5.2.1 If the Enrollee refuses an evaluation by a participating provider the Contractor may refuse to cover the prescription as long as the Enrollee's safety and the safety of others is considered in the decision. The Contractor shall document in writing the information and factors it considered in refusing the fill the prescription.

14.1.6 The Contractor must approve payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medication without regard to length of enrollment or examination by a participating provider.

14.1.7 The Contractor shall provide for the smooth transition of care for Enrollees who lose Medicaid eligibility while hospitalized in behavioral health inpatient or residential treatment facilities or while incarcerated or in homeless shelters. The Contractor shall include protocols for coordination with the BH-ASO to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care.

14.1.8 The Contractor shall provide Care Coordination for children participating in WISE.

14.1.8.1 The Contractor must have policies and procedures consistent with the WISE Manual and ensure that subcontractors providing WISE services adhere to the most current version of the WISE Manual and participate in all WISE-related quality activities.

14.1.8.1.1 WISE subcontractors must participate in a review of WISE services conducted using the WISE Quality Improvement Review Tool (QIRT) at least once during the contract period.

14.1.8.2 The Contractor shall ensure that subcontracted WISE agency staff conduct Child Adolescent Needs and Strengths (CANS) screenings for children and youth referred for WISE services.

14.1.8.3 The Contractor shall:

14.1.8.3.1 Follow WISE policies and procedures to screen, identify, and engage children, youth, and caretakers who are eligible to receive the services under WISE.

14.1.8.3.2 Participate in the planning and implementation of a standardized screening and assessment process and uniform reporting of service level for children and youth with intensive behavioral health needs

with the Enrollee consent and according to the timelines and guidelines published by HCA to the extent they are not inconsistent with this Contract or federal regulations.

- 14.1.8.3.3 Report on actions taken in response to WISE Quality Management Plan reports and associated outcomes.
- 14.1.8.3.4 Develop and implement a plan to achieve and maintain a network of WISE providers adequate to meet monthly caseload targets as determined by HCA and the DSHS Research and Data Analysis Division (RDA). The Contractor's plan must take in to account the need to meet a demand for service that exceed the caseload targets. The Contractor shall meet monthly caseload enrollment targets for number of children and youth served in each of the Contractor's Regional Service Areas.
- 14.1.8.3.5 Submit a monthly progress report no later than the 15th of the month following the month of service that includes the following:
 - 14.1.8.3.5.1 The current WISE service capacity for the region and the number of the Contractor's Enrollees served in WISE.
 - 14.1.8.3.5.2 The increase or decrease of number of children/youth served compared to the previous month's progress report.
 - 14.1.8.3.5.2.1 If the Contractor has an action plan from a previous progress report, the Contractor shall identify what progress has been made to meet WISE caseload targets.
 - 14.1.8.3.5.2.2 If the Contractor has deficiencies in the number served for three consecutive months, HCA may consider imposing sanctions as described in the Payment and Sanctions section of this Contract.
- 14.1.8.3.6 The Contractor shall identify challenges in meeting their service capacity targets and develop strategies to address those challenges.

14.1.9 Continuity and Care Coordination for TAY:

- 14.1.9.1 The Contractor shall develop a comprehensive transition plan in collaboration with other systems and providers, including agencies contracted to provide services to Youth, that identifies the Enrollee's goals, objectives, and strategies to achieve goals. The transition plan shall take into account the following:
 - 14.1.9.1.1 Individual behavioral and physical health needs, which may include continued services in the adult behavioral or physical health systems. The transition plan shall address the need for continuity and coordination of services and supports for the Enrollee and the Enrollee's family and identify developmentally and culturally appropriate adult services;
 - 14.1.9.1.2 Connections with supportive housing and supported employment services through the Foundational Community Supports program, post-secondary education, technical training, housing community support, natural supports, and cross-system coordination as needed to attain the Enrollee's goals.

14.2 Population Health Management: Plan

The Contractor shall develop a plan to address Enrollee needs across the continuum of care, and ensure services are coordinated for all Enrollees. The plan shall be reviewed by HCA during the annual monitoring review. The Population Health Management plan shall include at a minimum the following focus areas:

- 14.2.1 Keeping Enrollees healthy;
- 14.2.2 Managing Enrollees with emerging risk;
- 14.2.3 Enrollee safety and outcomes across settings;
- 14.2.4 Managing multiple chronic conditions; and
- 14.2.5 Managing individuals with multiple service providers (e.g., physical health and behavioral health).

The Contractor's Population Health Management plan shall establish methods to identify targeted populations for each focus area and include interventions that meet the requirements of NCQA and the subsections below. The Contractor's Population Health Management plan shall take into account available and needed: (i) data and analytic infrastructure, (ii) HIT and HIE infrastructure and tool, and (iii) other resources needed to support population health management activities.

14.3 Population Health Management: Identification and Triage

- 14.3.1 Initial Health Screen.
- 14.3.2 The Contractor shall conduct a brief IHS containing behavioral, developmental, physical and oral health questions within sixty (60) calendar days of enrollment for all new Enrollees, including Family Connects and reconnects, beginning the first (1st) of the month after the month of enrollment (42 C.F.R. § 438.208(b)(3)).
 - 14.3.2.1 The Contractor shall use evidence-based screening tools

appropriate to the age of the Enrollee, which shall include but is not limited to:

14.3.2.1.1 Tobacco use assessment; and

14.3.2.1.2 Housing and housing instability assessment;

14.3.3 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, for Enrollees who are not referred for Health Home services. The requirements described in Exhibit H, Health Homes apply to Enrollees who are referred for Health Home services.

14.3.4 Initial Health Assessment (IHA): To assess identified Individuals who need Long Term Supports and Services (LTSS) or those with Special Health Care Needs who are not eligible for Health Home services, the Contractor's care coordinator shall conduct an Initial Health Assessment (IHA) within sixty (60) calendar days of the identification of special needs or IHS that indicates the need for care coordination. The assessment shall determine ongoing need for care coordination services and the need for clinical and non-clinical services, including referrals to specialists and community resources.

14.3.4.1 The assessment shall include, at minimum, an evaluation of the Enrollee's physical, behavioral, and oral health status, health services history, including receipt of preventive care services, current medications, and an evaluation of the need for or use of supportive services and resources, such as those described in the Coordination of Care provisions of this Contract.

14.3.4.2 The Contractor shall require the Enrollee's primary care provider and care coordinator to ensure arrangements are made for the Enrollee to receive follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or SUD providers or referral to community-based social services and LTSS.

14.3.4.3 The IHA shall be maintained in the Enrollees' medical record and in the Contractor's care coordination file and available during subsequent preventive health visits.

14.3.5 The Contractor will use other data sources to identify enrollees who need care coordination and care management services, including but not limited to:

- 14.3.5.1 Enrollees that have had contact with crisis services;
 - 14.3.5.2 Review of administrative data sets, such as PRISM;
 - 14.3.5.3 Children with elevated blood lead screen levels;
 - 14.3.5.4 Indicators of potential for high risk pregnancy;
 - 14.3.5.5 Enrollees with unmet care needs or evidence of being underserved;
 - 14.3.5.6 Claims or encounter data;
 - 14.3.5.7 Pharmacy data;
 - 14.3.5.8 Laboratory data;
 - 14.3.5.9 Electronic health records;
 - 14.3.5.10 Data in the CDR; or
 - 14.3.5.11 Results of Contractor-specific algorithms.
- 14.3.6 The Contractor will risk stratify the population to determine the level of intervention enrollees require.

14.4 Population Health Management: Interventions

- 14.4.1 The Contractor shall work with providers to achieve population health management goals, and shall provide PCPs with clinical information about their patients to improve their care.
- 14.4.1.1 The Contractor shall make clinical decision support tools available to providers for use at the point of care that follow evidence based guidelines for:
 - 14.4.1.1.1 Behavioral health conditions.
 - 14.4.1.1.2 Chronic medical conditions.
 - 14.4.1.1.3 Acute conditions.
 - 14.4.1.1.4 Unhealthy behaviors.
 - 14.4.1.1.5 Wellness.
 - 14.4.1.1.6 Overuse/appropriateness issues.

14.5 Bi-Directional Behavioral and Physical Health Integration

- 14.5.1 The Contractor shall promote bi-directional behavioral and physical health integration through education, training, financial, and nonfinancial incentives consistent with Section 14 of this Contract, recommendations of the Bree Collaborative, and other network initiatives to promote integrated care including, but not limited to:
- 14.5.1.1 Increased screening, identification, and referral for behavioral health conditions that commonly occur in primary care settings;
 - 14.5.1.2 Increased access to routine physical health services by individuals with serious mental illness and Substance Use Disorders;
 - 14.5.1.3 Development of collaborative care models and co-location of primary care and behavioral health providers;
 - 14.5.1.4 Development of data analytic tools to identify Enrollees with

behavioral health conditions who are in need of physical health care or Enrollees with physical health conditions in need of behavioral health care;

- 14.5.1.5 Improved Care Coordination consistent with requirements in Section 14 of the Contract including, but not limited to, use of required screening tools and use of Research- and Evidence-based Practices; and
- 14.5.1.6 Use of electronic health records, CDR, decision support tools, client registries, data sharing, Care Coordination, wellness initiatives targeting high-risk behavioral health populations, and other similar program innovations.

- 14.5.2 The Contractor shall submit a quarterly report on Bi-directional Behavioral and Physical Health Integration to HCA through MC-Track. The report shall include the factors listed in subsection 14.5.1 above, using the Bi-directional Behavioral and Physical Health Integration report template available through MC-Track. The quarterly reports are due to HCA no later than the 30th of the month beginning October of 2019. (July, October, January and April).

14.6 Care Coordination Services (CCS) General Requirements

The Contractor shall implement the following activities:

- 14.6.1 The Contractor shall offer Wellness and Prevention services to all Enrollees according to the benefits outlined in this Contract.
 - 14.6.1.1 Refer individuals identified in the IHS as having a need for Care Coordination services to the Enrollee's PCP, Mental Health Professional or SUD provider or to DSHS/Home and Community Services (HCS) for follow-up care and needed services within thirty (30) calendar days of screening and identification.
 - 14.6.1.2 Ensure the PCP has assessed and/or examined the Enrollee according to wellness assessment requirements and appointment scheduling standards (42 C.F.R. § 438.208(c)(2)).
 - 14.6.1.3 Ensure the Enrollee has received appropriate follow-up health care services, including preventive care, care for Chronic Conditions, and referrals to LTSS, social services and community-based organizations.
- 14.6.2 Care Coordination services are provided by the Contractor, clinic-based Care Coordinator staff, or community based organizations, and delivered to Enrollees who have short-term, or intermittent needs for coordination of care, such as those identified as Enrollees with Emerging Risk. Care Coordination services may be provided by non-licensed staff and include but are not limited to:
 - 14.6.2.1 Coordinating authorization of services such as Contractor timely approval of durable medical equipment, pharmacy, and medical supplies;
 - 14.6.2.2 Ensuring access to medically necessary behavioral health, or physical health services and coordination with entities that provide mental health, SUD services, and oral health services; or
 - 14.6.2.3 Ensuring access to community-based services, such as home care

or long-term services and supports.

- 14.6.3 The Care Coordinator and affiliated staff shall work with Enrollees to promote the following:
 - 14.6.3.1 Improved clinical outcomes;
 - 14.6.3.2 Enrollee participation in care;
 - 14.6.3.3 Continuity of Care;
 - 14.6.3.4 Increased self-management skills;
 - 14.6.3.5 Improved adherence to prescribed treatment; and
 - 14.6.3.6 Improved access to care or to services that address social needs.
- 14.6.4 The Care Coordinator shall provide or oversee interventions that address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices.
- 14.6.5 The Care Coordinator shall deliver services in a culturally competent manner that addresses health disparities by interacting directly and in-person with the Enrollee and his or her family in the Enrollee's primary language; with appropriate consideration of literacy and cultural preference.
- 14.6.6 The Care Coordinator is responsible for:
 - 14.6.6.1 Conducting IHS or collecting IHS data from providers, to assess Enrollees for unmet health care or social service needs;
 - 14.6.6.2 Communicating utilization patterns to providers and ensuring action by the provider on under or over-utilization patterns requiring action;
 - 14.6.6.3 Ensuring clinical and social service referrals are made to meet identified Enrollee health and community service needs;
 - 14.6.6.4 Ensuring referrals are made and services are delivered, including any follow-up action;
 - 14.6.6.5 Ensuring the deployment of standardized screening tools outlined in this Contract; and
 - 14.6.6.6 Ensuring collaboration with the regional Behavioral Health Administrative Services Organization (BH-ASO), including developing processes to ensure an Enrollee is followed up with within seven (7) calendar days of when the Enrollee has received crisis services.
- 14.6.7 The Contractor shall develop policies and procedures for Care Coordination services that include:
 - 14.6.7.1 Identification of gaps in care through IHS or analysis of claims and encounter data for Enrollee patterns of under- or overutilization.
 - 14.6.7.2 Referral of Enrollees identified through self-referral or the IHS as having a gap in behavioral, developmental, physical or oral health services to the Enrollee's PCP and as appropriate, to a Mental Health Professional or SUD provider for services and follow-up care

within thirty (30) calendar days of screening and identification.

- 14.6.7.3 Communication with the PCP and other providers regarding:
 - 14.6.7.3.1 The Contractor's medical necessity decisions to authorize care and services.
 - 14.6.7.3.2 Shared care plans and transitional services between the Care Coordinator and jails, crisis service system, prisons, acute withdrawal management and sobering centers, homeless service providers, and the PCP.
 - 14.6.7.3.3 Enrollee over-use of emergency department, preventable hospitalizations and re-hospitalizations, crisis service, and opioid use.
- 14.6.8 If an Enrollee changes enrollment to another AH MCO, the Contractor shall coordinate transition of the Enrollee to the new MCO's Care Coordination system to ensure services do not lapse and are not duplicated in the transition. The Contractor must also ensure Enrollee confidentiality and Enrollee rights are protected (42 C.F.R. § 438.208 (b)(6)).
- 14.6.9 Care Coordinators shall monitor, provide referrals to community-based social services and assess referral completion, education, and facilitate and encourage adherence to recommended treatment. Nothing in this requirement should be construed to limit in any way the Enrollee's right to refuse treatment.
- 14.6.10 The Contractor shall provide a toll-free line for PCPs and specialists who seek technical and referral assistance when any condition, including behavioral health conditions, requires treatment or developmental delays are suspected or identified.
 - 14.6.10.1 Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals and referrals to LTSS when appropriate. Communication about the availability of this consultation service shall be found on the front-page of the Contractor's website and in materials supplied to providers.
- 14.6.11 The Contractor shall implement policies and procedures to ensure the completion of Advance Directives (physical health and mental health).
- 14.6.12 Use and promotion of recovery and resiliency principles to mitigate future risk of the development of physical or behavioral health care conditions.
- 14.6.13 The Contractor shall support practice change activities including the deployment of evidence-based and Promising Practices, preventive screening of Enrollees and models of service delivery that optimize health care service delivery, Enrollee social support and coordinated health care and social services.
- 14.6.14 The Contractor shall participate in a workgroup with HCA to explore the extent to which health IT infrastructure can be developed and used to support the tasks described above. The workgroup shall gather information on the technology currently used, and whether it supports interoperable information exchange and re-use. The workgroup shall gather information on other methods used by care coordination services, and the barriers to using interoperable health IT.

14.7 Care Management Services

The Contractor shall implement activities for Enrollees identified as requiring Complex Case Management (CCM), or those with multiple chronic conditions.

- 14.7.1 Support of a person-centered approach to care in which Enrollee's needs, strengths, and preferences play a central role in the development and implementation of the care plan by:
 - 14.7.1.1 Ensuring the clinical appropriateness of care;
 - 14.7.1.2 Addressing gaps in care, including appropriate use of culturally appropriate, Evidence- or Research-Based Practices;
 - 14.7.1.3 Promoting recovery using Certified Peer Counselors, Community Health Workers and community and natural supports;
 - 14.7.1.4 Requesting modifications to treatment plans to address unmet service needs that limit progress;
 - 14.7.1.5 Assisting Enrollees in relapse/crisis prevention planning that goes beyond crisis intervention and includes development and incorporation of recovery action plans and Advance Directives for individuals with a history of frequent mental health readmissions or crisis system utilization; and
 - 14.7.1.6 Assuring coordination of assessments and evaluations with mental health, SUD and other providers.
 - 14.7.1.7 Supporting to the maximum extent possible, the development and implementation of, and updates to interoperable electronic care plans, to include at a minimum information in subsections 14.7.4.1 through 14.7.4.3. The Contractor shall participate in a workgroup with HCA to assess the utilization of interoperable care plans and barriers to using electronic care plans.
- 14.7.2 Individuals identified by HCA as Health Home eligible shall receive Health Home Services as described in Exhibit H if the Enrollee consents to participate.
- 14.7.3 Individuals identified by the Contractor as requiring CCM shall receive services in accordance with NCQA Standards and interventions as described elsewhere in Section 14.
- 14.7.4 Complete or verify the PCP completion of an Enrollee care plan. The care plan shall be developed in partnership with the Enrollee and in consultation with specialists and social service providers serving the Enrollee, updated at minimum annually and maintained in the Enrollee's health record (42 C.F.R. § 438.208(c)(3)); 42 C.F.R. § (438.208(c)(3)(i)). The care plan shall include all of the following:
 - 14.7.4.1 Presenting diagnosis(es) and health problems;
 - 14.7.4.2 An action plan, including agreed-upon health goals;
 - 14.7.4.3 Documentation of behavioral health, social service, and community resource interventions that promote child development, healthy behaviors, and early referral and treatment for mental health and SUD conditions, including recovery-based programs; and
 - 14.7.4.4 Documentation of Advance Directives (physical health and mental

health).

- 14.7.5 The Contractor shall respond to EPSDT referrals from primary medical care providers with a written notice that must at a minimum include date of intake and diagnosis.
- 14.7.6 The Contractor shall provide information on how to obtain a provider for children/Youth who do not have a PCP.
- 14.7.7 For Enrollees with Special Health Care Needs, the Contractor will develop the Enrollee's care plan in accordance with the requirements described throughout Section 14 and will ensure the plan is reviewed and revised upon reassessment, at least every twelve (12) months or when the Enrollee's circumstances or needs change, or when the Enrollee requests an update.
 - 14.7.7.1 For Enrollees determined to have LTSS needs, the Contractor shall coordinate with staff of Home and Community Services (HCS) to ensure the Enrollee has access to and appropriate evaluation and LTSS services.

14.8 Data Exchange Protocols

- 14.8.1 The Contractor shall develop data exchange protocols, including consent to release before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including sharing of claims and pharmacy data, treatment plans or care plans, crisis plans, critical incidents and Advance Directives necessary to coordinate service delivery, and care management for each Enrollee in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.

14.9 Allied System Coordination

- 14.9.1 Allied System Coordination Plan: For each RSA in which the Contractor participates, the Contractor shall develop a written Allied Systems Coordination Plan that describes how the Contractor will coordinate and collaborate with healthcare and other allied systems that serve Contractor Enrollees. The Contractor shall collaborate with ACH representatives and representatives of the entities listed in Subsection 14.11 to develop and update this plan as needed. The plan must describe how the Contractor will address the elements below and how the Contractor will interact with any Allied System that chooses not to participate in the jointly developed coordination plan and include the following elements:
 - 14.9.1.1 Clearly defined roles and responsibilities of the allied systems in helping Enrollees served by more than one system.
 - 14.9.1.1.1 For children this includes EPSDT coordination for any child serving agency and a process for participation by the agency in the development of a cross-system ISP when indicated under EPSDT.
 - 14.9.1.1.2 For individuals with behavioral health needs, who have current or prior criminal justice involvement, this includes processes for improving access to timely and appropriate treatment.
 - 14.9.1.2 Identification of needed local resources, including initiatives to

address those needs.

- 14.9.1.3 A process for facilitation of community reintegration from out-of-home placements (e.g., Facilities that provide care for individuals with 90 and 180-day civil commitments, Children's Long-term Inpatient facilities, Juvenile Rehabilitation Administration facilities, foster care, nursing facilities, and acute inpatient settings) for Enrollees of all ages.
- 14.9.1.4 A process for working with ACH, the BH-ASO managing crisis services, and first responders, evaluate the need to develop procedures to engage and collaborate with first responders that address:
 - 14.9.1.4.1 Education about Behavioral Health resources and crisis intervention to de-escalate volatile situations and prevent the use of lethal force.
 - 14.9.1.4.2 Strengthening relationships between first responders and Behavioral Health providers to improve access to timely crisis response services or to improve engagement in Behavioral Health treatment.
 - 14.9.1.4.3 Ensuring support to PCPs, emergency department, and local emergency management (fire, police) when Behavioral Health emergencies and urgent problems are encountered.
 - 14.9.1.4.4 Jail diversion response for TAY and adults with Serious and Persistent Mental Illness (SMI) or Co-Occurring Disorders (COD).
 - 14.9.1.4.5 Transition of incarcerated adults and TAY with SMI for the continuation of prescribed medications and other Behavioral Health services prior to re-entry to the community.
 - 14.9.1.4.6 Prevention and treatment of overdose.
- 14.9.1.5 Facilitating linkages with social services and criminal justice/courts and providers under contract with the county or state.
- 14.9.1.6 A procedure for Contractor representatives attending relevant stakeholder, planning, and advocacy meetings and communicating/coordinating with other entities to ensure the Contractor is aligned with state and local Behavioral Health initiatives.

14.9.2 The Contractor's Allied Coordination Plan shall include the following:

- 14.9.2.1 Processes for the sharing of information related to eligibility, access and authorization;
- 14.9.2.2 A process for sharing system issues;
- 14.9.2.3 Procedures to identify and address joint training needs; and
- 14.9.2.4 A process or format to address disputes related to service or payment responsibility, including attribution for hospital-related

claims.

14.10 Health Information Technology (HIT) Tools for Integrated Care

- 14.10.1 The Contractor shall support the use by contracted providers, of Health Information Technology (HIT)/Health Information exchange (HIE) tools and services such as:
 - 14.10.1.1 Certified EHR Technology (CEHRT);
 - 14.10.1.2 Emergency Department Information Exchange (EDIE);
 - 14.10.1.3 PreManage tools (including use by behavioral health providers);
 - 14.10.1.4 Services offered by OneHealthPort (OHP), (such as the Clinical Data Repository); and
 - 14.10.1.5 Other HIT/HIE tools and services to support the integration, coordination and continuity of care.
- 14.10.2 The Contractor shall consider how HIT/HIE can be used to support data exchange protocols and tools to support provider integration of behavioral health and medical services, transitional services, care coordination oversight and transitional planning for incarcerated individuals, and coordinate with the state to advance the use of statewide HIT/HIE tools/services and engage in the implementation of the HIT Operational Plan.
- 14.10.3 The Contractor shall develop policies and procedures for Care Coordination and Care Management Services that encourage and support the use of HIT and HIE technologies (Certified EHRs, existing statewide HIE and HIT, and other technology solutions) to coordinate care across the care continuum, including physical health, behavioral health, social service, and other community-based organizations.

14.11 Coordination Between the Contractor and External Entities

- 14.11.1 The Contractor shall coordinate with, and refer Enrollees to, health care and social services/programs, including, but not limited to:
 - 14.11.1.1 The Department of Social and Health Services:
 - 14.11.1.1.1 Aging and Long-Term Support Administration (AL TSA) Home and Community Services including contracted Area Agencies on Aging;
 - 14.11.1.1.2 Skilled nursing facilities and community-based residential programs;
 - 14.11.1.1.3 Behavioral Health Administration.
 - 14.11.1.1.4 Developmental Disabilities Administration;
 - 14.11.1.1.5 Division of Vocational Rehabilitation; and
 - 14.11.1.1.6 Juvenile Justice and Rehabilitation Administration (JJ&RA).
 - 14.11.1.2 Ombuds services;
 - 14.11.1.3 Oral Health services, including the promotion of oral health

screening and prevention;

- 14.11.1.3.1 Contractors operating in counties served by the Oral Health Connections Pilot Project shall identify and refer Enrollees eligible for the pilot project services, in coordination with the Arcora Foundation (Arcora) through Arcora's referral portal.
- 14.11.1.4 Department of Health (DOH) and Local Health Jurisdiction (LHJ) services, including Title V services for Children with Special Health Care Needs;
- 14.11.1.5 Department of Children, Youth and Families: Early childhood and family support services including home visiting, ESIT, ECLIPSE, ECEAP/Head Start;
- 14.11.1.6 Department of Corrections;
- 14.11.1.7 Criminal Justice Systems (courts, jails, law enforcement, public defenders);
- 14.11.1.8 State Hospitals;
- 14.11.1.9 Community hospitals/Evaluation and Treatment centers that provide care for individuals with 90 and 180-day civil commitments.
- 14.11.1.10 Children's Long-term Inpatient facilities;
- 14.11.1.11 Community Health Clinics, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Apple Health Managed Care Organizations;
- 14.11.1.12 Educational Service Districts (ESDs);
- 14.11.1.13 Support Services for families and family/kinship caregivers;
- 14.11.1.14 HCA First Steps Program - Maternity Support Services (MSS);
- 14.11.1.15 HCA Apple Health Integrated Foster Care program;
- 14.11.1.16 Qualified Health Homes contracted with HCA;
- 14.11.1.17 Supported Housing and Employment programs;
- 14.11.1.18 State and/or federal agencies and local partners that manage access to housing;
- 14.11.1.19 Tribal entities;
- 14.11.1.20 Non-Emergency Medicaid Transportation services;
- 14.11.1.21 Interpreter Services;
- 14.11.1.22 Women, Infants, and Children (WIC) providers and programs;
- 14.11.1.23 HCA's contracted Third Party Administrator for supportive housing and supported employment;
- 14.11.1.24 BH-ASOs outside of the RSA regarding state only, federal block grant, Ombuds, crisis services, and any other areas where information sharing would improve the services of either system;

and

- 14.11.1.25 Any Offender Re-entry Community Safety Program (ORCSP) within the boundaries of the Contractor that is not a Subcontractor of the Contractor.
- 14.11.2 The Contractor shall participate with, cooperate with, and coordinate with regional health alliances, such as the Southwest Washington Regional Health Alliance, Eastern Washington Regional Health Alliance, and CHOICE Regional Health Network.
- 14.11.3 The Contractor shall participate in the management or discussions held at the Bree Collaborative, or with the Foundation for Health Care Quality in their work on COAP, OB COAP, and SCOAP programs as well as coordinate with other organizations engaged in quality improvement in Washington State.
- 14.11.4 The Contractor will coordinate with HCA dental program to reduce emergency room visits for oral health services and ensure Enrollees with urgent or emergent oral health care needs are referred to a FFS dentist.
- 14.11.5 The Contractor shall join and pay a fee to be a member of the Washington Health Alliance (WHA) no later than February 15 of each calendar year.
 - 14.11.5.1 The Contractor shall actively cooperate and participate with the WHA in efforts to improve the quality and efficiency of health care services.
 - 14.11.5.2 The Contractor shall submit data to the WHA for the purpose of producing results for the Community Checkup, the Washington State Common Measure Set on Health Care Quality and Cost, and all other health care measurement and reporting completed by WHA, according to the terms and schedule defined by the WHA.
 - 14.11.5.2.1 As part of routine data submissions provided to the WHA as required under this subsection, the Contractor must include claim-line level financial information (e.g. Billed, Allowed, and Paid dollar amounts) as defined by the WHA.
- 14.11.6 The Contractor shall coordinate Enrollee information, including initial assessments, relevant SON reviews, and care plans, with other managed care entities as needed when an Enrollee changes from one MCO to another or, changes from one Health Home lead to another to reduce duplication of services and unnecessary delays in service provision for Enrollees.
- 14.11.7 For Enrollees who receive services through Centers of Excellence (COE) for hemophilia and other bleeding disorders, the Contractor shall coordinate care with the COE to avoid duplication or delays in service provision and factor replacement products and medications to AHMC Enrollees. The Contractor shall provide all care coordination and care management services other than those related to management of the Enrollee's hemophilia, but will ensure exchange of information necessary to coordinate these services with the COE.
- 14.11.8 The Contractor shall participate in the local Accountable Communities of Health (ACH) in each Regional Service Areas in which the Contractor provides services under this Contract. The Contractor is not required to participate in all committees and workgroups that each ACH identifies, but must participate as

follows:

- 14.11.8.1 Serve in a leadership or other supportive capacity;
- 14.11.8.2 Participate in the design and implementation of transformation projects;
- 14.11.8.3 Collaborate with provider networks to implement Value Based Purchasing Models; and
- 14.11.8.4 Provide technical assistance as needed on subjects relating to Managed Care programs.

14.12 Coordination and Continuity of Care: Behavioral Health Services Only (BHSO)

- 14.12.1 Behavioral Health Services Only
- 14.12.2 The Contractor shall coordinate care for any BHSO Enrollees who receive only Behavioral Health services but receive physical health services through another Managed Care program or the FFS delivery system. The Contractor's Care Coordination activities must include all of the following:
 - 14.12.2.1 Identification of the MCO that provides medical services to the following BHSO Enrollees:
 - 14.12.2.1.1 Full dual eligibles who are enrolled in a Medicare Part C plan.
 - 14.12.2.2 A signed Memorandum of Understanding/Agreement between the Contractor and the other Managed Care delivery system that describes the process for coordinating BHSO and medical benefits.
- 14.12.3 For Enrollees who receive their physical health benefits in the Medicare or Medicaid FFS delivery system, the Contractor must develop data sharing protocols between the Contractor and the Enrollee's PCP for Enrollees in an active course of Behavioral Health treatment.
- 14.12.4 For Enrollees who are enrolled in HCA's FFS Health Home program, the Contractor must develop data sharing protocols between the Contractor and the Enrollee's Qualified Health Home.
- 14.12.5 The Contractor shall ensure that in the process of coordinating care, an Enrollee's privacy is protected under the privacy requirements in 45 C.F.R. parts 160 and 164 subparts A and E and 42 C.F.R. part 2, to the extent they are applicable.

14.13 Children's Long-Term Care Inpatient Program (CLIP)

- 14.13.1 The Contractor will designate a single person within each region to be their "CLIP Liaison" who will participate in the monthly Regional CLIP Committee that acts as the referral mechanism for Enrollees seeking voluntary CLIP treatment and will coordinate with the BH-ASO to facilitate the CLIP Committee's review of all the region's Voluntary applications. Each AH-IMC Contractor is responsible for coordinating the CLIP Committee's review with the BH-ASO's Regional CLIP Committee Coordinator within thirty (30) calendar days.
- 14.13.2 The Contractor will collaborate with the BH-ASO and other MCOs operating in the RSA to develop a written Regional CLIP Committee Agreement that includes all the Managed Care Entities operating within the RSA and outlines roles and responsibilities for the operation of the region's monthly CLIP

Committee meeting. The Region's BH-ASO will be responsible for submitting the CLIP Committee Agreement to the CLIP Administration Office for approval by HCA's CLIP Administrator and CLIP Coordinator within thirty (30) calendar days of the start date of the Contract.

14.13.2.1 Contractor's CLIP Committee Roles and Responsibilities:

14.13.2.1.1 The Regional CLIP Committee determines whether appropriate, less restrictive services are available to the Enrollee, and when requested, must offer a plan of less restrictive alternatives to CLIP when an Enrollee is hospitalized involuntarily.

14.13.3 Upon request, the Contractor must collaborate on any Juvenile Rehabilitation (JR) transfers of youth court ordered for Forensic services on a 10.77 Evaluation and Restoration Order, and Parent Initiated Treatment (PIT) voluntary applicants. The Contractor must integrate resources for all children and youth applying, awaiting admission, or admitted to CLIP.

14.13.4 CLIP Committee determination to "recommend" or "not recommend" CLIP:

14.13.4.1 For all Voluntary CLIP applicants, within thirty (30) calendar days, the regional CLIP Committee will make a determination of whether CLIP treatment is recommended based on medical necessity criteria, whether CLIP treatment is the most appropriate level of treatment to address the needs of the client, or whether there are less restrictive services available that meet the Enrollee's needs. CLIP is not intended to be utilized as a placement resource.

14.13.5 Contractor CLIP Liaison Role:

14.13.5.1 The Contractor will designate a single person who is familiar with local resources and services to act as the Contractor's local "CLIP Liaison" and who attends the Region's monthly CLIP Committee. The CLIP Liaison provides guidance and support in preparing the Enrollee's CLIP applications, presents the Enrollee's application for CLIP consideration at the regional CLIP Committee meetings, and participates on a regular basis in care coordination activities, which may include preadmission meetings, facility admissions when necessary, treatment team meetings while the Enrollee is in CLIP treatment, and coordination with the CLIP Administration Office.

14.13.5.2 CLIP Liaison Role on Region's CLIP Committee:

14.13.5.2.1 The Contractor's designated CLIP Liaison is responsible for presenting all of the relevant facts, including clinical profile and treatment needs of the Enrollee to the CLIP Committee, as well as presenting any less restrictive services that have been attempted prior to consideration of CLIP treatment. The Contractor's CLIP Liaison may request that the CLIP Committee review an Enrollee's case *prior* to the CLIP application being complete. Before a CLIP Application is considered complete, the CLIP Liaison must submit the application and all required application materials to

the CLIP Administration office.

14.13.6 Requirements for a Voluntary CLIP Application: The Contractor or CLIP Liaison must ensure that the completed CLIP Application Form includes the following:

- 14.13.6.1 A signed Youth Agreement to CLIP Treatment signature page attesting that the Enrollee agrees to the CLIP admission;
- 14.13.6.2 The Enrollee's identifying information;
- 14.13.6.3 A current psychiatric evaluation completed within the last six months;
- 14.13.6.4 Contact information for the youth/family team and case manager responsible for coordination if/when the Enrollee is admitted to a CLIP Program;
- 14.13.6.5 Challenges and/or behavioral issues that lead to the request for CLIP treatment;
- 14.13.6.6 Enrollee's treatment needs to be addressed while in CLIP treatment;
- 14.13.6.7 Strengths and interests of the Enrollee and their family; and
- 14.13.6.8 A detailed continuity of care plan and post-discharge plan that outlines community-based behavioral health care services and involvement of other agencies and support services that may be needed post-discharge.

14.13.7 Contractor Notification of a Completed Voluntary CLIP Application:

- 14.13.7.1 The Contractor must notify the family within three (3) business days of receipt of a completed CLIP application. The regional CLIP Committee will convene within thirty (30) calendar days to review the application and make a final determination whether CLIP is recommended. The Contractor's CLIP Liaison may request the CLIP Committee review an Enrollee's application prior to having a completed application when the CLIP Liaison can demonstrate the following conditions have been met:
 - 14.13.7.1.1 The Enrollee has a severe psychiatric illness that warrants intensive inpatient treatment;
 - 14.13.7.1.2 The Enrollee has consented by signature attesting that the Enrollee is in agreement to CLIP treatment; and
 - 14.13.7.1.3 A psychiatric evaluation has been completed within the last six months by a Psychiatrist or a Psychiatric ARNP, and less restrictive services available in the community have not been able to meet the Enrollee's needs.
- 14.13.7.2 If the CLIP Committee makes the determination that CLIP "is recommended," the Contractor's CLIP Liaison is responsible to ensure that all required materials are submitted to the CLIP Administration for the application to be deemed "complete".

14.13.8 CLIP IS Recommended: If the regional CLIP Committee recommends CLIP

treatment, a written response will be provided to the legal guardian and Enrollee outlining suggestions for stabilizing the child or youth while the CLIP application is processed by the CLIP Administration. The Contractor's designated CLIP Liaison must ensure that all medically necessary services continue for the Enrollee and family to ensure intensive community services and plan of care continue while the youth awaits admission to a CLIP facility.

- 14.13.9 CLIP Is Not Recommended: The Contractor must provide the legal guardian and Enrollee aged 13 years and over with a written copy of the Appeal Process at the time the Contractor makes a determination to "not recommend" a voluntary application for CLIP services. If CLIP is not recommended by the regional CLIP Committee, this is considered an adverse benefit determination and a written response will be provided to the legal guardian and Enrollee specifying the reasons for not recommending CLIP and an outline of recommendations for alternative less restrictive services for the child or youth, along with the Enrollee's appeal rights.
- 14.13.10 180-day ITA Court Orders:
 - 14.13.10.1 When an Enrollee under age 18 years is committed on an Involuntary Treatment Act (ITA) court order for up to 180 calendar days under RCW 71.34, the Contractor's CLIP Liaison must be available to consult and assess the Enrollee's needs prior to CLIP admission. This includes consideration of less restrictive treatment options that may meet the needs of the youth and that are acceptable to the court.
 - 14.13.10.2 The Contractor's CLIP Liaison must collaborate with the CLIP Administration for children subject to court-ordered involuntary treatment and provide care coordination and assistance in the development of a less restrictive community plan when appropriate. The Contractor's CLIP Liaison will share the community and/or Family recommendations with the CLIP Administration Office for purposes of CLIP program assignment of committed youth.
- 14.13.11 Reasonable Efforts for Less Restrictive Orders and Services: The Contractor must collaborate and consult with the CLIP Administration Office and the CLIP facility regarding the behavioral health needs of Enrollees being transferred for evaluation purposes to the Child Study and Treatment Center under the requirements of RCW 10.77 or by the Rehabilitation Administration-Juvenile Rehabilitation (RA-JR) to a Juvenile Rehabilitation Facility. The CLIP Liaison will remain available to collaborate and consult with the CLIP facility and the CLIP Administration Office when the Enrollee returns to the community.
- 14.13.12 Child and Adolescent Needs and Strengths (CANS) Screening Requirements: The Contractor must ensure that a CANS screen is completed within the ninety (90) calendar days prior to the actual admission date to a CLIP facility and provide a full CANS within thirty (30) calendar days post-discharge from a CLIP facility for all Medicaid or Medicaid-eligible voluntary Enrollees.
- 14.13.13 Initial Contact with CLIP Facility Post-Admission: The Contractor's CLIP Liaison must ensure that initial contact with CLIP facility treatment staff occurs within three (3) business days of a CLIP admission.
- 14.13.14 Prioritizing WISE For Youth Discharging From CLIP: The Contractor must

prioritize access to WISE services for all youth qualified to receive WISE services that are discharging from CLIP.

- 14.13.15 Rehabilitation Case Management (RCM): The Contractor must provide Rehabilitation Case Management (RCM) throughout the entirety of the CLIP treatment from preadmission through discharge. RCM includes a range of activities conducted in or with a facility for the direct benefit of the admitted youth to improve treatment gains and plan for successful discharges from CLIP. Activities include:
- 14.13.15.1 Assessment for discharge from the CLIP facility or admission to community behavioral health care;
 - 14.13.15.2 Integrated behavioral health treatment planning;
 - 14.13.15.3 Identification of appropriate resources;
 - 14.13.15.4 Involvement of WISE team members while an enrollee is receiving CLIP treatment;
 - 14.13.15.5 Linkage to behavioral health rehabilitative services; and
 - 14.13.15.6 Collaborative development of individualized services that promote continuity of behavioral health care. These specialized coordination activities promote discharge from CLIP, maximize the benefits of treatment, minimize the risk of readmission, and increase likelihood that the Enrollee can remain in the community.
- 14.13.16 Coordination with The CLIP Administration Office: The Contractor's CLIP Liaison must coordinate with the CLIP Administration to ensure the Contractor follows the CLIP Policies and Procedures Manual, January 2016, or its successors. The Contractor's CLIP Liaison must provide the CLIP Administration any relevant information regarding the individual's treatment history that can assist in guiding CLIP program assignment, CLIP treatment, and/or Discharge planning.
- 14.13.17 CLIP Recertification of Need for Continued Stay in CLIP: If a recertification for continued stay by the CLIP Administration is required, the Contractor's CLIP Liaison will provide input in a recommendation for continued CLIP treatment. If there is a not consensus about the need for recertification, the Contractor will provide documentation to the CLIP Facility and the CLIP Administration outlining a plan of care and services available to support discharge back to the community. The proposed community plan will be considered in the final recertification made decision by the CLIP Administration.
- 14.13.18 CLIP Transfers to Short-Term/Acute Care: If a CLIP facility requests the transfer of an Enrollee from a CLIP facility to an acute care hospital setting, the Contractor's CLIP Liaison will collaborate with the CLIP Administration Office and the CLIP Program to decide if authorization is needed for transfer to short-term/acute hospitalization.
- 14.13.19 Tribal CLIP Services: The Contractor's Tribal Liaison and the Enrollee's Indian Health Care Provider shall participate in treatment and discharge planning, including continuity of care in the nearest clinically appropriate setting for all AI/AN Enrollees (including BHSO) admitted for voluntary inpatient psychiatric and/or residential SUD services.

14.14 Children Eligible for Apple Health Integrated Foster Care

- 14.14.1 When the Contractor is notified an Enrollee has been placed in foster care and enrolled with the Apple Health Integrated Foster Care (AHIFC) program, the Contractor shall coordinate with the AH-IFC Contractor to ensure the Enrollee is transitioned to AHIFC with minimal disruption in services.
- 14.14.2 Within the limits of available information, the Contractor shall ensure continuity of services if an Enrollee has been re-enrolled with the Contractor at the end of a foster care placement.

14.15 Children's Health Care Coordination

- 14.15.1 The Contractor shall ensure coordination for all Enrollees under age 21 in accordance with EPSDT requirements. The Contractor shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services needed to treat health problems and conditions when the Contractor becomes aware of an unmet need. This requirement does not preclude Enrollees under age 21 from receiving any other care coordination activity described in this Contract.
- 14.15.2 In accordance with chapter 74.09.337 RCW, when the Contractor receives notification or identifies children requiring mental health treatment, including behavioral intervention to treat autism, the Contractor will, as necessary:
 - 14.15.2.1 Coordinate mental health treatment and care based on the child's assessed needs, regardless of referral source, whether the referral occurred through primary care, school-based services, or another provider;
 - 14.15.2.2 Follow-up to ensure an appointment has been secured; and
 - 14.15.2.3 Coordinate with the PCP regarding development of a treatment plan, including medication management.
- 14.15.3 The Contractor will submit a report to HCA of children who have been identified as needing mental health care and appointment status. The quarterly Children's Mental Health report is due on the last business day of October, January, April, and July.
- 14.15.4 The Contractor will collaborate with Seattle Children's to receive Washington's Mental Health Referral Service for Children and Teens consultation letters. When Enrollee consultation letters are received, the Contractor will contact the Enrollee to ensure the Enrollee's needs are met and follow the provisions in this subsection as indicated.

14.16 American Indian/Alaska Natives

- 14.16.1 The Contractor must designate a tribal liaison to work with Indian Health Care Providers (IHCPs).
- 14.16.2 The Contractor must provide for training of its tribal liaison, conducted by one (1) or more IHCPs and/or the American Indian Health Commission for Washington State and/or the DSHS Indian Policy Advisory Committee, on AI/AN health disparities and needs, the Indian health care delivery system, the government-to-government relationship between the state of Washington and the federally recognized tribes, applicable federal and state laws and regulations, applicable provisions in this Contract, and matters specific to

IHCPs.

- 14.16.3 The Contractor must ensure its employees and agents receive training in cultural humility, including training on how to communicate with AI/AN Enrollees and IHCP staff, and in the history, culture, and services of IHCPs within the RSAs under the Contract. Training shall be obtained in collaboration with the tribes and IHCPs in such RSAs.
- 14.16.4 The Contractor must notify and coordinate care and transitions with any IHCP when the Contractor becomes aware an Enrollee is AI/AN or is receiving care from an IHCP and the Enrollee consents to such notification. To meet this requirement, the Contractor must develop and maintain a process for asking whether an Enrollee is a member of a federally recognized tribe or is receiving care from an IHCP and, if applicable, whether the Enrollee consents to the Contractor notifying such IHCP or federally recognized tribe.
- 14.16.5 With respect to voluntary psychiatric hospitalization authorization, the Contractor shall:
 - 14.16.5.1 Develop and maintain policies and procedures that explain how IHCP request voluntary psychiatric hospitalization authorizations for Enrollees.
 - 14.16.5.2 Obtain the approval of HCA's tribal liaison for such policies and procedures before they are implemented; and
 - 14.16.5.3 Make available to IHCPs information on how to request voluntary psychiatric hospitalization authorizations for Enrollees, including policies and procedures, and how to submit appeals and expedited appeals.
- 14.16.6 The Contractor's Tribal Liaison and the Enrollee's Indian Health Care Provider shall participate in treatment and discharge planning, including continuity of care in the nearest clinically appropriate setting for all AI/AN Enrollees (including BHSO) admitted for voluntary inpatient psychiatric and/or residential SUD services.

14.17 Transitional Services

- 14.17.1 The Contractor shall ensure transitional services described in this Section are provided to all Enrollees who are transferring from one care setting to another or one level of care to another.
- 14.17.2 The Contractor shall provide Transitional Care services to Enrollees who participate in Health Home services in accordance with Exhibit H, Health Homes. When a Health Home Enrollee moves from one coverage area to another, the Contractor in the new coverage area shall provide Care Management Coordination services or other services to ensure the care plan established by the Health Home Care Coordinator in the previous county of residence continues for the Enrollee. If Health Home services were not available in the previous county of residence, the Contractor shall ensure a Health Home-eligible Enrollee receives Health Home services in the new coverage area consistent with Exhibit H of this Contract.
- 14.17.3 The Contractor shall work with appropriate staff at any hospital, including a CPE facility, to implement a safe, comprehensive discharge plan that assures continued access to medically necessary covered services which will support

the client's recovery and prevent readmission. The Contractor shall have in place operational agreements or shall incorporate transitional language into existing subcontracts with the Contractor's contracted state and community physical and Behavioral Health hospitals, residential treatment facilities and long-term care facilities, to ensure Enrollee care transitions. The written agreements shall define the responsibility of each party in meeting the following requirements:

- 14.17.3.1 The Contractor must complete the Uniform Discharge Tool reporting template for every individual discharging from a mental health inpatient setting hospital stay. The template, developed collaboratively with contracted MCOs and HCA, will be finalized by the end of the first quarter of 2019 and submitted afterward as described below:
- 14.17.3.2 On a semi-annual basis, the Contractor must compile and submit a summary of aggregate scores derived from the Uniform Discharge Tool to HCA. The report is due on the fifteenth of July for the reporting period of January 1 through June 30 and the fifteenth of January for the reporting period of July 1 through December 31.
 - 14.17.3.2.1 HCA may request a copy of the Uniform Discharge Tool for an individual and the Contractor must provide the tool within one (1) business day of the request.
- 14.17.3.3 Development of an individual Enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include:
 - 14.17.3.3.1 Information that supports discharge care needs, Medication Management, interventions to ensure follow-up appointments are attended, and follow-up for self-management of the Enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Formal or informal caregivers shall be included in this process when requested by the Enrollee;
 - 14.17.3.3.2 A written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers;
 - 14.17.3.3.3 Systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care;
 - 14.17.3.3.4 Organized post-discharge services, such as home care services, after-treatment services, and occupational and physical therapy services;
 - 14.17.3.3.5 Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following Enrollee discharge;

- 14.17.3.3.6 Information on what to do if a problem arises following discharge;
- 14.17.3.3.7 For Enrollees at high risk of re-hospitalization, a visit by the PCP or Care Coordinator at the Facility before discharge to coordinate transition;
- 14.17.3.3.8 For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage of the Enrollee to appropriate referrals;
- 14.17.3.3.9 Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge;
- 14.17.3.3.10 Follow-up to ensure the Enrollee saw his/her provider; and
- 14.17.3.3.11 Planning that actively includes the patient and family caregivers and support network in assessing needs.
- 14.17.3.4 When appropriate, the Contractor will obtain the Enrollee's permission to share information with clinical and non-clinical providers to facilitate care transitions.
- 14.17.3.5 The Contractor, in collaboration with all hospitals including state hospitals; and other facilities that provide care for individuals with 90 and 180-day civil commitments, shall develop discharge planning policies and procedures.
 - 14.17.3.5.1 The Contractor shall process hospital prior authorization requests for all clinic services required by the Enrollee within two (2) business days. Such services shall include authorizations for any therapies, home care services, equipment or pharmaceuticals.
 - 14.17.3.5.2 The Contractor shall educate state hospitals, other facilities providing care for individuals with 90 and 180-day civil commitments, and discharge planning staff on clinical services requiring pre-authorization to facilitate timely discharge from these settings.
 - 14.17.3.5.3 The Contractor shall not delay discharge from a hospital because of Contractor authorization procedures that unnecessarily delay such discharges.

- 14.17.3.5.4 The Contractor must accept the 'honor authorization' for SUD residential admission when services are authorized by the Enrollee's previous MCO, in cases where an incarcerated Enrollee is authorized by one MCO but changes to another MCO upon release. This includes, but is not limited to:
 - 14.17.3.5.4.1 Enrollee selects a different MCO upon release than they were enrolled in at incarceration;
 - 14.17.3.5.4.2 The MCO that the Enrollee was enrolled in at incarceration is no longer being offered in the service area that the Enrollee was released in; or
 - 14.17.3.5.4.3 The Enrollee becomes associated with a household that has selected a different MCO than the Enrollee had prior to incarceration.
- 14.17.4 Care coordination and transitions between levels of care – Inpatient Treatment Agencies.
 - 14.17.4.1 The Contractor must require that behavioral health treatment agencies develop policies and procedures that enhance care coordination, including transitions between all levels of care, by July 1, 2019. Any new policies or procedures must take effect on or before October 1, 2019.
 - 14.17.4.2 The Contractor must work with behavioral health treatment agencies to ensure there is adequate coordination for Enrollees transitioning between various levels of treatment services to ensure continuity of care. As used in this section, "continuity of care" means the situation under which an Enrollee who is receiving services from an individual provider is entitled to receive timely and applicable follow-up services from ancillary referral agencies with the goal of providing immediate follow-up to address the holistic needs of the Enrollee. This will include, at a minimum, the following:
 - 14.17.4.3 The Contractor must work with the Subcontractor to ensure that discharge plans and facilitation to post-discharge services are documented in the Enrollee's electronic health record. The following must occur when the Enrollee is discharged or transitioned to a lower or higher level of care:
 - 14.17.4.3.1 Appropriate referrals are made to a behavioral health provider and coordination with the Enrollee's MCO.
 - 14.17.4.3.2 Follow up appointments must be scheduled to occur within seven calendar days of Enrollee discharge and documented as such in the Enrollee's electronic health record. Documentation must include:

- 14.17.4.3.2.1 Release of Information between behavioral health treatment agencies for the Enrollee; date and time of appointment; any current medications; and
 - 14.17.4.3.2.2 If applicable, sufficient supply and compliance plan for prescribed medications is documented as part of the discharge process.
 - 14.17.4.3.3 Enrollee's counselor or a designated outreach coordinator at the facility, will follow up via telephone, text message, or email with the Enrollee within one week post-discharge.
- 14.17.4.4 The Contractor must ensure continuity of MAT services for an Enrollee who transfers out of their region if that Enrollee was inducted or continued on FDA approved medications for all substance use disorders during the course of their treatment. For those receiving FDA approved medications for substance use disorder, the following must occur:
 - 14.17.4.4.1 The Contractor must ensure an intake appointment takes place within seven (7) calendar days of discharge from previous treatment facility.
 - 14.17.4.4.2 Upon Enrollee discharge, the subcontractor must ensure medication management to include sufficient medication until the Enrollee's scheduled appointment with community provider or behavioral health treatment agency.
 - 14.17.4.4.3 The Contractor must have enough subcontractors that provide MAT services to allow for potential referrals from Enrollees who transfer from other regions.
- 14.17.5 Transition from Inpatient SUD Behavioral Health Agency. The Contractor must coordinate with Subcontractors who provide inpatient treatment to ensure referrals of Enrollees to outpatient services post-discharge from their facility. This includes the following:
 - 14.17.5.1 Inpatient Treatment Provider must have Policies in place for prompt exchange of Enrollee information between behavioral health treatment agencies to facilitate continuity of care.
 - 14.17.5.2 Warm Hand-off: When an Enrollee completes or is discharged from an Inpatient Behavioral Health Agency, the subcontracting agency will have policies and practices in place to:
 - 14.17.5.2.1 Provide scheduled immediate appointments with community health care providers, to include, but not be limited to the following:
 - 14.17.5.2.1.1 Intensive Outpatient/Outpatient Services. Documentation of and

appointment referral for next level of treatment upon completion of residential services.

14.17.5.2.1.2 MAT. If the Enrollee was inducted or continued on FDA approved medications for SUD during their stay in an Inpatient Behavioral Health facility, the agency will coordinate a same day appointment with an outpatient provider to coincide with the individual's discharge date.

14.17.5.2.1.3 Peer Support and Recovery Based Services. The Inpatient Behavioral Health facility will document and provide the Enrollee with addresses and phone numbers at discharge for community based Peer Support and Recovery Support resources.

14.17.5.2.1.4 Housing. Enrollee's housing status must be verified through the Enrollee or authorized representative and documented within the electronic health record system. When necessary, the Behavioral Health facility will refer Enrollee to housing and community support services; documentation of any referrals must be placed in the electronic health record. When the Enrollee is prescribed FDA approved medications for SUD, the provider must document efforts to obtain housing to fit the individual's needs.

14.17.5.2.1.5 Transportation- Arrange for transportation for the individual, as needed, to scheduled appointments and recovery-based housing.

14.17.5.3 If the Enrollee discontinues services, the Subcontractor will document as such and attempt to facilitate transition back into the community.

14.17.5.4 If a behavioral health treatment agency discontinues treatment of an Enrollee, the agency must meet all discharge requirements noted in subsections 14.17.5.2 and 14.17.5 above.

14.18 Skilled Nursing Facility Coordination

14.18.1 Skilled Nursing Care is care provided by trained individuals (RN, PT, OT, ST, or

RT) that typically follows an acute hospital stay, or is provided as an alternative to skilled care in an acute care facility. It may be necessary for acute medical conditions (for example, rehab) or due to chronic medical conditions or disabilities. Skilled care is:

- 14.18.1.1 Rehabilitative: Care provided for or post an acute illness or injury with the intent of restoring or improving skills and/or function that was lost or impaired; or
- 14.18.1.2 Skilled Medical: Care provided daily and including, but not limited to, IV therapy, IM injections, indwelling and subrapubic catheters, tube feeding, TPN, respiratory therapy, or wound care.
- 14.18.2 The Contractor is responsible for medically necessary Skilled Nursing care in a SNF or NF when the Contractor determines Nursing Facility care is more appropriate than acute hospital care. The Contractor shall coordinate with the hospital or other acute care facility discharge planners and nursing facility Care Managers or social workers, as described in the Coordination between the Contractor and External Entities Subsection of this Contract to ensure a smooth transition of the Enrollee to or from a SNF or NF.
- 14.18.3 The Contractor shall coordinate with the SNF or NF to provide Care Coordination and transitional care services and shall ensure coverage of all Medically Necessary Services, prescriptions and equipment not included in the negotiated SNF daily rate. This includes but is not limited to: prescription medications, durable medical equipment, therapies, intravenous medications, and any other medically necessary service or product.
 - 14.18.3.1 If the Contractor, in coordination with the NF or SNF, anticipates the Enrollee will be in the Facility for additional days after an Enrollee no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Contractor shall coordinate with the DSHS/ALTSA/HCS to:
 - 14.18.3.1.1 Determine functional, financial, and institutional eligibility, if necessary; and
 - 14.18.3.1.2 Assist the Enrollee to explore all options available for care, including whether the Enrollee will be discharged to his or her home or a community residential setting, or remain in the SNF for Long-Term Services and Supports (LTSS).
 - 14.18.3.2 If the Enrollee is discharged home or a community residential setting, the Contractor shall coordinate with SNF/NF and HCS staff to ensure the Enrollee is discharged to a safe location and shall ensure Medically Necessary Services are available to the Enrollee including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services and any other services necessary to facilitate the Enrollee's recovery. The Contractor shall also ensure follow-up care is provided consistent with the Transitional Care Coordination requirements of this Contract.
- 14.18.4 If the Enrollee remains in the SNF/NF, the Enrollee remains enrolled in AH-IMC and ALTSA is responsible for payment of SNF/NF room and board beginning on

the date it is determined the Enrollee does not meet or no longer meets criteria for the rehabilitative or skilled benefit. The Contractor continues to be responsible for all Medically Necessary Services, prescriptions, and equipment not included in the ALTSA NF rate. The Contractor shall continue to monitor the Enrollee's status and assist in coordination of transitions back to the community.

14.18.5 Issuance of an award letter by ALTSA does not constitute a guarantee or promise of payment for nursing home care.

14.18.6 The Contractor must provide written notice to the Facility, including dates of service and the date coverage will end, if the Enrollee:

14.18.6.1 Is admitted under the rehabilitative or skilled benefit;

14.18.6.2 Does not meet rehabilitative or skilled nursing criteria; or

14.18.6.3 If a previously authorized stay is being reduced.

14.18.7 For purposes of this Section, "nursing facility level of care" means ongoing support services provided in a SNF/NF for Enrollees who do not meet the criteria for rehabilitative or skilled nursing services.

14.19 Care Coordination Oversight

14.19.1 The Contractor shall have internal monitoring processes in place to ensure compliance with the Care Coordination and ICM requirements and the quality and appropriateness of care furnished to individuals with special health care needs (42 C.F.R. § 438.208).

14.19.2 Quality assurance reviews of documented Care Coordination and ICM activities shall include:

14.19.2.1 Case identification and assessment according to established risk stratification system;

14.19.2.2 Documented treatment plans and care plans with evidence of periodic revision as appropriate to the Enrollee emerging needs;

14.19.2.3 Effective Enrollee monitoring, including management of barriers;

14.19.2.4 Referral management;

14.19.2.5 Effective coordination of care, including coordination of services that the Enrollee receives through the FFS system; and

14.19.2.6 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.

14.19.3 The Contractor shall conduct quality assurance reviews, at a minimum, on a quarterly basis.

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

14.20.1 When the required treatment plan of Individuals with Special Health Care Needs, Children with Special Health Care Needs or Enrollees meeting Level 2 eligibility indicates the need for frequent utilization of a course of treatment with or regular monitoring by a specialist, the Contractor shall allow these Individuals to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care (42 C.F.R. § 438.208(c)(4) and 438.6(m)).

14.21 Transitional Planning for Incarcerated Enrollees

For the purposes of this subsection, “correctional facility” includes city and county jails, Department of Corrections (DOC) facilities, and Juvenile Rehabilitation facilities.

14.21.1 In accordance with SSB 6430 (Laws of 2016, chapter 154), the Contractor shall coordinate care for Enrollees as they transition into a correctional facility or upon release from a correctional facility. The Contractor shall initiate development of and make progress toward obtaining data sharing agreements with correctional facilities to enable the Contractor and these facilities to share health information about the Enrollees. Transitional care coordination shall be provided for up to the first thirty (30) calendar days of incarceration or as needed and upon the Enrollee’s release, including honoring another MCOs prior authorization for admission to SUD residential facility. When correctional facilities opt out of this activity the Contractor is not required to pursue these facilities.

14.21.2 The Contractor shall:

14.21.2.1 Provide transitional Care Coordination services to Enrollees when they enter a correctional facility, including:

14.21.2.1.1 Working with the facility to define the responsible party at the facility who will provide Care Coordination activities in the facility;

14.21.2.1.2 Ensuring the facility is aware of the Enrollee's special needs, such as a PRISM score of 1 or higher, SUD, mental health needs, or chronic health conditions, and is aware of medications and supplies the enrollee needs; and

14.21.2.1.3 Providing information to enable the facility to maintain the Enrollee’s medication regimen while the Enrollee is incarcerated.

14.21.2.2 Provide services and Care Coordination for Enrollees upon release from a correctional facility, or other facilities that provide care for individuals with 90 and 180-day civil commitments, including:

14.21.2.2.1 Coordinating with the facility to get copies of the Enrollee’s medical records at the time of discharge;

14.21.2.2.2 Requesting the Enrollee sign a Release of Information to allow exchange of health care information between systems;

14.21.2.2.3 Using an evidence based approach to care coordination as the Enrollee transitions from incarceration to the community;

14.21.2.2.4 Ensuring expedited prior authorization for medications or supplies prescribed while the Enrollee was incarcerated, and for admissions to SUD residential treatment facilities when previously authorized by another MCO during the client’s incarceration period;

- 14.21.2.2.5 Prioritize Care Coordination for Enrollees with special needs, such as a PRISM score of 1 or higher, SUD, mental health needs, or chronic health conditions;
- 14.21.2.2.6 Providing the Enrollee with an overview of benefits for which the Enrollee is eligible through the Contractor;
- 14.21.2.2.7 Discuss with the Enrollee how to access a PCP, notify the Enrollee who their PCP is or help the Enrollee to find a PCP; and
- 14.21.2.2.8 Assist the Enrollee to access the following services:
 - 14.21.2.2.8.1 Transportation to Medicaid appointments;
 - 14.21.2.2.8.2 Follow-up appointments for Behavioral Health or medical services;
 - 14.21.2.2.8.3 Housing and employment assistance; and
 - 14.21.2.2.8.4 Other support services the Enrollee may need.

14.21.3 HCA shall provide:

- 14.21.3.1 Information to the Contractor about the Enrollee's incarceration status when the information is available to HCA.

14.21.4 When possible, HCA shall coordinate with the Contractor to re-enroll the Enrollee with the MCO he or she was enrolled in prior to incarceration, even when the incarceration was longer than six months.

14.22 Mental Health Parity

- 14.22.1 The Contractor shall not impose Non-Quantitative Treatment Limits (NQTL) for mental health or SUD benefits in any classification (inpatient, outpatient, emergency care, or prescription drugs) unless, under the Contractor's policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. (42 C.F.R. § 438.910(d)).
- 14.22.2 The Contractor shall monitor the Non-Quantitative Treatment Limits (NQTL) used in providing mental health or SUD benefits to Enrollees, to assure they are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors the Contractor uses to apply limitations for medical/surgical benefits in the appropriate classifications. (42 C.F.R. § 438.910(d)). The Contractor shall report disparate applications and parity concerns to HCA.
- 14.22.3 The Contractor shall use processes, strategies, evidentiary standards, or other

factors in determining access to out-of-network providers for mental health or SUD benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.

- 14.22.4 The Contractor may cover, in addition to services covered under the Medicaid State Plan, any services necessary for compliance with the requirements for parity in mental health and SUD benefits in 42 C.F.R. part 438, subpart K, and the contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the state or the Contractor. (42 C.F.R. § 438.3(e)(1)(ii)).
- 14.22.5 If Enrollees are provided mental health or SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or SUD benefits must be provided to the Enrollee in every classification in which medical/surgical benefits are provided. (42 C.F.R. § 438.910(b)(2)).
- 14.22.6 The Contractor's prior authorization requirements shall comply with the requirements for parity in mental health and SUD benefits in (42 C.F.R. § 438.910(d)).
- 14.22.7 The Contractor must provide all necessary documentation and reporting to HCA to establish and demonstrate compliance with 42 C.F.R. part 438, subpart K regarding parity in mental health and SUD benefits.
- 14.22.8 The Contractor shall make the criteria for medical necessity determinations made by the Contractor for mental health or substance abuse disorder benefits available to any enrollee, potential enrollee, or contracting provider upon request.
- 14.22.9 The Contractor shall not impose aggregate lifetime, annual dollar limits or any other financial limitations on Enrollees for mental health, SUD benefits regardless of whether the services are covered by the Contractor.

15 SPECIAL PROVISIONS

15.1 Special Provisions for Subcontracts with Indian Health Care Providers (IHCPs)

- 15.1.1 If, at any time during the term of this Contract, an IHCP submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such IHCP's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the IHCP.
 - 15.1.1.1 Any such subcontract must include the Special Terms and Conditions set forth in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (the IHCP Addendum) attached hereto as Exhibit L, Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs). To the extent that any provision set forth in the subcontract between the Contractor and the IHCP conflicts with the provisions set forth in the IHCP Addendum, the provisions of the IHCP Addendum shall prevail.
 - 15.1.1.2 Such subcontract may include additional Special Terms and Conditions that are approved by the IHCP and the Contractor. Each party must provide HCA Tribal Liaison with a complete copy of such additional Special Terms and Conditions, in the format specified by HCA, and a written statement that both parties have agreed to such additional Special Terms and Conditions.
- 15.1.2 Any subcontracts with IHCP 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 HCA Tribal Affairs Office to understand the legal protections applicable to IHCPs and American Indian/Alaska Native Medicaid recipients.
- 15.1.4 In the event that (a) the Contractor and the IHCP fail to reach an agreement on a subcontract within ninety (90) calendar days from the date of the IHCP's written request (as described in subsection 15.1.1) and (b) the IHCP submits a written request to HCA for a meeting to discuss the subcontract, the Contractor and the IHCP shall meet in person with HCA in Olympia, Washington or at an alternate location agreed upon by the parties involved within thirty (30) calendar days from the date of the IHCP's written consultation request in an effort to resolve differences and come to an agreement. Executive leadership of the Contractor must attend this meeting in person and be permitted to have legal counsel present.

15.2 IHCP Engagement

- 15.2.1 No later than April 30 of each year, the Contractor shall submit to HCA Tribal Affairs Office a report that includes:
 - 15.2.1.1 A plan that describes the outreach activities the Contractor will undertake during the upcoming year to work with IHCPs in developing and implementing various services, financing models,

and other activities for the Contractor to:

- 15.2.1.1.1 Support and enhance the care coordination services provided by IHCPs for Enrollees, both American Indian/Alaska Native and non-American Indian/Alaska Native, including coordination with non-IHCP;
- 15.2.1.1.2 Improve access for American Indian/Alaska Native Enrollees (including those who do not receive care at IHCPs) to receive trauma-informed care; and
- 15.2.1.1.3 A summary of the progress made during the previous year in building relationships, contractual and otherwise, with IHCPs.

15.3 Special Provisions for IHCPs and American Indians and Alaska Natives

- 15.3.1 If an American Indian/Alaska Native Enrollee indicates to the Contractor that he or she wishes to have an IHCP as his or her PCP, the Contractor must treat the IHCP as an in-network PCP under this Contract for such Enrollee regardless of whether or not such IHCP has entered into a subcontract with the Contractor.
- 15.3.2 The Contractor must honor the referral of an out-of-network IHCP who refers an AI/AN Enrollee to a network provider. (42 C.F.R. § 438.14(b)(6)).
- 15.3.3 In accordance with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided to AI/AN Enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP.
- 15.3.4 Tribal health programs that have been contracted or compacted under the Indian Self Determination and Education Assistance Act (Public Law 93-638) may self-identify with HCA as a Tribal Federally Qualified Health Center (Tribal FQHC) and agree to be paid under the FQHC Alternative Payment Methodology applicable to FQHCs as provided in the Medicaid State Plan, which sets the Tribal FQHC facility rate equal to the published Indian Health Services encounter rate. HCA will maintain a complete and up-to-date list of NPIs on the Tribal Affairs website of which sites are Tribal FQHCs.
- 15.3.5 Upon mutual agreement of HCA and the Contractor:
 - 15.3.5.1 Facilities of the Indian Health Service and facilities operated by a tribe or tribal organization and funded by Title I or III of the Indian Self Determination and Education Assistance Act, whether designated with the Medicaid program as a Tribal 638 Clinic or a Tribal Federally Qualified Health Center (a Tribal FQHC) the specific full encounter rate for each qualifying encounter as outlined in the Medicaid State Plan and in accordance with Federal Guidance.
 - 15.3.5.2 The encounter rates for each contracted Indian Health Service facility, Tribal 638 Clinic, and Tribal FQHC will be provided by HCA

to the Contractor with each accepted qualified claim. The rate files will be consistent with federal guidance found at <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules> under Tribal Health Program (which includes guidance for the Tribal FQHC program), and updated annually.

15.3.5.3 Claims paid to Indian Health Service facilities, Tribal 638 Clinics, and Tribal FQHCs and included in the encounter submission by the Contractor to HCA will include:

15.3.5.3.1 An encounter service as outlined in the Tribal Health Program Billing Guide or Tribal FQHC Billing Guide;

15.3.5.3.2 A T1015 procedure code; and

15.3.5.3.3 An NPI of an Indian Health Service facility, Tribal 638 Clinic, or Tribal FQHC (participating NPIs will be shared by HCA with Contractors on HCA Tribal affairs website found at <https://www.hca.wa.gov/assets/program/tribal-managed-care-plan-resources-npi-classifications.pdf> or by contacting tribalaffairs@hca.wa.gov).

15.3.5.4 HCA will reimburse the Contractor for:

15.3.5.4.1 AI/AN Enrollees, the difference between (a) the encounter rate for a Medicaid-covered service for each Indian Health Service facility, Tribal 638 clinic, and Tribal FQHC (whether contracted or not), and (b) the negotiated rate for equivalent applicable rate payable for such services, or

15.3.5.4.2 non-AI/AN Enrollees, the difference between (a) the encounter rate for a Medicaid-covered service for each contracted Tribal FQHC, and (b) the negotiated rate for equivalent applicable rate payable for such services, for each paid clean claim through ProviderOne for qualifying encounters as outlined in the ProviderOne Billing Guides and the Encounter Data Reporting Guide.

15.3.6 The Contractor shall ensure it has sufficiently trained staff to handle calls or inquiries from providers regarding the reimbursement process and how to ensure that services to AI/AN Enrollees are correctly processed.

15.4 Special Provisions for Substance Use Disorder Benefits

All Enrollees are entitled to an assessment of need for SUD services. The Contractor shall ensure use of ASAM Level of Care Guidelines to make prior authorization and continuing care decisions for all SUD services.

15.5 Special Provisions Regarding Behavioral Health Benefits

The Contractor's administration of behavioral health benefits also shall comply with the following provisions:

15.5.1 Unless otherwise agreed upon, Essential Behavioral Health Functions and

- required behavioral health personnel shall be located in Washington State and available during business hours.
- 15.5.2 Outside of business hours, information, crisis triage, referral services and prior authorization may be conducted out-of-state. Any Contractor staff that work outside of Washington State must be trained and have knowledge of Washington State-specific behavioral health Covered Services, Managed Care rules, UM protocols and Level of Care Guidelines.
- 15.5.3 The Contractor must maintain an adequate complement of qualified and trained staff located in Washington State to accomplish AH-IMC program goals and to meet the needs of individuals with serious emotional disturbance, serious mental illness and SUDs. The Contractor shall have behavioral health resources sufficient to meet all contract requirements and performance standards and shall require that all staff have the required education, experience, credentials, orientation and training to perform assigned job duties.
- 15.5.4 The Contractor shall designate employees who fulfil the following behavioral health functions:
- 15.5.4.1 A Behavioral Health Medical Director.
- 15.5.4.2 A Behavioral Health Clinical Director.
- 15.5.5 The Contractor shall designate managerial positions with the following behavioral health responsibilities:
- 15.5.5.1 A behavioral health Children's System Administrator.
- 15.5.5.2 An Addictions Administrator.
- 15.5.5.3 A behavioral health Utilization/Care Management Administrator.
- 15.5.5.4 A behavioral health network development manager.
- 15.5.5.5 A behavioral health provider relations manager.
- 15.5.6 In addition to the key and managerial staff, the Contractor shall have a sufficient number of qualified operational staff to meet its responsibilities under this Contract.
- 15.5.6.1 The Contractor shall locate a sufficient number of Provider Relations staff within the state to meet requirements under this Contract for provider education and training, provider profiling, and provider performance improvement or problem resolution.
- 15.5.6.2 The Contractor shall ensure that one (1) or more Data Management and Reporting Specialists shall have experience and expertise in Medicaid data analytics and behavioral health data systems to oversee all data interfaces and support the behavioral health specific reporting requirements under this Contract. This position can be located outside of Washington State.
- 15.5.6.3 The Contractor shall designate one (1) or more Community Liaisons to work within Washington State, county behavioral health leadership, and ACHs within its service area. This shall include a liaison to Enrollee and family organizations for children, youth and families and a liaison to other member-serving systems including, but not limited to State and local criminal and juvenile justice

agencies, foster care agencies, housing administrators/homeless services and vocational administration. Contractor shall participate and coordinate with the designated regional ACH and actively participate in at least one (1) health improvement strategy identified by the ACH.

- 15.5.6.4 The Contractor shall ensure a sufficient number of qualified staff to meet both new contract requirements and increased volume including the following functions: administrative and support, member services, Grievance and Appeal, claims, encounter processing, behavioral health supplemental transactions processing, data analysts, and financial reporting analysts.
- 15.5.6.5 The Contractor may administer claims out of state. If claims are administered in another location, physical and behavioral health provider relations staff shall have access to the claims payment and reporting platform during Business Hours.
- 15.5.7 The Contractor shall develop and maintain a human resources and staffing plan that describes how the Contractor will maintain adequate staffing:
 - 15.5.7.1 The Contractor shall hire employees for the key and required behavioral health functions specified in the Contract. Consultants must be prior approved by the state.
 - 15.5.7.2 The Contractor may propose a staffing plan, with prior approval by the State, which combines positions and functions with other positions.
 - 15.5.7.3 The Contractor shall develop and implement staff training plans that address how all staff will be trained on the requirements of this Contract.
- 15.5.8 The Contractor must ensure development and implementation of training programs for network providers that deliver, coordinate, or oversee Behavioral Health services to Enrollees. The individual(s) responsible for Behavioral Health training must have at least two (2) years' experience and expertise in developing training programs related to behavioral health systems comparable to those under the Contract.

16 BENEFITS

16.1 Scope of Services

- 16.1.1 Medically Necessary Services. The Contractor is responsible for covering medically necessary medical and behavioral health services to Enrollees sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished (42 C.F.R. § 438.210(a)(3)(ii)). The Contractor shall cover services that address the following (42 C.F.R. § 438.210(a)(4); and WAC 182-501-0060):
 - 16.1.1.1 The prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability 42 C.F.R. § 438.210(a)(5)(ii)(A).
 - 16.1.1.2 The ability for an Enrollee to achieve age-appropriate growth and development.
 - 16.1.1.3 The ability for an Enrollee to attain, maintain, or regain functional capacity.
- 16.1.2 Integrated behavioral health services that support a bi-directional delivery of care model. The Contractor shall implement coverage of designated services collaboratively with HCA to support an integrated model of care that has no barriers by provider type or place of service, except as driven by scope of licensure, CPT or correct coding initiatives. This will include coverage of selected codes, including those classified as collaborative care codes, behavioral health integration codes and primary care codes.
- 16.1.3 Except as otherwise specifically provided in this Contract, the Contractor must provide the same amount, duration and scope of services as described in the Medicaid State Plan (42 C.F.R. § 438.210(a)(1 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 shall also not be construed as requiring the Contractor to provide the specific items provided by HCA under its FFS program, but shall rather be construed to require the Contractor to provide the same scope of services. The Contractor is allowed to have guidelines, developed and overseen by appropriate Health Care Professionals, for approving services. All denials of Contracted Services are to be individual medical necessity decisions made by a Health Care Professional without being limited by such guidelines.
- 16.1.4 The Contractor makes the decision whether or not a contracted service is medically necessary. Medical necessity decisions are to be made based on an individual Enrollee's healthcare needs by a health care professional with expertise appropriate to the Enrollee's condition. The Contractor may not make global medical necessity decisions, since that is a coverage decision.
 - 16.1.4.1 The amount and duration of contracted services that are medically necessary depends on the Enrollee's condition (42 C.F.R. § 438.210(a)(3)(i)).
 - 16.1.4.2 The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the Enrollee's diagnosis, type of illness or condition (42 C.F.R. §

438.210(a)(3)(ii)).

- 16.1.5 Except as specifically provided in the provisions of the Authorization of Services Section, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary contracted services to Enrollees nor unduly burden providers or Enrollees. The Contractor's utilization control measures are not required to be the same as those in the Medicaid FFS program (42 C.F.R. § 438.210(a)(4)(ii)).
- 16.1.6 If the Contractor objects on moral or religious grounds to providing a counseling or referral service that it would otherwise be required to provide, reimburse for, or provide coverage for, the Contractor is not required to do so. The Contractor must document the grounds on which it objects to providing this service.
- 16.1.7 The Contractor shall ensure that utilization control measures imposed on family planning services are imposed in such a manner that the enrollee's right to choose the method of family planning to be used is protected.
- 16.1.8 For services that HCA determines are non-covered that are not specifically excluded by this Contract, excluded from coverage under federal regulation or excluded from coverage by HCA, the Contractor shall have policies and procedures consistent with WAC 182-501-0160, Exception to Rule (ETR). The Contractor shall cover a service when the criteria in this WAC are met.
- 16.1.9 For services that are covered, but with limits in scope, amount or duration the Contractor will have policies and procedures consistent with WAC 182-501-0169 Limitation Extension (LE) to determine medical necessity of services outside or more than the limit. The Contractor is responsible for covering a service when the criteria in this WAC are met and results in an approval of services outside or more than the limitation.
- 16.1.10 Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of contracted services (42 C.F.R. § 438.3). Services provided outside the scope of Contracted Services shall be reported separately to HCA and shall not be included in the rates development process.
- 16.1.11 Subject to the prior approval of HCA, the Contractor may provide services to Enrollees that are in addition to those covered under the Medicaid State Plan or otherwise included as a Contracted Service.
 - 16.1.11.1 The cost of an extra or "value added" service provided by the Contractor will not be reflected in rate setting.
 - 16.1.11.2 If the Contractor will provide a value added service on a routine basis and/or includes the service in the Managed Care handbook, the value added service must be prior approved in writing by the state. Any changes to an approved value added service must also be prior approved in writing by the state.
 - 16.1.11.3 The Contractor shall not require an Enrollee to accept a value added service instead of a Contracted Service.
- 16.1.12 The Contractor may limit the provision of contracted services to Participating Providers except for the following:

- 16.1.12.1 Emergency Services;
 - 16.1.12.2 Services provided outside the Service Areas as necessary to provide Medically Necessary Services;
 - 16.1.12.3 Coordination of Benefits, when an Enrollee has other primary comparable physical and/or behavioral health coverage as necessary to coordinate benefits; and
 - 16.1.12.4 Within the Contractor's service areas, as defined in the Service Areas provisions of the Enrollment Section of this Contract, the Contractor shall cover Enrollees for all physical and/or behavioral health necessary services.
- 16.1.13 Outside the Service Areas:
- 16.1.13.1 For Enrollees who are temporarily outside the service areas or who have moved to a service area not served by the Contractor and have not been enrolled with another MCO, the Contractor shall cover the following services:
 - 16.1.13.1.1 Emergency and Post-Stabilization Services.
 - 16.1.13.1.2 Urgent care services associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require prior-authorization for urgent care services as long as the wait times specified in the Appointment Standards provisions of the Access to Care and Provider Network Section of this Contract, are not exceeded.
 - 16.1.13.1.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until Enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area. The Contractor may require prior-authorization for such services as long as the wait times specified in the Appointment Standards provision of the Access to Care and Provider Network Section of this Contract are not exceeded.

16.2 Second Opinions

- 16.2.1 The Contractor must authorize a second opinion regarding the Enrollee's health care from a qualified health care professional within the Contractor's network, or provide authorization for the Enrollee to obtain a second opinion outside the Contractor's network, if the Contractor's network is unable to provide for an independent and impartial qualified health care professional. The appointment for a second opinion must occur within thirty (30) calendar days of the request unless the Enrollee requests a delay for the second opinion to a date later than thirty (30) calendar days.
- 16.2.2 If the Contractor refuses to authorize a second opinion, or a second opinion from a provider of the Enrollee's choice, the refusal is an Adverse Benefit Determination, which shall be subject to Appeal under the provisions of the

Grievance and Appeal System section of this Contract.

- 16.2.3 This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider.

16.3 Sterilizations and Hysterectomies

The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are in compliance with 42 C.F.R. § 441 Subpart F, and that a Consent for Sterilization form (HHS-687) is used. A hysterectomy requires the Hysterectomy Consent and Patient Information form (HCA 13-365). These forms can be accessed using the link provided in HCA Sterilization Supplemental Billing Guide.

16.4 Enrollee in Facility at Enrollment: Medical Conditions

- 16.4.1 If an Enrollee was admitted to a hospital the same month that enrollment occurs, the Contractor is responsible for the admission and all related services unless:
 - 16.4.1.1 The Enrollee is SSI Blind/Disabled and admitted to a CPE hospital. In this case, HCA is responsible for the inpatient claim and the Contractor is responsible for professional services and management of the authorization requirements.
- 16.4.2 HCA is responsible for payment of all hospital and professional services provided from the date of admission until the date the Enrollee is discharged from the acute hospital inpatient stay when:
 - 16.4.2.1 The client was admitted to the hospital in the same month Medicaid eligibility is established but enrollment is not completed until the following month; or
 - 16.4.2.2 The client was on FFS before the admission and is enrolled in AHMC during the admission; or
 - 16.4.2.3 The client's eligibility is retroactive to a month prior to the current month, the client is hospitalized, and enrollment is completed during the admission.
- 16.4.3 If an Enrollee was admitted to a skilled nursing or nursing facility, the same month that enrollment occurs, the Contractor is responsible for the admission and all related services, until the Enrollee no longer meets rehabilitation or skilled level of care criteria.
- 16.4.4 DSHS is responsible for payment of any nursing facility admissions including when the Enrollee meets rehabilitation or skilled level of care criteria, provided from the date of admission until the date the Enrollee is discharged from the nursing facility when:
 - 16.4.4.1 The client was admitted to the nursing facility in the same month Medicaid eligibility is established but enrollment is not completed until the following month; or
 - 16.4.4.2 The client was on FFS before the admission and is enrolled in AHMC during the admission; or
 - 16.4.4.3 The client's eligibility is retroactive to a month prior to the current month, the client is admitted, and enrollment is completed during

the admission

- 16.4.5 If the Enrollee's admission to a nursing facility is the responsibility of DSHS, under the provisions of subsection 16.4.4, the Contractor is responsible for all other services as described in this Contract, except for the room and board for the nursing facility, that are medically necessary and required to meet the client's needs, including professional services, specialty beds, specialty wheelchairs, etc. The Contractor is responsible for management of the authorization requirements for these services.
- 16.4.6 The Contractor is responsible for actively planning from either a hospital or a nursing facility when that admission is the responsibility of HCA or DSHS, respectively. The Contractor is also responsible for the delivery of care pursuant to this Contract once discharge has occurred, including any subsequent care: hospital inpatient, rehabilitation, outpatient, outpatient observation, any professional services, and any subsequent nursing facility placements that meet rehabilitative or skilled stay nursing level of care criteria.
 - 16.4.6.1 If the Enrollee is admitted to a hospital or a nursing facility after the first of the month in which enrollment occurred, the Contractor may conduct retrospective review to establish medical necessity of the admission.
- 16.4.7 If an Enrollee changes AH MCOs and the change becomes effective during an inpatient admission, the AH MCO that the Enrollee was enrolled with on the date of admission is responsible for payment of all covered inpatient facility and professional services. This responsibility continues from the date of admission until the date the Enrollee no longer meets criteria for the rehabilitative or skilled benefit, or is discharged from a facility to home or a community residential setting, consistent with the Skilled Nursing Facility Coordination subsection of this Contract. The AH MCO that is receiving the Enrollee is responsible for completing the responsibilities described in subsection 16.4.6
 - 16.4.7.1 The party responsible for payment under this Subsection remains responsible for medical necessity determinations and service authorizations.

16.5 Enrollee in Hospice at Enrollment

- 16.5.1 If an Enrollee changes AH MCOs and the change becomes effective while the Enrollee is receiving hospice services, the AH MCO that the Enrollee was enrolled with on the date of hospice admission is responsible for payment of all covered hospice services regardless of place of service. This responsibility continues from the date of admission until the date the Enrollee no longer meets criteria for hospice or is discharged from hospice. The AH MCO that is receiving the Enrollee is responsible for coordinating discharge and ensuring continuity of services for the Enrollee.

16.6 Enrollee in Facility at Enrollment: Behavioral Health

- 16.6.1 For Enrollees receiving inpatient or residential services through the Medicaid FFS system or Behavioral Health Organization (BHO) that were admitted prior to date of implementation in a new AH-IMC region, the Contractor shall be responsible for payment of all facility service costs beginning with the date of enrollment into AH-IMC or BHSO. This excludes all inpatient psychiatric community admissions for which HCA's Provider One system processes claims,

which will continue to be the responsibility of the BHO until the client is discharged.

16.7 Enrollee in Facility at Termination of Enrollment

If an Enrollee is in a facility at the time of termination of enrollment and the Enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered facility and professional services from the date of admission until one (1) of the following occurs:

- 16.7.1 The Enrollee is discharged from a facility to home or a community residential setting.
- 16.7.2 The Enrollee's eligibility to receive Medicaid services ends. The Contractor's obligation for payment ends at the end of the month the Enrollee's Medicaid eligibility ends.
- 16.7.3 The Enrollee no longer meets the Contractor's rehabilitative or skilled criteria.

16.8 Services Provided in Lieu of

- 16.8.1 Subject to the prior approval of HCA, the Contractor may provide to Enrollees "services provided in lieu of," which are cost-effective substitutes for those services covered under the Medicaid State Plan or otherwise included as a Contracted Service.
- 16.8.2 The Contractor shall perform a cost-benefit analysis for any in lieu of service it proposes to provide, as directed by the state, including how the proposed service would be cost-effective compared to a Contracted Service. A service will only be considered an in lieu of service if prior approved by the state. If the state determines that a service is cost-effective substitute for a Contracted Service, the state may provide credit for the "in lieu of" service in rate setting.
- 16.8.3 The Contractor may not provide services or settings that are in lieu of services or settings covered by the Medicaid State Plan without prior written approval from HCA as follows:
 - 16.8.3.1 At the request of the Contractor, HCA shall determine whether the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the Medicaid State Plan and provide the Contractor with written approval or denial of the request within no more than thirty (30) calendar days or as expeditiously as the Enrollee's health condition requires the response;
 - 16.8.3.2 The Enrollee is not required to use the alternative service or setting;
 - 16.8.3.3 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
 - 16.8.3.4 The utilization of the lieu of services is reported in the Contractor's encounter data submission.
- 16.8.4 IMD services, for the provision of no more than fifteen (15) days' worth of inpatient psychiatric treatment, are expressly included in this Contract as an in lieu of service. The state has determined that inpatient psychiatric treatment in an IMD is medically appropriate and cost effective substitute for other Covered

Services under the State Plan. Inpatient psychiatric treatment IMD services meet the in lieu of requirements in 42 C.F.R. § 438.3(e)(2)(i), (ii) and (iii).

16.9 Deliveries and Newborn Coverage

- 16.9.1 For newborns born while their mother is hospitalized:
 - 16.9.1.1 The party responsible for the payment of Covered Services for the mother's hospitalization shall be responsible for payment of all Covered Services provided to the mother from the date of admission until the date discharged from the acute care hospital.
 - 16.9.1.2 If the newborn is determined eligible and enrolled to the Contractor in the month of birth, the Contractor is responsible for payment of all Covered Services provided to the newborn from birth to date of discharge from the acute care hospital. If the newborn is not enrolled in the month of birth, facility costs, and professional services will be paid FFS.
- 16.9.2 If the mother is not covered during the birth, and the newborn is found eligible and enrolled with the Contractor in the month of birth, the Contractor will be responsible for all Covered Services provided to the enrolled newborn starting from the date of birth or admission.
- 16.9.3 If HCA is responsible for payment of labor and delivery services provided to a mother, HCA shall not pay the Contractor a Delivery Case Rate under the provisions of the Payment and Sanctions section of this Contract.
- 16.9.4 For covered deliveries in a birthing center, the Contractor shall pay for all Covered Services, including Facility costs and professional services provided to the mother and the newborn until the date the enrolled mother and newborn are discharged from the birthing center.
- 16.9.5 For home deliveries, the Contractor shall pay for all costs associated with the home delivery, including professional services provided to the mother and newborn.

17 General Description of Contracted Services

17.1 Contract Services

The Contractor shall provide the following services, as medically necessary, to Enrollees:

- 17.1.1 The Contractor shall provide a wellness exam to each Enrollee that documents the Enrollee's baseline health status and allows the Enrollee's PCP to monitor health improvements and outcome measures.
- 17.1.2 BHSO Enrollees are covered for behavioral health services as described in Section 13d, Rehabilitative Services, of the Medicaid State Plan.
- 17.1.3 The Contractor is responsible for providing integrated medical and behavioral health services as directed by Section 14.
- 17.1.4 Inpatient Services:
 - 17.1.4.1 Provided by acute care hospitals, including CPE hospitals and behavioral health inpatient facilities. Authorization and payment for services provided at CPE hospitals shall be made in accordance with the Payments to Hospitals section of this Contract.
 - 17.1.4.2 Provided by a Nursing Facility, Skilled Nursing Facility or other acute care setting, when services are determined medically necessary and are covered by this Contract.
 - 17.1.4.3 Consultations with specialty providers, including psychiatric or psychology consultations, are covered during hospital stays.
 - 17.1.4.4 Inpatient professional mental health services associated with an AH-IMC behavioral health approved ITA or voluntary inpatient psychiatric admission, including those services provided during admissions where the facility charges are covered by HCA in the Long Term Inpatient Mental Health Program stated in the Exclusions section of this Contract.
 - 17.1.4.5 Inpatient psychiatric mental health services except when the Enrollee is approved for placement in a state hospital, as stated in the Exclusions section of this Contract.
 - 17.1.4.6 Covered services provided during an inpatient admission for medical detoxification services.
 - 17.1.4.7 Any and all covered facility charges provided during an inpatient admission for the care and treatment of dental conditions.
- 17.1.5 Outpatient Hospital Services: Provided by acute care hospitals, including surgeries, labs, diagnostics and emergency room, including facility charges for the care and treatment of dental conditions.
- 17.1.6 Emergency Services:
 - 17.1.6.1 The Contractor will provide all inpatient and outpatient Emergency Services provided by a licensed provider, acting within their scope of practice, regardless of diagnosis, without regard to whether the provider is a participating provider, including dental and oral health services in accordance with the requirements of 42 C.F.R. §

438.114 as follows:

- 17.1.6.1.1 An Enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition (42 C.F.R. § 438.114(c)(1)(ii)(A)).
- 17.1.6.1.2 A participating provider or other Contractor representative instructs the Enrollee to seek emergency services (42 C.F.R. § 438.114(c)(1)(ii)(B)).
- 17.1.6.1.3 When the Enrollee presents at the emergency room with a psychiatric diagnosis:
 - 17.1.6.1.3.1 but is not admitted for inpatient treatment; or
 - 17.1.6.1.3.2 if the Enrollee was transferred for an approved mental health admission to a different facility. The Contractor is responsible for all covered psychotropic medications prescribed as a part of the emergency room visit.
- 17.1.6.2 The Contractor shall ensure that an Enrollee who has an Emergency Medical Condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient (42 C.F.R. 438.114(d)(2)).
- 17.1.6.3 The Contractor shall not refuse to cover emergency or Crisis Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider or the Contractor of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services (42 C.F.R. § 438.114 (d)(1)(ii)).
- 17.1.6.4 Emergency Services shall be provided without requiring prior authorization.
- 17.1.6.5 What constitutes an Emergency Medical Condition may not be limited on the basis of lists of diagnoses or symptoms (42 C.F.R. § 438.114(d)(1)(i)).
- 17.1.6.6 If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the Enrollee at the treating Facility prevails and is binding on the Contractor (42 C.F.R. § 438.114(d)(3)).
- 17.1.7 Post-Stabilization Services:
 - 17.1.7.1 The Contractor will provide all inpatient and outpatient Post-Stabilization Services provided by a licensed provider, acting within

their scope of practice, without regard to whether the provider is a participating provider, in accord with the requirements of 42 C.F.R. § 438.114 and 42 C.F.R. § 422.113(c).

- 17.1.7.2 The Contractor shall cover Post-Stabilization Services under the following circumstances (42 C.F.R. § 438.114(e) and 42 C.F.R. § 438.113(c)(2)(iii)):
 - 17.1.7.2.1 The services are pre-approved by a Participating Provider or other Contractor representative.
 - 17.1.7.2.2 The services are not pre-approved by a Participating Provider or other Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further post-stabilization care services.
 - 17.1.7.2.3 The services are not pre-approved by a Participating Provider or other Contractor representative, but are administered to maintain, improve, or resolve the Enrollee's stabilized condition and the Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(1)(d)), the Contractor cannot be contacted or the Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the Enrollee until a Contractor physician is reached or one (1) of the criteria identified in 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(3) is met.
 - 17.1.7.2.3.1 The Contractor's responsibility for Post-Stabilization Services it has not pre-approved ends when (42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(3)):
 - 17.1.7.2.3.1.1 A Participating Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;
 - 17.1.7.2.3.1.2 A Participating Provider assumes responsibility for the Enrollee's care through transfer;
 - 17.1.7.2.3.1.3 A Contractor representative and the treating physician

reach an agreement
concerning the Enrollee's
care; or

17.1.7.2.3.1.4 The Enrollee is discharged.

17.1.8 Ambulatory Surgery Center: Services provided at ambulatory centers.

17.1.8.1 Including all CPT (Medical) services for care and treatment of a dental conditions with the following exception:

17.1.8.1.1 Services with a CDT (Dental code) or CPT (medical) when the servicing provider is a dentist (taxonomy starts with '12') are excluded from this Contract.

17.1.9 Early, Intensive Behavior Intervention for Autism Spectrum Disorder and other related disorders (WAC 182-531A-0100 to -1200).

17.1.9.1 Initial Clinical Evaluation by a Center of Excellence (COE) for children under 21 years of age, with a diagnosis, or suspected diagnosis, of autism spectrum disorder, or other developmental delay conditions, for evaluation of the appropriateness of Applied Behavioral Analysis (ABA) as part of the child's plan of care.

17.1.9.2 ABA treatment services.

17.1.9.3 Care Coordination activities for children with a diagnosis or suspected diagnosis of autism spectrum disorder, when the Contractor becomes aware of a need for services, in accordance with EPSDT requirements.

17.1.10 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room, pharmacy, or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, naturopaths, pharmacists, midwives, podiatrists, audiologists, registered nurses, Mental Health Professionals, substance use disorder specialists, certified dietitians, and interns and residents under the supervision of a teaching physician.

17.1.10.1 Medical examinations and mental health evaluations, including wellness exams for adults and EPSDT screenings for children, and referrals for further behavioral health assessment and other services, as needed, to include:

17.1.10.1.1 ABCD services for children ages 0-5.

17.1.10.1.2 Fluoride varnish.

17.1.10.2 Annual depression screening for youth ages 12 to 18, and up to age 20 per EPSDT requirements.

17.1.10.3 Depression screening for mothers/caregivers of children up to six months old.

17.1.10.4 Immunizations, including the varicella zoster (shingles) vaccine for Enrollees age 60 and over. For Enrollees under age 60 the Contractor may require prior authorization.

17.1.10.5 Pregnant and postpartum Enrollees receive coverage for TDAP vaccine given in any setting (pharmacy, obstetrical provider, etc.)

whether or not ordered by PCP.

- 17.1.10.6 Family planning services provided or by referral from a Participating Provider or practitioner.
- 17.1.10.7 Performing and/or reading diagnostic tests.
- 17.1.10.8 Medically intensive children's private duty nursing services for children age 17 and younger, in home and group home settings. The Contractor shall conduct a mortality review for any Enrollee who expires while authorized for these services. The mortality review shall include identification and analysis of trends or patterns and result in implementation of needed training, policy change, or other related action.
- 17.1.10.9 Surgical services.
- 17.1.10.10 Services to correct defects from birth, illness, or trauma, and mastectomy reconstruction.
- 17.1.10.11 Telemedicine services, provided in accordance with Substitute Senate Bill 6519 (Chapter 68, Laws of 2016).
- 17.1.10.12 Anesthesia.
- 17.1.10.13 Administering pharmaceutical products.
- 17.1.10.14 Fitting prosthetic and orthotic devices.
- 17.1.10.15 Physical Medicine Rehabilitation services.
- 17.1.10.16 Enrollee health education.
- 17.1.10.17 Nutritional counseling by a certified registered dietician for specific conditions such as failure to thrive, feeding problems, cystic fibrosis, diabetes, high blood pressure, and anemia.
- 17.1.10.18 Bio-feedback training when determined medically necessary.
- 17.1.10.19 Genetic testing for all Enrollees. Genetic counseling for children and non-pregnant adults.
- 17.1.10.20 Palliative care for adults and children.
- 17.1.10.21 Hormone therapy for any transgender Enrollees and puberty-blocking treatment for transgender adolescents consistent with HCA's gender dysphoria treatment benefit.
- 17.1.10.22 Medication Assisted Treatment, including assessment, counseling, medical management, and prescribing to assist clients in treatment for SUD in a medical office setting.
- 17.1.10.23 MAT including medications prescribed or administered as part of a MAT protocol, except for methadone, when treatment is provided in a SUD clinic setting.
- 17.1.11 Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel, and peripheral blood stem cell. The MCO shall use the same standards respecting coverage and delivery of the services as the state uses.
- 17.1.12 Laboratory, Radiology, and Other Medical Imaging Services: Screening,

diagnostic services and radiation therapy.

- 17.1.13 Vision Care: Eye examinations once every twenty-four (24) months for adults and once every twelve (12) months for children under age 21. (WAC 182-531-1000. These limitations do not apply to additional services needed for medical conditions.
- 17.1.14 Inpatient Behavioral Health Services. The Contractor shall provide the following Inpatient Behavioral Health Services:
 - 17.1.14.1 Inpatient Withdrawal Management (substance acute withdrawal management) Services required for the care and/or treatment of individuals intoxicated or incapacitated by substances while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from substances. Services are provided in facilities with sixteen (16) beds or less and exclude room and board. Services include:
 - 17.1.14.1.1 Screening and acute withdrawal management; and
 - 17.1.14.1.2 Counseling of persons admitted to a program within a certified Facility, regarding their illness in order to stimulate motivation to obtain further treatment, and referral of detoxified persons with SUD to other appropriate substance use disorder treatment service providers.
 - 17.1.14.2 Inpatient/Residential Substance Abuse Treatment Services: Rehabilitative services including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward Enrollees who are harmfully affected by the use of mood-altering substances or have been diagnosed with a SUD. Techniques have a goal of recovery for individuals with SUDs. Provided in certified residential treatment facilities with sixteen (16) beds or less. Excludes room and board.
 - 17.1.14.3 Court-ordered behavioral health Involuntary Treatment Act (ITA) commitment inpatient admission, except as stated in the Exclusions section of this Contract.
 - 17.1.14.4 IMD Services. Covered Services provided to Enrollees who are primarily receiving short-term treatment and withdrawal management services for SUD in facilities that meet the definition of an IMD which are not otherwise matchable expenditures under Section 1903 of the Social Security Act. Excludes room and board.
- 17.1.15 Outpatient Behavioral Health Services. The Contractor shall provide the following Outpatient Behavioral Health Services, as defined in the Medicaid State Plan:

- 17.1.15.1 Brief Intervention Treatment.
- 17.1.15.2 Day Support, including in a club house setting.
- 17.1.15.3 Family Treatment.
- 17.1.15.4 Freestanding Evaluation and Treatment.
- 17.1.15.5 Mental Health Group Treatment Services.
- 17.1.15.6 High Intensity Treatment.
- 17.1.15.7 Individual Treatment Services.
- 17.1.15.8 Intake Evaluation.
- 17.1.15.9 Medication Management.
- 17.1.15.10 Medication Monitoring.
- 17.1.15.11 Mental Health Peer Support Services.
- 17.1.15.12 Psychological Assessment.
- 17.1.15.13 Rehabilitation Case Management.
- 17.1.15.14 Residential Mental Health Services.
- 17.1.15.15 Stabilization Services.
- 17.1.15.16 Special Population Evaluation.
- 17.1.15.17 Therapeutic Psychoeducation.
- 17.1.15.18 Substance Use Disorder Case Management.
- 17.1.15.19 Substance Use Disorder Outpatient Services.
- 17.1.15.20 Opiate Substitution Treatment;
- 17.1.15.21 Medication Assisted Treatment;
- 17.1.15.22 Collaborative Care Services;
- 17.1.15.23 The Contractor shall ensure Medication Management is:
 - 17.1.15.23.1 Provided by the PCP; or
 - 17.1.15.23.2 Provided in conjunction with a Mental Health Professional or SUDP contracted with the Contractor; or
 - 17.1.15.23.3 Provided by an appropriate behavioral health specialist; and
 - 17.1.15.23.4 In accord with the requirements of pharmacists under RCW 69.41.190(3).
- 17.1.15.24 Substance Use Disorder Peer Support Services.

17.1.16 WISe Services and Monitoring:

- 17.1.16.1 The Contractor shall provide intensive home and community-based services to help children receive behavioral health treatment and connect with natural supports in their homes, schools, and communities consistent with the requirements of the WISe program

and requirements of the T.R. v. Birch and Strange Settlement Agreement. (See <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20Manual%20v%201.7-FINAL.pdf>). The Contractor must maintain a monthly average of 10.5 service hours for children and youth participating in WISe.

17.1.16.2 Wraparound with Intensive Services (WISe) provides a combination of the services identified in the current Mental Health State Plan. Provision of WISe services must include, at a minimum, access to:

- 17.1.16.2.1 Intake Evaluation;
- 17.1.16.2.2 Intensive Care Coordination;
- 17.1.16.2.3 Intensive Services;
- 17.1.16.2.4 24/7 Crisis Intervention and Stabilization Services; and
- 17.1.16.2.5 Peer Support.

17.1.16.3 Provision of WISe services must also include any of the following services as determined medically necessary. The delivery of services must be focused on needs and strengths of the Enrollee and drive by youth and family voice and choice:

- 17.1.16.3.1 Crisis Services;
- 17.1.16.3.2 Family Treatment;
- 17.1.16.3.3 Group Treatment Services;
- 17.1.16.3.4 Individual Treatment Services;
- 17.1.16.3.5 Medication Management;
- 17.1.16.3.6 Medication Monitoring;
- 17.1.16.3.7 Peer Support;
- 17.1.16.3.8 Psychological Assessment;
- 17.1.16.3.9 Rehabilitation Case Management;
- 17.1.16.3.10 Special Population Evaluation; and
- 17.1.16.3.11 Therapeutic Psychoeducation.

17.1.16.4 Evaluation of WISe service includes:

- 17.1.16.4.1 Semi-annual review of Service Encounters.
- 17.1.16.4.2 Individual chart review – quarterly by supervisors, annually by state.
- 17.1.16.4.3 Feedback on service effectiveness to meet desired goals from youth/families through annual interviews.
- 17.1.16.4.4 Quarterly review of Notices of Adverse Benefit Determination that reflect an adverse decision.
- 17.1.16.4.5 Quarterly review of Grievances and Appeals related to WISe.

- 17.1.16.4.6 Annual Quality Improvement Review findings, based on outcomes from the Quality Improvement Review tool.
 - 17.1.16.4.7 Additional elements as detailed in the AIM of the WISe Quality Management Plan.
 - 17.1.17 Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an Enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability.
 - 17.1.17.1 The Contractor shall contract with Department of Health (DOH) recognized neurodevelopmental centers, recognizing them as a COE for treating children with significant health care needs. The Contractor will not impose prior authorization requirements for physical, occupational, or speech therapy services to ensure no delay in access to services, and shall enroll all qualified providers employed at the COE to ensure timely access to services and continuity of care. The Contractor may use concurrent review and retrospective review to ensure therapy services are medically necessary. The Contractor may contract with these providers for therapy services described above, but may also choose to contract for any other services the COE offers to children.
 - 17.1.18 Non-pharmaceutical birth control products, including:
 - 17.1.18.1 ParaGard® (T 380A);
 - 17.1.18.2 Fertility awareness-based methods, such as cycle beads, basal body temperature thermometers, and charts; and
 - 17.1.18.3 Essure© sterilization method.
 - 17.1.19 Enteral nutrition products, including the following:
 - 17.1.19.1 Parenteral nutritional supplements and supplies for all clients.
 - 17.1.19.2 Enteral nutrition products and supplies for tube-feeding are covered for all clients.
 - 17.1.19.3 Medically necessary oral enteral nutrition products, including prescribed infant formulas not covered by WIC or additional quantities beyond amounts allowed by WIC, for clients 20 years of age and under.
 - 17.1.20 Home Health Services: Home health services, including palliative care, through state-licensed agencies.
 - 17.1.21 Durable Medical Equipment (DME) and Supplies and any applicable sales tax including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for Enrollees over 3 years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the Enrollee agrees. The Contractor shall consult with the Washington State Department of Revenue for guidance on the applicable sales tax.
 - 17.1.22 Respiratory Care: Equipment, services and supplies.

- 17.1.23 Services rendered under the Collaborative Care model (CoCM) by an HCA approved CoCM provider.
- 17.1.24 Palliative Care and Care Coordination: Provision of skilled care services and care coordination to Enrollees with a life-limiting medical condition under a palliative care model. Services can be provided in the following settings, but not limited to, hospice care centers, hospitals, clinics, and the Enrollee's home.
- 17.1.25 Hospice Services: Includes services for adults and children and provided in Skilled Nursing Facilities/Nursing Facilities, hospitals, hospice care centers and the Enrollee's home. Hospice services include:
 - 17.1.25.1 Pediatric Concurrent Care- Treatment, including diagnostics, that is related to an Enrollee's terminal condition for an Enrollee aged 20 and younger who voluntarily elects hospice care. Pediatric concurrent care preserves the Enrollee's rights to hospice care without waiving any rights to services that the Enrollee is entitled to under Title XIX Medicaid and Title XXI CHIP. (WAC 182-551-1860).
- 17.1.26 Blood, Blood Components and Human Blood Products: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products, the Contractor shall cover the cost of the blood or blood products.
- 17.1.27 Treatment for Renal Failure: Hemodialysis, peritoneal dialysis, and other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.
- 17.1.28 Smoking Cessation Services with or without Primary Care Provider referral or Contractor prior authorization. The Contractor shall submit a quarterly report to HCA. The report shall include the number of Enrollees that have accessed the Contractor's Quit Line in the previous quarter. The quarterly reports are due to HCA no later than the fifteenth of the month of January, April, July and October.
- 17.1.29 Newborn Screenings: The Contractor shall cover all newborn screenings required by the Department of Health and shall contract with the DOH lab and cover all newborn screening by midwives for home births and other birthing scenarios in which the screening is not billed as part of the inpatient claim. These screenings shall be billed separately by the DOH lab.
- 17.1.30 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (42 U.S.C. § 1396a(a)(43), 1396d(a)(4)(b), 1396d(r)):
 - 17.1.30.1 The Contractor shall meet all requirements under the Social Security Act (SSA) Section 1905(r) and HCA EPSDT WAC 182-534-0100.
 - 17.1.30.1.1 Covered screening services include, but are not limited to: a complete health and developmental history that assess for physical and mental health conditions, developmental disorders, autism and SUDs, a comprehensive, unclothed physical exam, immunizations according to age and health history, laboratory tests, including appropriate blood lead screening, health education and anticipatory

guidance for both the child and caregiver, and screenings for: vision, dental, substance use conditions, mental health and hearing.

- 17.1.30.1.2 The Contractor shall conduct outreach efforts with Enrollees to promote completion of EPSDT services and coordinate EPSDT screening services both at established times and as requested (<https://www.hca.wa.gov/assets/billers-and-providers/EPSDT-bi-20180101.pdf>). The Contractor may implement Enrollee and Primary Care Provider incentives to ensure that Enrollees under the age of 21 receive screening services at least as frequently as the periodicity requirements for such services established by HCA. Screening services are also covered at other times, when medically necessary (42 U.S.C. § 1396(r)(1)).
- 17.1.30.1.3 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)).
- 17.1.30.1.4 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions.
- 17.1.30.1.5 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child.
- 17.1.30.2 Pursuant to WAC 182-501-0050, the Contractor shall review any request for a non-covered service to determine the medical necessity of the service, including evaluating the safety and effectiveness of the requested service and to establish it is not experimental. If a healthcare service is determined to be medically

necessary under the EPSDT benefit, the Contractor shall provide the service, whether or not it is a contracted service, unless it is specifically excluded by this Contract or prohibited by federal rules.

- 17.1.30.2.1 If any EPSDT service exceeds the “soft” limit placed on the scope, amount or duration of a service, the Contractor shall use LE procedures in accordance with WAC 182-501-0169 to determine medical necessity of the requested services and authorize the additional services as indicated.
- 17.1.30.3 If a child with special health care needs is assigned to a specialist for primary care, the assigned specialist is responsible for ensuring the child receives EPSDT services.
- 17.1.30.4 The Contractor may enter into contractual agreements with school-based health centers and family planning clinics to promote delivery of EPSDT services to children and youth accessing such services. Such contracts shall:
 - 17.1.30.4.1 Require providers to follow EPSDT requirements;
 - 17.1.30.4.2 Coordinate identified needs for specialty care, such as referrals for vision, mental health or SUD evaluation and treatment services with the Primary Care Provider;
 - 17.1.30.4.3 Not deny payment for EPSDT services delivered by more than one (1) provider (Primary Care Provider, school-based provider or family planning clinic) within a calendar year;
 - 17.1.30.4.4 Ensure the policies and procedures for accessing such services by contracting school-based health centers and family planning clinics are compliant with applicable federal and state statutes; and
 - 17.1.30.4.5 The Contractor shall coordinate with school-based health centers and other appropriate entities to assure activities performed by the Contractor are not duplicated.
- 17.1.30.5 The Contractor shall follow the guidelines found at the following website:
<https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.
- 17.1.31 Monaural and binaural hearing aids, including fitting, follow-up care, batteries, and repair.
- 17.1.32 Bilateral Cochlear Implants, including implants, parts, accessories, batteries, chargers, and repairs: For Enrollees age 20 and younger.
- 17.1.33 Bone-Anchored Hearing Aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts, and batteries: For Enrollees age 20 and younger.
- 17.1.34 Services to Inmates of City and County Jail Facilities: The Contractor shall provide inpatient hospital services to Enrollees who are inmates of a city or

county jail facility when an inpatient admission occurs during the first (1st) month of the incarceration period and HCA has paid a premium for that month to the Contractor. The Contractor's existing policies about establishing medical necessity for the inpatient admission and procedure(s) may be applied, even retrospectively, to determine payment. The Contractor shall provide transitional care coordination services to inmates upon release from jail in accordance with Subsection 14.21 of this Contract.

17.1.34.1 HCA may recoup a premium payment and retroactively terminate enrollment for an inmate if the inpatient hospital services occur after the first (1st) month of incarceration period and HCA has paid for a premium for the full month of enrollment.

17.1.35 Habilitative Services: Limited to Enrollees in the Medicaid expansion population that are eligible for the Alternative Benefit Plan (ABP). Devices for adults and children provided for this purpose are covered under the DME benefit.

17.1.35.1 For Children: No limitation.

17.1.35.2 For Adults: Twenty-four (24) units each for physical and occupational therapy and six (6) units of speech therapy, subject to Limitation Extensions as determined medically necessary.

17.1.35.3 Habilitative services do not include:

17.1.35.3.1 Day habilitation services designed to provide training, structured activities and specialized services to adults;

17.1.35.3.2 Chore services to assist with basic needs;

17.1.35.3.3 Vocational services;

17.1.35.3.4 Custodial services;

17.1.35.3.5 Respite care;

17.1.35.3.6 Recreational care;

17.1.35.3.7 Residential treatment;

17.1.35.3.8 Social services; and

17.1.35.3.9 Educational services.

17.1.36 Screening, Brief Intervention and Referral to Treatment (SBIRT) services (services are provided by SBIRT certified providers) for adolescents and adults who are at who are at high risk for Substance Use Disorder, to include substances with or without anxiety or depression. Screening conducted without Brief Intervention and referral to treatment is not reimbursable. SBIRT activities for identifying and reducing risk in individuals with substance use concerns shall be one (1) of the screening tools/interventions selected. Included as part of this effort are screens for depression and anxiety.

17.1.37 Comprehensive Medication Therapy Management Services.

17.1.38 Bariatric surgery consistent with WAC 182-531-1600 and WAC 182-550-2301.

17.1.39 Early, elective inductions (before 39 weeks) that meet medically necessary indicators set by the Joint Commission. Because the Joint Commission's criteria do not capture all situations in which an early delivery is medically

indicated, the Contractor shall provide a process for facilities to request a review of cases that do not meet that criteria, but which the hospital and delivering provider believe were medically necessary.

- 17.1.40 Services identified in this Section that are medically necessary to treat complications resulting from a non-covered or an excluded service (e.g. antibiotics to treat infection that occurs post operatively of a non-covered surgery or an excluded voluntary termination of pregnancy procedure).
- 17.1.41 Residential treatment facilities to offer MAT on-site or facilitate access off-site. The Contractor must require that residential and inpatient treatment agencies have policies and procedures to offer MAT on-site or facilitate access off-site.
 - 17.1.41.1 The Contractor must only subcontract with licensed SUD behavioral health treatment agencies that have policies and procedures in place to ensure Enrollees who are prescribed any of the Federal Drug Administration (FDA) approved medications to treat all substance use disorders will not be denied services.
 - 17.1.41.2 The Contractor must assure there is enough network capacity that Enrollees with an SUD receiving or desiring medication to treat SUD are able to have it prescribed while engaged in any level of ASAM SUD treatment.
 - 17.1.41.3 The Contractor may not subcontract with licensed SUD behavioral health treatment agencies that have policies and procedures in place that mandate titration of any prescribed FDA approved medications to treat any SUD as a condition of Enrollees receiving treatment or continuing to receive behavioral health treatment. Decisions concerning medication adjustment are based on medical necessity and in coordination with the prescribing provider.
 - 17.1.41.4 The Contractor must subcontract with licensed inpatient SUD behavioral health treatment agencies that have policies and procedures allowing Enrollees to seek FDA-approved medication for any SUD at any point in their course of treatment and ensuring the agency will provide or facilitate the induction of any prescribed FDA approved medications for any SUD.
 - 17.1.41.4.1 This may be done by:
 - 17.1.41.4.1.1 Having an appropriately credentialed prescriber on-site or available through telemedicine who is able to prescribe FDA approved medications for SUD; or
 - 17.1.41.4.1.2 Facilitating off-site transportation of Enrollees to medical or behavioral health treatment agencies that offer medications for SUD.
 - 17.1.41.5 The Contractor may only subcontract with licensed inpatient SUD behavioral health treatment agencies that have policies and procedures ensuring they will provide or facilitate the continuation of any prescribed FDA approved medications for any substance use

disorder. Decisions concerning medication adjustment must be based on medical necessity and in concert with the prescribing provider.

17.1.41.5.1 This may be done by:

17.1.41.5.1.1 Facilitating off-site transportation of Enrollees to medical or behavioral health treatment agencies that offer medications for substance use disorder; or

17.1.41.5.1.2 Allowing Enrollees currently on medications for substance use disorders to continue to take their medications as prescribed and provide a safe storage space for said medication during their course of treatment.

17.1.42 Outpatient treatment facilities. The Contractor must require that outpatient treatment agencies have policies and procedures to facilitate treatment access to Enrollees who are prescribed any of the Federal Drug Administration (FDA) approved medications to treat all substance use disorders.

17.1.42.1 The Contractor must only subcontract with licensed SUD behavioral health treatment agencies that have policies and procedures in place to ensure Enrollees who are prescribed any of the Federal Drug Administration (FDA) approved medications to treat all substance use disorders will not be denied services.

17.1.42.2 The Contractor must ensure there is enough network capacity that Enrollees with an SUD receiving or desiring medication to treat SUD are able to have it prescribed while engaged in any level of ASAM SUD treatment.

17.1.42.3 The Contractor may not subcontract with licensed SUD behavioral health treatment agencies that have policies and procedures in place that mandate titration of any prescribed FDA approved medications to treat any SUD as a condition of Enrollees receiving treatment and/or continuing to receive behavioral health treatment. Decisions concerning medication adjustment are based on medical necessity and in coordination with the prescribing provider.

17.1.42.4 The Contractor shall begin development of policies and procedures related to contracting with SUD Peer Supports.

17.2 Enrollee Self-Referral

17.2.1 Enrollees have the right to self-refer for certain services to participating or nonparticipating local health departments and participating or nonparticipating family planning clinics paid through separate arrangements with the state of Washington.

17.2.2 The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

- 17.2.3 The Enrollees also may choose to receive such services from the Contractor.
- 17.2.4 The Contractor shall ensure that Enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the Enrollee's choice of where to receive the services. If the Contractor in any manner prejudices, directs, or influences Enrollees' free choice to receive services through the Contractor, the Contractor shall pay the local health department or family planning facility for services provided to Enrollees up to the limits described herein.
- 17.2.5 The Contractor shall make a reasonable effort to subcontract with all local health departments, school-based health centers, family planning agencies contracted with HCA, and IHCP Providers.
- 17.2.6 If the Contractor subcontracts with local health departments, school-based health centers, family planning clinics or IHCP Providers as Participating Providers or refers Enrollees to them to receive services, the Contractor shall pay the provider for services provided up to the limits described in this Contract.
- 17.2.7 The services to which an Enrollee may self-refer are:
 - 17.2.7.1 Family planning services and supplies, and sexually transmitted disease screening and treatment services provided at participating or non-Participating Providers, including but not limited to family planning agencies, such as Planned Parenthood.
 - 17.2.7.2 Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through and if provided by a local health department.
 - 17.2.7.3 Immunizations, sexually transmitted disease screening, family planning and behavioral health services through and if provided by a school-based health center.
 - 17.2.7.4 All services received by American Indian or Alaska Native Enrollees under the Special Provisions for American Indians and Alaska Natives subsection of this Contract.
 - 17.2.7.5 Crisis Response Services, including crisis intervention; crisis respite; investigation and detention services; and, evaluation and treatment services. Self-referrals can also be made for assessment and intake for behavioral health services.

17.3 Pharmacy Benefits and Services

- 17.3.1 Contractor's with a subcontracted pharmacy benefit manager (PBM)
 - 17.3.1.1 On or before January 1, 2020, Contractors using a PBM shall require in their contract with the PBM that the PBM only seek reimbursement from the Contractor for the reimbursement amount paid to the participating pharmacy for an individual prescription claim dispensed to an Enrollee.
 - 17.3.1.2 On or before January 1, 2020, Contractor's PBM may not retroactively deny or reduce a payment made to a participating pharmacy for services after adjudication of the claim including direct and indirect remuneration, unless the original claim payment is

adjusted by the MCO or the original claim was determined to be an improper payment described in Subsection 12.5 of this Contract.

- 17.3.1.3 On or before January 1, 2020, Contractor's contract with a PBM must require that they pass all retroactive adjustments in payments made to participating pharmacies for services after adjudication of the claim back to the Contractor within thirty (30) calendar days, including all forms of direct and indirect remuneration.
- 17.3.1.4 HCA will audit this requirement through ad hoc Network Pharmacy Reimbursement Reconciliation reports. HCA may impose sanctions if the Contractor is out of compliance with this section.

17.3.2 General Requirements:

- 17.3.2.1 The Contractor shall ensure that the amount, duration, and scope of covered outpatient drugs provided under this Contract is consistent with coverage under the FFS program. The Contractor shall cover all covered outpatient drugs when determined to be Medically Necessary, unless otherwise excluded from coverage. This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.
- 17.3.2.2 The Contractor shall provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature, unless otherwise directed by HCA.
- 17.3.2.3 The Contractor must cover all prescription drugs produced by rebate eligible manufacturers, with the exception of those excluded under this Contract or those eligible for exclusion under 42 U.S.C. §1396r-8(d)(2) which HCA has not specifically instructed the Contractor to cover.
- 17.3.2.4 The Contractor shall ensure that prescription drugs produced by non-rebate eligible manufacturers are not covered, regardless of the general status of the drug on HCA defined formulary.
- 17.3.2.5 The Contractor shall have in place a mechanism to deny prescriptions:
 - 17.3.2.5.1 Written by excluded providers; and
 - 17.3.2.5.2 Prescribed for non-medically accepted indications.
- 17.3.2.6 The Contractor shall allow up to a ninety (90) day supply as an early prescription refill for prescriptions that are lost, stolen, or destroyed once per prescription per 6-month period. Exceptions to the 6-month period may be granted for extreme circumstances (e.g. fire, flood, natural disaster, etc.) at the MCOs discretion.
- 17.3.2.7 The Contractor shall allow, once every 6 months, up to a ninety (90)

day supply as an early prescription refill for a vacation for each prescription due during the vacation period.

- 17.3.2.8 The Contractor will follow the authorization criteria, quantity limits, step therapy protocols, and other restrictions recommended by the DUR Board or approved by HCA, unless otherwise directed by HCA. In the absence of an HCA approved policy the Contractor shall use its own drug specific policy if available.

17.3.3 Apple Health Preferred Drug List and Plan Formularies

17.3.3.1 Apple Health Preferred Drug List (AH PDL)

- 17.3.3.1.1 The Contractor must use the AH-PDL as its primary preferred drug list. HCA has final authority on the status of products included on the AH-PDL. HCA will provide the Contractor with opportunities to offer feedback on the preferred status of products on the AH-PDL. Contractor's representatives may attend the DUR Board and provide feedback directly to the DUR Board at the meeting.

- 17.3.3.1.2 The Contractor will follow the preferred status, authorization criteria, quantity limits, step therapy protocols, and other restrictions recommended by the DUR Board or approved by HCA, unless otherwise directed by HCA. HCA will provide Contractor with final authorization criteria and step therapy protocols in HCA clinical policy template ninety (90) calendar days prior to implementation.

- 17.3.3.1.3 HCA will notify the Contractor of major changes to the preferred status, authorization criteria, quantity limits, step therapy protocol, or other restrictions for products on the AH-PDL at least ninety (90) calendar days prior to implementation of the changes. The Contractor has ten (10) business days to review the file and submit questions or requests for changes to HCA. HCA will respond and provide final determination no later than sixty (60) calendar days prior to implementation.

- 17.3.3.1.4 HCA shall provide the Contractor with comprehensive files detailing the preferred status, authorization criteria, quantity limits, step therapy protocols, and other restrictions for products included in the AH-PDL. The file will also contain product specific information such as product identification number, active pharmaceutical ingredient, dosage form, route of administration, strength, and specific National Drug Code (NDC).

- 17.3.3.1.4.1 HCA will provide the AH-PDL file through secure file transfer protocol posted on HCA website. The file will

- be submitted in a format and at a frequency mutually agreed upon by all participating Apple Health Managed Care Contractors and HCA.
- 17.3.3.1.4.2 For new products to market the Contractor will adjudicate claims using the AH-PDL file within five (5) business days of notification the file is available.
 - 17.3.3.1.4.3 For changes to criteria for existing products on the AH-PDL which are not the result of DUR Board recommendations, the Contractor will adjudicate claims using the AH-PDL file within ten (10) business days of notification the file is available. If the Contractor determines any change is too complex to implement within the required timeframe, the Contractor must request an extension by close of business on the second business day after receiving the file. HCA will review the request and notify Contractor whether an extension is granted on the next business day.
 - 17.3.3.1.5 The Contractor shall place new drugs to market within a class included on AH-PDL in a non-preferred status until otherwise directed by HCA.
 - 17.3.3.1.6 The Contractor must achieve a threshold of at least 90 percent of the number of prescriptions written for preferred versus non-preferred products on the AH-PDL per calendar quarter, excluding drugs that were given permanent grandfathering status. For drugs that were grandfathered for three or six months, this provision applies to the first quarter after grandfathering expired. The Contractor shall provide data to HCA forty-five (45) calendar days after the end of each calendar quarter in a format determined by HCA. The first quarter AH PDL Compliance report is due May 15.
 - 17.3.3.1.7 The HCA may require a corrective action for any AH-PDL non-compliance. HCA may impose sanctions if corrective actions fail to improve AH-PDL compliance.
 - 17.3.3.1.8 The Contractor shall maintain individual product coverage and exceptions to coverage according to

this Section.

17.3.4 Wrap-around Drug Formulary Requirements for drugs not on the AH-PDL

17.3.4.1 The Contractor must develop and maintain a wraparound formulary for drugs not included within a class on the AH-PDL.

17.3.4.2 The Contractor's wrap-around formulary shall cover the following products and supplies unless specifically detailed in the AH-PDL:

17.3.4.2.1 Antigens and allergens;

17.3.4.2.2 Therapeutic vitamins and iron prescribed for prenatal and postnatal care;

17.3.4.2.3 Psychotropic medications according to the contractor's approved formulary when prescribed by a medical or mental health professional, when he or she is prescribing medications within his or her scope of practice.

17.3.4.2.4 Antihemophilic Blood Product – Blood factors VII, VIII, and IX and the anti-inhibitor provided to Enrollees with a diagnosis of hemophilia or von Willebrand disease when the Enrollee is receiving services in an inpatient setting.

17.3.4.2.5 All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies, including emergency contraception, all long acting reversible contraceptives, all over-the-counter (OTC) contraceptives and contraceptive methods which require administration or insertion by a health care professional in a medical setting. Coverage of contraceptive drugs, devices and supplies must include:

17.3.4.2.5.1 All OTC contraceptives without a prescription. This includes but is not limited to condoms, spermicides, sponges and any emergency contraceptive drug that is FDA-approved to be dispensed over-the-counter. There are no limits to these OTC contraceptives. OTC contraceptives must be covered without authorization or quantity limits.

17.3.4.2.5.2 Coverage when dispensed by either a pharmacy or a Family Planning Clinic at the time of a family planning visit. Contraceptives dispensed by a Family Planning Clinic must be covered under the medical benefit.

- 17.3.4.2.5.3 Dispensing of twelve (12) months of contraceptives at one time without authorization requirements related to quantity or days supplied. Duration of any authorization for contraceptives for other reasons must be no less than twelve (12) months.
- 17.3.4.2.5.4 Contraceptive dispensing in twelve (12) month supplies unless otherwise prescribed by the clinician or the Enrollee requests a smaller supply.
- 17.3.4.2.5.5 Promotion of appropriate prescribing and dispensing practices in accordance with clinical guidelines to ensure the health of the Enrollee while maximizing access to effective birth control methods or contraceptive drugs.
- 17.3.4.2.6 All drugs FDA labeled or prescribed as MAT or maintenance therapy for substance use disorders, with the exception of methadone dispensed directly by opiate substitution treatment programs. The Contractor will cover all MAT according to detailed guidelines and requirements determined by HCA.
- 17.3.4.2.7 The term "Formulary" as used in this subsection includes lists of products and their formulary status, preferred status, authorization requirements and coverage limitations available through retail specialty, and mail order pharmacies, and drugs paid by the Contractor under the medical benefits.
- 17.3.4.2.8 HCA may require changes to the formulary at any time, upon sixty (60) calendar days' written notice of the change. Required formulary changes may include any aspect of drug coverage, including, but not limited to: formulary status, limitations, prior authorization requirements, approval criteria, use of automated overrides, or determination of the benefit under which a product will be available. Failure to make requested changes by the date specified in HCA's notice may result in sanctions as described in the Sanctions subsection of this Contract.
- 17.3.4.2.9 If HCA determines the Contractor's online formulary does not accurately reflect coverage requirements, or the Contractor is not providing coverage as previously required by HCA, the Contractor shall make the necessary changes in coverage and

update its online formulary and related materials as required by HCA within five (5) business days of the request.

17.3.4.2.10 The Contractor shall have a process in place to allow access to all non-formulary drugs, other than those excluded from coverage by HCA, when determined to be Medically Necessary.

17.3.4.2.11 The Contractor shall submit its drug formulary and related material to HCA for review and approval no later than September 1 of each contract year. The submission shall be in an electronic format according to HCA specifications for the following benefit year.

17.3.4.2.11.1 HCA shall notify the Contractor of either the approval of or required changes to the formulary and related materials, no later than October 1, of each contract year.

17.3.4.2.11.2 If HCA notifies the Contractor of required changes, all such changes shall be completed and resubmitted to HCA no later than December 1, of each contract year.

17.3.4.2.11.3 Once approved, any change to the formulary must be approved in writing by HCA before publication. Any proposed changes to the formulary and utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. after January 1, must be submitted to HCA for review and approval prior to implementation, at least ninety (90) calendar days prior to implementing any changes.

17.3.4.2.12 The Contractor shall provide prominent public online access to the AH-PDL, the plan formulary and coverage criteria shall include information on how to request authorization for covered drugs, non-preferred drugs, and non-formulary drugs. The online formulary shall be easy to access and the website in which it is situated will be designed to use easily understandable language.

17.3.5 For excluded drugs fully managed by HCA, the Contractor shall not authorize any procedures in conjunction with or used to administer an excluded drug therapy until the Contractor has verified the provider has obtained approval for the excluded drug therapy from HCA.

- 17.3.6 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).
- 17.3.6.1 The Contractor will apply the drug status, authorization criteria, quantity limits, and other restrictions established by HCA policy 65.10.00 Analgesics Opioid Agonists found at:
<https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf>
- 17.3.6.1.1 The Contractor will apply the exception criteria established by HCA policy 65.10.00 Analgesics Opioid Agonists as an expedited authorization (EA) using the EA codes published on the Apple Health EA list.
- 17.3.6.1.2 The Contractor will use the attestation forms provided by HCA in relation to HCA policy 65.10.00 Analgesics Opioid Agonists. Contractor may modify the forms to include branding and Contractor specific contact information.
- 17.3.6.1.2.1 The Contractor and its Subcontractors shall maintain the member specific attestation form(s) as part of the member's medical record and follow the record requirements in Section 2 of this Contract.
- 17.3.6.1.3 Contractor will use the approval and denial language provided by HCA when reviewing requests in relation to HCA policy 65.10.00 Analgesics Opioid Agonists. For situations not accounted for in the provided approval or denial language the Contractor may use their own language for notifications and send a copy to the Applehealthpharmacypolicy@hca.wa.gov mailbox.
- 17.3.6.2 The Contractor shall submit the SUPPORT Act report through MC-Track using the template developed by HCA on a quarterly basis. The report will be due thirty (30) calendar days after the end of each quarter. The initial report is due January 30, 2020 and shall reflect data from fourth quarter of the previous calendar year.
- 17.3.7 Second Opinion for Children Prescribed Mental Health Medications.
- 17.3.7.1 The Contractor shall require a medication consultation by an HCA-approved Second Opinion Network (SON) provider before authorizing coverage of any psychotropic medication or medication regimens for children under 18 years of age that exceed the medication review thresholds established by HCA unless otherwise specified below:
- 17.3.7.1.1 For Enrollees who have previously filled prescriptions for the same drug at the same daily dosage, the Contractor shall authorize continuation

of psychotropic medications exceeding these review thresholds until receipt of written report containing treatment recommendations from the SON.

- 17.3.7.1.2 For Enrollees who have NOT previously filled prescriptions at the same daily dosage, the Contractor shall deny authorization of psychotropic medications exceeding these review thresholds until receipt of written report containing treatment recommendations from the SON or otherwise directed by HCA.
- 17.3.7.2 HCA will provide the Contractor with a list of products and definitions of review thresholds for certain psychotropic medications which require a second opinion. Changes to the medication review thresholds established by HCA will be communicated to the Contractor no less than ninety (90) calendar days before any required implementation date.
- 17.3.7.3 The Contractor must identify all psychotropic medication prescriptions that require a second opinion. HCA may require corrective action or apply sanctions if the Contractor incorrectly authorizes or fails to identify psychotropic medications requiring consultation.
- 17.3.7.4 For the defined list of psychotropic medications, the Contractor is prohibited from applying any clinically or therapeutically based claim rejections or authorization requirements which have not been reviewed and approved by HCA.
 - 17.3.7.4.1 No later than two (2) business days after an Enrollee is determined to exceed review thresholds, the Contractor shall contact the prescriber to request relevant clinical information and chart notes detailing the need for the requested medication(s). In the event that multiple prescribers are prescribing mental health medications for the same Enrollee, the Contractor shall request relevant documentation from each prescriber.
 - 17.3.7.4.2 If a prescriber fails to provide documentation to support a prescription which exceeds HCA defined review thresholds within ten (10) business days, the Contractor shall deny all medications exceeding thresholds within two (2) business days.
 - 17.3.7.4.3 No later than close of business of the first business day after obtaining all relevant documentation, the Contractor shall send notification of required authorization to applehealthpharmacypolicy@hca.wa.gov. Documentation received after close of business is considered received on the next business day. Notification shall include Enrollee's name, date of birth, ProviderOne client ID, National Drug Code of

the drug denied, prescribed quantity and days' supply, National Provider Identifier of prescriber, name of prescriber, fax or phone number for prescriber, National Provider Identifier of dispensing pharmacy, name of dispensing pharmacy, fax or phone number of dispensing pharmacy, date of denial by plan, and reason for denial.

- 17.3.7.4.4 Upon receipt of a written report from HCA, the Contractor shall approve or deny medications according to the recommendations of the SON within five (5) business days.
- 17.3.7.4.5 The Contractor shall have processes in place to accurately follow up with SON recommendations for future care, such as gradual tapering of medications, or required re-review based on other medication trials.
- 17.3.7.4.6 The Contractor shall provide case management to assist and facilitate the provision of any psychosocial recommendations made by SON.
 - 17.3.7.4.6.1 If the Contractor is unable to contact the Enrollee to provide case management, the Contractor shall inform the prescriber that participated in the SON review.
- 17.3.7.4.7 Upon notification by HCA that a prescriber has failed to participate in an SON consultation, the Contractor shall deny all medications exceeding thresholds within five (5) business days.
- 17.3.7.4.8 Changes to medications or medication regimens which exceed HCA review thresholds and which are not addressed in an existing SON report require the initiation of a new SON review by the Contractor. Reduction of medication doses or discontinuation of medications in a psychotropic polypharmacy regimen do not require a new SON.
- 17.3.7.4.9 If the provider submits a SON report or Partnership Access Line (PAL) consultation letter that addresses the requested medication regimen, the Contractor shall approve or deny medications according to the recommendations in the SON report or PAL consultations letter.
- 17.3.7.4.10 Payment to the SON provider for required reviews are the responsibility of HCA according to the provisions of HCA's contract with the SON provider.
- 17.3.7.4.11 The Contractor is responsible for payment to the prescribing practitioner for time spent engaging in medication review process with the SON.

17.3.7.4.12 To assist prescribers in meeting the needs of Enrollees who are children with a mental health diagnosis, and in order to minimize the need for required medication reviews, the Contractor shall inform network prescribers that HCA provides access to consultation with a child psychiatrist through the Partnership Access Line (PAL). The Contractor is not required to provide payment to prescribers for voluntarily accessing the PAL.

17.3.8 Provider and Enrollee Notification

17.3.8.1 The Contractor shall have policies and procedures for notifying Providers and Enrollees of changes to the Contractor's Formulary or AH-PDL, and any changes to Prior Authorization requirements.

17.3.8.1.1 The Contractor shall provide:

17.3.8.1.1.1 Written notification for changes to the Formulary or AH-PDL and Prior Authorization requirements to all affected Providers and Enrollees at least thirty (30) days prior to the effective date of the change.

17.3.8.1.1.2 Written information about changes to the Formulary or AH-PDL and Prior Authorization requirements upon request by Providers or Enrollees.

17.3.8.1.1.3 Provide information about Formulary, AH-PDL, and Prior Authorization changes through Member and Provider newsletters, its web site, or other regularly published media of general distribution.

17.3.9 Medication Therapy Management

17.3.9.1 The Contractor shall ensure its provider contracts include provider reimbursement methods within the medical billing processes that incentivize pharmacists or other qualified providers licensed in Washington State to provide chronic care management including comprehensive medication management services to individuals, consistent with the goals established in RCW 74.09.522.

17.3.10 Rebates

17.3.10.1 The Contractor or the Contractor's pharmacy benefit manager (PBM) is prohibited from negotiating and collecting rebates for utilization by Apple Health enrollees with drug companies for preferred or non-preferred pharmaceutical products included on the AH-PDL. If the Contractor or its Subcontractor has an existing rebate agreement with a manufacturer for a product on the AH-

- PDL, all Medicaid outpatient drug claims, including provider-administered drugs, must be exempt from such rebate agreements.
- 17.3.10.2 The Contractor or the Contractor's PBM, is authorized to negotiate and collect rebates with drug manufacturers for any product that is not included in a class on the AH-PDL.
 - 17.3.10.3 Section 2501(c) of the Patient Protection and Affordable Care Act (ACA) expanded the drug rebate requirement to include drugs dispensed to Enrollees. Covered outpatient drugs dispensed by the Contractor to Enrollees, including those administered by physicians in their offices, are subject to the same manufacturer rebate requirements as HCA's FFS outpatient drugs.
 - 17.3.10.4 The Contractor is subject to requirements for rebate agreements as defined in Section 1927 of the Social Security Act found at: http://www.ssa.gov/OP_Home/ssact/title19/1927.htm
 - 17.3.10.5 The Contractor shall ensure that:
 - 17.3.10.5.1 Products in the Contractor's drug formulary are purchased from a participating rebate eligible manufacturer as defined in this Contract. A list of eligible manufacturers can be found at: https://www.hca.wa.gov/assets/billers-and-providers/rebate_customer_list.xls;
 - 17.3.10.5.2 Bulk chemicals used in the compounding of medications are exempt from the federal rebate requirements.
 - 17.3.10.5.3 Drug rebate records are kept in accordance with the Records section of this Contract and are made available to HCA upon request.
 - 17.3.10.6 The Contractor will have processes in place to ensure the validity of medical claim data for rebate collection purposes, including but not limited to:
 - 17.3.10.6.1 Validating the association between submitted HCPC codes and their corresponding National Drug Code (NDC) using sources other than the CMS NDC - HCPCS Crosswalk for Medicare Part B Drugs. Validation must include processes for correctly paying claims with previously unknown NDC-HCPC associations as well as denying claims for invalid associations.
 - 17.3.10.6.2 Denying claims for products that come in unbreakable package sizes such as single-dose vials when the number of units billed is not a multiple of the number of units included in the unbreakable package.
 - 17.3.10.7 HCA retains all funds collected from pharmaceutical manufacturers from rebates under the federal Medicaid Drug Rebate Program

based on drug utilization by the Contractor's Enrollees.

17.3.10.8 HCA retains all funds collected from pharmaceutical manufacturers from rebates negotiated by HCA under its supplemental rebate program for utilization of drugs by the Contractor's Enrollees that are listed on the AH-PDL.

17.3.10.9 The Contractor retains all funds from rebates or discounts negotiated by the contractor with pharmaceutical manufacturers for drugs not included in the AH-PDL, and must report those to HCA as an offset to the costs of providing healthcare.

17.3.11 Reports

17.3.11.1 Prior Authorization

17.3.11.1.1 The Contractor shall submit a report of all prescription drug authorizations forty-five (45) calendar days after the end of the calendar quarter in a format determined by HCA. Detail must be provided by drug label name, number of requests, number denied, and number approved. The first quarter Prescription Drug Authorization report is due May 15.

17.3.11.2 Drug Utilization Review (DUR)

17.3.11.2.1 The Contractor shall submit an Annual Drug Utilization Review report on the CMS-approved template by the specific due dates stated in subsection 11.1.1.2. The report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

17.3.11.3 Rebates and Pharmacy Reimbursement

17.3.11.3.1 The Contractor shall provide a Network Pharmacy Reimbursement Reconciliation report detailing the actual ingredient cost and dispensing fee paid to network pharmacies by the Contractor or by the Contractor's PBM for all paid claims as well as total amount paid to the PBM for the same claims that the Contractor reported to HCA through submission of encounter data. The Network Pharmacy Reimbursement Reconciliation report is due on an ad hoc basis.

17.3.11.3.2 The Contractor shall provide a quarterly Drug Rebate report no later than forty-five (45) calendar days following the end of the calendar quarter estimating the amounts of rebates or discounts

negotiated with drug manufacturers that will be invoiced to manufacturers for drug utilization by managed care Enrollees in the preceding calendar quarter. The reports shall be in a format determined by HCA and will include, at a minimum, detail by NDC of units invoiced, rebate amounts per unit, and total rebate projected or collected. The first quarter Drug Rebate report is due May 15.

- 17.3.11.3.3 The Contractor shall provide an annual Drug Rebate report, no later than June 30, of any actual savings collected from manufacturers for rebates or discounts negotiated by the Contractor with drug manufacturers for utilization in the previous calendar year. The reports shall be in a format determined by HCA and will include, at a minimum, detail by NDC of units invoiced, rebate amounts per unit, and total rebate projected or collected.

17.3.11.4 Historical Reports

- 17.3.11.4.1 The Contractor shall provide a report by April 30 of all rebates or discounts received from drug manufacturers for drug utilization by Enrollees for each calendar quarter April 1, 2016 through December 31, 2017. The report shall be in a format determined by HCA and will include, at a minimum, manufacturer, drug name, rebate amounts invoiced and collected per drug, and total rebate projected or collected. The Historical Drug Rebate report shall be submitted as one document but broken down by calendar quarters that span 2016 and 2017. For example: April through June, 2016, etc.

17.3.11.5 Confidentiality of Proprietary Rebate Information

- 17.3.11.5.1 The Contractor shall identify any confidential or proprietary information contained within reports. Failure to label such materials or failure to respond timely after notice of request for public disclosure has been given shall be deemed a waiver by the Contractor of any claim that information contained in the submitted reports is confidential, proprietary or trade secrets.

17.4 Exclusions

The following services and supplies are excluded from coverage under this Contract.

- 17.4.1 Unless otherwise required by this Contract, Ancillary Services resulting solely from, or ordered in the course of receiving non-contracted or excluded services are also non-covered or an excluded service (e.g. dressing supplies as a non-durable medical supply to care for an incision related to a cosmetic abdominoplasty).

- 17.4.2 The Contractor shall not provide or pay for services that violate the Assisted

Suicide Funding Restriction Act of 1997 (SSA § 1903(i)(16)).

- 17.4.3 The Contractor is not responsible for coverage of any services when an Enrollee is outside the United States of America and its territories and possessions.
- 17.4.4 Early, elective inductions (before thirty-nine (39) weeks) that do not meet medically necessary indicators set by the Joint Commission.
- 17.4.5 The following Covered Services are provided by the state and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication, or Contractor publications.
 - 17.4.5.1 Inpatient Hospital charges at Certified Public Expenditure (CPE) hospitals for Categorically Needy – Blind and Disabled identified by HCA;
 - 17.4.5.2 School-based Health Care Services for Children in Special Education with an Individualized Education Plan or Individualized Family Service Plan who have a disability, developmental delay or are diagnosed with a physical or mental condition;
 - 17.4.5.3 Eyeglass frames, lenses, and fabrication services covered under HCA's selective contract for these services for children under age 21, and associated fitting and dispensing services. The Contractor is encouraged to inform eye practitioners of the availability of Airway Heights Correctional Center to access glasses for adult Enrollees age 21 and over if not offered by the Contractor as a value added benefit;
 - 17.4.5.4 Voluntary Termination of Pregnancy;
 - 17.4.5.5 Court-ordered transportation services, including ambulance services;
 - 17.4.5.6 Long Term Inpatient Psych Program covered by HCA: Per diem bed rate for court-ordered mental health Involuntary Treatment Act (ITA) commitment starting the date the ninety (90) to one hundred eighty (180) day court order is issued, where the individual is approved for placement in a state hospital or HCA-contracted long-term mental health community hospital bed or E&T;
 - 17.4.5.7 Transportation Services other than ambulance, including but not limited to: taxi, cabulance, voluntary transportation, public transportation, and common carriers;
 - 17.4.5.8 Ambulance services, including air and ground ambulance transportation services with dates of service after December 31, 2017;
 - 17.4.5.9 Professional services provided by a dentist, dental surgeon, dental hygienist, denturist, dental anesthesiologist, endodontist, periodontist, or other dental specialist for care and treatment of a

- dental condition, including anesthesia for dental care;
- 17.4.5.10 Orthodontics;
 - 17.4.5.11 HCA First Steps Program - Maternity Support Services (MSS), consistent with the Marketing and Information, Subcontracts, and Care Coordination provisions of this Contract;
 - 17.4.5.12 Sterilizations for Enrollees under age 21, or those that do not meet other federal requirements (42 C.F.R. § 441 Subpart F);
 - 17.4.5.13 Services provided by a health department when an Enrollee self-refers for care if the health department is not contracted with the Contractor;
 - 17.4.5.14 HIV Case Management;
 - 17.4.5.15 Prenatal Genetic Counseling;
 - 17.4.5.16 HCA will review and determine which new drugs may be excluded from the Contractor's rate and when they will be added back into the rates. A new drug will be excluded if it is indicated for treatment of patients with rare diseases that are not likely to be equally distributed across the Medicaid plans or if it has a price such that the Contractor's premium is no longer actuarially sound. Excluded drugs are listed in Table 1 below:
 - 17.4.5.16.1 Excluded drugs will be published in HCA professional billing guide.
 - 17.4.5.16.2 A drug excluded from the benefit is excluded regardless of claim reimbursement type. HCA may choose to not exclude drugs administered inpatient.
 - 17.4.5.16.3 If a drug is administered as part of a procedure, only the cost of the drug is excluded. Ancillary drugs and services provided pursuant to the administration of the drug are not excluded.
 - 17.4.5.16.4 The exclusion of the drugs listed in the table below does not apply to any other services related to the treatment or diagnosis of conditions for which the drug may be prescribed. No services will be considered ancillary to this exclusion under subsection 17.4.1, including the treatment of complications from or adverse reactions to treatment with the drugs. The Contractor shall cover all new drugs regardless of cost, unless HCA notifies the Contractor the drug will be excluded.
 - 17.4.5.16.5 The drugs listed in the table below are excluded from the premium payment described in subsection 5.2.1 of this Contract for the Apple Health Family Adult, Apple Health Family Child, Apple Health State Children's Health Insurance Program (SCHIP), Apple Health Blind Disabled (AHBD), Apple Health Community Options Program Entry System

(COPES), Developmental Disability Administration (DDA) and Apple Health Adult Coverage (AHAC) populations.

Table 1: Excluded Drugs

AVXS-101 (Zolgensma®)
axicabtagene ciloleucel (Yescarta®)
burosumab-twza (Crysvita®)
Cerliponase alfa (Brineura™)
Edaravone (Radicava™)
Elapegademase-lvlr (Revcovi™)
Emapalumab (Gamifant™)
Eteplirsen (Exondys51™)
Hemophiliac Products – Anti-hemophiliac blood factors VII, VIII, and IX, anti-inhibitor, and biological products FDA approved with an indication for use in treatment of hemophilia or von Willebrand disease when distributed for administration in the Enrollee's home or other outpatient setting.
Immune modulators and anti-viral medications to treat Hepatitis C. This exclusion does not apply to any other contracted service related to the diagnosis or treatment of Hepatitis C.
Lutetium Lu 177 dotatate (Lutathera®)
Nusinersen (Spinraza®)
Pegvaliase-pqpz (Palynziq™)
Tisagenlecleucel-t (Kymriah™)
Voretigene neparvovec-ryzl (Luxturna™)

- 17.4.5.17 Long-term private duty nursing for Enrollees 18 and over. These services are covered by DSHS, Aging and Long-Term Support Administration;
- 17.4.5.18 Sexual reassignment surgery as described in WAC 182-531-1675(6)(d) and (e) as well as hospitalizations, physician, and Ancillary Services required to treat postoperative complications of these procedures;
- 17.4.5.19 Chemical-Using Pregnant (CUP) Women program as described in WAC 182-533-0730 when provided by an HCA-approved CUP provider; and
- 17.4.5.20 "Treat and Refer", or treatment with no transport when provided by eligible providers defined as fire departments pursuant to a community assistance referral and education services program (CARES) as described in RCW 35.21.930.
- 17.4.6 The following services are covered by other state agencies and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication or Contractor publications.
 - 17.4.6.1 Community-based services (e.g., COPES, CFC and Personal Care Services) covered through the Aging and Long-Term Support Administration (ALTSA);
 - 17.4.6.2 Nursing facility stays that do not meet rehabilitative or skilled criteria are covered through the Aging and Long-Term Support

- Administration (ALTSA);
- 17.4.6.3 Health care services covered through the DSHS, Developmental Disabilities Administration (DDA) for institutionalized clients;
 - 17.4.6.4 Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health;
 - 17.4.6.5 Any service provided to an Enrollee while incarcerated with the Washington State Department of Corrections (DOC); and
 - 17.4.6.6 Early Childhood services (e.g., home visiting, ESIT, ECLIPSE, ECEAP/Head Start) covered by DCYF.

17.5 Patient Review and Coordination (PRC)

- 17.5.1 The Contractor shall have a PRC program that meets the requirements of WAC 182-501-0135. PRC is authorized by 42 U.S.C. § 1396n(a)(2) and 42 C.F.R. § 431.54.
- 17.5.2 Clinical oversight of the PRC review process must be provided by a qualified professional who is legally licensed and authorized by law or rule to determine if Enrollees have used health care services at a frequency or amount that is not medically necessary. Licensed professionals that may provide this clinical oversight include Physician, ARNP, Physician's Assistant, and Registered Nurse.
- 17.5.3 If either the Contractor or HCA places an Enrollee into the PRC program, both parties will honor that placement.
- 17.5.4 The Contractor's placement of an Enrollee into the PRC program shall be considered an Adverse Benefit Determination, which shall be subject to Appeal under the provisions of the Grievance and Appeal System section of this Contract. If the Enrollee Appeals the PRC placement, the Contractor will notify HCA of the Appeal and the outcome.
- 17.5.5 When an Enrollee is placed in the Contractor's PRC program, the Contractor shall send the Enrollee a written notice of the Enrollee's PRC placement, or any change of status, in accordance with the requirements of WAC 182-501-0135.
- 17.5.6 The Contractor shall send HCA a written notice of the Enrollee's PRC placement, or any change of status, in accordance with the required format provided in the Patient Review and Coordination Program Guide published by HCA.
- 17.5.7 The Contractor shall ensure PRC Enrollees and providers have direct access to the Contractor's PRC-trained program staff during the Business Day, including access to make needed changes to assigned providers. The Contractor may also subcontract to provide this service.
- 17.5.8 The Contractor shall have policies to ensure PRC Enrollees do not experience a lapse in access to program staff that can assist with the Enrollee's ability to obtain needed prescriptions from the narcotics prescriber or Primary Care Provider.
- 17.5.9 For an Enrollee admitted to a residential treatment center, the Contractor shall allow a representative of the center to make changes to assigned providers, including pharmacies, on the Enrollee's behalf without the Enrollee's written or

oral consent.

- 17.5.10 In accord with WAC 182-501-0135, HCA will limit the ability of an Enrollee placed in the PRC program to change their enrolled Contractor for twelve (12) months after the Enrollee is placed in the PRC program by HCA or the Contractor unless the PRC Enrollee moves to a residence outside the Contractor's service areas, the Enrollee's assigned PCP no longer participates with the Contractor and is available in another MCO, or if the Enrollee is admitted to a subacute mental health Facility. The Contractor shall allow for a temporary change in PCP or pharmacy for the Enrollee. The Contractor shall accept notification from the Facility of the change in Enrollee status and the need for a newly assigned PCP and pharmacy. The temporary change in providers is effective until the date of discharge from the Facility.
- 17.5.11 Family members of an Enrollee whose ability to change their enrolled MCO is limited because of placement in the PRC program may still change enrollment as provided in this Contract.

18 Third Party Liability

18.1 Definitions. For the purposes of this Section:

- 18.1.1 “Coordination of Benefits Agreement” or “COBA” means the national model contract which standardized the way the eligibility and Medicare Claims payment information within a claims crossover context is exchanged to allow plans that provide health or prescription coverage for a person with Medicare to determine their respective payment responsibilities when an individual is covered by more than one plan.
- 18.1.2 “Cost Avoidance” means a method used by HCA to avoid payment when other primary insurance resources are available to the Enrollee. When claims are submitted on behalf of Enrollees who have other primary insurance on file, payment will be denied and claims returned to the providers, who are then required to bill and collect payment from any liable third parties. (42 C.F.R. § 433.139(b)).
- 18.1.3 “Cost Recovery” (also known as “pay and chase”) means that the payer pays providers for submitted claims and then attempts to recover payments from liable third parties. Payers pay and chase claims for two primary reasons: post-payment identification of primary third party resources and Social Security Act exceptions to cost avoidance that require States to pay and chase claims instead of using cost avoidance. This is required when (1) the service is preventive pediatric care, (2) the service is covered under EPSDT, including Applied Behavior Analysis (ABA) treatment services, 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)).
- 18.1.4 “Post Payment Recovery” means seeking reimbursement from third parties whenever claims have been paid for which there is Third Party Liability (TPL). “Cost Recovery”, “Post Payment Recovery” may be referred to as “pay and chase”.
- 18.1.5 “Third Party Liability” means the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid 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 shall 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 shall assume full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the liability of third parties to pay for services provided to Enrollees under this Contract. The Contractor also shall be responsible for identifying existing TPL resources, undertaking cost avoidance, and recovering any liability from the third party. The Contractor shall develop and implement policies and procedures to meet its obligations regarding TPL including but not limited to:
 - 18.2.2.1 Implementation of Coordination of Benefits Agreement (COBA) with

CMS and the Federal Benefits Coordination and Recovery Center (BCRC) by July 1, 2018 to allow for automated crossover claims processing for dual-eligible clients.

- 18.2.3 For Enrollees who have primary health insurance, the Contractor shall coordinate benefits in accordance with 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 shall:
 - 18.2.4.1 Identify third party resources consistent with the Contractor's policies and procedures;
 - 18.2.4.2 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts;
 - 18.2.4.3 Attempt to recover any third-party resources available to Enrollees (42 C.F.R. § 433 Subpart D) and shall make all records pertaining to coordination of benefits collections for Enrollees available for audit and review under Subsection 12.10 of this Contract;
 - 18.2.4.4 Pay preventive pediatric care, and services covered under EPSDT, including Applied Behavior Analysis treatment services and medically intensive children's program services, 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 shall pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount paid by the primary insurer.

- 18.2.6 The Contractor shall have policies and procedures in place to investigate potential TPL resources related to trauma or accident and pursue recoveries.

18.3 Provider Agreements

- 18.3.1 All provider agreements executed by the Contractor and all provider agreements executed by subcontracting entities or organizations shall define the provider's responsibilities regarding TPL, including the provider's obligation to identify TPL coverage and, except as otherwise provided in this Contract, to seek such third party payment before submitting claims to the Contractor.

18.4 Cost Avoidance

- 18.4.1 The Contractor shall ensure coverage by all potential third-party payers is exhausted before the Contractor makes a payment for covered services, by directing subcontracted providers to submit a claim and receive final determination from the identified Third Party payer before billing the Contractor for services.
- 18.4.2 The Contractor shall use a Cost Avoidance procedure for all claims or services subject to third-party payment to the extent permitted by state and federal law. If the Contractor has established the probable existence of TPL at the time the provider submits a claim, the Contractor shall deny the claim and provide information about the Third Party payer to the billing provider.

18.5 Post-Payment Recoveries

- 18.5.1 The Contractor shall recover funds post payment in cases where the Contractor was not aware of third-party coverage at the time services were rendered or paid for, or the Contractor was not able to use a Cost Avoidance procedure. The Contractor shall identify and pursue all potential TPL payments. Potentially liable third party coverage sources include, but are not limited to:
 - 18.5.1.1 Third party liability insurance (for example, group health plans including medical, pharmacy);
 - 18.5.1.2 Self-insured plans;
 - 18.5.1.3 Managed care organizations;
 - 18.5.1.4 Pharmacy benefit managers;
 - 18.5.1.5 Union and other fraternal organizations; and
 - 18.5.1.6 Certain other state or federal programs.
- 18.5.2 Cost Benefit. (1) The Contractor's Post Payment Recovery processes shall not require the Contractor to spend more on an individual claim basis than the threshold limits established by the Medicaid State Plan. (2) The Contractor shall use Cost Avoidance procedures to avoid payment on any claim where TPL is on file, other than those in Subsection 18.10 below.
- 18.5.3 Contractor must attempt to recover any third party resources available to Enrollees (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 subsection 12.10 of this Contract.

- 18.5.3.1 Contractor must pay and chase if the claim is for a service provided to an Enrollee on whose behalf child support enforcement is being carried out if, 1) the third party coverage is through an absent parent; and 2) the Provider certifies that, if the Provider has billed a third party the provider has waited thirty (30) calendar days from the date of billing without receiving payment before billing Medicaid (42 C.F.R. § 433.139(b)(3)(ii).
- 18.5.4 Retention of Recoveries. The Contractor is entitled to retain any amounts recovered through its efforts. Distributions of recoveries will be made to the Contractor, in an amount equal to the Contractor's expenditures for the individual on whose behalf the collection was based, and to the beneficiary, any remaining amount.
- 18.5.5 Unsuccessful Effort. If the Contractor is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after a period of sixty (60) calendar days of such efforts, 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 shall include information about known TPL resources on the daily 834 enrollment files. Any new TPL resources learned of by HCA through its contractor(s) are added to the next available enrollment file.
 - 18.6.2 The Contractor shall:
 - 18.6.2.1 Proactively identify those Enrollees with other primary health insurance including their enrollment and disenrollment dates, and provide this information to HCA on the Enrollees with Other Health Insurance (OHI) report;
 - 18.6.2.2 Cooperate with HCA in any manner necessary to ensure collection of this information;
 - 18.6.2.3 Include all third party payments by Enrollee in its regular encounter data submissions; and
 - 18.6.2.4 Provide TPL data to any contracted provider having a claim denied by the Contractor based on the third party coverage.
- 18.7 **Reports**
 - 18.7.1 The Contractor shall submit a quarterly *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well as claims that the Contractor denies due to TPL coverage. The report shall include recoveries or denied claim payments for any covered service. The Contractor shall calculate cost savings in categories described by HCA. The Contractor shall treat funds recovered from third parties as offsets to claims payments and reflect those offsets in encounter data submitted to HCA. The report is due by the sixtieth (60th) calendar day following the end of the quarter.
 - 18.7.2 The Contractor shall submit to HCA on the 15th of the month following the end of the monthly reporting period a report (Enrollees with Other Health Care Insurance) of Enrollees with any other health care insurance coverage with any carrier, including the Contractor.

- 18.7.3 The Contractor shall submit to HCA on the 20th of the following month a report (Subrogation Rights of Third Party Liability (TPL) – Investigations) of any Enrollees who the Contractor newly becomes aware of a cause of action to recover health care costs for which the Contractor has paid under this Contract.
- 18.7.4 HCA will continue to terminate enrollment for clients who become eligible for Medicare.

18.8 Compliance

- 18.8.1 HCA may determine whether the Contractor is in compliance with the requirements in this Section by inspecting source documents for:
 - 18.8.1.1 Appropriateness of recovery attempt;
 - 18.8.1.2 Timeliness of billing;
 - 18.8.1.3 Accounting for third party payments;
 - 18.8.1.4 Settlement of claims; and
 - 18.8.1.5 Other monitoring deemed necessary by HCA.
- 18.8.2 The Contractor shall demonstrate, upon request, to HCA that reasonable efforts have been made to seek, collect and/or report third party recoveries. HCA shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. In making its determination, HCA shall (a) take into account reasonable industry standards and practices and (b) have the right to inspect the Contractor's books and records in accordance with Subsection 12.10.

18.9 Subrogation of Rights and Third Party Liability

- 18.9.1 For the purposes of this subsection:
 - 18.9.1.1 "Injured person" means an Enrollee who sustains bodily injury.
 - 18.9.1.2 "Contractor's health care expense" means the expense incurred by the Contractor for the care or treatment of the injury sustained, computed in accord with the Contractor's FFS schedule.
- 18.9.2 If an Enrollee requires health care services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.
- 18.9.3 HCA specifically assigns to the Contractor HCA's rights to such third party payments for health care provided to an Enrollee on behalf of HCA, which the Enrollee assigned to HCA as provided in WAC 182-503-0540.
- 18.9.4 HCA also assigns to the Contractor its statutory lien under RCW 41.05A.070. The Contractor shall be subrogated to HCA's rights and remedies under RCW 74.09.180(2) and 41.05A.050 through 41.05A.080 with respect to covered services provided to Enrollees on behalf of HCA under chapter 74.09 RCW.
- 18.9.5 The Contractor may obtain a signed agreement from the Enrollee in which the Enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.

18.9.6 The Contractor shall notify HCA of the name, address, and other identifying information of any Enrollee and the Enrollee's attorney:

18.9.6.1 Who settles a claim without protecting the Contractor's interest in contravention of RCW 41.05A.060; or

18.9.6.2 When a claim has been identified as having potential TPL.

18.10 Good Cause Exemption from Billing Third Party Insurance

18.10.1 The Contractor must have a policy to allow Enrollees the right to be exempt from billing third party insurance due to good cause. This includes a procedure that allows for the good cause process to apply on an individual claim basis and a means to flag the Enrollee's account so that the need for additional privacy and precaution can be easily seen. "Good cause" means that the use of the third-party coverage would violate an Enrollee's confidentiality because the third party:

18.10.1.1 Routinely sends verification of services to the third-party subscriber and that subscriber is someone other than the Enrollee;

18.10.1.2 Requires the Enrollee to use a primary care provider who is likely to report the Enrollee's request for family planning services to the subscriber;

18.10.1.3 The Enrollee has a reasonable belief that cooperating with the Contractor in identifying TPL coverage could result in serious physical or emotional harm to the Enrollee, a child in his or her care, or a child related to him or her; or

18.10.1.4 The Enrollee is incapacitated without the ability to cooperate with the Contractor.

18.10.2 A description of this process, including any steps the Enrollee must take to seek exemption based on good cause, must be included in every notice the Contractor provides to Enrollees regarding Third Party billing or seeking cooperation with such billing. The notices must include that reasons such as fear of domestic violence or other harm are included in good cause. The Contractor's policy must include a procedure that allows for the good cause process to apply on an individual claim basis. Any denial of good cause is an adverse benefit determination. Any communications or billing must be suspended pending a good cause request or appeal of a request denial.

19 BUSINESS CONTINUITY AND DISASTER RECOVERY

19.1 Primary and Back-up Systems

19.1.1 The Contractor shall have in place a primary and back-up system for electronic submission of data requested by HCA. This must include the use of the Inter-Governmental Network (IGN); state of Washington, Washington Technology Solutions (WaTech) approved secured Virtual Private Network (VPN) or other WaTech approved dial-up.

19.1.1.1 In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on HCA Enterprise Technology Service's (ETS) review and approval.

19.2 Business Continuity and Disaster Recovery Plan

19.2.1 The Contractor shall develop and maintain a business continuity and disaster recovery plan that ensures timely reestablishment of the Enrollee information system following total loss of the primary system or a substantial loss of functionality.

19.2.1.1 The Contractor shall submit an annual statement by January 1 of each Contract year, certifying that there is an up-to-date business continuity disaster plan in place for both the Contractor and Subcontractors. The certification must indicate that the system, data backup and recovery procedures have been tested, and that copies of the Contractor and Subcontractor plans are available for HCA to review and audit. The disaster plan must include the following:

19.2.1.1.1 A mission or scope statement.

19.2.1.1.2 Identification of the information services disaster recovery staff.

19.2.1.1.3 Provisions for back up of key personnel, identified emergency procedures and visibly listed emergency telephone numbers.

19.2.1.1.4 Procedures for allowing effective communication, applications inventory and business recovery priority and hardware and software vendor list.

19.2.1.1.5 Confirmation of updated system and operations documentation and process for frequent back up of systems and data.

19.2.1.1.6 Description and location of off -site storage of system and data back-ups and ability to recover data and systems from back up files.

19.2.1.1.7 Designated recovery options which may include use of a hot or cold site.

19.2.1.1.8 Documentation that disaster recovery tests or drills have been performed.

EXHIBIT B

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EXHIBIT C

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Exhibit D Integrated Managed Care (IMC)

Value-Based Purchasing

1. Quality Improvement – 2 percent Withhold

- 1.1. HCA will withhold a percentage of monthly Capitation Payments, as defined under subsection 1.5 of this Exhibit, paid by HCA under this Contract. The Contractor will be eligible to earn back part or all of the Withhold (“Withhold”) as set out in this Exhibit.
- 1.2. All incentive arrangements are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state’s quality strategy.
- 1.3. The time periods covered by the Withhold and the applicable percentage amount of the Withhold for each time period are set out in Table 1. Each Withhold Performance Year, Improvement Baseline Performance Year and Evaluation Period identified in Table 1 shall encompass services provided in the defined time period and payments for those services.

**Table 1
Performance Years (PY), Time Periods and Thresholds**

Withhold			Improvement Baseline		Benchmark Comparison ³		Withhold Percent	Evaluation Period ²	Provider Incentives Threshold ²	VBP Payments Threshold ²
Year	PY ¹	HEDIS Reporting Year	PY	HEDIS Reporting Year	PY	HEDIS Reporting Year				
1	2017	2018	2016	2017	2014	2015	1.00%	10/1/17 - 12/31/17	0.75%	30%
2	2018	2019	2017	2018	2015	2016	1.50%	10/1/18 - 12/31/18	1%	50%
3	2019	2020	2018	2019	2017	2018	1.50%	N/A	1%	75%
4	2020	2021	2019	2020	2019	2020	2.00%	N/A	1.25%	85%
5	2021	2022	2020	2021	2020	2021	2.00%	N/A	TBD	90%

¹The Withhold Performance Year 2017 preceded the addition of this Exhibit to this Contract, but was subject to a VBP withhold under the Apple Health Managed Care contract.

²The limited Evaluation Period, Provider Incentives Threshold, and VBP Payments Threshold applies only as set out in Sections 2 and 3 of this Exhibit.

³The Benchmark Comparison for Withhold Performance Year 2018 and 2019 includes a mean and a target. The Benchmark Comparison for Withhold Performance Year 2020 and 2021 is a percentile target only.

1.4. Table 1 Definitions

- 1.4.1. **Withhold Performance Year** – The Withhold Performance is a calendar year in which a percentage withhold is applied to managed care rates and paid back

contingent on performance in the same calendar year period.

- 1.4.2. **Improvement Baseline Performance Year** – The Improvement Baseline Performance Year is the calendar year immediately preceding the Withhold Performance Year. The performance in this year is used as a baseline to gauge how well a MCO improved given its performance in the Withhold Performance Year.
- 1.4.3. **Benchmark Comparison Performance Year** – The Benchmark Comparison Year is, for the component of the QIS that compares the Contractor's Withhold Performance Year to statewide or national benchmarks, the performance year on which these benchmarks are based. These benchmarks include means and percentile targets.
- 1.5. Following each Withhold Performance Year, HCA will determine the total amount of the Withhold for the Withhold Performance Year and the amount of such Withhold that the Contractor is eligible to earn back. The Contractor will be eligible to earn back part or all of the Withhold based on performance measures in the following three areas:
 - 1.5.1. Up to 12.5 percent of the Withhold may be earned back by implementing qualifying Provider Incentives tied to quality and financial attainment as described in Section 2 of this Exhibit (the "Provider Incentives Portion" of the Withhold);
 - 1.5.2. Up to 12.5 percent of the Withhold may be earned through use of Value-Based Purchasing arrangements as described in Section 3 of this Exhibit (the "VBP Payments Portion" of the Withhold); and
 - 1.5.3. Up to 75 percent of the Withhold may be earned by achieving quality improvement and attainment targets as described in Section 4 of this Exhibit (the "QIS Portion" of the Withhold).
- 1.6. No later than November 30 following each Withhold Performance Year, HCA will notify the Contractor of the amount of the Withhold that the Contractor has earned back for the Withhold Performance Year. HCA will schedule payment to the Contractor based on the calculated method as described in Section 7 of this Exhibit. HCA will also provide the Contractor with a copy of Value-Based Purchasing Withhold Calculation Summary Form, Attachment C to this Exhibit, signed by the HCA Chief Financial Officer, outlining the percent withhold recovered through Provider Incentive Portion, The VBP Payments Portion, and the QIS Portion.
- 1.7. Capitation Payments subject to the 2 percent Withhold are specified in Section 5.2 of this Contract. They exclude any administrative, Washington State Health Insurance Pool (WSHIP), Safety Net Assessment Fund (SNAF), or Provider Access Payment (PAP) Program funding.
- 1.8. For Sections 2 and 3 of this Exhibit, "Assessed Payments" shall refer to all Contractor payments made to providers using funds that were subject to the Withhold as defined under subsection 1.5 of this Exhibit, with the exception of any case payments for delivery and low birth weight, administrative dollars, or other payments funded through WSHIP, premium tax, or Institutions for Mental Disease (IMD) funding.
- 1.9. For purposes of this Exhibit, a "Value-Based Payment Arrangement" means a payment

arrangement that meets the definition of Category 2C or higher of the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework Final Whitepaper version dated 1/12/2016, attached as Attachment A (“Whitepaper”).

- 1.10. For purposes of reporting regional data, each regional service area is defined as follows:
 - 1.10.1. Better Health Together (BHT) includes Ferry, Stevens, Pend Oreille, Spokane, Lincoln, and Adams Counties.
 - 1.10.2. Cascade Pacific Action Alliance (Cascade) includes Grays Harbor, Mason, Thurston, Pacific, Lewis, Cowlitz, and Wahkiakum Counties.
 - 1.10.3. Greater Columbia (GC) includes Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield, Whitman, and Asotin Counties.
 - 1.10.4. King includes King County.
 - 1.10.5. North Central (NC) includes Chelan, Douglas, Grant, and Okanogan Counties.
 - 1.10.6. North Sound (NS) includes Whatcom, Skagit, San Juan, Island, and Snohomish Counties.
 - 1.10.7. Olympic includes Clallam, Jefferson, and Kitsap Counties.
 - 1.10.8. Pierce includes Pierce County.
 - 1.10.9. South West Washington Regional Health Alliance (SW WA) includes Clark, Skamania, and Klickitat Counties.

2. Qualifying Provider Incentives – (“Provider Incentives Portion” of the Withhold)

- 2.1. For purposes of this Section, the term “Provider Incentives” means Payment Incentives and Payment Disincentives that apply to base payments that are Assessed Payments in a Value-Based Payment Arrangement.
- 2.2. For purposes of this Section, the term “Payment Incentives” means the portion of contractor rates that are paid to providers in a Value-Based Payment Arrangement conditioned on the quality of services provided. Examples include retrospective bonus payments made on top of a provider's existing reimbursement structure (i.e. upside only), savings achieved by a provider under a shared-savings arrangement whereby the provider's portion of the savings is tied to quality reporting and/or performance, or prospective care management incentive or payment, on top of a provider's existing reimbursement structure, that is tied to quality reporting and/or performance.
- 2.3. For purposes of this Section, the term “Payment Disincentives” means the portion of contractor rates that are charged to providers in a Value-Based Payment Arrangement conditioned on the quality of services provided. Examples include downside risk arrangements whereby providers make payments to contracted payer(s) from their existing reimbursement structure based on quality reporting and/or performance, deficit payments made by a provider to contracted payer(s) based on quality reporting and/or performance, or withheld payments from existing provider reimbursement structures based on quality reporting and/or performance.
- 2.4. The Provider Incentives Portion of the Withhold shall be 12.5 percent of the total

Withhold. The Provider Incentives Portion may be earned back in whole or in part by establishing Payment Incentives and Payment Disincentives tied to quality and financial attainment, and by satisfying the additional requirements set out in this Section. The formula under which all or part of the Provider Incentives Portion of the Withhold may be earned back is set out in this Section.

- 2.5. During the Withhold Performance Year, the Contractor at its discretion can seek feedback from HCA on whether provider payment arrangements qualify as Provider Incentives.
- 2.6. On or before August 1 following each Withhold Performance Year, the Contractor shall report to HCA the total statewide and regional Assessed Payments that the Contractor made to providers for the Withhold Performance Year, and the amount of statewide and regional Payment Incentives and Payment Disincentives for the Withhold Performance Year (“Provider Incentives Data”). Failure to provide the report by the deadline may result in loss of the Withhold described in this Exhibit.
 - 2.6.1. Provider Incentives will be assigned to each region based on the location of the Provider.
 - 2.6.2. Assessed Payments will be considered to have been made when the services have been provided.
- 2.7. The Contractor shall report the Provider Incentives Data, and provide examples of the types of Payment Incentives and Payment Disincentives implemented in each region, in the format set out in Table 2. For each Withhold Performance Year, the Contractor shall provide the data identified in this subsection for the Withhold Performance Year and Evaluation Period, if applicable, using a separate table for the Withhold Performance Year and Evaluation Period.

Table 2
Statewide and Regional Qualifying Incentives

Region	Assessed Payments	Payment Incentives		Payment Disincentives	
		Total Amount	Describe*	Total Amount	Describe*
BHT					
Cascade					
GC					
King					
NC					
NS					
Olympic					
Pierce					
SW WA					
Statewide total					

**For example: “Downside risk arrangement whereby providers make payments to contracted payers from an existing reimbursement structure based on quality reporting and performance.”*

- 2.8. A third-party contractor to HCA will validate the Contractor’s reported actual Payment Incentives and Payment Disincentives to network providers.

- 2.9. Provider Incentives should be reported in the period in which they are paid or accrue in the Contractor's financial statements. The method of reporting should be consistent to ensure that amounts are not double-counted from year to year.
- 2.10. HCA will use the data supplied by the Contractor to calculate the total Provider Incentives for the Withhold Performance Year as a percent of total Assessed Payments for the Contractor Withhold Performance Year, except that in Withhold Performance Year 2018, HCA calculated the total Provider Incentives for the Evaluation Period as a percent of total Assessed Payments for the Evaluation Period.
 - 2.10.1. If the percent calculated is less than 1.25 percent, then the percentage calculated under subsection 2.10 of this Exhibit will be recalculated as a percentage of 1.25 percent. The resulting Provider Incentives "Partial Earn-Back Percentage" will then be the percentage of the Provider Incentives Portion of the Withhold that the Contractor is eligible to earn back.
 - 2.10.2. The results of the calculations are rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.
- 2.11. For the Contractor to earn back the Provider Incentives Portion of the Withhold in full, the total Provider Incentives for the Withhold Performance Year must equal at least Provider Incentives Threshold percent of Assessed Payments made during the Withhold Performance Year, except that for Withhold Performance Year 2018, the total Provider Incentives for the Evaluation Period must equal at least the Provider Incentives Threshold percent of Assessed Payments made during the Evaluation Period. The Provider Incentives Threshold for each Withhold Performance Year is set out in Table 1.

3. Qualifying Value-Based Payments – ("VBP Payments Portion" of the Withhold)

- 3.1. For purposes of this Section, "Payments in a Value-Based Payment Arrangement" means Assessed Payments in a Value-Based Payment Arrangement.
- 3.2. For purposes of this Section, "Hybrid Payment Models" means payment arrangements that incorporate multiple APMs. Payments in Hybrid Payment Model shall assign Total Payments to the most dominant APM Category. The dominant APM Category is defined as the APM Category under which a plurality of payments are made.
- 3.3. For purposes of this Section, "Integrated Primary Care Payment and Delivery Systems" are systems whereby a primary care provider is held accountable for the total cost of care for their patient population. Assessed Payments that are Integrated Primary Care Payment and Delivery Systems shall be included in APM Category 3A (for an upside only, shared savings arrangement) or Category 3B (for a two-sided, shared savings and downside risk arrangement).
- 3.4. The VBP Payments Portion of the Withhold shall be 12.5 percent of the total Withhold. The VBP Payments Portion of the Withhold may be earned back in whole or in part by ensuring that Assessed Payments are tied to Value-Based Payment Arrangements. The formula under which all or part of the VBP Payments Portion of the Withhold may be earned back is set out in this Section.

- 3.5. On or before August 1 following the Withhold Performance Year, the Contractor shall report to HCA the total regional and statewide Assessed Payments in each HCP-LAN Category as defined under subsection 1.7 of this Exhibit. In addition, the Contractor shall report to HCA the total regional and statewide Assessed Payments made by the Contractor in MACRA A-APM payment models certified through the Centers for Medicare and Medicaid Services (CMS). Failure to provide the report by the deadline may result in loss of the amount withheld. Payments will be assigned to each region based on the location of the Provider.
- 3.6. The Contractor shall report the data outlined in subsection 3.5 of this Exhibit in the format laid out in Table 3. For Withhold Performance Year 2018, the Contractor provided the data identified in this subsection for the Withhold Performance Year and Evaluation Period using a separate table for the Withhold Performance Year and Evaluation Period.

Table 3
Statewide and Regional Payments by HCP-LAN Category

Medicaid Total Assessed Payments by APM Category													
Category			Region: Accountable Communities of Health										
APM Category	APM Sub-category	Strategy	Better Health Together	Cascade	Greater Columbia	King	North Central	North Sound	Olympic	Pierce	SW WAn	Out-of-State	All
1 FFS - No Link to Quality	1	Fee-for-Service											
2 FFS - Link to Quality	2A	Foundational Payments for Infrastructure & Operations											
	2B	Pay for Reporting											
	2C	Rewards for Performance											
	2D	Rewards and Penalties for Performance											
3 APMs built on FFS Architecture	3A	APMs with Upside Gainsharing											
	3B	APMs with Upside Gainsharing and Downside Risk											
4 Population-Based Payment	4A	Condition-Specific Population-Based Payment											
	4B	Comprehensive Population-Based Payment											
Total Annual Payments													
Payments in MACRA A-APMs (all payments entered here should ALSO be entered under categories 1-4 above)													
For additional details on APM Categories, see HCP-LAN Alternative Payment Models (APM) Framework													

- 3.7. The Contractor shall report the total annual covered lives in each HCP-LAN category at a statewide and regional level as described in Table 4. Covered lives shall be reported

for Enrollee member months as defined in this Contract. For Withhold Performance Year 2018, the Contractor provided the data identified in this subsection for the Withhold Performance Year and Evaluation Period using a separate table for the Withhold Performance Year and Evaluation Period.

- 3.8. Where an Enrollee receives services that are funded under multiple payment models, the Enrollee shall be reported under the dominant category of payment model either by month or over the total reporting period so long as a consistent method is used. The dominant category for this purpose shall be the payment category with the greatest assessed payments for the Enrollee.

Table 4
Statewide and Regional Covered Lives by HCP-LAN Category

Medicaid Total Statewide Covered Lives by APM Category													
Category			Region: Accountable Communities of Health										
APM Category	APM Sub-category	Strategy	All										
			Better Health Together	Cascade	Greater Columbia	King	North Central	North Sound	Olympic	Pierce	SW WA	Out-of-State	All
1 FFS - No Link to Quality	1	Fee-for-Service											
	2A	Foundational Payments for Infrastructure & Operations											
	2B	Pay for Reporting											
	2C	Rewards for Performance											
2 FFS - Link to Quality	2D	Rewards and Penalties for Performance											
	3A	APMs with Upside Gainsharing											
	3B	APMs with Upside Gainsharing and Downside Risk											
	4A	Condition-Specific Population-Based Payment											
3 APMs built on FFS Architecture	4B	Comprehensive Population-Based Payment											
4 Population-Based Payment													
Total Covered Lives													
Covered Lives in MACRA A-APMs (all covered lives entered here should ALSO be entered under categories 1-4 above)													
For additional details on APM Categories, see HCP-LAN Alternative Payment Models (APM) Framework													

- 3.9. A third party contractor to HCA shall validate the Contractor's reporting of the total amounts and categorization of the reported Payments in a Value-Based Payment Arrangement.

- 3.10. HCA will use the data supplied by the Contractor to calculate the total Payments in a Value-Based Payment Arrangement as a percent of total Assessed Payments for the Contractor for the Withhold Performance Year, except that in Withhold Performance Year 2018, HCA calculated the total Payments in a Value-Based Payment Arrangement for the Evaluation Period as a percent of total Assessed Payments for the Contractor for the Evaluation period.
- 3.10.1. If for the Withhold Performance Year the percentage calculated under subsection 3.10 of this Exhibit is less than the VBP Payments Threshold for the Withhold Performance Year, then the percentage calculated under subsection 3.10 of this Exhibit will be recalculated as a percentage of the VBP Payments Threshold for the Withhold Performance Year. The resulting VBP Payments “Partial Earn-Back Percentage” will then be the percentage of the VBP Payments Portion of the Withhold that the Contractor is eligible to earn back.
- 3.10.2. The results of the calculation made in subsections 3.10 and 3.10.1 of this Exhibit are rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.
- 3.11. For the Contractor to earn back the VBP Payments Portion of the Withhold in full, the total Payments in a Value-Based Payment Arrangement for the Withhold Performance Year must equal at least the VBP Payments Threshold Percent of Assessed Payments made during the Withhold Performance Year, except that for Withhold Performance Year 2018, the total Payments in a Value-Based Payment Arrangement for the Evaluation Period must equal at least the VBP Payments Threshold percent of Assessed Payments made during the Evaluation Period. The VBP Payments Threshold for each Withhold Performance Year is set out in Table 1.

4. Overall Quality Improvement Score Calculation – (“QIS Portion” of the Withhold)

- 4.1. The QIS Portion of the Withhold shall be 75 percent of the total Withhold. The QIS Portion may be earned back in whole or in part by achieving quality improvement and attainment targets on the basis of Healthcare Effectiveness Data and Information Set HEDIS® scores and non-HEDIS scores, and by satisfying the additional requirements set out in this Section.
- 4.2. The Contractor shall report HEDIS® measures in accordance with the Performance Measures subsection of this Contract. HCA will produce the non-HEDIS scores in accordance with the Performance Measures subsection of this Contract. Specific measures will be evaluated to determine the share of the QIS Portion of the Withhold that the Contractor is eligible to earn back and are identified in Tables 5, 6 and 7. Failure to meet the requirements of this paragraph, or failure to pass the HEDIS audit or performance measure validation may result in loss of the amount withheld.
- 4.3. If the value for one or more measures is missing or not available, the HCA Chief Medical Officer (CMO), in his or her sole discretion, will determine the values to be used in place of the missing values using publicly available sources. If the value is missing or not available, using publicly available sources, the HCA CMO will either determine an

alternative measure or exclude the measure from the calculation.

- 4.4. The values in Table 5 shall apply for Withhold Performance Year 2019, the values in Table 6 shall apply for Withhold Performance Year 2018, and the values in Table 7 shall apply for Withhold Performance Year 2020.
- 4.5. The comparison values used for HEDIS® performance are NCQA Quality Compass Medicaid HMO Values in the year set out in Table 1.
- 4.6. The QIS score calculation methodology differs by year. See Section 5 and 6 of this Exhibit.

5. Quality Improvement Score Calculation (“QIS Portion” of the Withhold) for Withhold Performance Year 2018 and 2019

- 5.1. HCA will use the data supplied by the Contractor to calculate a single Quality Improvement Score (QIS) for the Contractor for the Withhold Performance Year. The total QIS will reflect a weighted average of individual composite scores (the “Measure Composite Score”) that assess annual improvement (the “Measure Improvement Score”) and objective attainment (the “Measure Quality Score”) on each Quality Measure.
- 5.2. The Measure Improvement Score and Measure Quality Score for each Quality Measure will measure the HEDIS® scores provided by the Contractor and non-HEDIS scores against Target Measure Score and Mean Measure Score values shown in Tables 5 and 6.
 - 5.2.1. The Target Measure Score values referenced in Table 5 that are identified as HEDIS® scores are NCQA Quality Compass Medicaid HMO 90th percentile values for the year immediately preceding the Withhold Performance Year, as identified in Table 1. The Target Measure Score values referenced in Table 5 that are identified as non-HEDIS scores will be one percentage point above the Mean Measure Score for the year immediately preceding the Withhold Performance Year.
 - 5.2.2. The Mean Measure Score values referenced in Table 5 that are identified as HEDIS® scores are NCQA Quality Compass Medicaid HMO average values for the year immediately preceding the Withhold Performance Year, as identified in Table 1. The Mean Measure Score values referenced in Table 5 that are identified as non-HEDIS scores are statewide averages for the year immediately preceding the Withhold Performance Year.
 - 5.2.3. The Target Measure Score values referenced in Table 6 that are identified as HEDIS® scores are NCQA Quality Compass Medicaid HMO values for 2016.
- 5.3. The Measure Quality Score QS(i) for a given measure will reflect the Contractor’s attainment beyond the Mean Measure Score in terms of the total distance between the Mean Measure Score and the Target Measure Score. This relationship is initially calculated as the Measure QS Ratio where Measure QS Ratio = $(\text{Withhold Year Measure Score} - \text{Mean Measure Score}) / (\text{Target Measure Score} - \text{Mean Measure Score})$.

- 5.3.1. The Measure QS Ratio is rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.
- 5.3.2. The Measure QS Ratio will be transformed into a curved distribution using a lookup table provided in Attachment B of this Exhibit, QIS Lookup Table. The result of the lookup transformation will be a QS Table Lookup Value.
- 5.3.3. For a given measure, the QS Table Lookup Value is the value where the horizontal axis that equals the absolute value of the (Withhold Year Measure Score - Mean Measure Score) intersects with the vertical axis that equals the absolute value of the (Target Measure Score - Mean Measure Score). However, if the Withhold Year Measure Score is less than the Mean Measure Score, then the QS Table Lookup Value shall be considered to be zero.
- 5.4. The Measure Improvement Score IS(i) for a given measure will reflect the Contractor's improvement from the Improvement Baseline Year Measure Score in terms of the total distance between the Improvement Baseline Year Measure Score and the Target Measure Score. This relationship is initially calculated as the Measure IS Ratio where $\text{Measure IS Ratio} = (\text{Withhold Year Measure Score} - \text{Improvement Baseline Year Measure Score}) / (\text{Target Measure Score} - \text{Improvement Baseline Year Measure Score})$.
 - 5.4.1. The Measure IS Ratio is rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.
 - 5.4.2. The Measure IS Ratio will be transformed into a curved distribution using the lookup table provided in Attachment B of this Exhibit, QIS Lookup Table. The result of the lookup transformation will be an IS Table Lookup Value.
 - 5.4.3. For a given measure, the IS Table Lookup Value is the value where the horizontal axis that equals the absolute value of the (Withhold Year Measure Score - Improvement Baseline Year Measure Score) intersects with the vertical axis that equals the absolute value of the (Target Measure Score - Improvement Baseline Year Measure Score). However, if the Withhold Year Measure Score is less than the Improvement Baseline Year Measure Score, then the IS Table Lookup Value shall be considered to be zero.
- 5.5. The Measure Q-I Weighting Factor for a given measure will determine the respective weight given to the Measure Quality Score and the Measure Improvement Score in calculating the Measure Composite Score. The Measure Q-I Weighting Factor shall range from 0.25 to 1, dependent on the Measure QS Ratio (not the QS Table Lookup Value) as follows:
 - 5.5.1. If the Measure QS Ratio is equal to or less than 0.25, then the Measure Q-I Weighting Factor shall equal 0.25.
 - 5.5.2. If the Measure QS Ratio is more than 0.25 and less than 1 then the Measure Q-I

Weighting Factor shall equal the Measure QS Ratio.

5.5.3. If the Measure QS Ratio is equal to or greater than 1, then the Measure Q-I Weighting Factor shall equal 1.

5.6. The Measure Quality Score QS(i) for a given measure shall equal the QS Table Lookup Value multiplied by the Measure Q-I Weighting Factor.

5.7. The Measure Improvement Score IS(i) for a given measure shall equal the IS Table Lookup Value multiplied by a value equal to one minus the Measure Q-I Weighting Factor.

5.8. The Measure Composite Score QIS(i) for a given measure shall equal the sum of the Measure Improvement Score IS(i) and the Measure Quality Score QS(i).

5.9. The overall Quality Improvement Score, QIS, is the weighted average of all the individual Measure Composite Scores, QIS(i), where the Measure Weight for each measure is specified in Tables 5 and 6. The resulting number (e.g. 0.14) is converted to a percentage (e.g. 14 percent).

5.9.1. In the Contractor's first year of operation under this Contract for Integrated Managed Care, the Behavioral Health Measures shall be given a weight of zero. In the Contractor's second year of operation under this Contract for Integrated Managed Care, the measures titled Substance Use Disorder Initiation and Substance Use Disorder Engagement shall be given a weight of zero.

5.10. For the Contractor to earn back the QIS Portion of the Withhold in full, the overall Quality Improvement Score, QIS, for the Withhold Year must equal at least 20 percent.

5.11. If the Quality Improvement Score for the Withhold Year is equal to less than 20 percent, then the Quality Improvement Score will be recalculated as a percentage of 20 percent. The resulting QIS "Partial Earn-Back Percentage" will then be the percentage of the QIS Portion of the Withhold that the contractor is eligible to earn back.

5.11.1. The results of the calculation made in subsections 5.9 and 5.11 of this Exhibit are rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

Table 5
Measure Weights, Target Measure Scores and
Mean Measure Scores for Withhold Performance Year 2019

	Quality Measures Description	HEDIS®	Measure Weight	Target Measure Score	Mean Measure Score
Adult	Comprehensive Diabetes Care - Poor Hb A1c Control (>9%) **	Yes	Full	Quality Compass 90th Percentile	Quality Compass Mean
	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	Yes	Full	Quality Compass 90th Percentile	Quality Compass Mean
	Controlling High Blood Pressure (<140/90)	Yes	No weight	Quality Compass 90th Percentile	Quality Compass Mean
	Antidepressant Medication Management –Effective Acute Phase Treatment	Yes	Half	Quality Compass 90th Percentile	Quality Compass Mean
	Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months)	Yes	Half	Quality Compass 90th Percentile	Quality Compass Mean
Pediatric	Childhood Immunization Status - Combo 10	Yes	Full	Quality Compass 90th Percentile	Quality Compass Mean
	Well-child visits in the 3rd, 4th, 5th and 6th years of life	Yes	Full	Quality Compass 90th Percentile	Quality Compass Mean
	Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11)	Yes	Half	Quality Compass 90th Percentile	Quality Compass Mean
	Medication Management for people with Asthma: Medication Compliance 75% (Ages 12-18)	Yes	Half	Quality Compass 90th Percentile	Quality Compass Mean
Behavioral Health	Alcohol and Drug Treatment (Service) Penetration Total (Ages 18-64, All Eligible Enrollees, including IMC, BHSO, AHMC, AHIFC)	No	*Full	Statewide Mean + 1 percentage point	Statewide Mean
	Substance Use Disorder Initiation	No	No Weight	Statewide Mean + 1 percentage point	Statewide Mean
	Substance Use Disorder Engagement	No	No Weight	Statewide Mean + 1 percentage point	Statewide Mean
	Mental Health Treatment (Service) Penetration – Total (Ages 18-64 years, All Eligible Enrollees, including IMC, BHSO, AHMC, AH-IFC)	No	*Full	Statewide Mean + 1 percentage point	Statewide Mean

*In the Contractor's first year of operation under this Contract for Apple Health Integrated Managed Care, the Behavioral Health Measures shall be given a weight of zero.

**The poor HbA1c control CDC measure referenced in Table 5 is a measure where a lower value indicates better performance.

Table 6
Measure Weights, Target Measure Scores and Mean Measure Scores for Withhold
Performance Year 2018

	Quality Measures Description	HEDIS®	Measure Weight	Target Measure	Mean Measure
Adult	Comprehensive Diabetes Care - Poor Hb A1c Control (>9%)**	Yes	SW WA: 11.11% NC: 14.29%	70.77%	54.65%
	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	Yes	SW WA: 11.11% NC: 14.29%	75.73%	59.04%
	Controlling High Blood Pressure (<140/90)	Yes	SW WA: 11.11% NC: 14.29%	70.69%	54.74%
	Antidepressant Medication Management – Effective Acute Phase Treatment	Yes	SW WA: 5.56% NC: 7.14%	67.57%	54.45%
	Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months)	Yes	SW WA: 5.56% NC: 7.14%	54.3%	39.44%
Pediatric	Childhood Immunization Status - Combo 10	Yes	SW WA: 11.11% NC: 14.29%	46.47%	33.24%
	Well-child visits in the 3rd, 4th, 5th and 6th years of life	Yes	SW WA: 11.11% NC: 14.29%	82.97%	71.27%
	Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11)	Yes	SW WA: 5.56% NC: 7.14%	41.18%	28.33%
	Medication Management for people with Asthma: Medication Compliance 75% (Ages 12-18)	Yes	SW WA: 5.56% NC: 7.14%	37.63%	26.33%
Behavioral Health	Alcohol and Drug Treatment (Service) Penetration	No	SW WA: 11.11% NC: 0.00%	PY 2016 Statewide Mean + 1 percentage point	PY 2016 Statewide Mean
	Substance Use Disorder Initiation	No	0.00%	PY 2016 Statewide Mean + 1 percentage point	PY 2016 Statewide Mean
	Substance Use Disorder Engagement	No	0.00%	PY 2016 Statewide Mean + 1 percentage point	PY 2016 Statewide Mean
	Mental Health Treatment (Service) Penetration	No	SW WA: 11.11% NC: 0.00%	PY 2016 Statewide Mean + 1 percentage point	PY 2016 Statewide Mean

**The poor HbA1c control CDC measure referenced in Table 6 is a measure where a lower value indicates better performance.

6. Quality Improvement Score Calculation (“QIS Portion” of the Withhold) for Withhold Year 2020

- 6.1. Washington State Engrossed Substitute House Bill (ESHB) 1109 requires the HCA to annually select performance measures after an analysis by the contracted External Quality Improvement Organization (EQRO). After the contracted EQRO evaluates the change in performance for the selected measures, HCA will then return the Withhold according to the Contractor’s performance when compared to the top national Medicaid quartile; or if it is determined by the EQRO that the change represents a statistically significant improvement. The performance measures identified in Table 7 were selected by HCA for the Contractor’s Withhold Performance Year after EQRO analysis and recommendation. Performance measures are marked according to legislative direction as Common Measures, which are shared quality measures for all AH-IMC Contractors, and MCO-Specific Measures, chosen for individual Contractors. The QIS evaluation will occur in the year following the Withhold Performance Year according to legislation as set out in this Section.
- 6.2. The QIS for Withhold Performance Year 2020 and forward rewards performance for Quality Measures for which the Contractor in the Withhold Performance Year achieves top national Medicaid quartile from the Benchmark Comparison Performance Year, or demonstrates statically significant improvement relative to the Improvement Baseline Performance Year as listed in Table 1.
 - 6.2.1. The QIS = equals the number of measures with either performance in the top quartile or statistically significant improvement, divided by the total number of measures. Measures with sub measures will incorporate sub-measure performance according to the measure weights in Table 7.
 - 6.2.2. The QIS Portion of the Withhold to be earned back is the QIS times 75 percent of the Withhold amount.

Table 7: Performance Measure for Common and MCO-Specific Measures and Measure Weights for Withhold Performance Year 2020

	IMC Quality Measure Description	IMC Quality Sub-measure Description (if applicable)	Measure Steward	Measure Weight	Amerigroup	Coordinated Care of Washington	Community Health Plan of WA	Molina Healthcare	UnitedHealthcare
Common Measures	Antidepressant Medication Management (AMM)	Acute Phase	HEDIS®	Half-weight	X	X	X	X	X
		Continuation Phase	HEDIS®	Half-weight	X	X	X	X	X
	MH Treatment Penetration-Broad Definition - Total (Ages 6+, All Eligible Apple Health Enrollees, including IMC, BHSO, AHMC, AHIFC)		RDA	Full-weight	X	X	X	X	X
	Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	HEDIS®	Half-weight	X	X	X	X	X
		Postpartum care	HEDIS®	Half-weight	X	X	X	X	X
	Asthma Medication Ratio (AMR) - Total		HEDIS®	Full-weight	X	X	X	X	X
MCO-specific Measures	Substance Use Disorder Treatment Penetration - Total (Ages 12+, All Eligible Apple Health Enrollees, including IMC, BHSO, AHMC, AHIFC)		RDA	Full-weight	X	X	X	X	X
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)		HEDIS®	Full-weight	X	X	X	X	X
	Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Initiation Phase		HEDIS®	Full-weight		X	X		
	Comprehensive Diabetes Care (CDC) – Hemoglobin A1c Poor Control (HbA1c >9%)**		HEDIS®	Full-weight				X	X
	Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy		HEDIS®	Full-weight	X				

**The poor HbA1c control CDC measure referenced in Table 7 is a measure where a lower value indicates better performance.

- 6.3. HCA's contracted EQRO will assess the Contractor's performance for the HEDIS measures listed in Table 7. DSHS' Research and Data Analysis (RDA) will assess the Contractor's performance for the RDA measures listed in Table 7.
 - 6.3.1. The Evaluating Entity (EQRO or RDA) will determine if the following criteria are met for each measure. If either are met, the Contractor is allowed the proportion of the Withhold for that measure.
 - 6.3.2. The EQRO will determine if each of the HEDIS scores is equal to or above the 75th national Medicaid percentile benchmark for the year designated in Table 1. RDA will determine if each of the RDA behavioral health statewide measures is equal to or above the HCA-determined benchmark for the year designated in Table 1.
 - 6.3.2.1. For the RDA measures, the HCA-determined benchmark for the Withhold Performance Year is the score of the second-best performing MCO for the Benchmark Comparison Year as designated in Table 1. This establishes the 75th percentile standard for the RDA behavioral health statewide measures.
 - 6.3.3. If the above achievement is not met, the Evaluating Entity will compare the Contractor's performance year score with the Contractor's prior year score and determine whether statistically significant improvement occurred by assessing whether an improvement occurred over the previous score for each measure.
 - 6.3.4. Note that for those specific measures where a lower score indicates better performance, the current performance score must be below the previous year performance to show statistically significant improvement.

7. Payment

- 7.1. On or before October 31 of the year following the Withhold Performance Year, HCA will provide the Contractor with a completed Value-Based Purchasing Withhold Calculation Summary Form provided in Attachment C to notify the Contractor in writing of its percentage of Withhold earned back based on the calculations described this Exhibit.
- 7.2. The Contractor will have 20 calendar days from the date the Contractor is notified of its percentage Withhold earned back to review and sign the Value-Based Purchasing Withhold Calculation Summary Form provided in Attachment C and return to HCA, in writing, any alleged discrepancies with the calculations.
- 7.3. If the Contractor submits in writing any alleged discrepancies with the calculations, HCA will respond in writing to the Contractor within 10 calendar days following HCA's receipt.
- 7.4. HCA will schedule payment for the percentage of the Withhold earned back no later than November 30 of the year following the Withhold Performance Year.

Exhibit D, Attachment C
Value-Based Purchasing Withhold Calculation Summary Form

Contractor/Vendor Name: _____

Contract No: _____

Performance Period: _____ to _____

Percent of qualifying Provider incentive payments tied to quality: _____

Percent of payments in a qualifying Value Based Purchasing Arrangements: _____

Quality Improvement Score: _____

The Contractor earned back _____% of the Value-Based Purchasing Withhold described in Exhibit D.

Washington State Health Care Authority Chief Financial Officer Signature:

Signature Date

Print Name & Title

Email Address: _____

Contractor hereby agrees to the accuracy of this Value-Based Purchasing Withhold Calculation Summary and the underlying calculations.

Contractor Authorized Agent Signature

Signature Date

Print Name & Title

Email Address: _____



ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

Final White Paper

Written by:

Alternative Payment Model Framework
and Progress Tracking (APM FPT) Work Group

For Public Release
Version Date: 1/12/2016

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Executive Summary

The Health Care Payment Learning & Action Network (LAN) was created to drive alignment in payment approaches across the public and private sectors of the U.S. health care system. The CMS Alliance to Modernize Healthcare (CAMH), the federally funded research and development center operated by the MITRE Corporation, was asked to convene this large national initiative.

To advance this goal, the Alternative Payment Models Framework and Progress Tracking Work Group (“the Work Group”) was charged with creating an alternative payment model (APM) Framework (“the APM Framework”) that could be used to track progress towards payment reform. Composed of diverse health care stakeholders, the Work Group has deliberated and reached consensus on many critical issues related to the classification of APMs, resulting in a rationale and a pathway for payment reform that is capable of supporting the delivery of person centered care.

Although the Work Group was not charged with developing a working definition of person centered care, it thought that it was important to do so because it views payment reform as one means for accomplishing the larger goal of person centered care. The Work Group believes that person centered care rests on three pillars: quality, cost effectiveness, and patient engagement. For the purposes of the White Paper, the term is nominally defined as follows: *high quality care that is both evidence based and delivered in an efficient manner, and where patients’ and caregivers’ individual preferences, needs, and values are paramount*. In addition, it should be noted that the opinions expressed within the White Paper are those of the Work Group Members and not of the organizations of which they are affiliated.

The Work Group is committed to the notion that transitioning the U.S. health care system away from fee for service (FFS) and towards shared risk and population based payment is necessary, though not sufficient in its own right, to a value based health care system. Financial incentives to increase the volume of services provided are inherent in FFS payments, and certain types of services are systematically undervalued. This is not conducive to the delivery of person centered care because it does not reward high quality, cost effective care. By contrast, population based payments (including bundled payments for clinical episodes of care) offer providers the flexibility to strategically invest delivery system resources in areas with the greatest return, enable providers to treat patients holistically, and encourage care coordination. Because these and other attributes are very well suited to support the delivery of high valued health care, the Work Group and the LAN as a whole believe that the health care system should transition towards shared risk and population based payments. The Work Group hopes the Framework will be useful in this context to establish a common nomenclature upon which progress can be discussed and measured.

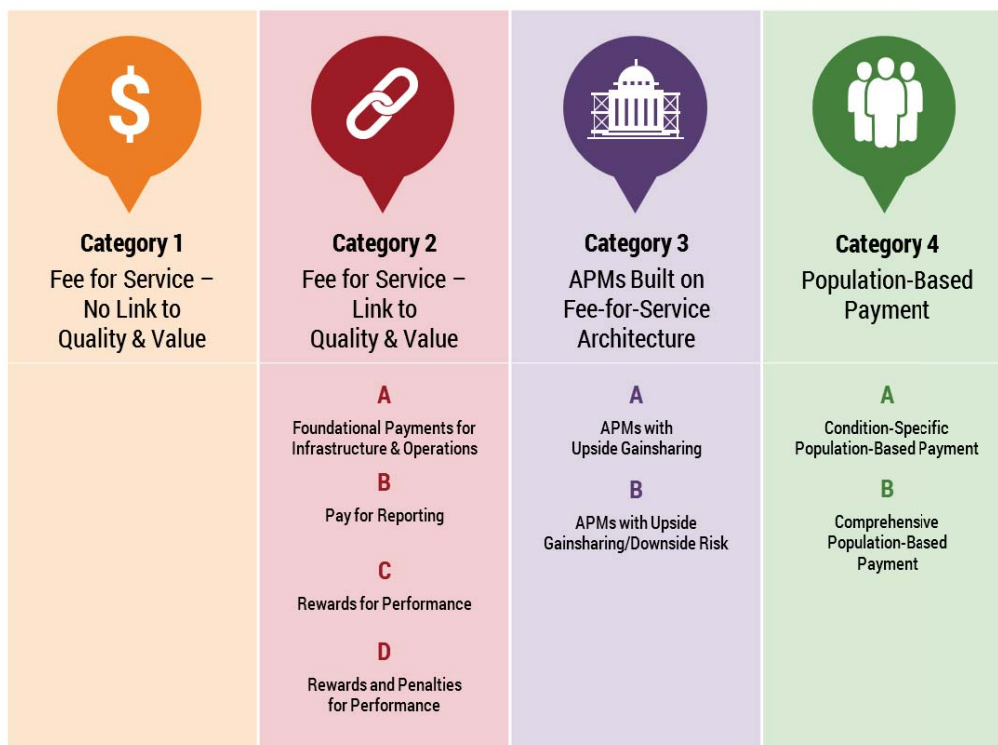
The APM Framework rests on seven principles, which can be summarized as follows:

1. Changing providers’ financial incentives is not sufficient to achieve person centered care, so it will be essential to empower patients to be partners in health care transformation.
2. The goal for payment reform is to shift U.S. health care spending significantly towards population based (and more person focused) payments.
3. Value based incentives should ideally reach the providers that deliver care.
4. Payment models that do not take quality into account are not considered APMs in the APM Framework, and do not count as progress toward payment reform.
5. Value based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.

6. APMs will be classified according to the dominant form of payment when more than one type of payment is used.
7. Centers of excellence, accountable care organizations, and patient centered medical homes are examples, rather than Categories, in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

With these principles in place, the Work Group began with the payment model classification scheme originally put forward by the Centers for Medicare & Medicaid Services (CMS), and subsequently reached a consensus on a variety of modifications and refinements. The resulting Framework is subdivided into four Categories and eight subcategories, as illustrated below:

Figure 1. APM Framework (At-A-Glance)



Overview

A LAN Guiding Committee was established in May 2015 as the collaborative body charged with advancing the alignment of payment approaches across and within the public and private sectors. This alignment will accelerate the adoption and dissemination of meaningful financial incentives to reward providers that deliver higher quality and more affordable care. In alignment with the goals of the U.S. Department of Health and Human Services (HHS), the LAN aims to have 30% of U.S. health care payments in APMs or population based payments by year 2016, and 50% by year 2018.

The Guiding Committee convened the Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group (the “Work Group”) and charged it with creating a Framework for categorizing APMs and establishing a standardized and nationally accepted method to measure progress in the adoption of APMs across the U.S. health care system (the “APM Framework”). The Work Group brought together public and private stakeholders to assess APMs in use across the nation and to define terms and concepts essential for understanding, categorizing, and measuring APMs. (A roster of Work Group members, representing the diverse constituencies convened by the LAN, is provided in [Appendix A](#). Please note that opinions expressed within the White Paper are those of the Work Group Members not of the organizations of which they are affiliated.) The aim of the Work Group is to create a clear and understandable APM Framework, to provide a deeper understanding of payment models and how those models can enhance health and health care, and to provide examples of how public and private payment models are organized within the APM Framework.

The Work Group is aware that CMS is in the process of soliciting recommendations on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Work Group is hopeful that this White Paper will help CMS consider some of the issues involved in implementing MACRA, but stresses that providing formal recommendations on how to do so is explicitly not part of the Work Group’s charge. Although the Work Group is no longer soliciting comments on the White Paper, formal recommendations for implementing MACRA and/or other CMS programs and policies should continue to be made directly to CMS.

Health Care Payment Learning & Action Network (LAN)

To achieve the goal of better care, smarter spending, and healthier people, the U.S. health care system must substantially reform its payment structure to incentivize quality, health outcomes, and value over volume. Such alignment requires a fundamental change in how health care is organized and delivered, and requires the participation of the entire health care ecosystem. To enable these reforms, the Health Care Payment Learning & Action Network (LAN) was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care community. By making a commitment to changing payment models, by establishing a common framework and aligning approaches to payment innovation, and by sharing information about successful models and encouraging use of best practices, the LAN can help to reduce barriers and accelerate the adoption of alternative payment models (APMs).

U.S. Health Care Payments in APMs



The Case for Reforming the Health Care Payment System

The LAN and the Work Group are unanimous in their desire to drive payment approaches that improve the quality and safety of care and the overall performance and sustainability of the U.S. health system. The Work Group, along with many other stakeholders, envisions a health care system that provides person centered care. Recognizing that the Work Group was not charged with developing a comprehensive definition of the term or its constituent components, and that these terms may encompass additional characteristics that are not captured below, the Work Group understands person centered care to mean *high quality care that is both evidence based and delivered in an efficient manner, and where patients' and caregivers' individual preferences, needs, and values are paramount*. The Work Group believes that person centered care, so defined, rests upon three pillars:

- **Quality:** This term indicates that patients receive appropriate and timely care that not only is consistent with evidence based guidelines and patient goals, but also results in optimal patient outcomes and patient experience. Ideally, quality should be evaluated using a harmonized set of appropriately adjusted process, outcome, patient reported outcome, and patient experience measures that both provide an accurate and comprehensive assessment of clinical and behavioral health, and that report results that can be meaningfully accessed, understood, and used by patients and consumers.
- **Cost Effectiveness:** This term indicates a level of severity adjusted total costs (and, when relevant, unit prices) that reflect benchmarked best achievable results, and that are consistent with robust and competitive health insurance marketplaces as characterized by the deployment of multiple affordable, attractive products across employer group, individual commercial, and government programs sectors. Care that is less expensive than expected, but that results in poor clinical outcomes, is not considered cost effective. Conversely, care that is costly but that results in dramatic improvements in patient outcomes could be considered cost effective. Affordable health care services are vital to ensuring that the nation can support investments in education, housing, and other social determinants that can independently improve population health.
- **Patient Engagement:** This term encompasses the important aspects of care that improve patient experience, enhance shared decision making, and ensure that patients and consumers achieve their health goals. Patient engagement should occur at all levels of care delivery, with patients and caregivers serving as partners when setting treatment plans and goals at the point of care; when designing and redesigning delivery and payment models; on governance boards and decision making bodies; and when identifying and establishing connections to social support services. Engaged patients and consumers are informed of their health status and share in their own care; they are easily able to access appointments and clinical opinions; they seek care at the appropriate site; they possess the information they need to identify high value providers and to tailor treatment plans to individual health goals; they provide ongoing feedback that providers can use to improve patient experience; they are able to obtain transparent price information about services and their value for patients and consumers; and they can move seamlessly among providers that are engaged in different aspects of their care. Routine communication with family caregivers and other support members is also a critical part of comprehensive, person centered care.

As evidenced by the creation of the LAN, there is an emerging consensus among providers, payers, patients and consumers, purchasers, and other stakeholders in the health care system that efforts to deliver person centered care have been stymied, in large part, by a payment system that is oriented largely towards volume, as opposed to value for patients and caregivers. These stakeholders and the

Work Group believe that by reconfiguring payments to incentivize value, and by ensuring that valuable activities (e.g., care coordination) are compensated appropriately, providers will be able to invest in care delivery systems that are optimized for the provision of care that is more focused on patient needs. In other words, changes in payment are necessary (though insufficient on their own) to change provider behavior and drive delivery system transformations, thereby ensuring that health care costs reflect appropriate and necessary spending for individuals, government, employers, and other payers.

The Work Group believes that shifting from traditional fee for service (FFS) payments to person focused payments (in which all or much of a person's overall care or care for related conditions is encompassed within a single payment) is a particularly promising approach to creating and sustaining delivery systems that value quality, cost effectiveness, and patient engagement. Such payments should thus include accountability for the quality of care at the population level, rather than for the volume of particular services. Although it is not yet possible to reach a definitive, evidence based conclusion about the impact of population based payments on patient care, there is a belief that these types of payment models are designed in a way that holds substantial promise. This is because person focused, population based payments give providers more flexibility to coordinate and manage care for individuals and populations. In combination with substantially reduced incentives to increase volume, and increased incentives to provide services that are currently undervalued in FFS, there is a consensus that this flexibility will expedite fruitful innovations in care delivery, particularly for individuals with chronic, complex, or costly illnesses.

At present, FFS payments are ill suited for initiating investments and sustaining population health management innovations, such as information technology, clinical decision support tools, patient engagement and care coordination functions, and additional opportunities to increase access to care (e.g., payments for telehealth, home visits, and additional office hours). This is because FFS incentivizes providers to optimize volume. As a result, FFS may at times discourage the perspective that patients require individualized and highly coordinated care. Population based payments may enable providers to develop more innovative approaches to person centered health care delivery because they reward providers that successfully manage all or much of an individual's care. Provided that safeguards are put in place to ensure that quality and patient engagement are not sacrificed to reduce costs, and that the care delivered is state of the art and takes advantage of valuable advances in science and technology, these innovative approaches to health care delivery stand to benefit patients and society alike. Patients may come to expect a more coordinated, more accessible, and more effective health care system, and the nation would benefit from reductions in national health care expenditures, and a healthier, more productive workforce.

The Work Group recognizes that new payment models require providers to make fundamental changes in the way they provide care, and that the transition away from FFS may be costly and administratively difficult. The Work Group also recognizes that participation in shared risk and population based payment models involves financial risk for providers, that not all provider organizations possess the capacity to successfully operate in these payment models, and that providers will need assistance to develop additional capabilities. In order to smooth and accelerate this transition, the Work Group believes that a critical mass of public and private payers must adopt aligned approaches and send a clear and consistent message that payers are committed to a population based health system that delivers the best health care possible. If providers were able to participate in APMs that were consistently deployed across multiple payer networks, this would reduce the administrative burden of making the transition and allow investments to be applied to all patient populations, independent of payer. Aligned payments from a critical mass of payers would enable providers to establish an infrastructure that would increase the likelihood of success for innovative delivery systems over the long term. The Work Group

expects that the adoption and diffusion of these innovative delivery systems should ultimately improve the quality, efficiency, safety, and experience of patient care, while becoming sustainable business models for providers that are eager to take a more comprehensive and coordinated approach to medical practice.

The Work Group believes that a shift to person focused, population based payments will, in concert with other reforms, result in an expansion of high value care in the United States. The Work Group recognizes the possibility that shifts in payment can result in unintended and unanticipated consequences, such as cost increases owing to provider consolidation, reduced provider willingness to exchange data, and a potential reduction in costly but effective medical services. The Work Group believes that it is therefore absolutely essential to monitor the impact of population based payment systems on patient outcomes, health care costs, and other indicators of significance to patients and other stakeholders in the health care system. The Work Group envisions the shift to person focused, population based payment as a course correcting feedback loop between innovation, implementation, and evaluation; it also anticipates that its forthcoming effort to measure progress will help accelerate this process. The Work Group is hopeful this, the first in a series of LAN publications, will help align stakeholders in the public and private sectors and support the implementation of payment systems that promote person centered care.

Purpose of the White Paper

In order to accelerate the transformations described above, the Guiding Committee charged the Work Group with creating an APM Framework through which progress towards payment reform can be described and measured. In addition to providing a roadmap to measure progress, the APM Framework helps establish a common nomenclature and a shared set of conventions that can facilitate discussions among stakeholders and expedite the generation of evidence based knowledge about the capabilities and results of APMs.

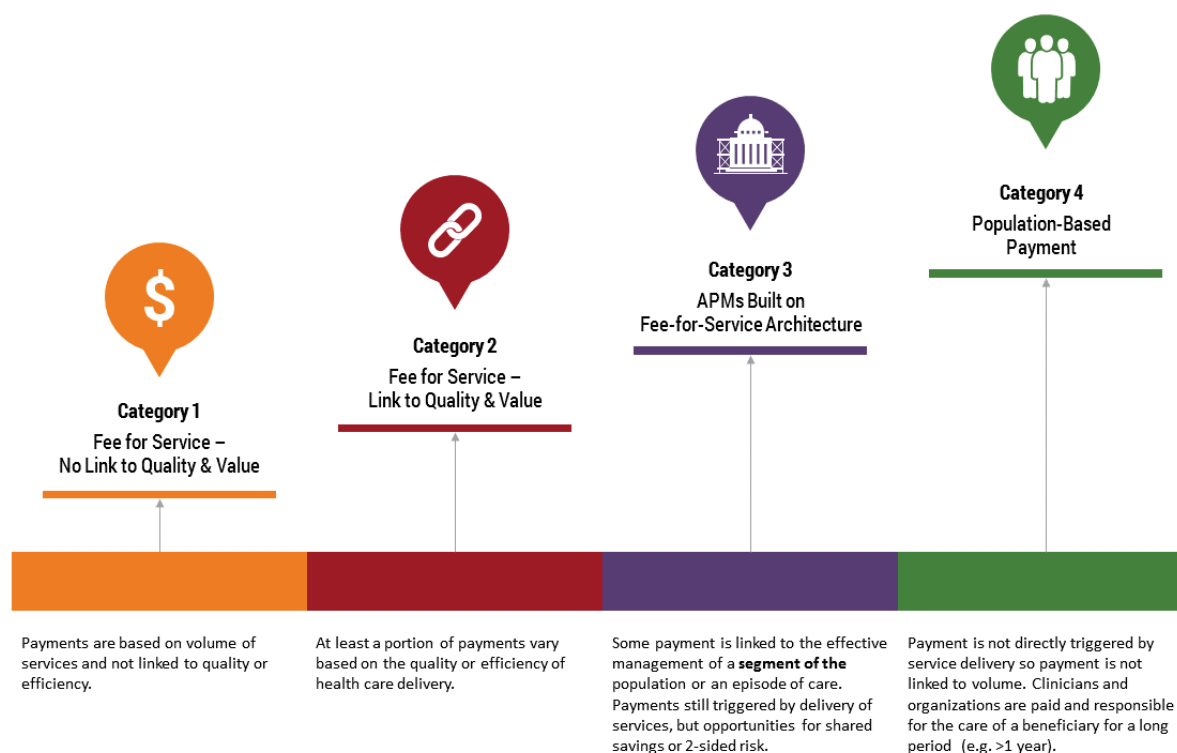
The White Paper begins by describing the approach that the Work Group used to develop the APM Framework, and then describes the principles upon which the APM Framework is based. With these principles in mind, the White Paper differentiates the Categories within the APM Framework by explaining how the Categories are defined and where their boundaries lie. The White Paper concludes with a summary of the Work Group's key findings and recommendations, as well as recommendations for how various stakeholders can use the Framework to accelerate payment reform. To further clarify the classification of individual APMs, the Work Group has separately released a collection of APMs that are currently in use.

Approach

When developing the APM Framework, the Work Group began with the payment model classification scheme that CMS recently advanced,¹ and expanded it by introducing refinements that are described in more detail below. As illustrated in Figure 2, the CMS Framework assigns payments from plans to health care providers to four Categories, such that movement from Category 1 to Category 4 involves increasing provider accountability for both quality and total cost of care, with a greater focus on population health management (as opposed to payment for specific services).

¹ Rajkumar R, Conway PH, Tavenner M. [CMS: Engaging multiple payers in payment reform](#). JAMA. 2014 May 21; 311(19):1967-8.

Figure 2. CMS Payment Framework



The Work Group added to and refined the CMS model by: 1) articulating key principles to explain what the APM Framework does and does not mean to convey; 2) introducing four new Categories to account for payment models that are not considered progress towards payment reform; 3) introducing eight subcategories to account for nuanced but important distinctions between APMs within a single Category; 4) delineating explicit decision rules that can be used to place a specific APM within a specific subcategory; and 5) compiling, with the help of the LAN, examples of APMs that illustrate key characteristics of each of the subcategories.

Key Principles for the APM Framework

The Work Group's Framework is predicated on several key principles. To provide context for understanding the APM Framework and the Work Group's recommendations, these principles are delineated and explained below.

Principle 1: *Changing the financial reward to providers is only one way to stimulate and sustain innovative approaches to the delivery of person centered care. In the future, it will be important to monitor progress in initiatives that empower patients to have a voice in model design, to seek care from high value providers (via performance metrics, financial incentives, and other means), and to become active participants in shared decision making.*

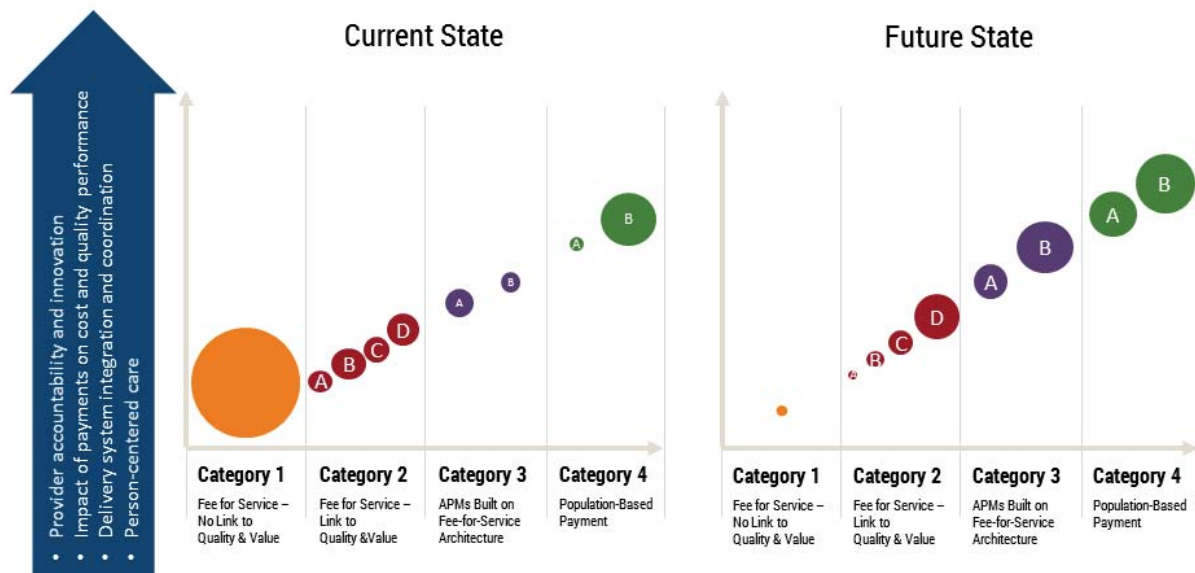
Although it was necessary to focus on financial incentives for providers as a critical first step, the Work Group recognizes that additional efforts to engage patients and consumers will be needed to achieve a high value, coordinated health care system. As more providers begin to participate in payment models that are divorced from traditional FFS, the Work Group expects all stakeholders to collaborate on approaches to empower patients to become active partners as they strive to achieve their health goals. Such approaches may include strategies to clearly and meaningfully communicate, to patients and consumers, information about provider and health plan performance on clinical and patient experience measures; financial rewards for patients and consumers to select high value providers and to successfully manage chronic diseases; and efforts to enlist patients and caregivers as partners in the setting of health goals and the development of treatment plans. In order to avoid unintended consequences associated with APMs, the Work Group also believes it is essential for payment models to include safeguards to prevent selection against individuals with more complex illnesses or a greater need for social support, and that patients and consumers will be informed of providers' financial incentives in APMs. Additional activities and monitoring will also be needed to ensure that the expansion of population based payments does not lead to disparities in health outcomes or to a decline in access to care.

***Principle 2:** As delivery systems evolve, the goal is to drive a shift towards shared risk and population based payment models that incentivize improvements in the quality and efficiency of person centered care.*

The overarching objective of the LAN is to encourage alignment between and within the public and private sectors as the health care system moves away from traditional FFS payment. Consistent with this objective, the Work Group recommends that over time, the U.S. health care system should move concertedly towards APMs in Categories 3 and 4. Nevertheless, the Work Group strongly believes that providers should clearly understand the requirements for financial and clinical participation in APMs, as well as that participation in APMs should be voluntary and that providers should not take on risk that they are not prepared to accept. The Work Group also recognizes that market forces have led to different levels of delivery system organization and integration, and investment in infrastructure and management will be required to build the capabilities that will ensure greater success of more robust population health payments. Therefore, APMs in Categories 3 and 4 will not be readily achievable in every market, for every clinical domain (e.g., dental care), or for every patient population. Furthermore, the Work Group anticipates that some regional markets may be slower to make the transition to these Categories. In particular, the Work Group expects participation in Category 3 and 4 APMs to be more limited for rural providers and for certain small or solo practices. Additionally, the transition may be more challenging for safety net providers, given the broad array of other services needed by their patient populations that are not integrated into health care, unless such services can be better integrated into payment reform.

A more detailed depiction of the Work Group's goals for the health care system appears in Figure 3.

Figure 3. The Work Group's Goals for Health Care Reform



** Note: The values presented in the above "current state" graphic are based on available data on private plans from Catalyst for Payment Reform and Medicare FFS allocations. This graphic is meant to represent the Work Group's belief of how the health care system should change, and it takes into account the likely impact of Medicare's Merit Based Incentive Payment System. The Work Group cautions that values displayed in the graphic are not precise, nor are they intended to lay out specific targets for health care reform.*

In Figure 3, the size of the various circles represents spending across various types of payment models. As Figure 3 illustrates, payments are expected to shift over time from Categories 1 and 2 into Categories 3 and 4. Additionally, the Work Group expects that, over time, APMs within a particular category will increase the extent to which payments are linked to provider accountability, enable more innovation in care, make a greater impact on quality and cost performance, increase coordination in delivery systems, and result in more value based care.

Principle 3: *To the greatest extent possible, value based incentives should reach providers across the care team that directly delivers care.*

Based on the experience of members of the Work Group, payment reforms for quality improvement and cost reduction are most effective when they directly impact payments for providers that are principally responsible for providing care to patients. These incentives are effective because providers delivering patient care are best positioned to develop mechanisms that drive person centered, well-coordinated, and high value care that ultimately lead to better outcomes. For example, an accountable care organization (ACO) that is at risk for cost and quality would ideally design financial incentives for individual physicians and hospitals in a way that aligns with the ACO's incentives as an organization. The Work Group recognizes that it may not always be possible to measure accurately the degree to which incentive payments reach individual practitioners. Nevertheless, the Work Group considers this a best practice and affirms that all delivery systems participating in Category 3 and 4 APMs should commit to

this principle. The Work Group believes that making population based payments to provider organizations that, in turn, pay individual providers on an FFS basis will not harness the full potential of the incentives in the APM.

***Principle 4:** Payment models that do not take quality and value into account will be classified within the appropriate category with a designation that distinguishes them as a payment model that is not value based. They will not be considered APMs for the purposes of tracking progress towards payment reform.*

As illustrated in Figure 4, the APM Framework represents a continuum of payment approaches across four Categories. Category 1 represents FFS payment not linked to quality incentives. Categories 2 through 4 are organized according to the degree to which they advance beyond traditional FFS payment. The Work Group believes strongly that there is limited merit in moving toward population based payments if the resulting payment models do not include incentives to deliver quality health care based on current clinical knowledge. Although the Work Group was not charged with making specific recommendations about what constitutes meaningful quality measurement, it believes that APMs should use harmonized measure sets that include process, clinical outcome, patient reported outcome, and patient experience of care measures. Quality measures should be appropriately adjusted for patient mix, and whenever possible the measures used should be endorsed by professional organizations, the National Quality Forum, the Core Quality Measures Collaborative, and others involved in developing consensus. Measure sets should also be robust enough to provide a comprehensive portrait of a population's clinical and behavioral health. Payment models that represent some movement away from traditional FFS, but that do not take quality (and therefore value) into account, will be placed under the appropriate payment category and marked with an "N" to indicate "No Quality" considerations (e.g., population based payments not linked to value will fall into Category 4N). Accordingly, such models will not be considered to represent progress toward true payment reform, and the Work Group will not track them as part of measuring the achievement of the LAN's goals.

***Principle 5:** In order to reach the LAN's goals for health care reform, value based incentives should be intense enough for providers to invest in and implement delivery reforms, and they should increase over time. However, the strength of incentives does not affect the classification of APMs in the APM Framework.*

The Work Group believes that APMs can be effective stimuli for delivery system change if providers are given meaningful incentives to develop and sustain innovative approaches to care delivery, and it acknowledges that shifting to person focused, population based payment systems will require substantial investments on the part of providers. Accordingly, it is critical that value based incentives be large enough to motivate providers to invest in and adopt new approaches to care delivery, and—over time—to outweigh profits that could be generated by increasing FFS billing. For example, the Work Group believes that a two sided incentive of plus or minus 10% is likely to promote change to a greater extent than a plus or minus 2% incentive. To accelerate and sustain progress throughout the entire health care system, the Work Group also believes that the size of this incentive should grow over time, as providers obtain greater experience in advancing quality while managing costs. A similar principle

applies to the setting of cost and quality benchmarks, in the sense that higher expectations for quality improvements and cost reductions are more effective at stimulating innovative approaches to care delivery.

At this time the Work Group classifies APMs without considering the intensity of the associated incentive payments because it believes that doing so would unnecessarily complicate the APM Framework. Using the example above, an episode based payment with a 10% financial risk/reward is classified the same as an episode based payment with a 2% financial risk/reward. The Work Group believes that more experience and analysis will be needed to determine what the “right” risk/reward level is to promote progress, while also recognizing that it may be different for hospitals and health systems than for physician organizations and health professionals. Nevertheless, the Work Group believes that a minimal threshold of risk and reward should be 5%, but likely greater.

***Principle 6:** For tracking purposes, when health plans adopt hybrid payment models that incorporate multiple APMs, the payment dollars will count towards the category of the most dominant APM. This will avoid double counting payments through APMs.*

The Work Group recognizes that a particular payment model may utilize several APMs concurrently, especially as the model is evolving. For example, an ACO may utilize a shared savings model in years one and two along with nominal pay for performance incentives, and then transition to a shared risk model in year three. For the purpose of tracking progress in such hybrid cases, the entire payment model will be placed in the category that best captures the “dominant” APM (in this case, shared savings for years one and two, and shared risk in year three). It is also possible that bundled payments may be used within gainsharing, shared risk, and population health models, and that a patient centered medical home may be supported by FFS based care coordination fees, pay for performance, and shared savings. In these and other scenarios, payment dollars will count towards the most dominant APM in use, meaning the APM to which the greatest amount of incentive payments are directed.

***Principle 7:** Centers of excellence, patient centered medical homes, and accountable care organizations are delivery models, not payment models. In many instances, these delivery models have an infrastructure to support care coordination and have succeeded in advancing quality. They enable APMs and need the support of APMs, but none of them are synonymous with a specific APM. Accordingly, they appear in multiple categories of the APM Framework, depending on the underlying payment model that supports them.*

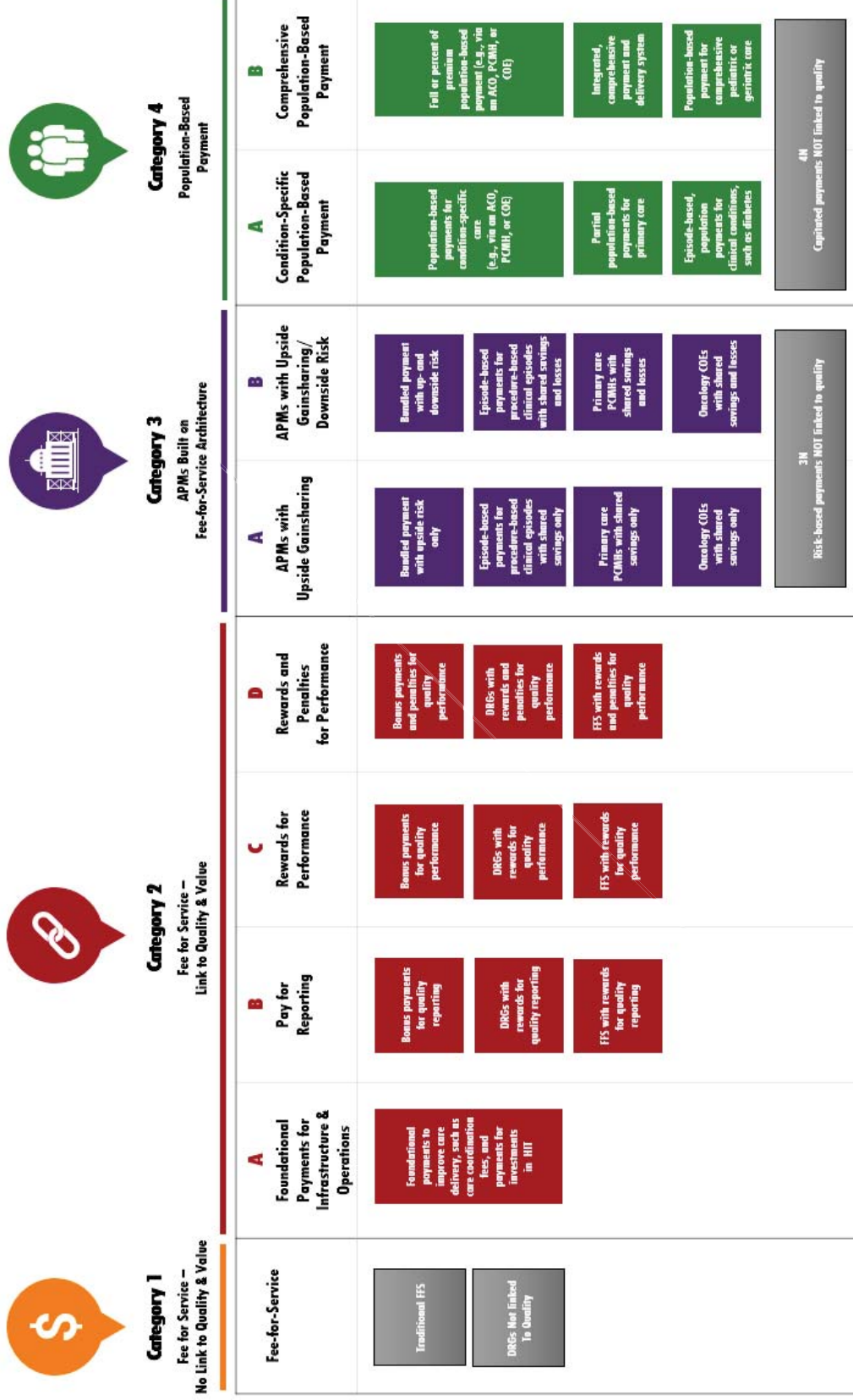
Consistent with the mission of the LAN, the Work Group limited the scope of the APM Framework to payment models, as opposed to delivery models. Because centers of excellence (COEs), patient centered medical homes (PCMHs), and ACOs are delivery models that can accommodate a wide variety of payment arrangements, they will be listed according to their underlying payment arrangement when they appear in the APM Framework. For example, a PCMH that participates in a shared savings/risk model will be classified in Category 3, but a PCMH that receives population based payments linked to value will be classified in Category 4. The Work Group recognizes that PCMHs and ACOs are commonly understood to be associated with risk sharing payment models. Nevertheless, the Work Group strongly

recommends maintaining a clear distinction between concepts that describe payment models and those that describe delivery models. At the same time, the Work Group believes these delivery models have been developed with the goal of driving care coordination and delivery improvements, and will enable more advanced payment models while at the same time requiring more advanced payment models to succeed. In recognition of their dramatic potential to improve the delivery of high quality and efficient health care, the Work Group elected to represent ACOs, PCMHs, and COEs in multiple categories, where corresponding APMs exist today and, likely, in the future.

The APM Framework

The Work Group's APM Framework is depicted in Figure 4. The Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations. The following discussion identifies the organizing principles that serve as the foundation for each Category, explains how the Categories are differentiated, and highlights examples of APMs in each Category. Please note that the examples in Figure 4 are not meant to be exhaustive, but are rather intended to give a sense of possible arrangements in each of the subcategories.

Figure 4. APM Framework



■ = example payment models will not count toward APM goal. N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

① *Fee for Service with No Link to Quality & Value (Category 1):*

Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments are made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor for provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1. This is because the Work Group has determined that DRGs are used to reimburse a group of services delivered within a hospitalization, and while DRGs drive efficiencies in inpatient care, hospitals typically bill DRGs in much the same way that physicians bill services that are paid on a fee schedule. In both instances, the provider's incentive may be to bill for additional services because they are paid more for more volume.

Payments in Category 1 are distinguished from those in Category 2 in that the latter incentivizes infrastructure investments and/or involves some method of reporting or assessing the quality of the care delivered. Unlike payments made in Category 1, payments made in Category 2 are influenced by whether a provider invests in infrastructure, reports quality data, or achieves quality targets.

② *Fee for Service Linked to Quality & Value (Category 2):*

Payment models classified in Category 2 utilize traditional FFS payments (i.e., payments that are made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics.

The Work Group has split Category 2 into subcategories A, B, C, and D as outlined below:

- Payments placed into **Category 2A** involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. For example, payments designated for staffing a care coordination nurse or upgrading to electronic health records would fall under Category 2A. Because investments in these and similar delivery enhancements will likely improve patient experience and quality of care, the Work Group considers these types of FFS or per member per month (PMPM) payments an important—though preliminary—step toward payment reform.
- Payments placed into **Category 2B** provide positive or negative incentives to report quality data to the health plan and—preferably—to the public. Providers may have initial difficulties reporting clinical data accurately. Participation in a pay for reporting program therefore gives providers an opportunity to familiarize themselves with performance metrics, build internal resources to collect data, and better navigate a health plan's reporting system. Because pay for reporting does not link payment to quality performance, the Work Group maintains that participation in Category 2B payment models should be time limited and that participation in Category 2B payment models will often evolve into subsequent categories.
- Payments are placed into **Category 2C** if they provide rewards for high performance on clinical quality measures. Much like pay for reporting programs, pay for performance programs that only reward high performance on quality metrics give providers an opportunity to acclimate themselves to the applicable reporting systems and measures before they are subject to penalties for low performance. In some instances, these programs have an extensive set of performance measures

that assess clinical outcomes, such as a reduction in emergency room visits for individuals with chronic illnesses or a reduction in a hospital acquired infections.

- Payments placed into **Category 2D** reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. For example, providers may receive lower updates to their FFS baseline or may receive a percent reduction on all claims paid if they do not meet quality goals. (Please note that payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets, but may take into account performance on a more limited set of cost measures.)

In addition to their capacity to stimulate and focus quality improvement initiatives, investments in quality performance assessment are also valuable because they can drive the development and expansion of health information technology (HIT). Although the Work Group was not tasked with developing specific recommendations on HIT and data sharing, it believes that providers should invest in interoperable systems; that administrative reporting requirements should be minimized as much as possible; that patients and caregivers should have free and ready access to patient records; and that HIT should be used to maintain patient registries and contribute to the development of clinical measures and guidelines.

As indicated in the discussion above, the Work Group expects that providers receiving Category 2A and 2B payments are investing in the HIT and other infrastructure needed to assess and improve quality performance, and that payments in these categories will be an “on ramp” to participation in subsequent categories. In other words, the Work Group expects that under most circumstances, providers and provider groups will transition quickly into Categories 2C and 2D, though they may do so in different ways. In the private sector, few payment plans support pay for reporting arrangements, and providers often move directly into pay for performance models. By contrast, Medicare pay for reporting programs typically precede and serve as the foundation for pay for performance programs in the same facility setting. Because data from the former determine payment adjustments in the latter, providers paid under that Medicare arrangement are typically eligible to receive both Category 2B and Category 2D payment adjustments. The Work Group stresses that the payment models in Categories 2A through 2C will prepare providers to take on the additional accountability and financial risk associated with APMs in Categories 3 and 4. This concept of Categories 2A and 2B as an “on ramp” for subsequent categories will be assessed as the Work Group measures and tracks progress towards adoption of APMs.

Payments that fall under Category 2 are distinguished from those that fall under Category 3 in two respects. First, Category 2 payments do not involve arrangements in which providers assume either shared savings or shared losses based on established cost targets. Second, FFS based payments in Category 3 reflect, to a greater degree, care that is provided longitudinally, such that multiple providers are responsible for the cost and quality associated with a particular set of procedures or services. By contrast, Category 2 payments are limited to specific providers.

③ *APMs Built on Fee for Service Architecture (Category 3):*

Payment models classified in Category 3 are based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account (as in Category 2), Category 3 payments are based on cost performance against a target, irrespective of how the financial benchmark is established, updated, or adjusted. For APMs in Category 3, providers that meet their cost and quality targets are eligible for shared savings, and those that do not may be held financially accountable.

Additionally, payments in Category 3 are structured to encourage providers to deliver effective and efficient care. Episode based and other types of bundled payments encourage care coordination because they cover a complete set of related services for a procedure that may be delivered by multiple providers. Clinical episode payments fall into Category 3 if they are tied to specific procedures, such as hip replacement or back surgery.

The Work Group has split Category 3 into subcategories A and B as outlined below:

- **Category 3A** gives providers an opportunity to share in the savings they generate. If a provider participating in a Category 3A APM meets quality targets but does not meet cost targets, then the provider is not held financially responsible for excess spending.
- Payments in **Category 3B** involve both upside gainsharing (i.e., positive payment adjustments) and downside risk (i.e., negative payment adjustments) based on performance on cost measures.

Most ACO arrangements today can be placed into either Category 3A (most often) or Category 3B, depending on whether the underlying risk arrangement includes only upside gainsharing or both upside gainsharing and downside risk for providers. The Work Group believes payments in Category 3 will advance clinical integration and affordability to a greater extent than payments in Category 2 because risk sharing arrangements provide stronger incentives to manage health care costs and reward care coordination across the span of care.

The most important distinction between Category 3 and Category 4 payments is that the latter involve a single payment that encompasses a broad array of services, whereas providers participating in Category 3 models are eligible for only a portion of the losses and/or savings they generate. Additional conditions must be met before a payment model can be placed into Category 4. Specifically, Category 4 payments reflect the total cost of care for treating a primary (typically chronic) condition, or for maintaining the health and managing the illness of an entire population. By contrast, even if they are fully capitated, payments that cover a more limited set of specialty services (including primary care) would be classified in Category 3. For example, a Category 4 model for pediatric care would have to cover a wide range of medical, preventive, and developmental services, whereas a population based payment model for primary care would fall under Category 3 if it did not hold primary care providers accountable for care coordination and the appropriate utilization of specialty services. Similarly, clinical episode payments tied to conditions (e.g., diabetes or cancer) fall under Category 4, whereas clinical episode payments tied to procedures (e.g., hip replacement or back surgery) fall under Category 3, even if they are made on a per member per month basis. As such, Category 4 payments are more person focused, insofar as they include stronger incentives to promote health and wellness throughout the care continuum.

④ *Population Based Payment (Category 4):*

Payment models classified as Category 4 involve population based payments, structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined (4A) or overall (4B) budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments within Category 4 are intended to cover a wide range of preventive health, health maintenance, and health improvement services, and these payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Additionally, and in contrast to capitated arrangements in Category 4N, providers participating in Category 4A and 4B APMs are held accountable for delivering high quality, clinically necessary, and appropriate care.

The Work Group has split Category 4 into subcategories A and B as outlined below:

- **Category 4A** payments are limited to certain sets of condition specific services (e.g., asthma, diabetes, or cancer), but they remain person focused in the sense that they hold providers accountable for the total cost and quality of care related to that condition. For example, bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. The Work Group recognizes that in certain instances patient care will predominantly revolve around the management of particular types of conditions, such as cancer or heart disease. In such cases, we recognize that Category 4A may become a suitable and justifiable endpoint, especially for smaller provider organizations which may never be able to deliver certain types of care (such as transplants). Nevertheless, the Work Group maintains that providers should ideally be paid to maintain health and manage illness for an entire population, rather than compartmentalizing payments according to particular conditions. We also believe that condition specific payments should, in time, become part of a comprehensive approach to improving health and reducing costs for an entire population. For highly integrated delivery systems, the Work Group envisions that Category 4A payments will evolve into Category 4B.
- Payments in **Category 4B** are capitated or population based for all of the individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements with varying degrees of integration between plans and provider groups. On one end of the spectrum, plans and providers in Category 4B models may be virtually integrated. On the other end of the spectrum are highly integrated arrangements that are characterized by vertical integration of financing and care delivery, common ownership, and strong linkage across strategy, clinical performance, quality, and resource use. These groups may also have a higher percentage of salaried physicians. After reviewing the literature and discussing these highly integrated arrangements with people who operate within them, the Work Group has reached the conclusion that they can be ideally suited for delivering person centered care because they: 1) force transformational thinking about delivery system reform; 2) optimize coordination of infrastructure investments; 3) most fully remove financial incentives for volume; and 4) expedite community investment and engagement. Although the underlying payment approaches were not sufficiently distinct to warrant the creation of a separate subcategory for highly integrated payment and delivery systems, the Work Group believes that these arrangements yield key benefits and efficiencies, because they have a greater impact on organizational responses to quality and value incentives.

Category 4 represents the furthest departure from traditional FFS payments, while simultaneously ensuring that providers possess the strongest possible incentives to deliver high quality and efficient care. Nevertheless, the Work Group recognizes that not every market currently is suited to support APMs in Category 4, and that the journey to Category 4 will occur along different trajectories in different markets, based in significant part on the organization of care delivery systems.

Conclusion

As set forth in this document, the Work Group is committed to the concept that transitioning from FFS to population based payments is critical for health care transformation. Keeping in mind the underlying principles, the APM Framework provides a high level mapping of payment approaches, as well as a pathway for payment reform and a foundation for measuring progress. The Work Group envisions that these mappings will be useful for all stakeholders and prove enduring as they navigate the health care ecosystem.

While the Work Group believes that this Framework identifies and encompasses all models of payment reform and will be enduring, Work Group members hope to return to the White Paper at a later date to take into account new developments in the health care sector. Nevertheless, the Work Group intends the APM Framework to be robust enough to accommodate foreseeable changes, and it strongly believes that this should become the overarching framework for discussing and evaluating payments in the U.S. health care system. The LAN intends to continue compiling and periodically releasing case studies of payment models. (See APM Framework White Paper Addendum.) The Work Group believes this is important because it will disseminate lessons learned and provide the nation with models to consider as public and private plans align around common payment approaches.

Stakeholders and the APM Framework

Patient Advocacy Groups can use the APM Framework to understand the context behind plan and benefit design so that they can identify and communicate desirable elements and become empowered to participate in decisions about how to design payment plans and delivery systems.

Providers can use the APM Framework to make sense of the types of payment reforms underway, to achieve a better understanding of where they are situated, to begin to conceive of where they might like to end up, and—most importantly—to plan for the future.

Plans can use the APM Framework to drive payment and contracting models and as an accounting tool to track spending and the distribution of members/beneficiaries and providers. This is crucially important, because adopting a common classification scheme would represent a first step towards the alignment of payment approaches.

Purchasers can use the APM Framework to engage and educate their employees about the health insurance landscape and to share information for population based plans, along with the safeguards and benefits that would tip them towards enrolling in such plans.

Appendix A: Work Group Members and Staff

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CAMH, sponsored by CMS, is an FFRDC operated by The MITRE Corporation. MITRE is chartered to work in the public interest.

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Table 1
Positive QS(i) and IS(i) - Score Values for Lookup

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Exhibit E

Challenge Pool Value-Based Purchasing Incentives

1. Value-Based Purchasing Incentives

- 1.1. As outlined in HCA's Value-Based Roadmap and Apple Health Appendix, which can be found on HCA's website and is incorporated by reference, funding will be available under the terms of this Exhibit to encourage the transition among MCOs to Alternative Payment Models (APMs). This Exhibit describes the funds that are available and the conditions under which these funds may be earned, including reporting requirements and the performance measures that will be used.
- 1.2. All incentive arrangements are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy.
- 1.3. The Challenge Pool described in this Exhibit, and from which all funds earned under this Exhibit will be drawn, is a pool of funding that will be distributed annually based on reporting and performance metrics that are defined under HCA's Apple Health Contracts, including Apple Health Managed Care, Apple Health Integrated Managed Care, and Apple Health Foster Care contracts. Where more than one of these contracts is effective between HCA and the Contractor, the amount earned under this Exhibit will not be calculated separately for each contract, but will be calculated as a single payment to the Contractor based on data aggregated from each of the Contractor's Apple Health Contract(s). Each Apple Health Contract includes the same Challenge Pool Exhibit, describing the same pool of funding and set of conditions under which these funds may be earned.
- 1.4. The funding that the Contractor is eligible to receive under this Exhibit draws from annual Delivery System Reform Incentive Payment System (DSRIP) funds via the Healthier Washington Medicaid Transformation (Medicaid Transformation) may be earned under Sections 2, 3 and 4 of this Exhibit. The Total Available Funds per year is set out in Table 1 of this Exhibit. The amounts in Table 1 are subject to amendment by HCA without prior notice to the Contractor and subject to the availability of state and federal funding.
- 1.5. The Base Earnable Funds (BEF) is the amount that the Contractor can earn under Sections 2 and 3 of this Exhibit. The BEF will be a share of the annual DSRIP Funds based on the Contractor's share of the total attributed member months under signed Apple Health Contracts for the year. The Contractor's BEF shall be calculated as the Contractor's attributed state-wide managed care member months for the Performance Year divided by the state wide managed care member months for the Performance Year, multiplied by total state-wide DSRIP Funds available for that Performance Year. The Contractor's Base Earnable Funds for the Performance Year may be earned on two bases, referred to as Pay for Reporting (P4R) and Pay for Performance (P4P).
- 1.6. In the event that the Contractor or any other HCA-contracted Apple Health MCO does not earn the full BEF that have been allocated to it for a Performance Year under the P4R and P4P terms set out in the Apple Health Contracts, the unearned Challenge Pool Remaining Funds will be distributed to the MCOs using a formula that accounts for the MCO's achievement related to high level APMs (HCP LAN

Categories 3A-4B) as well as the MCO's Quality Improvement Score (QIS) as calculated under the Contractor's Apple Health Contract(s). The conditions under which the Contractor may earn these Challenge Pool Remaining Funds are set out in Section 4 of this Exhibit.

- 1.7. For purposes of this Exhibit, reporting and measurement relating to the adoption of APMs will be based on the APM categorization set out in the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework Final Whitepaper version dated January 12, 2016, attached as Attachment A (Whitepaper) of the VBP Exhibit. The performance measures will assess the percentage of Contractor payments to providers that fits into each APM category under the Whitepaper.
- 1.8. The Challenge Pool will operate over the five-year period as set out in Table 1. Table 1 shows the relevant time periods, and the division of funding in each year between P4R and P4P.

Table 1
Performance Years, Time Periods and Thresholds

Time Periods			Funding			
Year	Performance Year	Improvement Baseline Year	Total Available (millions)	Base Earnable Funds (BEF)	P4R Portion of BEF	P4P Portion of BEF
PY1	1/1/17 – 12/31/17	1/1/16 – 12/31/16	\$0	\$0	75%	25%
PY2	1/1/18 – 12/31/18	1/1/17 – 12/31/17	\$8	TBD	50%	50%
PY3	1/1/19 – 12/31/19	1/1/18 – 12/31/18	\$8	TBD	25%	75%
PY4	1/1/20 – 12/31/20	1/1/19 – 12/31/19	\$8	TBD	0%	100%
PY5	1/1/21 – 12/31/21	1/1/20 – 12/31/20	\$8	TBD	0%	100%

- 1.9. The conditions for earning full or partial payment of the funds identified in Table 1 are set out below.
- 1.10. During the Performance Year, the Contractor may, at its discretion, seek feedback from HCA on whether provider payment arrangements qualify as APMs that will result in earned Challenge Pool funds.

2. Pay for Reporting (P4R)

- 2.1. The Pay for Reporting (P4R) portion of the Base Earnable Funds will be available to the Contractor for the complete and timely reporting of data required to assess the Contractor's progress toward meeting performance targets. The amount of the P4R portion of Base Earnable Funds will be determined by HCA as set out in Table 1.
- 2.2. The required data to be submitted under this Section is set out in the VBP Exhibit to the Contractor's Apple Health Contract(s) with HCA. All terms for the submission of data in the VBP Exhibit identified in this subsection are applicable

here and must be met for HCA to deem that the Contractor has met the terms of this Section.

- 2.3. If all requirements are met under this Section, then the full amount of the P4R portion will be due to the Contractor. If all requirements under this Section are not met, then no funds will be paid to the Contractor under this Section.

3. Pay for Performance (P4P)

- 3.1. The Pay for Performance (P4P) portion of Base Earnable Funds will be available to the Contractor based on its performance in adopting Alternative Payment Models as set out in this Section. The amount of the P4P portion of Base Earnable Funds will be determined by HCA as set out in Table 1.
- 3.2. The amount of the P4P Portion of the Base Earnable Funds that the Contractor earns will be determined by a model that incorporates attainment of thresholds and targets, and improvement over the Contractor's APM adoption levels in the Baseline Year. Each of these elements is set out in Table 2.

Table 2
P4P Weights, Targets and Thresholds

Year	Performance Targets & Thresholds			Calculation Weight		
	HCP LAN 2C-4B Target	HCP LAN 3A-4B Threshold Score*	MACRA A-APMs Target	Achievement Score	Achievement Subset Score	Improvement Score
PY1	30%	N/A	N/A	40%	0%	60%
PY2	50%	10%	N/A	35%	5%	60%
PY3	75%	20%	10%**	45%	5%	50%
PY4	85%	30%	10%	50%	5%	45%
PY5	90%	50%	TBD	55%	5%	40%

* In all years the HCP LAN 3A-4B Threshold Score applies under Section 4 of this Exhibit. In PY4 and PY5 the HCP LAN 3A-4B Threshold Score is additionally applicable under subsection 3.3.5 of this Exhibit.

**This percentage is subject to approval by the Centers for Medicare and Medicaid Services (CMS).

- 3.3. By meeting each of the Performance Targets and Thresholds set out in Table 2, the Contractor can earn all or part of the P4P portion of the Total Earnable Funds available to the Contractor. HCA will determine the amount of Base Earnable Funds that the Contractor can earn as follows.

- 3.3.1. The Contractor's Achievement Percentages for the Performance Year will be established using the data submitted by the Contractor and validated as set out in the Contractor's Apple Health Contract(s), the definition of "Assessed Payments," and other terms included in Contractor's Apple Health Contract(s). VBP adoption Achievement Percentages are measured as the share of MCO Assessed Payments to providers via one or more specified APMs out of total MCO Assessed Payments to providers. For purposes of these measures, MCO Assessed Payments by category of APM and total MCO Assessed

Payments to providers will be aggregated across Contracts identified in this subsection. Failure to provide data by the deadlines set out in any of the Contracts referenced in this subsection may result in loss of eligibility to earn any funds under this Exhibit.

3.3.2. Achievement Score: In each Performance Year HCA will calculate an Achievement Score for the Contractor. The Contractor will have reached or exceeded the HCP LAN 2C-4B Target for the Performance Year (AS Item 1) if the Contractor's Achievement Percentage for HCP LAN categories 2C-4B is equal to or greater than the HCP LAN 2C-4B Target for the Performance Year. The Contractor will have reached or exceeded the HCP LAN 3A-4B Threshold Score for the Performance year (AS Item 2) if the Contractor's Achievement Percentage for HCP LAN categories 3A-4B is equal to or greater than the HCP LAN 3A-4B Target for the Performance Year. The Contractor will have reached or exceeded the MACRA A-APMs Target for the Performance Year (AS Item 3) if the Contractor's Achievement Percentage for MACRA A-APMs is equal to or greater than the MACRA A-APMs Target for the Performance Year.

3.3.2.1. For PY2: If the Contractor has reached or exceeded the HCP LAN 2C-4B Target for the Performance Year (AS Item 1), then the Achievement Score will be 100 percent. If not, the Achievement Score shall be zero percent.

3.3.2.2. For PY3, PY4 and PY5: The Achievement Score will consist of three additive parts. If the Contractor has reached or exceeded AS Item 1 under subsection 3.3.2 for the Performance Year, the Contractor earns 50 percent toward the Achievement Score. If the Contractor has reached or exceeded AS Item 2 under subsection 3.3.2 for the Performance Year, the Contractor earns 40 percent toward the Achievement Score. If the Contractor has reached or exceeded AS Item 3 for the Performance Year, the Contractor earns 10 percent toward the Achievement Score. For instance, if the Contractor has reached or exceeded AS Item 1 and AS Item 3, but not AS Item 2, then the Achievement Score shall be 60 percent for the Performance Year (50 percent + 10 percent). If the Contractor has not reached or exceeded any of the three AS Items for the Performance Year, then the Achievement Score shall be zero percent.

3.3.3. Achievement Subset Score: In PY2, PY3, PY4, and PY5 HCA will assess whether the Contractor has met an annual Subset Attainment Target. In PY2, the Subset Attainment Target requires that the Contractor have at least one VBP contract in HCP-LAN category 3B or above. In PY3, the Subset Attainment Target additionally requires that the Contractor achieve certification from CMS for at least one VBP arrangement as an Other Payer Advanced Alternative Payment Model under the MACRA Quality Payment Program. In PY4 and PY5 at least one VBP contract in category 3B or above and including at least one of the following features: 1) More than nominal risk for shared losses, 2) Payments tied to provider improvement or attainment on statewide common measure set using

HCA quality Improvement model or similar tool, 3) care transformation requirements including state-level best practices, or 4) use of certified EHR technology in support of VBP methods. A single contract may satisfy more than one requirement in this subsection. If the Contractor has met the Subset Attainment Target for the Performance Year, then the Achievement Subset Score will be 100 percent, and if the Contractor has not met the Subset Attainment Target for the Performance Year, then the Achievement Subset Score will be zero percent.

- 3.3.4. Improvement Score: In each Performance Year HCA will calculate an Improvement Score for the Contractor. If the Contractor has met the HCP LAN 2C-4B Performance Target for the Performance Year, then the Improvement Score shall be 100 percent. If the Contractor has not met the HCP LAN 2C-4B Performance Target for the Performance Year, then the Improvement Score shall be calculated as the percent change from the Improvement Baseline Year achievement percentage for HCP LAN 2C-4B to the Performance Year achievement percentage for HCP LAN 2C-4B such that Improvement Score = (Performance Year Achievement Percentage – Improvement Baseline Year Achievement Percentage) / Improvement Baseline Year Achievement Percentage). Where the prior calculation produces a negative percentage, the Improvement Score shall be zero percent. The Improvement Score is capped at 100 percent.
- 3.3.5. HCP LAN 3A-4B Threshold Score: An achievement threshold applies in years four and five for HCP LAN 3A – 4B such that no funds under the P4P portion of Base Earnable Funds may be earned by the Contractor unless the threshold is met.
- 3.3.6. In each year, the Contractor's total P4P Score will be calculated as follows. First, the Achievement Score, Achievement Subset Score, and Improvement Score will each be multiplied by their respective weights as set out in Table 2. The resulting products will be summed to produce the provisional P4P score. In PY2 and PY3 the provisional P4P score will be the final P4P score for the Contractor. In PY4 and PY5 the provisional P4P score will be the final P4P score for the Contractor if the Contractor has met the HCP LAN 3A-4B Threshold Score, but if the Contractor has not met the HCP LAN 3A-4B Threshold Score then the final P4P score will be zero percent. In all years the final P4P score will range from zero percent to 100 percent.
- 3.3.7. The Contractor's final P4P Score will represent the percent of the P4P Portion of the Contractor's Base Earnable Funds that the Contractor is eligible to receive.

4. Remaining Challenge Pool Funds Share

- 4.1. If funds remain in the Challenge Pool for a given Performance Year as described in subsection 1.6 of this Exhibit, the Challenge Pool Remaining Funds will be distributed as set out in this Section.
- 4.2. Each MCO with Apple Health Contract(s), will be eligible to earn a Challenge Pool Remaining Funds Share that is determined by two factors as follows.
 - 4.2.1. HCP LAN 3A-4B Threshold Score: First HCA will determine if the MCO

has met the HCP LAN 3A-4B Threshold Score for the Performance Year set out in Table 2. To make this determination, HCA will use the data and methodology outlined in subsection 3.3.1 of this Exhibit to establish the HCP LAN 3A-4B achievement percentage for the MCO. If the MCO's annual HCP LAN 3A-4B achievement percentage is less than the annual HCP LAN 3A-4B Threshold Score then the Challenge Pool Remaining Funds Share for the MCO will be zero percent of the Challenge Pool Remaining Funds. If the MCO's annual HCP LAN 3A-4B achievement percentage is equal to or greater than the annual HCP LAN 3A-4B Threshold Score then the Challenge Pool Remaining Funds Share shall be calculated under subsection 4.2.2 below.

4.2.2. Relative QIS Adjusted for Relative Membership: Second, if the MCO has met the HCP LAN 3A-4B Threshold Score for the Performance Year then the MCO will receive a percentage of the Challenge Pool Remaining Funds that is determined by the relative magnitude of each MCO's all-contract QIS score established under the Contractor's Apple Health Contract(s), adjusted for attributed member months per MCO.

4.2.2.1. To calculate the Contractor's all-contract QIS score, HCA will calculate an average of the Contractor's QIS score calculated under the Contractor's Apple Health Contract(s), weighted by the share of Apple Health Managed Care Member Months attributable to each contract for the Performance Year. The same methodology will be used to calculate an all-contract QIS score for each of HCA's contracted Apple Health MCOs.

4.2.2.2. The all-contract QIS scores of all MCOs that meet the HCP LAN 3A-4B Threshold Score will be summed to find the Challenge Pool Remaining Funds Denominator. For each MCO that meets the HCP LAN 3A-4B Threshold Score, the preliminary Challenge Pool Remaining Funds Share for the MCO shall then be calculated as the all-contract QIS for the MCO divided by the Challenge Pool Remaining Funds Denominator times the total Challenge Pool Remaining Funds under subsection 1.6 of this Exhibit. Finally, the preliminary Challenge Pool Remaining Funds Share for the MCO will be adjusted for attributed member months to produce the final Challenge Pool Remaining Funds Share for the MCO. For this adjustment, HCA will multiply the preliminary Challenge Pool Remaining Funds Share by a Member Months Index and readjust the resulting product for each qualifying MCO on a proportional basis so that the percentage share for all MCOs adds up to 100 percent of Challenge Pool Remaining Funds.

4.2.2.3. The Member Months Index referenced in subsection 4.2.2.2 will be calculated for each MCO by dividing attributed member months for the MCO over the Performance Year by the average MCO attributed member months over the Performance Year.

5. Payment

- 5.1. The total amount that the Contractor is eligible to receive under this Exhibit will be the sum of the amounts earned under Sections 2 and 3 of this Exhibit for Reporting (P4R) and Performance (P4P), plus the Challenge Pool Remaining Funds Share for the Contractor under Section 4 of this Exhibit.
- 5.2. On or before October 30th following the end of each Performance Year, HCA will provide the Contractor with a completed Challenge Pool Calculation Summary Form provided in Attachment 1 to this Exhibit to notify the Contractor in writing of its Challenge Pool Value-Based Purchasing Incentives Earned based on the calculations described in this Exhibit.
- 5.3. The Contractor will have 20 calendar days from the date the Contractor is notified of its Challenge Pool Value-Based Purchasing Incentives Earned to review and sign the Challenge Pool Calculation Summary Form provided in Attachment 1 to this Exhibit and return to HCA, in writing, of any alleged discrepancies with the calculations.
- 5.4. If the Contractor submits in writing any alleged discrepancies with the calculations, HCA will respond in writing to the Contractor within 10 calendar days following HCA's receipt.
- 5.5. HCA will schedule payment for the percentage of the Challenge Pool Value-Based Purchasing Incentives Earned no later than June 30th following the receipt of Challenge Pool Calculation Summary Form.

Exhibit E, Attachment 1
Challenge Pool Calculation Summary Form

Contractor/Vendor Name: _____

Contract No: _____

Performance Period: _____ to _____

Base Earnable Funds

Base Earnable Funds for Performance year: _____

P4R Portion For Performance Year: _____

P4P Portion For Performance Year: _____

P4R

All Reporting requirements met: _____

Reporting elements not met: _____

Percent of P4R Portion of Base Earnable Funds Earned: _____

P4P

Assessed Payments

Total Assessed Payments: _____

Assessed Payments Categories 2C-4B: _____

Assessed Payments Categories 3A-4B: _____

Percent of all-contract payments in Categories 2C-4B

Performance Year: _____

Improvement Baseline Year: _____

All Subset Attainment Target Requirements Met: _____

Thresholds Met or Not Applicable for Performance Year: _____

Achievement Score: _____

Performance Weight: _____

Achievement Subset Score: _____

Achievement Subset Weight: _____

Improvement Score: _____

Improvement Weight: _____

Performance Threshold Score: _____

Percent of P4P Portion of Base Earnable Funds Earned: _____

Challenge Pool Remaining Funds and Share

Challenge Pool Remaining Funds Available to all HCA MCOs: _____

Contractor's all-contract QIS Score: _____

Challenge Pool Remaining Funds Denominator: _____

Member Months Index: _____

Percent of all-contract Assessed Payments in Categories 3A-4B: _____

HCP-LAN 3A-4B Threshold Score for Performance Year: _____

HCP-LAN 3A-4B Achievement Score for Performance Year: _____

Percent of Challenge Pool Remaining Funds Earned: _____

Totals

P4R Funds Earned: _____

P4P Funds Earned: _____

Challenge Pool Remaining Funds Share: _____

Total Challenge Pool Value-Based Purchasing Incentives Earned: _____

Washington State Health Care Authority Chief Financial Officer Signature:

Signature

Date

Print Name & Title

Email Address

Contractor hereby agrees to the accuracy of this Challenge Pool Calculation Summary and the underlying calculations.

Contractor Authorized Agent Signature

Signature

Date

Print Name & Title

Email Address

Exhibit F
Washington State Health Care Authority
Instructions for MLR Reporting
Apple Health Fully Integrated Managed Care

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Introduction

These instructions are for the Excel-based MLR Reporting Template. The Excel workbook is designed to collect all information needed for MLR reporting as required by CMS in 42 CFR §438.8. The federal rule regarding MLR requires that all Medicaid managed care contracts require the contracted managed care organizations to calculate and report a MLR.

The MLR Reporting Template is to be completed and submitted to the Health Care Authority (HCA) via MC-Track by May 31st of the year following the MLR reporting year.

If the state were to make a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit new MLR reports to the state for all impacted reporting years.

Throughout these instructions there will be references to the 2016 Medicaid/CHIP Managed Care Final Rule and other regulations. All regulations are part of 42 CFR unless cited otherwise. The information requested by the report follow regulation [§ 438.8\(k\)](#).

General Requirements

The Contractor will aggregate data for all Medicaid eligibility groups covered under this contract unless the state requires separate reporting and a separate MLR calculation for specific populations. If the data is aggregated, a description of the aggregation method used to calculate total incurred claims for each reporting year.

The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

Plan Information

Please fill out the contact information of your MCO.

Numerator

This worksheet collects information for items that are included or deducted from the numerator. Note that incurred claims by one MCO that is later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

The expenditures reported by the Contractor shall include non-claims costs and expenditures related to activities compliant with program integrity requirements 438.608(a)(1) - (5); 438.608(a)(7) - (8); and 438.608(b).

Please fill in the cells that are formatted with blue font.

Detail for each line can be found here:

NUMERATOR: INCURRED CLAIMS

Line 1.1 Incurred claims, including unpaid claim liabilities for the MLR reporting year: Note that this amount should be net of all fraud recoveries, including what is reported in or out of the claims system. See §§ [438.8\(e\)\(2\)\(i\)\(A\)](#) and [438.8\(e\)\(2\)\(i\)\(B\)](#):

(A) Direct claims that the MCO paid to providers for services or supplies covered under the contract and services meeting the requirements of § [438.3\(e\)](#) provided to enrollees.

(B) Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

Line 1.2 Incurred but not reported (IBNR) for claims incurred in the period expected to be paid in months after the known runout. This requires the MCO to estimate the cost of claims owed but not yet received. See § [438.8\(e\)\(2\)\(i\)\(F\)](#)

Line 1.3 Withholds from payments made to network providers: See § [438.8\(e\)\(2\)\(i\)\(C\)](#)

Line 1.4 Amount of incentive and bonus payments made, or expected to be made, to network providers: See § [438.8\(e\)\(2\)\(iii\)\(A\)](#)

Line 1.5 Changes in other claims-related reserves: See § [438.8\(e\)\(2\)\(i\)\(G\)](#)

Line 1.6 Reserves for contingent benefits and the medical claim portion of lawsuits: See § [438.8\(e\)\(2\)\(i\)\(H\)](#)

Line 1.7 Net payment or receipts related to state-mandated solvency funds: See § [438.8\(e\)\(2\)\(iv\)](#)

Line 1.8a Amount spent on fraud reduction: See § [438.8\(e\)\(2\)\(iii\)\(B\)](#)

The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include fraud prevention activities specified in paragraph (e)(4) of this section. § [438.8\(e\)\(4\)](#): *Fraud prevention activities. MCO expenditures on activities related to fraud prevention as adopted for the private market at [45 CFR part 158](#). Expenditures under this paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section.*

Line 1.8b Amount of claims payments recovered through fraud reduction: See also Line 1.8a.

Items Deducted from Incurred Claims

Line 1.9 Claims that are recoverable for anticipated coordination of benefits (payments from third party payors): See § [438.8\(e\)\(2\)\(i\)\(D\)](#)

Line 1.10 Claims payments recoveries received as a result of subrogation: See § [438.8\(e\)\(2\)\(i\)\(E\)](#)

Line 1.11 Overpayment recoveries received from network providers: The State expects this to include any anticipated settlements for claims incurred during the MLR reporting year, including those outside of the claims system. See § [438.8\(e\)\(2\)\(ii\)\(A\)](#)

Line 1.12 Prescription drug rebates received and accrued: See § [438.8\(e\)\(2\)\(ii\)\(B\)](#)

NUMERATOR: ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY

Line 2.1 MCO activity that meets [45 CFR § 158.150\(b\)](#) and is NOT EXCLUDED under [45 CFR § 158.150\(c\)](#): See § [438.8\(e\)\(3\)\(i\)](#)

Line 2.2 MCO activity related to any EQR-related activity as described in §§ [438.358\(b\)](#) and [438.358\(c\)](#): See § [438.8\(e\)\(3\)\(ii\)](#)

Line 2.3 MCO expenditure that is related to Health Information Technology and meaningful use: See § [438.8\(e\)\(3\)\(iii\)](#)

Excluded Non-Claim Costs

This worksheet collects information for items excluded from the numerator, but is required to be reported. Note that incurred claims by one MCO that are later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

Line 3.1 Amounts paid to third party vendors for secondary network savings: See § [438.8\(e\)\(2\)\(v\)\(A\)\(1\)](#)

Payments made by one managed care plan to another vendor to purchase their network for use as a secondary network. In practice, the managed care plan purchases another managed care plan's network to serve as contracted, out-of-network providers so as to

avoid single-case agreements with those providers, resulting in savings on out-of-network service costs.

Line 3.2 Amounts paid to third party vendors for network development, admin fees, claims: processing, and utilization management: See § [438.8\(e\)\(2\)\(v\)\(A\)\(2\)](#)

Line 3.3 Amounts paid to a provider for professional or administrative services outside of providing services to enrollees: See § [438.8\(e\)\(2\)\(v\)\(A\)\(3\)](#)

Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

§ 438.3(e): See Line 1.1

Line 3.4 Fines and penalties assessed by regulatory authorities: See § [438.8\(e\)\(2\)\(v\)\(A\)\(4\)](#)

Line 3.5 Amounts paid to the State as remittance for prior MLR experience: See § [438.8\(e\)\(2\)\(v\)\(B\)](#)

Remittance to the State if specific MLR is not met.

Line 3.6 Amounts for pass-through payments under § [438.6\(d\)](#): See § [438.8\(e\)\(2\)\(v\)\(C\)](#)
Amounts paid to network providers under to § [438.6\(d\)](#).

Denominator

DENOMINATOR: PREMIUM REVENUE

This worksheet collects information for the denominator. Note that the total amount of the denominator for a MCO, which is later assumed by another entity, must be reported by the assuming MCO for the entire MLR reporting year, and no amount for that year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

Line 4.1 State capitation payments, including adjustments, excluding pass-through payments: See § [438.8\(f\)\(2\)\(i\)](#)

State capitation payments, developed in accordance with § [438.4](#), to the MCO for all enrollees under a risk contract approved under § [438.3\(a\)](#), excluding payments made under to § [438.6\(d\)](#).

Line 4.2 State developed one time payments for specific life events of enrollees: See § [438.8\(f\)\(2\)\(ii\)](#)

Line 4.3 Earned premium withholds approved under § [438.6\(b\)\(3\)](#): See § [438.8\(f\)\(2\)\(iii\)](#)
Other payments to the MCO approved under § [438.6\(b\)\(3\)](#)

Line 4.4 Unpaid cost-sharing amount that the health plan could have collected from enrollees under the contract: See § [438.8\(f\)\(2\)\(iv\)](#)
Unpaid cost-sharing amounts that the MCO could have collected from enrollees under the contract, except those amounts the MCO can show it made a reasonable, but unsuccessful, effort to collect.

Does not apply.

Line 4.5 All changes to unearned premium reserves: See § [438.8\(f\)\(2\)\(v\)](#)
Does not apply.

Line 4.6 Net payments/receipts related to risk sharing mechanisms: The risk-sharing mechanisms referenced in § [438.5](#) and § [438.6](#) are risk adjustment, risk corridors, reinsurance, and stop loss limits: See § [438.8\(f\)\(2\)\(vi\)](#)

DENOMINATOR: FEDERAL, STATE, AND LOCAL TAXES

Taxes paid by the MCO if applicable.

Line 5.1 Statutory assessments to defray the operating expense of any state or federal department: See § [438.8\(f\)\(3\)\(i\)](#)
Does not apply.

Line 5.2 Examination fees in lieu of premium taxes as specified by state law: See § [438.8\(f\)\(3\)\(ii\)](#)
Does not apply.

Line 5.3 Federal taxes and assessments allocated to MCOs: See § [438.8\(f\)\(3\)\(iii\)](#)
Federal taxes and assessments allocated to MCOs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

Line 5.4 State and local taxes and assessments: See § [438.8\(f\)\(3\)\(iv\)](#)
(iv) State and local taxes and assessments including:
(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
(B) Guaranty fund assessments.
(C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
(D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
(E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

Line 5.5 Amounts otherwise exempt from Federal income taxes for community benefit

expenditures: See § [438.8\(f\)\(3\)\(v\)](#)

[45 CFR § 158.162\(c\)](#)

- (c) Community benefit expenditures. Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes any of the following activities that:
- (1) Are available broadly to the public and serve low-income consumers;
 - (2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);
 - (3) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
 - (4) Leverage or enhance public health department activities such as childhood immunization efforts; and
 - (5) Otherwise would become the responsibility of government or another tax-exempt organization.

MLR Calculation

This worksheet takes the prior amounts and summarizes them into subtotals and calculates the unadjusted MLR. There are also inputs for member months and credibility adjustments if applicable. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible but the Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

The MCO should enter the number of member months in the appropriate cell.

The State has elected a minimum MLR of 85%

Expense Allocation

Certain expenses may not be attributable to one line of business. Describe methods used to allocate these expenses and how they factor into the MLR calculated for this report. A description can be included in the workbook or a reference can be made to an attached document: See § [438.8\(g\)](#)

Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or

populations, or contracts other than those being reported, must be reported on pro rata basis.

Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results and shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

Remittance Calculation

Remittance of amounts owed to the State will be calculated as described in Gain Share Program section of the FIMC contract.

Financial Comparison

Per § [438.8\(k\)\(1\)\(xi\)](#), a comparison of the financial amounts included in this report and what is reported in audited financials is required. Show the comparison in this worksheet or reference an attached document with the comparison.

MLR Report Summary

This worksheet summarizes the information requested by CMS and meets § [438.8 \(k\)](#).

Attestation

An attestation to the accuracy of this MLR report is required per § [438.8\(n\)](#), § 438.604(a)(3), and § 438.606.

Exhibit G

DATA USE, SECURITY, AND CONFIDENTIALITY

1. Definitions

The definitions below apply to this Exhibit:

- 1.1. **“Authorized User”** means an individual or individuals with an authorized business need to access HCA's Confidential Information under this Contract.
- 1.2. **“Breach”** means the unauthorized acquisition, access, use, or disclosure of Data shared under this Contract that compromises the security, confidentiality or integrity of the Data.
- 1.3. **“Data”** means the information that is collected, accessed, disclosed, or exchanged as described by this Contract. For purposes of this Exhibit, Data means the same as “Confidential Information.”
- 1.4. **“Disclosure”** means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.
- 1.5. **“Electronic Protected Health Information (ePHI)”** means Protected Health Information that is transmitted by electronic media or maintained as described in the definition of electronic media at 45 C.F.R. § 160.103.
- 1.6. **“Hardened Password”** means a string of characters containing at least three of the following character classes: upper case letters; lower case letters; numerals; and special characters, such as an asterisk, ampersand or exclamation point.
 - 1.6.1. Passwords for external authentication must be a minimum of 10 characters long.
 - 1.6.2. Passwords for internal authentication must be a minimum of 8 characters long.
 - 1.6.3. Passwords used for system service or service accounts must be a minimum of 20 characters long.
- 1.7. **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, as amended, together with its implementing regulations, including the Privacy Rule, Breach Notification Rule, and Security Rule. The Privacy Rule is located at 45 C.F.R. Part 160 and Subparts A and E of 45 C.F.R. Part 164. The Breach Notification Rule is located in Subpart D of 45 C.F.R. Part 164. The Security Rule is located in 45 C.F.R. Part 160 and Subparts A and C of 45 C.F.R. Part 164.
- 1.8. **“HIPAA Rules”** means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and Part 164.
- 1.9. **“Medicare Data Use Requirements”** refers to the four documents attached and incorporated into this Exhibit as Schedules 1, 2, 3, and 4 that set out the terms and conditions Contractor must agree to for the access to and use of Medicare Data for the Enrollees who are dually eligible in the Medicare and Medicaid programs.
- 1.10. **“Portable/Removable Media”** means any Data storage device that can be detached or removed from a computer and transported, including but not limited to: optical media (e.g. CDs, DVDs); USB drives; or flash media (e.g. CompactFlash, SD, MMC).
- 1.11. **“Portable/Removable Devices”** means any small computing device that can be transported, including but not limited to: handhelds/PDAs/Smartphones; Ultramobile PC's, flash memory devices (e.g. USB flash drives, personal media players); and laptops/notebook/tablet computers. If used to store Confidential Information, devices should be Federal Information Processing Standards (FIPS) Level 2 compliant.
- 1.12. **“PRISM”** means the DSHS secure, web-based clinical decision support tool that shows administrative data for each Medicaid Enrollee and is organized to identify care coordination opportunities.
- 1.13. **“Protected Health Information”** or **“PHI”** has the same meaning as in HIPAA, except in this Contract the term includes information only relating to Clients.

- 1.14. **“ProviderOne”** means the Medicaid Management Information System, which is the State’s Medicaid payment system managed by HCA.
- 1.15. **“Tracking”** means a record keeping system that identifies when the sender begins delivery of Confidential Information to the authorized and intended recipient, and when the sender receives confirmation of delivery from the authorized and intended recipient of Confidential Information.
- 1.16. **“Transmitting”** means the transferring of data electronically, such as via email, SFTP, webservices, AWS Snowball, etc.
- 1.17. **“Transport”** means the movement of Confidential Information from one entity to another, or within an entity, that: places the Confidential Information outside of a Secured Area or system (such as a local area network); and is accomplished other than via a Trusted System.
- 1.18. **“Trusted System(s)”** means the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; (2) United States Postal Service (“USPS”) first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail; (3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.
- 1.19. **“U.S.C.”** means the United States Code. All references in this Exhibit to U.S.C. chapters or sections will include any successor, amended, or replacement statute. The U.S.C. may be accessed at <http://uscode.house.gov/>
- 1.20. **“Unique User ID”** means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase, or other mechanism, authenticates a user to an information system.
- 1.21. **“Use”** includes the sharing, employment, application, utilization, examination, or analysis, of Data.

2. Data Classification

- 2.1. The State classifies data into categories based on the sensitivity of the data pursuant to the Security policy and standards promulgated by the Office of the state of Washington Chief Information Officer. (See Section 4, *Data Security*, of *Securing IT Assets Standards* No. 141.10 in the *State Technology Manual* at <https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets>. Section 4 is hereby incorporated by reference.)
The Data that is the subject of this Contract is classified as Category 4 – Confidential Information Requiring Special Handling. Category 4 Data is information that is specifically protected from disclosure and for which:
 - 2.1.1. Especially strict handling requirements are dictated, such as by statutes, regulations, or agreements;
 - 2.1.2. Serious consequences could arise from unauthorized disclosure, such as threats to health and safety, or legal sanctions.

3. PRISM Access

- 3.1. Purpose. To provide Contractor, and subcontractors, with access to pertinent Enrollee-level Medicaid and Medicare Data via look-up access to the online PRISM application and to provide Contractor staff and Subcontractor staff who have a need to know Enrollee-level Data in order to coordinate care, improve quality, and manage services for their Enrollees, with selected quality improvement provider feedback reports.
- 3.2. Justification. The Data being accessed is necessary for Contractor to provide care coordination, quality improvement, and case management services for Enrollees.
- 3.3. PRISM Data Constraints.
 - 3.3.1. The Data contained in PRISM is owned and belongs to DSHS and HCA.

- 3.3.2. The Data shared may only be used for care coordination and quality improvement purposes, and no other purposes.
- 3.4. System Access. Contractor may request access for specific Authorized Users with a need-to-know to view Data in the PRISM System under this Contract.
 - 3.4.1. Contractor Contract Manager, or their designee, must complete and sign the PRISM Access Request Form, Schedule 5, for each proposed Authorized User. The completed form must be sent to prism.admin@dshs.wa.gov with a copy to hcamcprograms@hca.wa.gov. HCA and DSHS will only accept requests from the Contractor Contract Manager or their designee.
 - 3.4.2. Contractor must access these systems through SecureAccessWashington (SAW) or through another method of secure access approved by the HCA and DSHS.
 - 3.4.3. HCA and DSHS will grant the appropriate access permissions to Contractor employees or Subcontractor employees.
 - 3.4.4. HCA and DSHS **do not** allow shared User IDs and passwords for use with Confidential Information or to access systems that contain Confidential Information. Contractor must ensure that only Authorized Users access and use the systems and do not allow employees, agents, or Subcontractors who are not authorized to borrow a User ID or password to access any systems.
 - 3.4.5. Contractor will notify the prism.admin@dshs.wa.gov with a copy to hcamcprograms@hca.wa.gov within five (5) business days whenever an Authorized User who has access to the Data is no longer employed or contracted by the Contractor, or whenever an Authorized User's duties change such that the user no longer requires access to the Data.
 - 3.4.6. Contractor's access to the systems may be continuously tracked and monitored. HCA and DSHS reserve the right at any time to terminate the Data access for an individual, conduct audits of systems access and use, and to investigate possible violations of this Exhibit, federal, or state laws and regulations governing access to Protected Health Information.

4. Constraints on Use of Data

- 4.1. This Contract does not constitute a release of the Data for the Contractor's discretionary use. Contractor must use the Data received or accessed under this Contract only to carry out the purpose of this Contract. Any ad hoc analyses or other use or reporting of the Data is not permitted without HCA's prior written consent.
- 4.2. Data shared under this Contract includes data protected by 42 C.F.R. Part 2. In accordance with 42 C.F.R. § 2.32, this Data has been disclosed from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit Receiving Party from making any further disclosure of the Data that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (42 C.F.R. § 2.31). The federal rules restrict any use of the SUD Data to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 C.F.R. § 2.12(c)(5) and § 2.65.
 - 4.2.1. The information received under subsection 7.18.3 of the Contract is also protected by federal law, including 42 C.F.R. Part 2, Subpart D, § 2.53, which requires HCA and their Subcontractors to:
 - 4.2.1.1. Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under 42 C.F.R. § 2.16;
 - 4.2.1.2. Retain records in compliance with applicable federal, state, and local record retention laws; and
 - 4.2.1.3. Comply with the limitations on disclosure and Use in 42 C.F.R. Part 2, Subpart D, § 2.53(d).

- 4.3. Any disclosure of Data contrary to this Contract is unauthorized and is subject to penalties identified in law.
- 4.4. The Contractor must comply with the *Minimum Necessary Standard*, which means that Contractor will use the least amount of PHI necessary to accomplish the Purpose of this Contract.
 - 4.4.1. Contractor must identify:
 - 4.4.1.1. Those persons or classes of persons in its workforce who need access to PHI to carry out their duties; and
 - 4.4.1.2. For each such person or class of persons, the category or categories of PHI to which access is needed and any conditions appropriate to such access.
 - 4.4.2. Contractor must implement policies and procedures that limit the PHI disclosed to such persons or classes of persons to the amount reasonably necessary to achieve the purpose of the disclosure, in accordance with this Contract.
- 4.5. For all Data, including claims data, that is individually identifiable, shared outside of Contractor's system for research or data analytics not conducted on behalf of the Contractor, Contractor must provide HCA with thirty (30) calendar days' advance notice and opportunity for review and advisement to ensure alignment and coordination between Contractor and HCA data governance initiatives. Contractor will provide notice to HCAData@hca.wa.gov and hcamcprograms@hca.wa.gov. Notice will include:
 - 4.5.1. The party/ies the Data will be shared with;
 - 4.5.2. The purpose of the sharing; and
 - 4.5.3. A description of the types of Data involved, including specific data elements to be shared.
- 4.6. Contractor must provide a report by the 15th of each month of all Data, individually identifiable and de-identified, regarding Enrollees, including claims data, shared with external entities, including but not limited to Subcontractors and researchers, to HCA on the supplied template, Data Shared with External Entities Report via MC-Track.

5. Security of Data

- 5.1. Data Protection
 - 5.1.1. 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:
 - 5.1.1.1. Allowing access only to staff that have an authorized business requirement to view the Confidential Information.
 - 5.1.1.2. Physically securing any computers, documents, or other media containing the Confidential Information.
- 5.2. Data Security Standards
 - 5.2.1. 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.
 - 5.2.2. Data Transmitting
 - 5.2.2.1. 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.

- 5.2.2.2. When transmitting Data via paper documents, the Contractor must use a Trusted System.
- 5.2.3. Protection of Data. The Contractor agrees to store and protect Data as described.
 - 5.2.3.1. Data at Rest:
 - 5.2.3.1.1. 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.
 - 5.2.3.2. Data stored on Portable/Removable Media or Devices
 - 5.2.3.2.1. 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.
 - 5.2.3.2.2. 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:
 - 5.2.3.2.2.1. Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;
 - 5.2.3.2.2.2. Controlling access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics;
 - 5.2.3.2.2.3. Keeping devices in locked storage when not in use;
 - 5.2.3.2.2.4. Using check-in/check-out procedures when devices are shared;
 - 5.2.3.2.2.5. Maintaining an inventory of devices; and
 - 5.2.3.2.2.6. Ensuring that when being transported outside of a Secured Area, all devices containing Data are under the physical control of an Authorized User.
 - 5.2.3.3. 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.
- 5.2.4. Data Segregation
 - 5.2.4.1. 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:

 - 5.2.4.1.1. On media (e.g. hard disk, optical disc, tape, etc.) which contains only HCA Data;

- 5.2.4.1.2. In a logical container on electronic media, such as a partition or folder dedicated to HCA's Data;
- 5.2.4.1.3. In a database that contains only HCA Data;
- 5.2.4.1.4. Within a database – HCA data must be distinguishable from non-HCA Data by the value of a specific field or fields within database records;
- 5.2.4.1.5. Physically segregated from non-HCA Data in a drawer, folder, or other container when stored as physical paper documents.
- 5.2.4.2. 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.
- 5.3. Data Disposition
 - 5.3.1. 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 destroyed using a method documented within NIST 800-88 (<http://csrc.nist.gov/publications/PubsSPs.html>).
 - 5.3.2. 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 5.2.3, 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.

6. Data Confidentiality and Non-Disclosure

- 6.1. Data Confidentiality.
 - 6.1.1. 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:
 - 6.1.1.1. as provided by law; or
 - 6.1.1.2. with the prior written consent of the person or personal representative of the person who is the subject of the Confidential Information.
- 6.2. Non-Disclosure of Data
 - 6.2.1. 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.
 - 6.2.2. 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.
- 6.3. Penalties for Unauthorized Disclosure of Data
 - 6.3.1. The Contractor must comply with all applicable federal and state laws and regulations concerning collection, use, and disclosure of Personal Information and PHI. Violation of these laws may result in criminal or civil penalties or fines.
 - 6.3.2. The Contractor accepts full responsibility and liability for any noncompliance with applicable laws or this Contract by itself, its employees, and its Subcontractors.

7. Data Shared with Subcontractors

- 7.1. If Data access is to be provided to a Subcontractor under this Contract, the Contractor must include all of the Data security terms, conditions and requirements set forth in this Exhibit in any such Subcontract. However, no subcontract will terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any subcontractor. Contractor must provide an attestation by January 31, each year that all Subcontractor(s) meet, or continue to meet, the terms, conditions, and requirements in this Exhibit.

8. Data Breach Notification

- 8.1. 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:
 - 8.1.1. The identification of each individual whose PHI has been or may have been improperly accessed, acquired, used, or disclosed;
 - 8.1.2. 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;
 - 8.1.3. A description of the types of PHI involved;
 - 8.1.4. The investigative and remedial actions the Contractor or its Subcontractor took or will take to prevent and mitigate harmful effects, and protect against recurrence;
 - 8.1.5. 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
 - 8.1.6. Any other information HCA reasonably requests.
- 8.2. 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.
- 8.3. The Contractor must notify HCA in writing, as described in Section 8.1 above, within two (2) business days of determining notification must be sent to enrollees.
- 8.4. 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.
- 8.5. 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.

9. HIPAA Compliance

- 9.1. 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.
- 9.2. 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 initiated 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.

10. Inspection

- 10.1. 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.

11. Indemnification

- 11.1. The Contractor must indemnify and hold HCA and its employees harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Enrollees.

Medicare Data Use Requirements Documents

Schedule 1:	Washington State Approval Letter and Data Use Agreement (DUA) #21628
Schedule 2:	Medicare Attachment A to DUA
Schedule 3	Information Exchange Agreement for Disclosure of Medicare Part D Data
Schedule 4	Medicare Part D – Conflict of Interest Attestation
Schedule 5	PRISM Access Request Form

SCHEDULE 1
WASHINGTON STATE APPROVAL LETTER
DATA USE AGREEMENT

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop N1-24-08
Baltimore, Maryland 21244-1850



Cathie Ott
State of Washington
Health Care Authority
626 8th Avenue SE
Olympia, Washington 98504

Dear Ms. Ott:

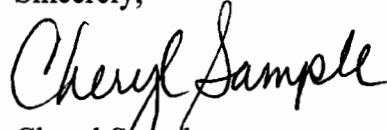
Enclosed is a copy of the signed Data Use Agreement (DUA) and the Information Exchange Agreement that the Centers for Medicare & Medicaid Services (CMS) have entered into with your organization for the CMS/Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) program entitled, "Part D - Care Coordination for Beneficiaries Who are Dually Eligible in the Medicare/Medicaid Programs." Please refer to DUA number 21628 when addressing inquiries of any nature concerning this agreement.

I have also enclosed the CMS DUA Guidelines which outlines your responsibilities in terms of safeguarding the confidentiality of CMS data. This approval is based on the understanding that personnel within your organization and any subcontracting organization's personnel will comply with all requirements of this Agreement into which you have entered. It is your responsibility to provide a copy of this agreement and CMS DUA Guidelines to the individuals listed below for your organization and/or any subcontracting organization. Please emphasize the importance of complying with this agreement. Note that this approval only applies to this request for the study mentioned above. Any additional purpose will have to be reviewed and approved by CMS.

Please note that any organization requesting CMS data that has an EXPIRED CMS DUA will not receive authorization to obtain any new data until their expired DUA has been resolved. The retention date stipulates the timeframe in which the information can be used. If your DUA is about to expire, and your project is still in need of the CMS data, you will need to request an extension date on the DUA. However, if your study is complete and the data is no longer required, you must contact CMS and request that the DUA be closed by providing written certification that you have destroyed the CMS data. More information regarding the resolution of expired DUAs can be found at the following CMS website:
www.cms.hhs.gov/PrivProtectedData/ under "DUA Extensions or Destruction of CMS Data."

If you have any questions about this DUA or the use of the CMS data, you may contact me at (410) 786-7185. If you have questions regarding the Care Coordination Program, please contact Karyn Anderson, Part D Care Coordination program official, at (410) 786-6696.

Sincerely,

A handwritten signature in black ink that reads "Cheryl Sample". The signature is fluid and cursive, with the first name "Cheryl" and last name "Sample" clearly distinguishable.

Cheryl Sample
Division of Information Security & Privacy Management
Enterprise Architecture and Strategy Group
Office of Information Services
Centers for Medicare & Medicaid Services

Enclosures

Cc:

Karyn Anderson, CMS, FCHCO

Centers for Medicare & Medicaid Services (CMS)
Data Use Agreement (DUA) Guidelines

1. Requestor agrees to notify CMS if their project is completed sooner than the expiration date specified in the DUA.
2. Requestor agrees that any data provided by CMS will not be physically moved or electronically transmitted in any way from the site indicated in the DUA without expressed written authorization from CMS. If location needs to be modified, the DUA should be updated to include the new location.
3. Upon completion of the project and/or expiration of the DUA, the data must be destroyed and a statement certifying this action sent to CMS. The Requestor agrees that no data, copies, or parts thereof, shall be retained when the file(s) are destroyed, unless CMS has authorized in writing such retention or said file(s). Further details are explained below:

Destroy data and submit a completed Certificate of Destruction (form may be downloaded at: <http://www.cms.hhs.gov/PrivProtectedData/Downloads/certificationofdestruction.pdf>.) The Requestor should forward this information to:

Director, Division of Information Security & Privacy Management
Enterprise Architecture and Strategy Group
Office of Information Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop: N1-24-08
Baltimore, Maryland 21244-1850

4. If the project is still active and the DUA has expired, a one (1) year extension may be granted. The extension will only be approved if the data will continue to be used for the original project purpose and the expiration date has occurred within the past year; otherwise, a new DUA must be negotiated. The letter requesting an extension should be directed to the name and address in item 3a above.
5. Please visit our new website, Privacy Protected Data Request: Policies and Procedures at: <http://www.cms.hhs.gov/PrivProtectedData/>.

DATA USE AGREEMENT

DUA #

21628

(AGREEMENT FOR USE OF CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DATA CONTAINING INDIVIDUAL IDENTIFIERS)

CMS agrees to provide the User with data that reside in a CMS Privacy Act System of Records as identified in this Agreement. In exchange, the User agrees to pay any applicable fees; the User agrees to use the data only for purposes that support the User's study, research or project referenced in this Agreement, which has been determined by CMS to provide assistance to CMS in monitoring, managing and improving the Medicare and Medicaid programs or the services provided to beneficiaries; and the User agrees to ensure the integrity, security, and confidentiality of the data by complying with the terms of this Agreement and applicable law, including the Privacy Act and the Health Insurance Portability and Accountability Act. In order to secure data that reside in a CMS Privacy Act System of Records; in order to ensure the integrity, security, and confidentiality of information maintained by the CMS; and to permit appropriate disclosure and use of such data as permitted by law, CMS and Health Care Authority, Washington State enter into this agreement to comply with the following specific paragraphs. (Requestor)

1. This Agreement is by and between the Centers for Medicare & Medicaid Services (CMS), a component of the U.S. Department of Health and Human Services (HHS), and Health Care Authority, Washington State, hereinafter termed "User." (Requestor)
2. This Agreement addresses the conditions under which CMS will disclose and the User will obtain, use, reuse and disclose the CMS data file(s) specified in section 5 and/or any derivative file(s) that contain direct individual identifiers or elements that can be used in concert with other information to identify individuals. This Agreement supersedes any and all agreements between the parties with respect to the use of data from the files specified in section 5 and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to any grant award or other prior communication from the Department of Health and Human Services or any of its components with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by the CMS point-of-contact or the CMS signatory to this Agreement shown in section 20.
3. The parties mutually agree that CMS retains all ownership rights to the data file(s) referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by CMS.
4. The User represents, and in furnishing the data file(s) specified in section 5 CMS relies upon such representation, that such data file(s) will be used solely for the following purpose(s).

Name of Study/Project
Care Coordination

CMS Contract No. (if applicable)

CMS Agreement No 2011-13

The User represents further that the facts and statements made in any study or research protocol or project plan submitted to CMS for each purpose are complete and accurate. Further, the User represents that said study protocol(s) or project plans, that have been approved by CMS or other appropriate entity as CMS may determine, represent the total use(s) to which the data file(s) specified in section 5 will be put.

The User agrees not to disclose, use or reuse the data covered by this agreement except as specified in an Attachment to this Agreement or except as CMS shall authorize in writing or as otherwise required by law, sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement. The User affirms that the requested data is the minimum necessary to achieve the purposes stated in this section. The User agrees that, within the User organization and the organizations of its agents, access to the data covered by this Agreement shall be limited to the minimum amount of data and minimum number of individuals necessary to achieve the purpose stated in this section (i.e., individual's access to the data will be on a need-to-know basis).

5. The following CMS data file(s) is/are covered under this Agreement.

File	Years(s)	System of Record
Part D Files	2006	System No. 09-70-0571
Part D Files	2007	System No. 09-70-0571
Part D Files	2008	System No. 09-70-0571
Part D Files	2009	System No. 09-70-0571
Part D Files	2010	System No. 09-70-0571
Part D Files	2011	System No. 09-70-0571

6. The parties mutually agree that the aforesaid file(s) (and/or any derivative file(s)), including those files that directly identify individuals or that directly identify bidding firms and/or such firms' proprietary, confidential or specific bidding information, and those files that can be used in concert with other information to identify individuals, may be retained by the User until 07/31/2016, hereinafter known as the "Retention Date." The User agrees to notify CMS within 30 days of the completion of the purpose specified in section 4 if the purpose is completed before the aforementioned retention date. Upon such notice or retention date, whichever occurs sooner, the User agrees to destroy such data. The User agrees to destroy and send written certification of the destruction of the files to CMS within 30 days. The User agrees not to retain CMS files or any parts thereof, after the aforementioned file(s) are destroyed unless the appropriate Systems Manager or the person designated in section 20 of this Agreement grants written authorization. The User acknowledges that the date is not contingent upon action by CMS.

The Agreement may be terminated by either party at any time for any reason upon 30 days written notice. Upon notice of termination by User, CMS will cease releasing data from the file(s) to the User under this Agreement and will notify the User to destroy such data file(s). Sections 3, 4, 6, 8, 9, 10, 11, 13, 14 and 15 shall survive termination of this Agreement.

7. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security requirements established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems (<http://www.whitehouse.gov/omb/circulars/a130/a130.html>) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (<http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf>); and, Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" (<http://csrc.nist.gov/publications/nistpubs/800-53-Rev2/sp800-53-rev2-final.pdf>). The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, bidder identifiable or deducible information derived from the file(s) specified in section 5 is prohibited. Further, the User agrees that the data must not be physically moved, transmitted or disclosed in any way from or by the site indicated in section 17 without written approval from CMS unless such movement, transmission or disclosure is required by a law.
8. The User agrees to grant access to the data to the authorized representatives of CMS or DHHS Office of the Inspector General at the site indicated in section 17 for the purpose of inspecting to confirm compliance with the terms of this agreement.

9. The User agrees not to disclose direct findings, listings, or information derived from the file(s) specified in section 5, with or without direct identifiers, if such findings, listings, or information can, by themselves or in combination with other data, be used to deduce an individual's identity. Examples of such data elements include, but are not limited to geographic location, age if > 89, sex, diagnosis and procedure, admission/discharge date(s), or date of death.

The User agrees that any use of CMS data in the creation of any document (manuscript, table, chart, study, report, etc.) concerning the purpose specified in section 4 (regardless of whether the report or other writing expressly refers to such purpose, to CMS, or to the files specified in section 5 or any data derived from such files) must adhere to CMS' current cell size suppression policy. **This policy stipulates that no cell (e.g. admittances, discharges, patients, services) 10 or less may be displayed.** Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell 10 or less. By signing this Agreement you hereby agree to abide by these rules and, therefore, will not be required to submit any written documents for CMS review. If you are unsure if you meet the above criteria, you may submit your written products for CMS review. CMS agrees to make a determination about approval and to notify the user within 4 to 6 weeks after receipt of findings. CMS may withhold approval for publication only if it determines that the format in which data are presented may result in identification of individual beneficiaries.

10. The User agrees that, absent express written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement to do so, the User shall not attempt to link records included in the file(s) specified in section 5 to any other individually identifiable source of information. This includes attempts to link the data to other CMS data file(s). A protocol that includes the linkage of specific files that has been approved in accordance with section 4 constitutes express authorization from CMS to link files as described in the protocol.
11. The User understands and agrees that they may not reuse original or derivative data file(s) without prior written approval from the appropriate System Manager or the person designated in section 20 of this Agreement.

12. The parties mutually agree that the following specified Attachments are part of this Agreement:

CMS Agreement No 2011-13

13. The User agrees that in the event CMS determines or has a reasonable belief that the User has made or may have made a use, reuse or disclosure of the aforesaid file(s) that is not authorized by this Agreement or another written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement, CMS, at its sole discretion, may require the User to: (a) promptly investigate and report to CMS the User's determinations regarding any alleged or actual unauthorized use, reuse or disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by CMS, submit a formal response to an allegation of unauthorized use, reuse or disclosure; (d) if requested by CMS, submit a corrective action plan with steps designed to prevent any future unauthorized uses, reuses or disclosures; and (e) if requested by CMS, return data files to CMS or destroy the data files it received from CMS under this agreement. The User understands that as a result of CMS's determination or reasonable belief that unauthorized uses, reuses or disclosures have taken place, CMS may refuse to release further CMS data to the User for a period of time to be determined by CMS.

The User agrees to report any breach of personally identifiable information (PII) from the CMS data file(s), loss of these data or disclosure to any unauthorized persons to the CMS Action Desk by telephone at (410) 786-2580 or by e-mail notification at cms_it_service_desk@cms.hhs.gov within one hour and to cooperate fully in the federal security incident process. While CMS retains all ownership rights to the data file(s), as outlined above, the User shall bear the cost and liability for any breaches of PII from the data file(s) while they are entrusted to the User. Furthermore, if CMS determines that the risk of harm requires notification of affected individual persons of the security breach and/or other remedies, the User agrees to carry out these remedies without cost to CMS.

14. The User hereby acknowledges that criminal penalties under §1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), including a fine not exceeding \$10,000 or imprisonment not exceeding 5 years, or both, may apply to disclosures of information that are covered by § 1106 and that are not authorized by regulation or by Federal law. The User further acknowledges that criminal penalties under the Privacy Act (5 U.S.C. § 552a(i) (3)) may apply if it is determined that the Requestor or Custodian, or any individual employed or affiliated therewith, knowingly and willfully obtained the file(s) under false pretenses. Any person found to have violated sec. (i)(3) of the Privacy Act shall be guilty of a misdemeanor and fined not more than \$5,000. Finally, the User acknowledges that criminal penalties may be imposed under 18 U.S.C. § 641 if it is determined that the User, or any individual employed or affiliated therewith, has taken or converted to his own use data file(s), or received the file(s) knowing that they were stolen or converted. Under such circumstances, they shall be fined under Title 18 or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of \$1,000, they shall be fined under Title 18 or imprisoned not more than 1 year, or both.
15. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement and acknowledges having received notice of potential criminal or administrative penalties for violation of the terms of the Agreement.
16. On behalf of the User the undersigned individual hereby attests that he or she is authorized to legally bind the User to the terms this Agreement and agrees to all the terms specified herein.

Name and Title of User (typed or printed)

Cathie Ott

Company/Organization

Health Care Authority

Street Address

626 8th Ave

City

Olympia

State

WA

ZIP Code

98504-5502

Office Telephone (Include Area Code)

360-725-2116

E-Mail Address (If applicable)

ottcl@hca.wa.gov

Signature

Cathie Ott

Date

7/12/2011

17. The parties mutually agree that the following named individual is designated as Custodian of the file(s) on behalf of the User and will be the person responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify CMS within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

The Custodian hereby acknowledges his/her appointment as Custodian of the aforesaid file(s) on behalf of the User, and agrees to comply with all of the provisions of this Agreement on behalf of the User.

Name of Custodian (typed or printed)

Cathie Ott

Company/Organization

Health Care Authority

Street Address

626 8th Avenue

City

Olympia

State

WA

ZIP Code

98504-5502

Office Telephone (Include Area Code)

360-725-2116

E-Mail Address (If applicable)

ottcl@hca.wa.gov

Signature

Cathie Ott

Date

7/12/2011

18. The disclosure provision(s) that allows the discretionary release of CMS data for the purpose(s) stated in section 4 follow(s). (To be completed by CMS staff.) _____

19. On behalf of _____ the undersigned individual hereby acknowledges that the aforesaid Federal agency sponsors or otherwise supports the User's request for and use of CMS data, agrees to support CMS in ensuring that the User maintains and uses CMS's data in accordance with the terms of this Agreement, and agrees further to make no statement to the User concerning the interpretation of the terms of this Agreement and to refer all questions of such interpretation or compliance with the terms of this Agreement to the CMS official named in section 20 (or to his or her successor).

Typed or Printed Name		Title of Federal Representative	
Signature		Date	
Office Telephone (Include Area Code)		E-Mail Address (If applicable)	

20. The parties mutually agree that the following named individual will be designated as point-of-contact for the Agreement on behalf of CMS.

On behalf of CMS the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

Name of CMS Representative (typed or printed) <i>Karyn Kai Anderson</i>			
Title/Component <i>Medicare-Medicaid Coordination Office</i>			
Street Address <i>7500 Security Blvd.</i>		Mail Stop <i>53-13-23</i>	
City <i>Baltimore</i>	State <i>MD</i>	ZIP Code <i>21244</i>	
Office Telephone (Include Area Code) <i>410-786-6696</i>		E-Mail Address (If applicable) <i>Karyn.Anderson@CMS.hhs.gov</i>	
A. Signature of CMS Representative <i>[Signature]</i>		Date <i>7/22/11</i>	
B. Concur/Nonconcur — Signature of CMS System Manager or Business Owner <i>[Signature]</i>		Date <i>7/22/11</i>	
Concur/Nonconcur — Signature of CMS System Manager or Business Owner		Date	
Concur/Nonconcur — Signature of CMS System Manager or Business Owner		Date	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0734. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: Reports Clearance Officer, Baltimore, Maryland 21244-1850.

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for Care Coordination for Dual Eligibles ☒. If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: 21628. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual (typed or printed)
David Mancuso, PhD

Task / Role of this individual in this project
Senior Research Supervisor

Company / Organization
Department of Social and Health Services

Street Address
14th and Jefferson, OB-2, MS: 45204

City
Olympia

State
WA

ZIP Code
98504

Office Telephone (include Area Code)
(360) 902-7557

E-Mail Address (if applicable)
MancuDC@dshs.wa.gov

Signature of Individual

Date
8/2/2011

Signature of CMS Representative

Date

Signature of CMS Project Officer (if applicable)

Date

Name and Title of Individual (typed or printed)

Task / Role of this individual in this project

Company / Organization

Street Address

City

State

ZIP Code

Office Telephone (include Area Code)

E-Mail Address (if applicable)

Signature of Individual

Date

Signature of CMS Representative

Date

Signature of CMS Project Officer (if applicable)

Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0734. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: Reports Clearance Officer, Baltimore, Maryland 21244-1850.

The Centers for Medicare and Medicaid Services Data Agreement & Data Shipping Tracking System

DADSS
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DUA

DUA Search

Search Results

Archived DUAs

Unfinished
DUAs

DUA Entry

Login StatusCHERYL
SAMPLE

5:22 PM

Logout

DUA Search

Search Results

Archived DUAs

Unfinished
DUAs

DUA Entry

dua edit - dua: 21628

1-Main Information

2-Data Descriptions

3-IDR Custodians

4-Requestor

5-Custodians

6-Subcontractors

7-Recipients

8-DESY Users

9-Comments

10-Finish

Session Summary:

DUA: 21628**Main Information:**

DUA #: 21628

Study Name: CARE COORDINATION FOR BENEFICIARIES WHO ARE
DUALY ELIGIBLE IN THE MEDICARE/MEDICAID
PROGRAMS

Category: 11 - STATES

Encryption: I - IDENTIFIABLE

Authorization: PA03-ST - STATE AGENCY RU

Privacy Board Approval Date:

DUA Effective Date: 08/02/2011 DUA Expiration Date: 07/13/2016

Extension: 0

Extension Date:

DESY Access: No

DESY Expiration Date:

Reuse: No

Reuse Information: NUL

DSAF Access: No

CMS Data Center Access: No

Foreign Tape: No

Bene Notification: N - NOT APPLICABLE

Contract/Grant No.: CMS/STATE IEA AGREEMENT #2011-13

Part D Approval Date: 07/22/2011

CMS Contact Name: KARYN ANDERSON

Federal Project Officer:

Data Descriptions:

#1 Data Description: PDE - PRESCRIPTION DRUG EVENT DATA

From Year: 2007

To Year: 2011

IDR Custodians:**Requestor:**

Address ID: 20120

Contact Info: CATHIE OTT

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

626 8TH AVENUE SE

OLYMPIA, WA 98504

UNITED STATES OF AMERICA

Phone: 360-725-2116

Email: ottcl@hca.wa.gov

Last Modified: 2011-08-02 14:47:24

Custodians:

#1 Address ID: 20120

Contact Info: CATHIE OTT

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

626 8TH AVENUE SE

OLYMPIA, WA 98504

UNITED STATES OF AMERICA

Phone: 360-725-2116

Email: ottcl@hca.wa.gov

Last Modified: 2011-08-02 14:47:24

#2 Address ID: 18110

Contact Info: DAVID MANCUSO

WASHINGTON DEPARTMENT OF SOCIAL AND
HEALTH SERVICES

AGING AND DISABILITY SERVICES
ADMINISTRATION
14TH & JEFFERSON STREET
PO BOX 45204
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-902-7557
Email: mancudc@dshs.wa.gov
Last Modified: 2011-08-04 16:01:09

Subcontractors:

None

Recipients:

#1 Address ID: 20120

Contact Info: CATHIE OTT

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8TH AVENUE SE
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-725-2116
Email: ottcl@hca.wa.gov
Last Modified: 2011-08-02 14:47:24

#2 Address ID: 18110

Contact Info: DAVID MANCUSO

WASHINGTON DEPARTMENT OF SOCIAL AND
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AGING AND DISABILITY SERVICES
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14TH & JEFFERSON STREET
PO BOX 45204
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-902-7557
Email: mancudc@dshs.wa.gov
Last Modified: 2011-08-04 16:01:09

DESY Users:**Comments:**

Timestamp: Thu Aug 04 17:24:26 EDT 2011

User Name: CHERYL SAMPLE

Text: added David Mancuso as additional data custodian.

Timestamp: Tue Aug 02 14:51:36 EDT 2011

User Name: CHERYL SAMPLE

Text: WA approved by PDE business owner for use of PDE data (IEA lists data elements--27) for care coordination program under direction of Sharon Donovan and Kai Anderson, CMS/ FCHCO/Duals Office program officials. OIS/EDG to process data feed.

History:

Timestamp: Thu Aug 04 17:24:21 EDT 2011

User Name: CHERYL SAMPLE

Type of Change: RECIPIENT HAS BEEN ADDED

Timestamp: Thu Aug 04 17:24:21 EDT 2011

User Name: CHERYL SAMPLE

Type of Change: CUSTODIAN HAS BEEN ADDED

Submit

Cancel

SCHEDULE 2
MEDICARE ATTACHMENT A

SCHEDULE 2: MEDICARE ATTACHMENT A

This Attachment supplements the Data Use Agreement between the Centers for Medicare & Medicaid Services ("CMS") and the Users. To the extent that the provisions of this Attachment are inconsistent with any terms in the Data Use Agreement, this Attachment modifies and overrides the Data Use Agreement.

USE OF THE INFORMATION

A-1. Users are defined as the State Medicaid Agencies and downstream entities that are Health Insurance Portability and Accountability Act (HIPAA) Covered Entities that are given individually identifiable data to carry out care coordination and quality improvement work, as well as the business associates of such entities and any sub-contractor Business Associates of such entities.

Users may include providers and care coordination organizations that wish to use individually identifiable data about beneficiaries of the Medicare and Medicaid programs (Medicare-Medicaid enrollees) to provide care coordination and quality improvement programs on behalf of the State Medicaid Agency and/or one or more HIPAA Covered Entity providers. Such work would need to be done subject to a HIPAA business associate agreement with that State Medicaid Agency and/or those HIPAA Covered Entity providers.

The Users must use any individually identifiable information that they receive under 1.a. to further the delivery of seamless, coordinated care for individuals who are Medicare-Medicaid enrollees to promote better care, better health, and lower growth in expenditures.

A-2. Subject to the limitations described below, users may reuse original or derivative data from the files specified in Section 5 of the Data Use Agreement, with or without direct identifiers, without prior written authorization from CMS, for clinical treatment, case management and care coordination, and quality improvement activities. Information derived from the files specified in Section 5 of the Data Use Agreement may be shared and used within the legal confines of the Users authority in a manner consistent with this section to improve care integration. When using or disclosing protected health information (PHI) or personally identifiable information (PII), obtained under the Data Use Agreement, Users must make "reasonable efforts to limit" the information that is used or disclosed to the "minimum necessary" to accomplish the intended purpose of the use or disclosure. Users shall limit disclosure of information to that which CMS would be permitted to disclose under the established Privacy Act "routine uses," which are categories of disclosures or uses permitted by CMS's system of records notice available at www.cms.hhs.gov/privacy, as well as other permitted disclosures found in the Privacy Act at 5 U.S.C. §552a(b)(1) through (b)(12).

A-3. Nothing in the Data Use Agreement, including but not limited to Section 9, governs the use and/or disclosure of any information that is obtained independent of the Data Use Agreement, regardless of whether the information was also obtained or could also be derived from the files specified in Section 5 of the Data Use Agreement.

A-4. Users are expressly authorized to undertake further investigation into events and individuals related to the files specified in Section 5 in a manner consistent with Section 1.b. This includes, but is not limited to, reviewing other records, interviewing individuals, and attempting to link the files specified in Section 5 to other files.

POTENTIAL PENALTIES

A-5. Users acknowledge having received notice of potential criminal or administrative penalties for violation of the terms of the Data Use Agreement and this attachment.

For: [Name of Downstream Entity]

Washington State Health Care Authority
For: State Medicaid Agency

SCHEDULE 3
INFORMATION EXCHANGE AGREEMENT FOR
DISCLOSURE OF MEDICARE PART D DATA

SCHEDULE 3

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Privacy Act of 1974**

**INFORMATION EXCHANGE AGREEMENT
BETWEEN
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
THE PARTICIPATING STATE MEDICAID AGENCY
FOR
DISCLOSURE OF MEDICARE PART D DATA**

CMS Computer Matching Agreement Number 2011-13

WASHINGTON STATE

INFORMATION EXCHANGE AGREEMENT

**INFORMATION EXCHANGE AGREEMENT
BETWEEN
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
THE PARTICIPATING STATE MEDICAID AGENCY
FOR
DISCLOSURE OF MEDICARE PART D DATA
CMS AGREEMENT No. 2011-13**

I. PURPOSE, LEGAL AUTHORITY, AND DEFINITIONS

A. Purpose

This Information Exchange Agreement (IEA) establishes the terms, conditions, safeguards, and procedures under which the Centers for Medicare & Medicaid Services (CMS) will disclose Medicare Part D prescription drug event (PDE) data to the State Medicaid Agency for the State of Washington ("the Participating State"). Under this Agreement, PDE data that are maintained by CMS and subject to the requirements of the Privacy Act will be disclosed exclusively for use in care coordination for beneficiaries who are dually eligible for both the Medicare and Medicaid programs ("dual eligible beneficiaries"). The criteria for considering a purpose to be "care coordination" is that the specific uses of the data (e.g., analysis, monitoring, or feedback) support interventions at the individual dual eligible beneficiary level that have the potential to improve the care of dual eligible beneficiaries.

This Agreement describes the Medicare Part D PDE data elements that CMS agrees to provide, the timeframes within which the data or access will be provided, the approved uses of the data, the approved downstream disclosures of the data (if applicable), and the CMS reporting requirements. Certain protections for the data that are required under the terms of this IEA are reinforced in the Data Use Agreement (DUA) Form CMS-R-0235.

B. Legal Authority

The legal authority for CMS's disclosure of information to the State Medicaid agency is provided by the Privacy Act of 1974 (5 U.S.C. § 552a), as amended, section 1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), and the regulations and guidance promulgated there under. The release of Part D data by CMS to a State is also governed by 42 CFR 423.505. CMS data will be released to the State Medicaid Agency pursuant to the routine use as set forth in the system notice.

Disclosures under this agreement do not constitute a matching program as defined by the Privacy Act, 5 U.S.C. § 552a (a)(8), but are made in accordance with applicable requirements and other relevant provisions of the Privacy Act, 5 U.S.C. § 552a. The purpose of the disclosures described herein is not for (1) establishing or verifying initial or continuing entitlement or eligibility of individuals or entities (be they applicants for, recipients of, participants in, or providers of services) with respect to Federal benefit programs, (2) verifying compliance with statutory and regulatory requirements of such programs, or (3) recouping payments or delinquent debts under such Federal benefit programs.

This Agreement supports the responsibilities of the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office") as established by the Patient Protection and Affordable Care Act (Affordable Care Act) Section 2602, which specifically include providing States with the tools necessary to develop programs to align Medicare and Medicaid benefits for dual eligible beneficiaries.

C. Definitions

1. "BI" means Business Intelligence (BI) tool.
2. "Care coordination" means uses of the data (e.g., analysis, monitoring, or feedback) to support interventions at the individual dual eligible beneficiary level that have the potential to improve the care of dual eligible beneficiaries.
3. "CMS" means the Centers for Medicare & Medicaid Services.
4. "Custodian" or "custodian agent" means a designated employee of the State Medicaid Agency who is responsible for protecting the confidentiality of data disclosed in accordance with this agreement.
5. "Downstream user" means any entity (e.g., treating provider or contractor) that has been approved by CMS to receive PDE data that was provided to the State Medicaid Agency under this Agreement for care coordination purposes.
6. "DUA" means the CMS Data Use Agreement which accompanies this IEA.
7. "Dual eligible beneficiary" means an individual who is concomitantly enrolled in Medicare and has been determined to be eligible for full benefits under the Participating State's Medicaid program.
8. "Medicare-Medicaid Coordination Office" or "MMCO" means the Federal Coordinated Health Care Office.
9. "HIP AA" means the Health Insurance Portability and Accountability Act.

10. "Medicaid" means the Medicaid program established under Title XIX of the Social Security Act.
11. "Medicare" means the health insurance program established under Title XVIII of the Social Security Act.
12. "PDE data" means Medicare Part D Prescription Drug Event data that are reported to CMS by Part D prescription drug plan sponsors and maintained by CMS.
13. "State Medicaid Agency" means the Medicaid Agency for the State of Washington.
14. "Treating provider" is a clinician who is currently responsible for care provision and/or care coordination for dual eligible beneficiaries.

II. RESPONSIBILITIES OF CMS AND STATE MEDICAID AGENCY

Under the terms of this Agreement, CMS will provide to the State Medicaid agency certain Medicare PDE data maintained by CMS. PDE data will only be shared for dual eligible beneficiaries who are eligible to receive full Medicaid benefits in the Participating State; PDE data for this population will be made available to the Participating State whether or not the prescription was filled in the Participating State. Financial data and internal plan and pharmacy prescription identification numbers will be excluded as indicated in MMCOCMCS Informational Bulletin of May 11, 2011.

CMS will provide to the State Medicaid Agency the tools necessary to develop, implement, and monitor care coordination programs to better align and improve the delivery of Medicare and Medicaid benefits for dual eligible beneficiaries. In accordance with the stipulations described throughout both this Agreement and the DUA, this data sharing Agreement will permit State Medicaid Agencies to use and disclose Medicare Part D data solely for CMS approved purposes.

Once CMS approves the State Medicaid Agency's PDE data requests, the State or its custodian should fill out the attached "Approved Uses and Downstream Users. (Please see Attachment 1). CMS will provide the State with access to Medicare Part D PDE data that may include a one-time file of historical data as well as subsequent PDE data updated on a monthly basis. The State Medicaid Agency or its custodian represents further that the facts and statements made in any data use proposal submitted to CMS using Attachment 1 are complete and accurate. Further, the State Medicaid Agency or its custodian represents that said data uses listed in Attachment 1, and as approved by CMS, represent the total use(s) to which the PDE data will be applied.

The PDE data disclosed under this IEA will be used by State Medicaid Agency employees and approved downstream users solely for the uses and purposes identified above. All downstream users that will receive, view or access these data must hold a valid and current state data use agreement with the State Medicaid Agency. The state

data use agreement must comply with all the terms and conditions of this IEA and the applicable CMS DUA. The State Medicaid Agency must obtain prior CMS approval in the form of an additional DUA Addendum before sharing these data with any additional downstream user. These data may not be used for any purposes that are not indicated in this agreement, such as research, fraud detection, or payment (e.g., calculating risk adjustment factors).

In exchange for the data provided under this Agreement, every six months the State Medicaid Agency agrees to brief CMS on whether and how the data are being used and the results of its care coordination activities. Among these results will be findings on potential best practices for care coordination, quality improvement, and cost savings. In addition, the State Medicaid Agency will provide directly to CMS any written reports based on these results, which may be used or disseminated by CMS at its discretion. Upon request by CMS at any time, the State Medicaid Agency will also provide CMS with any additional updates as requested. Finally, if requested by CMS, and if the CMS use of the data complies with the Privacy Act and is otherwise permitted by law, the State Medicaid Agency will provide to CMS all linked Medicare/Medicaid data that have been made possible by this data sharing Agreement.

III. DESCRIPTION OF THE DATA TO BE DISCLOSED

Each Information Exchange Agreement for protected data must describe the records which will be matched and exchanged, including a sample of data elements that will be used, the approximate number of records that will be matched, and the projected starting and completion dates of the program.

A. Systems of Records

CMS data that will be released to the State Medicaid Agency are maintained in the following database: Medicare Integrated Data Repository (IDR), System No. 09-70-0571 was published at 71 Fed. Reg. 74915 (December 13, 2006). Data maintained in this system will be released pursuant to routine use number 2 as set forth in the system notice. (A copy of the system notice is given as Attachment 2).

B. Projected Starting and Completion Dates

The Agreement shall remain in effect for a period not to exceed 5 years; however, within 3 months prior to the expiration of this Agreement, without additional review, CMS may renew this Agreement for not more than 5 additional years.

C. Number of Records Involved and Operational Time Factors

1. CMS PDE records in 2010 contained approximately 336 million individual Medicare PDE records for dual eligible beneficiaries. Medicare records disclosed to the Participating State under this agreement will include approved PDE data elements for approved timeframes for all dual eligible beneficiaries residing in the Participating State.

2. The total full benefit dual eligible beneficiary population of all States in 2010 includes approximately 7 million individuals. Each Participating State's records file will contain records representing that State's approved PDE data elements for approved time frames for its full benefit dual eligible beneficiaries.

IV. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The State Medicaid Agency will only use the data disclosed under this agreement for the care coordination activities described herein, and will assure that any downstream users with whom it is approved to share these data limit their use to care coordination activities as approved by CMS. In the event these care coordination activities terminate, the State Medicaid Agency will be required to return to CMS or destroy the data files and any derivative data files.

V. PROCEDURES FOR SECURITY

A. CMS and the State Medicaid Agency agree to safeguard the Medicare PDE data as follows:

1. CMS and the State Medicaid Agency will comply with all Federal laws, guidance, and policies for all automated information systems security. For computerized records, safeguards have been established in accordance with the Privacy Act of 1974, as amended, the Computer Security Act of 1987, OMB Circular A-130, revised, Information Resource Management Circular No. 10, HHS Automated Information Systems Security Program, CMS's "IT Systems Security Policies, Standards, and Guidelines Handbook," and other CMS systems security policies. In accordance with the Privacy Act, each automated information system must ensure a level of security commensurate with the level of sensitivity of the data, risk, and magnitude of the harm that may result from the loss, misuse, disclosure, or modification of the information contained in the system.
2. CMS and the State Medicaid Agency will limit access to the data and any derivative files to authorized employees and officials who need them to perform their official duties in connection with the uses and disclosures authorized under this Agreement. Further, all personnel who will have access to the data and any derivative files will be advised of the confidential nature of the information, the safeguards required to protect the records, and the civil and criminal sanctions for non-compliance contained in applicable Federal laws.
3. The State Medicaid Agency will only disclose the data and any derivative files with downstream users after it receives explicit prior approval from CMS. If a disclosure is approved, State Medicaid Agency will place limitations on the downstream user's reuse or redisclosure of the data as a condition of the release of the data. Such limitations are to include a provision barring reuse or redisclosure absent CMS written prior approval.

4. The State Medicaid Agency agrees to limit approved data users to employees of the State Medicaid Agency or users who have a signed data use agreement with the State Medicaid Agency. If data provided under this Agreement are to be shared with a contractor or any other downstream users, the state data use agreement with those users must include all of the data security provisions within this Agreement, and the attachments or exhibits to this Agreement. If any contractor or any other downstream user cannot protect the data as articulated within this Agreement and the attachments or exhibits to this Agreement, then the CMS contact must be notified in writing, data-sharing with that user must be terminated immediately, and data must be destroyed or returned to the State Medicaid Agency. Access to the Medicare PDE data protected by this Agreement will be controlled by the State Medicaid Agency staff who will issue authentication credentials (e.g., a unique user ID and complex password) to authorized downstream users. Contractor or other downstream users will notify State Medicaid Agency staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the contractor or other downstream user, and whenever a user's duties change such that the user no longer requires access to perform work for this Agreement.
 5. The records provided and any records created by the project will be stored in an area that is physically safe from access by unauthorized persons during duty hours as well as non-duty hours or when not in use.
 6. The records provided, and any records created by the match, will be processed under the immediate supervision and control of authorized personnel, to protect the confidentiality of the records in such a way that unauthorized persons cannot retrieve any such records by means of computer, remote terminal, or other means.
 7. The records provided and records created by the project will be transported under appropriate safeguards in compliance with Section 7 of the DUA. This includes encrypting any data that will be in transit outside the State Medicaid Agency's internal network, for example, during transit over the public Internet.
 8. CMS may make onsite inspections, with or without advance notice, and may make other provisions to ensure that the State Medicaid Agency and any downstream users are maintaining adequate safeguards.
- B. The Participating State agency shall report any breach, inappropriate use of data, or security incident of which it becomes aware to CMS within one hour. CMS will take actions in response to any data breach, inappropriate use of data, or security incident in accordance with CMS Breach Notification Procedures, as defined in Memorandum ISP~ 2007-007 entitled, "Departmental Response to the Office of Management and Budget (OMB) Memorandum (M) 07-16," Safeguarding Against and Responding to the Breach of Personally Identifiable Information, and the HIPAA Security Rule.

VI. RECORDS USAGE, DUPLICATION AND REDISCLOSURE RESTRICTIONS

The State Medicaid Agency agrees to the following limitations on the access to, and disclosure and use of, the electronic files and information provided by CMS:

- A. That the files provided by CMS as part of this Agreement will remain the property of CMS and will be returned or destroyed as soon as the use, as stipulated by Section I.A of this Agreement, of the data by the State Medicaid Agency is completed.
- B. That the data supplied by CMS will be used only as provided in this Agreement.
- C. That the files provided by CMS will not be used to extract information concerning the individuals therein for any purpose not specified in this Agreement.
- D. That the files provided by CMS will only be duplicated, disseminated, and accessed within the State Medicaid Agency or with CMS-approved downstream users per the conditions stipulated in this Agreement. The PDE data provided by CMS will only be disclosed outside the State Medicaid Agency if there is signed DUA with each downstream user, and CMS has approved the disclosure per Section II of this Agreement. Otherwise, CMS shall not give such permission unless the redisclosure is required by law.
- E. That the files will not be used to investigate fraud and that the files will not be matched to any files that are used for purposes of fraud detection.

VII. REIMBURSEMENT AND REPORTING

No funds will be exchanged under this Information Exchange Agreement for any work to be performed by the Participating State to carry out the requirements of this IEA. CMS will provide data to the State Medicaid Agency at no cost.

VIII. APPROVAL AND DURATION OF AGREEMENT

- A. This Agreement is effective upon approval by CMS and the State Medicaid Agency signatories and remains in effect indefinitely or until it is amended or superseded by a new Agreement. This Agreement may be amended at any time through a written modification that is signed by both parties.
- B. Either party may unilaterally terminate this Agreement upon written notice to the other party, in which case the termination shall generally be effective 30 days after the date of the notice or at a later date specified in the notice, but in no instance shall such a termination be effective prior to the return or destruction of all data that were supplied to the State Medicaid Agency and to downstream entities in accordance with Section IV of this Agreement.
- C. CMS may immediately and unilaterally terminate this Agreement if CMS determines that there have been unauthorized uses or redisclosures of the data by

the State Medicaid Agency or downstream users, a violation of the security requirements of the data, or a violation of, or a failure to follow, any of the terms of this Agreement. In such cases, termination shall be effective in 24 hours from the time and date of such determination; any and all data that were supplied to the State Medicaid Agency are to be destroyed or returned to CMS within 24 hours of the determination, per Section IV of this agreement, and; the State Medicaid Agency will be subject to any or all applicable penalties in accordance with applicable law.

- D. CMS may make a unilateral suspension of this Agreement if it suspects that the State Medicaid Agency has breached the terms for privacy and security of data until such time as CMS makes a definite determination regarding a breach.
- E. CMS may unilaterally terminate this Agreement if there is no evidence that the State Medicaid Agency has used the data for care coordination purposes within nine (9) months of receiving it.

IX. PERSONS TO CONTACT

- A. The CMS program and policy contact:

Karyn Kai Anderson, Ph.D., M.P.H.
Federal Coordinated Health Care Office
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: S3-13-23
Baltimore, MD 21244-1850
(410) 786-6696
E-Mail: Karyn.Anderson@cms.hhs.gov

- B. The CMS contact for Privacy issues:

Walter Stone
CMS Privacy Officer
Division of Privacy Compliance
Enterprise Architecture & Strategy Group
Office of Information Services
Mail-stop: NI-24-08
7500 Security Boulevard
Baltimore Md. 21244-1850
Phone: (410) 786-5357
Fax: (410) 786-5636
Email: Walter.Stone@cms.gov

- C. The contact person for the State Medicaid Agency can be found on the State's signature page.
- D. The contact person for the Custodian can be found on the Custodian signature page.

X. APPROVALS

A. Centers for Medicare & Medicaid Services Program Official

The authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved by (Signature of Authorized CMS Program Official)

[Signature on File]

Sharon Donovan
Group Director
Program Alignment Group
Federal Coordinated Health Care Office
Centers for Medicare & Medicaid Services

B. Centers for Medicare & Medicaid Services Approving Official

The authorized approving official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved by (Signature of Authorized CMS Approving Official)

[Signature on File]

Tony Trenkle
Chief Information Officer & Director
Office of Information Services
Centers for Medicare & Medicaid Services

C. Participating State Program Official

The authorized Participating State program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

NAME OF PARTICIPATING STATE MEDICAID AGENCY

State of Washington

Health Care Authority

Approved By (Signature of Authorized State Approving Official)

[Signature on File]

Doug Porter
Director
Health Care Authority

PERSONS TO CONTACT

The Health Care Authority for Approval Issues:

Doug Porter
Director
Health Care Authority
Post Office Box 45502
626 8th Avenue, SE
Olympia, WA 98504-5502
Office: (360) 725-1863
Facsimile: (360) 586-9551
E-Mail: PORTEJD@hca.wa.gov

D. State Agency Custodian Official

The authorized State Agency Custodial official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

NAME OF PARTICIPATING STATE MEDICAID AGENCY

State of Washington

Health Care Authority

Approved By (Signature of Authorized State Custodian Official)

[Signature on File]

Cathie Ott
Deputy Chief Information Officer
Health Care Authority

PERSONS TO CONTACT

The Health Care Authority for Data Custodian issues contact:

Cathie Ott

Deputy Chief Information Officer
Health Care Authority
Post Office Box 45564
626 8th Avenue, SE
Olympia, WA 98504-5564
Office: (360) 725-2116
Facsimile: (360) 586-9551
E-Mail: OTTCL@hca.wa.gov

Attachments:

- 1) Approved Uses and Downstream Users
- 2) System Notice-- CMS No. 09-70-0571--Medicare Integrated Data Repository

Attachment 1 -Approved Uses and Downstream Users

Planned Use or Disclosure of PDE Data	Purpose (i.e., how the Planned Use supports goals of care coordination)	Data User category	Name of Downstream User (if applicable)	Approved ? (for CMS use only)
Development of predictive risk indicators – ie risk of future hospital admission, nursing home placement, future medical expenditures, etc.	Analysis of high opportunity conditions and individuals for targeting or specific care coordination/ support strategies	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted analysts	
Development of web-based clinical decision support tool, PRISM (Predictive Risk Intelligence System) integrating risk factors and available data for care coordinators and management of health care and related services	To enable care coordinators to easily view integrated patient data and effectively implement care coordination	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted care coordination organizations/ individuals	
Patient summaries provided by care coordinators to patients, families and treating health providers, such as medication lists; health risk summaries	To implement care coordination, care plans and treatment alternatives	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted care coordination organizations/individuals; Patients, Families, Treating health providers	
Program Administration – Model development and analysis including quality and performance incentive alternatives; sub-population profiles (utilization, costs, outcomes, access); development of performance measures, clinical guidelines, performance feedback reports; program monitoring and evaluation including client and provider surveys	For care coordination program and model development, implementation, analysis, monitoring and feedback Analysis and monitoring through profiling of utilization, costs, outcomes and access of the dual population for care coordination program development and modeling of program, qualify and performance incentive alternatives	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted analysts	

Attachment 2 - System Notice

CMS No. 09-70-0571--Medicare Integrated Data Repository

SYSTEM NO. 09-70-0571

SYSTEM NAME:

"Medicare Integrated Data Repository (IDR), HHS/CMS/OIS"

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive Data

SYSTEM LOCATION:

The Centers for Medicare & Medicaid Services (CMS) Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244-1850.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

This system maintains information on individuals age 65 or over who have been, or currently are, entitled to health insurance (Medicare) benefits under Title XVIII of the Social Security Act (the Act) or under provisions of the Railroad Retirement Act; individuals under age 65 who have been, or currently are, entitled to such benefits on the basis of having been entitled for not less than 24 months to disability benefits under Title II of the Act or under the Railroad Retirement Act; individuals who have been, or currently are, entitled to such benefits because they have End-Stage Renal Disease (ESRD); individuals age 64 and 8 months or over who are likely to become entitled to health insurance (Medicare) benefits upon attaining age 65, and individuals under age 65 who have at least 21 months of disability benefits who are likely to become entitled to Medicare upon the 25th month or entitlement to such benefits and those populations that are dually eligible for both Medicare and Medicaid (Title XIX of the Act). Additionally, this system will maintain information on Medicare beneficiaries Parts A, B, C, and D and physicians, providers, employer plans, Medicaid recipients and Medicare secondary payers.

CATEGORIES OF RECORDS IN THE SYSTEM:

Information maintained in the system include, but are not limited to: standard data for identification such as health insurance claim number, social security number, gender, race/ethnicity, date of birth, geographic location, Medicare enrollment and entitlement information, MSP data necessary for appropriate

Medicare claim payment, hospice election, MA plan elections and enrollment, End Stage Renal Disease (ESRD) entitlement, historic and current listing of residences, and Medicare eligibility and Managed Care institutional status. Additionally, this system will maintain identifying information on physicians, providers, employer plans, Medicaid recipients and Medicare secondary payers.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Authority for the collection of data maintained in this system is given under §§ 226, 226A, 1811, 1818, 1818A, 1831, 1833(a) (1) (A), 1836, 1837, 1838, 1843, 1866, 1874a, 1875, 1876, 1881, and 1902(a) (6) of the Social Security Act (the Act). The following are the corresponding sections from Title 42 of the United States Code (U.S.C.): 426, 426-1, 1395c, 1395i-2, 1395i-2a, 1395j, 1395l(a)(1)(A), 1395o, 1395p, 1395q, 1395v, 1395cc, 1395kk-1, 1395ll, 1395mm, 1395n-, 1396a(a)(6), and § 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Public Law 108M 113), which established the Medicare Part D program.

PURPOSE(S) OF THE SYSTEM:

The primary purpose of this system is to establish an enterprise resource that will provide one integrated view of all CMS data to administer the Medicare and Medicaid programs. Information retrieved from this system of records will also be disclosed to: (1) support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, consultant or CMS grantee; (2) assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) support providers and suppliers of services for administration of Title XVIII; (4) assist third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (5) assist Medicare Advantage Plans and Part D Prescription Drug Plans; (6) support Quality Improvement Organizations (QIO); (7) assist other insurers for processing individual insurance claims; (8) facilitate research on the quality and effectiveness of care provided, as well as payment related projects; (9) support litigation involving the agency; and (10) combat fraud, waste, and abuse in certain health benefits programs.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OR USERS AND THE PURPOSES OF SUCH USES:

The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a "routine use." The proposed routine uses in this system meet the compatibility requirement of the Privacy Act. We are proposing to

establish the following routine use disclosures of information maintained in the system:

1. To support agency contractors, consultants or grantees who have been engaged by the agency to assist in the performance of a service related to this system and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent to:
 - a. contribute to the accuracy of CMS' proper payment of Medicare benefits,
 - b. enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, and/or
 - c. assist Federal/state Medicaid programs within the state.
3. To support providers and suppliers of services directly or through fiscal intermediaries or carriers for the administration of Title XVIII of the Act.
4. To assist third party contact in situations where the party to be contacted has, or is expected to have information relating to the individual's capacity to manage his or her affairs or to his or her eligibility for, or an entitlement to, benefits under the Medicare program and;
 - a. the individual is unable to provide the information being sought (an individual is considered to be unable to provide certain types of information when any of the following conditions exists: the individual is confined, to a mental institution, a court of competent jurisdiction has appointed a guardian to manage the affairs of that individual, a court of competent jurisdiction has declared the individual to be mentally incompetent, or the individual's attending physician has certified that the individual is not sufficiently mentally competent to manage his or her own affairs or to provide the information being sought, the individual cannot read or write, cannot afford the cost of obtaining the information, a language barrier exist, or the custodian of the information will not, as a matter of policy, provide it to the individual), or
 - b. the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns one or more of the following: the individual's entitlement to benefits under the Medicare program, the amount of reimbursement, and in cases in which the evidence is being reviewed as a result of suspected fraud,

waste, and abuse, program integrity, quality appraisal, or evaluation and measurement of activities.

5. To assist Medicare Advantage Plans, Part D Prescription Drug Plans and their Prescription Drug Event submitters, providing protection against medical expenses of their enrollees without the beneficiary's authorization, and having knowledge of the occurrence of any event affecting (a) an individual's right to any such benefit or payment, or (b) the initial right to any such benefit or payment, for the purpose of coordination of benefits with the Medicare program and implementation of the Medicare Secondary Payer provision at 42 U.S.C. 1395y (b).

Information to be disclosed shall be limited to Medicare entitlement, enrollment and utilization data necessary to perform that specific function. In order to receive the information, they must agree to:

- a. certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a Third Party Administrator;
 - b. utilize the information solely for the purpose of processing the individual's enrollment or insurance claim; and
 - c. safeguard the confidentiality of the data and prevent unauthorized access.
6. To support Quality Improvement Organizations (QIO) in connection with review of claims, or in connection with studies or other review activities conducted pursuant to Part B of Title XI of the Act, and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans. As established by the Part D Program, QIOs will conduct reviews of prescription drug events data, or in connection with studies or other review activities conducted pursuant to Part D of Title XVIII of the Act.
 7. To assist other insurers, underwriters, third party administrators (TPAs), self-insurers, group health plans, employers, health maintenance organizations, health and welfare benefit funds, Federal agencies, a state or local government or political subdivision of either (when the organization has assumed the role of an insurer, underwriter, or third party administrator, or in the case of a state that assumes the liabilities of an insolvent insurers pool or fund), multiple employers trusts, no-fault medical, automobile insurers, workers' compensation carriers plans, liability insurers, and other groups providing protection against medical expenses who are primary payers to Medicare in accordance with 42

U.S.C. 1395y(b), or any entity having knowledge of the occurrence of any event affecting;

- a. an individual's right to any such benefit or payment, or
- b. the initial or continued right to any such benefit or payment.(for example, a State Medicaid Agency, State Workers' Compensation Board, or Department of Motor Vehicles) for the purpose of coordination of benefits with the Medicare program and implementation of the MSP provisions at 42 U.S.C. 1395 y(b). The information CMS may disclose will be:

- Beneficiary Name
- Beneficiary Address
- Beneficiary Health Insurance Claim Number
- Beneficiary Social Security Number
- Beneficiary Gender
- Beneficiary Date of Birth
- Amount of Medicare Conditional Payment
- Provider Name and Number
- Physician Name and Number
- Supplier Name and Number
- Dates of Service
- Nature of Service
- Diagnosis

To administer the MSP provision at 42 U.S.C. 1395 y (b) (2), (3), and (4) more effectively, CMS would receive (to the extent that it is available) and may disclose the following types of information from insurers, underwriters, third party administrator, self-insurers, etc.:

- Subscriber Name and Address
- Subscriber Date of Birth
- Subscriber Social Security number
- Dependent Name
- Dependent Date of Birth
- Dependent Social Security Number
- Dependent Relationship to Subscriber
- Insurer/Underwriter/TPA Name and Address
- Insurer/Underwriter/TPA Group Number
- Insurer/Underwriter/Group Name
- Prescription Drug Coverage
- Policy Number

- Effective Date of Coverage
- Employer Name, Employer Identification Number (EIN) and Address
- Employment Status
- Amounts of Payment

To administer the MSP provision at 42 U.S.C. 1395y(b) (1) more effectively for entities such as Workers' Compensation carriers or boards, liability insurers, no-fault and automobile medical policies or plans, CMS would receive (to the extent that it is available) and may disclose the following information:

- Beneficiary's Name and Address
- Beneficiary's Date of Birth
- Beneficiary's Social Security number
- Name of insured
- Insurer Name and Address
- Type of coverage; automobile medical, no-fault, liability payment, or workers' compensation settlement
- Insured's Policy Number
- Effective Date of Coverage
- Date of accident, injury or illness
- Amount of payment under liability, no-fault, or automobile medical policies, plans, and workers' compensation settlements
- Employer Name and Address (Workers' Compensation Only)
- Name of insured could be the driver of the car, a business, the beneficiary (i.e., the name of the individual or entity which carries the insurance policy or plan).

In order to receive this information the entity must agree to the following conditions; to utilize the information solely for the purpose of coordination of benefits with the Medicare program and other third party payer in accordance with Title 42 U.S.C. 1395 y (b); to safeguard the confidentiality of the data and to prevent unauthorized access to it; and, to prohibit the use of beneficiary-specific data for the purposes other than for the coordination of benefits among third party payers and the Medicare program. This agreement would allow the entities to use the information to determine cases where they or other third party payers have primary responsibility for payment. Examples of prohibited uses would include but are not limited to; creation of a mailing list, sale or transfer of data.

To administer the MSP provisions more effectively, CMS may receive or disclose the following types of information from or to entities

including insurers, underwriters, TPAs, and self-insured plans, concerning potentially affected individuals:

- Subscriber HICN
 - Dependent Name
 - Funding arrangements of employer group health plans, for example, contributory or non-contributory plan, self-insured, re-insured, HMO, TPA insurance
 - Claims payment information, for example, the amount paid, the date of payment, the name of the insurers or payer
 - Dates of employment including termination date, if appropriate
 - Number of full and/or part-time employees in the current and preceding calendar years
 - Employment status of subscriber, for example, full or part time or self-employed
8. To assist an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.
 9. To support the Department of Justice (DOJ), court or adjudicatory body when: the agency or any component thereof, or any employee of the agency in his or her official capacity, or any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or the United States Government, is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.
 10. To support a CMS contractor (including, but not necessarily limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, detect, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such program.
 11. To support another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in

part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such programs.

E. Additional Provisions Affecting Routine Use Disclosures

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation "Standards for Privacy of Individually Identifiable Health Information" (45 CFR Parts 160 and 164, Subparts A and E) 65 Fed. Reg. 82462 (12-28-00), as modified at 67 Fed. Reg. 53,182 (8-14-2002). Disclosures of such PHI that are otherwise authorized by these routine uses may only be made if, and as, permitted or required by the "Standards for Privacy of Individually Identifiable Health Information."

In addition, our policy will be to prohibit release even of data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that, because of the small size, use this information to deduce the identity of the beneficiary).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

All records are stored electronically.

RETRIEVABILITY:

All Medicare records are accessible by HICN, SSN, and unique provider identification number.

SAFEGUARDS:

CMS has safeguards in place for authorized users and monitors such users to ensure against unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information

security and data privacy. These laws and regulations may apply but are not limited to: the Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A-130, Management of Federal Resources, Appendix III, and Security of Federal Automated Information Resources also apply. Federal, HHS, and CMS policies and standards include but are not limited to: all pertinent National Institute of Standards and Technology publications; the HHS Information Systems Program Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

Records are maintained for a period of 6 years and 3 months. All claims-related records are encompassed by the document preservation order and will be retained until notification is received from DOJ.

SYSTEM MANAGER AND ADDRESS:

Director, Division of Business Analysis & Analysis, Enterprise Databases Group, Office of Information Services, CMS, Room NI-14-08, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the system manager who will require the system name, HICN, address, date of birth, and gender, and for verification purposes, the subject individual's name (woman's maiden name, if applicable), and SSN. Furnishing the SSN is voluntary, but it may make searching for a record easier and prevent delay.

RECORD ACCESS PROCEDURE:

For purpose of access, use the same procedures outlined in Notification Procedures above. Requestors should also specify the record contents being sought. (These procedures are in accordance with department regulation 45 CFR 5b.5 (a) (2)).

CONTESTING RECORDS PROCEDURES:

The subject individual should contact the system manager named above, and reasonably identify the records and specify the information to be contested. State the corrective action sought and the reasons for the correction with supporting justification. (These Procedures are in accordance with Department regulation 45 CFR 5b.7).

RECORDS SOURCE CATEGORIES:

The data collected and maintained in this system are retrieved from the following databases: Medicare Drug Data Processing System, System No. 09-70-0553 (70 *Federal Register* (Fed. Reg.) 58436 (October 6, 2005)); Medicare Beneficiary Database, System No. 09-70-0536 (71 Fed. Reg. 11425 (March 7, 2006)); Medicare Advantage Prescription Drug System, System No. 09-70-4001 (70 Fed. Reg. 60530 (October 18, 2005)); Medicaid Statistical Information System, System No. 09-70-0541 (71 Fed. Reg. 65527 (November 8, 2006)); Retiree Drug Subsidy Program, System No. 09-70-0550 (70 Fed. Reg. 41035 (July 15, 2005)); Common Working File, System No. 09-70-0526 (71 Fed. Reg. 64955 (November 6, 2006)); National Claims History, System No. 09-70-0005 (67 Fed. Reg. 57015 (September 6, 2002)); Enrollment Database, System No. 09-70-0502 (67 Fed. Reg. 3203 (January 23, 2002)); Multi-Carrier Claims System (formerly known as the Carrier Medicare Claims Record), System No. 09-70-0501 (71 Fed. Reg. 64968 (November 6, 2006)); Fiscal Intermediary Shared System (formerly known as the Intermediary Medicare Claims Record), System No. 09-70-0503 (71 Fed. Reg. 64961 (November 6, 2006)); Unique Physician/Provider Identification Number, System No. 09-70-0525, (69 Fed. Reg. 75316 (December 16, 2004)); Medicare Supplier Identification File, System No. 09-70-0530 (71 Fed. Reg. 65527 (November 8, 2006). Information will also be provided from the application submitted by the individual through state Medicaid agencies, the Social Security Administration and through other entities assisting beneficiaries.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

SCHEDULE 4
MEDICARE PART D
CONFLICT OF INTEREST ATTESTATION

SCHEDULE 4: MEDICARE PART D – CONFLICT OF INTEREST ATTESTATION

[Date]

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

Dear Beverly Court,

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

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

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

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

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

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

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

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

SCHEDULE 5
PRISM ACCESS REQUEST FORM

PRISM Access Request for Multiple Organizations

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

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

Changes to Access for Users

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

Requesting Organizations (to be completed by PRISM Lead)		
CONTRACTOR'S NAME	STREET ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)	
1.		
2.		
3.		
User Registration Information (to be completed by User)		
USER'S NAME (FIRST, MIDDLE, LAST)	USER'S JOB TITLE	
USER'S BUSINESS EMAIL ADDRESS	USER'S BUSINESS PHONE NUMBER (INCLUDE AREA CODE)	
USER'S EMPLOYER	DATE IT SECURITY TRAINING COMPLETED (REQUIRED YEARLY)	
If user will be completing Health Action Plans (HAPs), enter the date training was completed:	DATE HAP TRAINING COMPLETED	DATE HIPAA TRAINING COMPLETED (REQUIRED)
PRISM USER'S SIGNATURE	DATE	PRISM USER'S PRINTED NAME
Authorizing Signature(s)		
Protected Data Access Authorization <p>The HIPAA Security rule states that every employee that needs access to electronic Protected Health Information (ePHI) receives authorization from an appropriate authority and that the need for this access based on job function or responsibility is documented. I, the undersigned PRISM Lead, verify that the individual for whom this access is being requested (User or Subcontractor User) has a business need to access this data, has completed the required HIPAA Privacy training and the annual IT Security training and has signed the required <i>User Agreement and Non-Disclosure of Confidential Information</i> included with this Access Request. This User's access to this electronic Protected Health Information (ePHI) is appropriate under the HIPAA Information Access Management Standard and the Privacy Rule. In addition, if applicable, this employee has been instructed on 42 Code of Federal Regulations (CFR) Part 2 that governs the use of alcohol and drug use information and is aware that this type of data must be used only in accordance with these regulations. I have also ensured that the necessary steps have been taken to validate the User's identity before approving access to confidential and protected information. If a Subcontractor is indicated, I attest that the contract with the Subcontractor includes a HIPAA Business Associate Agreement, and where appropriate Medicare data share language.</p>		
PRISM LEAD SIGNATURE (CONTRACTOR 1)	DATE	PRISM LEAD NAME 1 (PRINT)
PRISM LEAD SIGNATURE (CONTRACTOR 2)	DATE	PRISM LEAD NAME 2 (PRINT)
PRISM LEAD SIGNATURE (CONTRACTOR 3)	DATE	PRISM LEAD NAME 3 (PRINT)

User Agreement and Non-Disclosure of Confidential Information

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

Confidential Information

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

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

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

Regulatory Requirements and Penalties

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

User Agreement and Assurance of Confidentiality

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

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

User's Signature

PRISM USER'S SIGNATURE

DATE

PRISM USER'S PRINTED NAME

Exhibit H Health Homes

1. Health Homes Definitions

- 1.1. "Aging and Long-Term Support Administration (ALTSA)" means the administration within the Department of Social and Health Services responsible for providing long-term services and supports to individuals who are functionally and financially eligible to receive such services.
- 1.2. "Allied or Affiliated Staff" means community health workers, peer counselors, wellness or health coaches or other non-clinical personnel who provide supportive services outreach and engagement to the enrollee under the direction and supervision of the Health Home Care Coordinator.
- 1.3. "Area Agency on Aging (AAA)" means a network of state and local programs that help older people to plan and care for their life long needs.
- 1.4. "Authorizing Entity" means an organization contracted by the state to approve or disapprove covered benefits for Medicaid beneficiaries following utilization guidelines. Examples include Managed Care Organizations, Behavioral Health Administrative Service Organizations, and Home and Community-based or Area Agency on Aging service entities.
- 1.5. "Behavioral Health Administrative Services Organization (BH-ASO)" means an entity selected by HCA to administer behavioral health services and programs, including Crisis and Ombuds Services for individuals in a defined Regional Service Area. The BH-ASO administers Crisis and Ombuds Services for all individuals in its defined service area, regardless of ability to pay, including Medicaid eligible members.
- 1.6. "Behavioral Health Services" means services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.
- 1.7. "Behavioral Health Services Only (BHSO)" means those Enrollees who receive only behavioral health benefits through this Contract and the companion non-Medicaid Contract.
- 1.8. "Care Coordination Organization (CCO)" means an organization within the Qualified Health Home network that is responsible for delivering Health Home services.
- 1.9. "Caregiver Activation Measure® (CAM®)" means an assessment that gauges the knowledge, skills and confidence essential to a caregiver providing care for a person with chronic conditions.
- 1.10. "Comprehensive Assessment Report and Evaluation (CARE)" means a person centered tool used by case managers to document a client's functional ability, determine eligibility for long-term care services, evaluate what and how much assistance a client will receive, and develop a plan of care, as defined in chapter 388-106 WAC.
- 1.11. "Coverage Area(s)" means pre-determined geographical areas composed of specific counties.

- 1.12. "Department of Social and Health Services (DSHS)" means the Washington State Department of Social and Health Services.
- 1.13. "Designated Staff" means either the Contractor's employee(s) or employee of any Subcontractor or employees of any Health Home Provider with whom the Contractor has a MOA to provide Health Home Services to the Contractor's enrollees and whom have been authorized by their employer to access data.
- 1.14. "Developmental Disabilities Administration (DDA)" means the administration within the Department of Social and Health Services that provides services to individuals with developmental disabilities who are functionally and financially eligible to receive such services.
- 1.15. "Engagement" means the enrollee's agreement to participate in Health Homes as demonstrated by the completion of the enrollee's Health Action Plan.
- 1.16. "Fee-For-Service (FFS)" means the Medicaid delivery system that provides covered Medicaid benefits to eligible beneficiaries through any willing and contracted provider. Providers are paid on a per service basis.
- 1.17. "Full Dual Eligible" means a Medicare Beneficiary who is also eligible for the full scope of Medicaid covered benefits.
- 1.18. "Hallmark Events" means elevated episodes of care that have potential to seriously affect the enrollee's health or health outcomes.
- 1.19. "Health Action Plan (HAP)" means an enrollee-prioritized plan identifying what the enrollee plans to do to improve his or her health and well-being.
- 1.20. "Health Home Care Coordinator" means an individual employed by the Contractor or a CCO who provides Health Home Services.
- 1.21. "Health Home Participation Authorization and Information Sharing Consent Form" means a release form signed by the enrollee to confirm the Enrollee's consent to participate in the health home program and to authorize the release of information to facilitate the sharing of the enrollee's health information.
- 1.22. "Health Home Services" means a group of six services defined under Section 2703 of the Affordable Care Act. The six (6) Health Home Services are:
 - 1.22.1. Comprehensive Care Management
 - 1.22.2. Care Coordination and Health Promotion
 - 1.22.3. Comprehensive transitional care from inpatient to other settings including appropriate follow-up
 - 1.22.4. Individual and Family Support
 - 1.22.5. Referral to Community and Social Support Services
 - 1.22.6. The use of Health Information Technology to link services, as appropriate
- 1.23. "Katz Index of Independence in Activities of Daily Living (Katz ADL)" means a screening instrument used to assess basic activities of daily living in older adults in a variety of care settings.
- 1.24. "Long Term Services and Supports (LTSS)" means the variety of services and supports that help people with functional impairments meet their daily needs for

assistance in community-based settings and improve the quality of their lives.

- 1.25. "Memorandum of Agreement/Understanding (MOA or MOU)" means a business agreement for partnerships that do not involve a financial arrangement describing the roles and responsibilities of each party to the agreement.
- 1.26. "Parent Patient Activation Measure® (PPAM®)" means an assessment that gauges the knowledge, skills and confidence of the parent's management of their child's health.
- 1.27. "Patient Activation Measure® (PAM®)" means an assessment that gauges the knowledge, skills and confidence essential to managing one's own health and health care.
- 1.28. "Patient Protection and Affordable Care Act" or "ACA" means Public Laws 111-148 and 111-152 (both enacted in March 2010).
- 1.29. "PRISM User Coordinator" means the employee appointed by the Contractor to be the point of contact for the HCA and DSHS's PRISM Administration Team.
- 1.30. "Qualified Health Home" means an entity qualified by the state to administer the Health Home program to eligible beneficiaries.

2. Health Home Services for IMC Enrollees

- 2.1. The Contractor shall provide Health Home services in addition to the Care Coordination Services described in Section 14 of the IMC Contract, to high cost, high needs enrollees who meet Health Home eligibility criteria.
- 2.2. Health Home Services shall be community-based, integrated and coordinated across medical, behavioral health, and long-term services and supports to enrollees based on the services described in Section 1945(h)(4) of the Social Security Act.
- 2.3. The Contractor shall ensure that the following are operational:
 - 2.3.1. Submission of completed and updated Health Action Plan (HAP) data through the *OneHealthPort* Health Information Exchange using the OneHealthPort Canonical Guide located at:
http://www.hca.wa.gov/medicaid/health_homes/Documents/HAP_CanonicalGuide.pdf. The HAP data will be stored in a Medicaid data base for evaluation purposes;
 - 2.3.2. A system to track and share enrollee information and care needs among providers, to monitor processes of care and outcomes, and to initiate recommended changes in care as necessary to support health action goals, including the enrollee's preferences and identified needs;
 - 2.3.3. A system to track Health Home Services through claims paid or services rendered and report the encounter data in accordance with HCA Encounter Data Reporting Guide;
 - 2.3.4. Enrollee access to a toll-free line and customer service representative to answer questions, 8:00 a.m. to 5:00 p.m. from Monday through Friday regarding Health Home enrollment, disenrollment, and how to access services or request a change to another CCO;
 - 2.3.5. A system for emergency consultation and general information available 24/7;

- 2.3.6. Lead Entities must have executed a MOU or MOA with organizations that authorize Medicaid services such as DSHS Home and Community Services (HCS), BH-ASOs, DDA, and Area Agencies on Aging (AAAs) to ensure continuity of care. MOU/MOAs must contain information related to Enrollee privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.
- 2.3.7. The Contractor shall submit encounter data according to the three tier process listed below:
 - 2.3.7.1. Tier One: Outreach, Engagement, and Health Action Plan Development includes:
 - 2.3.7.1.1. Outreach by mail; phone; or other methods, continues until the eligible enrollee agrees to participate or declines participation in the Health Home program. Contractor must document all attempts to contact Enrollee.
 - 2.3.7.1.2. Engagement occurs when the Enrollee agrees to a face-to-face visit between the Enrollee and the Health Home Care Coordinator in a location of the Enrollee's choosing, such as their home or provider's office.
 - 2.3.7.1.3. Health Action Plan Development includes face-to-face visits to complete the initial Health Action Plan, the Health Home Participation Authorization and Information Sharing Consent form, and coaching to assist the Enrollee in identifying short and long-term goals and associated action steps.
 - 2.3.7.2. Tier Two: Intensive Health Home Care Coordination is the highest level of Health Home Care Coordination services using one (1) or more elements of the six defined Health Home Services and includes evidence that the Care Coordinator, the Enrollee, and the Enrollee's caregivers are:
 - 2.3.7.2.1. Actively engaged in achieving health action goals;
 - 2.3.7.2.2. Participating in activities that support improved health and well-being; and
 - 2.3.7.2.3. Have value for the Enrollee and caregivers, supporting an active level of care coordination through delivery of Health Home Services.
 - 2.3.7.2.4. Typically Intensive Health Home Care Coordination includes one face-to-face visit with the Enrollee every month in which a qualified Health Home Service is provided. Exceptions to the monthly face-to-face visit may be approved by the Contractor as long as the Health Home Services provided during the month achieve one or more of the following:
 - 2.3.7.2.4.1. Clinical, functional, and resource use screens, including screens for depression, alcohol or

- substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual;
 - 2.3.7.2.4.2. Continuity and coordination of care through in-person visits, and the ability to accompany Beneficiaries to health care provider appointments, as needed;
 - 2.3.7.2.4.3. Enrollee assessments to determine readiness for self-management and to promote self-management skills to improve functional or health status, or prevent or slow declines in functioning;
 - 2.3.7.2.4.4. Fostering communication between the providers of care, including the treating primary care provider, medical specialists, personal care providers and others, and entities authorizing behavioral health and long-term services and supports;
 - 2.3.7.2.4.5. Promoting optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;
 - 2.3.7.2.4.6. Health education and coaching designed to assist Beneficiaries to increase self-management skills and improve health outcomes; and
 - 2.3.7.2.4.7. Use of peer supports, support groups, and self-care programs to increase the Enrollee's knowledge about their health care conditions and improve adherence to prescribed treatment.
 - 2.3.7.3. Tier Three: Low-Level Health Home Care Coordination occurs when the Enrollee and Health Home Care Coordinator identify that the Enrollee has achieved a sustainable level of progress toward meeting self-directed goals, or upon the Enrollee's request.
 - 2.3.7.3.1. Low-Level Health Home Care Coordination includes monitoring the Enrollee's health care needs and progress toward meeting self-directed goals using one (1) or more of the six defined Health Home Services.
 - 2.3.7.3.2. At least one (1) qualified Health Home Service must be delivered during the month through face-to-face visits or telephone calls.
- 2.3.8. The Contractor's PRISM Coordinator shall identify all Designated Staff who have a business need to access PRISM.

- 2.3.8.1. The Contractor shall ensure that Designated Staff complete and submit to the DSHS PRISM Administration Team all the necessary forms required by CMS and DSHS for data authorization and PRISM access, including:
 - 2.3.8.1.1. The PRISM Registration form; and
 - 2.3.8.1.2. The DSHS provided spreadsheet.
- 2.3.8.2. The Contractor shall promptly notify the DSHS PRISM Administration Team to remove established Designated Staff user accounts due to employment termination, job reassignment, or other changes in circumstances.
- 2.3.9. Policies and Procedures: The Contractor shall abide by all HCA policies and procedures for Health Home services, and maintain regularly updated Contractor-specific policies and procedures that address the following:
 - 2.3.9.1. The requirement to maintain frequent, in-person contact between the Health Home enrollee and the Health Home Care Coordinator when delivering Health Home services;
 - 2.3.9.2. Ongoing availability of support staff to complement the work, collaborate, receive direction and report to the Health Home Care Coordinator;
 - 2.3.9.3. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions;
 - 2.3.9.4. The Contractor's and subcontractor's roles and responsibilities for enrollee engagement;
 - 2.3.9.5. Ensuring an appointment reminder system is in place for enrollees.
 - 2.3.9.6. Tracking of enrollee assignment to Care Coordination Organizations;
 - 2.3.9.7. Referrals to HCA for eligibility review of any potential enrollee who seeks or needs Health Home services;
 - 2.3.9.8. Transitional care services for enrollees transferring to or from a hospital, other inpatient setting, or emergency departments;
 - 2.3.9.9. A policy and procedure to deal with the compromise or potential compromise of Data that complies with the HITECH Act of ARRA; and
 - 2.3.9.10. Due diligence for contacting the enrollee for affirmation of participation.
 - 2.3.9.11. Identify and address enrollee gaps in care through:
 - 2.3.9.11.1. Assessment of existing data sources (e.g., PRISM, CARE, etc.) for evidence of the standard of care for and preventive care appropriate to the enrollee's age and underlying chronic conditions;
 - 2.3.9.11.2. Evaluation of enrollee perception of gaps in care;
 - 2.3.9.11.3. Documentation of gaps in care in the enrollee case file;

2.3.9.11.4. Documentation of interventions in HAP and progress notes;

2.3.9.11.5. Findings from the enrollee's response to interventions; and

2.3.9.11.6. Documentation of follow-up actions, and the person or organization responsible for follow-up.

3. Health Home Care Coordinator Qualification and Training Requirements

The Contractor shall ensure that:

- 3.1. Health Home Coordinators must possess one of the following licenses or credentials:
 - 3.1.1. Current license as registered nurses, advanced registered nurse practitioners, practical nurses, psychiatric nurses, psychiatrists, physician assistants, clinical psychologists, mental health counselors, agency affiliated counselors, marriage and family therapists; or certified chemical dependency professionals; or
 - 3.1.2. Master's or Bachelor's in social work, psychology, social services, human services, or behavioral sciences; or
 - 3.1.3. Certified Medical Assistants with an Associate Degree or Indian Health Service (IHS) Certified Community Health Representatives (CHR).
- 3.2. Health Home Care Coordinators and affiliated staff complete enrollee confidentiality, data security, and mandatory reporting training upon hire and annually thereafter.
- 3.3. Health Home Care Coordinators complete the State-approved Health Home Care Coordinator training prior to completing the HAP with the enrollee.
- 3.4. Health Home Care Coordinators complete the following training modules through State-sponsored classroom training or using State-developed training materials published on the DSHS website within six (6) months of hire.
 - 3.4.1. Outreach and Engagement Strategies;
 - 3.4.2. Navigating the LTSS System;
 - 3.4.3. Cultural and Disability Considerations;
 - 3.4.4. Assessment Screening Tools; and
 - 3.4.5. Coaching and Engaging Clients with Mental Health Needs.
- 3.5. Health Home Care Coordinators and affiliated personnel comply with continued training requirements as necessary.
- 3.6. Evidence of satisfactory completion of training requirements is maintained in the appropriate personnel records.
- 3.7. The Contractor has a Health Home Care Coordinator trainer on staff, or shall subcontract for Health Home Care Coordinator training services.
 - 3.7.1. The trainer shall be qualified by DSHS prior to providing Health Home Care Coordinator training.

- 3.7.2. Trainer Qualification includes:
 - 3.7.2.1. Completion of the Health Home Care Coordinator training course;
 - 3.7.2.2. Completion of a State-sponsored trainer's preparation course;
 - 3.7.2.3. Satisfactory delivery of a Health Home Care Coordinator training observed by DSHS; and
 - 3.7.2.4. Receipt of a State-issued letter authorizing the individual to provide training to Health Home Care Coordinators.
- 3.7.3. The Contractor shall ensure that the trainer uses and maintains fidelity to the State-developed Training Manual for Health Home Care Coordinators.
- 3.8. The Health Home Care Coordinator training must be delivered using only DSHS approved materials. Training should not include any additional curriculum or materials.
- 3.9. The trainer shall not change, alter, or modify the State-approved Health Home Care Coordinator training, activities, curriculum or materials or include unauthorized topics, curriculum, or material in the Health Home Care Coordinator Training.

4. Eligibility and Enrollment

HCA shall determine eligibility and identify enrollees who are eligible for the Contractor's Health Home program.

- 4.1. Those determined eligible for Health Home services must have at least one chronic condition and be at risk of a second as determined by a minimum PRISM score of 1.5. The chronic conditions are:
 - 4.1.1. Mental health conditions;
 - 4.1.2. Substance use disorders;
 - 4.1.3. Asthma;
 - 4.1.4. Diabetes;
 - 4.1.5. Heart disease;
 - 4.1.6. Cancer;
 - 4.1.7. Cerebrovascular disease;
 - 4.1.8. Coronary artery disease;
 - 4.1.9. Dementia or Alzheimer's disease;
 - 4.1.10. Intellectual disability or disease;
 - 4.1.11. HIV/AIDS;
 - 4.1.12. Renal failure;
 - 4.1.13. Chronic respiratory conditions;
 - 4.1.14. Neurological disease;
 - 4.1.15. Gastrointestinal disease;
 - 4.1.16. Hematological conditions; and

4.1.17. Musculoskeletal conditions.

- 4.2. HCA shall include a Health Home Clinical Indicator in the monthly enrollment file of IMC and BHSO enrollees that meet Health Home criteria.
- 4.2.1. The Contractor shall ensure eligible IMC Health Home enrollees are offered Health Home services through a contracted Qualified Health Home or a CCO until they agree to participate or decline to participate in the Health Home program.
- 4.2.2. The Contractor must document in the client record why an eligible enrollee declines to participate, unless the enrollee does not want to explain his or her decision.
- 4.2.3. When an enrollee's PRISM risk score falls below 1.0 for six (6) consecutive months and the enrollee has not been engaged in Health Home services, the enrollee may be temporarily disenrolled at the Contractor's request via a Health Home Eligibility Update Project report initiated by HCA. If the enrollee meets Health Home eligibility criteria, they must be re-enrolled with the Contractor.
- 4.3. The Contractor shall ensure Health Home eligible enrollees are assigned a Health Home Care Coordinator through a Qualified Health Home.
- 4.4. Enrollees who have agreed to participate may disenroll from the Health Home program at any time. The Contractor shall maintain a record of all enrollees who choose to disenroll from the Health Home program and the reason why.
- 4.5. Enrollees may be reenrolled in the Health Home program at any time if they meet the eligibility criteria at the time of the reenrollment request.
- 4.6. The Contractor shall use a standardized tool provided by the State to determine initial eligibility for Health Home services if the enrollee has less than fifteen (15) months of claims history or is referred by a provider. The Contractor shall notify HCA when the enrollee has been screened. When HCA determines the enrollee qualifies, the Contractor shall ensure the enrollee receives Health Home services unless the enrollee declines to participate in the program.
- 4.7. The Contractor shall accept referrals for Health Home services from any health care provider, whether or not the provider is contracted with the Contractor.

5. Assignment

- 5.1. The Contractor shall use a smart assignment process that takes into account the enrollee's current health care provider(s) when assigning Health Home enrollees to community based subcontracted CCOs. The Contractor will:
- 5.1.1. Use PRISM or other data systems to match the enrollee to a CCO that provides most of the enrollee's services; or
- 5.1.2. Allow enrollee choice of CCOs.
- 5.2. Subcontracted community based CCOs will receive a priority in the assignment of the

total Health Home eligible enrollees.

- 5.3. The Contractor shall ensure the Health Home eligible enrollee is assigned to a Health Home CCO or internal Health Home Care Coordinator within thirty (30) calendar days of initial date of Health Home identification and enrollment.
- 5.4. The Contractor shall achieve and maintain the managed care Health Home eligible enrollee engagement rate of at least 15 percent based on HCA's monthly Health Home Enrollment and Encounter Summary.
- 5.5. The Health Home Care Coordinator or affiliated staff shall:
 - 5.5.1. Arrange an in-person visit in the Enrollee's choice of location;
 - 5.5.2. Describe the program to the Enrollee including a description of Health Home services and care coordination;
 - 5.5.3. Arrange an appointment with the Health Home Care Coordination to complete the HAP;

6. Health Action Plan

- 6.1. The Contractor shall ensure initial HAPs are completed within ninety (90) calendar days from the date of notification of the enrollee's Health Home eligibility. A complete HAP must include documentation of agreement by the enrollee to participate in the Health Home program.
- 6.2. The Contractor shall ensure the Health Home Care Coordinator uses the following resources to develop enrollee HAPs:
 - 6.2.1. The enrollee's medical record, if available;
 - 6.2.2. PRISM data;
 - 6.2.3. Treatment plans, CARE assessments, and results of previous screens and assessments, if available;
 - 6.2.4. Information from the Contractor's authorization and service utilization systems; and
 - 6.2.5. Input from the enrollee and his or her family and/or caregivers.
- 6.3. The Health Home Care Coordinator shall meet with the enrollee in person to complete the HAP including the following:
 - 6.3.1. The Health Home Care Coordinator meets in-person with each enrollee at the enrollee's choice of location;
 - 6.3.2. The Health Home Participation Authorization and Information Sharing Consent form is completed;
 - 6.3.3. The Care Coordinator evaluate the enrollee's support system;
 - 6.3.4. The Care Coordinator explains, develops, and completes the HAP with input from the enrollee and/or the enrollee's caregiver(s);
 - 6.3.5. The HAP documents the enrollee's diagnosis, long-term goals, short-term

- goals, and related action steps to achieve those goals identifying the individual responsible to complete the action steps;
- 6.3.6. The HAP includes the required BMI, Katz ADL, and PSC-17 or PHQ-9 screening scores;
 - 6.3.7. The HAP includes the required Patient Activation Measure (PAM®), or Patient Parent Activation Measure (PPAM®), or Caregiver Activation Measure (CAM®) activation level and screening score;
 - 6.3.8. The Health Home Care Coordinator also documents in the HAP all other screenings administered when medically indicated; and
 - 6.3.9. The HAP includes the reason the enrollee declined assessment or screening tools.
 - 6.3.10. HAPs must be reviewed and updated by the Health Home Care Coordinator at a minimum:
 - 6.3.10.1. After every four (4) month activity period to update the PAM®, PPAM®, or CAM®; BMI; Katz ADL; and PSC-17 or PHQ-9 screening scores and reassess the enrollee's progress towards meeting self-identified health action goals, add new goals or change in current goals; and
 - 6.3.10.2. Whenever there is a change in the enrollee's health status or a change in the enrollee's needs or preferences.
 - 6.3.11. A completed and updated HAP with the enrollee's goals and action steps must be provided to the enrollee and with the enrollee's consent shared with the enrollee's caregiver and family in a format that is easily understood. Any additional information shall be included as an addendum to the HAP.
 - 6.3.12. Additional information not included in the State-developed HAP form must be included as an addendum.
 - 6.3.13. Written information in the HAP must use language that is understandable to the enrollee and/or the enrollee's caregiver(s).
 - 6.3.14. Upon request, completed and updated HAPs must be shared with other individuals identified and authorized by the enrollee on the signed Health Home Participation Authorization and Information Sharing Consent form.
 - 6.3.15. The Health Home Care Coordinator shall meet with the enrollee in person to complete the HAP, including the following:
 - 6.3.15.1. Explain the HAP and the development process to the enrollee;
 - 6.3.15.2. Complete a Health Home Participation Authorization and Information Sharing Consent form;
 - 6.3.15.3. Evaluate the enrollee's support system; and
 - 6.3.15.4. Administer and score either the PAM®, PPAM® or CAM®.
 - 6.3.16. The Health Home Care Coordinator uses the PAM®, PPAM®, or CAM® to:
 - 6.3.16.1. Measure activation and behaviors that underlie activation including ability to self-manage, collaborate with providers, maintain function,

- prevent declines and access appropriate and high quality health care;
- 6.3.16.2. Target tools and resources commensurate with the enrollee's level of activation;
- 6.3.16.3. Provide insight into how to reduce unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health;
- 6.3.16.4. Document health care problems through the combined review of medical records, PRISM and face-to-face visits with the enrollee; and
- 6.3.16.5. As indicated by clinical judgment, complete HCA-approved screening tools for behavioral health conditions, if not already obtained from other sources.

7. Care Coordinator Responsibilities

- 7.1. The Health Home Care Coordinator shall provide or oversee interventions that address the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting enrollee's health and health care choices available to Health Home enrollees.
- 7.2. The Health Home Care Coordinator shall provide or oversee Health Home Services in a culturally and linguistically appropriate manner and address health disparities by:
 - 7.2.1. Interacting directly with the enrollee and his or her family in the enrollee's primary language and recognizing cultural differences when developing the HAP;
 - 7.2.2. Understanding the dynamics of substance use disorder without judgment; and
 - 7.2.3. Recognizing obstacles faced by persons with developmental disabilities and providing assistance to the enrollee and his or her caregivers in addressing the obstacles.
- 7.3. The Health Home Care Coordinator shall:
 - 7.3.1. Discuss changes in enrollee circumstances or condition with the treating/authorizing entities who serve the enrollee;
 - 7.3.2. Document changes in the enrollee's circumstances or conditions in the HAP in a timely manner;
 - 7.3.3. With the enrollee's permission, include paid or unpaid caregivers who have a role in supporting the enrollee to achieve health action goals and access health care and other services;
 - 7.3.4. Collaborate with health care professionals such as primary care providers, mental health professionals, substance use disorder treatment providers, social workers, and direct care providers;
 - 7.3.5. Have access to providers from the local community who authorize Medicaid, state or federally funded mental health, long-term services and supports (including the direct care workforce), substance use disorder and medical services. This group may include BH-ASOs, DSHS-Home and Community Services (HCS), Community Mental Health Agencies (CMHA's), Area Agencies

on Aging (AAAs), substance use disorder providers, and community supports that assist with housing; and

- 7.3.6. Coordinate or collaborate with nutritionist/dieticians, direct care workers, pharmacists, peer specialists, family members, and housing or employment representatives or others to support the enrollee's HAP.

8. Health Home Key Services

8.1. Comprehensive Care Management Services

8.1.1. The Contractor shall ensure the Health Home Care Coordinator:

- 8.1.1.1. Documents interactions with the Health Home enrollee including periodic follow-up, both in-person and telephonically;
- 8.1.1.2. Assesses enrollee's readiness for self-management and promotion of self-management skills;
- 8.1.1.3. Reassesses the HAP and Health Home enrollee's progress in meeting goals;
- 8.1.1.4. Manages barriers to achieving health action goals;
- 8.1.1.5. Facilitates communication between the Health Home enrollee and service providers to address barriers and achieve health action goals;
- 8.1.1.6. Supports the achievement of self-directed, health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning;
- 8.1.1.7. Reassesses patient activation at minimum every four (4) month activity period, or more frequently if changes warrant reassessment using the PAM®, PPAM® or CAM® and documents the results in the HAP; and
- 8.1.1.8. Ensures communication, coordination, and care management functions are not duplicated between the Health Home Care Coordinator and Medicaid case managers involved in the enrollee's care, including DSHS and AAA case managers.

8.2. Care coordination and health promotion

8.2.1. The Contractor shall ensure the Health Home Care Coordinator:

- 8.2.1.1. Develops and executes cross-system care coordination to assist enrollees to access and navigate needed services;
- 8.2.1.2. Fosters communication between the care providers, including the treating primary care provider, medical specialists, behavioral health providers and entities authorizing behavioral health and long-term services and supports;
- 8.2.1.3. Maintains a caseload that ensures timely intervention;
- 8.2.1.4. Uses community health workers, peer counselors or other non-clinical staff to assist clinical staff in the delivery of Health Home Services;
- 8.2.1.5. Provides interventions that recognize and are tailored for the medical,

social, economic, behavioral health, functional impairment, cultural and environmental factors that affect an enrollee's health and health care choices; and

8.2.1.6. Provides educational materials that promote the following:

8.2.1.6.1. Improved clinical outcomes;

8.2.1.6.2. Enrollee participation in his or her care;

8.2.1.6.3. Continuity of care;

8.2.1.6.4. Increased self-management skills; and

8.2.1.6.5. Use of peer supports to increase the enrollee's knowledge about his or her health conditions and improve adherence to prescribed treatment.

8.2.2. Shares the HAP with individuals identified by the enrollee, with the enrollee's written consent. These individuals may include, but are not limited to: family, caregivers, primary care providers, mental health treatment providers, and authorizers of long term services and supports and/or substance use disorder treatment providers.

8.2.2.1. The HAP shall provide written evidence of:

8.2.2.1.1. The enrollee's chronic conditions, severity factors and gaps in care, activation level, and opportunities to prevent avoidable emergency room, inpatient hospital and institutional use;

8.2.2.1.2. Enrollee self-identified goals;

8.2.2.1.3. Needed interventions and desired outcomes;

8.2.2.1.4. Transitional care planning, including assessment and deployment of needed supports; and

8.2.2.1.5. Use of self-management, recovery and resiliency principles that employ person-identified supports, including family members, and paid or unpaid caregivers.

8.2.2.2. The Health Home Care Coordinator shall assess the enrollee's patient activation scores and level to determine the appropriate coaching methods and a teaching and support plan that includes:

8.2.2.2.1. Introduction of customized educational materials based on the enrollee's readiness for change;

8.2.2.2.2. Progression of customized educational materials in combination with the enrollee's level of confidence and self-management abilities;

8.2.2.2.3. Documentation of opportunities for mentoring and modeling communication with health care providers provided through joint office visits and communications with health care providers by the enrollee and the Health Home Care Coordinator;

- 8.2.2.2.4. Documentation of wellness and prevention education specific to the enrollee's chronic conditions, including assessment of need and facilitation of routine preventive care;
 - 8.2.2.2.5. Support for improved social connections to community networks, and links the enrollee with resources that support a health promoting lifestyle; and
 - 8.2.2.2.6. Links to resources for, but not limited to: smoking cessation, substance use disorder prevention, nutritional counseling, obesity reduction, increasing physical activity, disease-specific or chronic care management self-help resources, and other services, such as housing, based on individual needs and preferences.
- 8.2.3. Accompanies the enrollee to critical health care and social service appointments when necessary to assist the enrollee in achieving his or her health action goals.
 - 8.2.4. Ensures treating providers and authorizing entities coordinate and mobilize to reinforce and support the enrollee's health action goals.

8.3. Transitional Care

- 8.3.1. The Contractor shall provide and document the comprehensive transitional care for Health Home enrollees to prevent avoidable readmission after discharge from an inpatient facility and to ensure proper and timely follow-up care.
- 8.3.2. In addition to services described in Transitional Care provisions of this Contract, the Contractor's transitional care planning process must include:
 - 8.3.2.1. Participation by the Health Home Care Coordinator in appropriate phases of care transitions, including discharge planning; visits during hospitalizations or nursing home stays; home visits; post hospital/institutional stays; and follow-up telephone calls;
 - 8.3.2.2. A notification system between the Contractor and facilities that provides prompt notification of an enrollee's admission or discharge from an emergency department or inpatient setting;
 - 8.3.2.3. Progress notes or a case file that documents the notification;
 - 8.3.2.4. Transition planning details such as medication reconciliation, follow-up with providers and monitoring documented in the HAP;
 - 8.3.2.5. The Contractor may employ staff that have been trained specifically to provide transitional services, as long as the Health Home Care Coordinator is an active participant in the transitional planning process; and
 - 8.3.2.6. Established frequency of communicating hallmark events to the assigned Health Home Care Coordinator.

8.4. Individual and family support

- 8.4.1. The Contractor shall use peer supports, support groups, and self-management programs as needed, to increase the enrollee's and caregiver's knowledge of the enrollee's chronic conditions, promote the enrollee's capabilities and engagement in self-management, and help the enrollee improve adherence to prescribed treatment.
- 8.4.2. The Contractor shall ensure the Health Home Care Coordinator, with the enrollee's participation:
 - 8.4.2.1. Identifies the role that the enrollee's family, informal supports and paid caregivers provide to help the enrollee achieve self-management and optimal levels of physical and cognitive function;
 - 8.4.2.2. Educates and supports self-management; self-help recovery and other resources necessary for the enrollee, his or her family and caregivers to support the enrollee's individual health action goals;
 - 8.4.2.3. Documents discussion of advance care planning with the enrollee within the first year of the Enrollee's agreement to participate in the Health Home program; and
 - 8.4.2.4. Communicates and shares information with the enrollee's family and other caregivers, with appropriate consideration of language, activation level, literacy, and cultural preferences.

8.5. Referral to community and social support services

- 8.5.1. The Health Home Care Coordinator shall ensure that:
 - 8.5.1.1. Available community resources are identified and accessible to the Health Home enrollee.
 - 8.5.1.2. Referrals:
 - 8.5.1.2.1. Are overseen by the Health Home Care Coordinator;
 - 8.5.1.2.2. Support the enrollee's health action goals;
 - 8.5.1.2.3. Include long-term services and supports, mental health, substance use disorder and other community and social supports; and
 - 8.5.1.2.4. Are documented in the enrollee's progress notes and HAP.
 - 8.5.1.3. Assistance is provided to the enrollee to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services, when needed and not provided through other case management systems.
 - 8.5.1.4. Services are coordinated with appropriate departments of local, state, and federal governments and community-based organizations.

9. Quarterly Quality Reports

- 9.1. The Contractor shall submit quality reports to HCA in the format provided by HCA in accordance with the following reporting periods:
 - 9.1.1. January through March due May 1;
 - 9.1.2. April through June due August 1;
 - 9.1.3. July through September due November 1; and
 - 9.1.4. October through December due February 1.

EXHIBIT I
INTEGRATED MANAGED CARE
REGIONAL SERVICE AREA
Effective January 1, 2020

Region/County	Amerigroup	Community Health Plan	Coordinated Care	Molina Healthcare	United Healthcare
GREATER COLUMBIA	X	X	X	X	
ASOTIN, BENTON, COLUMBIA, FRANKLIN, GARFIELD, KITTITAS, WALLA WALLA, WHITMAN, YAKIMA					
GREAT RIVERS	X			X	X
COWLITZ, GRAYS HARBOR, LEWIS, PACIFIC, WAHKIAKUM					
KING	X	X	X	X	X
King					
NORTH CENTRAL	X		X	X	
CHELAN, DOUGLAS, GRANT, OKANOGAN					
NORTH SOUND	X	X	X	X	X
ISLAND, SAN JUAN, SKAGIT, SNOHOMISH, WHATCOM					
PIERCE	X		X	X	X
Pierce					
SALISH	X			X	X
CLALLAM, JEFFERSON, KITSAP					
SOUTHWEST	X	X		X	
CLARK, KLICKITAT, SKAMANIA					
SPOKANE	X	X		X	
ADAMS, FERRY, LINCOLN, PEND OREILLE, SPOKANE, STEVENS					
THURSTON-MASON	X			X	X
MASON, THURSTON					

Exhibit J, RAC Codes

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

Exhibit J: RAC Codes

Non-duals Medicare status code 0, 0H

Category	Description	FIMC	BHSO	Current RACs (*Disabled RACs are in bold)
(a) Apple Health Family = Healthy Options (HO) CNP	Washington Apple Health managed care for families (parents, children, and pregnant women)	X		1018, 1023 , 1026, 1028, 1029, 1030, 1031, 1095, 1197, 1198, 1199, 1200, 1202, 1203, 1204, 1205
(b) Apple Health Blind Disabled = Healthy Options Blind/Disabled (HOBD) CNP	Washington Apple Health managed care for blind/disabled clients. Supplemental Security Income (SSI) and SSI related. Categorically Needy Program and may receive home and community based waiver/hospice services	X		1047, 1105, 1107, 1110, 1111, 1121, 1134, 1147, 1150, 1151, 1153, 1175, 1219, 1221, 1224, 1225, 1237, 1239, 1245, 1247, 1252, 1253, 1254, 1255, 1258, 1259, 1261, 1263, 1267, 1268, 1269, 1271
	Categorically Needy Program, Long-Term Care child <19, pregnant age 19+ in hospital or facility over 30 days; or 19-22 in a mental institution since before 21 st birthday	X		1052, 1053, 1055 *living arrangement/institutional status code is "not IM"
	Categorically Needy Program, Long-Term Care 65+ *Added to HOBD program effective 04/01/2016	X		1065, 1068, 1071, 1073 *living arrangement/ institutional status "not IM"
	Categorically Needy Program, Long-Term Care, Blind/Disabled *Added to HOBD program effective 04/01/2016	X		1067, 1070, 1162, 1163 *living arrangement/ institutional status "not IM"
	Categorically Needy Program, 65+ *Added to HOBD program effective 04/01/2016	X		1046, 1104, 1106, 1108, 1109, 1146, 1148, 1149, 1152, 1174, 1218, 1220, 1222, 1223, 1236, 1238, 1244, 1246, 1248, 1249, 1250, 1251, 1256, 1257, 1260, 1262, 1264, 1265, 1266
(c) Apple Health Adult Coverage (AHAC) ABP	Washington Apple Health managed care for single adults (expansion population). Categorically Needy Program plus habilitative services	X		1201, 1217
(d) State Children's Health Insurance Program (SCHIP) CNP	Children with incomes above Medicaid limit. Are enrolled in Apple Family Health = Healthy Options but pay a small premium. Categorically needy program benefits.	X		1032, 1140, 1206, 1207

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

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

Medicaid Dual Eligible Population (a)

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

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

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

Comparable Coverage (Third Party Insurance/Liability) (c)

A Medicaid client who also has other insurance that HCA has determined provides a full scope of health care benefits.

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

Spend-down (d)

Category	Description	FIMC	BHSO	Current RACS (*Disabled RACs are in bold)
LCP-MNP Spenddown child under 19	Limited Casualty- Medically Needy Program, spenddown child under 19		X	1039
LCP-MNP , Duals, 65+, Spenddown	Limited Casualty-Medically Needy Program, dual coverage on spenddown		X	1124
LCP-MNP , Spenddown, Blind/Disabled	Limited Casualty-Medically needy Program on spenddown, blind/disabled		X	1126
LCP-MNP , Pregnancy, Spenddown	Limited Casualty-Medically Needy Program, pregnancy on spenddown		X	1101, 1102
LCP-MNP , ALF, 65+,	Limited Casualty - Medically Needy Program, living in Alternate Living Facility (adult family home, boarding home or other DDD group home). 65+ and may have spenddown		X	1048
LCP-MNP , ALF, Blind/Disabled	Limited Casualty - Medically Needy Program, living in Alternate Living Facility (adult family home, boarding home or other DDD group home). Blind/disabled and may have spenddown		X	1049
LCP-MNP , LTC, Spenddown, Blind/Disabled	Limited Casualty-Medically Needy Program on spenddown, blind/disabled		X	1086, 1091
LCP-MNP , Dual, 65+, LTC, Spenddown	Limited Casualty-Medically Needy Program, long term care with dual coverage, 65+, spenddown		X	1083, 1088

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

Institution for Mental Disease (e)

Category	Description	FIMC	BHSO	Current RACS (*Disabled RACs are in bold)
CNP , Institutional SSI and Institutional SSI Related in IMD (child under 22), Blind/Disabled	Categorically Needy Program, blind/disabled in Institution for Mental Disease Long Term Care (child under 22)	.	X	1164, 1165, 1168, 1169
CNP , Institutional SSI and Institutional SSI Related in IMD 65+	Categorically Needy Program, SSI eligible, , in Institution for Mental Disease (65+)		X	1066, 1069, 1072, 1074
MNP , Institutional SSI and Institutional SSI Related in IMD, Blind/Disabled	Medically Needy Program, blind/disabled, in Institution for Mental Disease, age <=22 may have spenddown		X	1166, 1167
LCP-MNP , Institutional SSI and Institutional SSI Related in IMD, Spenddown	Limited Casualty -Medically Needy Program, in Institution for Mental Disease, (65+) may have spenddown		X	1084, 1089
CNP , LTC	Categorically Needy Program, Long-Term Care child <19, pregnant woman age 19> in hospital or facility over 30 days; or 19-22 in a mental institution since before 21 st birthday; or 65> in mental institution		X	1052, 1053, 1055 If living arrangement or institutional status code is "IM"
LCP-MNP , LTC	Limited Casualty - Medically Needy Program, Long Term Care, in institution for Mental Disease, may have spenddown.		X	1059, 1061
Pregnant Women non-citizens (undocumented) (f)				
CNP , MAGI, Federally funded pregnancy for non-citizens (undocumented)	Categorically Needy Program, Modified Adjusted Gross Income, Federally funded pregnancy for non-citizens (undocumented)		X	1096, 1209
CNP , BCCTP	Categorically Needy Program, Breast and Cervical Cancer Treatment Program for women (BCCTP)		X	1122

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

Foster Care (g)

Category	Description	FIMC	BHSO	Current RACS (*Disabled RACs are in bold)
Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	X		1014, 1015, 1016, 1017, 1019, 1020, 1021, 1022
CNP, Foster Care Alumni	Categorically Needy, Foster Care under 26 (if in Foster Care at age 18)	X		1196

Hospice (h)

CNP, Hospice, SSI,CNIL, SIL, 65+	Hospice Categorically Needy Income level, Special Income Level to determine eligibility, 65+		X	1240, 1241
CNP, Hospice, SSI,CNIL, SIL, Blind/Disabled	Hospice Categorically Needy Income level, Special Income Level to determine eligibility, blind /disabled		X	1242, 1243

Long Term Care Institutional (i)

CNP , LTC,65+	Categorically Needy Program, Long- Term Care 65+		X	1065, 1068, 1071, 1073 living arrangement /institutional status "IM"
CNP , SSI or SSI related institutional, Blind/Disabled	Categorically Needy Program, Long-Term Care, blind/disabled		X	1067, 1070, 1162, 1163 living arrangement /institutional status "IM"

Refugees (j)

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

Breast and Cervical Cancer (k)

CNP, BCCTP	Categorically Needy Program, Breast and Cervical Cancer Treatment Program (BCCTP) for women		X	1122
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Pregnant Women (not federally qualified) (l)

CNP	Categorically Needy Magi Pregnancy Medicaid; for pregnant women who are not federally qualified due to citizenship/alien status.		X	1209
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EXHIBIT K

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EXHIBIT L

Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs)

Exhibit L

Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

1. Purpose of Addendum; Supersession.

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____ (herein "Managed Care Plan") and _____ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

For purposes of this Addendum, the following terms and definitions shall apply:

- a. "American Indian/Alaska Native (AI/AN)" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:
- i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
 - ii. Is an Eskimo or Aleut or other Alaska Native;
 - iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - iv. Is determined to be an Indian under regulations issued by the Secretary.

The term "AI/AN" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

- b. "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 USC 1603).
- c. "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Manager (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. § 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.
- d. "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCA Section 601, 25 USC 1661.

- e. "Indian tribe" has the meaning given in the IHClA Section 4(14), 25 USC 1603(14).
- f. "Tribal health program" has the meaning given in the IHClA Section 4(25), 25 USC 1603(25).
- g. "Tribal organization" has the meaning given in the IHClA Section 4(26), 25 USC 1603(26).
- h. "Urban Indian organization" has the meaning given in the IHClA Section 4(29), 25 USC 1603(29).

3. Description of IHCP.

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

☐ IHS.

☐ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 USC 450 et seq.

☐ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 USC 450 et seq.

☐ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 USC 47 (commonly known as the Buy Indian Act).

☐ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHClA.

4. Cost-Sharing Exemption for AI/ANs; No Reduction in Payments.

The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an AI/AN who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an AI/AN who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 USC 1396o-(j)), 42 C.F.R. § 447.56 and 457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP.

The Managed Care Plan shall allow any AI/AN otherwise eligible to receive services from an IHCP to choose the IHCP as the AI/AN's primary health care provider if the IHCP has the capacity to provide primary care services to such AI/AN, and any referral from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 USC 1396u-2(h)), 42 C.F.R § 438.14((b)(3), and § 457.1209.

6. Agreement to Pay IHCP.

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 C.F.R. § 438.14 and § 457.1209.

7. Persons Eligible for Items and Services from IHCP.

- a. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCA, 25 USC 1601 et seq. and/or 42 C.F.R. Part 136.
- b. No term or condition of the Managed Care Plan's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers.

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix A.

9. Non-Taxable Entity.

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. Insurance and Indemnification.

- a. Indian Health Service. The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.
- b. Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 USC 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS

pursuant to the ISDEAA, 25 USC 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

- c. Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.

Pursuant to 25 USC 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the state or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the state or local law where the entity is located, if the professional is licensed in another state.

12. Dispute Resolution.

In the event of any dispute arising under the Managed Care Plan's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law.

The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.

To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA (25 USC 1675).

15. Claims Format.

The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA (25 USC 1621e(h)), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. Payment of Claims.

The Managed Care Plan shall pay claims from the IHCP in accordance section 1932(h)(2) of the Act, (42 USC 1396u-2(h)), 42 C.F.R. § 438.14(c)(2), and § 457.1209 (the “Federal Payment Amount Requirements”), and shall pay at either the rate provided under the state plan in a Fee-For-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the IHS (the “IHS Encounter Rate”), whichever is higher; provided that, if the Managed Care Plan does not pay the IHS Encounter Rate, the state shall pay the difference between the IHS Encounter Rate and the amount paid by the Managed Care Plan such that the IHCP receives the amount to which it is entitled under the Federal Payment Amount Requirements.

17. Hours and Days of Service.

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. Sovereign Immunity.

Nothing in the Managed Care Plan’s network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. Endorsement.

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan:

For the IHCP:

By: _____

By: _____

Name: _____

Name: _____

Date: _____

Date: _____

APPENDIX A

The following laws apply to each type of IHCP as follows:

(a) Indian Health Service:

- (1) Anti-Deficiency Act, 31 U.S.C. § 1341;
- (2) ISDEAA, 25 U.S.C. § 450 et seq.;
- (3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:

- (1) ISDEAA, 25 U.S.C. § 450 et seq.;
- (2) IHCIA, 25 U.S.C. § 1601 et seq.; (3) FTCA, 28 U.S.C. §§ 2671-2680;
- (3) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (4) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (5) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:

- (1) IHCIA, 25 U.S.C. § 1601 et seq.
- (2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (3) HIPAA, 45 C.F.R. Parts 160 and 164.

ATTACHMENT 1

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Attachment 2
HEDIS® Performance Measures

2020 HEDIS® Reporting Year (Performance Year 2019)

Apple Health Integrated Managed Care (AH-IMC)
Apple Health Integrated Foster Care (AH-IFC)

The Contractor shall report the following HEDIS® measures statewide for all eligible Enrollees enrolled through Apple Health Managed Care (AHMC), AH-IMC, and AH-IFC contracts during the performance year. The contract marked in the Notes column applies to performance year. All measures must be publically reported by plan name to the NCQA Quality Compass. If “Hybrid” is noted in the Notes column, the Contractor is contractually required to report using this methodology.

NCQA Abbreviation	Measure	Notes
Prevention and Screening		
ABA	Adult BMI Assessment	Hybrid
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Hybrid
CIS	Childhood Immunization Status	Hybrid
IMA	Immunizations for Adolescents	Hybrid
LSC	Lead Screening in Children	Hybrid
BCS	Breast Cancer Screening	
CCS	Cervical Cancer Screening	Hybrid
CHL	Chlamydia Screening in Women	
Respiratory Conditions		
CWP	Appropriate Testing for Pharyngitis	
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	
PCE	Pharmacotherapy Management of COPD Exacerbation	
MMA	Medication Management for People With Asthma	
AMR	Asthma Medication Ratio	
Cardiovascular		
CBP	Controlling High Blood Pressure	Hybrid
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	
SPC	Statin Therapy for Patients With Cardiovascular Disease	
Diabetes		
CDC	CDC: Hemoglobin A1c (HbA1c) Testing	Hybrid
CDC	CDC: HbA1c Poor Control (>9.0%)	Hybrid
CDC	CDC: HbA1c Control (<8.0%)	Hybrid
CDC	CDC: Eye Exam	Hybrid
CDC	CDC: Medical Attention for Nephropathy	Hybrid
CDC	CDC: Blood Pressure Control (<140/90 mm Hg)	Hybrid
SPD	Statin Therapy for Patients With Diabetes	

NCQA Abbreviation	Measure	Notes
Behavioral Healthcare		
AMM	Antidepressant Medication Management	
ADD	Follow-Up Care for Children Prescribed ADHD Medication	
FUH	Follow-Up After Hospitalization for Mental Illness	AHMC: No Benefit AH-IMC/AH-IFC: Required
FUM	Follow-Up After Emergency Department Visit for Mental Illness	AHMC: No Benefit AH-IMC/AH-IFC: Required
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	AHMC: No Benefit AH-IMC/AH-IFC: Required
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	
SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Overuse/Appropriateness		
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females	
URI	Appropriate Treatment for Upper Respiratory Infection	
AAB	Avoidance of Antibiotic Therapy for Acute Bronchitis	
LBP	Use of Imaging Studies for Low Back Pain	
HDO	Use of Opioids at High Dosage	
UOP	Use of Opioids from Multiple Providers	
COU	Risk of Chronic Opioid Use	
Access/Availability of Care		
AAP	Adults' Access to Preventive/Ambulatory Health Services	
CAP	Children and Adolescents' Access to Primary Care Practitioners	
ADV	Annual Dental Visit	No Benefit
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	AHMC: No Benefit AH-IMC/AH-IFC: Required
PPC	Prenatal and Postpartum Care	Hybrid
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	

NCQA Abbreviation	Measure	Notes
Use of Services		
W15	Well-Child Visits in the First 15 Months of Life	Hybrid
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Hybrid
AWC	Adolescent Well-Care Visits	Hybrid
FSP	Frequency of Selected Procedures	
AMB	Ambulatory Care	
IPU	Inpatient Utilization–General Hospital/Acute Care	
IAD	Identification of Alcohol and Other Drug Services	AHMC: No Benefit AH-IMC/AH-IFC: Required
MPT	Mental Health Utilization	AHMC: Report the Outpatient/ED category. NO BENEFIT for the following categories: Inpatient Intensive Outpatient/ Partial Hospitalization, or Telehealth. AH-IMC/AH-IFC: Report all categories. ALL: Consult with HEDIS® auditor for specific measure tab to use for reporting.
ABX	Antibiotic Utilization	
Risk Adjusted Utilization		
PCR	Plan All-Cause Readmission	
NCQA Abbreviation	Health Plan Descriptive Information	Notes
ENPA	Enrollment by Product Line - Total	
EBS	Enrollment by State	
LDM	Language Diversity of Membership	
RDM	Race/Ethnicity Diversity of Membership	
TLM	Total Membership	

NCQA Abbreviation	Measure	Notes
NEW HEDIS® MEASURE 2020		
FUI	Follow-Up After High Intensity Care for Substance Use Disorder	New measure To be reported to HCA
POD	Pharmacotherapy for Opioid Use Disorder	New measure To be reported to HCA
PND	Prenatal Depression Screening and Follow-Up	New measure To be reported to HCA
PDS	Postpartum Depression Screening and Follow-Up	New measure To be reported to HCA

HCA reserves the right to issue changes to this attachment or measure requirements, such as due to changes in HEDIS® technical specifications.

ATTACHMENT 3

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Attachment 4

Oral Health Connections Pilot Project

In Section 213(1)(nn) of the Substitute Senate Bill 5883 (2017) and Section 213(1)(oo) of SSB 6032 (2018), HCA was directed to implement the Oral Health Connections Pilot Project, modeled after the ABCD program. The directive to HCA and Arcora (previously known as Washington Dental Foundation) is to work jointly from inception to completion of the program. Implementation is set for January 1, 2019 and the pilot project will run for three (3) years.

The Oral Health Connections Pilot Project's purpose is to integrate oral-systemic health care in two predetermined populations, in three select counties in anticipation of influencing health outcomes and controlling chronic disease. Adults with diabetes and pregnant women (not including Dual-Eligible Clients), located in Cowlitz, Thurston, or Spokane counties are the target populations of the Oral Health Connections Pilot Project.

Arcora is responsible for:

- Financing and developing, in partnership with the University of Washington (UW), a training module and exam for participating dental providers;
- Providing the exam, in partnership with UW;
- Notifying HCA, within 5 business days, of successful course completion by participating dental providers;
- Developing tools and systems to assist medical providers with oral assessments;
- Developing referral and patient care coordination tools;
- Developing systems and processes to facilitate shared care between medical and dental providers;
- Developing systems and processes to assist dental provider offices in scheduling and keeping appointments;
- Recruiting dental providers to participate in the program;
- Attending local and statewide dental provider association meetings;
- Educating providers about the pilot, including background, duration, enhanced fees, and indicators;
- Recruiting and educating of medical providers on demographics of Oral Health Connections Pilot Project target populations;
- Training medical providers about oral systemic link between oral health and diabetes and/or pregnancy, including how to address oral health in medical settings while reinforcing the importance of medical and dental collaboration; and
- Developing and implementing an Oral Health Connections Pilot Project evaluation tool.

Both medical and dental Oral Health Connections Pilot Project providers will use a referral tool developed by Arcora, called DentistLink, to connect Clients to dental providers in the following ways:

- Medical provider will refer Clients diagnosed with diabetes or pregnancy to a trained dental provider participating in the Oral Health Connections Pilot Project through DentistLink;
- Medical Managed Care Organizations (MCOs) will refer Enrollees, with flagged qualifying diagnosis(es), through care coordination and DentistLink;

Dental providers will coordinate with medical providers through DentistLink to receive referrals for patients who are in the two identified target populations. Dental providers will be educated in the specifics of intervention and training for the identified Client population. The Oral Health Connections Pilot Project will also test the effects an enhanced dental benefit has on access to dental care, health care outcomes, and related medical costs.

Trained, participating dental providers will be eligible for enhanced reimbursement rates for specific CDT codes per Oral Health Connections Pilot Project guidelines. Periodontal health, in specific, will be the target of the enhancements. Medicaid will pay enhanced fees for codes D0150 (Comprehensive Oral Exam), D0210 (Intraoral complete series of radiographic images), D0274 (Bitewings four radiographic images), D4341 (Periodontal Scaling and Root Planing-4 or more teeth), D4342 (Periodontal Scaling and Root Planing 3 or more teeth per quadrant), D4910 (Periodontal maintenance). The Client will be eligible to receive up to three (3) additional D4910 (periodontal maintenance) per twelve-month period.

The Oral Health Connections Pilot Project success will be determined through measures evaluating access, cost, and health outcomes.

Attachment 5

Access to Baby and Child Dentistry (ABCD) Program

The Access to Baby and Child Dentistry (ABCD) Program was established to increase access to dental services for Medicaid-eligible Clients through age 5. The Program's goal is to ensure positive dental experiences in early childhood will lead to lifelong practices of good oral health. The ABCD Program is a partnership between public and private sectors, such as the Washington State Health Care Authority (HCA), the Washington State Department of Health (DOH), the University of Washington School of Dentistry (UW), Arcora, Washington State Dental Association (WSDA), local dental societies, and local health jurisdictions.

The design of the ABCD Program is to develop competency in dental practices to deliver dental services to children; and in primary medical care practices to provide oral health education, oral assessments and treatments, or refer for treatment.

HCA has contracted with UW to provide technical and procedural consultation, develop training curriculum and materials, and train dental providers to become ABCD Dental Champions. UW also issues and tracks all certifications for dental providers, and dental champions. UW also provides the Interim Therapeutic Restoration (ITR) certification. The UW sends a list of ABCD-certified providers to HCA and HCA places an indicator on the provider's ProviderOne profile which allows HCA to identify these providers as eligible for the enhanced ABCD rates.

HCA contracts with 26 Coordinators to perform community outreach, including identification and referral of eligible children to ABCD providers. These Coordinators are either a local health jurisdiction or a community agency. Each Coordinator has one or more Dental Champions. who works to recruit, and train, local general dentists to become ABCD-certified providers.

HCA also contracts with Arcora to provide centralized management of the ABCD Program. Arcora also trains, and issues and tracks all certifications for, medical PCPs through in-office continuing education (1.5 hours) by Arcora. Arcora is also responsible for sending confirmation of certification to HCA to ensure an indicator is placed on the PCP's ProviderOne profile. The training educates providers on delivery of the following preventive services:

- Links between oral health and total health;
- Oral health screening and risk assessment;
- Providing oral health education and anticipatory guidance to clients and families;
- Application of topical fluoride;
- Billing; and
- Referrals for dental care.

ABCD services provided by a trained Medical PCP will be covered under the medical managed care or fee-for-service effective January 1, 2020.