Washington State Health Care Authority	**WASHINGTON BEHAVIORIAL HEALTH SERVICES WRAPAROUND CONTRACT**	HCA Contract Number: Resulting from Solicitation Number (If applicable):

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

CONTRACTOR NAME «Organization_Name»		
CONTRACTOR ADDRESS «City», «State» «Zip_Code»		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) «UBI»
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	HCA CONTACT ADDRESS Post Office Box 45502 Olympia, WA 98504-5502
HCA CONTACT TELEPHONE	HCA CONTACT E-MAIL ADDRESS

IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? ☐YES ☒NO	CFDA NUMBER(S)	FFATA Form Required ☐YES ☒NO

CONTRACT START DATE **January 1, 2020**	**CONTRACT END DATE** **December 31, 2020**
	TOTAL MAXIMUM CONTRACT AMOUNT

PURPOSE OF CONTRACT: Contract for Behavioral Health Wrap Around Services

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:

☒ Exhibits (specify):

Exhibit A: Non-Medicaid Funding Allocation
Exhibit B: Non-Medicaid Monthly Expenditure Report Format
Exhibit C: State Hospital Bed Allocation
Exhibit D: Essential Behavioral Health Providers
Exhibit E: Data Use, Security and Confidentiality
Exhibit F: Regional Service Areas

☒ Attachments: Attachment 1, RFP 15-008 – Apple Health – Fully Integrated Managed Care (incorporated by reference, available upon request); Attachment 2 – Contractors Response to RFP 15-008 – Apple Health – Fully Integrated Managed Care (incorporated by reference, available upon request); Attachment 3 - RFP 1812 – Integrated Managed Care (incorporated by reference, available upon request); Attachment 4 – Contractors Response to RFP 1812 Integrated Managed Care (incorporated by reference, available upon request); Attachment 5 - RFP 2567 – Integrated Managed Care (incorporated by reference, available upon request); and Attachment 6 – Contractors Response to RFP 2567 Integrated Managed Care (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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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 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 and a Healthier Washington. ACHs convene multiple sectors and communities to coordinate systems that influence health, including public health, health care providers, and systems that influence social determinations of health.

1.2 Action

"Action" means the denial or limited authorization of a requested Contracted Service for reasons of medical necessity.

1.3 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 other applicable laws.

1.4 Advance Directive

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

1.5 Adverse Authorization Determination

"Adverse authorization determination" means the denial or limited authorization of a requested Contracted Services for reasons of medical necessity (Action) or any other reason such as lack of Available Resources.

1.6 Alcohol/Drug Information School

"Alcohol/Drug Information School" means costs incurred for Alcohol/Drug information schools provide information regarding the use and abuse of alcohol/drugs in a structured educational setting. Alcohol/Drug Information Schools must meet the certification standards. (The service as described satisfies the level of intensity in ASAM Level 0.5).

1.7 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:

1.7.1 Fraud hotline complaints;

1.7.2 Claims data mining;

1.7.3 Referral of potential fraud received from the Contractor; and

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

1.8 American Society of Addiction Medicine (ASAM)

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

1.9 American Society of Addiction Medicine (ASAM) Criteria

"American Society of Addiction Medicine (ASAM) Criteria" means a comprehensive set of guidelines for determining placement, continued stay and transfer or discharge of Enrollees with addiction conditions.

1.10 Appeal

"Appeal" means a request for review of an Action.

1.11 Appeal Process

"Appeal Process" means the Contractor's procedures for reviewing an Action.

1.12 Available Resources

"Available Resources" means funds appropriated for the purpose of providing community behavorial health programs. This includes, federal funds, except those provided according to Title XIX of the Social Security Act; and state funds appropriated under RCW 71.24 or RCW 71.05 by the legislature.

1.13 Behavioral Health

"Behavioral Health" means mental health and SUD and/or conditions and related benefits.

1.14 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.

1.15 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.

1.16 Behavioral Health Data Systems (BHDS)

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

1.17 Behavioral Health Services Only (BHSO)

"Behavioral Health Services Only" means those Enrollees who receive only Behavioral Health benefits through this Contract and the AH-IMC Medicaid Contract.

1.18 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 determinate data, as well as service episode and outcome data necessary for federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant reporting and other state reporting needs.

1.19 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.

1.20 Business Day

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

1.21 Care Coordination

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

1.22 Care Management

"Care Management" means a set of services, delivered by Care Coordinators, 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 Care Management as warranted by Enrollee improvement and stabilization.

1.23 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.

1.24 Certified Substance Use Disorder Professional (SUDP)

"Certified Substance Use Disorder Professional (SUDP)" means an individual who is certified according to chapter 18.205 RCW and the certification requirements of WAC 246-811-030 to provide Substance Use Disorder (SUD) services.

1.25 Childcare Services

"Childcare Services" means the provision of child care services, when needed, to children of parents in treatment in order to complete the parent's plan for Substance Use Disorder treatment services. Childcare services must be provided by licensed childcare providers.

1.26 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.

1.27 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).

1.28 Community Health Workers (CHW)

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

1.29 Community Outreach

"Community Outreach" means an activity of providing critical information and referral regarding behavioral health services to people who might not otherwise have access to that information. This may include assisting individuals to navigate through different systems including health care enrollment, scheduling appointments for a substance use disorder assessment and ongoing treatment, or providing transportation to appointments. Outreach tasks may include educating communities, family members, significant others, or partners about services and to support access to services where care coordination may be necessary. Costs to be covered may also include responding to requests for information to be presented both in and out of the treatment facility by individuals, the general public and community organizations.

1.30 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.

1.31 Confidential Information

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

1.32 Continuing Education and Training

"Continuing Education/Training" means costs incurred for activities to support educational programs, training projects, and/or other professional development programs directed toward: 1) improving the professional and clinical expertise of prevention and treatment facility staff; 2) the knowledge base of county employees who oversee the program agreement; and 3) to meet minimum standards and contract requirements.

1.33 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.

1.34 Contract

"Contract" means this 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.

1.35 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.

1.36 Contracted Services

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

1.37 Covered Services

"Covered Services" means health care services that HCA determines are covered for Enrollees within Available Resources. When funding is exhausted, services are no longer covered and cannot be authorized regardless of medical necessity.

1.38 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).

1.39 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.

1.40 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.

1.41 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:

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

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

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

1.42 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 chapters71.05 and 71.34 RCW.

1.43 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.

1.44 Division of Behavioral Health and Recovery (DBHR)

"Division of Behavioral Health and Recovery DBHR" means the HCA designated behavioral health division for state only, federal grants, and Medicaid funded behavioral health programs in community settings.

1.45 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.

1.46 Emergency Services

"Emergency Services" means inpatient and outpatient Contracted Services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition.

1.47 Encounter Data Reporting Guide EDRG

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

1.48 Encrypt

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

1.49 Enrollee

"Enrollee" means an individual enrolled in Integrated Managed Care (IMC) or a Behavioral Health Services Only Managed Care Plan through a MCO having a Contract with HCA. For purposes of this Contract, an Enrollee may receive General Funds-State (GFS) Contracted Services if he/she meets the eligibility requirements for such services.

1.50 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.

1.51 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 disorder, and which is licensed or certified as such by the department (RCW 71.05.020).

1.52 Evidence-Based Practices (Physical Health [PH] and [BH] 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).

1.53 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.

1.54 Family Hardship Services

"Family Hardship Services" means the provision of transportation and lodging for family members traveling more than fifty (50) miles from home to a treatment facility to support a Youth receiving services in a facility to allow the family to participate in treatment.

1.55 Federally Qualified Health Center (FQHC)

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

1.56 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).

1.57 General Fund State (GFS)

"General Fund State (GFS)" means the payment source for services provided by the Contractor under this Contract.

1.58 Grievance

"Grievance" means an expression of dissatisfaction about any matter other than an action. 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.

1.59 Grievance and Appeal System

"Grievance and Appeal System" means the overall system that includes Grievances and Appeals handled by the Contractor and access to the hearing system.

1.60 Grievance Process

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

1.61 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.

1.62 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.

1.63 Health Care Professional

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

1.64 Health Care Provider (HCP)

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

1.65 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 Substance Use Disorder treatment agencies.

1.66 Indian Health Care Provider (IHCP)

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

1.67 Individual Service Plan

"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).

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

"Individuals with Intellectual or Developmental Disability (I/DD)" means 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.

1.69 Institute for Mental Disease (IMD)

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

1.70 Intake Evaluation

"Intake Evaluation" means an evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, stabilization services and free-standing Evaluation and Treatment.

1.71 Interim Services

"Interim Services" means services to individuals who are currently waiting to enter a treatment program to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease. Such services are provided until the individual is admitted to a treatment program. Services include referral for prenatal care for a pregnant patient, brief screening activities, the development of a service plan, individual or group contacts to assist the person either directly or by way of referral in meeting his/her basic needs, updates to advise him/her of treatment availability, and information to prepare him/her for treatment, counseling, education, and referral regarding HIV and tuberculosis (TB) education, if necessary referral to treatment for HIV and TB.

1.72 Involuntary Treatment Act (ITA)

"Involuntary Treatment Act (ITA)" allows for individuals to be committed by court order to a facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who may

be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to seventy-two (72) hours, but, if necessary, individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days (RCW 71.05.180, RCW 71.05.230, RCW 71.05.240 and RCW 71.05.290).

1.73 Less Restrictive Alternative Treatment (LRA)

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

1.74 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.

1.75 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.

1.76 Managed Care

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

1.77 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.

1.78 Marketing

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

1.79 Material Provider

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

1.80 Medicaid Fraud Control Division (MFCD)

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

1.81 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).

1.82 Medication Assisted Treatment (MAT)

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

1.83 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.

1.84 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).

1.85 Mental Health Care Provider (MHCP)

"Mental Health Care Provider (MHCP)" means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum

qualifications are a B.A. level in a related field or A.A. level with two (2) years' experience in the mental health or related fields.

1.86 Mental Health Professional

"Mental Health Professional" means:

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

1.86.2 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 therapist associate;

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

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

1.86.5 A person who has an approved exception to perform the duties of a Mental Health Professional by the HCA/Division of Behavioral Health and Recovery (HCA/DBHR) before July 1, 2001; or

1.86.6 A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional by the HCA/DBHR.

1.87 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.

1.88 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 within the access standards outlined in the Contract, within Available Resources.

1.89 Non-Participating Provider

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

1.90 Notice of Action

"Notice of Action" means a written notice that must be provided to Enrollees to inform them that GFS Contracted Services have not been authorized based on medical necessity criteria.

1.91 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.

1.92 Opiate Dependency/HIV Services Outreach

"Opiate Dependency/HIV Services Outreach" means costs incurred to provide Outreach and referral services to special populations such as Opiate use disorder, injecting drug users (IDU), HIV or Hepatitis C-positive individuals. Opiate Dependency/HIV and Hepatitis C Outreach is specifically designed to encourage injecting drug users (IDUs) and other high-risk groups such as opiate use disorder and HIV or Hepatitis C-positive individuals to undergo treatment and to reduce transmission of HIV and Hepatitis C disease. Costs include providing information and skills training to non-injecting, drug using sex partners of IDUs and other high-risk groups such as street youths. Programs may employ street outreach activities, as well as more formal education and risk-reduction counseling. Referral services include referral to assessment, treatment, interim services, and other appropriate support services. Costs do not include ongoing therapeutic or rehabilitative services.

1.93 Outreach and Engagement

"Outreach and Engagement" means identification of hard-to-reach individuals with a possible SUD and engagement of these individuals in assessment and ongoing treatment services as necessary. This includes: providing critical information and referral regarding Behavioral Health services to people who might not otherwise have access to that information, providing information on SUD and the impact of SUD on families, providing information on treatment options or resources, re-engaging individuals in the treatment process. This does not include ongoing therapeutic or rehabilitative services.

1.94 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. See RCW 41.05A.010.

1.95 Participating Provider

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

1.96 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.

1.97 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).

1.98 Post-Service Authorization

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

1.99 Potential Enrollee

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

1.100 Pregnant and Post-Partum Women and Parenting Persons (PPW)

"Pregnant and Post-Partum Women and Parenting Persons (PPW)" means: (i) women who are pregnant; (ii) women who are postpartum during the first year after pregnancy completion regardless of the outcome of the pregnancy or placement of children; or (iii) women who are parenting children, including those attempting to gain custody of children supervised by the Department of Children, Youth and Family (DCYF).

1.101 Pregnant, Post-Partum or Parenting Women's (PPW) Housing Support Services

"PPW Housing Support Services" means the costs incurred to provide support services to PPW individuals with children under the age of six (6) in a transitional residential housing program designed exclusively for this population.

1.102 Program of Assertive Community Treatment (PACT)

"Program of Assertive Community Treatment (PACT)" means a team-based, evidence-based mental health service delivery model that incorporates the values of Recovery and Resiliency. PACT is also a client-centered, recovery-oriented, mental health service delivery model that utilizes a multi-discliplinary team approach providing services to individuals with severe and persistent mental illnesses and co-occuring disorders.

1.103 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).

1.104 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 so by the State in which it delivers the services.

1.105 ProviderOne

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

1.106 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.

1.107 Recovery

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

1.108 Recovery Support Services

"Recovery Support Services" means a broad range of non-clinical services that assist individuals and families to initiate, stabilize, and maintain long-term Recovery from Substance Use Disorders. Recovery Support Services may include: peer delivered motivational interviewing; peer wellness coaching; peer-run respite services; person-center planning; self-care and wellness approaches; WRAP; supported employment; peer health navigators; supportive housing; promotors; Recovery community centers; whole health action management; wellness-based community campaign; mutual aid groups for individuals with co-occurring disorders; peer specialists; Recovery coaching; shared decision-making; telephone Recovery checkups; warm lines; peer-run crisis diversion services.

1.109 Regional Service Area (RSA)

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

1.110 Regulation

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

1.111 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.

1.112 Resilience

"Resilience" means the ability to become strong, healthy or successful after something bad happens.

1.113 Revised Code of Washington (RCW)

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

1.114 Room and Board

"Room and Board" means costs incurred for services in a twenty-four (24) hour-a-day setting, including the provision of accessible, clean and well-maintained sleeping quarters with sufficient space, light and comfortable furnishings for sleeping and personal activities along with nutritionally adequate meals provided three times a day at regular intervals. Room and Board must be provided consistent with the requirements for Residential Treatment Facility Licensing through the Department of Health WAC 246-337.

1.115 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.

1.116 Security Incident

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

1.117 Service Encounter Reporting Instructions (SERI)

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

1.118 Single Case Agreement

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

1.119 Sobering Services

"Sobering Services" means short-term (less than 24 consecutive hours) emergency shelter, screening, and referral services to persons who are intoxicated or in active withdrawal.

1.120 State Hospitals

"State Hospitals" means a State Hospital operated and maintained by the state of Washington for handling the most complicated long-term care needs of patients with a primary diagnosis of mental disorder.

1.121 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.

1.122 Substance Use Disorder (SUD)

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

1.123 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. Providers listed in the SAM should not be awarded a contract with the Contractor.

1.124 Therapeutic Interventions for Children

"Therapeutic Interventions for Children" means services promoting the health and welfare of children that include: developmental assessment using recognized, standardized instruments; play therapy; behavioral modification; individual counseling; self-esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior.

1.125 Transitional Age Youth (TAY)

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

1.126 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.

1.127 Transport

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

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

1.127.2 Is accomplished other than via a Trusted System.

1.127.3 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.

1.128 Urgent Medical Condition

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

1.129 Validation

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

1.130 Washington Administrative Code (WAC)

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

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

"Washington Apple Health –Integrated Managed Care (AH-IMC)" means the program under which a Managed Care MCO provides GFS services and, under separate contract, Medicaid funded physical and Behavioral Health services.

1.132 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.

1.133 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 for 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.

1.134 Young Adult

"Young Adult" means a person from age 18 through age 20.

1.135 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 which provide corrective or clarifying information.

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

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

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

2.2 Assignment

The Contractor shall not assign this Contract to a third party without the prior written consent of HCA. 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 one hundred and twenty (120) days after the end of the state fiscal year in which the services were performed unless otherwise specified in this Contract.

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 or that come into effect during the term of this Contract. The provisions of this Contract that are in conflict with applicable state or federal laws or regulations are hereby amended to conform to the minimum requirements of such laws or regulations. A provision of this Contract that is stricter than

such laws or regulations will not be deemed a conflict. Applicable laws and regulations include, but are not limited to:

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 Health Insurance Portability and Accountability Act (HIPAA).

2.4.9 The American Recovery and Reinvestment Act (ARRA).

2.4.10 The Patient Protection and Affordable Care Act (PPACA or ACA).

2.4.11 The Health Care and Education Reconciliation Act.

2.4.12 The Mental Health Parity and Addiction Equity Act (MHPAEA) and final rule.

2.4.13 The 21st Century Cures Act;

2.4.14 21 C.F.R. Food and Drugs, Chapter 1 Subchapter C – Drugs – General.

2.4.15 42 C.F.R. Subchapter A, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.

2.4.16 42 C.F.R. Subchapter A – Part 8 – Certification of Opioid Treatment Programs.

2.4.17 45 C.F.R. 96 Block Grants.

2.4.18 45 C.F.R. 96.126 Capacity of Treatment for Intravenous Substance Abusers who Receive Services under Block Grant funding.

2.4.19 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.

2.4.20 Chapter 71.05 RCW Mental Illness.

2.4.21 Chapter 71.24 RCW Community Mental Health Services Act.

2.4.22 Chapter 71.34 RCW Mental Health Services for Minors.

2.4.23 Community Mental Health and Involuntary Treatment Programs.

2.4.24 Behavioral Health Services Administrative Requirements.

2.4.25 Substance Use Disorder Services.

2.4.26 RCW 43.20A Department of Social and Health Services.

2.4.27 Senate Bill 6312 (Chapter 225. Laws of 2014) State Purchasing of Mental Health and Chemical Dependency Treatment Services.

2.4.28 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:

2.4.28.1 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.

2.4.28.2 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.

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

2.4.28.4 Those specified in Title 18 RCW for professional licensing.

2.4.29 Industrial Insurance – Title 51 RCW.

2.4.30 Reporting of abuse as required by RCW 26.44.030 and chapter 74.34 RCW.

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

2.4.32 EEO Provisions.

2.4.33 Copeland Anti-Kickback Act.

2.4.34 Davis-Bacon Act.

2.4.35 Byrd Anti-Lobbying Amendment.

2.4.36 All federal and state nondiscrimination laws and regulations.

2.4.37 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.

2.4.38 All applicable Office of Insurance Commissioner's (OIC) statutes and regulations.

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 E, 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 agrees to include the above requirement in any and all subcontracts into which it enters, and also agrees that it shall not employ debarred individuals or subcontract with any debarred providers, persons, or entities. 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 2.36 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, 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, PO 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).

2.9.2.1 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.

2.9.2.2 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.

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

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

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

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 the 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 the 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.

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.

2.13.3 The Contractor shall, in accordance with RCW 48.44.055, 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, 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.

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

2.15 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 or security law(s) or regulation(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 (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 the 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 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) 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. If key personnel will not be available for a period exceeding thirty (30) days, or are no longer working full-time in the key position, the Contractor shall notify the HCA within seven (7) days after the date of notification of the change.

2.19 Order of Precedence

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

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

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

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

2.19.4 General Terms and Conditions of this Contract.

2.19.5 RFP Documents

2.19.5.1 Attachment 1, RFP 15-008 – Integrated Managed Care – (incorporated by reference, available upon request);

2.19.5.2 Attachment 3, RFP 1812 – Integrated Managed Care (incorporated by reference, available upon request); and

2.19.5.3 Attachment 5, RFP 2567 – Integrated Managed Care (incorporated by reference, available upon request).

2.19.6 Contractor's Response to RFP:

2.19.6.1 Attachment 2, Contractor's response to RFP 15-008 – Integrated Managed Care – (incorporated by reference, available upon request);

2.19.6.2 Attachment 4, Contractor's Response to RFP 1812 - Integrated Managed Care (incorporated by reference, available upon request); and

2.19.6.3 Attachment 6, Contractor's Response to RFP 2567 - Integrated Managed Care (incorporated by reference, available upon request).

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

2.19.8 Any other material incorporated herein by reference.

2.20 Severability

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

2.21 Survivability

The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: Confidentiality, Fraud, Overpayment, Indemnification and Hold Harmless, Inspection, Maintenance of Records, Constraints on Use of Data, Security of Data, Data Confidentiality and Non-Disclosure of Data, Data Breach Notification and Obligations, and Material Breach. After termination of this Contract, the Contractor remains obligated to:

2.21.1 Submit all data and reports required in this Contract.

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

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

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

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

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

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

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

2.22 Waiver

Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the

terms and conditions of this Contract. Only the Director of the HCA or his or her designee has the authority to waive any term or condition of this Contract on behalf of HCA.

2.23 Contractor Certification Regarding Ethics

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

2.24 Health and Safety

The 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.

2.25 Indemnification and Hold Harmless

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

2.26 Industrial Insurance Coverage

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

2.27 No Federal or State Endorsement

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

2.28 Notices

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

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

Name
MCO
Address
City, State Zip

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

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

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

2.28.4 Either party may at any time change its address for notification purposes by mailing a notice in 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.

2.29 Notice of Overpayment

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

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

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

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

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

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

2.29.2.5 Include a copy of the Notice of Overpayment.

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

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

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

2.30 Proprietary Data or Trade Secrets

2.30.1 Except as required by law, regulation, or court order, data identified by the Contractor as proprietary trade secret information, including paid amount information as described in section 5.2.3, 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.

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

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

2.30.4 Notwithstanding other requirements in this Section, nothing in this Contract

prohibits HCA from making the following types of disclosures:

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

2.30.4.1.1 Litigation, with an appropriate court order;

2.30.4.1.1.1 HCA will provide Contractor with notice and opportunity to file legal proceedings in accordance with subsection 2.30.2.

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

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

2.30.4.2 Disclosures of information that is not directly identifiable by MCO, including disclosures:

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

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

2.30.4.3 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;

2.30.4.4 Disclosures of aggregated information; and

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

2.31 Ownership of Material

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

2.32 Solvency

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

of chapters 48.21, 48.21A, 48.44 or 48.46 RCW, as amended.

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

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

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

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

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

2.33 Conflict of Interest Safeguards

The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public Contracting (41 U.S.C. § 423).

2.34 Reservation of Rights and Remedies

A material default or breach in this Contract will cause irreparable injury to HCA. In the event of any claim for default or breach of this Contract, no provision in this Contract shall be construed, expressly or by implication, as a waiver by the state of Washington to any existing or future right or remedy available by law. Failure of the state of Washington to insist upon the strict performance of any term or condition of this Contract or to exercise or delay the exercise of any right or remedy provided in this Contract or by law, or the acceptance of (or payment for) materials, equipment or services, shall not release Contractor from any responsibilities or obligations imposed by this Contract or by law, and shall not be deemed a waiver of any right of the state of Washington to insist upon the strict performance of this Contract. In addition to any other remedies that may be available for default or breach of this Contract, in equity or otherwise, HCA may seek injunctive relief

against any threatened or actual breach of this Contract without the necessity of proving actual damages. HCA reserves the right to recover any or all administrative costs incurred in the performance of this Contract during or as a result of any threatened or actual breach.

2.35 Termination by Default

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

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

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

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

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

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

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

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

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

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

2.35.2.9 The Contractor failed to permit access to one (1) of the Contractor's locations for site visits under 42 C.F.R. § 455.432 (42 C.F.R. 455.416(f)).

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

2.36 Termination for Convenience

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

2.37 Terminations: Pre-termination Processes

2.37.1 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.

2.37.2 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.

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

2.38 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.

2.39 Termination - Information on Outstanding Claims

In the event this Contract is terminated, the Contractor shall provide HCA, within ninety (90) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims or bills for GFS services to Enrollees. Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions Section of this Contract.

2.40 Administrative Simplification

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

2.40.1 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:

2.40.1.1 Current Procedural Terminology (CPT).

2.40.1.2 International Classification of Diseases (ICD).

2.40.1.3 Healthcare Common Procedure Coding System (HCPCS).

2.40.1.4 The Diagnostic and Statistical Manual of Mental Disorders.

2.40.1.5 NCPDP Telecommunication Standard D.O.

2.40.1.6 Medi-Span® Master Drug Data Base or other nationally recognized drug data base with approval by HCA.

2.40.2 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 claims. The NCCI editing should occur in addition to current procedure code review and editing by the Contractor's claims payment systems.

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

2.40.4 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. Marketing materials must be developed and submitted in accordance with the Marketing Guidelines developed and distributed by the HCA. Marketing materials include any items developed by the Contractor for distribution to Enrollees or Potential Enrollees that are intended to provide information about the Contractor's benefit administration, including:

3.1.1.1 Print media;

3.1.1.2 Websites; and

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

3.1.2 Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information.

3.1.3 Marketing materials must be distributed in all service areas the Contractor serves.

3.1.4 Marketing materials shall not contain an invitation, implied or implicit, for an Enrollee to change from one MCO to the Contractor, or imply that the Contractor's benefits are substantially different from any other MCO.

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 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.

3.1.7 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 new Enrollees the information needed to understand benefit coverage and obtain care in accordance with the provisions of this Section. Specifically, the Contractor shall provide information to Enrollees on the GFS services, including how to access them. The information shall be provided at least once a year upon request and within fifteen (15)

working days of enrollment. In providing this information to the Enrollees, the Contractor may use an existing member handbook that is otherwise provided to Enrollees; however, such handbook must be prior approved in writing by the HCA.

3.2.2 The Contractor shall submit branding materials developed by the Contractor that specifically mention GFS services for review and approval. No such materials shall be disseminated to Enrollees, providers or other members of the public without HCA's approval.

3.2.3 The Contractor shall submit Enrollee information developed by the Contractor that specifically mentions GFS services provided under this Contract at least thirty (30) calendar days prior to distribution for review and approval. All other Enrollee materials shall be submitted as informational. HCA may waive the thirty (30) day requirement if, in HCA's sole judgment, it is in the best interest of HCA and its clients to do so.

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).

3.3.1 Oral Information

3.3.1.1 The Contractor shall assure 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 F.F.R. § 438.10(d)(4)) Interpreter services 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 appointments with any provider for any Covered Service,

3.3.1.1.3 Emergency Services, and

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

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

3.3.1.3 HCA is responsible for payment of interpreter services provided

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

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

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

3.3.2 Written Information

3.3.2.1 The Contractor shall provide all generally available and Enrollee-specific written materials in a language and format which may be understood by each individual Enrollee and Potential Enrollee if 5 percent or more of the Contractor's Enrollees speak a language other than English.

3.3.2.2 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:

3.3.2.2.1 Translating the material into the Enrollee's or Potential Enrollee's primary reading language.

3.3.2.2.2 Providing the material in an audio format in the Enrollee's or Potential Enrollee's primary language.

3.3.2.2.3 Having an interpreter read the material to the Enrollee or Potential Enrollee in the Enrollee's primary language.

3.3.2.2.4 Providing the material in another alternative medium or 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 in the Enrollee's record.

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

3.3.3 The Contractor shall ensure that all written information provided to Enrollees or Potential Enrollees is accurate, is not misleading, is comprehensible to its intended audience, designed to provide the greatest degree of understanding, is written at the sixth grade reading level, and fulfills other requirements of the Contract as may be applicable to the materials.

3.3.4 HCA may make exceptions to the sixth (6th) grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth grade reading level or the Enrollees' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth (6th) grade reading level must be in writing.

3.3.5 Educational materials about topics or other information used by the Contractor for health promotion efforts must be submitted to HCA, but do not require HCA approval as long as they do not specifically mention the GFS services provided under this Contract.

3.3.6 Educational materials that are not developed by the Contractor or developed under Contract with the Contractor are not required to meet the sixth (6th) grade reading level requirement and do not require HCA approval.

3.3.7 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.

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. The Contractor's RSAs are identified in Exhibit F, Regional Service Area.

4.2 Eligibility and Enrollment

4.2.1 To be eligible for GFS services under this Contract, an individual must: (i) be eligible for Medicaid and an Enrollee in the Contractor's plan; and (ii) meet the clinical or program eligibility criteria for the GFS service.

4.2.2 Meeting the eligibility requirements under this Contract does not guarantee the Enrollee will receive the GFS service.

4.2.3 HCA shall determine Medicaid eligibility for enrollment over the term of this Contract. Individuals eligible for Medicaid and enrolled with the Contractor will be presumed to meet financial eligibility requirements for GFS services.

4.2.4 At HCA's direction, the Contractor shall participate in a regional initiative to develop and implement consistent protocols to determine clinical or program eligibility for the limited-benefit GFS services.

4.2.5 At HCA's discretion, the Contractor shall participate in developing protocols for individuals with frequent Medicaid eligibility changes (including those individuals who are eligible through spend-down). The protocols will address, at a minimum, coordination with the BH-ASO, referrals, reconciliations and potential transfer of GFS funds to promote Continuity of Care for the individual. Any reconciliations will occur at a frequency determined by HCA but no less than quarterly with potential for up to monthly reconciliations in the last quarter of the allocation year.

4.3 Termination of Enrollment

4.3.1 The Enrollee remains eligible for GFS services until HCA has notified the Contractor in writing that enrollment in the AH-IMC plan is terminated, or the Enrollee no longer meets clinical/program eligibility requirements, contingent on Available Resources.

4.3.2 An Enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month remains eligible as a Medicaid Enrollee to receive Contracted Services through the end of that month as long as the Enrollee meets the clinical eligibility requirements for the GFS services.

5. PAYMENT AND SANCTIONS

5.1 Funding

5.1.1 The funds under this Contract are dependent upon HCA's receipt of continued state and federal funding awards. If HCA does not receive continued state and federal funding awards, HCA may terminate this Contract in accordance with this Contract's General Terms and Conditions.

5.1.2 HCA will provide the Contractor with their budget of GFS and proviso funds annually, identified in Exhibit A. The Contractor's budget is based upon available funding for the regional service area as a whole and the Contractor's share of the eligible enrollment in the region.

5.1.3 A maximum of 10 percent of the GFS and proviso funds expended by the Contractor may be used for administrative costs, taxes and other fees per RCW 71.24.330 and must be reported on the quarterly expenditure report, as identified in Exhibit B.

5.1.4 HCA will pay the Contractor GFS and proviso funds, including the administrative portion, in equal monthly amounts, or as identified in Exhibit A, based upon the budget identified in Exhibit A.

5.1.5 The Contractor shall send a quarterly expenditure report to the HCA Contract Manager. The expenditure report format is identified in Exhibit B. The expenditure report is due to the HCA no later than thirty (30) calendar days after the last day of the quarter. The expenditures reported shall represent the payments made for services under this Contract during the quarter being reported. The 10 percent administrative load, as identified in Section 5.1.3 will be included on this expenditure report.

5.1.6 If the expenditures reported by the Contractor on the expenditure report, exceed the Contractor's budget identified in Exhibit A, HCA will not pay the Contractor for the amount that exceeds the budget.

5.1.7 HCA will perform a reconciliation of the Contractor's expenditure reports to their budget at least annually. Based upon the results of the reconciliation, at HCA's discretion,the allocation and distribution of GFS and proviso funds may be reevaluated and unspent funds may be reallocated retrospectively.

5.1.8 Funds paid under this Contract that are not expended by the end of the applicable fiscal year may be used or carried forward to the subsequent applicable fiscal year. Unspent allocations shall be reported to HCA at the end of the applicable state fiscal year, as specified in this Contract. In order to expend these funds the next fiscal year, the Contractor shall submit a plan to HCA for approval.

5.1.9 The Contractor shall ensure that all funds provided pursuant to this Contract, including interest earned, are used to provide services as described in this Contract.

5.1.10 HCA shall not be obligated to provide funding to the Contractor for any services

or activities performed prior to the effective date of this Contract.

5.1.11 The Contractor shall administer services provided under this Contract in a manner that best maintains Available Resources throughout the Contract period. The Contractor shall maintain financial records that track the funding received and the expenditures for services provided under this Contract by category of service, funding source and state fiscal year.

5.1.12 Upon completing the PMPM recoupment reconciliation for Enrollees who have stayed in an (IMD) for sixteen (16) calendar days or more, within a single calendar month, as outlined in the Apple Health Integrated Managed Care Medicaid contract, the Contractor shall invoice HCA for all physical health claims for Enrollees that have had a PMPM recouped by HCA. The Contract shall use the state of Washington A-19 invoice form and provide claim transaction control numbers (TCN) as back up for the invoiced amount. The TCNs must have an "Accepted" business status in HCAs ProviderOne Medicaid Management Information System. The Contractor will upload the invoice and a file with claim TCNs thirty (30) calendar days after completion of IMD PMPM recoupment reconciliation. If claims are processed by the Contractor after the initial amount is reported, but within the limitations described in the Billing Limitations section 2.3 of this contract, the Contractor shall submit the claims to HCA within thirty (30) calendar days of payment.

5.1.12.1 The Contractor shall report the total physical health claims paid on behalf of each IMD Enrollee to HCA within thirty (30) calendar days of notification from HCA of the Enrollee's IMD status. Within thirty (30) calendar days of notification, HCA will reimburse the Contractor for the physical health cost of claims paid on behalf of an IMD Enrollee during the calendar month for which the premium was recouped.

5.2 Encounter Data

5.2.1 For purposes of this Subsection:

5.2.1.1 "Encounter" means a single Behavioral Health care service or a period of examination or treatment.

5.2.1.2 "Encounter Data" means records of 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.

5.2.1.3 "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.

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

5.2.2 The Contractor shall submit and maintain accurate, timely and complete data as to not cause harm to rate development and enhanced payments that are dependent upon accurate encounter data. The Contractor shall comply with the following:

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

5.2.2.2 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. The Contractor shall submit encounter data using assigned program identifiers corresponding to each program (e.g., AH-IMC, BHSO, etc.) the Contractor provides. The data shall adhere to the following data quality standards:

5.2.2.2.1 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;

5.2.2.2.2 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;

5.2.2.2.3 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

5.2.2.2.4 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.

5.2.2.3 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.

5.2.3 The Contractor must report the paid date, paid unit and paid amount paid 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 2.30, Proprietary Data or Trade Secrets.

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

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

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

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

5.2.5.3 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 is the individual certifying the submission.

5.2.5.3.1 The individual certifying must attest that based on the best knowledge, information, and belief as of the date indicated, all information submitted to HCA in the submission is accurate, complete, truthful, and no material fact has been omitted from the submission; and

5.2.5.3.2 The certification must indicate if the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the encounter data submission.

5.2.6 HCA collects and uses this data for many reasons such as: Audits, investigations, identifications of improper payments and other program integrity activities, federal reporting (42 C.F.R. § 438.242(b)(1)), rate setting and risk adjustment, service verification, Managed Care quality improvement program, utilization patterns and access to care; HCA hospital rate setting; pharmacy rebates, and research studies.

5.2.7 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. The SERI Guide can be found at: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/services-encounter-reporting-instructions-seri:

5.2.7.1 HCA may change the Encounter Data Reporting Guide and SERI Guide with ninety (90) calendar days' written notice to the

Contractor.

5.2.7.2 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.

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

5.2.8 The Contractor shall ensure that final reporting of encounters for services provided under this Contract shall occur no more than ninety (90) days after the end of each fiscal year of this Contract.

5.3 Non-Compliance

5.3.1 Failure to Maintain Reporting Requirements

5.3.1.1 In the event the Contractor or a Subcontractor fails to maintain its reporting obligations under this Contract, HCA reserves the right to withhold reimbursements to the Contractor until the obligations are met.

5.3.2 Recovery of Costs Claimed in Error

5.3.2.1 If the Contractor claims and HCA reimburses for expenditures under this Contract which HCA later finds were (1) claimed in error or (2) not allowable costs under the terms of the Contract, HCA shall recover those costs and the Contractor shall fully cooperate with the Recovery.

5.3.3 Stop Placement

5.3.3.1 HCA may stop the placement of Enrollee in a treatment facility immediately upon finding that the Contractor or a Subcontractor is not in substantial compliance, as determined by HCA, with provisions of the Contract or any WAC related to behavioral health treatment. The treatment facility will be notified by HCA of this decision in writing.

5.3.4 Additional Remuneration Prohibited

5.3.4.1 The Contractor shall not charge or accept additional fees from any Enrollee, relative, or any other person, for GFS services provided under this Contract other than those specifically authorized by HCA. The Contractor shall require its Subcontractors to adhere to this requirement. In the event the Contractor or Subcontractor charges or accepts prohibited fees, HCA shall have the right to assert a claim against the Contractor or Subcontractors on behalf of the client, per RCW 74.09. Any violation of this provision shall be deemed a material breach of this Contract.

5.4 Overpayments or Underpayments

5.4.1 If, at HCA's sole discretion, HCA determines as a result of data errors or inadequacies, policy changes beyond the control of the Contractors, or other causes there are material errors or omissions in the allocation of GFS funds, HCA may make prospective and/or retrospective modifications to the allocations, as necessary. At the explicit written approval of HCA, the Contractor can elect to make a lump sum or similar arrangement for payment.

5.5 Sanctions

5.5.1 HCA may initiate remedial action if it is determined that any of the following situations exist:

5.5.1.1 A problem exists that negatively impacts Enrollees receiving services.

5.5.1.2 The Contractor has failed to perform any of the GFS services required in this Contract.

5.5.1.3 The Contractor has failed to develop, produce, and/or deliver to HCA any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Contract.

5.5.1.4 The Contractor has failed to perform any administrative function required under this Contract. For the purposes of this section, "administrative function" is defined as any obligation other than the actual provision of Behavioral Health services.

5.5.1.5 The Contractor has failed to implement corrective action required by the state and within HCA prescribed timeframes.

5.5.2 HCA may impose any of the following remedial actions:

5.5.2.1 Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to HCA within thirty (30) calendar days of notification. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Contract. HCA may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

5.5.2.1.1 Corrective action plans must include:

5.5.2.1.1.1 A brief description of the situation requiring corrective action.

5.5.2.1.1.2 The specific actions to be taken to remedy the situation.

5.5.2.1.1.3 A timetable for completion of the actions.

5.5.2.1.1.4 Identification of individuals responsible for implementation of the plan.

5.5.2.1.2 Corrective action plans are subject to approval by HCA, which may:

5.5.2.1.2.1 Accept the plan as submitted.

5.5.2.1.2.2 Accept the plan with specified modifications.

5.5.2.1.2.3 Request a modified plan.

5.5.2.1.2.4 Reject the plan.

5.5.3 HCA will withhold up to 5 percent of the next payment and each payment thereafter until the corrective action has achieved resolution. The amount of the withhold will be based on the severity of the situation as detailed in this section. HCA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

5.5.4 Increase withholdings identified above by up to an additional 3 percent for each successive month during which the remedial situation has not been resolved.

5.5.5 Deny any incentive payment to which the Contractor might otherwise have been entitled under this Contract.

5.5.6 Terminate for Default as described in the General Terms and Conditions.

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 GFS services under this Contract to its Enrollees. The Contractor may 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 needs of Enrollees in a manner consistent with this Contract. To the extent necessary to comply with the provider Network Adequacy and distance standards required under this Contract, the Contractor may 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.

6.1.2 The Contractor must submit documentation quarterly assuring adequate capacity and services, including information regarding its maintenance, monitoring and analysis of the network to include full provider network submissions to determine compliance with the requirements of this Section, at any time upon HCA request or when there has been a change in the Contractor's network or operations that, in the sole judgment of HCA, would affect adequate capacity and/or the Contractor's ability to provide services. The quarterly reports shall include a one (1) page narrative describing the contracting activities in bordering communities and service areas. The quarterly reports are due no later than the 15th of the month following the quarter.

6.1.3 The Contractor shall submit updated provider network information as requested by HCA:

6.1.3.1 At the time it enters into a Contract with HCA and within ten (10) business days of HCA's request.

6.1.3.2 At any time there has been a significant change in the Contractor's operations that would affect adequate capacity and services, including:

6.1.3.2.1 Changes in GFS services, geographic service area;

6.1.3.2.2 The termination or addition of a subcontract with an entity that provides Behavioral Health services, the closing of a Subcontractor site that is providing services under this Contract or temporary inability of a subcontracted provider to deliver services such as strike or other work stoppage;

6.1.3.2.3 Enrollment of a new population in the Contractor;

6.1.3.2.4 The closing of a Subcontractor, agency or provider that is providing services under this Contract; and

6.1.3.2.5 Any other changes that result in the Contractor being unable to meet access including a decrease in the number or frequency of a required service, employee strike or other work stoppage related to union activities, or any changes that results in the Contractor being unable to provide timely services.

6.1.4 The Contractor shall notify HCA ninety (90) days prior to terminating any of its Subcontracts with entities that provide direct services or entering into new subcontracts with entities that provide direct services. This notification shall occur prior to any public announcement of this change.

6.1.4.1 If a Subcontract is terminated in less than ninety (90) days or a site closure occurs in less than ninety (90) days, the Contractor shall notify HCA as soon as possible and prior to a public announcement.

6.1.4.2 If a subcontract is terminated or a site closes, the Contractor shall submit a plan to HCA that includes at a minimum:

6.1.4.2.1 Notification to Ombuds services;

6.1.4.2.2 Individual notification plan;

6.1.4.2.3 Plan for provision of uninterrupted services; and

6.1.4.2.4 Any information released to the media.

6.1.4.3 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.

6.1.4.3.1 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.

6.1.5 The updated 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 incorporate the following requirements when developing its network:

6.1.6.1 Only licensed Behavioral Health providers shall provide Behavioral Health services to Enrollees. 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.

6.1.6.2 The Contractor shall establish and maintain contracts with Washington State determined Essential Behavioral Health Providers. The current list of Essential Behavioral Health Providers can be found in Exhibit D.

6.1.6.3 The Contractor shall, in partnership with the BH-ASO, assist the state to expand community-based alternatives for crisis stabilization, such as mobile crisis or crisis residential and respite beds.

6.1.6.4 The Contractor shall assist the state to expand community-based, recovery-oriented services and research- and evidence-based practices.

6.1.6.5 The Contractor shall implement an adequate plan to provide Evaluation and Treatment services to Enrollees, which may include the development of less restrictive alternative to involuntary treatment or prevention programs reasonably calculated to reduce the demand for Evaluation and Treatment services.

6.1.7 If the Contractor, in HCA's sole opinion, and in conjunction with recommendations provided by the ACH, fails to maintain an adequate network of Behavioral Health providers in any contracted service area for two (2) consecutive quarters, and after notification following the first quarter, HCA reserves the right to immediately terminate the Contractor's services for that service area. The network established under the Contract must complement and support the network of Medicaid providers established by the AH-IMC Medicaid Contract.

6.1.8 The Contractor shall update and maintain the Contractor's existing provider manual to include all relevant information regarding GFS services and requirements.

6.1.9 The Contractor shall update its existing database to meet the following requirements:

6.1.9.1 Includes a list of all GFS providers.

6.1.9.2 Includes the providers' names, locations, telephone numbers, GFS services offered, clinical specialty and areas of expertise.

6.1.9.3 Includes a description of each provider's language(s) spoken and if appropriate, a brief description of the provider's skills or experiences that would support the cultural or linguistic needs of its Enrollees when provided by a provider.

6.1.9.4 Indicates whether each provider has capacity to serve new patients and the limits on capacity for each provider.

6.1.9.5 Updates to the provider database shall be made: no less than quarterly or whenever there is a change in the Contractor's network that would affect adequate capacity in a service area.

6.1.9.6 Contractor program staff shall be available to conduct provider searches based on office or facility location, clinical specialty, provider discipline, provider capacity, available languages and allowable fund sources (e.g., Medicaid, GFS).

6.2 Service Delivery Network

6.2.1 In establishing, maintaining, monitoring and reporting of its network, the Contractor must consider the following:

6.2.1.1 The impact of anticipated enrollment levels, expected utilization of services, characteristics and health care needs of the population, the number and types of providers (training, experience and specialization) able to furnish services, and the geographic location of providers and individuals (including distance, travel time, means of transportation ordinarily used by clients, and whether the location is ADA accessible) for all Contractor funded Behavioral Health programs and services on the availability of GFS services.

6.2.2 The Contractor and its Subcontractors shall:

6.2.2.1 Ensure that all services and activities provided under this Contract shall be designed and delivered in a manner sensitive to the needs of all diverse populations;

6.2.2.2 Initiate actions to ensure or improve access, retention, and cultural relevance of treatment, prevention or other appropriate services, for ethnic minorities and other diverse populations in need of services under this Contract as identified in their needs assessment; and

6.2.2.3 Take the initiative to strengthen working relationships with other agencies serving these populations.

6.3 Hours of Operation for Network Providers

The Contractor must require that network providers offer hours of operation for Enrollees that are no less than the hours of operation offered to any other patient.

6.4 24/7 Availability

The Contractor shall have the following services available twenty-four (24) hour-a-day, by a toll free telephone number. These services may be provided directly by the Contractor or may be delegated to subcontractors. The Contractor shall have a single toll-free number for Enrollees to call regarding Medicaid and GFS services at its expense. The Contractor shall not have a separate toll-free number for GFS services.

6.4.1 Medical and Behavioral Health advice for Enrollees from licensed Health Care Professionals.

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

6.4.3 The toll-free line staff must be able to make a warm handoff to the regional crisis line managed by the BH-ASO.

6.4.4 Information, triage and referral for GFS funded services with access to licensed Health Care Professionals and, licensed agencies or clinics to address emergent or urgent needs.

6.5 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.

6.5.1 The Contractor shall report by December 1st of each year its scheduled non-business days for the upcoming calendar year.

6.5.2 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.

6.5.3 The Contractor Enrollee customer service centers, if any, shall comply with the following customer service performance standards:

6.5.3.1 Telephone abandonment rate – standard is less than 5 percent.

6.5.3.2 Telephone response time – average speed of answer within thirty (30) seconds.

6.5.4 The Contractor provider help desks, if any, shall comply with the following customer service performance standards:

6.5.4.1 Telephone abandonment rate – standard is less than 5 percent.

6.5.4.2 Telephone response time – average speed of answer within thirty (30) seconds.

6.5.5 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 GFS service eligibility requirements and benefits; navigation of the eligibility systems to access Medicaid benefits and GFS services; refer for Behavioral Health services; Appeal or Grievance; and resolve and triage Grievances and Appeals.

6.5.6 The Contractor shall submit its customer service policies and procedures to the HCA for review. Customer service policies and procedures shall address the following:

6.5.6.1 Information on the GFS services including where and how to access them;

6.5.6.2 Authorization requirements;

6.5.6.3 Requirements for responding promptly to family members and other service systems including, but not limited to the regional BH-ASO, law enforcement, criminal justice system and social services; and

6.5.6.4 Assisting and triaging Enrollees 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 Enrollee for services or to his or her provider, or resolve the crisis as appropriate.

6.5.7 The Contractor shall train customer service representatives on revised GFS policies and procedures.

6.6 Data Collection

6.6.1 The Contractor shall collect and report on Enrollee information as specified in this Contract. The Contractor's disclosure of individually identifiable information is authorized by law, including 42 C.F.R. § 2.53, authorizing disclosure of Enrollee records for purposes of Medicaid evaluation.

6.7 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.

6.7.1 The Contractor shall prepare a network inventory, including licensure, to quantify the number of providers offering GFS services.

6.8 Access to Services

6.8.1 The Contractor shall, subject to allocated and available funds, ensure that

services are not denied to any eligible Enrollee regardless of:

6.8.1.1 The Enrollee's drug(s) of choice.

6.8.1.2 The fact that an Enrollee is taking medically-prescribed medications.

6.8.1.3 The fact that a person is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.

6.8.2 Enrollees cannot be required to relinquish custody of minor children in order to access residential SUD treatment services.

6.8.3 A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of detoxification, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within twenty-four (24) hours.

7. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1 Quality Management Program

7.1.1 The Contractor shall ensure its Quality Management (QM) program addresses GFS requirements.

7.1.2 The Contractor shall comply with the following QM requirements:

7.1.2.1 The Contractor shall participate in the single RSA Community Behavioral Health Advisory Board (CBHA).

7.2 Quality Review Activities

7.2.1 The HCA, Office of the State Auditor, or any of their duly-authorized representatives, may conduct announced and unannounced:

7.2.1.1 Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Contract;

7.2.1.2 Audits regarding the quality, appropriateness, and timeliness of Behavioral Health services provided under this Contract; and

7.2.1.3 Audits and inspections of financial records.

7.2.2 The Contractor shall participate with HCA in review activities. Participation will include at a minimum:

7.2.2.1 The submission of requested materials necessary for an HCA initiated review within thirty (30) days of the request.

7.2.2.2 The completion of site visit protocols provided by HCA.

7.2.2.3 Assistance in scheduling interviews and agency visits required for the completion of the review.

7.2.3 The Contractor shall notify HCA when an entity other than the State Auditor performs any audit described above related to any activity contained in this Contract.

7.3 Performance-Based Goals and Other Reporting Requirements

7.3.1 At HCA's discretion, performance will be linked to payment.

7.3.2 HCA defined reporting and data submission methods for Performance Measurement and Reporting:

7.3.2.1 The Contractor shall comply with the reporting and data submissions requirements as directed by HCA and shall make reports available to HCA at least annually through the HCA monitoring process or more frequently, as requested by HCA. Should the HCA adopt a subsequent set of requirements during

the term of this Contract, the HCA shall update the performance requirements as necessary.

7.3.3 All performance measures are subject to an audit; HCA will fund the audit.

7.3.4 The Contractor shall report all instances of suspected Enrollee abuse to HCA

7.4 Practice Guidelines

7.4.1 The Contractor shall adopt Behavioral Health practice guidelines known to be effective in improving health outcomes. Practice guidelines shall meet the following requirements:

7.4.1.1 Valid and reliable clinical scientific evidence;

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

7.4.1.3 In the absence of scientific evidence and professional standards, a consensus of Health Care Professionals in the particular field.

7.4.2 The Contractor may adopt guidelines developed by recognized sources that develop or promote evidence-based clinical practice guidelines such as United States Preventive Services Task Force (USPSTF), 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:

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

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

7.4.2.3 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.

7.4.2.4 Be reviewed and updated at least every two (2) years and more often if national guidelines change during that time.

7.4.2.5 Be disseminated to all affected providers and, upon request, to HCA, Enrollees and Potential Enrollees.

7.4.2.6 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.

7.4.2.7 Be the basis for and are consistent with decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply.

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

7.5 Health Information Systems

The Contractor shall establish and maintain, and shall require Subcontractors to maintain, a health information system that complies with the requirements of 42 C.F.R. § 438.242, 42 C.F.R. § 164, HCA Security Policies and standards 6-05 through 6-15-01, and OCIO Security Standard 141.10, and provides the information necessary to meet the Contractor's obligations under this Contract. HCA Security Policies and Standards. OCIO Security Standards are available at: https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets. The Contractor shall have in place mechanisms to verify the health information received from Subcontractors. The Contractor shall:

7.5.1 Collect, analyze, integrate, and report data. The system must provide information on areas including, but not limited to: utilization, Grievance and Appeals.

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

7.5.2.1 Verifying the accuracy and timeliness of reported data;

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

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

7.5.3 Make all collected data available to HCA upon request, to the extent permitted by the HIPAA Privacy Rule (45 C.F.R. Part 160 and Subparts A and E of Part 164), 42 C.F.R. Part 2, and RCW 70.02.005 et seq.

7.5.4 Establish and maintain protocols to support timely and accurate data exchange with any Subcontractor that will perform any delegated functions under the Contract.

7.5.5 Establish and maintain web-based portals with appropriate security features that allow referrals, requests for prior authorizations, encounter submission, for GFS services.

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

7.5.7 Maintain Behavioral Health content on a website that meets the following minimum requirements. The Contractor may use its Medicaid website as long as the website includes information on GFS services.

7.5.7.1 Public and secure access via multi-level portals for providing web-based training, standard reporting, and data access for the effective management and evaluation of the performance of the Contract and the service delivery system as described under this Contract.

7.5.7.2 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:

7.5.7.2.1 Hours of operations;

7.5.7.2.2 How to access GFS services, including crisis contact information and toll-free crisis telephone numbers;

7.5.7.2.3 Telecommunications device for the deaf/text telephone numbers;

7.5.7.2.4 Information on the right to choose a qualified Behavioral Health service provider, when available and medically necessary;

7.5.7.2.5 An overview of the range of Behavioral Health services being provided;

7.5.7.2.6 Access to Behavioral Health-medical integration tools and supports to support provider integration initiatives;

7.5.7.2.7 Access to information for Transitional Age Youth (TAY);

7.5.7.2.8 A library, for providers and Enrollees, that provides comprehensive information and practical recommendations related to mental illness, addiction and recovery, life events and daily living skills;

7.5.7.2.9 Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for Enrollees, family members, providers and stakeholders to become involved;

7.5.7.2.10 Information regarding advocacy organizations, including how Enrollees and other family members may access advocacy services; and

7.5.7.2.11 Opportunities, including surveys, for Enrollees, family members, network providers, and other stakeholders to provide satisfaction/complaint feedback.

7.6 Required Reporting for Behavioral Health Services

7.6.1 The Contractor will comply with required reporting for Behavioral Health services in this Contract for both AH-IMC and BHSO Enrollees. 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.

7.6.2 The Contractor must comply with behavioral health reporting requirements, including Service Encounter Reporting Instructions (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.

7.6.2.1 HCA will provide training or technical assistance for this report to the Contractor. The Contractor must provide training or technical assistance to their Subcontractor.

7.7 Technical Assistance

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

8. POLICIES AND PROCEDURES

The Contractor shall develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of this Contract. The Contractor shall submit policies and procedures to the HCA for review and approval in accordance with 8.2 of this Section, Assessment of Policies and Procedures. The Contractor may use policies and procedures it has developed under other contracts with the HCA to the extent the policies and procedures meet the requirements of this Contract. However, the Contractor shall re-submit such policies and procedures and note that such policy/procedure was previously approved by the HCA under another contract.

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; and

8.1.4 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, except as limited in Section 9.5. However, the Contractor is legally responsible to HCA for any work performed under this Contract and for oversight of any functions and/or responsibilities it delegates to any Subcontractor.

9.1.1 Beginning January 1, 2020, the Contractor will submit to HCA for approval an HCA Self-Assessment form and any templates used 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 the:

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 45 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 Provider Nondiscrimination

9.2.1 The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold.

9.2.2 If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

9.2.3 The Contractor's policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

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

9.2.4.1 Require the Contractor to contract with providers beyond the number necessary to meet the needs of its Enrollees within Available Resources.

9.2.4.2 Preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty.

9.2.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs.

9.3 Required Provisions

Subcontracts shall be in writing, and available to HCA upon request. All Subcontracts shall contain applicable provision contained in Subsection 9.4 and 9.5 of this Contract and the following provisions:

9.3.1 Identification of the parties of the Subcontract and their legal basis for operation in the state of Washington.

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

9.3.3 The responsibilities of the Quality Management section of this Contract may not be delegated to a Contracted Network Behavioral Health Agency.

9.3.4 The Contractor may not delegate its responsibility to contract with a provider network, without express permission from HCA. This does not prohibit a contracted, licensed provider from subcontracting with other appropriately licensed providers so long as the subcontracting provisions of this Contract are met.

9.3.5 Procedures and specific criteria for terminating the Subcontract and for any other remedies the Contractor provides if HCA or the Contractor determines that the subcontractor has not performed satisfactorily.

9.3.6 Identification of the services to be performed 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. (45 C.F.R. 92.35).

9.3.7 Reimbursement rates and procedures for services provided under the Subcontract.

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

9.3.9 Reasonable access to facilities and financial and medical records for duly authorized representatives of HCA or DOH for audit purposes and immediate access for Medicaid Fraud investigators.

9.3.10 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.

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

9.3.12 The Contractor shall provide the following information regarding the Grievance system for GFS funded services to all Subcontractors:

9.3.12.1 The toll-free numbers to file oral Grievances and Appeals.

9.3.12.2 The availability of assistance in filing a Grievance or Appeal, including informing the Enrollee about Ombuds services and how to access these services.

9.3.12.3 The Enrollees do not have a right to continuation of benefits during an Appeal Process or the Administrative Hearing process.

9.3.12.4 The Enrollee’s right to file Grievances and Appeals and their requirements and timeframes for filing.

9.3.12.5 The Enrollee’s right to a hearing, how to obtain a hearing and representation rules at a hearing.

9.3.13 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 the Inspector General, 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.

9.3.14 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 9.3.13. If the requesting agency asks for copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or 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 Management of Subcontracts

9.4.1 The Contractor must monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the HCA, consistent with industry standards or state law and regulation.

9.4.1.1 This review may be combined with a formal review of services performed pursuant to the Contractor's Medicaid Contract between the Contractor and HCA.

9.4.1.2 The review must be based on the specific delegation agreement with each Subcontractor, and must address compliance with Contract requirements for each delegated function, which may include but is not limited to:

9.4.1.2.1 Documentation and appropriateness of medical necessity determinations.

9.4.1.2.2 Enrollee record reviews to ensure services are appropriate based on diagnosis, the treatment plan is based on the Enrollee's needs and progress notes support the use of each service.

9.4.1.2.3 Enrollee record reviews to ensure the treatment plans are consistent with WAC 246-341-0620 and 246-341-0640.

9.4.1.2.4 Timeliness of service.

9.4.1.2.5 Network adequacy.

9.4.1.2.6 Cultural, ethnic, linguistic, disability or age related needs are addressed.

9.4.1.2.7 Coordination with primary care.

9.4.1.2.8 Provider adherence to practice guidelines, as relevant.

9.4.1.2.9

9.4.1.2.10 Provider compliance with reporting and managing critical incidents.

9.4.1.2.11 Information security.

9.4.1.2.12 Disaster recovery plans.

9.4.1.2.13 Fiscal management, including documenting the provider's cost allocations, revenues, expenditures and reserves in order to ensure that funds under this Contract are being spent appropriately.

9.4.1.2.14 Licensing and certification reviews, including oversight of any issues noted during licensing and/or certification reviews conducted by the Department of Health and communicated to the Contractor.

9.4.2 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.

9.4.3 Unless a county is a licensed service provider and the Contractor is contracting with the county for direct services, the Contractor shall not provide GFS funds to a county without a contract or single-case agreement.

9.5 Health Care Provider Subcontracts

The Contractor's Subcontracts shall also contain the following provisions:

9.5.1 A statement that Subcontractors receiving GFS funds shall cooperate with Contractor or HCA-sponsored Quality Improvement (QI) activities.

9.5.2 A means to keep records necessary to adequately document services provided to Enrollees for all delegated activities including Quality Improvement, Utilization Management, Enrollee Rights and Protections, and Credentialing and Recredentialing.

9.5.3 For providers in twenty-four (24) hour settings, a requirement to provide discharge planning services which shall, at a minimum:

9.5.3.1 Coordinate a community-based discharge plan for each Enrollee served under this Contract beginning at intake. Discharge planning shall apply to all Enrollees regardless of length of stay or whether they complete treatment;

9.5.3.2 Coordinate exchange of assessment, admission, treatment progress, and continuing care information with the referring entity. Contact with the referral agency shall be made within the first week of residential treatment;

9.5.3.3 Establish referral relationships with assessment entities, outpatient providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of entities making referrals in treatment activities;

9.5.3.4 Coordinate, as needed, with HCA/DBHR prevention services,

vocational services, housing services and supports, and other community resources and services that may be appropriate, such as DCYF services for children and families, including, DCYF-contracted home visiting, Early Support for Infants and Toddlers (ESIT), Early Childhood Intervention and Prevention Services (ECLIPSE), Early Childhood Education and Assistance Program (ECEAP) and Head Start programs using the informational letter template jointly developed by the DCYF and HCA; and

9.5.3.5 Coordinate services to financially-eligible Enrollees who are in need of medical services.

9.5.4 Requirements for information and data sharing to support care coordination consistent with Section 14 of this Contract.

9.5.5 A requirement to implement a Grievance process as described in the Grievance Section of this Contract.

9.5.6 A requirement that termination of a subcontract shall not be grounds for a fair hearing or a Grievance for the Enrollee if similar services are immediately available in the service area.

9.5.7 How Enrollees will be informed of their right to a Grievance in the case of:

9.5.7.1 Denial or termination of service related to medical necessity determinations.

9.5.7.2 Denial or termination of service related to Available Resources.

9.5.7.3 Failure to act upon a request for services with reasonable promptness.

9.5.8 A requirement that the Subcontractor shall comply with Chapter 71.32 RCW (Mental Health Advance Directives).

9.5.9 A requirement to provide Enrollees access to translated information and interpreter services as described in Section 3 of this Contract.

9.5.10 Adherence to established protocols for determining eligibility for services consistent with Section 4 of this Contract.

9.5.11 A requirement to use HCA/DBHR approved Integrated Co-Occurring Disorder Screening and Assessment Tool(s); this shall include requirements for training staff that will be using the tool(s) to address the screening and assessment process, the tool and quadrant placement as well as requirements for corrective action if the process is not implemented and maintained throughout the Contract's period of performance.

9.5.12 A requirement to participate in training when requested by the HCA; exceptions must be in writing and include a plan for how the required information shall be provided to targeted Subcontracted staff.

9.5.13 A requirement to conduct criminal background checks and maintain related policies and procedures and personnel files consistent with requirements in Chapter 43.43 RCW and Chapter 388-06 WAC.

9.5.14 Requirements for nondiscrimination in employment and Enrollee services.

9.5.15 Protocols for screening for debarment and suspension of certification.

9.5.16 Requirements to identify funding sources consistent with Section 5 and Federal Block Grant reporting requirements.

9.5.17 A requirement that the Subcontractor shall respond in a full and timely manner to law enforcement inquiries regarding an individual's eligibility to possess a firearm under RCW 9.41.040(2)(a)(iv).

9.5.18 Delegated activities are documented and agreed upon between Contractor and Subcontractor. The document must include:

9.5.18.1 Assigned responsibilities.

9.5.18.2 Delegated activities.

9.5.18.3 A mechanism for evaluation.

9.5.18.4 Corrective action policy and procedure.

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

9.5.20 The Subcontractor accepts payment from the Contractor as payment in full; shall not request payment from HCA or any Enrollee for Contracted Services performed under the subcontract, and shall comply with WAC 182-502-160 requirements applicable to providers.

9.5.21 The Subcontractor agrees to hold harmless HCA and its employees, and all Enrollees served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or Contractors.

9.5.22 A ninety (90) day termination notice provision.

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

9.5.24 The Subcontractor agrees to comply with all relevant provisions of this Contract, including, but not limited to, the appointment wait time standards and the obligation to report accurately the information required for the Contractor's provider directory and any changes thereto. The subcontract must provide for

regular monitoring of timely access and corrective action if the Subcontractor fails to comply with the appointment wait time standards.

9.5.25 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, except as noted below, and must identify deficiencies or areas for improvement and provide for corrective action.

9.5.25.1 The Contractor shall conduct a Subcontractor review which shall include at least one onsite visit every two (2) years to each Subcontractor site providing state funded treatment services during the period of performance of this Contract in order to monitor and document compliance with requirements of the subcontract.

9.5.25.2 The Contractor shall ensure that Subcontractors have complied with data submission requirements established by HCA for all services funded under the Contract.

9.5.25.3 The Contractor shall ensure that the Subcontractor updates Enrollee funding information when the funding source changes.

9.5.25.4 The Contractor shall maintain written or electronic records of all Subcontractor monitoring activities and make them available to HCA upon request.

9.5.26 A statement that Subcontractors shall comply with required audits, including authority to conduct a facility inspection and Office of Management and Budget (OMB) Circular and 2 C.F.R. part 200, subpart F – Audit Requirements audits, as applicable to the Subcontractor.

9.5.26.1 The Contractor shall submit a copy of the 2 C.F.R. – part 200, subpart F – Audit Requirements audit performed by the State Auditor to the HCA Contact identified on page one (1) of the Contract within ninety (90) days of receipt by the Contractor of the completed audit.

9.5.26.1.1 If a Subcontractor is subject to OMB Circular and 2 C.F.R. Part 200, Subpart F – Audit Requirements, the Contractor shall require a copy of the completed Single Audit and ensure corrective action is taken for any audit finding, per 2 C.F.R. Part 200, Subpart F – Audit Requirements.

9.5.26.1.2 If a Subcontractor is not subject to OMB Circular 2 C.F.R. Part 200, Subpart F – Audit Requirements, the Contractor shall perform subrecipient monitoring in compliance with federal requirements.

9.5.27 The Contractor shall document and confirm in writing all single-case agreements with providers. The agreement shall include:

9.5.27.1 The description of the services;

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

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

9.5.27.4 Any other specifics of the negotiated rate.

9.5.28 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).

9.5.29 The Contractor shall maintain a record of the single-case agreements for a period of six (6) years.

9.6 Health Care Provider Subcontracts Delegating Administrative Functions

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

9.6.1.1 For those Subcontractors at financial risk, 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 If Grievances are delegated, the Contractor must ensure that network providers have a process in place for reporting, tracking, and resolving customer expressions of dissatisfaction. The Contractor must monitor and report Grievances documented at the provider level.

9.6.1.4 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.

9.6.1.5 Provisions for revoking delegation or imposing sanctions if the Subcontractor's performance is inadequate.

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

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

9.6.2 The Contractor shall submit a report of all current delegated entities, activities delegated and the number of Enrollees assigned or serviced by the delegated entity to the HCA as part of the annual monitoring review, or as required by the 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 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 an 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 Provider Education

9.8.1 The Contractor shall keep Participating Providers informed about:

9.8.1.1 Covered Services for Enrollees served under this Contract.

9.8.1.2 Coordination of care requirements.

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

9.8.1.4 Data interpretation.

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

9.8.1.6 Behavioral Health services through the Contractor.

9.8.1.7 Behavioral Health resource line (RCW 74.09).

9.8.1.8 The information required for utilization management (UM) decision making, procedure coding and submitting claims for GFS services. The Contractor shall inform GFS providers in writing regarding these requirements.

9.8.1.9 Contractor Care Management staff for assistance in care transitions and Care Management activity.

9.8.1.10 Program Integrity requirements.

9.8.1.11 DCYF services for children and families, including, but not limited to, DCYF-contracted home visiting, ESIT, ECLIPSE, and ECEAP/Head Start programs using the informational letter template jointly developed by DCYF and HCA.

9.8.2 The Contractor shall develop and deliver ongoing training, technical assistance and support tools for GFS providers regarding GFS protocols and requirements. The training materials and documents shall be pre-approved by HCA. The training program shall meet the following minimum requirements:

9.8.2.1 Training shall be accessible to GFS 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. The Contractor shall make reasonable efforts to ensure that:

9.8.2.1.1 Training is developed in collaboration with peer MCOs.

9.8.2.1.2 Training is made available to treatment staff.

9.8.2.1.3 Subcontractors provide opportunities for staff to attend trainings.

9.8.2.2 Training for GFS providers address the following requirements:

9.8.2.2.1 Screening and assessment tools and protocols, including the GAINS-SS.

9.8.2.2.2 Referral protocols.

9.8.2.2.3 Claims and encounter submission.

9.8.2.2.4 Other data submission and reporting required under the Contract.

9.8.2.2.5 Evidence-Based Practices, as relevant to the service(s) provided.

9.8.2.2.6 Transition protocols for individuals moving between funding sources or with frequent Medicaid eligibility status changes.

9.8.2.2.7 Training includes the application of Evidence-Based, research-based, Promising Practices related to the assessment and treatment of Behavioral Health conditions.

9.8.2.2.8 Recovery and Resilience principles are incorporated in service provision as well as policies and procedures.

9.8.2.3 Enrollees, family members and other caregivers are involved in the planning, development and delivery of trainings specific to delivery of GFS services.

9.8.2.4 Cultural competency is incorporated into provider training specific to delivery of GFS services.

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

9.8.3 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.

9.8.4 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.

9.9 Provider Payment Standards

9.9.1 The Contractor shall meet the same timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a) (37) (A) of the Social Security Act, 42 C.F.R. § 447.46 and specified for health carriers in WAC 284-43-321 for paying providers who submit claims and encounters for GFS services. 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 and encounters within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) calendar days of receipt and 99 percent of claims within ninety (90) calendar days of receipt. The Contractor and its providers

may agree to a different payment requirement in writing on an individual claim.

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

9.9.1.2 A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

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

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

9.9.2 The Contractor must support both hardcopy and electronic submission of claims, encounters and bills for all GFS services types.

9.9.3 The Contractor must support hardcopy and electronic submission of claim, encounter or bill inquiry forms, adjustment claims, encounters and bills.

9.9.4 The Contractor shall update its claims and encounter system to support processing of payments for the GFS services.

9.9.5 The Contractor shall support Behavioral Health Providers in new IMC Contracted Regions to transition to the requirement to submit HIPAA-compliant encounters.

9.9.5.1 The Contractor shall work with BH Providers to rapidly resolve encounters or claims not approved on initial submission, to quickly identify and resolve errors in encounter submission before they become widespread and systemic, and to address other billing issues in the first 180 days of the Contract.

9.9.5.2 The Contractor shall ensure prompt payment to the BH providers, including developing a contingency plan that will ensure payment for services delivered to enrollees in the event that a mental health or substance use disorder provider cannot submit HIPAA-compliant encounters or electronic claims.

9.9.5.3 The Contractor shall produce reports for contracted BH providers that assist them with claims management, such as monthly reports with numbers of accepted claims or encounters vs. those that are not accepted on initial submission, and error rates by types of errors.

9.10 Provider Credentialing

The Contractor's policies and procedures shall be in writing and follow the State's requirements related to the credentialing and recredentialing of Health Care Professionals who have signed contracts or participation agreements with the Contractor (Chapter 246-12

WAC). The Contractor shall ensure and demonstrate compliance with the requirements described in this Contract.

9.10.1 The Contractor's policies and procedures related to the credentialing and recredentialing of Health Care Professionals shall ensure compliance with the requirements described in this section.

9.10.1.1 The Contractor's BH Medical Director or other designated physician who is a board certified psychiatrist or physician certified in addiction medicine shall have direct responsibility for and participation in the credentialing program.

9.10.1.2 The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.

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

9.10.2.1 Identification of the type of providers credentialed and recredentialed, including but not limited to, acute, primary, behavioral, substance use disorder and LTSS providers, as appropriate.

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

9.10.2.3 A process for provisional credentialing that affirms that:

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

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

9.10.2.3.3 Provisional credentialing shall include an assessment of:

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

9.10.2.3.3.2 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

9.10.2.3.3.3 A current signed application with attestation.

9.10.2.4 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.

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

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

9.10.3 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:

9.10.3.1 Review materials.

9.10.3.2 Correct incorrect or erroneous information.

9.10.3.3 Be informed of their credentialing status.

9.10.4 The Contractor's process for notifying providers within sixty (60) calendar days of the credentialing committee's decision.

9.10.5 An Appeal process for providers for quality reasons and reporting of quality issues to the appropriate authority and in accordance with the Program Integrity requirements of this Contract.

9.10.6 The Contractor's process to ensure confidentiality.

9.10.7 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.

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

9.10.9 The Contractor's process to ensure that offices of all Health Care Professionals meet office site standards established by the Contractor.

9.10.10 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.

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

9.10.12 The criteria used by the Contractor to credential and recredential practitioners shall include:

9.10.12.1 Evidence of a current valid license or certification to practice;

9.10.12.2 A valid DEA or CDS certificate if applicable;

9.10.12.3 Evidence of appropriate education and training;

9.10.12.4 Board certification if applicable;

9.10.12.5 Evaluation of work history;

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

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

9.10.12.7.1 The lack of present illegal drug use;

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

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

9.10.12.7.4 Current malpractice coverage;

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

9.10.12.7.6 Accuracy and completeness of the application.

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

9.10.13 The Contractor shall ensure that all subcontracted providers have completed a background check consistent with RCW 43.43 and WAC 388-06.

9.10.14 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).

9.10.15 The Contractor shall notify HCA in accordance 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.

9.10.16 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.

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.

10.1.2 The Contractor shall require that Mental Health Professionals, MHCPs, and SUDPs acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of an Enrollee with respect to:

10.1.2.1 The Enrollee's Behavioral Health status;

10.1.2.2 Receiving all information regarding mental health and/or SUD treatment options including any alternative or self-administered treatment, in a culturally-competent manner.

10.1.2.3 Any information the Enrollee needs in order to decide among all relevant Behavioral Health treatment options.

10.1.2.4 The risks, benefits, and consequences of Behavioral Health treatment (including the option of no treatment);

10.1.2.5 The Enrollee's right to participate in decisions regarding his or her Behavioral Health care, including the right to refuse treatment and to express preferences about future treatment decisions;

10.1.2.6 The Enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy;

10.1.2.7 The Enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

10.1.2.8 The Enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. Part 164; and

10.1.2.9 The Enrollee's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the Contractor treats the Enrollee.

10.1.3 The Contractor shall provide information including but not limited to education, licensure, and board certification or re-certification or registration of Mental Health Professionals and MHCPs upon an Enrollee's request.

10.1.4 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, consistent with Chapter 388-06 WAC. If the employee or volunteer has been working in another state within the last twelve

(12) months, a background check from that state will be required.

10.2 Cultural Considerations

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.

10.2.1 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.

10.2.2 At a minimum, the Contractor shall:

10.2.2.1 Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis (CLAS Standard 4);

10.2.2.2 Offer language assistance to individuals who have limited English proficiency or other communication needs, at no cost to them, to facilitate timely access to all health care and services (CLAS Standard 5);

10.2.2.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (CLAS Standard 6);

10.2.2.4 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals or minors as interpreters should be avoided (CLAS Standard 7);

10.2.2.5 Provide easy–to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (CLAS Standard 8);

10.2.2.6 Establish culturally and linguistically appropriate goals (CLAS Standard 9);

10.2.2.7 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);

10.2.2.8 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 Standard 11); and

10.2.2.9 Create conflict and Grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints (CLAS Standard 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. § 438.6, 438.10, 422.128, 489.100 and 489 Subpart I as described in this section.

10.3.2 The Contractor's Advance Directive policies and procedures shall be disseminated to all affected providers, Enrollees, HCA, and, upon request, Potential Enrollees.

10.3.2.1 The Contractor shall develop policies and procedures to address Physician Orders for Life Sustaining Treatment (POLST) and ensure that they are distributed in the same manner as those governing Advance Directives.

10.3.2.2 The Contractor's policies and procedures respecting the implementation of advance directives and POLST rights shall be included in the Enrollee handbook at a location designated in its template by HCA, and shall be featured on the Contractor's website in the member/enrollee section.

10.3.3 The Contractor's written policies respecting the implementation of Advance Directive POLST rights shall include a clear and precise statement of limitation if the Contractor cannot implement an Advance Directive as a matter of conscience. 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 a Directive information to the Enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated Enrollee or to a surrogate or other concerned persons in accordance with state law. The Contractor is not relieved of its obligation to provide this information to the Enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

10.3.5 The Contractor must require and ensure that the Enrollee's medical record documents, in a prominent part, whether or not the individual has executed an Advance Directive or received a POLST.

10.3.6 The Contractor shall not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an Advance Directive or received a POLST.

10.3.7 The Contractor shall ensure compliance with requirements of state and federal law (whether statutory or recognized by the courts of the State) regarding Advance Directives or POLSTs.

10.3.8 The Contractor shall provide education to staff concerning its policies and procedures on Advance Directives or POLSTs.

10.3.9 The Contractor shall provide community education regarding Advance Directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an Advance Directive, emphasizing that an Advance Directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state and federal law concerning Advance Directives. The Contractor shall document its community education efforts.

10.3.10 The Contractor is not required to provide care that conflicts with an Advance Directive; and is not required to implement an Advance Directive if, as a matter of conscience, the Contractor cannot implement an Advance Directive and state law allows the Contractor or any Subcontractor providing services under this Contract to conscientiously object.

10.3.11 The Contractor shall inform Enrollees that they may file a Grievance with the Contractor if the Enrollee is dissatisfied with the Contractor's Advance Directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform Enrollees that they may file a Grievance with the Washington State Department of Health (DOH) 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 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 Behavioral Health Provider

10.5.1 An Enrollee may maintain existing Behavioral Health provider relationships

when funding is available and when the GFS services are medically necessary. However, Enrollees are not guaranteed choice of Behavioral Health providers for GFS services.

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 (WAC 182-502-0160).

10.6.2 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.

10.6.3 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 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.

10.6.5 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.

10.7 Enrollee Self-Determination

The Contractor shall ensure that all providers: obtain informed consent prior to treatment from Enrollees, or persons authorized to consent on behalf of an Enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (Chapter 70.122 RCW) and state rules concerning Advance Directives (WAC 182-501-0125); and, when appropriate, inform Enrollees of their right to make anatomical gifts (Chapter 68.64 RCW).

11. UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 Utilization Management Requirements

11.1.1 The Contractor's BH Medical Director will provide guidance, leadership and oversight of the Contractor's UM program for Contracted Services. The following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the BH Medical Director to oversee:

11.1.1.1 Processes for evaluation and referral to Contracted Services.

11.1.1.2 Review of consistent application of criteria for provision of services within Available Resources and related Grievances.

11.1.1.3 Review of assessment and treatment services against clinical practice standards. Clinical practice standards include, but are not limited to evidenced-based practice guidelines, culturally appropriate services, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals. This review must include a review of the coordination with Indian Health Service, Indian Tribal Organizations, and Indian Health Care Providers (IHCP) and other Enrollee serving agencies.

11.1.1.4 Monitoring for over-utilization and under-utilization of services and ensuring that resource management and UM activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue Medically Necessary mental health services inconsistent with the Contractors policy and procedures for determining eligibility for services within Available Resources.

11.1.2 The Contractor shall develop and implement UM protocols for all services and supports funded solely or in part through GFS funds. The UM protocols shall comply with the following provisions:

11.1.2.1 The Contractor must have policies and procedures that establish a standardized methodology for determining when GFS resources are available for the provision of Behavioral Health services. The methodology shall include the following components:

11.1.2.1.1 A plan to address under- or over-utilization patterns with any provider to avoid unspent funds or gaps in service at the end of a contract period due to limits in Available Resources;

11.1.2.1.2 Education and technical assistance to address issues related to Quality of Care, medical necessity, timely and accurate claims submission or aligning service utilization with allocated funds

to avoid disruption in service or unspent funds at the end of a contract year;

11.1.2.1.3 Corrective action with providers, as necessary, to address issues with compliance with state and federal regulations or ongoing issues with patterns of service utilization; and

11.1.2.1.4 A process to make payment denials and adjustments when patterns of utilization deviate from state, federal or contract requirements (e.g., single source funding).

11.1.2.2 The Contractor shall monitor provider discharge planning to ensure GFS providers meet contractual requirements for discharge planning defined in this Contract.

11.1.3 The Contractor shall educate UM staff in the application of UM protocols, communicating the criteria used in making UM decisions. UM protocols shall recognize and respect the cultural needs of diverse populations.

11.1.4 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 are authorizing and managing 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.

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 UM requirements described in this section.

11.1.6 Authorization reviews shall be conducted by licensed behavioral health professionals with experience working with the populations and settings under review.

11.1.6.1 The Contractor shall have UM staff with experience and expertise in working with individuals of all ages with a SUD and who are receiving medication-assisted treatment.

11.1.7 Actions, including any decision to authorize a service in an amount, duration or scope that is less than requested, shall be conducted by:

11.1.7.1 A physician board-certified or board-eligible in Psychiatry or Child and Adolescent Psychiatry;

11.1.7.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry; or by ASAM, or

11.1.7.3 A licensed, doctoral level psychologist.

11.1.8 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 complex cases, treatment plan issues and other treatment needs.

11.1.9 The Contractor shall ensure that any 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 a Washington State service center, to include participation in initial orientation and at least annual training on Washington State specific benefits, protocols and initiatives.

11.1.10 The Contractor shall ensure that any Behavioral Health Actions 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:

11.1.10.1 A physician board-certified or board-eligible in Psychiatry must review all inpatient level of care Actions (full or partial denials, terminations and reductions) for psychiatric treatment.

11.1.10.2 A physician board-certified or board-eligible in Addiction Medicine, or a Subspecialty in Addiction Psychiatry; must review all inpatient level of care Actions (full or partial denials, termination and reductions) for SUD treatment.

11.1.11 The Contractor shall ensure that Appeals of Actions shall be evaluated by Health Care Providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease (WAC 284-43-620(4)).

11.1.11.1 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.

11.1.12 The Contractor's Care Management system must include a periodic review of Enrollees that have an Individual Service Plan to ensure the requirements are being met. The Contractor must establish criteria for, document and monitor:

11.1.12.1 Consistent application of Medical Necessity criteria and Level of Care Guidelines; and

11.1.12.2 Over and under-utilization of services.

11.1.13 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.

11.2 Medical Necessity Determination

The Contractor shall collect all information necessary to make medical necessity determinations. The Contractor shall determine which services are medically necessary, according to the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding Appeals, hearings and independent review.

11.3 Authorization of Services

11.3.1 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.

11.3.2 The Contractor shall consult with the requesting provider when appropriate.

11.4 Timeframes for Authorization Decisions

11.4.1 The Contractor must provide a written Notice of Action to the Enrollee, or their legal representative, if a denial, reduction, termination or suspension occurs based on the Level of Care Guidelines.

11.4.2 The Contractor shall adhere to the requirements set forth in Section 11.5, Notification of Coverage and Authorization Determination.

11.4.3 The Contractor shall provide for the following timeframes for authorization decisions and notices:

11.4.3.1 For denial of payment that may result in payment liability for the Enrollee, at the time of any Adverse Authorization Determination affecting the claim.

11.4.3.2 For termination, suspension, or reduction of previously authorized Contracted Service, ten (10) calendar days prior to such termination, suspension, or reduction, except if the criteria stated in 42 C.F.R. § 431.213 and 431.214 are met.

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

11.4.3.3.1 The Contractor shall notify the Enrollee and the requesting provider within two (2) business days of the Contractor's determination.

11.4.3.3.2 Standard Appeal timeframes apply to post-service denials.

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

11.5 Notification of Coverage and Authorization Determinations

11.5.1 For all Actions and adverse authorization determinations, which includes denial of a Contracted Service based on lack of Available Resources, the Contractor must notify the ordering provider, facility, and the Enrollee.

11.5.1.1 The Contractor must inform the parties, other than the Enrollee, in advance whether it will provide notification by phone, mail, fax or other means.

11.5.1.2 The Contractor must notify the Enrollee in writing of the decision.

11.5.1.3 For an adverse authorization decision involving an expedited authorization request the Contractor may initially provide notice orally.

11.5.1.4 For all adverse authorization decisions, the Contractor shall provide written notification within seventy-two (72) hours of the decision.

11.5.1.5 The Contractor shall give notice at least ten (10) calendar days before the effective date of adverse authorization determination when it involves a termination, suspension or reduction of previously authorized Contracted Services when Enrollee Fraud has been verified.

11.6 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 compliance with the requirements of this section.

12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts and provider application, credentialing and recredentialing processes.

12.1.3 The following are relevant citations for Program Integrity compliance. The Contractor is expected to be familiar with, comply with, and require compliance with all regulations related to Program Integrity whether or not those regulations are listed.

12.1.3.1 Section 1902(a) (68) of the Social Security Act; and

12.1.3.2 Chapters 74.09 and 74.66 RCW.

12.2 Program Integrity

The Contractor shall ensure compliance with the program integrity provisions of this Contract, including proper payments to providers or Subcontractors and methods for detection of Fraud, waste, and abuse.

12.2.1 The Contractor shall perform ongoing analysis of its utilization, claims, billing, and encounter data to detect Overpayments, and shall perform audits and investigations of Subcontractor providers and provider entities. For the purpose 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.

12.2.1.1 When the Contractor or the state identifies an Overpayment, pursuant to RCW 74.09.220, the funds must be recovered by and returned to the state or the Contractor. For the purpose 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.

12.2.1.2 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 state and the Contractor, such Overpayments may be recovered by HCA.

12.2.1.3 Consistent with subsection 12.7 of this Contract, the Contractor shall submit quarterly reports of any recoveries made by the Contractor during the course of its claims review/analysis.

12.3 Fraud, Waste and Abuse (FWA)

12.3.1 The Contractor's Fraud, Waste and Abuse program shall have:

12.3.1.1 A process to inform officers, employees, agents and Subcontractors regarding the False Claims Act.

12.3.1.2 Administrative and management arrangements or procedures, and a mandatory compliance plan.

12.3.1.3 Standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards.

12.3.1.4 The designation of a compliance officer and a compliance committee that is accountable to senior management.

12.3.1.5 Effective Fraud, waste and abuse training for all affected parties.

12.3.1.6 Effective lines of communication between the compliance officer and the Contractor's staff and Subcontractors.

12.3.1.7 Enforcement of standards through well-publicized disciplinary guidelines.

12.3.1.8 Provision for internal monitoring and auditing.

12.3.1.9 Provision for prompt response to detected offenses, and for development of corrective action initiatives.

12.3.1.10 Provision for notification of the Contractor's program integrity activities when requested by HCA and MFCD to prevent duplication of activities.

12.3.1.11 Provision for prompt reporting of all overpayments identified and recovered, specifying the overpayments due to potential fraud, to HCA.

12.3.1.12 Provision for prompt referral of any potential fraud the Contractor identifies to HCA Program Integrity and to the MFCD pursuant to subsection 12.4.

12.3.1.13 Provision of detailed information to employees and Subcontractors regarding Fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(68) of the Social Security Act and the Washington false claims statutes, Chapter 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.

12.3.1.14 Provision for full cooperation with any federal, state or HCA investigation including promptly supplying all data and information requested for the investigation.

12.3.1.15 Verification that services billed by providers were actually provided to Enrollees. 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).

12.3.1.16 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.

12.3.2 When the Contractor conducts an audit of a Contractor's provider or subcontractor, the Contractor must:

12.3.2.1 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 activites.

12.3.2.2 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, MFCS, or another governmental or law enforcement entity.

12.3.2.3 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.

12.3.2.4 Issue draft or preliminary findings within one-hundred twenty (120) calendar days from receipt of all provider or subcontractor information required to conduct the audit.

12.3.2.5 Extrapolate only when there is a sustained high level of payment error or when documented provider or subcontractor educational intervention has failed to correct the level of payment error.

12.3.2.6 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:

12.3.2.6.1 The reason for the adverse determination;

12.3.2.6.2 The specific criteria on which the adverse determination was based;

12.3.2.6.3 An explanation of the provider's appeal rights; and

12.3.2.6.4 If applicable, the appropriate procedure to submit a claim adjustment.

12.3.2.7 Ensure any appeal process is completed before recouping overpayments.

12.3.2.8 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 (12) months.

12.3.2.9 In any appeal by a health care provider, employ or contract with a medical, mental 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.

12.3.2.10 Provide educational and training programs annually for providers. The training docs must include a summary of audit results, a description of common issues, problems and mistakes identified through audits and reviews, and opportunities for improvement.

12.3.2.11 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 Enrollee name, date of service and procedure.

12.3.2.12 Provide HCA with carbon copies of all letters sent to the provider or subcontractor being audited through MCTrack.

12.3.3 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.

12.3.4 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.

12.3.5 In an effort to identify fraud, waste, and abuse,HCA will:

12.3.5.1 Conduct proactive data mining of the Contractor's encounter data; and

12.3.5.2 Conduct audits of the Contractor's provider and subcontractor.

12.3.6 The Contractor must audit their providers and subcontractors to detect and identify fraud, waste, and abuse.

12.3.6.1 Identified improper payments must be reported to the HCA on the monthly Program Integrity Report.

12.3.6.2 Identified improper payments must be recovered by the Contractor in accordance with Section 1128J(d) of the Social Security Act.

12.3.6.3 HCA will monitor the Contractor's activities through the Monthly

Program Integrity Report.

12.4 Referrig of Allegations of Potential Fraud and Invoking Provider Payment Suspensions

12.4.1 The Contractor shall establish policies and procedures for referring all identified allegations of suspected 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. (42 C.F.R § 455.23).

12.4.2 When the Contractor has concluded that an Allegation of suspected fraud exists, the Contractor shall make a referral to MFCD and HCA within five (5) business days of the determination. The referral must be submitted to HCA through programintegrity@hca.wa.gov and emailed to MFCUreferrals@atg.wa.gov. The Contractor shall submit the report using the -WA-Fraud Referral form.

12.4.3 HCA shall notify the Contractor's compliance officers whether MFCD, or other law enforcement agency, accepts or declines the referral within five (5) business days. If HCA, MFCD, or other law enforcement agency accepts the referral, HCA will notify the Contractor's compliance officers within five (5) business days of any determination to suspend payments. Unless otherwise notified by HCA to suspend payment, the Contractor shall not suspend payment of any provider(s) identified in the referral. If HCA, MFCD, or other law enforcement agencies decline to investigate the fraud referral, the Contractor may proceed with its own investigation and comply with the reporting requirements contained in this subsection 12.4.

12.4.4 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 MFCD or other law enforcement agency requests a temporary withhold of the notice.

12.4.5 The notice of payment suspension must include or address all of the following:

12.4.5.1 State that payments are being suspended in accordance with this provision;

12.4.5.2 Set forth the general allegations identified by HCA. The notice should not disclose any specific information concerning an ongoing investigation;

12.4.5.3 State that the suspension is for a temporary period and cite suspension will be lifted when notified by HCA that is no longer in place;

12.4.5.4 Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

12.4.5.5 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.

12.4.6 All suspension of payment actions under this section will be temporary and will not continue after either of the following:

12.4.6.1 The Contractor is notified by HCA, MFCD or other law enforcement agency that there is insufficient evidence of fraud buy the provider; or

12.4.6.2 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.

12.4.7 The Contractor must document in writing the termination of a suspension and issue a notice of the termination to the provider and to HCA.

12.4.8 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:

12.4.8.1 MFCD or law enforcement agencies have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

12.4.8.2 Other available remedies are implemented by the Contractor, after HCA approves the remedy, as more effective or timely to protect GFS funds.

12.4.8.3 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.

12.4.8.4 Enrollee access to items or services would be jeopardized by a payment suspension because of either of the following:

12.4.8.4.1 An individual or entity is the sole community physician or the sole source of essential specialized services in a community.

12.4.8.4.2 The individual or entity serves a large number of Enrollees within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.

12.4.8.5 MFCD or law enforcement declines to vertify that a matter continues to be under investigation.

12.4.8.6 HCA determines that payment suspension is not in the best interests of the GFS program.

12.4.9 The Contractor shall maintain for a minimum of ten (10) years from the date of issuance all materials documenting:

12.4.9.1 Details of payment suspensions that were imposed in whole or in part; and

12.4.9.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.

12.4.10 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 Section of this Contract.

12.4.11 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, the entirety of such monetary recovery belongs exclusively to the state of Washington and the Contractor has no claim to any portion of this recovery.

12.4.12 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 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.

12.4.13 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

12.4.14 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.

12.5 Investigations

12.5.1 The Contractor must cooperate with all state and federal agencies that investigate Fraud, waste and abuse.

12.5.2 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.

12.5.2.1 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:

12.5.2.1.1 Proceed with any further investigation, audit, or other program integrity activity until notified otherwise by HCA, MFCD, or other law enforcement agency.

12.5.2.1.2 Notify the provider or subcontractor in any way about the acceptance of the referral by MFCD or other law enforcement agency.

12.5.2.1.3 Seek to recover or identify any overpayment identified in the Contractor's investigation, audit, or other program integrity activity.

12.5.2.1.4 Suspend payments until directed by HCA.

12.5.2.1.5 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.

12.5.2.1.6 Terminate the provider due to any reason identified in the Contractor's investigation.

12.5.2.1.7 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.

12.5.3 The Contractor shall maintain all records, documents and claim 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.

12.5.4 The Contractor must comply with directives resulting from the state or federal agency investigations.

12.5.5 The Contractor must request a refund from a third-party payor, provider or subcontractor when an investigation indicates that such a refund is due. These refunds must be reported to HCA as Overpayments in the Monthly Program Imtegrity Report.

12.6 Excluded Individuals and Entities

12.6.1 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

(Social Security Act (SSA) section 1903(i)(2) ; 42 C.F.R. § 455.104, § 455.106, and § 1001.1901(b)).

12.6.1.1 The Contractor shall monitor for excluded individuals and entities by:

12.6.1.1.1 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.

12.6.1.1.2 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.

12.6.1.1.3 Screen, the LEIE and SAM lists monthly no later than the 15th of each month, 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) and SMD letter 2/20/98.

12.6.1.2 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.

12.6.1.3 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.

12.6.1.4 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)).

12.6.1.5 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.

12.6.1.6 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).

12.6.1.7 The HCA will validate that the Contractor is conducting all screenings required by this Section during its annual monitoring review.

12.7 Reporting

12.7.1 All Program Integrity reporting to HCA shall be in accordance with the Notices provisions of the General Terms and Conditions of this Contract unless otherwise specified herein.

12.7.2 On a monthly basis, the Contractor shall use the Program Integrity Form to report the following:

12.7.2.1 Allegations of provider and subcontractor fraud received and reviewed by the Contractor.

12.7.2.2 Program Integrity Activities and all required notifications found in section 12.3.

12.7.2.3 Provider Termination Report to include but not limited to:

12.7.2.3.1 Termination for convenience;

12.7.2.3.2 Provider self-termination;

12.7.2.3.3 Terminations due to:

12.7.2.3.3.1 Sanction;

12.7.2.3.3.2 Invalid Licenses;

12.7.2.3.3.3 Services or Billing Errors;

12.7.2.3.3.4 Re-credentialing Errors;

12.7.2.3.3.5 Data Mining;

12.7.2.3.3.6 Investigation; or

12.7.2.3.3.7 Any other related program integrity involuntary terminations.

12.7.3 Any excluded individuals and entities discovered in the screening described in the Fraud 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 individuals/entities shall be reported the WA Excluded Individual Reporting form.

12.7.4 The Contractor shall investigate and disclose to HCA, at Contract execution or renewal, and upon request of HCA, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XXI services program since the inception of those programs and:

12.7.4.1 Who is an agent or person who has been delegated the authority to obligate or act on behalf of the Contractor; or

12.7.4.2 Any person entering into a provider or subcontractor agreement with the Contractor, or

12.7.4.3 Any person who has ownership or control interest in a provider or subcontractor, or

12.7.4.4 Is an agent or managing employee of the provider or subcontractor.

12.7.5 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 database and provided to HCA upon request.

12.7.6 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.

12.7.7 The Contractor shall submit the Program Integrity reports to the SOPI mailbox at: ProgramIntegrity@hca.wa.gov

DELIVERABLES	FREQUENCY	DUE DATE
Annual Program Integrity Plan for WA State	Annual	60 days after the execution of the new contract or extension of the contract.
Records	On Request, or while On-site	Within three (3) business days from the date of the request unless otherwise specified by HCA.
Program Integrity Report	Monthly	Thirty (30) calendar days after the end of the reporting month.
WA Excluded Individual Reporting Form	Ad Hoc	Within five (5) business days from the date of discovery.
– WA Fraud Referral Form	Ad Hoc	Within five (5) business days from the date of determining a Fraud Allegation of potential Fraud exists.

12.8 Access to Records and On-site Inspections

12.8.1 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.

12.8.2 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 12.8.1. 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)).

12.8.3 A record, in this Section, includes, but is not limited to:

12.8.3.1 Medical records;

12.8.3.2 Billing records;

12.8.3.3 Financial records;

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

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

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

12.8.4 Upon request, the Contractor, its provider or subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate HCA or other state or federal agency.

12.9 Liquidated Damages for Failure to Report Recoveries

12.9.1 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.

12.9.2 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.

12.9.3 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.

12.9.4 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.

12.9.5 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.

12.9.6 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.

12.9.7 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 the Contract or in federal regulations.

13. GRIEVANCE AND APPEAL SYSTEM

13.1 General Requirements

The Contractor shall have a Grievance and Appeal System. The Grievance and Appeal System shall include a Grievance process, an Appeal Process, access to independent review, and access to the hearing process. 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 system.

13.1.2 The Contractor shall inform Enrollees about Ombuds services and how to access Ombuds services. Enrollees may use the free and confidential regional Ombuds services at any time. The Contractor shall also provide Enrollees any reasonable assistance necessary in completing forms and other procedural steps for Grievances and Appeals.

13.1.3 The Contractor shall acknowledge receipt of each Grievance, either orally or in writing, within two (2) business days. WAC 182-538B-110(3).

13.1.4 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 seventy-two (72) hours of receipt of the Appeal (WAC 284-43-3030).

13.1.5 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 WAC 182-538B-110(4) and 284-43-3110(6) and 4040(4)).

13.1.6 Decisions regarding Grievances and Appeals shall be made by Health Care Professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

13.1.6.1 If the Enrollee is Appealing an Action.

13.1.6.2 If the Grievance or Appeal involves any clinical issues.

13.1.7 With respect to any decisions described in 13.1.6, the Contractor shall ensure that the Health Care Professionals making such decisions:

13.1.7.1 Have clinical expertise in treating the Enrollee's condition or disease that is age appropriate and when clinically indicated (e.g., a pediatric psychiatrist for a child Enrollee).

13.1.7.2 Are physician board-certified or board-eligible in Psychiatry or Child and Adolescent Psychiatry if the Grievance or Appeal is related to inpatient level of care denials for psychiatric treatment.

13.1.7.3 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.

13.1.7.4 Are one 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:

13.1.7.4.1 Physicians board-certified or board-eligible in Psychiatry, Addiction Medicine or a sub-specialty in Addiction Psychiatry or by ASAM;

13.1.7.4.2 Licensed, doctoral level psychologists; or

13.1.7.4.3 Pharmacists.

13.2 Grievance Process

The following requirements are specific to the Grievance process:

13.2.1 An Enrollee, the Enrollee's authorized representative, or a provider acting on behalf of the Enrollee with written consent may file a Grievance with the Contractor at any time.

13.2.2 The Contractor shall accept, document, record, and process Grievances forwarded by HCA.

13.2.3 The Contractor shall provide a written response to HCA within three (3) business days to any constituent Grievance. For the purpose of this subsection, "constituent Grievance" means a complaint or request for information from any elected official or agency director or designee.

13.2.4 The Contractor shall assist the Enrollee with all Grievance and Appeal processes (WAC 284-43-4020(2)(d)).

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

13.2.6 The Contractor shall consider all information submitted by the covered person or representative (WAC 284-43-4020(2)(f)).

13.2.7 The Contractor shall investigate and resolve all Grievances whether received orally or in writing (WAC 182-538B-110(2)). The Contractor shall not require an Enrollee or his/her authorized representative to provide written follow-up for a Grievance or Appeal the Contractor received orally.

13.2.8 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 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.

13.2.8.1 If the Contractor extends the timeline for a grievance not at the request of the Enrollee, it must give the Enrollee written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision.

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

13.2.10 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. (WAC 182-538B-110(3).

13.2.11 Enrollees do not have the right to a hearing in regard to the disposition of a Grievance. (WAC 182-538B-110(3)

13.3 Appeal Process

The following requirements are specific to the Appeal Process (see also WAC 182-538B-110:

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 Action. (WAC 182-538B-110(4)).

13.3.1.1 If a provider has requested an Appeal on behalf of an Enrollee, but without the Enrollee's written consent, the MCO shall not dismiss the Appeal without first contacting the Enrollee, informing the Enrollee that an Appeal has been made on the Enrollee's behalf, and then asking if the Enrollee would like to continue the Appeal.

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.

13.3.2 If HCA receives a request to Appeal an Action of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the Enrollee.

13.3.3 An Enrollee may Appeal an Action by filing an Appeal, either orally or in writing, within sixty (60) calendar days of the date of the Contractor's Notice of Action. The Contractor will not be obligated to continue services pending the results of

the Appeal.

13.3.4 Oral inquiries seeking to Appeal an Action shall be treated as Appeals and be confirmed in writing. The Appeal acknowledgement letter sent by the MCO to an Enrollee shall serve as written confirmation of an Appeal filed orally by an Enrollee.

13.3.5 The Appeal Process shall provide the Enrollee a reasonable opportunity to present evidence, and allegations of fact or law in writing. The Contractor shall inform the Enrollee of the limited time available sufficiently in advance of the resolution timeframe for appeals.

13.3.6 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 Action. The 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 time frame for appeals as specified in WAC 182-538B-110(4).

13.3.7 The Appeal Process shall include as parties to the Appeal, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate.

13.3.8 In any Appeal of an Action 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 the medical necessity determination.

13.3.9 The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within the following timeframes:

13.3.9.1 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.

13.3.9.2 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.

13.3.9.2.1 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.

13.3.10 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:

13.3.10.1 Be in writing and sent to the Enrollee and the requesting provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

13.3.10.2 Include the date completed and reasons for the determination in easily understood language.

13.3.10.3 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.

13.3.10.4 For Appeals not resolved wholly in favor of the Enrollee, include information on the Enrollee's right to request a hearing and how to do so.

13.4 Expedited Appeal Process

13.4.1 The Contractor shall establish and maintain an expedited Appeal review process for Appeals when the Contractor determines or a provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain, or regain maximum function.

13.4.2 The Enrollee may file an expedited Appeal either orally or in writing. 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:

13.4.3.1 For expedited resolution of appeals, 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.

13.4.5 If the Contractor denies a request for expedited resolution of an Appeal, it shall transfer the Appeal to the timeframe for standard resolution and make reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of denial.

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

13.5 Administrative Hearing

13.5.1 Only the Enrollee or the Enrollee's authorized representative may request a hearing. A provider may not request a hearing on behalf of an Enrollee. (WAC 182-538B-110(5)).

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 ninety (90) calendar days of the date of notice of the resolution of the Appeal (See WAC 182-538B-110(5) and 182-526-0200). The Contractor will not be obligated to continue services pending the results of the hearing.

13.5.3 If the Enrollee requests a hearing, the Contractor shall provide to HCA and the Enrollee, upon request, and within three (3) working days, 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 The Contractor is an independent party and is responsible for its own representation in any hearing, independent review, appeal to the Board of Appeals and any subsequent judicial proceedings.

13.5.5 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.

13.5.6 The Contractor's Medical Director or designee shall review all cases where a hearing is requested and any related Appeals.

13.5.7 The Enrollee must exhaust all levels of resolution and Appeal within the Contractor's Grievance and Appeal System 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 WAC 182-538B-110(4)(i).

13.5.8 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.

13.5.9 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.

13.6 Independent Review

After exhausting both the Contractor's Appeal Process and an Initial Order being issued from the Administrative Hearing, an Enrollee has a right to request an independent review in accordance with RCW 48.43.535, WAC 182-526-0200, and Chapter 284-43 WAC. Independent review is at the option of the Enrollee but is not a prerequisite for filing a Petition for Review at HCA's Board of Appeals.

13.7 Petition for Review

Any party may Appeal the Initial Order from the Administrative Hearing to the 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 or the written decision of the Independent Review Organization.

If an Enrollee or HCA disagrees with the independent review decision, the Enrollee or HCA may Appeal the independent review decision to the HCA Board of Appeals; the Contractor may not Appeal the independent review decision to the HCA Board of Appeals. See RCW 48.43.535 and Chapter 182-526 WAC.

13.8 Effect of Reversed Resolutions of Appeals and Hearings

13.8.1 If the Contractor's decision not to provide Contracted Services is reversed, either through a final order of the Office of Administrative Hearings or of the HCA Board of Appeals, the Contractor shall provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires.

13.9 Recording and Reporting Actions, Grievances, Appeals and Independent Reviews

The Contractor shall maintain records of all Actions, Adverse Authorization Determinations, Grievances, Appeals and independent reviews.

13.9.1 The records shall include Actions, Adverse Authorization Determinations, Grievances and Appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of responding to such Actions, Adverse Authorization Determinations, Grievances, Appeals, and independent reviews.

13.9.2 The Contractor shall provide a separate report of all Actions, Adverse Authorization Determinations, Grievances, Appeals and independent reviews related to Contracted Services to HCA in accordance with the Grievance System Reporting Requirements published by HCA.

13.9.3 The Contractor is responsible for maintenance of records for and reporting of any Adverse Authorization Determinations, Grievance, Actions, and Appeals handled by delegated entities.

13.9.4 Delegated Actions, Adverse Authorization Determinations, Grievances, and Appeals are to be integrated into the Contractor's report.

13.9.5 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.

13.9.6 The report medium shall be specified by HCA and shall be in accordance with the Grievance and Appeal System Reporting Requirements published by HCA.

13.9.7 Reporting of actions shall include all medical necessity determinations 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.

13.9.8 The Contractor shall provide information to HCA regarding denial of payment to providers upon request.

13.9.9 Reporting of Grievances shall include all expressions of Enrollee dissatisfaction not related to an Action. 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.

13.10 Available Resources Exhausted

When GFS funding for a requested Contracted Service is exhausted, any Appeals process, independent review, or agency Administrative Hearing process will be terminated since Contracted Services cannot be authorized without funding regardless of medical necessity.

14. CARE COORDINATION

The Contractor shall develop policies that promote quality and efficient healthcare for the Enrollee. The Contractor's Care Coordination policies shall include integration of GFS funded services into the AH-IMC program. Considerations shall include use of GFS funds to care for Enrollees in alternative settings such as homeless shelters, permanent supported housing, nursing homes or group homes.

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.

14.1 Care Coordination: Filing of an Unavailable Detention Facilities Report

14.1.1 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.

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

14.1.1.1.1 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.

14.2 Care Coordination and Continuity of Care: State Hospitals and Community Hospital and Evaluation and Treatment 90/180 Civil Commitment Facilities

14.2.1 Utilization of State Hospital Beds

14.2.1.1 The Contractor will be assigned Enrollees for discharge planning purposes in accordance with agency assignment process within each RSA in which the Contractor operates. Assignment process considers Enrollee choice, Enrollee history with an MCO, and direct agency assignment proportionally for the overall enrolled population.

14.2.1.1.1 If the Contractor disagrees with the AH-IMC Enrollee assignment, it must request a reassignment within thirty (30) days of admission. If a request to change the assignment is made within thirty (30) days of admission and the request is granted, the reassignment will be retroactive to the date of admission.

14.2.1.1.2 If the Contractor's request is received by HCA after the thirtieth (30) day of admission and is granted, the effective date of the reassignment will be based on the date HCA receives the reassignment request form.

14.2.1.1.3 The Contractor will be responsible for coordinating discharge for the Enrollees assigned and, until discharged.

14.2.1.1.4 The Contractor may not enter into any agreement or make other arrangements for use of State Hospital beds outside of this Contract.

14.2.1.1.5 The Contractor will be notified of changes to the allocation targets on an annual basis. If allocation targets are updated during an annual period, the allocation shall require an amendment to this Contract.

14.2.2 Admission and Discharge Planning for State Hospital and Community 90/180 Civil Commitment Facilities.

14.2.2.1 The Contractor shall meet the requirements of the State Hospital MOU or working Agreement.

14.2.2.2 The Contractor shall ensure Enrollees are medically cleared, if possible, prior to admission to a State Psychiatric Hospital or 90/180 Community Civil Commitment facility.

14.2.2.3 The Contractor shall use best efforts to divert admissions and expedite discharges by utilizing alternative community resources and mental health services.

14.2.2.4 The Contractor shall work with the discharge team to identify potential placement options and resolve barriers to placement, to assure that individuals will be discharged back to the community after the physician/treatment team determines the individual is ready for discharge.

14.2.2.5 The Contractor or its subcontractor shall monitor enrollees discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 to ensure compliance with LRA requirements.

14.2.2.6 The Contractor shall provide behavioral health services to assure compliance with LRA requirements.

14.2.2.7 The Contractor shall respond to requests for participation, implementation, and monitoring of Enrollees receiving services on Conditional Release (CR) consistent with RCW 71.05.340. The Contractor or Subcontractor shall provide behavioral health

services to assist with compliance with CR requirements.

14.2.2.8 The Contractor shall ensure provision of behavioral health services to individuals on a CR under RCW 10.77.150 and RCW 71.05.340.

14.2.2.9 CR Enrollees in transitional status in Pierce or Spokane County will transfer back to the MCO they were enrolled in prior to entering the State Hospital, upon completion of transitional care.

14.2.2.10 The Contractor shall coordinate with the DSHS, Aging and Long Term Support Administration (ALTSA)-Home and Community Services (HCS) regional office or its designee to support the placement of persons discharged or diverted from state hospitals or Community 90/180 Community Civil Commitment facilitiesinto HCS placements. In order to accomplish this, the Contractor shall:

14.2.2.10.1 Ensure that a request for a Comprehensive Assessment Reporting Evaluation (CARE) is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all persons who might be eligible for long-term care services. HCS will prioritize requests for CARE assessments for individuals who have been detained to an E&T or in another setting.

14.2.2.10.2 If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to determine individualized Enrollee-centered service needs and attempt a community placement prior to referral to the state hospital whenever it supports individualized Enrollee need.

14.2.2.10.3 Ensure that a request for a Comprehensive Assessment Reporting Evaluation (CARE) is made as soon as possible after it is determined that a Enrollee is ready for discharge from the State Hospital in order to initiate placement activities for persons who might be eligible for long-term care services.

14.2.2.10.4 When individuals being discharged or diverted from state hospitals or Community 90/180 Civil Detention facilities are placed in a long-term care setting, the Contractor shall:

14.2.2.10.4.1 Coordinate with HCS and any residential provider to develop a

crisis plan to support the placement.

14.3 Behavioral Health Personal Care (BHPC) and Related Services Funding

Behavioral Health Personal Care is the sharing of funding between the behavioral health system (contractor) and Home and Community Services (HCS) for personal care and related services provided to individuals whose need for personal care is primarily related to a psychiatric diagnosis and the Enrollee meets established criteria.

14.3.1 The Contractor shall approve Behavioral Health Personal Care funding using the following criteria:

14.3.1.1 The psychiatric diagnosis is the primary need for personal care and at least one of the following apply:

14.3.1.1.1 The Individual has a primary diagnosis of a serious mental illness (schizophrenia, bi-polar disorder, major depressive disorder).

14.3.1.1.2 Behaviors/symptoms of a mental illness that cause impairment and functional limitations in self-care/self-management activities.

14.3.1.2 Excluded primary diagnoses are: intellectual disabilities, Alzheimer's/dementia, traumatic brain injury or, a primary diagnosis of Substance Use Disorder. Considerations will be made for these diagnoses when a co-occurring serious mental illness diagnosis is present.

14.3.1.3 The Enrollee is currently receiving mental health services or, there is a plan to engage Enrollee in needed mental health services or, Enrollee's needs are met by Residential Services Waiver (RSW) services through HCS (e.g. ECS, SBS, ESF, other).

14.3.2 The Contractor shall abide by the following funding request process:

14.3.2.1 HCS or its designee will use the CARE tool to determine personal care needs.

14.3.2.2 HCS will send a funding request to the Contractor at the initial assessment and annually thereafter, if the Enrollee appears to meet criteria, for either new or ongoing personal care services. HCS will provide the following:

14.3.2.2.1 Funding Request Form (13-712); and

14.3.2.2.2 A copy of the CARE assessment including a Service Summary.

14.3.3 To support completion of an accurate assessment, the Contractor shall provide

the following information when it is missing from the request:

14.3.3.1 Information to connect HCS or its designee with the Enrollee's outpatient behavioral health providers.

14.3.3.2 Historical information relating to emergency department visits, inpatient stays, medications, and/or medical and behavioral health providers.

14.3.4 Personal care and related services authorized by HCS must not duplicate services the Contractor is required to provide.

14.3.5 The Contractor shall provide HCS Headquarters with updates to internal contacts for funding requests, care coordination escalation and billing within five (5) business days of a change or when requested.

14.3.6 BHPC Funding decisions must be based on the following:

14.3.6.1 A review of the request to determine if the Individual is currently residing in and eligible to receive Behavioral Health services in the Contractor's Service Area.

14.3.6.2 Verification that the need for personal care and related services is related to a psychiatric disability. Services shall not be denied should the CARE assessment include other diagnosis unrelated to the need for personal care.

14.3.6.3 The Contractor may request additional information from HCS or its designee if questions arise regarding services, providers or if there are questions about the assessment.

14.3.6.3.1 If changes are made to the assessment or funding request, HCS or its designee will provide a corrected 13-712 for signature.

14.3.6.4 A review of the requested services to determine if the Enrollee's personal care and related services or other needs could be met through provision of other available Behavioral Health services.

14.3.6.5 Additional information, as necessary in making a decision about whether the above criteria are met, including contractor care management information systems, PRISM, conversation with the HCS/AAA worker, conversation with the Enrollee's Mental Health Provider and others involved providers.

14.3.7 For funding requests that exceed the CARE generated rate:

14.3.7.1 The Contractor agrees to fund BHPC in line with the Contractor guideline created and agreed to by all Contractors for funding level alignment.

14.3.8 The Contractor must adhere to the following funding timeframe requirements:

14.3.8.1 Funding timelines should align with the CARE plan period.

14.3.8.2 The start date can be adjusted to the date received by MCO at the MCO's discretion if the requested state date is more than thirty (30) days before date of request.

14.3.8.3 If the requested start dare is less than thirty (30) days before the date of the request, the MCO will back date to the requested start date.

14.3.8.4 Without the exceptions listed above, the time period of authorization cannot be shortened by the MCO after the agreement to fund the services has been provided.

14.3.8.5 The Contract may not have policies that inhibit Enrollees from obtaining medically necessary personal care or related services. Funding for personal care and related services is needed on an ongoing basis. Authorization shall not be required any more frequently than for the care plan period, unless there is a significant change in condition that changes the level of need for personal care or related services.

14.3.9 The Contractor must respond within the following timeframes for funding requests:

14.3.9.1 The Contractor or its designee must acknowledge the receipt of a funding request from HCS or its designee with two (2) business days.

14.3.9.2 If the request is marked urgent the acknowledgement will be within one (1) business day.

14.3.9.3 The Contractor or its designee must make a decision on complete requests from HCS within five (5) business days of receipt of a complete request.

14.3.9.4 The Contractor and the local HCS office or its designee may mutually agree in writing to extend the five (5) business day requirement.

14.3.9.5 If the Contractor does not approve the funding, the Contractor shall provide clear rationale for why the request did not meet the criteria, and/or what services will be provided to the Enrollee.

14.3.10 When the Contractor denies authorization based on the provision of other services, a plan (e.g., Individual Service Plan) must be developed by the Contractor and implemented to meet the service needs identified in the CARE assessment.

14.3.11 If a dispute arises amongst parties regarding a funding request or relating to services, the following process will be followed:

14.3.11.1 All parties agree to participate in discussions when circumstances arise regarding disagreements pertaining to eligibility, effectiveness and appropriateness of BHPC and related services. This may include: changes in psychiatric symptoms, environment and related risk factors.

14.3.11.2 Disagreements regarding the need for BHPC and assignment of financial responsibility shall be worked out between the escalation contacts identified in the contact list for HCS/AAA or their designees and the Contractor.

14.3.11.3 The Contractor agrees to participate in discussions and case staffing, as needed, to resolve differences.

14.3.12 When an Enrollee is approved for BHPC funding for the plan period (typically one [1] year) by the Contractor, but transitions to another Contractor during the same plan period, the receiving Contractor will honor the funding approval of the previous Contractor for a period no less than one hundred eighty (180) days and up to the rest of the plan period to ensure continuity of care.

14.3.13 The Contractor shall provide ALTSA fiscal staff on the last day of each month, a spreadsheet of all Enrollees authorized for BHPC by emailing to MCOBHOforms@dshs.wa.gov.

14.3.14 The Contractor will adhere to the following billing and payment process:

14.3.14.1 HCS or its designee will authorize services in ProviderOne, upon receipt of the Contractor's approval of DSHS Personal Care Transmittal form (13-712).

14.3.14.2 ALTSA financial will bill the Contractor for monthly GFS cost of services billed each month by the 25th of the following month.

14.3.14.3 The Contractor shall review the invoice provided by ALTSA for accuracy. If the Contractor does not agree with any billed costs, it must provide a written dispute to ALTSA within fifteen (15) days of each monthly billing.

14.3.14.3.1 ALTSA will respond to a Contractor dispute within fifteen (15) days.

14.3.14.4 The Contractor shall provide a copy of the final ALTSA invoice to HCA, with a copy to ALTSA at MCOBHObilling@dshs.wa.gov, within fifteen (15) calendar days of agreement between ALTSA and the Contractor on the billed cost.

14.3.14.5 HCA will deduct the amount on the invoice from the Contractor's next monthly GFS payment.

14.3.15 The Contractor must provide the following documentation to DSHS, HCS or its designee on request:

14.3.15.1 the original funding request from HCS or its designee;

14.3.15.2 any information provided by HCS or its designee including the CARE assessment;

14.3.15.3 a copy of the Contractor's determination and written response provided to HCS or its designee; and

14.3.15.4 a copy of the plan developed and implemented to meet the Individual's needs through provision of other services when a BHPC funding request has been denied based on the Contractor's determination.

14.4 Care Coordination General Requirements

14.4.1 The Care Coordinator shall

14.4.1.1 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.

14.4.1.2 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.

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

15. GENERAL REQUIREMENTS

15.1 Second Opinions

15.1.1 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 a qualified Health Care Professional. The appointment for a second opinion must occur within thirty (30) days of the request. The Enrollee may request to postpone the second opinion to a date later than thirty (30) days.

15.1.2 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.

15.2 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 criteria to make medical necessity decisions for all SUD services.

15.3 Special Provisions Regarding Behavioral Health Benefits

The Contractor's administration of Behavioral Health benefits also shall comply with the following provisions:

15.3.1 Unless otherwise noted, Essential Behavioral Health Administrative Functions and required Behavioral Health personnel shall be located in Washington State and available during Business Hours.

15.3.2 Outside of Business Hours, information, crisis triage, referral services and prior authorization may be conducted out-of-state. Any Contractor staff that work outside of Washington State must be trained and have knowledge of Washington State-specific Behavioral Health Covered Services, Managed Care rules, UM protocols and level of care guidelines.

15.3.3 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, including services funded through state general funds covered by this Contract. 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.

15.3.4 The Contractor shall designate employees who fulfill the following Behavioral Health key functions:

15.3.4.1 A Behavioral Health Medical Director.

15.3.4.2 A Behavioral Health Clinical Director.

15.3.5 The Contractor shall designate managerial positions with the following Behavioral Health responsibilities:

15.3.5.1 A Behavioral Health Children's System Administrator.

15.3.5.2 An Addictions Administrator.

15.3.5.3 A Behavioral Health Utilization/Care Management Administrator.

15.3.5.4 A Behavioral Health network development manager.

15.3.5.5 A Behavioral Health provider relations manager.

15.3.6 In addition to the key and managerial staff, the Contractor shall have a sufficient number of qualified operational staff to meet its responsibilities under this Contract.

15.3.6.1 The Contractor shall locate a sufficient number of Provider Relations staff within the state to meet requirements under this Contract for provider education and training, provider profiling, and provider performance improvement or problem resolution.

15.3.6.2 The Contractor shall ensure that one or more Data Management and Reporting Specialists shall have experience and expertise in BH 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.

15.3.6.3 The Contractor shall ensure a sufficient number of qualified staff 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.

15.3.6.4 The Contractor may administer claims out-of-state. If claims are administered in another location, provider relations staff shall have access to the claims payment and reporting platform during Business Hours.

15.3.7 The Contractor shall develop and maintain a human resources and staffing plan that describes how the Contractor will maintain adequate staffing.

15.3.7.1 The Contractor shall hire employees for the key and required Behavioral Health functions specified in the Contract. Consultants must be prior approved by the state.

15.3.7.2 The Contractor may propose a staffing plan, with prior approval by the state, which combines positions and functions with other positions.

15.3.7.3 The Contractor shall develop and implement staff training plans

that address how all staff will be trained on the requirements of this Contract.

15.3.8 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 The Contractor is responsible for covering medically necessary 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. The Contractor is responsible for meeting the medical necessity needs of all Enrollees, and is responsible for providing clinically appropriate non-Medicaid services to Enrollees, in the event that the Contractor has Available Resources to provide GFS services under this Contract. Within Available Resources, the Contractor shall cover services related to the following:

16.1.1.1 The prevention, intervention, treatment, and after-care of Behavioral Health conditions.

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 maintain or regain functional capacity.

16.1.2 This Contract does not in any manner delegate coverage decisions to the Contractor. The Contractor makes the decision whether or not a contracted non-Medicaid 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 is allowed to have guidelines, developed and overseen by appropriate Health Care Professionals, for approving services. All retrospective denials of Contracted Services are to be individual medical necessity decisions made by a Health Care Professional.

16.1.3 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. For specific Contracted Services, the requirements of this Section shall also not be construed as requiring the Contractor to provide the specific items provided by the Health Care Authority under its fee-for-service program, but shall rather be construed to require the Contractor, at a minimum, to provide the same scope of services.

16.1.4 The Contractor may limit the provision of Contracted Services to Participating Providers except as specifically provided in this Contract; and the following provisions of this subsection:

16.1.4.1 Emergency services;

16.1.4.2 Services outside of the service areas as necessary to provide Medically Necessary Services; and

16.1.4.3 Coordination of Benefits, when an Enrollee has other primary comparable Behavioral Health coverage as necessary to coordinate benefits.

16.1.5 Within the Service Areas

16.1.5.1 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 Behavioral Health Medically Necessary Services included in the scope of services covered by this Contract.

16.1.6 Outside the Service Areas

16.1.6.1 For the Enrollees who are temporarily outside of the service areas or who have moved to a service area not served by the Contractor, the Contractor shall cover the following services:

16.1.6.1.1 Emergency and post-stabilization services.

16.1.6.1.2 Urgent care services associated with the presentation of Behavioral Health conditions that require immediate attention, but are not life threatening.

16.1.6.1.3 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.

16.1.6.1.4 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.

16.2 General Description of Contracted Services

16.2.1 The Contractor shall ensure services are paid through Medicaid when the service is a covered Medicaid service. GFS funding shall be used for Medicaid Enrollees only when the service is not covered by Medicaid. GFS funds shall be used to cover the following services within Available Resources. The Contractor must utilize GFS funds in accordance with funding allowances provided in Exhibit A.

16.2.2 The Contractor shall establish criteria, and policies and procedures to determine the provision or denial of the following services:

16.2.2.1 Room and board: With funds provided under this Agreement the Contractor is expected to prioritize payment for expenditures associated with providing medically necessary residential

services to Medicaid Enrollees that are not included in the Medicaid State Plan or 1915(b) Waiver, this includes, but is not limited to, Room and Board in hospital diversion settings, SUD and mental health residential settings or freestanding Evaluation and Treatment facilities.

16.2.2.2 Urinalysis Testing.

16.2.2.3 Therapeutic Interventions for Children.

16.2.2.4 High Intensity Treatment, including non-Medicaid PACT services and supports.

16.2.2.5 Sobering Services.

16.2.2.6 Rehabilitation Case Management.

16.2.3 Within available resource, the contractor may also provide any other appropriate services to Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver, such as, but not limited to:.

16.2.3.1 Interim Services.

16.2.3.2 Opiate Dependency/HIV Services Outreach

16.2.3.3 Childcare Services.

16.2.3.4 Expanded Community Services.

16.2.3.5 Recovery support services.

16.2.3.6 Outreach and Engagement.

16.2.3.7 Assistance with transportation that would not otherwise be covered by Medicaid.

16.2.3.8 Family Hardship services.

16.2.3.9 Continuing Education and Training.

16.2.3.10 Assistance with application for entitlement programs.

16.2.3.11 Alcohol/Drug Information School.

16.2.3.12 PPW Housing Support Services.

16.2.3.13 Supported Employment.

16.2.3.14 Jail Transition Services.

17. BUSINESS CONTINUITY AND DISASTER RECOVERY

17.1 Business Continuity and Disaster Recovery

17.1.1 The Contractor shall demonstrate 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); Information Systems Services Division (ISSD) approved secured virtual private network (VPN) or other ISSD-approved dial-up. 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 approval.

17.1.2 The Contractor shall create and maintain a business continuity and disaster Recovery plan that insures timely reinstitution of the Enrollee information system following total loss of the primary system or a substantial loss of functionality. The plan must be in written format, have an identified update process (at least annually) and a copy must be stored off site.

17.1.2.1 The Contractor must submit an annual certification statement indicating there is a business continuity disaster plan in place for both the Contractor and all Subcontractors that manage or store data. The certification must be submitted by January 1 of each year of this Contract. The certification must indicate that the plans are up to date, the system and data backup and recovery procedures have been tested, and copies of the Contractor and Subcontractor plans are available for HCA to review and audit. The plan must address the following:

17.1.2.1.1 A mission or scope statement.

17.1.2.1.2 An appointed information services disaster Recovery staff.

17.1.2.1.3 Provisions for back up of key personnel, identified emergency procedures and visibly listed emergency telephone numbers.

17.1.2.1.4 Procedures for allowing effective communication, applications inventory and business Recovery priority and hardware and software vendor list.

17.1.2.1.5 Confirmation of updated system and operations documentation and process for frequent back up of systems and data.

17.1.2.1.6 Off-site storage of system and data back-ups and ability to recover data and systems from back up files.

17.1.2.1.7 Designated Recovery options which may include use of a hot or cold site.

17.1.2.1.8 Evidence that disaster Recovery tests or drills have been performed.

18. SPECIAL PROVISIONS FOR IHCP PROVIDERS AND AMERICAN INDIAN/ALASKA NATIVE ENROLLEES

18.1 Special Provisions for Subcontracts with IHCP Providers

18.1.1 If at any time during the term of this Contract a IHCP Provider submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such IHCP Provider's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the IHCP Provider.

18.1.1.1 Such subcontract must include the Special Terms and Conditions set forth in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (the IHCP Addendum) issued by the Centers for Medicare and Medicaid Services (CMS). To the extent that any provision set forth in the subcontract between the Contractor and the IHCP Provider conflicts with the provisions set forth in the IHCP Provider Addendum, the provisions of the IHCP Provider Addendum shall prevail.

18.1.1.2 Such subcontract may include additional Special Terms and Conditions that are approved by the IHCP Provider and the Contractor. Each party must provide the HCA Tribal Liaison with a complete copy of such additional Special Terms and Conditions, in the format specified by the Agency, and a written statement that both parties have agreed to such additional Special Terms and Conditions.

18.1.2 Any subcontracts with IHCP Providers must be consistent with the laws and regulations that are applicable to the IHCP Provider. The Contractor must work with each IHCP Provider to prevent the Contractor's business operations from placing requirements on the IHCP Provider that are not consistent with applicable law or any of the special terms and conditions in the subcontract between the Contractor and the IHCP Provider.

18.1.3 The Contractor may seek technical assistance from the HCA Tribal Affairs Office to understand the legal protections applicable to IHCP Providers and American Indian/Alaska Native Medicaid recipients.

18.1.4 In the event that:

18.1.4.1 The Contractor and the IHCP Provider fail to reach an agreement on a subcontract within ninety (90) calendar days from the date of the IHCP Provider's written request (as described in Section 18.1); and

18.1.4.2 The IHCP Provider submits a written request to HCA for a meeting to discuss the subcontract, the Contractor and the IHCP Provider shall meet in person with HCA in Olympia Washington or an alternate location agreed upon by the parties involved within thirty (30) days from the date of the IHCP Provider'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.

18.2 Special Provisions for American Indian/Alaska Native Enrollees

18.2.1 No later than April 30, the Contractor shall submit to the HCA Tribal Liaison a plan that describes various services, financing models, and other activities for the Contractor to:

18.2.1.1 Support the recommendations set forth in the Tribal Centric Behavioral Health Report to the Washington State Legislature under 2SSB 5732, Section 7, Chapter 388, Laws of 2013, issued on November 30, 2013.

18.2.1.2 Support and enhance the Care Coordination services provided by IHCP Providers for Enrollees, both American Indian/Alaska Native and non-American Indian/Alaska Native, including coordination with non-IHCP Provider:

18.2.1.2.1 Mental health services;

18.2.1.2.2 Substance use disorder treatment services;

18.2.1.2.3 Crisis services;

18.2.1.2.4 Voluntary inpatient services;

18.2.1.2.5 Involuntary commitment evaluation services; and

18.2.1.2.6 Inpatient discharge services.

18.2.1.3 Improve access for American Indian/Alaska Native Enrollees (including those who do not receive care at IHCP Providers) to receive:

18.2.1.3.1 Behavioral Health prevention services;

18.2.1.3.2 Physical and Behavioral Health care services for co-occurring disorders, and

18.2.1.3.3 Culturally appropriate physical and Behavioral Health care.

18.2.2 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 IHCP Providers for Contracted Services provided to American Indian/Alaska Native enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP Provider. 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 a IHCP Provider.

18.2.3 Care Coordination and Continuity of Care: Tribal Members

18.2.3.1 The Contractor must amend or attempt to amend its Tribal and Recognized American Indian Organization (RAIO) Coordination Implementation Plan with each Tribe and RAIO to address protocols for coordination of care, or transition of care for members losing eligibility, for any tribal member in need of GFS funded services. If requested by HCA, the Contractor must provide documentation of attempts to amend its plan if any Tribe or RAIO declines to participate.

Exhibit B
Non-Medicaid Quarterly Expenditure Report Format

Attached as a separate document and incorporated by reference.

Exhibit C

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Exhibit D: List of Essential Behavioral Health Providers

List of Essential Behavioral Health Providers:

- Certified residential treatment providers[1]
- DBHR Licensed Community MH Agencies
- DBHR-certified Substance Use Disorder Treatment Provider Agencies
- DOH-certified medication assisted treatment (e.g. buprenorphine)
- DBHR-certified opiate substitution providers (Methadone Treatment programs)
- Evaluation and Treatment in DOH-licensed and DBHR-certified free-standing inpatient, hospitals, or psychiatric inpatient facilities
- DOH-licensed and DBHR certified detox facilities (for acute and sub-acute)
- DOH licensed and DBHR certified residential treatment facility to provide crisis stabilization

[1] Certified residential treatment providers: residential programs must have Department of Health (DOH) Residential Treatment Facility (RTF) license and then can apply for DBHR Certification for a type of service such as, Evaluation and Treatment, Crisis Stabilization, Intensive Inpatient, Recovery House, Long Term and Detoxification.

Exhibit E
DATA USE, SECURITY, AND CONFIDENTIALITY

1. Definitions

The definitions below apply to this Exhibit E:

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 E, 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" means information that relates to the provision of health care to an individual; the past, present, or future physical or mental health or condition of an individual; or past, present or future payment for provision of health care to an individual. 45 C.F.R. §160 and 164. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe, can be used to identify the individual. 45 C.F.R. § 160.103. PHI is information transmitted, maintained, or stored in any form or medium. 45 C.F.R. § 164.501. PHI does not include education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. § 1232g(a)(4)(b)(iv).

1.14 "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. Party 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (42 C.F.R. § 2.31). The federal rules restrict any use of the SUD Data to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 C.F.R. § 2.12(c)(5) and § 2.65.

4.2.1 The information received under subsection 7.6 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 regarding Enrollees,including individually identifiable and de-identified, including claims data, shared with external entities, including but not limited to Subcontractors and researchers, to HCA via hcamcprograms@hca.wa.gov on the supplied template, Data Shared with External Entities Report.

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.

5.3.2 Media are to be destoryed using a method documented within NIST 800-88 (http://csrc.nist.gov/publications/PubsSPs.html).

5.3.3 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 E 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 initated by the Office for Civil Rights based on an allegation of violation of HIPAA or the HIPAA Rules and must inform HCA of the outcome of that action. Contractor bears all responsibility for any penalties, fines, or sanctions imposed against Contractor for violations of HIPAA or the HIPAA Rules and for any sanction imposed against its Subcontractors or agents for which it is found liable.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop N1-24-08
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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,

Cheryl Sample

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 (Requestor) enter into this agreement to comply with the following specific paragraphs.

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 (Requestor), hereinafter termed "User."

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 files(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	State	ZIP Code
Olympia	WA	98504-5502
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
360-725-2116	ottcl@hca.wa.gov	
Signature		Date
Cathie Ott		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	State	ZIP Code
Olympia	WA	98504-5502
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
360-725-2116	ottcl@hca.wa.gov	
Signature		Date
Cathie Ott		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)* Karyn Kai Anderson			
Title/Component Medicare-Medicaid Coordination Office			
Street Address 7500 Security Blvd.			Mail Stop 53-13-23
City Baltimore	State MD	ZIP Code 21244	
Office Telephone *(Include Area Code)* 410-786-6696		E-Mail Address *(If applicable)* Karyn.Anderson@CMS.hhs.gov	
A. Signature of CMS Representative			Date 7/22/11
B. Concur/Nonconcur — Signature of CMS System Manager or Business Owner			Date 7/22/11
Concur/Nonconcur — Signature of CMS System Manager or Business Owner			Date
Concur/Nonconcur — Signature of CMS System Manager or Business Owner			Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0734

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

dua edit - dua: 21628

Session Summary: **DUA: 21628**

Main Information:

DUA #:	21628		
Study Name:	CARE COORDINATION FOR BENEFICIARIES WHO ARE DUALLY 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 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

DESY Users:

Comments:

Timestamp: Thu Aug 04 17:24:26 EDT 2011 User Name: CHERYL SAMPLE
Text: added David Mancuso as addtional 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

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

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 (lEA) 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 lEA 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. § S52a), 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 lEA.

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 p1·ogram 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 l 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 lEA 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 individua1s. 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 lEA. 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: Nl-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 ve1·bal 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-l, 13951l, 1395mm, 1395n·, 1396a(a)(6), and§ 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of2003 (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 pu1pose 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, dete1o, 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 Nl-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 regu1ation 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

[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]

PRISM Access Request for Multiple Organizations

An Organization may request access to PRISM for its employees or employees of Subcontractors (**Users)** under its Data Share Agreement (DSA) with HCA. The Organization **PRISM Lead** reviews and completes the "Requesting Organization" section. The PRISM Access Request form must be signed by the **PRISM Lead** authorizing the request, which attests to the **Users**' business need for electronic Protected Health Information, and in the case of a Subcontractor User, attests that the contract with the Subcontractor includes a HIPAA Business Associate Agreement and Medicare data share language, as appropriate. The **User** completes the "User Registration Information" section below and signs the "User Agreement and Non-Disclosure of Confidential Information" page. The **PRISM Lead** then forwards the request to: PRISM.Admin@dshs.wa.gov.

Upon review and acceptance, DSHS and HCA will grant the appropriate access permissions to the User and notify the **PRISM Lead**.

Changes to Access for Users

The **PRISM Lead** must notify the **PRISM Administrator** within five (5) business days whenever a **User** with access rights leaves employment or has a change of duties such that the User no longer requires access. If the removal of access is emergent, please include that information with the request.

Requesting Organizations (to be completed by PRISM Lead)	
CONTRACTOR'S NAME	STREET ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)
1.	
2.	
3.	

User Registration Information (to be completed by User)		
USER'S NAME (FIRST, MIDDLE, LAST)		USER'S JOB TITLE
USER'S BUSINESS EMAIL ADDRESS		USER'S BUSINESS PHONE NUMBER (INCLUDE AREA CODE)
USER'S EMPLOYER		DATE IT SECURITY TRAINING COMPLETED (REQUIRED YEARLY)
If user will be completing Health Action Plans (HAPs), enter the date training was completed:	DATE HAP TRAINING COMPLETED	DATE HIPAA TRAINING COMPLETED (REQUIRED)
PRISM USER'S SIGNATURE DATE		PRISM USER'S PRINTED NAME

Authorizing Signature(s)

Protected Data Access Authorization

The HIPAA Security rule states that every employee that needs access to electronic Protected Health Information (ePHI) receives authorization from an appropriate authority and that the need for this access based on job function or responsibility is documented. I, the undersigned **PRISM Lead**, verify that the individual for whom this access is being requested (User or Subcontractor User) has a business need to access this data, has completed the required HIPAA Privacy training and the annual IT Security training and has signed the required *User Agreement and Non-Disclosure of Confidential Information* included with this Access Request. This User's access to this electronic Protected Health Information (ePHI) is appropriate under the HIPAA Information Access Management Standard and the Privacy Rule. In addition, if applicable, this employee has been instructed on 42 Code of Federal Regulations (CFR) Part 2 that governs the use of alcohol and drug use information and is aware that this type of data must be used only in accordance with these regulations. I have also ensured that the necessary steps have been taken to validate the User's identity before approving access to confidential and protected information. If a Subcontractor is indicated, I attest that the contract with the Subcontractor includes a HIPAA Business Associate Agreement, and where appropriate Medicare data share language.

PRISM LEAD SIGNATURE (CONTRACTOR 1)	DATE	PRISM LEAD NAME 1 (PRINT)
PRISM LEAD SIGNATURE (CONTRACTOR 2)	DATE	PRISM LEAD NAME 2 (PRINT)
PRISM LEAD SIGNATURE (CONTRACTOR 3)	DATE	PRISM LEAD NAME 3 (PRINT)

User Agreement and Non-Disclosure of Confidential Information

Your Organization has entered into a Data Share Agreement (DSA) with the state of Washington Health Care Authority (HCA) that will allow you to access data and records that are deemed Confidential Information as defined below. Prior to accessing this Confidential Information you must sign this **User Agreement and Non-Disclosure of Confidential Information** form.

Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Protected Health Information and Personal Information.

"Protected Health Information" means information that relates to: the provision of health care to an individual; the past, present, or future physical or mental health or condition of an individual; or the past, present or future payment for provision of health care to an individual and includes demographic information that identifies the individual or can be used to identify the individual.

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

Regulatory Requirements and Penalties

State laws (including, but not limited to, RCW 74.04.060, RCW 74.34.095, RCW 70.02.020 and RC2.70.02.230) and federal regulations (including, but not limited to, HIPAA Privacy and Security Rules, 45 CFR Part 160 and Part 164; Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2; and Safeguarding Information on Applicants and Beneficiaries, 42 CFR Part 431, Subpart F) prohibit unauthorized access, use, or disclosure of Confidential Information. Violation of these laws may result in criminal or civil penalties or fines.

User Agreement and Assurance of Confidentiality

In consideration for DSHS and HCA granting me access to PRISM or other systems and the Confidential Information in those systems, I agree that I:

1) Will access, use, and disclose Confidential Information only in accordance with the terms of this Agreement and consistent with applicable statutes, regulations, and policies.
2) Have an authorized business requirement to access and use DSHS or HCA systems and view DSHS or HCA Confidential Information.
3) Will not use or disclose any Confidential Information gained by reason of this Agreement for any commercial, personal, or research purpose, or any other purpose that is not directly connected with client care coordination and quality improvement.
4) Will not use my access to look up or view information about family members, friends, the relatives or friends of other employees, or any persons who are not directly related to my assigned job duties.
5) Will not discuss Confidential Information in public spaces in a manner in which unauthorized individuals could overhear and will not discuss Confidential Information with unauthorized individuals, including spouses, domestic partners, family members, or friends.
6) Will protect all Confidential Information against unauthorized use, access, disclosure, or loss by employing reasonable security measures, including physically securing any computers, documents, or other media containing Confidential Information and viewing Confidential Information only on secure workstations in non-public areas.
7) Will not make copies of Confidential Information, or print system screens unless necessary to perform my assigned job duties and will not transfer any Confidential Information to a portable electronic device or medium, or remove Confidential Information on a portable device or medium from facility premises, unless the information is encrypted and I have obtained prior permission from my supervisor.
8) Will access, use or disclose only the "minimum necessary" Confidential Information required to perform my assigned job duties.
9) Will protect my DSHS and HCA systems User ID and password and not share them with anyone or allow others to use any DSHS or HCA system logged in as me.
10) Will not distribute, transfer, or otherwise share any DSHS software with anyone.
11) Will forward any requests that I may receive to disclose Confidential Information to my supervisor for resolution and will immediately inform my supervisor of any actual or potential security breaches involving Confidential Information, or of any access to or use of Confidential Information by unauthorized users.
12) Understand at any time, DSHS or HCA may audit, investigate, monitor, access, and disclose information about my use of the systems and that my intentional or unintentional violation of the terms of this Agreement may result in revocation of privileges to access the systems, disciplinary actions against me, or possible civil or criminal penalties or fines.
13) Understand that my assurance of confidentiality and these requirements will continue and do not cease at the time I terminate my relationship with my employer.

User's Signature

PRISM USER'S SIGNATURE	DATE	PRISM USER'S PRINTED NAME

Exhibit F

REGIONAL SERVICE AREA

January 1, 2019

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, SKAMANIA, KLICKITAT					
SPOKANE	**X**	**X**		**X**	
ADAMS, FERRY, LINCOLN, PEND OREILLE, SPOKANE, STEVENS					
THURSTON-MASON	**X**			**X**	**X**
MASON, THURSTON					