|  |  |  |
| --- | --- | --- |
| C:\Users\ANDERM\Desktop\HCA-logo.png | PROFESSIONAL SERVICES CONTRACT forExternal Quality Review | HCA Contract Number: K3866Resulting from Solicitation Number (If applicable: Contractor/Vendor Contract Number:  |
| **THIS CONTRACT** is made by and between Washington State Health Care Authority, (HCA) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Contractor). |
| CONTRACTOR NAME | CONTRACTOR doing business as (DBA) |
|       |       |
| CONTRACTOR ADDRESS | Street | City | State | Zip Code |
|       |       |       |       |
| CONTRACTOR CONTACT | CONTRACTOR TELEPHONE | CONTRACTOR E-MAIL ADDRESS |
|       |       |       |
| Is Contractor a Subrecipient under this Contract? | CFDA NUMBER(S): | FFATA Form Required |
|  [ ] YES [ ] NO |  |  [ ] YES [ ] NO |
|  |  |
| HCA PROGRAM  | HCA DIVISION/SECTION |
| Medicaid Compliance Review and Analytics | MPOI |
| HCA CONTACT NAME AND TITLE  | HCA CONTACT ADDRESS |
|      ,       | Health Care Authority626 8th Avenue SEPO Box \_\_\_\_ Olympia, WA 98504-\_\_\_\_ |
| HCA CONTACT TELEPHONE  | HCA CONTACT E-MAIL ADDRESS |
| (360) 725-      |       |
|  |  |  |
| CONTRACT START DATE | CONTRACT END DATE  | TOTAL MAXIMUM CONTRACT AMOUNT |
| January 1, 2020 | December 31, 2023 |       |
| PURPOSE OF CONTRACT: |  |  |
| Conduct External Quality Review (EQR) and Quality Improvement Organization (QIO) activities to meet 42 C.F.R. Part 462, and 42 C.F.R. Part 438, Managed Care, Subpart E, External Quality Review. |
|  |  |  |
| The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract will 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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Note: Exhibits A and B are not attached but are available upon request from the HCA Contracts Administrator.

Contract #K3866 for External Quality Review Services

# Recitals

The state of Washington, acting by and through the Health Care Authority (HCA), issued a Request for Proposals/Qualifications and Quotation (RFP or RFQQ) dated August 5, 2019, (Exhibit A) for the purpose of purchasing External Quality Review Services in accordance with its authority under chapters 39.26 and 41.05 RCW.

[Contractor Name] submitted a timely Response to HCA’s RFP #3866 (Exhibit B).

HCA evaluated all properly submitted Responses to the above-referenced RFP and has identified [Contractor Name] as the Apparent Successful Bidder.

HCA has determined that entering into a Contract with [Contractor Name] will meet HCA’s needs and will be in the State’s best interest.

NOW THEREFORE, HCA awards to [Contractor Name] this Contract, the terms and conditions of which will govern Contractor’s providing to HCA the External Quality Review Services.

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

# Statement of Work (SOW)

The Contractor will provide the services and staff as described in Schedule A: *Statement of Work*.

# Definitions

**“Authorized Representative”** means a person to whom signature authority has been delegated in writing acting within the limits of his/her authority.

**“Breach”** means the unauthorized acquisition, access, use, or disclosure of Confidential Information that compromises the security, confidentiality, or integrity of the Confidential Information.

**“Business Associate”** means a Business Associate as defined in 45 C.F.R. § 160.103, who performs or assists in the performance of an activity for or on behalf of HCA, a Covered Entity, that involves the use or disclosure of protected health information (PHI). Any reference to Business Associate in this DSA includes Business Associate’s employees, agents, officers, Subcontractors, third party contractors, volunteers, or directors.

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

**“Centers for Medicare and Medicaid Services”** or **“CMS”** means the federal office under the Secretary of the United States Department of Health and Human Services, responsible for the Medicare and Medicaid programs.

**“C.F.R.”** means the Code of Federal Regulations. All references in this Contract to C.F.R. chapters or sections include any successor, amended, or replacement regulation. The C.F.R. may be accessed at <http://www.ecfr.gov/cgi-bin/ECFR?page=browse>.

**“Confidential Information”** means information that may be exempt from disclosure to the public or other unauthorized persons under chapter 42.56 RCW or chapter 70.02 RCW or other state or federal statutes or regulations. Confidential Information includes, but is not limited to, any information identifiable to an individual that relates to a natural person’s health, (see also Protected Health Information); finances, education, business, use or receipt of governmental services, names, addresses, telephone numbers, social security numbers, driver license numbers, financial profiles, credit card numbers, financial identifiers and any other identifying numbers, law enforcement records, HCA source code or object code, or HCA or State security information.

**“Contract”** means this Contract document and all schedules, exhibits, attachments, incorporated documents and amendments.

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

**“Covered entity”** means a health plan, a health care clearinghouse or a health care provider who transmits any health information in electronic form to carry out financial or administrative activities related to health care, as defined in 45 C.F.R. § 160.103.

**“Data”** means information produced, furnished, acquired, or used by Contractor in meeting requirements under this Contract.

**“Effective Date”** means the first date this Contract is in full force and effect. It may be a specific date agreed to by the parties; or, if not so specified, the date of the last signature of a party to this Contract.

**“HCA Contract Manager”** means the individual identified on the cover page of this Contract who will provide oversight of the Contractor’s activities conducted under this Contract.

**“Health Care Authority”** or **“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.

**"Overpayment"** means any payment or benefit to the Contractor in excess of that to which the Contractor is entitled by law, rule, or this Contract, including amounts in dispute.

**“Proprietary Information”** means information owned by Contractor to which Contractor claims a protectable interest under law. Proprietary Information includes, but is not limited to, information protected by copyright, patent, trademark, or trade secret laws.

“**Protected Health Information**” or **“PHI”** means individually identifiable 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, as defined in 45 C.F.R. § 160.103. Individually identifiable information is information that identifies the individual or about which there is a reasonable basis to believe it can be used to identify the individual, and includes demographic information. 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 Rights and Privacy Act, as amended, 20 USC 1232g(a)(4)(b)(iv).

**“Response”** means Contractor’s Response to HCA’s RFP #3866 for External Quality Review Services and is Exhibit B hereto.

**“RCW”** means the Revised Code of Washington. All references in this Contract to RCW chapters or sections include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at: <http://apps.leg.wa.gov/rcw/>.

**“RFP”** means the Request for Proposal used as the solicitation document to establish this Contract, including all its amendments and modifications and is Exhibit A hereto.

**“Statement of Work”** or **“SOW”** means a detailed description of the work activities the Contractor is required to perform under the terms and conditions of this Contract, including the deliverables and timeline, and is Schedule A hereto.

**“Subcontractor”** means a person or entity that is not in the employment of the Contractor, who is performing all or part of the business activities under this Contract under a separate contract with Contractor. The term “Subcontractor” means subcontractor(s) of any tier.

**“Subrecipient”** shall have the meaning given in 45 C.F.R. § 75.2, or any successor or replacement to such definition, for any federal award from HHS; or 2 C.F.R. § 200.93, or any successor or replacement to such definition, for any other federal award.

**“USC”** means the United States Code. All references in this Contract to USC chapters or sections will include any successor, amended, or replacement statute. The USC may be accessed at <http://uscode.house.gov/>

**“WAC”** means the Washington Administrative Code. All references to WAC chapters or sections will include any successor, amended, or replacement regulation. Pertinent WACs may be accessed at: <http://app.leg.wa.gov/wac/>.

# Special Terms and Conditions

## Performance Expectations

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

### Knowledge of applicable state and federal laws and regulations pertaining to subject of contract;

### Use of professional judgment;

### Collaboration with HCA staff in Contractor’s conduct of the services;

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

### Timely, accurate and informed communications;

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

### Regular, punctual attendance at all meetings; and

### Provision of high quality services.

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

## Term

### The initial term of the Contract will commence on January 1, 2020, or date of last signature, whichever is later, and continue through December 31, 2023, unless terminated sooner as provided herein.

### This Contract may be extended through December 31, 2026 in whatever time increments HCA deems appropriate. No change in terms and conditions will be permitted during these extensions unless specifically agreed to in writing.

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

## Compensation

### The Maximum Compensation payable to Contractor for the performance of all things necessary for or incidental to the performance of work as set forth in Schedule A: *Statement of Work* is $     , and includes any allowable expenses.

### Contractor’s compensation for services rendered will be based on Schedule A, Section      , Deliverables and Task Schedule and Schedule B, Budget.

### Day-to-day expenses related to performance under the Contract, including but not limited to travel, lodging, meals, and incidentals, will not be reimbursed to Contractor. If Contractor is required by HCA to travel, any such travel must be authorized in writing by the HCA Contract Manager and reimbursement will be at rates not to exceed the then-current rules, regulations, and guidelines for State employees published by the Washington State Office of Financial Management in the Washington State Administrative and Accounting Manual (<http://www.ofm.wa.gov/policy/10.htm>); reimbursement will not exceed expenses actually incurred.

To receive reimbursement, Contractor must provide a detailed breakdown of authorized expenses and receipts for any expenses of $50 or more.

### Federal funds disbursed through this Contract were received by HCA through OMB Catalogue of Federal Domestic Assistance (CFDA) Number: 93.778.

## Invoice and Payment

### Contractor must submit accurate invoices to the following address for all amounts to be paid by HCA via e-mail to: Acctspay@hca.wa.gov. Include the HCA Contract number in the subject line of the email.

### Invoices must describe and document to HCA’s satisfaction a description of the work performed, the progress of the project, and fees. If expenses are invoiced, invoices must provide a detailed breakdown of each type. Any single expense in the amount of $50.00 or more must be accompanied by a receipt in order to receive reimbursement. All invoices will be reviewed and must be approved by the Contract Manager or his/her designee prior to payment.

### Contractor must submit properly itemized invoices to include the following information, as applicable:

#### HCA Contract number K3866;

#### Contractor name, address, phone number;

#### Description of Services;

#### Date(s) of delivery;

#### Net invoice price for each item;

#### Applicable taxes;

#### Total invoice price; and

#### Payment terms and any available prompt payment discount.

### HCA will return incorrect or incomplete invoices to the Contractor for correction and reissue. The Contract Number must appear on all invoices, bills of lading, packages, and correspondence relating to this Contract.

### In order to receive payment for services or products provided to a state agency, Contractor must register with the Statewide Payee Desk at <https://ofm.wa.gov/it-systems/statewide-vendorpayee-services/receiving-payment-state>. Payment will be considered timely if made by HCA within thirty (30) calendar days of receipt of properly completed invoices. Payment will be directly deposited in the bank account or sent to the address Contractor designated in its registration.

### Upon expiration of the Contract, any claims for payment for costs due and payable under this Contract that are incurred prior to the expiration date must be submitted by the Contractor to HCA within sixty (60) calendar days after the Contract expiration date. HCA is under no obligation to pay any claims that are submitted sixty-one (61) or more calendar days after the Contract expiration date (“Belated Claims”). HCA will pay Belated Claims at its sole discretion, and any such potential payment is contingent upon the availability of funds.

## Contractor and HCA Contract Managers

### Contractor’s Contract Manager will have prime responsibility and final authority for the services provided under this Contract and be the principal point of contact for the HCA Contract Manager for all business matters, performance matters, and administrative activities.

### HCA’s Contract Manager is responsible for monitoring the Contractor’s performance and will be the contact person for all communications regarding contract performance and deliverables. The HCA Contract Manager has the authority to accept or reject the services provided and must approve Contractor’s invoices prior to payment.

### The contact information provided below may be changed by written notice of the change (email acceptable) to the other party.

|  |  |
| --- | --- |
| CONTRACTORContract Manager Information | Health Care AuthorityContract Manager Information |
| Name: |       | Name: |       |
| Title: |       | Title: |       |
| Address: |       | Address: |       |
| Phone:  |       | Phone:  |       |
| Email:  |       | Email:  |       |

## Key Staff

### Except in the case of a legally required leave of absence, sickness, death, termination of employment or unpaid leave of absence, Key Staff must not be changed during the term of the Statement of Work (SOW) from the people who were described in the Response for the first SOW or those Key Staff initially assigned to subsequent SOWs, without the prior written approval of HCA until completion of their assigned tasks.

### During the term of the Statement of Work (SOW), HCA reserves the right to approve or disapprove Contractor’s Key Staff assigned to this Contract, to approve or disapprove any proposed changes in Contractor’s Key Staff, or to require the removal or reassignment of any Contractor staff found unacceptable by HCA, subject to HCA’s compliance with applicable laws and regulations. Contractor must provide a resume to HCA of any replacement Key Staff and all staff proposed by Contractor as replacements for other staff must have comparable or greater skills for performing the activities as performed by the staff being replaced.

## Legal Notices

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

### In the case of notice to the Contractor:

[Contractor Contact Information]

### In the case of notice to HCA:

**Attention:** Contracts Administrator

Health Care Authority

Division of Legal Services

Post Office Box 42702

Olympia, WA 98504-2702

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

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

## Incorporation of Documents and Order of Precedence

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

### Applicable Federal and State of Washington statutes and regulations;

### Schedule C: Business Associate Agreement;

### Schedule D: Data Use, Security, and Confidentiality;

### Recitals

### Special Terms and Conditions;

### General Terms and Conditions;

### Attachment 1: Confidential Information Security Requirements;

### Schedule A: Statement of Work;

### Schedule B: Budget

### Exhibit A: HCA RFP #3866 for External Quality Review Services, dated August 5, 2019;

### Exhibit B: *Contractor’s Response* dated      ; and

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

## Insurance

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

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

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

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

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

### Privacy Breach Response Coverage. Contractor must maintain insurance for the term of this Agreement and three (3) years following its termination or expiration to cover costs incurred in connection with a Breach, or potential Breach, including:

#### Computer forensics assistance to assess the impact of the Breach or potential Breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach notification laws.

#### Notification and call center services for individuals affected by a Breach.

#### Breach resolution and mitigation services for individuals affected by a Breach, including fraud prevention, credit monitoring and identity theft assistance.

#### 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).

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

[Alternate for self-insured]

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

# General Terms and Conditions

## Access to Data

In compliance with RCW 39.26.180 (2) and federal rules, the Contractor must provide access to any data generated under this Contract to HCA, the Joint Legislative Audit and Review Committee, the State Auditor, and any other state or federal officials so authorized by law, rule, regulation, or agreement at no additional cost. This includes access to all information that supports the findings, conclusions, and recommendations of the Contractor’s reports, including computer models and methodology for those models.

## Advance Payment Prohbited

No advance payment will be made for services furnished by the Contractor pursuant to this Contract.

## Amendments

This Contract may be amended by mutual agreement of the parties. Such amendments will not be binding unless they are in writing and signed by personnel authorized to bind each of the parties.

## Assignment

### Contractor may not assign or transfer all or any portion of this Contract or any of its rights hereunder, or delegate any of its duties hereunder, except delegations as set forth in Section 4.37, *Subcontracting*, without the prior written consent of HCA. Any permitted assignment will not operate to relieve Contractor of any of its duties and obligations hereunder, nor will such assignment affect any remedies available to HCA that may arise from any breach of the provisions of this Contract or warranties made herein, including but not limited to, rights of setoff. Any attempted assignment, transfer or delegation in contravention of this Subsection 4.4.1 of the Contract will be null and void.

### HCA may assign this Contract to any public agency, commission, board, or the like, within the political boundaries of the State of Washington, with written notice of thirty (30) calendar days to Contractor.

### This Contract will inure to the benefit of and be binding on the parties hereto and their permitted successors and assigns.

## Attorneys’ Fees

In the event of litigation or other action brought to enforce the terms of this Contract, each party agrees to bear its own attorneys’ fees and costs.

## Change in Status

In the event of any substantive change in its legal status, organizational structure, or fiscal reporting responsibility, Contractor will notify HCA of the change. Contractor must provide notice as soon as practicable, but no later than thirty (30) calendar days after such a change takes effect.

## Confidential Information Protection

### Contractor acknowledges that some of the material and information that may come into its possession or knowledge in connection with this Contract or its performance may consist of Confidential Information. Contractor agrees to adhere to the requirements of Schedule C, Data Use, Security, and Confidentiality. Contractor agrees to implement physical, electronic, and managerial safeguards to prevent unauthorized access to Confidential Information (See Attachment 1: *Confidential Information Security Requirements*).

### Contractors that come into contact with Protected Health Information may be required to enter into a Business Associate Agreement with HCA in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as modified by the American Recovery and Reinvestment Act of 2009 (“ARRA”), Sec. 13400 – 13424, H.R. 1 (2009) (HITECH Act) (HIPAA).

### HCA reserves the right to monitor, audit, or investigate the use of Confidential Information collected, used, or acquired by Contractor through this Contract. Violation of this section by Contractor or its Subcontractors may result in termination of this Contract and demand for return of all Confidential Information, monetary damages, or penalties.

### The obligations set forth in this Section will survive completion, cancellation, expiration, or termination of this Contract.

## Confidential Information Security

The federal government, including the Centers for Medicare and Medicaid Services (CMS), and the State of Washington all maintain security requirements regarding privacy, data access, and other areas. Contractor is required to comply with the Confidential Information Security Requirements set out in Attachment 1 to this Contract and appropriate portions of the Washington OCIO Security Standard, 141.10 (<https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets>).

## Confidential Information Breach Notification and Obligations

### Contractor must notify the HCA Privacy Officer (HCAPrivacyOfficer@hca.wa.gov) within five Business Days of discovery of any Breach or suspected Breach of Confidential Information.

### Contractor will take steps necessary to mitigate any known harmful effects of such unauthorized access including, but not limited to, sanctioning employees and taking steps necessary to stop further unauthorized access. Contractor agrees to indemnify and hold HCA harmless for any damages related to unauthorized use or disclosure of Confidential Information by Contractor, its officers, directors, employees, Subcontractors or agents.

### If notification of the Breach or possible Breach must (in the judgment of HCA) be made under the HIPAA Breach Notification Rule, or RCW 42.56.590 or RCW 19.255.010, or other law or rule, then:

#### HCA may choose to make any required notifications to the individuals, to the U.S. Department of Health and Human Services Secretary (DHHS) Secretary, and to the media, or direct Contractor to make them or any of them.

#### In any case, Contractor will pay the reasonable costs of notification to individuals, media, and governmental agencies and of other actions HCA reasonably considers appropriate to protect HCA clients (such as paying for regular credit watches in some cases).

#### Contractor will compensate HCA clients for harms caused to them by any Breach or possible Breach.

### Any breach of this clause may result in termination of the Contract and the demand for return or disposition (Attachment 1, Section 6) of all Confidential Information.

### Contractor’s obligations regarding Breach notification survive the termination of this Contract and continue for as long as Contractor maintains the Confidential Information and for any breach or possible breach at any time.

## Contractor’s Proprietary Information

Contractor acknowledges that HCA is subject to chapter 42.56 RCW, the Public Records Act, and that this Contract will be a public record as defined in chapter 42.56 RCW. Any specific information that is claimed by Contractor to be Proprietary Information must be clearly identified as such by Contractor. To the extent consistent with chapter 42.56 RCW, HCA will maintain the confidentiality of Contractor’s information in its possession that is marked Proprietary. If a public disclosure request is made to view Contractor’s Proprietary Information, HCA will notify Contractor of the request and of the date that such records will be released to the requester unless Contractor obtains a court order from a court of competent jurisdiction enjoining that disclosure. If Contractor fails to obtain the court order enjoining disclosure, HCA will release the requested information on the date specified.

## Covenant Against Contingent Fees

Contractor warrants that no person or selling agent has been employed or retained to solicit or secure this Contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, excepting bona fide employees or bona fide established agents maintained by the Contractor for the purpose of securing business. HCA will have the right, in the event of breach of this clause by the Contractor, to annul this Contract without liability or, in its discretion, to deduct from the contract price or consideration or recover by other means the full amount of such commission, percentage, brokerage or contingent fee.

## Debarment

By signing this Contract, Contractor certifies that it 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). Contractor agrees to include the above requirement in any and all subcontracts into which it enters, and also agrees that it will not employ debarred individuals. Contractor must immediately notify HCA if, during the term of this Contract, Contractor becomes debarred. HCA may immediately terminate this Contract by providing Contractor written notice, if Contractor becomes debarred during the term hereof.

## Disputes

The parties will use their best, good faith efforts to cooperatively resolve disputes and problems that arise in connection with this Contract. Both parties will continue without delay to carry out their respective responsibilities under this Contract while attempting to resolve any dispute. When a genuine dispute arises between HCA and the Contractor regarding the terms of this Contract or the responsibilities imposed herein and it cannot be resolved between the parties’ Contract Managers, either party may initiate the following dispute resolution process.

### The initiating party will reduce its description of the dispute to writing and deliver it to the responding party (email acceptable). The responding party will respond in writing within five (5) Business Days (email acceptable). If the initiating party is not satisfied with the response of the responding party, then the initiating party may request that the HCA Director review the dispute. Any such request from the initiating party must be submitted in writing to the HCA Director within five (5) Business Days after receiving the response of the responding party. The HCA Director will have sole discretion in determining the procedural manner in which he or she will review the dispute. The HCA Director will inform the parties in writing within five (5) Business Days of the procedural manner in which he or she will review the dispute, including a timeframe in which he or she will issue a written decision.

### A party's request for a dispute resolution must:

#### Be in writing;

#### Include a written description of the dispute;

#### State the relative positions of the parties and the remedy sought;

#### State the Contract Number and the names and contact information for the parties;

### This dispute resolution process constitutes the sole administrative remedy available under this Contract. The parties agree that this resolution process will precede any action in a judicial or quasi-judicial tribunal.

## Entire Agreement

HCA and Contractor agree that the Contract is the complete and exclusive statement of the agreement between the parties relating to the subject matter of the Contract and supersedes all letters of intent or prior contracts, oral or written, between the parties relating to the subject matter of the Contract, except as provided in Section 4.44 *Warranties*.

## Force Majeure

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

## Funding Withdrawn, Reduced, or Limited

If HCA determines in its sole discretion that the funds it relied upon to establish this Contract have been withdrawn, reduced or limited, or if additional or modified conditions are placed on such funding after the effective date of this contract but prior to the normal completion of this Contract, then HCA, at its sole discretion, may:

### Terminate this Contract pursuant to Section 4.41.3, *Termination for Non-Allocation of Funds*;

### Renegotiate the Contract under the revised funding conditions; or

### Suspend Contractor’s performance under the Contract upon five (5) Business Days’ advance written notice to Contractor. HCA will use this option only when HCA determines that there is reasonable likelihood that the funding insufficiency may be resolved in a timeframe that would allow Contractor’s performance to be resumed prior to the normal completion date of this Contract.

#### During the period of suspension of performance, each party will inform the other of any conditions that may reasonably affect the potential for resumption of performance.

#### When HCA determines in its sole discretion that the funding insufficiency is resolved, it will give Contractor written notice to resume performance. Upon the receipt of this notice, Contractor will provide written notice to HCA informing HCA whether it can resume performance and, if so, the date of resumption. For purposes of this subsection, “written notice” may include email.

#### If the Contractor’s proposed resumption date is not acceptable to HCA and an acceptable date cannot be negotiated, HCA may terminate the contract by giving written notice to Contractor. The parties agree that the Contract will be terminated retroactive to the date of the notice of suspension. HCA will be liable only for payment in accordance with the terms of this Contract for services rendered prior to the retroactive date of termination.

## Governing Law

This Contract is governed in all respects by the laws of the state of Washington, without reference to conflict of law principles. The jurisdiction for any action hereunder is exclusively in the Superior Court for the state of Washington, and the venue of any action hereunder is in the Superior Court for Thurston County, Washington. Nothing in this Contract will be construed as a waiver by HCA of the State’s immunity under the 11th Amendment to the United States Constitution.

## HCA Network Security

Contractor agrees not to attach any Contractor-supplied computers, peripherals or software to the HCA Network without prior written authorization from HCA’s Chief Information Officer. Unauthorized access to HCA networks and systems is a violation of HCA Policy and constitutes computer trespass in the first degree pursuant to RCW 9A.52.110. Violation of any of these laws or policies could result in termination of the contract and other penalties.

Contractor will have access to the HCA visitor Wi-Fi Internet connection while on site.

## Indemnification

Contractor must defend, indemnify, and save HCA harmless from and against all claims, including reasonable attorneys’ fees resulting from such claims, for any or all injuries to persons or damage to property, or Breach of its confidentiality and notification obligations under Section 4.7 *Confidential Information Protection* and Section 4.8 *Confidentiality Breach-Required Notification*, arising from intentional or negligent acts or omissions of Contractor, its officers, employees, or agents, or Subcontractors, their officers, employees, or agents, in the performance of this Contract.

## Independent Capacity of the ContractorINDEPENDENT CAPACITY OF THE CONTRACTOR

The parties intend that an independent contractor relationship will be created by this Contract. Contractor and its employees or agents performing under this Contract are not employees or agents of HCA. Contractor will not hold itself out as or claim to be an officer or employee of HCA or of the State of Washington by reason hereof, nor will Contractor make any claim of right, privilege or benefit that would accrue to such employee under law. Conduct and control of the work will be solely with Contractor.

## Industrial Insurance Coverage

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

## Legal and Regualtory Compliance

### During the term of this Contract, Contractor must comply with all local, state, and federal licensing, accreditation and registration requirements/standards, necessary for the performance of this Contract and all other applicable federal, state and local laws, rules, and regulations, and all amendments thereto that are in effect when the Contract is signed (42 C.F.R. § 438.3). The provisions of this Contract that are in conflict with applicable state or federal laws or regulations are hereby amended to conform to the minimum requirements of such laws or regulations. A provision of this Contract that is stricter than such laws or regulations will not be deemed a conflict. Applicable laws and regulations include, but are not limited to, the following laws as amended:

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

#### Title VI of the Civil Rights Act of 1964;

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

#### Age Discrimination Act of 1975;

#### Rehabilitation Act of 1973;

#### Budget Deficit Reduction Act of 2005;

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

#### Health Insurance Portability and Accountability Act (HIPAA);

#### American Recovery and Reinvestment Act (ARRA);

#### Patient Protection and Affordable Care Act (PPACA or ACA)

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

##### 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 will be reported to HCA, HHS, and the EPA.

##### 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.

#### Industrial Insurance – Title 51 RCW;

#### Reporting of abuse as required by RCW 26.44.030 and RCW 74.34;

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

#### EEO Provisions;

#### Copeland Anti-Kickback Act;

#### Davis-Bacon Act;

#### Byrd Anti-Lobbying Amendments;

#### All federal and state non-discrimination laws and regulations; and

#### Any other requirements associated with the receive of federal funds.

### While on the HCA premises, Contractor must comply with HCA operations and process standards and policies (e.g., ethics, Internet / email usage, data, network and building security, harassment, as applicable). HCA will make an electronic copy of all such policies available to Contractor.

### Failure to comply with any provisions of this section may result in Contract termination.

## Limitation of Authority

Only the HCA Authorized Representative has the express, implied, or apparent authority to alter, amend, modify, or waive any clause or condition of this Contract. Furthermore, any alteration, amendment, modification, or waiver or any clause or condition of this Contract is not effective or binding unless made in writing and signed by the HCA Authorized Representative.

## No Third-Party Beneficiaries

HCA and Contractor are the only parties to this contract. Nothing in this Contract gives or is intended to give any benefit of this Contract to any third parties.

## Non-Discrimination

During the performance of this Contract, the Contractor must comply with all federal and state non-discrimination laws, regulations and policies, including but not limited to: Title VII of the Civil Rights Act, 42 U.S.C. §12101 et seq.; the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §12101 et seq., 28 C.F.R. Part 35; and Title 49.60 RCW, Washington Law Against Discrimination. In the event of Contractor’s noncompliance or refusal to comply with any nondiscrimination law, regulation or policy, this Contract may be rescinded, canceled, or terminated in whole or in part under the Termination for Default sections, and Contractor may be declared ineligible for further contracts with HCA.

## Overpayments to Contractor

In the event that overpayments or erroneous payments have been made to the Contractor under this Contract, HCA will provide written notice to Contractor and Contractor will refund the full amount to HCA within thirty (30) calendar days of the notice. If Contractor fails to make timely refund, HCA may charge Contractor one percent (1%) per month on the amount due, until paid in full. If the Contractor disagrees with HCA’s actions under this section, then it may invoke the dispute resolution provisions of Section 4.13 *Disputes*.

## Pay Equity

### Contractor represents and warrants that, as required by Washington state law (Laws of 2017, Chap. 1, § 213), during the term of this Contract, it agrees to equality among its workers by ensuring similarly employed individuals are compensated as equals. For purposes of this provision, employees are similarly employed if (i) the individuals work for Contractor, (ii) the performance of the job requires comparable skill, effort, and responsibility, and (iii) the jobs are performed under similar working conditions.  Job titles alone are not determinative of whether employees are similarly employed.

### Contractor may allow differentials in compensation for its workers based in good faith on any of the following:  (i) a seniority system; (ii) a merit system; (iii) a system that measures earnings by quantity or quality of production; (iv) bona fide job-related factor(s); or (v) a bona fide regional difference in compensation levels.

### Bona fide job-related factor(s)” may include, but not be limited to, education,  training, or experience, that is: (i) consistent with business necessity; (ii) not based on or derived from a gender-based differential; and (iii) accounts for the entire differential.

### A “bona fide regional difference in compensation level” must be (i) consistent with business necessity; (ii) not based on or derived from a gender-based differential; and (iii) account for the entire differential.

### Notwithstanding any provision to the contrary, upon breach of warranty and Contractor’s failure to provide satisfactory evidence of compliance within thirty (30) Days of HCA’s request for such evidence, HCA may suspend or terminate this Contract.

## Publicity

### The award of this Contract to Contractor is not in any way an endorsement of Contractor or Contractor’s Services by HCA and must not be so construed by Contractor in any advertising or other publicity materials.

### Contractor agrees to submit to HCA, all advertising, sales promotion, and other publicity materials relating to this Contract or any Service furnished by Contractor in which HCA’s name is mentioned, language is used, or Internet links are provided from which the connection of HCA’s name with Contractor’s Services may, in HCA’s judgment, be inferred or implied. Contractor further agrees not to publish or use such advertising, marketing, sales promotion materials, publicity or the like through print, voice, the Web, and other communication media in existence or hereinafter developed without the express written consent of HCA prior to such use.

## Records and Document Review

### The Contractor must maintain books, records, documents, magnetic media, receipts, invoices or other evidence relating to this Contract and the performance of the services rendered, along with accounting procedures and practices, all of which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Contract. At no additional cost, these records, including materials generated under this Contract, are subject at all reasonable times to inspection, review, or audit by HCA, the Office of the State Auditor, and state and federal officials so authorized by law, rule, regulation, or agreement [See 42 USC 1396a(a)(27)(B); 42 USC 1396a(a)(37)(B); 42 USC 1396a(a)(42(A); 42 C.F.R. § 431, Subpart Q; and 42 C.F.R. § 447.202].

### The Contractor must retain such records for a period of six (6) years after the date of final payment under this Contract.

### If any litigation, claim or audit is started before the expiration of the six (6) year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved.

## Remedies Non-Exclusive

The remedies provided in this Contract are not exclusive, but are in addition to all other remedies available under law.

## Right of Inspection

The Contractor must provide right of access to its facilities to HCA, or any of its officers, or to any other authorized agent or official of the state of Washington or the federal government, at all reasonable times, in order to monitor and evaluate performance, compliance, and/or quality assurance under this Contract.

## Rights in Data/Ownership

### HCA and Contractor agree that all data and work products (collectively “Work Product”) produced pursuant to this Contract will be considered a *work for hire* under the U.S. Copyright Act, 17 U.S.C. §101 *et seq*, and will be owned by HCA. Contractor is hereby commissioned to create the Work Product. Work Product includes, but is not limited to, discoveries, formulae, ideas, improvements, inventions, methods, models, processes, techniques, findings, conclusions, recommendations, reports, designs, plans, diagrams, drawings, Software, databases, documents, pamphlets, advertisements, books, magazines, surveys, studies, computer programs, films, tapes, and/or sound reproductions, to the extent provided by law. Ownership includes the right to copyright, patent, register and the ability to transfer these rights and all information used to formulate such Work Product.

### If for any reason the Work Product would not be considered a *work for hire* under applicable law, Contractor assigns and transfers to HCA, the entire right, title and interest in and to all rights in the Work Product and any registrations and copyright applications relating thereto and any renewals and extensions thereof.

### Contractor will execute all documents and perform such other proper acts as HCA may deem necessary to secure for HCA the rights pursuant to this section.

### Contractor will not use or in any manner disseminate any Work Product to any third party, or represent in any way Contractor ownership of any Work Product, without the prior written permission of HCA. Contractor will take all reasonable steps necessary to ensure that its agents, employees, or Subcontractors will not copy or disclose, transmit or perform any Work Product or any portion thereof, in any form, to any third party.

### Material that is delivered under this Contract, but that does not originate therefrom (“Preexisting Material”), must be transferred to HCA with a nonexclusive, royalty-free, irrevocable license to publish, translate, reproduce, deliver, perform, display, and dispose of such Preexisting Material, and to authorize others to do so. Contractor agrees to obtain, at its own expense, express written consent of the copyright holder for the inclusion of Preexisting Material. HCA will have the right to modify or remove any restrictive markings placed upon the Preexisting Material by Contractor.

### Contractor must identify all Preexisting Material when it is delivered under this Contract and must advise HCA of any and all known or potential infringements of publicity, privacy or of intellectual property affecting any Preexisting Material at the time of delivery of such Preexisting Material. Contractor must provide HCA with prompt written notice of each notice or claim of copyright infringement or infringement of other intellectual property right worldwide received by Contractor with respect to any Preexisting Material delivered under this Contract.

## Rights of State and Federal Governments

In accordance with 45 C.F.R. § 95.617, all appropriate state and federal agencies, including but not limited to the Centers for Medicare and Medicaid Services (CMS), will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use for Federal Government purposes: (i) software, modifications, and documentation designed, developed or installed with Federal Financial Participation (FFP) under 45 C.F.R. Part 95, subpart F; (ii) the Custom Software and modifications of the Custom Software, and associated Documentation designed, developed, or installed with FFP under this Contract; (iii) the copyright in any work developed under this Contract; and (iv) any rights of copyright to which Contractor purchases ownership under this Contract.

## Severability

If any provision of this Contract or the application thereof to any person(s) or circumstances is held invalid, such invalidity will not affect the other provisions or applications of this Contract that can be given effect without the invalid provision, and to this end the provisions or application of this Contract are declared severable.

## Site Security

While on HCA premises, Contractor, its agents, employees, or Subcontractors must conform in all respects with physical, fire or other security policies or regulations. Failure to comply with these regulations may be grounds for revoking or suspending security access to these facilities. HCA reserves the right and authority to immediately revoke security access to Contractor staff for any real or threatened breach of this provision. Upon reassignment or termination of any Contractor staff, Contractor agrees to promptly notify HCA.

## Subcontracting

### Neither Contractor, nor any Subcontractors, may enter into subcontracts for any of the work contemplated under this Contract without prior written approval of HCA. HCA has sole discretion to determine whether or not to approve any such subcontract. In no event will the existence of the subcontract operate to release or reduce the liability of Contractor to HCA for any breach in the performance of Contractor’s duties.

### Contractor is responsible for ensuring that all terms, conditions, assurances and certifications set forth in this Contract are included in any subcontracts.

### If at any time during the progress of the work HCA determines in its sole judgment that any Subcontractor is incompetent or undesirable, HCA will notify Contractor, and Contractor must take immediate steps to terminate the Subcontractor's involvement in the work.

### The rejection or approval by the HCA of any Subcontractor or the termination of a Subcontractor will not relieve Contractor of any of its responsibilities under the Contract, nor be the basis for additional charges to HCA.

### HCA has no contractual obligations to any Subcontractor or vendor under contract to the Contractor. Contractor is fully responsible for all contractual obligations, financial or otherwise, to its Subcontractors.

## Survival

The terms and conditions contained in this Contract that, by their sense and context, are intended to survive the completion, cancellation, termination, or expiration of the Contract will survive. In addition, the terms of the sections titled *Confidential Information Protection, Confidential Information Breach – Required Notification, Contractor’s Proprietary Information, Disputes, Overpayments to Contractor, Publicity, Records and Documents Review, Rights in Data/Ownership, and Rights of State and Federal Governments* will survive the termination of this Contract. The right of HCA to recover any overpayments will also survive the termination of this Contract.

## Taxes

HCA will pay sales or use taxes, if any, imposed on the services acquired hereunder. Contractor must pay all other taxes including, but not limited to, Washington Business and Occupation Tax, other taxes based on Contractor’s income or gross receipts, or personal property taxes levied or assessed on Contractor’s personal property. HCA, as an agency of Washington State government, is exempt from property tax.

Contractor must complete registration with the Washington State Department of Revenue and be responsible for payment of all taxes due on payments made under this Contract.

## Termination

### Termination for Default

In the event HCA determines that Contractor has failed to comply with the terms and conditions of this Contract, HCA has the right to suspend or terminate this Contract. HCA will notify Contractor in writing of the need to take corrective action. If corrective action is not taken within five (5) Business Days, or other time period agreed to in writing by both parties, the Contract may be terminated. HCA reserves the right to suspend all or part of the Contract, withhold further payments, or prohibit Contractor from incurring additional obligations of funds during investigation of the alleged compliance breach and pending corrective action by Contractor or a decision by HCA to terminate the Contract.

In the event of termination for default, Contractor will be liable for damages as authorized by law including, but not limited to, any cost difference between the original Contract and the replacement or cover Contract and all administrative costs directly related to the replacement Contract, e.g., cost of the competitive bidding, mailing, advertising, and staff time.

If it is determined that Contractor: (i) was not in default, or (ii) its failure to perform was outside of its control, fault or negligence, the termination will be deemed a “Termination for Convenience.”

### Termination for Convenience

When, at HCA’s sole discretion, it is in the best interest of the State, HCA may terminate this Contract in whole or in part by providing ten (10) calendar days’ written notice. If this Contract is so terminated, HCA will be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination. No penalty will accrue to HCA in the event the termination option in this section is exercised.

### Termination for Non-Allocation of Funds

If funds are not allocated to continue this Contract in any future period, HCA may immediately terminate this Contract by providing written notice to the Contractor. The termination will be effective on the date specified in the termination notice. HCA will be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination. HCA agrees to notify Contractor of such nonallocation at the earliest possible time. No penalty will accrue to HCA in the event the termination option in this section is exercised.

### Termination for Withdrawal of Authority

In the event that the authority of HCA to perform any of its duties is withdrawn, reduced, or limited in any way after the commencement of this Contract and prior to normal completion, HCA may immediately terminate this Contract by providing written notice to the Contractor. The termination will be effective on the date specified in the termination notice. HCA will be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination. HCA agrees to notify Contractor of such withdrawal of authority at the earliest possible time. No penalty will accrue to HCA in the event the termination option in this section is exercised.

### Termination for Conflict of Interest

HCA may terminate this Contract by written notice to the Contractor if HCA determines, after due notice and examination, that there is a violation of the Ethics in Public Service Act, Chapter 42.52 RCW, or any other laws regarding ethics in public acquisitions and procurement and performance of contracts. In the event this Contract is so terminated, HCA will be entitled to pursue the same remedies against the Contractor as it could pursue in the event Contractor breaches the contract.

## Termination Procedures

### Upon termination of this Contract, HCA, in addition to any other rights provided in this Contract, may require Contractor to deliver to HCA any property specifically produced or acquired for the performance of such part of this Contract as has been terminated.

### HCA will pay Contractor the agreed-upon price, if separately stated, for completed work and services accepted by HCA and the amount agreed upon by the Contractor and HCA for (i) completed work and services for which no separate price is stated; (ii) partially completed work and services; (iii) other property or services that are accepted by HCA; and (iv) the protection and preservation of property, unless the termination is for default, in which case HCA will determine the extent of the liability. Failure to agree with such determination will be a dispute within the meaning of Section 4.13 *Disputes*. HCA may withhold from any amounts due the Contractor such sum as HCA determines to be necessary to protect HCA against potential loss or liability.

### After receipt of notice of termination, and except as otherwise directed by HCA, Contractor must:

#### Stop work under the Contract on the date of, and to the extent specified in, the notice;

#### Place no further orders or subcontracts for materials, services, or facilities except as may be necessary for completion of such portion of the work under the Contract that is not terminated;

#### Assign to HCA, in the manner, at the times, and to the extent directed by HCA, all the rights, title, and interest of the Contractor under the orders and subcontracts so terminated; in which case HCA has the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;

#### Settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, with the approval or ratification of HCA to the extent HCA may require, which approval or ratification will be final for all the purposes of this clause;

#### Transfer title to and deliver as directed by HCA any property required to be furnished to HCA;

#### Complete performance of any part of the work that was not terminated by HCA; and

#### Take such action as may be necessary, or as HCA may direct, for the protection and preservation of the records related to this Contract that are in the possession of the Contractor and in which HCA has or may acquire an interest.

## Waiver

Waiver of any breach of any term or condition of this Contract will not be deemed a waiver of any prior or subsequent breach or default. No term or condition of this Contract will be held to be waived, modified, or deleted except by a written instrument signed by the parties. Only the HCA Authorized Representative has the authority to waive any term or condition of this Contract on behalf of HCA.

## Warranties

### Contractor represents and warrants that it will perform all services pursuant to this Contract in a professional manner and with high quality and will immediately re-perform any services that are not in compliance with this representation and warranty at no cost to HCA.

### Contractor represents and warrants that it will comply with all applicable local, State, and federal licensing, accreditation and registration requirements and standards necessary in the performance of the Services.

### Any written commitment by Contractor within the scope of this Contract will be binding upon Contractor. Failure of Contractor to fulfill such a commitment may constitute breach and will render Contractor liable for damages under the terms of this Contract. For purposes of this section, a commitment by Contractor includes: (i) Prices, discounts, and options committed to remain in force over a specified period of time; and (ii) any warranty or representation made by Contractor to HCA or contained in any Contractor publications, or descriptions of services in written or other communication medium, used to influence HCA to enter into this Contract.

Schedule A

**Statement of Work**

1. Definitions
	1. “Accountable Communites of Health” or “ACH” means regionally governed, public-private collaborative or structure tailored by the region to align actions and initiatives of a diverse coalition of players in order to achieve healthy communities and populations. For the purposes of this Contract, ACH is interchangeable with the term Communities of Health or COH.
	2. “Apple Health – Managed Care” or “AHMC” means the overarching umbrella term for the HCA Apple Health Managed Care program. The term is also used to reflect a subpopulation of Managed Care enrollee, i.e., Temporary Assistance for Needy Families (TANF) and TANF eligibles, Blind and Disabled, and Patient Protection and Affordable Care Act (PPACA) expansion population.
	3. “Blind and Disabled” or “B/D” means a Washington Apple Health program serving individuals who are blind and disabled, including those seeking disability determinations.
	4. “CAHPS® Database” (previously known as National CAHPS® Benchmarking Database or NCBD) means a national repository for data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The database facilitates comparisons of CAHPS® survey results by survey sponsors. Data is compiled into a single national database, which enables NCBD participants to compare their own results to relevant benchmarks (i.e., reference points such as national and regional averages). The NCBD also offers an important source of primary data for specialized research related to consumer assessments of quality as measured by CAHPS®.
	5. “Centers for Medicare and Medicaid Services” or “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 State Children’s Health Insurance Program (SCHIP), and health insurance portability standards.
	6. “Children’s Health Insurance Program” or “CHIP” means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children’s Health Insurance Program Reauthorization Act of 2009, RCW 74.09.470 and WAC 388-505.
	7. “Communities of Health” or “COH” means a term used by the Washington State Legislature in Chapter 223, Laws of 2014 (E2SHB 2572) and is interchangeable with Accountable Communities of Health.
	8. “Consumer Assessment of Healthcare Providers and Systems” or “CAHPS®” means a suite of commercial and Apple Health standardized survey instruments used to measure client experience of health care.
	9. “Enrollee” means an individual who is enrolled in managed care through a Managed Care Organization having a contract with HCA (42 C.F.R. § 438.10(a)).
	10. “External Stakeholder Report” means an annual, technical report synthesizing data from all managed care quality oversight activities which includes conclusions regarding the quality, timeliness and access to care furnished by the MCO or PIHP to Medicaid eligibles enrolled in state managed care arrangements.
	11. “External Quality Review” or “EQR” means the review and evaluation by an External Quality Review Organization of information on quality, timeliness, and access to the health care and services that a Managed Care Organization (MCO) or their contractor(s) furnish to Apple Health recipients.
	12. “External Quality Review Organization” or “EQRO” means an organization that meets the competence and independence requirements set forth in 42 C.F.R. §§ 438.354(c), 438.356(d), and 438.310(c)(2), and performs external quality review and other EQR-related activities as set forth in 42 C.F.R. § 438.358, or both (42 C.F.R. § 438.320).
	13. “External Quality Review Protocols” means a series of nine (9) procedures or rules to monitor, measure, and document information on quality, timeliness, and access to the health care and services that an MCO or their contractors furnish to Apple Health recipients.
	14. “Fee-for-Service” or “FFS” means a health care delivery program whereby Washington Apple Health clients are served by health care providers reimbursed on a per service or point of service basis.
	15. “Fully Integrated Managed Care” or “FIMC” or “Apple Health Integrated Managed Care” or “AH-IMC” means a managed care program that coordinates physical health, mental health, and substance use disorder treatment services to help provide whole-person care unde one health plan. The program includes a subpopulation of Managed Care enrollees, including Temporary Asssistance for Needy Families (TANF) and TANF-eligibles, Blind and Disabled, CHIP, BHSO, and Patient Protection and Affordable Care Act (PPACA) expansion population.
	16. “Health Benefit Exchange” or “HBE” means a quasi-governmental Washington agency where an individual or small business can compare the costs of various health plans and different types of health coverage benefits.
	17. “Healthcare Effectiveness Data and Information Set” or “HEDIS®” means a set of standardized Performance Measures designed to ensure that health care purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS® also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS® is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).
	18. “HEDIS® Compliance Audit Program” means a set of standards and audit methods conducted by a NCQA licensed organization used by a certified HEDIS® compliance auditor to evaluate information systems capabilities assessment and a Contractor's ability to comply with HEDIS® specifications.
	19. “HEDIS® Record of Administration, Data, Management, and Processes” or “HEDIS® Roadmap” means a required component of the NCQA HEDIS Compliance Audit Process. The HEDIS Roadmap collects information about MCO information management systems and practices and provides HEDIS Compliance Auditors with preliminary information needed to conduct the HEDIS Compliance Audit.
	20. “Healthplanfinder” or “HPF” means the official ACA-compliant Health Benefit Exchange on-line marketplace where a Washington citizen can shop for free and low-cost health plans.
	21. “Integrated Foster Care” or “IFC” or Apple Health Integrated Foster Care” or AH-IFC” means a managed care program developed specifically to meet the needs of children and youth in foster care and adoption support programs, and former foster children between the ages of 18 and 26 who are eligible for physical health, mental health, and substance use disorder treatment services to help provide whole-person care under one health plan.
	22. “Managed Care” means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services.
	23. “Managed Care Organization” or “MCO” means an organization having a certificate of authority or certificate of registration from the State of Washington Office of the Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA enrollees under Washington Apple Health.
	24. “Mixed Mode Methodology” means a survey process where multiple methods are used to contact and survey respondents. Methods may include use of mail, phone or email to make contact with survey respondents to complete the intended survey.
	25. “National CAHPS® Benchmarking Database” or “NCBD” means a national repository for data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The database facilitates comparisons of CAHPS® survey results by survey sponsors. Data is compiled into a single national database, which enables NCBD participants to compare their own results to relevant benchmarks (i.e., reference points such as national and regional averages). The NCBD also offers an important source of primary data for specialized research related to consumer assessments of quality as measured by CAHPS®.
	26. “National Committee for Quality Assurance” or “NCQA” means a private 501(c)(3) not-for-profit dedicated to improving health care quality. NCQA develops health care measures that assess the quality of care and services that commercial and Apple Health Managed Care clients receive.
	27. “NCQA Quality Compass Report” means a report produced annually by NCQA which provides MCO-specific and national averages for HEDIS® measures and benchmark data for the Apple Health program.
	28. “Patient Protection and Affordable Care Act” or “PPACA” or “ACA” means the Public Laws 111-148 and 111-152 (both enacted in March 2010).
	29. “Performance Improvement Project” or “PIP” means the activities conducted by Managed Care Organizations designed to improve the quality of care or services received by Apple Health Managed Care recipients.
	30. “Performance Measures” means the measures of the quality, timeliness, and access of care provided by Managed Care Organizations or Prepaid Inpatient Health Plans.
	31. “Prepaid Inpatient Health Plan” or “PIHP” means an entity that—(1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates. (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract (42 C.F.R. § 438.2). The BHSO services contracted to the MCOs are classified as PIHP.
	32. “Quality” means the degree to which a Managed Care Organization or Prepaid Inpatient Health Plan 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.
	33. “Quality Strategy” means a written document that describes methods HCA uses to assess and improve the quality of Managed Care services offered by all Managed Care Organizations.
	34. “Statistical Analysis Software” or “SAS File” or “SAS” means a file extension for an ASCII file used with Statistical Analysis Software. SAS files contain the source code for a program or sub-program used for data modeling and analysis. SAS files can be opened by Statistical Analysis Software.
	35. “TEAMoniter” or “TM” means an interagency team of reviewers responsible for monitoring Managed Care plans’ compliance with standards for healthcare quality management, provider access and availability, credentialing, utilization management, enrollee grievances and appeals, contractual requirements, and applicable state and federal laws. TEAMonitor conducts the monitoring review required in 438.358(b)(3) yearly, with an every three (3) year comprehensive assessment for the Apple Health Managed Care MCOs. Additionally, TM staff conduct yearly performance improvement project reviews as described in 438.358(b)(1).
	36. “Validation” means the review of information, data, and procedures to determine the extent to which they are accurate, reliable and free from bias and in accord with standards for data collection and analysis.
	37. “Washington Apple Health” or “Apple Health” or “AH” means a title that expresses the rebranding name of the Washington State Medicaid program.
	38. “Washington Apple Health – Health Home” means an entity composed of community-based providers, qualified by the state to provide Health Home Services to Medicaid enrollees. The entity is responsible for coordinating and integrating care across the continuum of services needed and used by eligible enrollees. A Qualified Health Home includes providers from the local community that authorize Medicaid, state or federally funded behavioral health, long term services and supports, and primary and acute services.
	39. “Washington Apple Health Primary Care Case Management” or “PCCM” means a managed care program provided through tribal clinics and urban Indian centers. The State consults with American Indian/Alaska native tribal organizations and clinics on all program aspects, including the Department of social and Health Services’ Indian Policy Advisory Committee (IPAC) and the American Indian Health Commission (AIHC).
	40. Wraparound with Intensive Services (WISe) means intensive mental health services and supports, provided in home and community settings, for Medicaid eligible individuals, up to 21 years of age, with complex behavioral health needs and their families. WISe provides behavioral health services and supports in home and community setttings, care coordination, 24/7 crisis and stabilization interventions and peer support, which are all required components of the delivery model. The goal of WISe is for youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements while receiving behavioral health treatment services.
2. Statement of Work
	1. The Contractor will provide the services and staff and otherwise do all things necessary and incidental to the performance of work as set forth in the deliverables and tasks described in this Contract.
		1. The Contractor will notify HCA of independence as required and defined by 42 C.F.R. § 438.354 prior to engaging in external review activities for any newly contracted MCOs, PIHPs, PAHPs, or PCCM entities during this Contract.
	2. Any corrective actions, or other steps taken, related to discrepancies that are identified as a result of findings under the terms of this Contract are the responsibility of HCA.
	3. In completing deliverables the Contractor must comply with all applicable sections of 42 C.F.R. § 438.358.
	4. Requirements
		1. External Quality Review Annual Technical Report (§ 438.364):
			1. Annually produce an External Stakeholder Report describing the manner in which data from all activities conducted in accord with 42 C.F.R. § 438.358 are collected and aggregated. Data related to the quality, timeliness, and access to care furnished by Medicaid managed care will be analyzed and synthesized into an annual report.
			2. The Technical Report shall address all contracted Medicaid managed care entities, as required by C.F.R. Five MCOs meet the C.F.R. requirements to include in the Annual Technical Report, contracted with the AH-IMC and one of the MCOs is also contracted as the single AH-IFC contractor. The BHSO enrollees are included within the Technical Report as PIHP-contracted services. Any future managed care entities contracted with HCA, which meet the C.F.R. requirement for inclusion are assumed to be included within this deliverable.
			3. The Technical Report will be written in accord with 42 C.F.R. § 438.364, External Quality Review Results. This report must information as specified by C.F.R, including EQRO-contracted findings, TEAMonitor compliance review, and PIP validation activities conducted by the HCA. HCA will provide annual TEAMonitor reports with findings from HCA compliance monitoring and PIP validation activities.
			4. The report shall be produced annually by December 15th and include the following:
				1. An assessment of each MCO’s strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Apple Health recipients;
				2. Recommendations for improving the quality of health care services furnished by each MCO;
				3. Methodologically comparative information about all MCOs; and
				4. An assessment of quality of data collected and recommendations regarding improving data collection and usability to improve performance improvement both for the state and MCOs.
			5. Submit for approval an external quality review report project plan to HCA by the last business day of March annually.
				1. The project plan must address any data collection required from sources outside the Contractor to support the activities to be incorporated within the report.
				2. Meet with HCA to verify purpose of the report, target audience, scope, objectives, deliverable requirements, review and approval requirements, and deadlines.
			6. Design and draft a report template, for HCA’s review and approval, due by the last business day of August annually.
				1. Meet with HCA to present and receive approval from HCA for the provisional report design.
				2. Include a section of an introduction by HCA to address changes within the Medicaid managed care program structure and initiatives.
				3. Review literature/best practices from other state Medicaid agencies and include any Centers for Medicare and Medicaid Services (CMS) feedback in the production of the EQR report.
			7. Write a draft report and submit electronically to HCA by November 15th annually for review and comment. Review preliminary analysis and findings with HCA.
				1. Develop an analysis plan including selection of appropriate statistics, adjustments and weighting protocols.
				2. Design analytic and reporting tables and databases and develop a detailed data management plan and timeline.
				3. Extract and compile data from additional resources.
				4. Analyze and interpret data from data sources.
				5. Perform statistical analysis, tabulate data, validate, standardize, format and analyze data, develop key observations, conclusions and recommendations.
			8. Submit final PDF and Word versions of the report to HCA, due by December 15th annually.
				1. The Contractor shall follow PDF web usability guidelines as published by Adobe.
				2. Send final report to HCA and each MCO electronically and send one (1) hard copy to each MCO and five (5) hard copies to HCA.
				3. The annual December payment shall be issued after completion of the Technical Report and upon HCA’s acceptance of this deliverable.
		2. Performance Measure Comparative Analysis (42 C.F.R. § 438.364)
			1. Produce the Performance Measure Comparative Analysis Report with regional analysis. Conduct analyses of MCO performance measures including comparisons amongst the MCOs, comparisons with a calculated MCO state average, and state or national benchmarks, such as NCQA ninetieth (90th) percentile for Medicaid managed care organizations; and produce charts and tables displaying the data.
			2. Measure analysis shall address the following:
				1. Comparisons amongst the MCOs past and present performance,
				2. Comparison to Washington State peer MCOs,
				3. The state average, and
				4. National Medicaid all plan HEDIS® performance or other benchmark if there is regional or national benchmark data by which to compare performance as permitted by the NCQA licensing agreement for Medicaid managed care organizations.
				5. Comparison between Medicaid eligibility programs (e.g., Blind/Disabled and CHIP). The HCA will provide the matrix that maps eligibility categories, called “Recipient Aid Category (RAC)”, to Medicaid programs; the Contractor shall map the Member Level Data (MLD) enrollee RACs to program for this comparison.
				6. Analysis of regional variations. Performance measure data will be analyzed regionally to identify differences in regional performance across all MCOs using HCA Regional Service Area (RSA) geographic boundaries. The Report narrative shall include recommendations regarding specific RSAs when data indicates a significant regional disparity.
				7. Analysis of variation by race, ethnicity, and language to identify statistically significant disparity. Narrative will include recommendations regarding racial/ethnic/language break-out when data supports specific intervention to address health equity.
			3. Tables and charts shall include plan-to-plan comparison, plan-to-state all MCO average, and MCO to national or regional MCO benchmarks all depicted in graphs and charts. An Appendix B containing all data must be part of the Comparative Analysis Report.
			4. Any narrative accompanying charts and graphs shall be based on the most current, peer-reviewed literature and national and regional trends for Medicaid enrollees.
			5. Submit performance measure comparative analysis project plan, due by last business day of March annually.
				1. Meet with HCA to verify purpose of the report, target audience, scope, objectives, deliverable requirements, review and approval requirements, and deadlines.
			6. Design and submit for HCA approval chart and table formats for displaying HEDIS® and non-HEDIS data, due April 15th annually.
			7. Design and draft a report template for HCA’s review and approval. Due the last business day of August, annually.
			8. Write a draft report and submit electronically to HCA by the 1st Friday of November annually for review and comment. Meet with HCA to present preliminary analysis and findings and receive approval from HCA for the provisional report design.
				1. Review literature/best practices from other state Medicaid agencies and include any Centers for Medicare and Medicaid Services (CMS) feedback in the production of the report.
				2. Using both summed and raw data from the MCOs, analyze and interpret the data according to the analysis plan.
				3. Develop an analysis plan including selection of appropriate statistics, adjustments and weighting protocols.
				4. Design analytic and reporting tables and databases and develop a detailed data management plan and timeline.
				5. Extract and compile data from external resources, such as up to four non-HEDIS measures as requested by HCA.
				6. Analyze and interpret data from data sources. Group the measures into appropriate composite measures across domains with analyses.
				7. Perform statistical analysis of plan-specific and comparative plan (plan to plan and year to year), tabulate data, validate, standardize, format and analyze data, develop key observations, conclusions and recommendations.
				8. Narrative to include: Executive summary; Methodology used to conduct the analyses; Interpretation of results and analyses; and Recommendations.
			9. Submit final PDF and Word versions of the report to HCA, due by the 1st Friday of December annually. Send final report to HCA and each MCO electronically and five (5) hard copies to HCA.
		3. Enrollee Quality Report
			1. Produce annual enrollee quality report (informally termed the Star Report) showing MCO performance using a star rating system on a subset of Performance Measures and consumer survey data. This report will be displayed to Apple Health recipients on the Washington State Health Benefit Exchange (HBE) website, Healthplanfinder (HPF) to support selection of MCO for enrollment.
			2. Submit an annual enrollee quality report methodology design and template for HCA approval, due the last business day in April annually.
				1. Meet with HCA to verify purpose of the report, target audience, scope, objectives, deliverable requirements, review and approval requirements, and deadlines.
				2. HCA will select the measures presented.
				3. CAHPS data will be included based on availability, alternating Child with Chronic Conditions and Adult surveys conducted by the MCOs according to the HCA/MCO AH-IMC Contract.
			3. Submit a draft Enrollee Quality Report and separate, corresponding methology narrative document to HCA by the 3rd Friday in August annually for review and comment.
			4. The final Enrollee Quality Report report and separate, corresponding methology narrative document will be submitted electronically to HCA annually, due by the 2nd Friday in September.
		4. Validation of Performance Measures (42 C.F.R. § 438.358(b)(2)).
			1. Annually validate MCO performance measures and methods used to collect Healthcare Effectiveness Data and Information Set (HEDIS®) and non-HEDIS Performance Measures. Work shall align with the Centers for Medicare and Medicaid Services (CMS) Validating Performance Measures protocol. The External Quality Review Protocols can be found at Quality of Care External Quality Review | Medicaid.gov: (<https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>).
			2. Healthcare Effectiveness Data and Information Set (HEDIS®) Performance Measure Validation
				1. Annually validate MCO performance measures and methods used to collect Healthcare Effectiveness Data and Information Set (HEDIS®). The validation process will be accomplished through methods described in the most recent version of the National Committee for Quality Assurance (NCQA) HEDIS® Compliance Audit™. Specifications shall be complemented by the Centers for Medicare and Medicaid Services (CMS) Validating Performance Measures.

A HEDIS® audit will be conducted annually. All Apple Health MCOs are subject to these requirements, which are inclusive of ACA Adults, TANF/Apple Health, Blind/Disabled, CHIP, and AH-IFC populations.

If an MCO is required to produce both HEDIS® and non-HEDIS Performance Measures, methods combining both the NCQA and CMS auditing approaches will be employed so as to reduce MCO burden and meet the specifications required in regulation.

All contracted MCOs will be required to submit Performance Measures according to NCQA specifications for reporting, unless otherwise defined by Apple Health Contracts.

All MCOs will be subject to an annual, full HEDIS® audit.

For the single MCO (Coordinated Care of Washington, Inc.) contracted for both AH-IMC and AH-IFC, both populations (AH-IFC and AH-IMC) will be included within the annual, full HEDIS® audit.

Children enrolled in the CHIP program are not subject to separate performance measure requirements, as this population is included within the HEDIS® audit.

A copy of the list of performance measures required in each contract is found in Attachments 4, July 2019 Apple Health – Integrated Managed Care Model Contract, and 5, July 2019 Apple Health – Integrated Foster Care Model Contract, Section 7, and the contracts’ Attachment 2.

The audit meets the C.F.R. requirements for compliance monitoring of Health Information Systems (42 C.F.R. § 438.242).

Annual verification of MCO methods used to collect Healthcare Effectiveness Data and Information Set (HEDIS®) and non-HEDIS Performance Measures. The validation process will be accomplished through methods described in the most recent version of the National Committee for Quality Assurance (NCQA) HEDIS® Compliance Audit™. Specifications and shall be complemented by the Centers for Medicare and Medicaid Services (CMS) Validating Performance Measures Reported by the CMS EQR Protocol 2 (https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html). The protocol can be found at Quality of Care External Quality Review (EQR) | Medicaid.gov.

The audit will be conducted annually. AHMC (inclusive of ACA Adults, TANF, B/D and CHIP populations), FIMC, and IFC MCOs are subject to these requirements. If an MCO is required to produce both HEDIS® and non-HEDIS Performance Measures, methods combining both the NCQA and CMS auditing approaches will be employed so as to reduce MCO burden and meet the specifications required in regulation.

* + - * 1. Conduct an all MCO audit kick-off webinar to allow the MCOs to ask questions they have about the HEDIS® Compliance Audit™. Conduct additional webinars for each MCO to explain audit processes, all participating parties’ roles and responsibilities and work on each MCO draft audit work plan. Due by the last business day of January for the first year of the contract and then due by December 15, 2020 and annually by December 15th thereafter to address the upcoming contracted HEDIS season.
				2. Schedule and hold conference calls or webinars with MCOs whenever necessary to share changes and/or updates to the NCQA HEDIS® performance measures and NCQA HEDIS® audit program rules.
				3. Develop and maintain website project management reports so the Contractor’s management system is transparent to MCO and HCA.
				4. Throughout the audit process, the Contractor shall notify each MCO of all findings that impact the HEDIS® measures, reportable within two (2) business days of detection with recommended corrective actions. A worksheet detailing identified issues with recommended corrective action shall be submitted to HCA monthly throughout the audit season, which begins in January and ends in June of each year.
				5. Prepare a request for documentation from each MCO that includes the HEDIS® Roadmap, validation of sample frame, and the plan for an MCO site visit. The Contractor shall be available to each MCO to answer any questions or concerns regarding the development of the HEDIS® Roadmap. Due date must support MCO submission of Roadmap on NCQA timeline; Due by the last business day of January for the first year of the contract and then due by December 15, 2020 and annually by December 15th thereafter to address the upcoming contracted HEDIS season.
				6. Review each MCO’s completed assessment tool and assess the data systems that feed into collection and reporting of performance measures including: membership data, provider data, medical record review processes, claims/encounter data, vendor data and data integration process. Following the HEDIS® Roadmap review, the Contractor shall identify, in a Roadmap review report, any outstanding issues or concerns in advance of the site visit. January - February: annually.
				7. The Contractor will review each MCO’s CAHPS® source code and CAHPS sample frame for accuracy and completeness. The Contractor will ensure that the MCO has obtained NCQA approval on all supplemental questions for the CAHPS® survey via the MCO’s certified HEDIS® CAHPS® vendors. January 2020 and thereafter December-January annually .
				8. The Contractor will review each MCO’s preliminary HEDIS® rates and compare the MCO rates to national Medicaid reporting benchmarks as well as Washington state Medicaid reporting benchmarks. This activity shall assess data completeness and accuracy early in the audit process. The Contractor will record and discuss with the MCOs any significant rate variations and assist with corrective actions.
				9. Conduct on-site compliance audits with each MCO and HCA staff, including all of the following:

Review of data management processes;

Evaluation of algorithmic compliance focusing on claims and encounter data processing, membership and provider data, numerator and denominator identification, sampling and algorithmic compliance; and

Primary source verification including:

Live demonstration of the claims and encounter processing systems and procedures;

Review of provider files and enrollment eligibility processing system data extraction from systems used to house production files and generate reports; and

A discussion with MCO staff of the source code review component of the audit. February-April: annually.

* + - * 1. Conduct post on-site activities to include: production of an initial written report identifying any perceived issues of noncompliance, problematic measures and recommended opportunities for improvement and submit to HCA within 10 business days of on-site visit. The initial report shall include results of the documentation review, the site visit, the specifications, and the source code review. March – May: annually.
				2. Early in the MCO’s medical record review process, the Contractor will review a small number of processed medical records to uncover potential problems that may require corrective action. The Contractor will select up to ten (10) hybrid measures that may be difficult to review because of complex logic or system problems. For these measures, the Contractor will get copies of at least two (2) completed medical record review tools and medical charts that qualify as positive numerator events or exclusions. The Contractor may request copies of negative events, exclusions or additional positive records based on findings from the Roadmap or other process reviews.

The Contractor will compare the completed tools with the medical records to determine if the organization correctly identified the numerator or exclusion events. The MCO can correct any systemic problems in its Medical Record Review (MRR) process before proceeding with additional reviews. Convenience samples may be waived if three (3) criteria are met: (1) MCO participated in a HEDIS® audit in the prior year and passed the medical record review validation portion; (2) MCO’s current MRR process has not changed significantly from the prior year (e.g., medical record review team qualifications, training, documentation, abstraction forms and quality control processes are similar); (3) MCO does not report hybrid measures that the Contractor determines to be at risk of inaccurate reporting.

* + - * 1. Review the current version of the HEDIS® Hybrid Medical Record Review Abstraction Forms and come to an agreement if any issues or disagreement occurs prior to or during the on-site visits. Discuss the MCO’s progress in completing medical record reviews.
				2. Over-read the MCO’s abstracted medical record review data. The Contractor will:

Conduct medical record review validation to include review of supervisor and staff qualifications for medical record reviews, training of reviewers, medical record abstraction tools, and quality assurance testing of review results.

Select one (1) measure from each NCQA Specified Medical Review Measure Group, and all exclusions for the exclusions group, that applies to the MCO. The selection should be based on new or revised measures, complex measures, or low rates in previous years. The MCO may not select the measures. By the NCQA-designated date in May of each year, the MCO sends the Contractor a list of all numerator-positive members for each selected measure, and all hybrid exclusions for all measures. If the MCO completes the medical record review process early, it may submit measures for validation with the understanding that no additional medical records hits will be accepted.

The Contractor will pick a random sample of sixteen (16) records from each numerator-positive member list, for each selected measure and from the exclusions group, and informs the MCO, which sends the charts for review. If there are fewer than sixteen (16) numerator-positive charts for the measure, the Contractor will expand the sample by including other products, counties, or regions. If expanding the sample is not an option, the Contractor will review all charts available for the measure. If a record is not available for the Contractor’s review, it is considered an error.

The Contractor may select a seventeenth (17th) chart only if a provider refuses to provide a chart from the original list of sixteen (16) records. The Contractor must show evidence of provider refusal before using the seventeenth (17th) chart. Refusal may be explicit or implicit (e.g., the provider did not respond to the Contractor’s attempts at contact). The Contractor will review the records for adherence to the HEDIS® specifications and rejects the charts that do not pass review. The Contractor will look for critical errors that change the member’s numerator compliance (e.g., from positive to negative).

At the Contractor’s discretion, noncritical errors may be allowed, such as a misidentified date that does not change member compliance. If no charts fail, the measure and the measure group will pass the process.

If errors are detected, the following rules apply:

Measures with one (1) error: Measures with one (1) error do not pass the validation process, and the corresponding measure group is considered at risk for Not Reportable (NR) audit results. The Contractor is required to document the investigation of the error type and whether it could affect other measures in the group;

Error in the original sample: If only one (1) error is found in the original medical record review validation sample, the Contractor must retest using a different, randomly selected sixteen (16) record sample that does not include the original sampled records. Pulling another sample may require using records from another product line, county, region and so on;

If the second sample is free of errors, the measure and measure group pass;

If there are one (1) or more errors in the second sample, the measure and measure group do not pass and cannot be reported until all errors are corrected and reviewed by the Contractor; and

Two (2) or more errors in the original sample: If there are two (2) or more errors in the original sample, the Contractor does not perform additional testing because the likelihood of the second sample failing is high. The measure and measure group do not pass until the plan corrects all errors and the Contractor approves the charts.

All applicable NCQA confidentiality and HIPAA guidelines shall be followed in its review of the medical records, onsite materials, claims/encounters, enrollment data, provider data, vendor data and supplemental data. January-December: annually.

* + - * 1. The Contractor shall provide an electronic report of the final audit findings to both the MCO and HCA by July 15, annually marking the conclusion of the review. The report shall build upon the earlier report of preliminary findings and include:

Updated text and findings based on comments to the initial report, including but not limited to recommendations to the MCO regarding improvement methodologies;

Results of any corrected programming logic, including corrections made to numerators, denominators or sampling used for final measure calculation; and

A summary table signifying performance measures that are reportable or not reportable (due to a material bias in the calculated rate for a measure). July 15, annually.

* + - * 1. Submit an electronic report of audited rates using the NCQA Interactive Data Submission System (IDSS) or other NCQA-approved method to NCQA for inclusion in Quality Compass and the NCBD. June 15, annually.
				2. Submit an electronic summary report of all audit activities with audit findings including an assessment of MCO compliance with NCQA’s Information System Standards and audit designations for each reported measure. July 15, annually.
			1. Validation of non-HEDIS Performance Measures. Annual Validation of Performance Measures (42 C.F.R. § 438.358 (c)(5)) utilized during the preceding twelve (12) months to comply with requirements set forth in § 438.330(b)(2).
				1. Performance measure validation for the PIHP-contracted work addressing BHSO enrollees. Validation shall be of the following non-HEDIS behavioral health performance measures calculated by Research and Data Administration (RDA) within the Departent of Social and Health Services (DSHS). Validation shall be per MCO at the statewide level:

Behavioral Health Access Monitoring Measure (BHAM); and

Substance Use Disorder Treatment Initiation and Engagement (SUD IET).

* + - * 1. Describe the manner in which the data from the validation of measures were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO.
				2. Clearly document which measures the state required the EQRO to validate for the current EQR review cycle.
				3. Indicate that the EQR performed an assessment of the MCO information system as part of the validation process.
				4. Include validation results for each MCO for the current EQR review cycle.
				5. Include outcomes information associated with each performance measure for the current EQR review cycle.
				6. Completion of a HEDIS® Compliance Audit meets the federal protocols for an Information System Capability Assessment (ISCA). Document whether the MCO completed the annual HEDIS® Compliance Audit successfully.
				7. The following tasks apply to MCOs conducting or reporting Non-HEDIS Performance Measures. The Contractor shall:

Contact the MCO to explain the procedures and timeline for performance measure calculation activities, request identification of personnel within the MCO responsible for request for documentation or information and scheduling of interviews; and communicate the policies and procedures for handling of confidential information. Due by the last business day of March, 2020 and then due by December 15, 2020 and annually by December 15th thereafter to address the upcoming contracted HEDIS season.

Request documentation from the MCO that includes the non-HEDIS measures programming source code for the measure and the measure results. Due by the last business day of January, 2020 and then due by December 15, 2020 and annually by December 15th thereafter to address the upcoming contracted HEDIS season.

Analyze the MCO’s non-HEDIS measure programming source code and measure results and assess the data systems that feed into collection and reporting of performance measures, including membership data, provider data, medical record review processes, claims/encounter data, vendor data and data integrations process. Following the review of the Roadmap and Information Systems Capabilities Assessment (ISCA) data elements, as applicable, the Contractor shall identify any findings and examine the implications of these findings on the calculation of the MCO’s performance measures in advance of the site visit. Due March 15, annually.

During the site visit, for all non-HEDIS measures, review member level detail for numerators, denominators, sampling, and exclusions to ensure measure compliance. February - April: annually.

Conduct on-site compliance audits with the MCOs and HCA staff (February – April: annually), including all of the following:

Assessment of data integration and control necessary for accurate calculation of performance measures;

Assurance of complete and accurate documentation of data processes used to collect, calculate, and report performance measures;

Assurance of valid processes to identify denominators of performance measures;

Examination of the validity of processes used to determine numerators of performance measures (for administrative and hybrid methods);

Except for measures calculated through administrative data alone, assure the validity of processes used to sample the appropriate population for calculation of performance measures; and

Examination of proper submission of required performance measure reports to HCA.

Conduct post on-site activities to include: an initial written report identifying any perceived issues of noncompliance, problematic measures and recommended opportunities for improvement and submit to HCA within ten (10) business days of the on-site visit. The initial report shall include results of the documentation review, the on-site visit, the specifications, and the source code review. March – May: annually.

Evaluate follow-up information and corrective actions from the MCO response to the initial written report and review of medical records during the period of March – May: annually. HCA shall retain responsibility for issuing Corrective Action or taking other steps related to discrepancies found.

Provide an electronic report of the final audit findings to both the MCO and HCA no later than July 15, annually, six (6) weeks after the on-site visit, marking the conclusion of the review. The report shall build upon the earlier report of preliminary findings and include all of the following:

Updated narrative and findings based on comments to the initial report including but not limited to recommendations on possible improvement methodologies;

Results of any corrected programming logic, including corrections made to numerators, denominators, or sampling used for final measure calculation; and

A summary table indicating the measures that are reportable or not reportable (due to a material bias in the calculated rate for a measure). July 15, annually.

The Contractor shall submit electronically a summary report of all audit activities, including attachments and tools described in the CMS Calculation Performance Measures Protocol with audit findings and audit designations for each reported non-HEDIS® measure. July 15, annually.

* + 1. Consumer Assessment of Healthcare Providers and Systems Surveys® (42 C.F.R. § 438.358(c)(2):
			1. Analyze and report on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, following NCQA protocol. The Contractor shall conduct and report CAHPS results as described below and to support State compliance with Sections 1139(A) and 1139(B) of the Social Security Act. Surveys shall include:
				1. Apple Health Integrated Foster Care (AH-IFC): Child CAHPS conducted annually by the MCO’s CAHPS vendor; summarized and reported by the Contractor.

For the IFC, MCO-administered survey: Review and report results for the IFC-specific CAHPS survey, conducted by the MCO vendor as specified in the AH-IFC contract. Provide a summary of strengths and recommendations to the HCA. Summary level results and reporting shall be included within the technical report. The population meeting CAHPS® specifications will be selected by the MCO and provided to the Contactor. The survey report will be supplied by the MCO to the contractor for analysis and production of summary report to HCA.

* + - * 1. Apple Health Integrated Managed Care (AH-IMC): Child with Chronic Conditions and Adult CAHPS Surveys will be alternated every other year and administered by the MCOs’ CAHPS vendors; statewide analysis of data, summary of findings, and report by the Contractor.

For the AH-IMC, MCO-administered surveys: Collect raw data, aggregate MCO survey data, and produce a statewide report of the CAHPS data conducted by the MCO CAHPS vendors. The survey will be Medicaid CAHPS Adult or Child with Chronic Conditions survey, as specified in the Apple Health contracts and rotated every year between Adult and Child with Chronic Conditions. MCO survey samples will be validated by the Contractor. Survey data will be supplied by the MCOs to the Contractor for comparative analysis and production of survey reports.

Upon completion of the AH-IMC CAHPS® survey by the MCOs, the Contractor will ensure the MCOs submit sample-level data to the CAHPS Database, following file requirements and submit a copy of each data file to HCA.

* + - * 1. Children’s Health Insurance Program (CHIP): Child CAHPS® Survey administered, analyzed, and reported by the Contractor (CHIPRA section 402).

Administer statewide Medicaid Child CAHPS survey every other year, specific to the CHIP population. The survey will be conducted in even years beginning in 2020. The population meeting CAHPS specifications will be selected from the population by the Contractor. The Contractor will conduct the survey and produce a survey report.

* + - 1. The following tasks will be performed by the Contractor when administering a CAHPS survey:
				1. Contractor will administer the surveys using the NCQA CAHPS® Consortium Guidelines to define the survey sample size and survey data collection protocols.
				2. Conduct the MCO sample validation; or when the Contractor conducts the survey for HCA, verify clean survey sample data.
				3. Follow Mixed Mode Methodology of survey administration, consisting of a minimum of: two (2) questionnaire mailings, two (2) reminder postcards, and up to six (6) phone attempts.

The contractor may administer surveys using on-line survey capability if email contact information is available and known by survey vendor; and

Use enrollee incentives or similar approaches to increase survey response.

* + - * 1. Administer the survey in English with the option to complete the survey in Spanish.
				2. Complete administrative forms (e.g., survey introductory letter and postcard reminders to enrollees).
				3. Submit weekly disposition reports to the HCA Contract Manager.
				4. Prepare member-level data files and dictionaries for each population surveyed.
				5. Produce MCO reports that include each population surveyed.
				6. Raw data (frequency tables in EXCEL) on each completed survey question to send to each MCO and HCA;
				7. Ase mix adjusted ratings (below average, average, and above average) for each Managed Care program. Average is the statewide mean;
				8. SAS flat file that contains all responses in the original sample, both responders and non-responders with identifiers removed, including a data dictionary;
				9. CAHPS Database report following the data submission requirements; include a copy to HCA of a flat file in SAS and/or other appropriate format on all completed survey questions for adult and child samples;
				10. Production of annual CAHPS stakeholder report provided in electronic format only, in PDF and WORD file formats.
			1. Collect copy of fully annotated survey instrument from each MCO assuring consistency and placement of supplemental survey questions are the same with each plan and the contractor’s survey instrument. January annually.
			2. Conduct MCO sample validation per NCQA guidelines and CMS protocol; or when the Contractor conducts the survey for HCA, verify clean, survey sample data. January annually. The validation of the sample frame for the CAHPS® survey activity shall include:
				1. Evaluation of computer programming (source code) used to access and manipulate data;
				2. Review of testing plans for the source code to ensure data is correctly queried in output files;
				3. Review of the survey eligibility file elements, e.g., unique member ID, members’ program enrollment, subscriber ID, member name, gender, date of birth, etc. and where appropriate, validation that the MCO selected a certified CAHPS® vendor to administer the survey. January annually.
				4. Completion of the NCQA-compliant CAHPS® survey validation worksheet described in NCQA’s HEDIS® Compliance Audit Volume 5. January-February: annually.
			3. Complete administrative forms (e.g., survey introductory letter and post card reminders to enrollees). January annually.
			4. Collect National CAHPS® Benchmarking Database (NCBD) Health Plan Information and NCBD Sponsor Registration forms from each MCO. April 11, annually.
			5. Follow Mixed Mode Methodology of survey administration, consisting of a minimum of: two (2) questionnaire mailings, two (2) reminder post cards, and up to six (6) phone attempts. March-April: annually.
			6. Administer surveys using on-line survey capability if email contact information is available and known by survey vendor and use enrollee incentives or similar approaches to increase survey response. March-April: annually.
			7. Administer the survey in English with the option to complete the survey in Spanish either in written format or orally over a toll free phone call. March-April: annually.
			8. Submit weekly survey status reports to HCA for surveys conducted by the Contractor. These reports shall contain the following information reported by HCA program: total number of surveys mailed total number of competed surveys; total number of postcards mailed; total number of surveys completed by telephone and the number of final refusals. April-May: annually.
			9. Analyze data for each surveyed population and produce reports using current CAHPS® analytic routines and calculation of composites and rating questions. Other analysis may be designed and developed in collaboration with HCA. May-June: annually.
			10. Develop and produce the following custom reports as applicable in collaboration with HCA: June-August: annually.
				1. An External Stakeholder CAHPS® Report which is a detailed analytic report that compares case-mix adjusted results between MCOs and identifies outliers to the state average for composites, global ratings, and individual items.
				2. AH-IMC and CHIP Survey Reports will include an executive summary, achievement scoring representative of responses indicating satisfaction, bivariate correlation analysis for each performance-related item and the composite scores against the overall satisfaction variable, priority matrix graphs and/or key driver analysis to identify opportunities for improvement, detailed responses by question, sample disposition, and methodology summary.
				3. A comparison between plan and statewide scores, with significance testing
		1. Value-Based Purchasing (VBP) Performance Measure Recommendation and Evaluation
			1. VBP Performance Measure Recommendation
				1. Consistent with Washington State Budget Proviso 2019 (211)(50) (the Proviso) and the requirements under that Proviso, the HCA’s contracted EQRO is required to annually analyze the performance of managed care organizations providing services to Clients. The recommendation required under the Proviso and Contractor’s duties under this Deliverable is to support HCA decision-making in selecting the seven performance measures required by the Proviso. Up to four non-HEDIS measures may be included in the analysis and recommendation at HCA’s direction, if resources are available for the alternate methodology required due to lack of top quartile performance data (according to Proviso (50)(g)).

Contractor will meet with the HCA VBP Workgroup to discuss the work outlined within this Deliverable on a weekly basis until HCA has completed the notification to the MCOs required in the Proviso, due September 15, annually. VBP meetings may be cancelled by HCA, at its sole discretion.

Recommendations will be based on analysis of the most recent performance measure data, such as current year HEDIS® results, finalized in June each year.

Recommendations will be in alignment with current HCA Quality Management, Monitoring and Improvement (QMMI) Guiding Principles for Measure Selection for Contracts, summarized below:

Improve health outcomes

Increase alignment across state contracts

Decrease the administrative burden of measurement

Decrease/avoid unintended consequences

* + - * 1. Provide VBP Performance Measures Recommendation Narrative Report and Data Tool by the end of July annually. The Narrative Report shall address assumptions; rationale for each performance measure selected; whether selected measures meet criteria; definitions and framework for criteria; and recommended and prioritized measures. The accompanying Data Tool shall provide detailed data reflecting the evaluation of performance measures and MCO performance of those measures in table format (e.g., using Microsoft Excel). The Data Tool shall address all measures evaluated, measures not selected with rationale, recommended measures indicated by type of measure (shared vs. MCO-specific) with rationale.

Contractor will recommend the following number of performance measures to meet the requirement of the Proviso:

At least 6-8 shared measures to meet the requirements of the four common measures in the Proviso section (50)(a)(i), including

At least two which meet the requirement to impact managed care costs

At least two which meet the requirement to be weighted towards population health management; and

At least 5-6 measures per MCO that meet the requirement of the quality focus performance measures specific to an MCO according to Proviso section (50)(a)(ii). Quality focus performance measures must:

Be chosen from the statewide common measure set;

Reflect specific measures where a managed care organization has poor performance; and

Be substantive and clinically meaningful in promoting health status.

Contractor’s report for this Deliverable will be approximately 10 to 20 pages in length. The final draft report is due to HCA no later than end of July for review and feedback by HCA. The final report is due to HCA no later than the second Friday of August.

* + - 1. VBP Performance Measure Evaluation. The assumptions for the VBP Performance Measure Evaluation work are:
				1. Analyze and report on individual MCO performance in VBP measures, as selected by HCA. The results of the performance measure analysis have a direct effect on the reimbursement to the MCOs. Analysis must include:

Standard tests of statistical significance to determine if the MCO had statistically significant improvement during the contract year under review.

Comparison to the top national Medicaid quartile of performance measure. The current year 75th percentile Medicaid HMO values will be used within the NCQA Quality Compass for HEDIS® measures to determine if the MCO reached this level of performance. Where top national Medicaid quartile performance data is unavailable, the EQRO will consult with HCA to determine an alternative methodology to be used to approximate top national quartile performance for no more than two MCO-specific measures.

* + - 1. Provide VBP Performance Measures Evaluation Report annually, including narrative and supporting data for both the shared measures and the MCO-specific measures.
		1. Validation of Network Adequacy
			1. When the methodology for network adequacy validation is released by CMS in a revised EQRO protocol, the EQRO will validate MCO network adequacy, per 42 C.F.R. § 438.358 (b)(iv).
		2. Communication and Education
			1. The Contractor will provide in-person, one day educational meetings to keep key stakeholders informed and involved in quality initiatives. Quality Forums are focused to provide quality improvement education to MCOs, BH-ASOs, and HCA to support system-wide quality improvement and Apple Health quality initiatives.
			2. The Contractor will provide the location and catering for a Quality Forum annually, which accommodates stakeholder attendance of up to three per entity, in addition to HCA staff, to equal approximately 50 attendees. Location will be in the greater Olympia or Sound Sound area.
			3. Develop a plan to elicit input from stakeholders about their educational needs and how this information will be used to develop the educational meetings.
			4. Lead agenda preparation, topic selection, and speaker arrangement, with consultation and approval from HCA to inform this work.
			5. Submit written materials intended for MCO communication or education activities to HCA for approval in advance of distribution to stakeholders.
		3. Wraparound with Intensive Services (WISe) Implementation Quality Improvement Review Tool (QIRT) Reviews (42 C.F.R. § 438.358(c)(5)). *HCA is currently funded for these activities for January 2020 through June 2021.*
			1. The WISe work described herein will be in alignment with the settlement agreemend under T.R. vs. Birch & Strange (formerly known as T.R. vs. Quigley & Teeter), HCA’s WISe Program, Policy, and Procedure Manual (<https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf>), and the WISe Quality Plan (<https://www.hca.wa.gov/assets/billers-and-providers/wise%20quality%20plan%20final.pdf>).
			2. Focused study, review, and reporting on the Children’s Mental Health system, using the Quality Implementation Review Tool (QIRT) to review the WISe records of MCOs providing WISe services during year. On-site review will be over a two (2) day period, and will require three (3) reviewers who have been trained in the QIRT review tool. There will be up to 10 WISe client files reviewed at each provider site. HCA will select the records for review and will provide a guidance sheet for each site that lists: files for review; time period to be reviewed; and modules to be completed in QIRT.
				1. The reviews as quailty improvement-focused activities intended to inform providers, MCOs, HCA, and other stakeholders about how to improve the WISe delivery system for clients and families.
				2. HCA will perform corresponding client and family interviews to complement the chart review and compelte the quality review feedback.
				3. Approximately 20-25 providers will be reviewed each fiscal year.
			3. Submit final Individual Provider Reports, annually, identifying recommendations for provider improvement, a summary of the findings, and provider strengths.
				1. The reports are intended for the providers and to support practice improvement for the providers.
				2. Reports should focus on themes and issues not captured within the QIRT data during chart review.
				3. Reports will include QIRT-generated dashboards and information identified during the provider QIRT reviews.
				4. Expected length for each individual provider report is three (3) pages.
				5. Contractor will submit draft individual provider reports to HCA for approval. HCA will distribute the final report to providers and MCOs.
			4. Submit quarterly QIRT Summary Reports to HCA, to provide trends in findings and make recommendations to HCA and MCOs on areas of improvement in the quailty of WISe services.
				1. Quarterly Summary Reports will include aggregated QIRT-generated dashboard and information identifed during individual QIRT reviews.
				2. The reports are intended for HCA and the MCOs to support system change and quality improvement.
				3. Expected length for each quarterly QIRT Summary Report is five (5) pages.
				4. Contractor shall submit a draft to HCA for approval. HCA will distribute the final report to the MCOs and through the WISe Quality Improvement Infrastructure.
			5. Contractor will request QIRT training for new staff thirty (30) days in advance to the HCA Contract Manager.
				1. Training requires reviewers to attend two (2) full days in person.
1. Deliverables
	1. External Quality Review Annual Technical Report (42 C.F.R. § 438.364).
		1. The report shall be produced annually.
			1. Submit to HCA for approval an external quality review report project plan. Due the last business day of March, annually.
			2. Design and draft a report template for HCA’s review and approval. Due the last business day of August, annually.
			3. Write a draft report and submit electronically to HCA for review and comment by November 15th of each year.
			4. Submit the final Technical Report. Send an electronic copy to HCA and each MCO, and one (1) hard copy to each MCO and five (5) hard copies to HCA. Submit final PDF and Word versions of the report to HCA. The Contractor shall follow PDF web usability guidelines as published by Adobe. Due December 15, annually.
	2. Performance Measure Comparative Analysis (42 C.F.R. § 438.364).

The Contractor will conduct analyses of MCO performance measures including comparisons amongst the MCOs past and present performance, comparisons with a calculated MCO state average, and state or national benchmarks, permitted by NCQA licensing agreement for Medicaid managed care organizations; and produce charts and tables displaying the data.

* + 1. Submit performance measure comparative analysis project plan. Due last business day of March, annually.
		2. Design and submit for HCA approval chart and table formats for displaying HEDIS® and non-HEDIS data in produced reports. Due April 15, annually.
		3. Design and draft a report template for HCA’s review and approval. Due the last business day of August, annually.
		4. Submit for HCA comment and approval a draft comparative analysis report by 1st Friday of November, annually.
		5. Submit final comparative analysis report by 1st Friday of December, annually.
		6. Provide technical assistance, data consulting and ad hoc analyses related to metrics and plan performance as mutually agreed upon by HCA and Contractor.
	1. Enrollee Quality Report
		1. Submit an annual enrollee quality report methodology design and template for HCA approval, due the last business day in April annually.
		2. Submit a draft Enrollee Quality Report and separate, corresponding methology narrative document to HCA by the third Friday in August annually for review and comment.
		3. The final Enrollee Quality Report report and separate, corresponding methology narrative document will be submitted electronically to HCA annually, due by the 2nd Friday in September.
	2. Annual Validation of Performance Measures for HEDIS® and non-HEDIS Performance Measures
		1. Submit annual performance measure project plan. Due last business day of January, annually.
		2. HEDIS® Compliance Audit™
			1. Conduct an all MCO audit kick-off webinar to allow the MCOs to ask questions they have about the HEDIS® Compliance Audit™. Conduct additional webinars for each MCO to explain audit processes, all participating parties’ roles and responsibilities and work on each MCO draft audit work plan. Due by the last business day of January for the first year of the contract and then due by December 15, 2020 and annually by December 15th thereafter to address the upcoming contracted HEDIS season.
			2. Throughout the audit process, the Contractor shall notify each MCO of all findings that impact the HEDIS® measures, reportable within two (2) business days of detection with recommended corrective actions. A worksheet detailing identified issues with recommended corrective action shall be submitted to HCA monthly throughout the audit season, which begins in January and ends in June of each year.
			3. Production of an initial written post-onsite report for each MCO identifying any perceived issues of noncompliance, problematic measures and recommended opportunities for improvement and submit to HCA within 10 business days of on-site visit. The initial report shall include results of the documentation review, the site visit, the specifications, and the source code review. Due within March – May, annually.
			4. The Contractor shall provide the HEDIS® Final Audit Findings Report, an electronic report of the final compliance audit findings marking the conclusion of the review, to both the MCO and HCA by July 15, annually. The report shall build upon the earlier report of preliminary findings and include:
				1. Updated text and findings based on comments to the initial report, including but not limited to recommendations to the MCO regarding improvement methodologies;
				2. Results of any corrected programming logic, including corrections made to numerators, denominators or sampling used for final measure calculation; and
				3. A summary table signifying performance measures that are reportable or not reportable (due to a material bias in the calculated rate for a measure).
			5. Submit an electronic report of audited rates using the NCQA Interactive Data Submission System (IDSS) or other NCQA-approved method to NCQA for inclusion in Quality Compass and the CAHPS Database. Provide IDSS files to HCA. Due June 15 or as required by NCQA, annually.
			6. Submit an electronic summary report of all audit activities with audit findings, including an assessment of MCO compliance with NCQA’s Information System Standards and audit designations for each reported measure. July 15, annually.
		3. The following tasks apply to MCOs conducting or reporting Non-HEDIS Performance Measures. The Contractor shall:
			1. Contact the MCO to explain the procedures and timeline for performance measure calculation activities, request identification of personnel within the MCO responsible for request for documentation or information and scheduling of interviews; and communicate the policies and procedures for handling of confidential information. Due by the last business day of March for the first year of the contract and then due by December 15, 2020 and annually by December 15th thereafter to address the upcoming contracted HEDIS season.
			2. Request documentation from the MCO that includes the non-HEDIS measures programming source code for the measure and the measure results. Due by the last business day of January for the first year of the contract and then due by December 15, 2020 and annually by December 15th thereafter to address the upcoming contracted HEDIS season.
				1. Analyze the MCO’s non-HEDIS measure programming source code and measure results and assess the data systems that feed into collection and reporting of performance measures, including membership data, provider data, medical record review processes, claims/encounter data, vendor data and data integrations process. Following the review of the Roadmap and Information Systems Capabilities Assessment (ISCA) data elements, as applicable, the Contractor shall identify any findings and examine the implications of these findings on the calculation of the MCO’s performance measures in advance of the site visit. Due March 15, annually.
				2. During the site visit, for all non-HEDIS measures, review member level detail for numerators, denominators, sampling, and exclusions to ensure measure compliance. February - April: annually.
				3. Conduct on-site compliance audits with the MCOs and HCA staff, including all of the following:

Assessment of data integration and control necessary for accurate calculation of performance measures;

Assurance of complete and accurate documentation of data processes used to collect, calculate, and report performance measures;

Assurance of valid processes to identify denominators of performance measures;

Examination of the validity of processes used to determine numerators of performance measures (for administrative and hybrid methods);

Except for measures calculated through administrative data alone, assure the validity of processes used to sample the appropriate population for calculation of performance measures; and

Examination of proper submission of required performance measure reports to HCA. February – April: annually.

* + - * 1. Conduct post on-site activities to include: an initial written report identifying any perceived issues of noncompliance, problematic measures and recommended opportunities for improvement and submit to HCA within ten (10) business days of the on-site visit. The initial report shall include results of the documentation review, the on-site visit, the specifications, and the source code review. March – May: annually.
				2. Evaluate follow-up information and corrective actions from the MCO response to the initial written report and review of medical records during the period of March – May: annually. HCA shall retain responsibility for issuing Corrective Action or taking other steps related to discrepancies found.
				3. Provide an electronic report of the final audit findings to both the MCO and HCA no later than July 15, annually, six (6) weeks after the on-site visit, marking the conclusion of the review. The report shall build upon the earlier report of preliminary findings and include all of the following:

Updated narrative and findings based on comments to the initial report including but not limited to recommendations on possible improvement methodologies;

Results of any corrected programming logic, including corrections made to numerators, denominators, or sampling used for final measure calculation; and

A summary table indicating the measures that are reportable or not reportable (due to a material bias in the calculated rate for a measure). July 15, annually.

* + - * 1. The Contractor shall submit electronically a summary report of all audit activities, including attachments and tools described in the CMS Calculation Performance Measures Protocol with audit findings and audit designations for each reported non-HEDIS measure. July 15, annually.
	1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys (42 C.F.R. § 438.358(c)(2)).
		1. Submit CAHPS® project schedule. Due January, annually.
		2. Submit weekly survey status reports to HCA for surveys conducted by the Contractor. These reports shall contain the following information reported by HCA program: total number of surveys mailed total number of competed surveys; total number of postcards mailed; total number of surveys completed by telephone and the number of final refusals. April-May: annually.
		3. Produce a draft External Stakeholder CAHPS® Report for the CHIP Survey for HCA review and feedback. Due 15th of July, annually in even years.
		4. Submit Final CAHPS® Report for the CHIP Survey. Due end of September, annually in even years.
		5. Submit summary of AH-IFC CAHPS Survey Report to HCA and MCO. Address trends, opportunities for improvement, and recommendations to the state and MCO. Due the 15th of September annually.
		6. Provide a draft Statewide AH-IMC CAHPS Survey Report for HCA review and feedback. Provide a detailed analytic report that compares case-mix adjusted results between MCOs and identifies outliers to the state average for composites, global ratings, and individual items. Due last business day of August, annually.
		7. Provide a Final Statewide AH-IMC CAHPS Survey Report for HCA review and feedback. Due last business day of September, annually.
	2. Value-Based Purchasing
		1. Provide VBP Project Plan, due last business day of March annually.
		2. VBP Recommendations
			1. Provide weekly status reports including draft Data Tool to HCA for review during weekly meetings, due between June and September until finalization of the Data Tool
			2. Provide initial draft of VBP Performance Measures Recommendation Narrative Report and Data Tool by 3rd Friday of July annually.
			3. Provide final draft VBP Performance Measures Recommendation Narrative Report and Data Tool by the end of July annually prior to presentation to HCA Clinical Quality Council.
			4. Provide Final VBP Performance Measures Recommendation Narrative Report and Data Tool by the 15th of August annually.
			5. Presentation to HCA Clinical Quality Council, with visual aids to include an introductory PowerPoint, the VBP Performance Measures Recommendation Narrative Report, and VBP Performance Measures Recommendation Data Tool.
		3. VBP Evaluation
			1. Provide weekly status reports, due between September until completion of this Deliverable. Meetings to be scheduled with HCA at the intiation and completion of this Deliverable.
			2. Provide draft template of the charts and graphs in which the supporting data will be provided within the VBP Performance Measures Evaluation Report, due by the 3rd Friday of September annually. Meet with HCA to present format and receive feedback.
			3. Provide draft VBP Performance Measures Evaluation Report and supporting data in charts and graphs, by the 15th of October annually.
			4. Provide Final VBP Performance Measures Evaluation Report and supporting data in charts and graphs, by the 30th of October annually.
	3. Communication and Education

The Contractor will plan, prepare, and implement communication and Quality Improvement educational approaches used by the Contractor to MCOs, BH-ASOs, HCA, and key Stakeholders to support system-wide quality improvement and HCA quality initiatives.

* + 1. Submit to HCA a communication and education project plan. Include a plan to elicit input from MCOs and other stakeholders about their educational needs and how this information will be used to develop the educational meetings. Collaborate with HCA on a schedule for the educational quality forum. Due end of January: annually.
		2. Submit Quality Forum Plan, including schedule, attendee plan, catering and location information, draft agenda, topic selection, and speaker arrangement. Due six weeks prior to when the Quality Forum is scheduled.
	1. Wraparound with Intensive Services (WISe)

The Contractor will review the HCA-selected WISe records of provider WISe services during the year.

* + 1. Request QIRT training for new staff 30 days in advance to HCA Contract Manager.
		2. Individual Provider Reports. Individual Provider Reports will include a summary of the findings, agency strenghts, QIRT-generated reports, and recommendations for improvement.
		3. Quarterly QIRT Summary Report. This report will summarize trends in findings and make recommendations to HCA on areas for improvement on the quality of WISe services.
			1. Provide draft Quarterly QIRT Summary Report to HCA for review and feedback by the 15th of the month following the quarter (in April, July, Oct, and Jan).
			2. Provide Final Quarterly QIRT Summary Report to HCA by the last business day of the month following the quarter (in April, July, Oct, and Jan).
	1. Monthly EQRO Progress
		1. Submit monthly written updates summarizing progress towards completion of all Contract related tasks, including documentation of any barriers to timely completion, lessons learned from activities completed, and recommendations for improvement to the State. This deliverable shall be submitted along with the monthly invoice to confirm progress and work completed. Due the last business day of the month.
		2. Hold monthly meeting with HCA to provide status updates towards completion of all Contract-related tasks and inform HCA of any need for information or assistance.

Schedule B

**Budget**

Schedule C

**Business Associate Agreement**

1. Definitions

In addition to the definitions set out in section 2, Definitions, of the Contract, the definitions below apply to this Schedule:

The following terms used in this Schedule have the same meaning as those terms in the HIPAA Rules: Breach, Business Associate, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy, Practices, Secretary, Security Incident, Unsecured Protected Health Information (PHI), and Use.

“Access attempts” means probes, scans, “pings,” and other activities that may not indicate threats, whose sources may be difficult or impossible to identify, and whose motives are unknown, and which do not result in access or risk to any information system or PHI.

“Day” means business days observed by Washington State government.

“Clients” or “Individuals” means people who have health or other coverage or benefits from or through HCA. They include: Medicaid clients, Public Employees Benefits Board subscribers and enrollees, and others.

“HIPAA Rules, Security, Breach Notification, and Privacy Rules” means the Privacy, Security, Breach Notification and Enforcement Rules at 45 C.F.R. Parts 160 and 164, as now in effect and as amended. The Security Rule is 45 C.F.R. Part 164, Subpart C (beginning with § 164.302). The Breach Notification Rule is 45 C.F.R. Part 164, Subpart D (beginning with § 164.400). The Privacy Rule is 45 C.F.R. Part 164, Subpart E (beginning with § 164.500).

1. Obligations and Activities of Business Associate
	1. Limits

Business Associate will not use or disclose PHI other than as permitted or required by the Contract or this Schedule, or as required by law. Except as otherwise limited in this Contract, Business Associate may use or disclose PHI on behalf of, or as necessary for purposes of the Contract, if such use or disclosure of PHI would not violate the Privacy Rule if done by a Covered Entity and is the minimum necessary.

* 1. Safeguards

Business Associate will use appropriate safeguards, and will comply with the Security Rule with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Contract. Business Associate will store and transfer PHI in encrypted form.

* 1. Reporting Security Incidents
		1. Business Associate will report security incidents that materially interfere with an information system used in connection with PHI. Business Associate will report those security incidents to HCA with five (5) days of their discovery by Business Associate. If such an incident is also a Breach, or may be a Breach, subsection 2.4 applies instead of this provision.
		2. Access Attempts will be recorded in Business Associate’s system logs. Access Attempts are not categorically considered unauthorized Use or Disclosure, but Access Attempts do fall under the definition of Security Incident and Business Associate is required to report them to HCA.

Since Business Associate’s reporting and HCA’s review of all records of Access Attempts would be materially burdensome to both parties without necessarily reducing risks to information systems or PHI, the parties agree that Business Associate will review logs and other records of Access Attempts, will investigate events where it is not clear whether or not an apparent Access Attempt was successful, and determine whether an Access Attempt:

1. Was, in fact, a “successful” unauthorized Access to, or unauthorized Use, Disclosure, modification, or destruction of PHI subject to this Contract; or
2. Resulted in material interference with Business Associate’s information system used with respect to PHI subjecct to this Contract; or
3. Caused an unauthorized Use or Disclosure.
	* 1. Subject to Business Associate’s performance as described in 2.3.2, this provision will serve as Business Associate’s notice to HCA that Access Attempts will cocur and are anticipated to continue occurring with respect to Business Associate’s information systems. HCA acknowledges this notification, and Business Associate is not required to provide further notifications of Access Attempts unless they are successful as described in Section 2.3.2, above, in which case Business Associate will report them in accordance with Section 2.3.1 or Section 2.4, whichever is applicable.
	1. Breach Notification
		1. “Breach” is defined in the Breach Notification Rule. The time when a Breach is considered to have been discovered is explained in that Rule. HCA, or its designee, is responsible for determining whether an unauthorized Use or Disclosure constitutes a Breach under the Breach Notification Rule, RCW 42.56.590, RCW 19.255.010, or other law or rule, and for any notification under the Breach Notification Rule, RCW 42.56.590, RCW 19.255.010, or other law or rule.
		2. Business Associate will notify HCA of any unauthorized Use or Disclosure and any other possible Breach within one (1) business day of discovery. If Business Associate does not have full details at that time, it will report what information it has, and provide full details within 15 calendar days after discovery. The initial report may be oral. Business Assocaite will give a written report to HCA as soon as possible. To the extent possible, these reports must include the following:
4. The identification of each individual whose PHI has been or may have been accessed, acquired, or disclosed;
5. 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;
6. A description of the types of PHI involved;
7. The investigative and remedial actions the Business Associate or its subcontractor took or will take to prevent and mitigate harmful effects, and protect against recurrence;
8. Any details necessary for a determination of the potential harm to Individuals whose PHI is believed to have been Used or Disclosed and the steps such Individuals should take to protect themselves; and
9. Such other information as HCA may reasonable request.
	* 1. If Business Associate determines that it has or may have an independent notification obligation under any state breach notification laws, Business Associate will promptly notify HCA. In any event, Business Associate will notify HCA of its intent to give any notification under a state breach notification law no fewer than ten (10) business days before giving such notification.
		2. If Business Associate or any subcontractor or agent of Business Associate actually makes or causes, or fails to prevent, a Use or Disclosure constituting a Breach within the meaning of the Breach Notification Rule, and if notification of that Use or Disclosure must, in the judgment of HCA) be made under the Breach Notification Rule, RCW 42.56.590, RCW 19.255.010, or other law or rule, then:
10. HCA may choose to make any notifications to the individuals, to the Secretary, and to the medica, or direct Business Associate to make them or any of them;
11. In any case, Business Associate will pay the reasonable costs of notification to individuals, media, and governmental agencies, and of other actions HCA reasonably considers appropriate to protect clients (such as paying for regular credit watches in some cases); and
12. Business Associate will compensate HCA clients for harms caused to them by the Breach or possible Breach described above.
	* 1. Business Associate’s obligations regarding breach notification survive the termination of this Contract and for as long as Business Associate maintains the PHI and for any Breach or possible Breach at any time.
	1. Subcontractors

Business Associate will ensure that any subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to protective restrictions, conditions, and requirements at least as strict as those that apply to Business Associate with respect to that information. Upon request by HCA, Business Associate will identify to HCA all of its subcontractors and provide copies of its agreements, including business associate agreements or contracts, with them. The fact that Business Associate subcontracted or otherwise delegated any responsibility to a subcontractor or anyone else does not relieve Business Associate of its responsibilities.

* 1. Access

Business Associate will make available PHI in a designated record set to HCA as necessary to satisfy HCA’s obligations under 45 C.F.R. § 164.524. Business Associate will give the information to HCA within five (5) business days of the request from the individual or HCA, whichever is earlier. If HCA requests, Business Associate will make that information available directly to the individual. If Business Associate receives a request for access directly from the individual, Business Associate will inform HCA of the request within three (3) business days, and if requested by HCA will provide the access in accordance with the HIPAA Rules.

* 1. Amending PHI

Business Associate will make any amendments to PHI in a designated record set as directed or agreed to by HCA pursuant to 45 C.F.R. § 164.526, or take other measures requested by HCA to satisfy HCA’s obligations under that provision. If Business Associate receives a request for amendment directly from an individual, Business Associate will both acknowledge it and inform HCA within three (3) business days, and if HCA so requests act on it within ten (10) business days and inform HCA of its actions.

* 1. Accounting

Business Associate will maintain and make available to HCA the information required to provide an accounting of disclosures as necessary to satisfy HCA’s obligations under 45 C.F.R. § 164.528. If Business Associate receives an individual’s request for an accounting, it will either provide the accounting as required by the Privacy Rule or, at its option, pass the request on to HCA within ten (10) business days after receiving it.

* 1. Obligations

To the extent Business Associate is to carry out one or more of HCA’s obligations under the Privacy Rule, it will comply with the requirements of that rule that apply to HCA in the performance of such obligations.

* 1. Books

Business Associate will make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

* 1. Mitigation

Business Associate will mitigate, to the extent practicable, any harmful effective of a Use or Disclosure of PHI by Business Associate or any of its agents or subcontractors in violation of the requirements of any of the HIPAA Rules, or this Contract.

* 1. Indemnification

To the fullest extent permitted by law, Business Associate will indemnify, defend, and hold harmless the state of Washington, HCA, and all officials, agents, and employees of the State from and against all claims of any kind arising out of or resulting from the performance of this Business Associate Agreement, including Breach or violation of HIPAA Rules.

1. Permitted Uses and Disclosures by Business Associate
	1. Limited Use and Disclosure

Except as provided in Section 3, Business Associate may Use or Disclose PHI only as necessary to perform the services set forth in the Contract.

* 1. General Limitation

Business Associate will not Use or Disclose PHI in a manner that would violate the Privacy Rule if done by HCA.

* 1. Required by Law

Business Associate may Use or Disclose PHI as required by law.

* 1. De-Identifying

Business Associate may Use or Disclose de-identified PHI in accordance with 45 C.F.R. § 164.514(a)-(c).

* 1. Minimum Necessary

Business Associate will make Uses and Disclosures of only the minimum necessary PHI, and will request only the minimum necessary PHI.

* 1. Disclosure for Management and Administration of Business Associate
		1. Subject to subsection 3.6.2, Business Associate may Disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.
		2. The Disclosures referred to in subsection 3.6.1 above are permitted only if either:
1. The Disclosures are required by law; or
2. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and that the person will notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
	1. Aggregation

Business Associate may use PHI to provide data aggregation services relating to the health care operations of the HCA, if those services are part of the Contract.

1. Activities of HCA
	1. Notice of Privacy Practices

HCA will provide a copy of its current notice of privacy practices under the Privacy Rule to Business Associate on request. HCA will also provide any revised versions of that notice by posting on its website, and will sent it on request.

* 1. Changes in Permissions

HCA will notify Business Associate of any changes in, or revocation of, the permission by an individual to Use or Disclose their PHI, to the extent that such changes may affect Business ASssociate’s Use or Disclosure of PHI.

* 1. Restrictions

HCA will notify Business Associate of any restriction on the Use or Disclosure of PHI that HCA has agreed to or is required to abide by under 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate’s Use or Disclosure of PHI. Business Associate will comply with any such restriction.

1. Termination
	1. Termination for Cause

HCA may terminate this Contract if HCA determines Business Associate has violated a material term of the Business Associate Agreement. The termination will be effective as of the date stated in the notice of termination.

* 1. Obligations of Business Associate Upon Termination

The obligations of the Business Associate under this subsection survive the termination of the Business Associate Agreement or Contract. Upon termination of this Business Associate Agreement or Contract for any reason, Business Associate will:

* + 1. Retain only that PHI that is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
		2. Return to HCA or, if agreed to by HCA, destroy/dispose the PHI that the Business Associate and any subcontractor of Business Associate still has in any form in accordance with Schedule D, Section 5.3, and provide HCA with appropriate certification of destruction or disposition.
		3. Continue to use appropriate safeguards and comply with the Security Rule with respect to electronic PHI to prevent Use or Disclosure of the PHI, other than as provided for in this Business Associate Agreement, for as long as Business Associate retains any of the PHI.
		4. Not Use or Disclose any PHI retained by Business Associate other than for the purposes for which the PHI was retained and subject to the same conditions that applied before termination.
		5. Return to HCA, or if agreed to by HCA, destroy/dispose of, the PHI retained by Business Associate when it is no longer needed by Business Associate in accordance with Schedule D, Section 5.3, and provide HCA with appropriate certification of destruction or disposition.
		6. Business Associate’s obligations relating to providing information to the Secretary and other government survive the termination of this Business Associate Agreement or Contract for any reason.
	1. Successor

Nothing in this Business Associate Agreement or Contract limits the obligations of Business Associate under the Contract regarding giving data to HCA or to a successor Business Associate after termination of the Contract.

1. Miscellaneous
	1. Interpretation

Any ambiguity in this Business Associate Agreement will be interpreted to permit compliance with the HIPAA Rules.

* 1. HCA Contact for Reporting and Notification Requirements

Business Associate will address all reporting and notification communications required in this Schedule to:

HCA Privacy Officer

Washington State Health Care Authority

626 8th Avenue SE

PO Box 42704

Olympia, WA 98504-2704

Phone: (360) 725-2108

Email: PrivacyOfficer@hca.wa.gov

Schedule D

**Data Use, Security, and Confidentiality**

1. Definitions

In addition to the definitions set out in section [#], Definitions, of the Contract, the definitions below apply to this Schedule:

“**Authorized User**” means an individual or individuals with an authorized business need to access HCA’s Confidential Information under this Contract.

“**Client**” means an individual who is eligible for or receiving Medicaid services.

“**Data**” means the information that is disclosed or exchanged as described by this Contract. For purposes of this Contract, Data means the same as “Confidential Information.”

“**Disclosure**” means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the 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, address, telephone numbers, social security numbers, driver’s license numbers, credit card numbers, any other identifying numbers, and any financial identifiers.

“**ProviderOne**” means the Medicaid Management Information System (MMIS), which is the State’s Medicaid payment system managed by HCA.

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

“**Use**” includes the sharing, employment, application, utilization, examination, or analysis of Data.

1. Description of Data
	1. [Short Description of Data]. The Data will be provided [frequency, format, delivery].
	2. Data Use Purpose. (if more detail from purpose of overarcing agreement is needed (i.e., more restrictions, etc.)
	3. The Data to be shared is: [(description, elements, etc) OR (set out in attached Schedule 1: Description of Shared Data)]
	4. The Data may be linked with the following [data/sources]:
2. Data Classification

The State classifies data into categories based on the sensitivity of the data pursuant to the Security policy and standards promulgated by the Office of the state of Washington Chief Information Officer. (See Section 4, Data Security, of Securing IT Assets Standards No. 141.10 in the State Technology Manual at <https://ocio.wa.gov/policy/securing-information-technology-assets>. Section 4 is hereby incorporated by reference.)

The Data that is the subject of this Contract may be in any of the Categories indicated below:

[ ]  Category 1 – Public Information

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

[ ]  Category 2 – Sensitive Information

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

[ ]  Category 3 – Confidential Information

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

* Personal Information about individuals, regardless of how that information is obtained;
* Information concerning employee personnel records;
* Information regarding IT infrastructure and security of computer and telecommunications systems;

[ ]  Category 4 – Confidential Information Requiring Special Handling.

Category 4 Data is information that is specifically protected from disclosure and for which:

* Especially strict handling requirements are dictated, such as by statutes, regulations, or agreements;
* Serious consequences could arise from unauthorized disclosure, such as threats to health and safety, or legal sanctions.
1. Constraints on Use of Data
	1. The Data being shared/accessed is owned and belongs to HCA.
	2. This Contract does not constitute a release of the Data for the Contractor’s discretionary use. Contractor must use the Data received or accessed under this Contract only to carry out the purpose of this Contract. Any analyses, use, or reporting that is not within the Purpose of this Contract is not permitted without HCA’s prior written consent.
	3. Any disclosure of Data contrary to this Contract is unauthorized and is subject to penalties identified in law.
2. Security of Data
	1. Data Protection
		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:
		2. Allowing access only to staff that have an authorized business requirement to view the Confidential Information; and
		3. Physically securing any computer, documents, or other media containing the Confidential Information.
	2. Data Security Standards

Contractor must comply with the Data Security Requirements set out in Attachment 1, *Confidential Information Security Requirements*, and the Washington OCIO Security Standard, 141.10, which will include any successor, amended, or replacement regulation (<https://ocio.wa.gov/policy/securing-information-technology-assets>.) The Security Standard 141.10 is hereby incorporated by reference into this Contract.

* 1. Data Disposition

For the purposes of this section “fiscal year” is from July 1 to June 30.

Upon request by HCA, at the end of the Contract term, when no longer needed, or 6 years after the end of the fiscal year in which the Data is received, Confidential Information/Data must be returned to HCA or disposed of as set out in Attachment 1, *Confidential Information Security Requirements*,except as required to be maintained for compliance or accounting purposes.

1. Data Confidentiality and Non-Disclosure
	1. Data Confidentiality
		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:
2. as provided by law; or
3. with the prior written consent of the person or personal representative of the person who is the subject of the Confidential Information.
	1. Non-Disclosure of Data
		1. The Contractor must 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 made aware of the use restrictions and protection requirements of this Contract before gaining access to the Data identified herein. The Contractor will also instruct and make any new employee aware of the use restrictions and protection requirements of this Contract before they gain access to the Data.
		2. The Contractor will ensure that each employee or Subcontractor who will access the Data signs the *User Agreement on Non-Disclosure of Confidential Information*, Attachment 2 hereto. The Contractor will retain the signed copy of the *User Agreement on Non-Disclosure of Confidential Information* in each employee’s personnel file for a minimum of six years from the date the employee’s access to the Data ends. The documentation must be available to HCA upon request.
	2. Penalties for Unauthorized Disclosure of Data

State laws (including RCW 74.04.060 and RCW 70.02.020) and federal regulations (including HIPAA Privacy and Security Rules, 45 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. The Contractor must comply with all applicable federal 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.

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

1. Data Shared with Subcontractors

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 Contract 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

1. Inspection

HCA reserves the right to monitor, audit, or investigate compliance with this Contract in regards to the Personal Information and PHI of Enrollees collected, used, or acquired by Contractor during the term of this Contract and for six (6) years following termination or expiration of this Contract. HCA will have access to Contractor’s records and place of business for this purpose. 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.

1. Indemnification for Unauthorized Use or Release

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.

Attachment 1

**Confidential Information Security Requirements**

1. Definitions

In addition to the definitions set out in Section 2 of this Contract K3866 for External Quality Review Services, the definitions below apply to this Attachment.

1. “Hardened Password” means a string of characters containing at least three of the following character classes: upper case letters; lower case letters; numerals; and special characters, such as an asterisk, ampersand or exclamation point.
	1. Passwords for external authentication must be a minimum of 10 characters long.
	2. Passwords for internal authentication must be a minimum of 8 characters long.
	3. Passwords used for system service or service accounts must be a minimum of 20 characters long.
2. “Portable/Removable Media” means any Data storage device that can be detached or removed from a computer and transported, including but not limited to: optical media (e.g. CDs, DVDs); USB drives; or flash media (e.g. CompactFlash, SD, MMC).
3. “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.
4. “Secured Area” means an area to which only Authorized Users have access. Secured Areas may include buildings, rooms, or locked storage containers (such as a filing cabinet) within a room, as long as access to the Confidential Information is not available to unauthorized personnel.
5. “Transmitting” means the transferring of data electronically, such as via email, SFTP, webservices, AWS Snowball, etc.
6. “Trusted System(s)” means the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; (2) United States Postal Service (“USPS”) first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail; (3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.
7. “Unique User ID” means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase, or other mechanism, authenticates a user to an information system.
8. Confidential Information Transmitting
9. When transmitting HCA’s Confidential Information electronically, including via email, the Data must be encrypted using NIST 800-series approved algorithms (<http://csrc.nist.gov/publications/PubsSPs.html>). This includes transmission over the public internet.
10. When transmitting HCA’s Confidential Information via paper documents, the Receiving Party must use a Trusted System.
11. Protection of Confidential Information

The Contractor agrees to store Confidential Information as described:

1. Data at Rest:
2. Data will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data. Access to the Data will be restricted to Authorized Users through the use of access control lists, a Unique User ID, and a Hardened Password, or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Systems which contain or provide access to Confidential Information must be located in an area that is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
3. Data stored on Portable/Removable Media or Devices:
* 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.
* HCA’s data must not be stored by the Receiving Party on Portable Devices or Media unless specifically authorized within the Data Share Agreement. If so authorized, the Receiving Party must protect the Data by:
1. Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;
2. Control access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics;
3. Keeping devices in locked storage when not in use;
4. Using check-in/check-out procedures when devices are shared;
5. Maintain an inventory of devices; and
6. Ensure that when being transported outside of a Secured Area, all devices with Data are under the physical control of an Authorized User.
7. 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.
8. Confidential Information Segregation

HCA Confidential Information 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 HCA Confidential Information can be identified for return or destruction. It also aids in determining whether HCA Confidential Information has or may have been compromised in the event of a security Breach.

* 1. The HCA Confidential Information must be kept in one of the following ways:
1. on media (e.g. hard disk, optical disc, tape, etc.) which will contain only HCA Data; or
2. in a logical container on electronic media, such as a partition or folder dedicated to HCA’s Data; or
3. in a database that will contain only HCA Data; or
4. within a database and will be distinguishable from non-HCA Data by the value of a specific field or fields within database records; or
5. when stored as physical paper documents, physically segregated from non-HCA Data in a drawer, folder, or other container.
	1. When it is not feasible or practical to segregate HCA Confidential Information from non-HCA data, then both the HCA Confidential Information and the non-HCA data with which it is commingled must be protected as described in this Attachment.
6. Confidential Information Shared with Subcontractors

If HCA Confidential Information provided under this Contract is to be shared with a Subcontractor, the contract with the Subcontractor must include all of the Confidential Information Security Requirements.

1. Confidential Information Disposition

When the Confidential Information is no longer needed, except as noted below, the Confidential Information must be returned to HCA or destroyed. Media are to be destroyed using a method documented within NIST 800-88 (<http://csrc.nist.gov/publications/PubsSPs.html>).

1. For HCA’s Confidential Information stored on network disks, deleting unneeded Confidential Information is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in Section 3, above. Destruction of the Confidential Information as outlined in this section of this Attachment may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

|  |
| --- |
| User Agreement on Non-Disclosure of Confidential Information |
| Your organization has entered into a Contract with the state of Washington Health Care Authority (HCA) that will allow you access to data and records that are deemed Confidential Information as defined below. Prior to accessing this Confidential Information you must sign this *User Agreement on Non-Disclosure of Confidential Information.*  |
| 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. For purposes of the pertinent Contract, Confidential Information means the same as “Data.”“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, and RCW 70.02.020) 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 Assurance of Confidentiality |
| In consideration for HCA granting me access to the Confidential Information that is the subject of this Agreement, 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 the Confidential Information.
3. Will not use or disclose any Confidential Information gained by reason of this Agreement for any commercial or personal purpose, or any other purpose that is not directly connected with this Agreement.
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 not distribute, transfer, or otherwise share any software with anyone.
10. 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.
11. Understand at any time, HCA may audit, investigate, monitor, access, and disclose information about my use of the Confidential Information and that my intentional or unintentional violation of the terms of this Agreement may result in revocation of privileges to access the Confidential Information, disciplinary actions against me, or possible civil or criminal penalties or fines.
12. 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.
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| Signature |
| Print User’s Name | User Signature | Date |
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