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| C:\Users\ANDERM\Desktop\HCA-logo.png | | PROFESSIONAL SERVICES CONTRACT  for Fully Insured Group Medical Plan | | | | | | | | | HCA Contract Number: K  Resulting from Solicitation Number (If applicable: 2716  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 | | | | | | | 93.778; | | | | | | YES NO | | |
|  | | | | | | | | |  | | | | | | |
| HCA PROGRAM | | | | | | | | | HCA DIVISION/SECTION | | | | | | |
| School Employees Benefits Board (SEBB) Program | | | | | | | | | Employees and Retirees Benefits (ERB) Division | | | | | | |
| HCA CONTACT NAME AND TITLE | | | | | | | | HCA CONTACT ADDRESS | | | | | | | |
| , | | | | | | | | Health Care Authority  626 8th Avenue SE  PO Box \_\_\_\_  Olympia, WA 98504-\_\_\_\_ | | | | | | | |
| HCA CONTACT TELEPHONE | | | | | | | | | HCA CONTACT E-MAIL ADDRESS | | | | | | |
| (360) 725- | | | | | | | | |  | | | | | | |
|  | | |  | | | | | | |  | | | | | |
| CONTRACT START DATE | | | CONTRACT END DATE | | | | | | | TOTAL MAXIMUM CONTRACT AMOUNT | | | | | |
|  | | |  | | | | | | |  | | | | | |
| PURPOSE OF CONTRACT: | | |  | | | | | | |  | | | | | |
| Contractor agrees to provide all contracted insurance plans and administrative services, as herein specified, for Members enrolled in the School Employees Benefits Board (SEBB) Program. | | | | | | | | | | | | | | | |
|  | | |  | | | | | | |  | | | | | |
| 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 1 and 2 are not attached but are available upon request from HCA’s Contracts Administrator.

Contract #K      for Fully Insured Medical Plans

# OVERVIEW

## Recitals

The State of Washington, acting by and through the Health Care Authority (HCA), issued a Request for Proposals (RFP) dated June 8, 2018, (Exhibit 1 – *HCA RFP 2716*) for the purpose of purchasing fully insured group medical plan(s) for the School Employees Benefits Board (SEBB) Program in accordance with its authority under chapters 39.26 and 41.05 RCW.

[Contractor Name] submitted a timely Response to HCA’s RFP #2716 (*Exhibit 2 – Bidder Response to HCA RFP 2716*).

HCA evaluated all properly submitted responses to the above-referenced RFP and has identified [Contractor Name] as an Apparently 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 insured plans and administrative services defined herein.

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

## Purpose and Scope

The purpose of this Contract is to establish Contractor as a provider of SEBB Medical Plan(s), as described in this agreement, for the School Employees Benefits Board (SEBB) Program, in which the Contractor will assume financial responsibility for their Members' medical Claims and for all incurred administrative costs. The following categories of services that Contractor will provide to HCA, all as more fully described in this Contract and all exhibits and attachments hereto are:

### Benefits Services - This includes, but is not limited to: providing benefits in accordance with the Certificate of Coverage in effect during the Contract year, Clinical Management, Utilization Management, Chronic Condition Management, Case Management, and Health Savings Account (HSA) administration.

### Administrative Services - This includes, but is not limited to: implementation, Claims administration, customer service provided via toll-free line and fax lines, Member communications including mailing of members' materials and identification cards, online services, and processing Appeals and Complaints.

### Health Transformation Services - This includes, but is not limited to: rewarding patient-centered, high value care; improving quality outcomes and patient experience; driving standardization based on evidence and best-practice recommendations; striving for the Triple Aim; and implementing purchasing strategies that align with HCA’s purchasing goals.

# DEFINITIONS

**“Accountable Communities of Health”** or **“ACHs”** is a regionally governed, public-private collaborative tailored by the region to align actions and initiatives of diverse coalition of players in order to achieve healthy communities. Nine ACHs serve the entirety of Washington State, the boundaries of which align with Medicaid Regional Service Areas.

**“All Payer Claims Database”** or **“APCD”** is Washington’s statewide all-payer health care claims database to support transparent public reporting of health care information as described in RCW 43.371.020.

**“Annual Open Enrollment”** means an annual event set aside for a period of time when Subscribers may make changes to their SEBB Medical Plan enrollment and salary reduction elections for the following Plan Year. During the Annual Open Enrollment, Subscribers may transfer from one SEBB Medical Plan to another, enroll or remove Dependents from coverage, or enroll or waive enrollment in SEBB Program medical. School Employees eligible to participate in the salary reduction plan may enroll in or re-enroll under the dependent care assistance program (DCAP), or the medical flexible spending arrangement (FSA). They may also enroll in or opt-out of the premium payment plan.

**“Appeal”** means a written or oral request for reconsideration of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services, including the admission to, or continued stay in, a health care facility.

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

**"Book-of-Business"** means all commercial business of the Contractor, including any and all fully insured and self-insured products within the Contractor’s accounts.

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

**“Bree Collaborative”** means the statewide public-private consortium established in 2011 by the Washington State Legislature “to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State." Annually, the Bree Collaborative identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree are sent to HCA to guide state purchasing for programs such as Medicaid and Public Employees Benefits Board.

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

**“Cafeteria Plan”** means a separate written plan maintained by an employer for employees that meets the specific requirements of and regulations of section 125 of the Internal Revenue Code. It provides participants an opportunity to recive certain benefits on a pretax basis[[1]](#footnote-1).

**“Calendar Days”** means any day of the week, including weekends.

**"Case Management"** means a collaborative process of assessment, planning, facilitation, Care Coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

**"Centers for Disease Control and Prevention"** or **"CDC"** means the the federal office responsible for controlling the introduction and spread of infectious diseases.

**“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.

**“Center of Excellence”** or **“COE”** isa health care provider or facility that is identified by the Contractor and/or HCA as a high quality, cost efficient provider that produces the best outcomes for a specific service.

**"Certificate of Coverage"** or **"COC"** means a summary of the essential features of the group coverage contract produced and made available to each covered person. The COC is in effect during a given benefit year in which the date of service(s) received by the Member, falls.

**“Choosing Wisely”** means the national initiative lead by the American Board of Internal Medicine (ABIM) to promote conversations between clinicians and their patients in order to avoid unnecessary medical tests, treatment, and procedures.

**"Chronic Condition Management"** means the oversight and education activities conducted by health care professionals to help members with chronic diseases and health conditions such as diabetes, high blood pressure, congestive heart failure, and chronic obstructive pulmonary disease learn to understand their condition and live successfully with it. The work involves motivating members to persist in necessary therapies and interventions and helping them to achieve an ongoing, reasonable quality of life.

**"Claim"** means the written notice on a form acceptable by the Contractor for reimbursement for any health care service or supply pursuant to the terms of the applicable Certificate of Coverage.

**"Clinical Management"** means the programs that apply systems, science, incentives, and information to improve medical practice and assist both consumers and their support system to become engaged in a collaborative process designed to manage medical/social/behavioral health conditions more effectively. The goal of Clinical Management is to achieve an optimal level of wellness and improve Care Coordination while providing cost effective, non-duplicative services.

**"Code of Federal Regulations"** or **“CFR”** means the annual codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. All references in this Contract to CFR chapters or sections include any successor, amended, or replacement regulation. The CFR may be accessed at [www.ecfr.gov](http://www.ecfr.gov/cgi-bin/ECFR?page=browse).

**"Complaint"** means an oral or written expression of dissatisfaction submitted by or on behalf of a Member regarding: (i) the denial of health care services or payment for health care services; (ii) issues other than denial of or payment for health care services, including dissatisfaction with health care services, delays in obtaining health care services, conflicts with Carrier staff or providers; or (iii) dissatisfaction with the Plan practices or actions unrelated to health care services.

**“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.

**"Consolidated Omnibus Budget Reconciliation Act"** or **"COBRA"** means the federal law administered by a governmental plan under Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. 300bb-1 through 300bb-8.

**“Consumer**-**Directed Health Plan”** or **“CDHP”** has the same meaning as a Health Savings (HSA) qualified high-deductible health plan (HDHP). A CDHP has two main components, it is: (1) an IRS defined high-deductible health plan; and (2) a Health Savings Account through an IRS qualified trustee.

**"Continuation Coverage"** means the temporary continuation of health plan coverage available to Enrollees after a qualifying event occurs as administered under COBRA, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or SEBB insurance coverage extended by the SEB Board.

**“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.

**“Coordination of Benefits”** or “**COB”** is defined in WAC 284.51.195(7).

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

**“Deliverable”** means all tangible objects, reports, work product, program or tool documentation, designs, formulas, methods, or other documents and materials provided or delivered by Contractor to HCA pursuant to the terms of this Contract.

**“Dependent”** means a spouse, state-registered domestic partner, or child of the Subscriber, who meets SEBB Program eligibility requirements as described in the SEB Board policy resolutions SEBB 2018-01, SEBB 2018-02, and SEBB 2018-03 (or subsequent amended versions of these resolutions).

**"Enrollee"** means a person who meets all eligibility requirements defined in chapter 182-31 WAC, who is enrolled in SEBB benefits, and for whom applicable premium payments have been made.

**"Explanation of Benefits"** or **"EOB"** means a statement sent to covered individuals explaining what medical treatments and/or services were paid on their behalf.

**“Formulary”** means a list of outpatient prescription drugs, selected by the Plan and revised periodically, that are covered when prescribed by a physician and filled at a participating pharmacy.

**“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.

**"Health Care Quality"** means the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

**"Health Equity"** is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health disparities or inequities, are types of unfair health differences closely linked with social, economic or environmental disadvantages that adversely affect groups of people.[[2]](#footnote-2)

**“Health Insurance Portability and Accountability Act”** or **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended from time to time, and its corresponding federal regulations.

**“Health Savings Account”** or **“HSA”** means a tax-advantaged medical savings account created for Submscribers who are enrolled in the Contractor’s CDHP plan. Funds from the account are sued to pay for medical expenses the CDHP plan does not cover.

**"Healthier Washington"** means the state initiative aimed at health transformation so Washington State residents experience better health and receive better, more affordable care.

**"HSA Trustee"** means the subcontracted IRS-qualified trustee responsible for managing HSA accounts.

**“LAN”** means the Health Care Payment Learning and Action Network, a collaborative effort between Department of Health and Human Services, acting through CMS and its private, public, and non-profit partners to transform the nation’s health system to emphasize value of care over volume.

**“Medicare”** refers to the program of medical care coverage set forth in Title XVIII of the Social Security Act as amended by Public Law 89-97 or as thereafter amended.

**“Member”** refers to Subscribers and their Dependents who have enrolled in a medical plan under this Contract, and for whom applicable premium contributions and any applicable premium surcharges have been made.

**“Monthly Premiums”** means the monthly payments made by HCA to Contractor as payment for the insurance coverage and services included in this Contract. Monthly Premiums will be calculated based on monthly per adult Member per month rates that will be negotiated and mutually agreed upon during the RFC Process and finalized by a formal amendment as described in *Exhibit 3 – Request for Completion Process (RFC Process)*.

**"National Committee for Quality Assurance"** or **"NCQA"** means a private 501(c)(3) not-for-profit organization dedicated to improving Health Care Quality. NCQA is one of several accreditation bodies for health plans in the United States. NCQA uses the Healthcare Effectiveness Data and Information Set (HEDIS) tool to measure health plan performance on important dimensions of care and service.

**"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.

**“Participating Provider”** means a person, practitioner, or entity that, at the time care is rendered to a Member, has a contract with Contractor or is employed by the Contractor to provide health related services to Members during the term of this Contract.

**"Patient Decision Aid"** means a tool that can help people engage in shared health decisions with their health care provider. Research shows that use of Patient Decision Aids leads to increased knowledge, more accurate risk perception, and fewer patients remaining passive or undecided about their care. A list of certified Patient Decision Aids can be found at: https://www.hca.wa.gov/about-hca/healthier-washington/certified-aids.

**“Patient Protections and Affordable Care Act”** or **“PPACA”** means the Patient Protections and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, together known as the Affordable Care Act (ACA).

**“Patient Reported Outcomes”** means the outcomes from medical care that are important to patients and their support groups.

**"Performance Credit"** means the financial consequence associated with failure to meet the applicable performance standards or guarantees.

**"Performance Guarantee"** means the list of expectations that HCA views as critical to the success of the plans provided under this Contract. Failure to achieve a Performance Guarantee will result in the issuance of Performance Credits.

**“Plan Year”** means the twelve (12) month duration beginning on January 1 of each year and ending December 31 of the same year.

**“Primary Care Provider” or “PCP”** means a Participating Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs, as designated by Contractor, may include, but are not limited to, pediatricians, family practitioners, general practitioners, internists, naturopathic physicians, physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNP) or, for women’s health services, providers listed in RCW 48.42.100(2).

**“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 CFR 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 CFR 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).

**"Quality Improvement"** means a systematic and continuous set of actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

**"Quality Management"** means a planned, systemic, organization-wide approach to the monitoring, analysis, and improvement of organizational performance, thereby continually improving the quality of patient care and services provided and the likelihood of desired patient outcomes.

**“Request for Completion”** or **“RFC”** means the letter HCA will draft to request information from a Contractor to finalize the details of the Contract (specifically rates and final plan design) as part of the RFC Process. The RFC is being used to amend the Contract to incorporate rates based on the SEB Board final approved plan designs.

**“Request for Completion Process”** or **“RFC Process”** means the process HCA will initiate after Contract execution in order to finalize rates and plan designs with the Contractor as set forth in Exhibit 3 – *Request for Completion Process (RFC Process)*.

**“Request for Completion Response”** or **“RFC Response”** means the Contractor’s response to HCA’s RFC that will include HCA's requested information and have a specific due date as part of the RFC Process.

**"Request for Proposals"** or **“RFP”** means the solicitation document used to establish this Contract, including all its amendments and modifications. Included by reference in Exhibit 1 – HCA RFP 2716.

**“Request for Renewal” or “RFR”** means the annual process used by HCA when issuing to request and/or require changes to benefits or Contractor’s deliverables for the next plan year. Once the Contractor and HCA come to a mutual agreement on the benefit change(s) or Contractor’s deliverables, the final is incorporated into the Contract as an amendment.

**“Response”** means Contractor’s Response to HCA’s RFP 2716 for SEBB fully insured medical plans. Included by reference in Exhibit 2 – *Bidder Response to HCA RFP 2716*.

**“Retiree”** has the same meaning as defined in RCW 41.05.011 (18) and (24)

**"Revised Code of Washington"** or **“RCW”** means the compilation of all permanent laws now in force. 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/>.

**"School Employee"** has the same meaning as 41.05.011(6)(b).

**“School Employees Benefits Board”** or **“SEB Board”** means the board made up of members appointed by the Governor that is authorized to design and approve insurance benefit plans for School Employees and to establish criteria for participation in benefit plans under RCW 41.05.740.

**“School Employees Benefits Board Program”** or **"SEBB Program"** means the program administered by HCA that purchases and coordinates benefits for eligible School Employees.

**"SEBB Medical Plan"** or **"Plan"** means a medical plan approved by the SEB Board that is offered under the SEBB Program.

**“SEBB Organization(s)”** means a public school district, or educaitonal service district or charter school established under chapter 28A.710 RCW that participates in benefit plans provided by the SEB Board.

**“Service Area”** means the designated geographical area, approved by HCA, within which a Member must reside or currently work to be eligible for enrollment. This area is comprised of the counties and zip codes listed in Exhibit 7– *Provider Adequacy and Service Areas*.

**"Shared Decision Making"** means the process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences.

**"Social Determinants of Health"** describes a set of factors surrounding Health Equity that contribute to a person’s current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature.

**“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.

**“Subscriber”** means the School Employee or Continuation Coverage Enrollee who has been determined eligible by the SEBB Program, school district, educational service district, or charter school and is the individual to whom the SEBB Program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of Members.

**"Summary of Benefits and Coverage"** means the document, required by law under the Affordable Care Act, that insurance companies and group health plans provide to consumers comparing benefits and coverage for different plans. The information provided must be concise, in plain language, and must be consistent with the health plans benefits and coverage information for consumers to easily compare different coverage options to select their health plan.

**"United States Code"** or **“USC”** means the consolidation and codification by subject matter of the general and permanent laws of the United States. All references in this Contract to USC chapters or sections shall include any successor, amended, or replacement statute. The USC may be accessed at <http://uscode.house.gov/>.

**"Utilization Management"** or **"UM"** means the evaluation of medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan. Utilization Management is sometimes called utilization review.

**"Value Based Payment"** or **"VBP"** means a form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness. HCA defines Value Based Payments as payment arrangements in the CMS Health Care Learning & Action Network Categories 2c – 4b (see Exhibit 10 - *CMS Framework for Value‐based Payments or Alternative Payment Models*).

**"Washington Administrative Code"** or **“WAC”** means the administrative rules and regulations by which state agencies operate to execute the laws enacted by the Legislature. The WAC codifies the regulations and arranges them by subject or agency. 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/>.

**"Washington Health Alliance"** or **“WHA"** means the nonprofit, nonpartisan organization that reports data on Health Care Quality and value through the collection and analysis of Claims and clinical data from providers, health plans, health trusts, and employers. They focus on evidence-based practices and providing information to providers, patients, employers, and union trusts in order to help them make better decisions about how to reduce waste and cost while focusing on quality.

**“Washington State Wide Common Measure Set”** or **"Common Measure Set"** means a set of statewide measures for Washington State that provide the foundation for health care accountability and measuring performance. The Performance Measures Coordinating Committee, which was created by legislation (RCW 41.05.690), approved a “starter set” of measures in December 2014 that are intended to evolve over time as the science of measurement and state priorities evolve.

**“WHA Community Checkup”** means the annual Community Checkup public report that is produced by the WHA. It reports on the quality of health care in Washington State by analyzing data submitted by more than 25 health plans, as well as self-insured employers, union trusts, and Washington State agencys, and reflects the outcomes of the fifty-six (56) measures in the Washington State Wide Common Measure Set.

# SPECIAL TERMS AND CONDITIONS

## Term

### The initial term of the Contract will commence on the last date of signature by both parties, and continue through December 31, 2023, unless terminated sooner as provided herein. Implementation will begin immediately following Contract execution. Covered benefits, Clinical Management, and other administrative services, such as processing Claims, will not begin until January 1, 2020.

### This Contract may be extended through December 31, 2031 in increments of no less than one (1) year, by mutual agreement of the parties. 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 have no obligation to pay any costs incurred before this Contract or any subsequent amendment(s) is fully executed.

## Deliverable Acceptance

### Upon receipt of a Deliverable submitted by Contractor, HCA will have an initial period of ten (10) Calendar Days to review and evaluate the Deliverable for deficiencies, unless a longer timeframe is mutually agreed to by the parties. HCA will provide written acceptance of the Deliverable if, in HCA’s sole reasonable discretion, it has no deficiencies.

### If a deficiency is found, HCA will notify the Contractor of such deficiency(-ies) in writing. Contractor will have five (5) Business Days to correct any deficiencies, unless a longer timeframe is mutually agreed to by the parties, and submit the corrected Deliverable to HCA. Upon receipt of the corrected Deliverable, HCA will have five (5) Business Days to review and evaluate the Deliverable for deficiencies. This process will be repeated until HCA provides written acceptance of the Deliverable.

### Once a corrected Deliverable has been accepted by HCA, the obligations described in the Deliverable will be enforceable subject to HCA’s rights and remedies contained in this Contract for Contractor’s failure to perform.

## Contractor and HCA Contract Managers

### Contractor’s Contract Manager will have primary responsibility and final authority for the services provided under this Contract and be the principal point of contact for HCA’s 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. HCA’s 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.

|  |  |  |  |
| --- | --- | --- | --- |
| CONTRACTOR  Contract Manager Information | | Health Care Authority  Contract Manager Information | |
| Name: |  | Name: |  |
| Title: |  | Title: |  |
| Address: |  | Address: |  |
| Phone: |  | Phone: |  |
| Email: |  | Email: |  |

## 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 either delivered in person, 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;

### Exhibit 14 – *Data Share Agreement*;

### Special Terms and Conditions, HCA Responsibilities, Contractor Obligations, and Strategic Partnering on Health Transformation;

### General Terms and Conditions;

### Attachment 1: Confidential Information Security Requirements;

### Exhibit 1: *HCA RFP #* 2716 *for SEBB Program Fully Insured Medical Plans*, dated June 8, 2018;

### Exhibit 2: *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 million 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 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).

### The policy must be maintained for the term of this Agreement and three (3) years following its termination.

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.

# HCA RESPONSIBILITIES

## Responsibility

While establishment of eligibility criteria is the statutory responsibility of the SEB Board, HCA retains administrative responsibility for individual eligibility determinations for SEBB Program benefits, and handles individual benefits eligibility Appeals. HCA has the right to delegate its administrative responsibility and benefit eligibility appeals to a SEBB Organization(s).

In addition, HCA reserves the right to authorize audits by third parties.

## Compensation

1. HCA shall pay to Contractors as compensation for the performance of all services necessary and incidental to meet Contractor’s obligations under this contract the Monthly Premiums. Initial rates used in calculating the Monthly Premium will be determined by the RFC Process as described in Exhibit 3 – *Request for Completion* *Process (RFC Process)* and finalized by a formal amendment to this Contract.
2. If this Contract is terminated pursuant to Section 7.40.F. such that none of Contractor’s medical plans are offered as a SEBB Medical Plan to Subscribers during the 2019 Annual Open Enrollment, HCA shall pay as compensation to Contractor for any implementation services and deliverables described in Exhibit 6 – *Implementation Plan* the lesser of (i) actual costs incurred by Contractor in the performance of such services and delivery of accepted deliverables, or (ii) $100,000. No other compensation will be owed by HCA to Contractor if this Contract is so terminated.
3. Any such payment made under Section 4.2.B. shall be contingent upon Contractor providing (i) all completed or in process Deliverables to HCA, and (ii) a detailed invoice of the costs incurred by Contractor in performing implementation services set forth in Exhibit 6 – *Implementation Plan*. Both (i) and (ii) of this subsection C. shall be as of the effective date of termination pursuant to Section 7.40.F.

## Eligibility Information

HCA will provide enrollment data to Contractor by way of a daily eligibility change file and a monthly file in American National Standards Institute (ANSI) 834 Benefit and Enrollment Maintenance Format. HCA agrees to accept responsibility for furnishing up to date enrollment information and Contractor may rely upon the latest information received as correct without further verification, unless there is an obvious error. Rarely, and only when necessary, HCA may provide updates by telephone, followed by confirmation via the standard ANSI 834 Benefit and Enrollment Maintenance Format.

## Procedures for Applying for SEBB Benefits

HCA will require all potential Members to follow consistent procedures as outlined in WAC and other HCA guidelines in applying for benefits.

## Information

HCA will furnish information and materials requested by Contractor that are in the possession of HCA as necessary for Contractor to provide its services as specified in this Contract. HCA is responsible for the completeness and accuracy of such information and materials.

## Member Communications

### HCA will define, in WAC, eligibility and coverage requirements to be used by Contractor in Member communications. HCA will establish and comply with document control policies and procedures, and provide timelines to the Contractor.

### HCA will develop, educate, advertise, and deliver information on the Contractor's SEBB Medical Plan(s) to promote the Contractor's plan(s) to Members.

### HCA will provide a single point of contact to the Contractor at the beginning of each Plan Year for the Contractor to work directly with.

## Benefits Design

HCA will collaborate with Contractor on benefit design, however, final benefit design decisions will be made by HCA or the SEB Board.

# CONTRACTOR OBLIGATIONS

Contractor will comply with the provisions and obligations of this section during the term of this Contract, in order to receive timely payment by HCA as provided in section 4.2, *Compensation*.

## Account Management

### General:

#### All costs associated with staff assigned to the HCA account will be included in the Contractor's Monthly Premium payment.

#### Contractor will provide HCA with a list identifying all staff members of the Contractor’s account management team.

#### Contractor will provide an account management team that is proficient in coordinating resources and services to meet all Contract requirements and Performance Standards and is responsive to HCA requests for support and coordination.

#### No new employees will be assigned to the account team without HCA's written approval. HCA has the authority to require replacement of account team members. Contractor shall not replace account team members without the express written consent of HCA.

### Account Management Functions. The Contractor will:

#### Be responsive to HCA inquiries and problems, acknowledge receipt of each request within 24 hours of receiving the request and have an estimated resolution time within 48 hours.

#### Attempt to answer each request within three (3) Business Days; provided, however, requests designated by HCA as urgent of a legislative request must be answered within 24 hours.

#### Be sensitive to the economic and political environment associated with SEBB Medical Plans.

#### Keep HCA informed of new and outstanding issues that relate to the Contractor's administration of their Plan(s), such as down customer service call lines, microsite service interruptions, etc.

#### Have a point of contact for Members inquiries that come directly to HCA and a dedicated escalations process for the HCA Account Manager and the Contractor’s point of contact for working through escalated Member issues.

#### Attend all SEB Board meetings (via teleconference or in person) and work with the HCA Account Manager after meetings to follow-up on SEB Board questions.

#### Travel to in-person meetings as required by HCA.

#### Collaborate and coordinate with the Office of the Attorney General (AGO), including any Special Assistant Attorney General, when requested by the AGO, on any actual or potential legal action litigation against HCA related in any way to the Plan(s). This includes the gathering by Contractor of information, data, and documents used internally by Contractor or any Subcontractor, and providing witnesses as requested by the AGO or required as part of the litigation process. No additional fees will be paid for such services.

#### Manage the contract with the HSA Trustee for the Contractor's SEBB CDHP.

#### Comply with, or provide information and refund money to allow HCA to comply with, Washington State and other applicable laws relating to escheatment and unclaimed property, including chapter 63.29 RCW.

#### Inform HCA in writing of any changes among the Contractor’s executive leadership and management team who is involved with this Contract within ten (10) Business Days of Contractor’s knowledge of such change.

### Account Managers. The Account Managers will:

#### Be the daily points of contact for the HCA Contract Manager(s) and team, and for the escalation of issues between Contractor and HCA.

#### Coordinate and recommend strategies to the SEB Board with HCA, including lowering or maintaining cost trend, improving Utilization Management, and changing the health care market to achieve Healthier Washington goals.

#### Respond when called for urgent issues, as identified by HCA, within four (4) hours.

#### Be the point of contact for all Contract amendments, accounting, and finance questions.

### Medical Director (Doctor of Medicine (MD) or Osteopathic Medicine (DO))

#### Must be an employed physician of the Contractor who holds a current, active, and unrestricted license to practice medicine in Washington State. The MD or DO is responsible for the following:

#### Provide medical expertise and clinical guidance, and promote the delivery of evidence-based care.

#### Oversee the Quality Management and Improvement, Utilization Management, provider credentialing, and population health management programs.

#### Ensure implementation of components of the Bree Collaborative and other HCA-identified performance improvement requirements as they relate to the SEBB Medical Plan(s) and the State’s health care purchasing system.

### Implementation Management

#### The Implementation Management team will consist of:

#### Implementation Manager. The duties will include:

1. Serve as the single point of contact for HCA Account Manager and HCA project manager on implementation activities.
2. Coordinate and ensure performance of the implementation Services.
3. Work full-time in support of Contractor’s implementation services.
4. Provide services from the Effective Date through June 2020 for initial phase. If any new plans are added at a later date, Contractor will supply an implementation manager for such projects.

#### Project Managers:

1. Contractor will provide at least two (2) solely dedicated full-time employees to service as Project Managers reporting to the Implementation Manager.
2. Project Managers will support implementation activities as directed by the Implementation Manager, coordinate and ensure performance of the implementation services, and provide services from the Effective Date through June 2020 for initial phase.

### Emergency Response Account Management

#### The Contractor must be able to maintain specific business functions during an extended closure or emergency or sever weather event. Contractor will:

#### Within five (5) Business Days of a request from HCA, and annually on August 1, Contractor will provide its current Business Interruption and Disaster Management Plan specific to SEBB Medical Plan operations. An initial SEBB Medical Plan disaster plan and uninterrupted business plan and contact lists are included as Exhibit 16 – *Business Interruption and Disaster Management Plan*.

#### Maintain core business operations during an Event and provide HCA specific information that clearly relates the emergency response to the contracted SEBB Medical Plans during an Event no less frequent than once per 24-hours.

#### Maintain in an uninterrupted manner those business functions and services listed in the following sections:

1. 5.1 (Account Management),
2. 5.3 (Covered Services and Benefits),
3. 5.5 (Customer Services),
4. 5.6 (Online Services), and
5. 5.8 (Claims Services).

## Enrollment Provisions

### Eligibility for Enrollment

Eligibility of Subscribers and their Dependents and the terms of their coverage must be set forth in each Plan Years’ Certificates of Coverage (COCs), subject to amendment in accordance with current and future provisions of chapter 41.05 RCW and Title 182 WAC.

### Open Enrollment Periods

#### SEBB Annual Open Enrollment:

Contractor will support HCA’s designated SEBB Annual Open Enrollment activities each fall, to include, but not limited to: develop and deliver communications, attend benefit fairs, process eligibility files, etc.

#### Special Open Enrollment:

#### In addition to HIPAA special open enrollment, the HCA, at its discretion, will authorize special Open Enrollment periods consistent with those allowed under a Cafeteria Plan. Contractor agrees to accept new Members during a special Open Enrollment period at the then current rates. Special Open Enrollment periods will include a Special Open Enrollment due to a significant curtailment of coverage which will be used if a material provider network disruption occurs.

### Retroactive Enrollment

#### To the extent permitted by federal and state law, at the direction of HCA, Contractor will enroll any person for whom HCA pays such person’s Monthly Premium on a retroactive basis, even though the person may not have complied with the prescribed time limits for obtaining coverage. When a person has been retroactively enrolled, services covered during that retroactive period may be limited to those provided by Participating Providers (except if otherwise required by COB provisions; see section 5.4, *Coordination of Benefits (COB)*), and emergency care services. In addition, with regard to services that require preauthorization, retroactive coverage may be limited to services that would have been preauthorized (except if otherwise required by COB provisions) had the Member been actively enrolled at the time services were provided.

#### To the extent authorized by federal and state law, HCA may retroactively disenroll a Member who is not eligible for enrollment in the SEBB Medical Plan or who has not fully paid premiums when due, and recoup premium payments paid after the effective date of termination.

### Conditions for Enrollment

#### Subscribers must permanently reside, or be employed, within the Service Area. Contractor will notify HCA if it becomes aware that the Subscriber is no longer eligible for its plan. HCA may require Contractor to cover full zip codes and/or school districts that cross county borders served by Contractor in order to assure continuity of care or ready access to health care services. Contractor may require Members residing in a zip code or working at a school district that crosses the Service Area county border to access care in the county where Contractor has been awarded a contract.

#### Dependents will be eligible for enrollment only in the health plan selected by the Subscriber and must obtain all health care services from providers within any of the Contractor’s Service Areas, except for emergency care services within or outside the Service Area as set forth in the COCs.

### Enrollment Reconciliation

Contractor will perform a full file enrollment match not less frequently than monthly. Contractor will:

#### Initiate full file match process by:

1. Comparing the 834 monthly audit file that gets automatically created on the morning of the 1st of each calendar month; or
2. Sending an email to [ispebbsr@hca.wa.gov](mailto:ispebbsr@hca.wa.gov) to request an 834 audit file on a specific date.

#### Use the 834 monthly audit file to compare (not update) the Contractor’s enrollment with SEBB enrollment to ensure that every Member's enrollment match.

#### Create a file in txt format of only main Subscriber SSN(s) that didn't match (do not include the Dependent SSN even if the mismatched Member is the Dependent). Mismatch condition is either:

1. Member is not in SEBB's system, but in the Plan's system; or
2. Member is not in the Plan's system, but in is SEBB's system.

#### Upload the txt file of Subscriber SSN to <https://sft.wa.gov>.

#### Send email to [ispebbsr@hca.wa.gov](mailto:ispebbsr@hca.wa.gov) with notification that mismatch file is available.

Once Contractor has completed steps I-V above, HCA will download the file and create a separate 834 file with appropriate information with dates, as close as possible to the original date, to process against Contractor's file to bring Contractor's file in synchronization with HCA's file. For example: If Contractor's database has a Member that HCA does not have, HCA will send Contractor a "delete" record. If Contractor's database is missing a Member that HCA's database does have, HCA will send Contractor an "add" record. HCA will reply to the email from step V of this section when the mismatch 834 file is ready for Contractor pick-up.

## Covered Services and Benefits

### Certificates of Coverage (COCs)

#### Unless otherwise stated, the benefits and services described in the COCs are hereby incorporated by reference as if fully set forth herein (Covered Services). The parties understand the terms of coverage under this Contract are fully set forth in the COCs in effect for the Plan Year in which services were received.

#### Upon notification by HCA or the Office of Insurance Commissioner (OIC) that a COC contains provisions that are non-compliant with state or federal regulation or law, Contractor will amend the COC and provide notice of the changes to Subscribers as directed by HCA or OIC.

#### Contractor will update the COCs for each renewal Plan Year. Contractor will assume responsibility to write, design, print, and distribute the COCs for the Contractor's Plan(s) annually and in accordance with the timeline(s) provided by HCA, ensuring their compatibility with Contractor’s administration of the Plan(s) and HCA’s responsibility for defining eligibility and benefits. By March 15 of each year, Contractor will develop the review schedule subject to HCA’s approval. HCA has final approval of the COCs, which must be finalized in PDF format at least three (3) Business Day before Annual Open Enrollment of each year.

#### Contractor will deliver a total of fifty (50) printed copies of the COC for each Plan to HCA as soon as possible, but in no event later than December 15 of each year.

#### Contractor will make available, upon request, a printed copy of the COCs to Plan Members and prospective Plan Members at no cost to the Member (or prospective Member) or HCA.

### Benefit Access

#### Contractor will issue Members identification cards. Contractors will ensure that Participating Providers accept the HCA-issued notice of enrollment as sufficient verification of enrollment to access Covered Services until an official identification card is issued to the Member.

#### Contractor will ensure Members have access to Covered Services by the medically appropriate provider upon the effective date of enrollment.

#### Subscribers and their Dependents, eighteen (18) years of age and older, are eligible for participation in Contractor’s Diabetes Prevention Program at no cost, when the Subscriber and/or Dependent meet the qualifying criteria to participate in the program.

#### In accordance with the Americans with Disabilities Act, Contractor will:

1. Assure equal access of Covered Services for all Members when a Member’s oral or written language capabilities creates a barrier to such access;
2. Make reasonable accommodation for Members with disabilities for all Covered Services and will assure physical and communication barriers will not inhibit Members with disabilities from obtaining Covered Services; and
3. Provide TTY/TDD services, or other available modes of communication, to accommodate visually and hearing impaired Members .

#### Contractor will provide foreign language translation services that comply with Section 1557 of the Affordable Care Act at no additional charge for Members.

#### Neither Contractor, nor its Participating Providers, will require Members to sign forms or waivers promising not to sue, or requiring binding arbitrations.

### Network Adequacy

#### Contractor will maintain the support services and a provider network within the Contractor's Service Area(s), sufficient to serve Members and consistent with the requirements of this Contract. Contractor will provide the Covered Services required by this Contract through non-Participating Providers if its network of Participating Providers is insufficient to meet the medical needs of Members in a manner consistent with this Contract. Contractor will make Covered Services as accessible to Members under this Contract as under its other state, federal, or private contracts.

#### Participating Provider adequacy (access guidelines) is located in Exhibit 7– *Provider Adequacy and Service Areas*.

### 24/7 Availability of Services

Contractor will have the following services available on a 24-hour-a-day, 7 days-a-week (24/7) basis. These services may be provided directly by the Contractor or may be delegated to Subcontractors, provided that all Subcontractors perform subject to the applicable terms and conditions of this Contract:

#### Medical advice for Members from licensed health care professionals concerning the emergent, urgent, or routine nature of a medical condition through a nurse line, telemedicine, and virtual care.

#### Emergency services (in and out-of-network coverage), out-of-area urgent care, or care at other facilities when the use of participating facilities is not practical.

#### Access to the Member’s on-line account.

### Alternative Arrangements

#### Contractor agrees to make a reasonable effort to secure alternative arrangements for the provision of care by another Participating Provider without additional expense to the Member under the following circumstances:

1. In the event a Participating Provider’s contract is terminated.
2. In the event a Participating Provider is unable or unwilling to provide care to any Member, except as provided by this Contract.

#### If such alternative arrangements are not made available, or are not deemed satisfactory to HCA due to problems of access or quality of care, then Contractor agrees to provide all services and benefits of this Contract to the Member on a fee-for-service basis. In such an event, Contractor will reimburse Member for such fees, less any deductible or copayment specified in this Contract, and the limitation contained herein with respect to use of a Participating Provider will be of no force or effect.

#### If services or benefits are provided on a fee-for-service basis, they will continue until any affected treatment plan has been completed or until such time as the patient agrees to obtain services from another Participating Provider for the same condition or treatment plan, his or her enrollment is terminated, or enrollment is transferred to another plan offered to Members, whichever comes first.

### Certification of Disabled Dependents

#### Contractor will provide input to the SEBB Program regarding the Dependent's nature of the disability and dependence on the Subscriber. The SEBB Program will determine certification of disability for disabled Dependent status under the health plans covered by this Contract.

#### Contractor will provide their disabled Dependents certification process, which will be incorporated into the Contract as an exhibit.

### Office Appointment Standards

Contractor will comply with appointment standards that are no longer than the following:

#### Non-symptomatic office visits will be available from the Member’s PCP or an alternative provider within thirty (30) Calendar Days. A non-symptomatic office visit may include, but is not limited to, well or preventive care such as physical examinations, annual gynecological examinations, or children and adult immunizations.

#### Non-urgent, symptomatic (e.g., routine care) office visits will be available from the Member’s PCP or an alternative provider within seven (7) Calendar Days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

#### Urgent, symptomatic office visits will be available with twenty-four (24) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

#### Emergency medical care shall be available 24/7.

### Access to Specialty Care

Contractor will provide availability of necessary covered specialty care for Members available within the Contractor’s Participating Provider Network. If a Member needs specialty care from a specialist who is not available within Contractor’s Participating Provider network, Contractor will provide the necessary services with a qualified specialist outside Contractor’s Participating Provider network without additional expense (except applicable coinsurance or copayment amounts) to the Member or to HCA.

### Preventive Care

#### Preventive care services will be provided in accordance with the Patient Protection and Affordable Care Act (PPACA).

#### If any federal or state laws regarding preventive care services are repealed, Contractor will continue to cover said preventive care services, unless otherwise directed by the HCA.

#### Contractor will provide Members with a description and recommended schedule of preventive care benefits to be used by Contractor. Contractor’s preventive care benefit description and schedule will be submitted to HCA upon request.

#### Contractor will administer a preventive services program that ensures appropriate wellness and preventive services by providing targeted reminders for Members when data indicates a Member may be due for certain services.

### Tobacco Cessation Program (placeholder for negotiations)

### Diabetes Prevention Program

Contractor will contract for testing services and for the 16-week course/classes of the Diabetes Prevention Program (DPP) provided to non-Medicare Members age eighteen (18) and older with a CDC approved vendor(s), to be in person or by virtual care. Contractor agrees to provide monthly participation reports.

### Prescription Drugs, Insulin, and Diabetic Supplies

The Prescription Drug, Insulin and Diabetic Supplies benefit will be administered as follows:

#### Formulary: Contractor’s Formulary must reflect an evidence-based Formulary that includes all therapeutic classes of drugs and meets or exceeds the recommendations set forth by the Academy of Managed Care Pharmacists. The Formulary or list for Members must be available to Members upon request. Contractor must ensure Members know how to request the Formulary; Contractor will provide the list to the requesting Member within 2 Business Days of receipt.

#### Administration of copayments:

1. In no case may a Member’s copayment exceed the price of the drug.
2. If a brand-name drug has an AB-rated generic equivalent available, but Contractor chooses not to include it on its generic list, then a brand-name drug must be substituted at the generic copayment level. In a case where there is more than one AB-rated generic equivalent drug available, Contractor shall include at least one of these generic drugs on the Formulary or Contractor shall make a brand-name drug available at the Formulary generic copayment level.

#### Fill Restrictions:

1. Contractor may restrict the initial fill quantities of a drug where there is a sound clinical basis, such as for a new prescription with likely dosage, tolerance, or efficacy questions.
2. Contractor may limit newly released drugs and use for newly approved indications (for example, the first year after clinical approval for a specific indication) to specific circumstances and protocols when there is a sound clinical basis.
3. Contractor may require preauthorization for a drug. Approval criteria must be consistently applied to all Members.
4. If Contractor imposes any of these restrictions, the restriction must be described clearly in the COCs.

### Drug Formulary Changes

Contractor will give its Members sixty (60) Calendar Days’ notice when they are currently prescribed a drug that will be removed from Formulary status and notify the prescribing physician of the Formulary change. An exception to the notice requirement will be allowed when Contractor continues to cover a drug prescribed for a Member without interruption and under the same conditions, including copayment and limits that existed prior to the removal of the drug from Formulary status.

### Opioid Policy (placeholder for Contract negotiations)

Contractor will comply with HCA’s opioid policy; see Exhibit 15 – *HCA’s Opioid Policy*.

### Clinical Management Programs

The following are three Clinical Management programs that Contractor must provide for their SEBB Medical Plan(s). Additional Clinical Management programs will be found in Exhibit 12 - *Clinical Management Programs*.

#### Complex Case Management (placeholder for Contract negotiations)

#### Chronic Condition Management (placeholder for Contract negotiations)

#### Medical Benefit Drug Management (placeholder for Contract negotiations)

### Referrals

Any written referral by a Participating Provider is considered a Contractor-authorized referral unless the Member (or Member’s legal representative) is given a copy of a statement acknowledging that the referral services will not, or may not, be covered by Contractor, or that the referral must have prior authorization from Contractor to ensure that the services are a covered benefit. Contractor may not deny charges for referral services unless the Contractor, or a Participating Provider, on behalf of Contractor, has first provided the above-referenced statement to the Member or Member’s legal representative.

### Prior Authorization Standards

Contractor will comply with RCW 41.05.074. If Contractor imposes different prior authorization standards and criteria for Covered Services of contracted providers of the same licensed profession within the same health plan, Contractor will post which tier an individual provider or group of providers is in by posting this information on Contractor’s website in accordance with RCW 41.05.074. Contractor will ensure this information is accessible to both Enrollees and providers.

### Consumer-Directed Health Plan (CDHP) and Health Savings Account (HSA)

#### Contractor will administer an integrated-IRS qualified CDHP, coupled with a HSA, administered by the Contractor’s HSA Trustee. Contractor agrees to:

1. Brand their IRS qualified HDHP as a CDHP for the SEBB Program.
2. Maintain, in good standing, its trustee contract throughout the term of this Contract.
3. Electronically transmit timely SEBB CDHP enrollment and Member health care claims to HSA Trustee.
4. Use and/or disclose Member protected health information solely to perform the duties and services described in this Contract. All parties will comply with all laws and rules that regulate the use and disclosure of protected health information, including but not limited to HIPAA and applicable state laws.
5. Perform a CDHP enrollment match with HSA Trustee not less frequently than quarterly. It is the responsibility of Contractor to:
6. Contact HSA Trustee to coordinate transmittal of the full file match and reconcile exceptions; and
7. Reconcile discrepancies from the HSA Trustee data file within ten (10) Business Days and inform HCA’s Information Services team of any unreconciled enrollment discrepancies.
8. Actively monitor the performance and services provided under the terms of the HSA Trustee contract.
9. Ensure HSA Trustee mails the accountholder Forms 5498 and 1099 by the time deadlines required by the IRS.
10. Provide HCA with a written statement, upon request, signed by HSA Trustee that verifies the they are committed to render the SEBB Program administrative services required under this Contract in accordance with the their Contract with Contractor.

### Group Continuation Plan and Conversion of Coverage

The parties to this Contract understand that a Member is entitled to Continuation Coverage under the terms and conditions set forth in the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and conditions set forth in Washington law governing Continuation Coverage upon expiration of COBRA rights. Contractor will provide that coverage. Contractor also agrees to notify eligible Members of the availability of individual health options prior to their termination of COBRA coverage and Contractor will provide such notice.

## Coordination of Benefits (COB)

### When a Member is covered under one or more other plans, the benefits of this plan will be coordinated with the benefits payable by such other plans in accordance with the provisions set forth in the COCs and state and federal regulations. COB is allowed under RCW 48.21.200 and chapter 284-51 WAC in group and individual plans. The SEBB Program design does not include individual plans, as defined in Section VI.B., for purposes of COB. SEBB Medical Plans are designed to coordinate benefits between group products only.

## SEBB Medical Customer Services

Contractor's Member and customer service representatives will be responsible to understand SEBB benefits and eligibility information in order to provide knowledgeable, responsive, high quality customer service to all Enrollees, regardless of their location. Contractor’s center providing such services will be structured to provide a consistently high degree of Member and customer services and timeliness as measured through the applicable performance standards defined in Exhibit 4 – *Performance Guarantees (PG) and Medical Loss Ratio (MLR)*. All of the Contractor's Member and customer service team must be located within the United States. Claims processing must be located and performed within the United States. Contractor’s Member and customer service center must be well-versed in the geographic, cultural, and social aspects of Washington State, Oregon, and Idaho. Contractor will:

### Beginning on September 1, 2019, and each year thereafter on a day to be determined, provide at least two (2) trained staff for every SEBB Annual Open Enrollment benefits fair (which could be held multiple times in different locations in Washington over the SEBB Annual Open Enrollment period) who can knowledgeably discuss topics including benefits and cost-sharing, network providers, Claim procedures, Member services, and plan informational tools and resources.

### Provide interactive voice response (IVR) for providers to access Members' eligibility and Claims information, and for Members to access self-service customer service options.

### Provide a secure on-line portal to allow providers and Member’s access to eligibility and Claims information.

### Provide language translation services and TTY/TDD services, or other available modes of communication, to accommodate visually and hearing impaired Members in accordance with Washington State and federal law.

### Provide a backup customer service center when local customer service is disrupted.

### Provide customer service coordination with the Plans' eligibility and enrollment, with the other HCA vendors, as directed by HCA.

### Collect Member feedback and respond appropriately by the end of the next Business Day after receipt. Provide Member feedback to HCA, as requested.

### Establish and maintain a process and system for monitoring call quality and accuracy of information provided.

### Provide a clinical case manager or reviewer as the first point of contact for clinical programs.

### Provide customer service via telephone and live online chats (Monday through Friday, 8 a.m. to 8 p.m. Pacific Time and Saturday 8 a.m. to 4:30 p.m. Pacific Time), email, and mail.

## Online Services

### Contractor will collaborate with HCA to develop and host a SEBB-specific microsite for their Contracted SEBB Medical Plans. HCA will provide needed information, such as HCA logos. The design and content of the Contractor's microsite will be subject to HCA's review and approval. The Contractor will provide HCA thirty (30) Calendar Days' notice of any material proposed changes (including HCA's review and approval) to the content or functionality of the microsite. Contractor will do the following:

#### Provide ongoing maintenance of the microsite as funded by the Contractor's Monthly Premiums.

#### Except for scheduled downtime not exceeding three (3) hours per month, provide access to the Contractor's microsite 24/7, with continuity as provided in Section 5.1(F), *Emergency Response Account Management*.

#### Ensure information on the microsite is kept up-to-date, accurate, and complies with the ADA and other associated regulations, such as HIPAA.

#### Respond to all Member emails by the end of the next Business Day after receipt.

#### For testing and acceptance, see Exhibit 6 – *Implementation Plan*.

#### Capture and maintain all Member communications within a searchable data warehouse.

#### Allow for mobile/tablet access as well as desktop use.

### Microsite Security Standards. The online services must at all times meet or exceed the following state of Washington Information Technology Standards attached as Exhibit 5 – *OCIO Policies*, or their replacements or successors:

#### [Security](https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets);

#### [Accessibility Guidelines](https://ocio.wa.gov/policies/1000-g1-state-guidelines-%E2%80%93-accessibility-information-technology-individuals-disabilities); and

#### [Public Records Privacy Protection Policy](https://ocio.wa.gov/online-file-storage-guidance).

### Non-Secure Access. On any webpage of the Contractor's microsite that is available to the public and does not require specific sign in, Contractor will provide the following:

#### Identification of the SEBB Plans and statement relationship between HCA and Contractor.

#### Searchable up-to-date provider directory with the provider’s location that is searchable by zip code. This tool will support the goals and objectives of HCA while providing Members the support they need to effectively optimize their utilization of their Plan.

#### In-network provider ratings displayed at the provider and facility levels to identify high-value, high-performing providers, using the WHA Community Checkup where available. Ratings should take into account multiple performance and outcome measures resulting from authenticated member experiences.

#### Benefit information, to include COCs, Summaries of Benefits and Coverage, and other general benefit information.

#### Links to other Washington State or HCA vendor websites, as requested by HCA, including links to the following websites and any other Washington State or HCA vendor as requested:

1. Bree Collaborative public website;
2. Washington Health Foundation Choosing Wisely website.
3. HCA’s main SEBB Program webpage.

#### Downloadable forms in PDF or Word Format (authorization forms, etc.).

#### Resources for Members, to include, but not limited to:

1. Cost transparency tool for both medical and pharmacy, which considers Member benefit designs relative to copays and cost sharing.
2. Coverage exceptions and service limits.
3. Cost and outcome comparisons of alternative treatments linked to shared decision-making tools.
4. Pharmacy benefits.
5. Provider quality information.
6. Informed decision-making tools and education, including:
7. HCA certified shared decision making tools; and
8. For procedures where no HCA certified Patient Decision Aids exist, patient decision support aids for common decisions regarding surgeries, medical tests, medicines, and other health issues that guide Members through understanding their choices, comparing risks versus benefits, expressing their preferences, and making a decision that’s right for them. Aids should include a summary including key questions they can review with their doctor. This covers over 100 decisions regarding surgeries, medical tests, medicines, and other health issues.
9. HCA-certified Shared Decision Making tools.
10. A list of services requiring preauthorization and related standards, coverage criteria, or other information, to be updated monthly in accordance with RCW 41.05.0740.
11. List of Contractor's or vendor's discounts available to Members.
12. 24/7 nurse line.

### Secure Access. On any webpage of the Contractor's microsite that requires secure sign-in and provides PHI, such as services a Member has received, Contractor will provide the following:

#### Sign-in security approach that meets the OCIO security standards (see, Exhibit 5 – *OCIO Policies*) and in coordination with other vendors that provide Member online services to ensure a single sign-on across sites.

#### Personal and Dependent Claims history that complies with HIPAA privacy requirements (e.g., some Claim information or Dependents may need to be masked on the basis of diagnosis or age), accumulator status, deductible status, and out-of-pocket maximum status.

#### Masking all sensitive Claims individually or suppressing entire Dependent records from view for sensitive Claims.

#### Cost calculator to search medical costs by treatment code and diagnostic procedure, including office visits, inpatient and outpatient (including provider and facility costs), with filter capability by provider, facility, keyword or category, provider demographics, patient safety scores, clinical quality, measures for hospitals, experience match scores for providers and professionals, and patient satisfaction ratings where available. The cost calculator will include pharmacy benefits.

#### Contractor will train customer service staff on assisting Members in the use of the cost calculator. Training will include the source(s) of data used by the calculator, the services reported by the calculator, and the most common scenarios when customer service staff are expected to assist Members with the calculator.

#### Secure email to and from customer services with next Business Day response.

#### Secure messaging for Members to communicate with their providers.

## Member Communications and Marketing

### Contractor, and its Subcontractors, will not engage in any marketing activity related to this Contract without prior written approval of HCA.

### Contractor, and its Subcontractors, will not use the names, or any references to, or identifying marks of SEBB, HCA, or the state of Washington on any materials produced or issued by Contractor without the prior written consent of HCA. This includes, but is not limited to marketing, advertising, web text, or other direct communications to Members, terminated Members, or potential Members.

### Contractor will dual brand, between HCA and Contractor, communications pertaining to the Contractor's SEBB Medical Plan(s), with the HCA logo and Plan name the same size as Contractor's name and logo, unless otherwise agreed to by HCA. No Plan communications will be branded as being solely from the Contractor except with advance written approval of HCA.

### Contractor, and its Subcontractors, will not to represent itself as endorsed, supported by, or affiliated with the state of Washington.

### Contractor, and its Subcontractors, will collaborate with HCA to the fullest extent possible to develop and distribute written and web communications concerning matters relating to the scope of this Contract, including but not limited to the Contractor's SEBB Medical Plan(s) and HSA.

### At the beginning of each Plan Year, Contractor will provide HCA a single point of contact regarding the services outlined in this section 5.7, *Member Communications and Marketing*.

### Contractor will comply with the document control policies and procedures that are established by HCA.

### All communications will be readable and clear, ADA-compliant, and in full compliance with Section 1557 of the Affordable Care Act (including the availability of language translation services, and translated materials to be provided upon Member request within seven (7) Calendar Days).

### Contractor will write, design, print, and distribute the SEBB Annual Open Enrollment materials (both physical and electronic copies) listed below. All SEBB Annual Open Enrollment and new Plan Year communications must be approved by HCA thirty (30) Calendar Days prior to the start of the SEBB Annual Open Enrollment.

#### Benefits summary comparison documents;

#### CDHP materials;

#### Disclosure items required by the Washington State Health Care Patient Bill of Rights described in RCW 41.05.017;

#### Informational materials, including changes to the Plan(s) for the upcoming Plan Year;

#### Microsite promotional page;

#### Postcards used to request a hard copy of the COC;

#### Provider directories (print copies to be available for reference at annual benefit fairs and to Members upon request); and

#### Summary of Benefits and Coverage documents.

### For each Plan, write, design, print, and distribute a hard copy welcome packet and identification cards for new and renewing Members no later than (1) December 20 of each year if Contractor receives the full membership eligibility file by December 10, and (2) within thirty (30) Calendar Days for the enrollment of a new Member if Contractor receives the updated membership eligibility file within five (5) Business Days of the Member's start date. If Contractor does not receive the full membership eligibility file by December 10 of each year, then Contractor is obligated to mail the welcome packet and identification cards within seven (7) Calendar Days of receiving such file.

### Contractor, and its Subcontractors, will submit any materials or web text intended primarily for Members or prospective Members as part of a mass distribution for enrollment in SEBB coverage to HCA for review and prior approval. In addition, Contactor will submit to HCA a courtesy copy of all other materials sent to Members or prospective Members as part of a mass distribution. This subsection does not refer to such items as provider directories and plan-wide newsletters, as long as they do not contain information on eligibility, enrollment, benefits, and rates, which HCA must review.

### Contractor, and its Subcontractors, will not advertise or distribute any information to Members, terminated Members, prospective Members, or providers that contains false or misleading information. Violation of this subsection is subject to the rights and remedies defined in this Contract. Contractor further agrees that if erroneous or misleading information is sent to a Member or Subcontractors (including contracted providers) regarding any matter related to this Contract, HCA may require Contractor to mail a correction or clarification to correctly inform the recipients of such written materials, at Contractor’s expense.

Nothing in this Section will be construed to prohibit Contractor from acknowledging that it has entered into this Contract with HCA.

## Claims Services

Claims processing must be located and performed within the United States. Contractor will:

### Administer the Plan benefits as outlined in the most current COCs, as described in this Contract. HCA will approve all COCs for all SEBB Medical Plans every calendar year.

### Adjudicate all Claims in accordance with Plan benefits and Service Area/non-Service Areas in the applicable COC.

### Demonstrate strategic initiatives within the Contractor's SEBB Medical Plans that offer similar or better results to HCA's strategic initiatives and demonstration projects, such as Accountable Care Networks (ACNs), Centers of Excellence (COE) contracting, bundled payment, and tiered hospital networks. If the Contractor does not have any strategic initiatives, Contractor will support HCA's strategic initiatives in partnership with HCA based on an agreed to strategic plan, and in a manner that does not disrupt the Contractor's Book-of-Business.

### Provide fraud, waste, and abuse (collectively called program integrity) awareness, detection, and recovery services.

### Recover any payments the Contractor determines have been made erroneously.

### Provide a structured, dedicated, and adequately staffed Claims office that delivers a consistently high degree of Claims payment accuracy and timeliness as measured by the Performance Guarantees.

### Provide services for Claim adjudication, Appeals and Complaints management, reports and customer service for all Claims for dates-of-service during the Term.

### Resolve issues with Claims requiring additional information for proper adjudication, including:

#### Authorization;

#### Coordination of Benefits;

#### Member eligibility;

#### Referral;

#### Third-party liability; and

#### Workers’ Compensation information.

### Include all Claims and provider networks in one resource enabling Members to receive EOBs, access Claims information (electronic and paper based), and search for providers.

### For any new Value Based Payment arrangement, new alternative payment model, or change to an existing arrangement or model, co-develop, implement, and administer such arrangements or models as requested by HCA.

### Perform other Claims-related functions necessary to provide a complete administration of Claims service.

### Provide internal audit, training, and performance management programs to ensure consistency and accuracy of Claims processing, coverage decisions, customer service, and administrative performance.

### Provide a credit balance recovery service and provide HCA quarterly reports thereof.

### Make benefit revisions, and update the Claims system to pay accordingly, on sixty (60) Calendar Days’ advance notice from HCA.

### Collect information from Members via mail, or other methods approved by HCA, at least annually (at the same time after Annual Open Enrollment that “Welcome Packets” are mailed by Contractor) about other health insurance coverage the Member has for administration of Coordination of Benefits.

### Track and resolve incomplete or pending Claims using an automated process and within designated timeframes.

### Provide a fully operational Claims payment service by January 1, 2020 that includes the ability to accurately auto-adjudicate 85% of all non-Medicare Claims.

### Provide corrective action plan(s) for resolution of Claims adjudication issues, including administration in accordance with Plan benefits, Member eligibility, referral, authorization, Coordination of Benefits, third-party liability, subrogation, fraud, overpayments, or workers’ compensation information, within fifteen (15) Calendar Days of being notified of any such issue.

### Use only licensed clinicians when the need for consultation arises during any part of the Claims administration process. These licensed clinicians may be geographically located throughout the United States.

## Service Area

### Contractor's agreed to Service Area(s) can be found in Exhibit 7– *Provider Adequacy* and Service Areas.

### Contractor agrees that it will not withdraw from any Service Area where Members are enrolled during the term of this Contract without prior HCA approval. If Contractor experiences provider network disruptions or other similar circumstances that make it necessary for Members to change plans or providers, Contractor agrees to provide sixty (60) Calendar Days advance notice in writing to HCA and cooperate with HCA and other contracted SEBB Medical Plans in planning for the orderly transfer of Members as necessary.

### Contractor agrees to comply with Engrossed Substitute House Bill (ESHB) 2408 (Laws of 2018, Ch. 219) beginning January 1, 2020, including the associated Medical Loss Ratio percentage point in Exhibit 4 – *Performance Guarantees (PG)* *and Medical Loss Ratio (MLR)*.

### Contractor agrees to reimburse HCA for any costs incurred by HCA as a result of Contractor’s withdrawal from a Service Area (not including a withdraw from the Washington Health Benefit Exchange as outlined in Exhibit 4 – *Performance Guarantees (PG) and Medical Loss Ratio (MLR)* or the withdrawal of a material Subcontractor from the Service Area. HCA may reduce each subsequent payment of Contractor’s Monthly Premium until such costs are fully recovered. This will be in addition to any other provision of this Contract.

### Contractor agrees that if the U.S. Postal Service alters the zip codes within Contractor’s Service Area, HCA will re-determine the boundaries of the Service Area by written amendment to this Contract.

## Participating Providers

### Credentialing

Contractor will have in place credentialing requirements for its Participating Providers at least equal to those required by the National Committee on Quality Assurance (NCQA). Further, Contractor will have an ongoing review process to ensure that its Participating Providers remain in compliance with the representations and warranties set forth in this Contract. A copy of these requirements will be submitted to HCA immediately upon request.

### Physician/Hospital and Staff Turnover

Contractor will maintain records of the turnover of its Participating Providers, health care professional staff and customer service staff. Contractor routinely monitors this turnover to ensure that it does not disrupt the delivery of quality care and customer service.

### Provider Licenses

All of Contractor’s Participating Providers will be duly licensed or certified, as required by the laws of Washington State. Contractor will routinely monitor its Participating Providers’ licenses to ensure they are current. Contractor’s Participating Providers must not have any Department of Health (DOH), Medical Board of Washington, or National Practitioner Data Bank licensing restrictions.

### Provider Insurance:

Contractor will ensure its Participating Physicians are insured for malpractice, either independently or through Contractor, in a dollar amount sufficient for their practice and as may be required by law or accrediting entities. Contractor’s Participating Providers will also have other liability insurance in a dollar amount appropriate for their business practice.

### Notice Regarding Participating Provider Network Changes

#### Contractor will notify HCA of any pending material change in the composition of its Participating Provider network, or its Participating Provider network contracts, at least sixty (60) Calendar Days prior to the implementation of such change or as soon as reasonably possible upon learning of a material change.

#### If a PCP’s contract is terminated, or employment ends without cause, Contractor will notify his or her Member-patients in writing that he or she will no longer be a contracting provider at least sixty (60) Calendar Days prior to the contract termination or immediately upon Contractor’s knowledge of the termination if knowledge is acquired in less than sixty (60) Calendar Days.

## Quality Assurance

### Contractor will have in place a quality assurance program that, at a minimum, meets the following requirements:

#### Satisfies all applicable quality assurance requirements set forth by state and federal regulations;

#### Includes a review process to ensure that standards of care are in place for the delivery of health services;

#### Reaches out to Members to ensure appropriate detection of disease, optimal management of illness or injury, and preventive services are available and effectively delivered;

#### Supports efforts of Participating Providers to improve quality, service, safety, and effectiveness of care; and

#### Includes meaningful clinical initiatives and robust interventions relative to the Contractor’s population with specific measurable objectives.

### Contractor will require participating hospitals, ambulatory care surgery centers, and office-based surgery sites to endorse and adopt procedures for verifying the correct patient, the correct procedure, and the correct surgical site that meet or exceed those set forth in the Universal Protocol™ developed by the Joint Commission.

### Contractor will use data provided by HCA, DOH, OIC, any quality accrediting body, clinical utilization and Member Complaint and satisfaction surveys, and its own data, to identify and correct problems and to improve care and service to Members.

## Data Reporting Requirements

### Reporting Accuracy

#### All reports, documents, instruments, papers, data, information, and forms of evidence delivered to HCA with respect to this Contract must be accurate, correct, and complete in all material respects insofar as completeness may be necessary to give HCA true and accurate knowledge of the subject matter thereof, and do not contain any material misrepresentations or omissions.

#### Contractor will accept, store, process, and validate data from various sources (e.g., Claims, clinical data from EHRs, and other HCA vendors) in order to coordinate and integrate data sets across these sources.

#### Contractor will coordinate (a) Claims data with other HCA vendors at the Member level, (b) Member communication, (c) behavioral health outreach, (d) wellness programs and benefits, (e) and other HCA programs. HCA data vendors may include, but are not limited to, the outsourced wellness program, etc.

#### Contractor must require Participating Provider use of certified Electronic Health Record (EHR) systems as defined by the Office of the National Coordinator. Additionally, among providers that have a certified EHR system, or establish a certified EHR system, Contractor must require Participating Providers to agree to contribute clinical data from its EHR system to the state Health Information Exchange hosted by OneHealthPort. Use innovative, state-of-the-art risk adjustment approaches in data work.

#### All information sharing will be in full compliance with HIPAA and other applicable privacy laws and regulations, with information and reporting structured to meet the needs of Members, providers, HCA, the community, and other identified stakeholders.

### Performance Standards Reports

#### Contractor will comply with the reporting requirements set forth in Exhibit 4 – *Performance Guarantees (PG) and Medical Loss Ratio (MLR)*. If a due date falls on a non-business day, the due date will be the next Business Day. Unless instructed otherwise, reports will be submitted directly to HCA’s notification address on the signature page.

#### Increases or decreases in Contractor’s SEBB enrollment will not be considered a reason for non-compliance with these standards. Contractor agrees to maintain adequate records, satisfactory to HCA, documenting compliance with these standards and make such records available to HCA auditors upon request.

### Quality and Outcomes Data

#### Contractor will provide SEBB-specific HEDIS® measures and HEDIS®-like measures calculated using hybrid methodology as instructed by the accreditation body and the HCA, in all required measures no later than June 30 of each year. See Exhibit 8 - *SEBB Clinical Performance Measures*.

#### Contractor will provide other quality and outcomes data using mutually agreed upon specifications, format, and schedule.

#### Contractor will provide HCA with the results of its NCQA accreditation review and maintain accreditation over the term of this Contract.

### Consumer Assessment of Health Plans Survey (CAHPS™)

Contractor will submit a copy of their Adult CAHPS™ report or a survey and survey report determined by the HCA. HCA will determine whether the survey will be conducted on SEBB-specific or Book-of-Business members. The report will be received from the Contractor’s vendor no later than August 30 of each year.

### Data Share Agreement (DSA)

HCA and Contractor will maintain a current DSA (Exhibit 14 *– Data Share Agreement*). This agreement outlines the ways in which data will be shared and used by HCA and Contractor.

### HCA Secure Data Warehouse

Contractor will allow the third party actuary designated by HCA to pass Claims level data received from Contractor to HCA, subject to the DSA executed under section 5.12.E above.

### Data Requests

#### Contractor will respond to HCA data requests, including Claims data, within timeframes and in formats specified by HCA, subject to the DSA executed under section 5.12.E above.

#### Contractor will provide both standard and ad hoc customized reports to HCA on Plan quality, cost, and utilization performance, VBP arrangement(s), Member reported outcomes, provider performance, and population health measures.

#### Provide appropriate data and routine, standardized reporting on provider performance regarding various clinical and quality metrics, including Patient Reported Outcomes, patient experience and population health. This reporting must be understandable and accessible to providers and provider groups.

#### Provide data and/or analytical support as specified by HCA from community transparency initiatives and the system for measuring HCA's progress on core processes and key outcomes, called “Results HCA.”

### Hepatitis C Medication Reporting

Contractor will provide a monthly report on the utilization and costs associated with Hepatitis C medications using mutually agreed upon specifications, format, and schedule.

### Complaints and Appeals Report

#### In support of RCW 41.05.630, Contractor will submit an annual summary of its SEBB Complaints and Appeals data to HCA using the Complaint Categories reflected in section 5.7.9.3 or as defined by the National Committee for Quality Assurance. Reports are due by July 31 of each year. Complaints and Appeals processed between January 1, 2020 and June 30, 2020 will be reported on July 31, 2020. For each subsequent year, reports will report on Complaints and Appeals processed during the fiscal year (July 1 - June 30).

#### The Appeals and Complaints report will include the Appeals and Complaints for each of the following categories:

1. Availability of a health care service;
2. Customer services;
3. Quality of a health care services;
4. Total number of Appeals and Complaints;
5. Number of initial decisions overturned on Appeal; and
6. Actions taken as a result of analysis of Appeals and Complaint data and CAHPS survey results.

### Service Delivery Model Comparison Reporting

Contractor will collaborate with HCA to design and implement a process that results in regular reporting on utilization, Claims costs, and selected quality measures for staff model services delivery versus contracted staff services delivery by the end of the Contract period.

### Statewide Common Measure Set Committee Participation

Contractor will provide SEBB-specific data to the Washington Health Alliance (WHA) using measures and specifications recommended by the Statewide Common Measure Set Committee, and within the necessary data submittal timelines, at no cost to HCA. Contractor will allow WHA to publish results at the carrier, community-level as well as produce private reports for participating purchasers. The list of measures can be found in Exhibit 8 - *SEBB Clinical Performance* *Measures*.

### All Payer Claims Database (APCD) Participation

Per RCW 43.371.030, SEBB Medical Plans will be required to submit Claims data to the APCD to be established and maintained by the lead organization designated by the Office of Financial Management (OFM). The Contractor will adhere to the start time, frequency and format of SEBB Medical Plan reporting as established by the OFM director. In addition to submitting required claims data to the APCD, Carriers will submit the same claims data feed (including financial data) to the WHA database.

### Paid Claims and Annual Risk Assessment Data

#### Contractor will submit to HCA's designated actuary, non-Medicare paid Claims encounter and eligibility data electronically on a monthly basis reflecting the data elements listed in Exhibit 9 – *Paid Claims and Risk Assessment Data*. Claims paid through the calendar year will be used for the risk adjustment of rates during the annual procurement process. Specifically:

1. The most granular service lines for each Claim or encounter must be provided. Data must not be rolled up into aggregate stays or visits.
2. Data files will meet risk assessment data specifications as outlined in Exhibit 9 – *Paid Claims and Risk Assessment Data*. Risk assessment data will not be submitted quarterly, since it will be provided monthly.
3. Paid Claims data will be provided via monthly data files by the last Calendar Day of the month following the report month. (For example, January data will be due February 28th and February data will be due March 31st).
4. Contractor will be permitted a three (3) Business Day grace period for up to four files per year, resulting in those file being due on the third (3rd) Calendar Day of the second month following the report month, or the next Business Day if the third (3rd) Calendar Day falls on a weekend or holiday. (For example, January data would be due by March 3rd or the next Business Day using the grace period).
5. Contractor will also be permitted to send data up to one month late for up to two files per year in non-consecutive months, with notice of delays provided on or before the original due date. (For example, January data would be provided by March 31st).
6. Data will be submitted via file format and method agreed upon by HCA and the Contractor, including but not limited to DVD, USB Drive, FTP site, or other electronic media that is mutually agreeable.
7. Contractor will transfer data in a secure manner to HCA, which meets OCIO Standards as outlined in Exhibit 5 – *OCIO Policies*, and HCA’s contracted consultant and must be encrypted in a mutually agreed upon method.
8. The Contractor will provide all identifiers necessary to link providers and Members to HCA identifiers.
9. The data files will be comma separated or tab delimited.
10. The Contractor will supply control totals with the files that include the total number of records, the total number of Members for each month, and the total amount billed for each month. These totals must balance to Contractor financial reports.

#### Contractor will provide all outstanding data for the current Contract term whether or not this Contract is renewed for any subsequent term.

#### Failure to provide the annual risk assessment data in accordance with the terms of this Contract will constitute a material Breach of performance. Contractor agrees that HCA would be immediately and irreparably harmed by its failure to provide this data. Upon any such material Breach or threatened Breach, HCA is entitled to specific performance and injunctive relief pursuant to Section 7.32 without bond or other security. Contractor will pay HCA the costs of obtaining such relief, including, without limitation, reasonable legal fees and expenses. Such equitable remedies will not be HCA’s exclusive remedy for Contractor’s failure to meet the risk assessment data reporting obligations. HCA reserves the right, at its sole discretion, to pursue all other remedies available at law or equity.

## Audits

### Contractor agrees to provide, upon HCA request, detailed documentation on the SEBB-specific rate development methodology. Contractor will provide justification, documentation, and support used to determine rate changes, including providing adequately supported cost projections.

### Separate and apart from the annual SEBB rate setting process, Contractor will, upon request from HCA, share with HCA its non-proprietary information on trends, cost projections, assumptions, and key factors related to cost forecasting.

### HCA understands and agrees that Contractor will only be obligated to provide access to such information to the extent that: (1) access to such information is permitted by applicable state and federal law and regulation, including, but not limited to, state and federal law or regulation relating to confidential or private information and, (2) it would not cause Contractor to breach the terms of any contract to which Contractor is a party.

### Contractor agrees to provide a business plan upon HCA’s request addressing all of its key business operations and provide a general overview of cost control initiatives.

## Financial Reporting and Public Regulatory Studies

### All financial information delivered to HCA, including without limit, information relating to Contractor, its parent corporation, its affiliates and subsidiaries, its partners or joint venturers, or any guarantor fairly and accurately represents such financial condition and has been prepared in accordance with Statutory Accounting Principles, unless otherwise noted in such information.

### Contractor will submit to HCA a copy of any “early warning reports” which it files with the Office of Insurance Commissioner (OIC). These reports will be submitted to HCA concurrent with the filing with the OIC.

### Contractor will promptly notify HCA if the OIC requires enhanced reporting requirements within fourteen (14) Calendar Days after Contractor’s notification by the OIC. Contractor agrees that HCA may, at any time, access any financial reports submitted to the OIC in accordance with any enhanced reporting requirements and consult with OIC staff concerning information contained therein.

### Contractor will notify HCA within twenty-four (24) hours after any action by the OIC that may affect the relationship of the parties under this Contract.

### Contractor will submit to HCA immediately upon request, a copy of any financial audit report, Office of Insurance Commissioner market conduct report or special report, and of any public quality of care study or access study (including any supporting documentation submitted by the Contractor) prepared by a federal or state regulatory agency or by an accrediting body (Joint Commission, National Committee on Quality Assurance (NCAQ), or Utilization Review Accreditation Commission).

### Contractor will allow a representative designated by HCA to accompany any accreditation review team during the site visit in an official observer status. Contractor must provide HCA with at least ten (10) Business Days prior notice of any scheduled accreditation review in order that HCA might observe the review. The representative designated by HCA will share information with HCA, DOH, or DSHS, as needed, to reduce duplicated work for both Contractor and the state.

## Appeals and Complaints Process

### Contractor will establish and maintain an Appeals and Complaints process that complies with the state and federal regulations and NCQA accreditation requirements. If there is a conflict between state and/or federal regulations and NCQA standards, state and/or federal regulations take precedence.

### For Appeals and Complaints involving the delay, denial, or modification of health care services, Contractor’s written responses to Members shall describe the criteria used and the clinical reasons for its decision, including criteria and clinical reasons related to medical necessity. If Contractor provides a decision that delays, denies, or modifies health care services because it is not a covered benefit under this Contract, the decision will clearly specify the provisions in the COC that exclude that coverage.

## Utilization Management

### Contractor will have a Utilization Management process, which includes prior authorization and concurrent review.

### Contractor will provide HCA with a current list of its current programs for UM. Contractor will also provide HCA with a detailed description of their UM process.

### Contractor will have an Appeal process that allows providers to challenge Utilization Management decisions made by Contractor that they believe will not serve the best interests of their patients. Contractor agrees that the Appeal process will assure that the process of review will be neither arbitrary nor capricious, but fair and prompt, and comply with applicable state and federal laws, regulations, and NCQA Utilization Management standards. Contractor agrees that Utilization Management will not operate to prevent the delivery of emergency medical treatment.

## Transitions and Continuation of Care

Beginning January 1, 2020, Contractor will provide transitions and continuation of care to all Members requiring the services. Contractor will work closely with HCA, previous health plan carriers, and school organizations to ensure a seamless and safe transition and continuation of care.

### Transitions of Care:

Contractor will be required to work with a Member’s previous health plan carrier when transitioning the Member from their previous carrier’s coverage to the Contractor’s coverage. This includes, but is not limited to the following:

#### Covering out-of-network facilities as in network if the Member cannot be transferred prior to discharge to any of the Contractor’s in-network facilities; and

#### Honoring medical prior authorizations approved by the Member’s previous health plan carrier until the Contractor’s prior authorization process is ready, so long as the approved service(s) or treatment plan falls between January 1, 2020 and March 31, 2020.

#### Having a transition plan in place for handling pharmacy prior authorizations.

#### Contractor will provide adequate staff to handle all chronic, complex, high needs, and behavioral health condition transitions, including Contractor’s medically trained case managers.

#### Contractor will provide Policy/Procedure to HCA on Transitions and Continuation of Care.

### Continuation of Care:

Contractor will ensure continuity of care, as outlined in this Section, for new Members in an active course of treatment, active hospitalization, and chronic, complex, and acute medical conditions. The Contractor will ensure that all medically necessary care for Members is not interrupted and that transitions from one setting or level of care to another are promoted.

#### If possible and reasonable, the Contractor shall preserve Member-provider relationships through transitions;

#### The Contractor will notify new Members with chronic conditions of the impact of changes in:

1. Co-pays or deductibles;
2. Provider, clinic, and hospital status (preferred, participating, out-of-network) and change in provider;
3. Status impact on the Member’s out of pocket expenses; and
4. Any other change involving a financial impact to the Member, within ninety (90) Calendar Days of enrollment.

#### Unless otherwise required in this Contract, Contractor will provide coverage of previously prescribed medications for the first 120 days of a new member’s enrollment without requiring prior authorization or trial and failure of a preferred medication. The Contractor shall have a documented plan that includes communication to members and providers when the transition period will end, when and whether prior authorization or trial and failure of a preferred drug may be required, and how to request authorization for continued coverage of the prescribed medication.

## Statutory or Regulatory Impacts to Health Plan Benefits, Rates, or Terms

Contractor will notify HCA in writing as soon as possible, but no later than thirty (30) Business Days after Contractor becomes aware of any changes in state law or regulation that may require a change to health plan benefits, rates, or other terms under this Contract. For federal law or regulation changes, Contractor will notify HCA in writing as soon as possible, but no later than forty-five (45) Business Days after it becomes aware of any changes that may require a change to health plan benefits, rates, or other terms under this Contract. The scope of this notification is limited to the large group, fully insured commercial market. Contractor will notify HCA of the topic and source of change, and the date of the statute or regulation was finalized and its effective date. The sources of changes will include applicable statutes or regulations. For federal statutes or regulations, Contractor agrees to collaborate with HCA on making any necessary changes to this Contract.

## Fraud and Abuse Detection and Prevention Program

Contractor will provide HCA with a description of its current, or planned, fraud and abuse detection and prevention program upon request.

## Disaster Recovery Plan

Contractor will maintain a disaster recovery plan as it relates to SEBB and its enrolled Members. Upon request, and at HCA’s discretion, Contractor will allow HCA to access and review the entire disaster and recovery plan or provide a summary of the plan to include:

### A general description of Contractor’s disaster recovery plan.

### Specific details relating how Contractor will safeguard Member enrollment records and deal with Members who present to emergency rooms and other providers without their Contractor identification card during and after a disaster.

### Contractor’s plan and timeline for reestablishing communication with HCA staff after a disaster, including primary and backup contacts and contact information.

### Contractor’s plan and timeline for resuming data submissions, as required in this Contract, following a major disaster.

### A message for Members relating what they should do if they are in a disaster area and need health care services.

## Obligations Upon Termination or Non-Renewal

### In the event of termination or non-renewal of this Contract, Contractor will be responsible for administrative services associated with Covered Services under this Contract, including incurred Claims, runout Claims, and Member Appeals in compliance with OIC’s regulations. Contract termination will not extinguish or prejudice HCA’s right to remedies for any default by Contractor that has not been cured.

### From and after the effective date of termination or expiration of this Contract, Contractor will not be entitled to compensation for further services hereunder. If directed by HCA, not later than thirty (30) Calendar Days following such termination or non-renewal, Contractor will deliver to HCA a full accounting of the status of SEBB Medical Plan Claims or other payments and all property and documents of HCA then in the custody of Contractor. Contractor will have the right to demand the return of its property and documents from HCA during this same period.

### The termination or non-renewal of this Contract will not relieve Contractor of liability under the indemnification provisions of this Contract.

### Reporting requirements set forth in section 5.12, *Data Reporting Requirements*, survive termination of this Contract or its expiration. Contractor will reimburse HCA the reasonable cost of obtaining Contractor’s data in the event Contractor does not provide data in accordance with the terms of this Contract.

### Should Contractor merge, be acquired by, whether or not that plan is under contract with HCA at the time of the merger, or acquisition, Contractor agrees to provide the annual risk assessment data for the term of this Contract, as well as any other data for any report year for which data is outstanding on the date of the merger, or acquisition. In addition, HCA reserves the right to modify or clarify the data request at that time.

### Upon the termination or non-renewal of this Contract, Contractor will cooperate fully with HCA in order to effect an orderly transition of Members to another health care plan. This cooperation will include attending such post-termination meetings as will be reasonably requested by HCA, providing requested information to HCA or succeeding carrier, in compliance with applicable federal and state law and regulations, and communicating with affected Subscribers as requested by HCA.

### Transition information will be provided by Contractor within the timeframes agreed upon by HCA and Contractor, and in the form and manner specified by HCA, and may include, but is not limited to, the following:

#### Data regarding Contractor’s Participating Providers covered by this Contract.

#### Specific Member information necessary to assure continuity of care after the expiration date or effective date of termination of this Contract, to the extent permitted by applicable federal and state law and regulation.

## Administrative Simplification

### To maximize understanding, communication, and administrative economy among all SEBB contractors, subcontractors, governmental entities, and Members, Contractor will use and follow the most recent updated versions of:

#### Current Procedural Terminology (CPT);

#### International Classification of Diseases (ICD);

#### Healthcare Common Procedure Coding System (HCPCS);

#### CMS Relative Value Units (RVUs); and

#### CMS billing instructions and rules

### In lieu of the most recent versions, Contractor may request an exception. Such request must be in writing and will include Contractor’s reasons for requesting the exception. HCA’s consent thereto will not be unreasonably withheld.

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

## Electronic Commerce

HCA and Contractor have mutually agreed to conduct business transactions using electronic commerce. Contractor will comply with the applicable requirements of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 and the final regulations issued pursuant thereto by the U.S Department of Health and Human Services (DHHS) no later than the timeframes required by HIPAA. Contractor will require contracting providers of medical, pharmaceutical, and ancillary services to also comply with the requirements of HIPAA.

# STRATEGIC PARTNERING ON HEALTH TRANSFORMATION

Contractor will support and actively engage in activities that assist HCA to achieve its purchasing goal of ninety percent (90%) of state purchased health care payments, for the State Medicaid program and the SEBB and PEBB programs, that will be linked to quality and value of care by 2021. This is defined by the CMS LAN Alternative Payment Model Framework categories 2C – 4B (see Exhibit 10 - *CMS Framework for Value‐based Payments or Alternative Payment Models*).

## Innovative Leadership and Administrative Support

Contractor will:

### Actively support and participate in statewide health transformation efforts, including Healthier Washington Health Innovation Leadership Network.

### Support linkages between communities and clinical care to address Social Determinants of Health by participating in Accountable Communities of Health (ACHs) that are within the Contractor’s Service Area(s). Specifically, Contractor will:

#### Engage with ACH to discuss shared priorities and opportunities to align with VBP strategies;

#### Coordinate with ACH to establish appropriate communication and participation to support delivery system reform and health improvement efforts at the local level;

#### Provide ACHs with information regarding provider barriers and opportunities related to VBP uptake and performance on VBP metrics; and

#### Communicate with providers regarding the role of the ACH and opportunities to benefit from shared infrastructure and partnership opportunities led by the ACH.

### Use HCA’s clinical policies, care transformation vision and VBP, as well as foundational elements of the ACNs, in its Book-of-Business as outlined in Section 5.8, *Claims Services*, above.

### Provide and coordinate customized reporting of Plan offerings to HCA leadership at quarterly meetings on care transformation activities, VBP updates and other reporting, as requested by HCA.

### Design and implement new models of care that drive toward population-based care for Members, entire Book-of-Business and other purchasers as approved or requested by HCA as outlined in Section 5.8, *Claims Services*, above.

### Provide HCA the opportunity to participate in the pilot phase of new Clinical Management initiatives; however, HCA will determine in its sole discretion which initiatives in which it will participate.

### Create and distribute Member education materials for all value based purchasing programs to enhance Member health literacy.

### Deploy strategies that improve patient education and self-management as approved or requested by HCA.

### Facilitate conversations between HCA and providers on the subject matter within this section 6, *Strategic Partnering on Health Transformation*.

### Collaborate with HCA on development and implementation of new programs and services for HCA’s rural populations.

### Provide programs and assistance to rural providers. These programs may include, but are not limited to, incentive based reimbursement programs and/or the tailoring of Contractor’s total cost of care framework to make it more accessible and appealing to rural providers.

## Paying for Value Through Value Based Payments and Alternative Payment Models

Contractor will:

### Pay providers using VBP arrangements in CMS LAN APM Categories 2c through 4b (see Exhibit 10 - *CMS Framework for Value‐based Payments or Alternative Payment Models*) for its Washington State Book-of-Business as well as the SEBB Plan(s). Targets for these arrangements specific to CMS LAN APM Categories 3a through 4b will be developed in collaboration with HCA.

### Complete the VBP survey on an annual basis in accordance with HCA’s release of the survey and requested completion time. Contractor’s annual response will be incorporated by reference as Exhibit 11 - *Paying for Value Survey*.

### Administer different types of VBP and alternative payment models in different plan offerings in Washington State, and actively promote alternative payment models to other employers and entire Book-of-Business.

### Label all VBP and APM products and plan offerings using the CMS APM LAN Framework definitions.

### Promote the use of VBP and APM products and plan offerings to all of Contractor’s Book-of-Business, including using the CMS APM LAN Framework categories as set forth in Exhibit 10 - *CMS Framework for Value‐based Payments or Alternative Payment Models*.

### Offer suggestions to HCA on other forms of VBP strategies that have proven successful.

### Participate in multi-payer and data sharing initiatives as requested by HCA, provided that such participation does not materially disadvantage Contractor’s competitive position within the market as mutually agreed between Contractor and HCA.

### Tie hospital rate increases to meeting quality targets through Contractor’s hospital paying for performance. Targets for these arrangements will be developed in collaboration with HCA.

### Provide copies of Participating Provider agreement templates and Subcontractor agreements that are filed with the OIC Commissioner to facilitate HCA’s reviews for the inclusion of specific language provisions.

## Member Engagement and Experience

Contractor will offer the tools and resources listed in this Section to all Members.

### Shared Decision Making

#### HCA is committed to spreading the practice of Shared Decision Making through the use of HCA-certified Patient Decision Aids. This commitment stems from evidence that supports the use of Shared Decision Making, and decision aids in patient centered care.

#### The Contractor must support and encourage use of Shared Decision Making through its provider agreements, Member communications, and Member resources.

#### Certified Patient Decision Aids are available at <http://www.hca.wa.gov/about-hca/healthier-washington/patient-decision-aids-pdas>.

### Multichannel Communications, Tools, & Resources

#### Member Communications: Multiple channels and methods for Members to communicate with the plan: via email, secure messaging, telephone, in person, and/or text.

#### Members must be able to conduct transactional activities, such as managing their insurance accumulators, via the website or applications.

#### Use of EHR among providers and enable Members to access their own records (clinician chart notes, visit summaries, lab results, etc.) to help them take an active role in their own care.

#### Enable Members to communicate with their health plans through electronic means, schedule appointments with providers, request prescription refills, and communicate with providers online or through telehealth, virtual care services.

#### Include telehealth, virtual care vendor services for Members.

#### Access to a toll-free, 24/7 nurse line.

#### Tools for Members to seek expert medical opinions (EMO), particularly in specialties such as oncology, and online services offering second opinions.

#### Provide customer support for Member Complaints and Appeals related to Claims.

#### Access to forms for Claims, Appeals, Complaints, and enrollment.

### Tools and Resources for Self-Management & Health Literacy

#### Offer Members the ability to manage chronic diseases in an evidence-based way that is convenient and customizable to their needs.

#### Provide timely, evidence-based information to Members on different self-management and health topics (including choosing a value-based health plan, how to actively engage in self-care, how to choose appropriate care) from Choosing Wisely, the WHA, and other organizations as appropriate. Contractor must get HCA approval prior to any such information being made available or provided to Members.

#### Provide support for a culturally and linguistically diverse Membership as well as reasonable accommodations for communications that are consistent with ADA requirements for all Member-oriented tools.

#### Work collaboratively with HCA on the development and implementation of new initiatives and tools for self-management and engagement.

## Multi-Stakeholder Quality Improvement and Transparency Initiatives

Contractor must actively participate and encourage its contracted providers to actively participate in the following community initiatives including various workgroups and committees during the term of the Contract:

### Washington Health Alliance (WHA)

The WHA is a health system improvement nonprofit organization in Washington. Located in Seattle, the WHA brings together health care stakeholders to create a high quality, affordable system for the people of Washington state. The WHA also produces and shares the most reliable data on Health Care Quality and value in the state to help providers, patients, employers and union trusts make better decisions about health care. More information is available at [www.wahealthalliance.org](http://www.wahealthalliance.org).

### Bree Collaborative

The Bree Collaborative is a multi-stakeholder, Governor-appointed group working to improve the quality, health outcomes and cost effectiveness of care in Washington. The Bree Collaborative produces best practice recommendations for health care services that experience a high variation of care delivery, are frequently used but do not lead to better care or patient health, or that experience patient safety issues. More information is available at [www.breecollaborative.org](http://www.breecollaborative.org)

### Accountable Communities of Health (ACHs)

#### ACHs are regional health collaborative that bring together leaders from multiple health sectors with a common interest in improving health and Health Equity throughout the state. As ACHs align resources and activities that improve whole person health and wellness. Nine ACHs serve the entirety of Washington State, the boundaries of which align with Medicaid Regional Service Areas. More information is available at [www.hca.wa.gov/hw](http://www.hca.wa.gov/hw).

#### Contractor will support the goals of the ACHs and the relationship of the Medicaid transformation work with the health care delivery systems in Contractor’s commercial provider networks.

### Hutchinson Institute for Cancer Outcomes Research (HICOR)

HICOR is a research institute at Fred Hutchinson Cancer Research Center whose mission is to improve cancer prevention, detection and treatment in ways that will reduce the economic and human burden of cancer. HICOR brings together patient organizations, clinicians, industry leaders, insurers and policy developers to share cancer-related data and generate performance metrics that are clinically relevant and can guide improvements in cancer care. More information about HICOR is available at <https://www.fredhutch.org/en/labs/hicor.html>.

### National Business Coalition on Health e-Value8™ Initiative

e-Value8 is a transformational resource that helps purchasers and employers measure and evaluate health plan performance. The WHA sponsors a biannual e-Value8™ which is supported by HCA. More information about e-Value8™ is available at [www.nbch.org/evalue8](http://www.nbch.org/evalue8).

### Practice Transformation Support Hub

This is a key initiative to support clinical practices to incorporate evidence-based guidelines and Primary Care Medical Home (PCMH) concepts into care delivery.

### Improving Prior Authorization

Contractor will support HCA’s goal in improving health plans’ prior authorization processes in order to reduce the administrative burdens faced by providers attempting to comply with these various processes. Both prior authorization criteria and processes must be standardized, making it easier for providers to focus more resources on the patient. Accordingly, Contractor (a) commits to the principle of improving prior authorization for providers, and (b) will participate, and use its best efforts to take a leadership position in, any workgroup, partnership, collaboration, or other initiative, whether public, private, or a public-private joint effort, focused on the improvement and/or standardization of prior authorization criteria or processes. The Contractor will also implement recommendations from HCA-sponsored workgroups into the Plan(s).

### Transparency Initiative Participation

Unless prohibited by law, Contractor must provide a copy of Claims data for the Plan(s) and its Book-of-Business to the following community transparency initiatives:

#### WHA Community Checkup (per requirements established by the WHA).

#### HICOR.

#### All-Payer Claims Database (APCD) (when operational).

# 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 Prohibited

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 7.38, *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 7.4.A 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.

## Clerical Error

No clerical error on the part of HCA will operate to defeat or alter any term of this Contract or operate to defeat any of the rights, privileges, or benefits of any Member.

## 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 hold Confidential Information in strictest confidence and not to make use of Confidential Information for any purpose other than the performance of this Contract, to release it only to authorized employees or Subcontractors requiring such information for the purposes of carrying out this Contract, and not to release, divulge, publish, transfer, sell, disclose, or otherwise make the information known to any other party without HCA’s express written consent or as provided by law. 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 – Required Notification

### Contractor must notify the HCA Privacy Officer ([HCAPrivacyOfficer@hca.wa.gov](mailto: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.

### 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 may not charge HCA or Members to recoup costs for fulfilling obligations under this section 7.10.

### 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.

## Construction

### The parties agree that neither of them will be deemed the drafter of this Contract and that, in construing this Contract, no provision hereof will be construed in favor of one party on the ground that such provision was drafted by the other.

### In this Contract, where applicable, references to the singular will include the plural and references to the plural will include the singular.

### Regardless of capitalization, “including” means, unless the context requires otherwise, “including but not limited to.”

### If any deadline for performance of an obligation in this Contract does not fall on a Business Day, the deadline for performance will be the next Business Day.

## 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 7.44, *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 7.41.C, *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 HCA's 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 7.8 *Confidential Information Protection* and Section 7.10 *Confidential Information 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 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 Regulatory 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.

### 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.

## Nondiscrimination

During the performance of this Contract, the Contractor must comply with all federal and state nondiscrimination 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 CFR 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 shall refund or apply a credit for HCA in, the full amount to HCA within thirty (30) Calendar Days of the notice. If Contractor fails to make timely refund or apply a credit, 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 7.15, *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 Documents 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 CFR 431, Subpart Q; and 42 CFR 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.

### In addition to any other remedies that may be available for default or breach of this Contract, in equity or otherwise, HCA may seek injunctive relief and specific performance by the Contractor against any threatened or actual breach of this Contract without the necessity of proving actual damages. HCA reserves the right to recover any or all administrative costs incurred in the performance of this Contract during or as a result of any threatened or actual breach, including attorney fees.

## 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 shall 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.

## 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 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 NONALLOCATION 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 PRIOR TO OPEN ENROLLMENT FOR PLAN YEAR 2020

In the event that (I) HCA and Contractor are unable to agree on any rates as discussed in Exhibit 3 – *Request for Completion Process (RFC Process)*, or (II) the SEB Board does not authorize offering any of Contractor’s SEBB Medical Plan(s) to Subscribers in the initial fall 2019 SEBB Annual Open Enrollment, HCA has sole discretion to terminate the Contract. If such option is exercised, HCA will provide 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 Section 4.2.B. and C. of this Contract. No penalty will accrue to HCA in the event the termination option in this section is exercised.

## 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 7.15, *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 shall 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.

## Exhibit 1 – HCA RFP 2716

RFP 2716 (including any and all amendments) is an integral part of this Contract and is incorporated herein by this reference.

## Exhibit 2 – Bidder Response to HCA RFP 2716

Contractor’s proposal in response to RFP 2716 is an integral part of this Contract and is incorporated herein by this reference.

## Exhibit 3 – Request for Completion Process (RFC Process)

HCA will initiate a one-time RFC Process in December 2018 to obtain binding rates and final plan design options, and any other information that may be required to include in the Contract from Contractor. HCA anticipates completing the process of obtaining and negotiating rates from Contractor and determining final payment rates to Contractor in the following four (4) phases:

1. **Phase 1: September – November 2018**

Orientation to rates approach and methodology, including risk adjustment and area adjustment using geographic rating regions similar to OIC’s rating regions.

1. **Phase 2: December 2018 – February 2019**

Release of Request for Completion (RFC), submission of initial rates by Contractors, and negotiation of not-to-exceed (NTE) rates. Contractors will receive a data book that contains summarized School Employee data to assist in the development of proposed rates for the plan designs approved by the SEB Board. Contractors will use their current School Employee enrollment data to develop rates and use the statewide data as a reasonableness check. Prior to receiving this data, Contractors may be required to sign a non-disclosure agreement (NDA) or a data share agreement (DSA). The RFC will include instructions regarding how to access the claims data, and a specific due date by which a Contractor must provide their RFC Response. HCA anticipates that the RFC will go out in early December 2018.

1. **Phase 3: March - June 2019**

Negotiation of rates and plan designs as needed to align with 2019-2021 biennial budget development.

1. **Phase 4: June – August 2019**

Contract amendment for negotiated rates in Phase 3 will be signed for Monthly Premiums for Plan Year 2020.

1. **Phase 5: January – June 2020**

Final payment rates incorporated into the Contract via a contract amendment.

## Exhibit 4 – Performance Guarantees (PG) and Medical Loss Ratio (MLR)

1. **Performance Guarantees**
   1. **Definitions**

For purposes of this Exhibit, the following terms shall have these meanings:

"Abandoned Call" means the caller hangs up before being connected to a live agent working for or on behalf of Contractor.

“Abandoned Call Rate” means the number of Abandoned Calls divided by the total number of calls. Any call that is abandoned within ten (10) seconds of being placed in queue or is resolved by automated response will not be used in calculating the Abandoned Call Rate.

“Adjudication Accuracy” means the total number of Claims filed less the number of Claims processed with one or more Errors, then divided by the total number of Claims filed.

“Answer Time” means the time between the connection of a call to Contractor’s call center and the time when a Contractor employee, agent, Subcontractor, or representative answers the call.

“Appeals” includes both Expedited Appeals and Non-Expedited Appeals.

“Average Answer Time” means the mean Answer Time of all calls received by Contractor during the measurement period.

“Clean Claim” means any Claim that has no material defect, impropriety, lack of any required substantiating documentation, or special circumstances (e.g., suspected fraud, subrogation, or Coordination of Benefits) that prevents timely adjudication of the Claim.

“Error” means any inaccuracy in entering or processing a Claim, regardless of cause or whether the error has a financial impact.

“Expedited Appeals” shall have the meaning ascribed to it in the COC.

“Independent Review Request” shall have the meaning ascribed to it in the COC.

“Non-Expedited Appeals” shall have the meaning ascribed to it in the COC.

“Payment Accuracy” means Total Payments minus the absolute value of the sum of Overpayments and Underpayments, divided by Total Payments.

“Underpayments” means any payment made by Contractor under the Contract that, for any reason, (i) should have been paid but was not, or (ii) was less than what was required under the Contract.

“Total Payments” means all Claims payments made by Contractor pursuant to the Contract.

* 1. **General**
     1. Contractor agrees to the Performance Guarantees (PGs) and Performance Credits as stated in Attachment 2 – *Performance Guarantees and* *Credits*.
     2. There will be a "premium at risk" amount for each credit towards Monthly Premiums in the event of the Contractor's failure to meet the PGs as set for in Attachment 2 – *Performance Guarantees and Credits*.
     3. Failure to meet any one or more of these standards for two (2) consecutive measurement or reporting periods is grounds for Contract termination for cause pursuant to Section 7.40.A, *Termination for Default*.
     4. Any Performance Credit for failing to meet any ongoing Performance Guarantees shall be assessed during the MLR settlement.
     5. Contractor agrees to cooperate with HCA or its agent or consultant in auditing Contractor's performance against these standards.
     6. All PGs are SEBB Medical Plan specific (not Book-of-Business) measures, unless otherwise specified, and results (where appropriate) will be rounded to the nearest tenth of a percentage point (for example, 98.4499% becomes 98.4% and 98.4500% becomes 98.5%).
  2. **Performance Credits**

1. If Contractor misses one (1) or more of the PGs within each of the PG tables (Implementation, Ongoing Core, Reporting, Account Management, and Annual Member Satisfaction) Contractor agrees that HCA will be due the entire Performance Credit for that table.
2. Contractor will calculate all Performance Credits due to HCA for failing to meet Performance Guarantees as outlined in Attachment 2 – *Performance Guarantees and Credits*.
3. The Performance Credit will be in addition to, and not in place of, any other right or remedy available to HCA.
4. Any Performance Credit for failing to achieve any of the implementation PGs shall be reconciled to HCA in the August 2020 Monthly Premium invoice.
5. If total Performance Credit due by Contractor for any given reconciled Plan Year is a) under one percent (1%), the Performance Credit will be credited from the August Monthly Premium(s); or b) more than one percent (1%) the Performance Credit due to HCA will be spread equally over the August and September Monthly Premiums. As an example, if Contractor’s Performance Credit totals two percent (2%) for reporting year 2021, Contractor’s August and September 2022 Monthly Premium invoices will each be reduced by one percent (1%).
6. Upon termination of the Contract, if there is a Performance Credit balance due to HCA at the end of the term, the Contractor will send the rebate to HCA within sixty (60) Calendar Days of Contract termination.
   1. **Performance Guarantees**

See Attachment 2 – *Performance Guarantees and Credits* for the list of deliverables and amounts at risk.

* 1. **Measurement of Performance Standards**

1. Timeliness

Contractor must measure and report performance with respect to the above Performance Standards as set forth in Attachment 2 – Performance Guarantees and Credits.

1. Audit of Performance Standards
   * + 1. At the sole option of HCA, the accuracy of Contractor’s timeliness and reporting of performance results may be subject to an independent audit by HCA or a professional audit firm selected by HCA. The professional audit firm will be selected by the HCA in its sole discretion. Contractor will be given at least thirty (30) Calendar Days’ notice of the audit and will cooperate with requests from the auditor for Claims data and other related requests from the auditor. Unless otherwise stated above, these audits will be at HCA’s expense.
       2. Any such audit will be conducted consistent with applicable state and federal privacy laws. Preliminary results of any independent audit shall be provided to Contractor for review, in order to give Contractor the opportunity to address and correct any errors by the auditor in interpreting Contractor’s data or systems. Disputed points not resolved between the auditor and Contractor will be noted in the final audit report given to HCA. If the results of the independent audit are below the results reported by Contractor for the audit period by more than 5% for any single Performance Standard, then Contractor agrees that the results of the independent audit will be used as the basis for determining the performance with respect to potential amounts at risk.
       3. Contractor will allow, and cooperate fully with, both external and internal audits by HCA staff or any organization chosen by HCA to confirm Appeals and Complaints performance
2. Mechanism of Adjustment

Performance Credits will be satisfied as adjustments to Monthly Premiums. The reductions will be to the first fees otherwise payable after HCA determines Contractor has failed to meet a Performance Standard. HCA may choose, however, to spread the reduction over more than one Monthly Premiums invoice.

1. Failures Caused by HCA

Contractor will have no liability for Performance Credits if failure to meet Performance Standards is the result of a written directive from HCA to delay Claims or modify services.

1. Waiver

Notwithstanding any other provisions of this Contract, HCA may waive all or part of any Performance Credit at its sole discretion. Any waiver does not affect the right of HCA to apply a fee reduction with respect to any other failure to meet a Performance Standard.

1. Transition of Performance Standard Measures

Upon demonstration by Contractor of its ability to meet any or all the standard Performance Standards in this Exhibit, HCA may decide to negotiate different standard Performance Standards to reflect trends and goals of HCA at that time.

1. **Incentive Based Minimum Medical Loss Ratio (MLR) and HCA Premium Rebate**
   1. **Definitions**

For purposes of this Exhibit, the following terms shall have these meanings:

“MLR Incentive Adjustment” means the performance based incentive to lower the MLR Incentive Threshold based on the performance score. The MLR Incentive Adjustment should not be more than the difference between the MLR Incentive Threshold and the Minimum MLR of 85%.

“MLR Incentive Threshold” means the threshold that is set by HCA and must be at or higher than 85%, which is the Affordable Care Act (ACA) MLR threshold.

“Medical Loss Ratio” or “MLR” means the accounting guidance and procedures which describe the definitions of premiums, Quality Improvements, Claims, taxes and fees. The general definition of MLR is the ratio of Claims plus Quality Improvements to premiums less taxes and fees. The minimum MLR requirement threshold is 85% for large groups under the ACA.

“Payment Disincentives” means the portion of a provider’s payment that is owed to the Contractor as a condition of a VBP arrangement based on the provider’s quality of services results. Examples include: downside risk arrangements whereby providers make payments to contracted payer(s) from their existing reimbursement structure based on quality reporting and/or performance; deficit payments made by a provider to contracted payer(s) based on quality reporting and/or performance; or withheld payments from existing provider reimbursement structures based on quality reporting and/or performance.

“Payment Incentives” means the portion of a provider’s payment that is owed to the provider by Contractor as a condition of a VBP arrangement based on the provider’s quality of services results. Examples include: retrospective bonus payments made on top of a provider’s existing reimbursement structure (i.e. upside only); savings achieved by a provider under a shared-savings arrangement whereby the provider’s portion of the savings is tied to quality reporting and/or performance; or prospective care management incentive or payment, on top of a provider’s existing reimbursement structure, that is tied to quality reporting and/or performance.

“Premium Rebates” means the adjustment to premiums paid by HCA to the Contractor in order to satisfy the minimum MLR requirement. If premiums paid result in an MLR of 80% then there will be Premium Rebate of 11.12% of premiums less taxes and fees so that the MLR will rise to 90%. If the Contractor owes a Premium Rebate, the Premium Rebate will be paid by the Contractor to HCA.

“Provider Incentive” means Payment incentives and Payment Disincentives that apply to base payments that are Provider Payments in a VBP arrangement.

“Provider Payments” means actual payments made to the provider.

“Quality Component” means one (1) of the four (4) components of the MLR Incentive Adjustment, comprising 2% points of the default 5% point adjustment, and based on clinical quality measures in Table QC2.

“VBP Adoption Component” means one (1) of the four (4) components of the MLR Incentive Adjustment, comprising one 1% point of the default 5% point adjustment, based on the percentage of provider payments that are tied to VBP arrangements.

“VBP Significance Component” means one (1) of the four (4) components of the MLR Incentive Adjustment, comprising 1% point of the default 5% point adjustment, and measuring the percentage of base contractual payments that are at risk in connection with VBP arrangements.

“WA HBE Component” means one (1) of the four (4) components of the MLR Incentive Adjustment, comprising 1% point of the default 5% point adjustment, based on the Contractor’s compliance with offering a QHP.

* 1. **MLR Background**

1. Medical Loss Ratio (MLR) is a basic financial measurement created by the federal Affordable Care Act (45 CFR §158) to encourage health plan carriers to provide value to enrollees.
2. Under 45 CFR §158 the general definition of MLR is the ration of Claims plus Quality Improvements to premiums less taxes and fees. For example, if an insurer uses eighty (80) cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a MLR of 80%. A MLR of 80% indicates that the insurer is using the remaining twenty (20) cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions.
3. Under 45 CFR §158 the minimum MLR requirement threshold is eighty-five percent (85%) for large group lines of business.
4. Under 45 CFR §158.210 allows for distribution of a Premium Rebate if the Contractor has a MLR of less than eighty-five percent (85%).
   1. **General**

Utilizing the MLR to incentivize high quality health care, value-based payment and care transformation:

1. Under this Contract, the Contractor is required to meet a MLR Incentive Threshold, calculated as ninety percent (90%) minus (-) the MLR Incentive Adjustment. If the Contractor’s MLR is less than the MLR Incentive Threshold, the Contractor will distribute the incentive based Premium Rebate to HCA.
2. The MLR Incentive Adjustment will consist of four (4) additive components: a ***Quality Component*** (up to two (2) percentage points), a **WA HBE Component** (up to one (1) percentage point), a ***VBP Adoption Component*** (up to one (1) percentage point), and a ***VBP Significance Component*** (up to one (1) percentage point). Each component is set at zero (0) by default, but may be increased on the basis of performance measures as set out below in this exhibit.
3. The MLR Incentive Adjustment will modify the minimum MLR set under this Contract by up to five percentage (5%) points from the base MLR of ninety percent (90%) down to an adjusted MLR of 85%. For example, an MLR Incentive Adjustment of five percent (5%) would reduce the MLR from ninety percent (90%) to eight five percent (85%), and an MLR Incentive Adjustment of four percent (4%) would reduce the MLR from ninety percent (90%) to eighty six percent (86%). By maximizing the MLR Incentive Adjustment the Contractor can reduce its adjusted MLR.
4. HCA does not intend to reduce the Premium Rebate under 45 CFR §158. If the Contractor has a MLR of less than eighty five percent (85%) then the incentive based Premium Rebate will be limited to the difference between the Maximum MLR Incentive Adjustment and the MLR Incentive Adjustment. The incentive based Premium Rebate is expressed as a percentage of premium less the applicable taxes and fees, and intended to be consistent with the denominator of the MLR formula.
5. Under the illustrative performance where the MLR Incentive Threshold is eighty-seven percent (87%), and the actual MLR reported for the Contractor is eighty-one and a half percent (81.5%) then the MLR Incentive based Premium Rebate would result in a Premium Rebate of two percent (2%) of premium less applicable taxes and fees. The Premium Rebate relating to 45 CFR §158, would be three and a half percent (3.5%) of premium less applicable taxes and fees. The final adjusted loss ratio after application of both the incentive based Premium Rebate and the Federal Premium Rebate would be eighty-seven percent (87%).
6. Timing of the performance model will be such that the performance score will be available around June following the close of the Calendar Year, with the MLR being reported around that August.
   1. **Quality Component**

The Quality Component of the MLR Incentive Adjustment shall contribute up to two percentage (2%) points to the MLR Incentive Adjustment. The Quality Component may be earned via performance on a set of quality measures identified by HCA. The Quality Component will be calculated as set out below:

1. In the evaluation of performance, each measure will hold equal weight within the overall context of performance for the combined results for any plans offered through the SEBB medical fully-insured portfolio of benefits. Measure specifications are defined in the Washington Statewide Common Measures Set.
2. Once each measure is reported by the Contractor to HCA, HCA will compare performance on each measure to a Quality benchmark identified in Table QC1, below. Each measure will receive one (1) point for performance above the median (50th percentile), and one (1) additional point for each percentile of performance above the 51st percentile. Two (2) additional points will be awarded for each percentile of performance at the 70th percentile and above, and two (2) more additional points will be awarded for each percentile of performance at the 80th percentile and above. No additional points are awarded for performance above the 89th percentile and the score is capped at one hundred (100) for the measure. HCA will use linear interpolation for points between the benchmark source’s reported results to determine the score. See Table QC1 for performance scores at the various percentiles.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Table QC1 | | | | | | | |
| Measure Score for Percentile Performance | | | | | | | |
| Percentile | Score | Percentile | Score | Percentile | Score | Percentile | Score |
| 50 | 1 | 60 | 11 | 70 | 23 | 80 | 55 |
| 51 | 2 | 61 | 12 | 71 | 26 | 81 | 60 |
| 52 | 3 | 62 | 13 | 72 | 29 | 82 | 65 |
| 53 | 4 | 63 | 14 | 73 | 32 | 83 | 70 |
| 54 | 5 | 64 | 15 | 74 | 35 | 84 | 75 |
| 55 | 6 | 65 | 16 | 75 | 38 | 85 | 80 |
| 56 | 7 | 66 | 17 | 76 | 41 | 86 | 85 |
| 57 | 8 | 67 | 18 | 77 | 44 | 87 | 90 |
| 58 | 9 | 68 | 19 | 78 | 47 | 88 | 95 |
| 59 | 10 | 69 | 20 | 79 | 50 | 89 | 100 |

1. The total score across all measures will be calculated in June of each year for the previous Plan Year. Table QC2 below describes the performance measures and targets that HCA will use.

|  |  |  |
| --- | --- | --- |
| Table QC2 | | |
| Performance Measure | Benchmark Source | Benchmark Target |
| Adult Body Mass Index Assessment | Quality Compass (PPO) | 90th percentile |
| Antidepressant Medication Management – Effective Acute Phase Treatment\* | Quality Compass (PPO) | 90th percentile |
| Antidepressant Medication Management – Effective Continuation Phase Treatment\* | Quality Compass (PPO) | 90th percentile |
| Breast Cancer Screening\* | Quality Compass (PPO) | 90th percentile |
| Cervical Cancer Screening\* | Quality Compass (PPO) | 90th percentile |
| Childhood Immunization Status (Combo 10) | Quality Compass (PPO) | 90th percentile |
| Chlamydia Screening in Women | Quality Compass (PPO) | 90th percentile |
| Comprehensive Diabetes Care: Blood Pressure Control | Quality Compass (PPO) | 90th percentile |
| Comprehensive Diabetes Care: Eye Exam | Quality Compass (PPO) | 90th percentile |
| Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | Quality Compass (PPO) | 90th percentile |
| Controlling High Blood Pressure | Quality Compass (PPO) | 90th percentile |
| Medication Management for People with Asthma (Asthma Medication Ratio) | Quality Compass (PPO) | 90th percentile |
| Statin Therapy for Patients with Cardiovascular Disease (Received Statin Therapy) | Quality Compass (PPO) | 90th percentile |
| CAD Statin Adherence Measure | Washington Health Alliance | 90th percentile |
| Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life | Quality Compass (PPO) | 90th percentile |

\*These four measures will be implemented over a 4 year period to account for look-back periods defined in the measure specifications. See current HEDIS® Technical Specifications for Health Plans publications for further information.

1. For each Plan Year, the number of total points scored will be totaled for the selected performance measures in Table QC2 and divided by the threshold quality score, which is set at 200 for each Plan Year. The result, capped at a maximum of one hundred percent (1.000), will be the Contractor’s MLR Incentive Adjustment Quality Score. The MLR Incentive Adjustment Quality Score will be multiplied by three (3) percentage points to determine the Quality Component of the MLR Incentive Adjustment. For example, a Quality Score of one hundred percent (1.000) will result in a Quality Component of .02 × 1.000 = .02 or 2 percentage points, a Quality Score of fifty percent (0.500) will result in a Quality Component of .02 × 0.500 = .01 or 1 percentage point, and a Quality Score of twenty percent (0.200) will result in a Quality Component of .02 × 0.200 = .004 or .4 percentage points.
2. Contractor will be notified of any changes to the performance measures in advance of the measure taking effect so that the measure can be reported. Plan Year 2020 will be the first (1st) year to calculate the Quality Component of the MLR Incentive Adjustment based on 2020 experience. The implementation schedule for performance measures are described in Table QC4.

| Table QC4 | | |
| --- | --- | --- |
| Plan Year | Measurement and Reporting | Performance Measures Implementation Schedule |
| 2020 | Calculate clinical measures data | 2020 performance adjustment will be made in 2021. |
| 2021 | Calculate clinical measures data | 2021 performance adjustment will be made in 2022. |
| 2022 | Calculate clinical measures data | 2022 performance adjustment will be made in 2023. |
| 2023 | Approach as described in this table for Plan Years 2020, 2021, and 2022. | Approach as described in this table for Plan Years 2020, 2021, and 2022. |

* 1. **WA HBE Component**

The WA HBE Component of the MLR Incentive Adjustment shall contribute up to one (1) percentage point. The WA HBE Component will be earned by ensuring compliance with the following:

1. Beginning January 1, 2020, Contractor will ensure that at least one (1) health carrier in the insurance holding company the Contractor belongs to is offering on the Washington Health Benefit Exchange (HBE), at least one (1) silver and one (1) gold qualified health plan (QHP) in any county in which any health carrier in that insurance holding company system offers a fully insured health plant that was approved by the SEB Board to be offered to School Employees and their covered Dependents. Contractor must confirm to HCA that the following actions have been completed:
2. Contractor has filed the HBE's Letter of Intent by the indicated due date;
3. No later than May of each year, Contractor has timely filed proposed health plans with the OIC;
4. No later than July of each year, the Contractor has submitted the Participation Agreement to the HBE;
5. No later than July of each year, the Contractor has signed the EDI Trading Partner Agreement, required for the sharing of EDI files with the HBE; and
6. No later than November of each year, the Contractor's QHPs have been approved by the OIC and certified by the HBE Board, and that all Service Areas covered in SEBB are covered in the HBE.
   1. **VBP Adoption Component**

The VBP Adoption Component of the MLR Incentive Adjustment shall contribute up to one (1) percentage point. The VBP Adoption Component may be earned by ensuring that payments are tied to Value-Based Payment Arrangements as set out below.

1. Contractor shall report to HCA the total annual statewide Provider Payments in each HCP-LAN Category as defined under the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework Final Whitepaper version dated 1/12/2016, attached as Attachment 3 - *APM Whitepaper*. Contractor must report results to HCA within ninety (90) Calendar Days after the end of each reporting period. HCA will provide the reporting table.
2. Provider Payments will consist of the total medical and pharmacy spend for all covered and administered lives in the Contractor’s Book-of-Business.
3. HCA will use the data supplied by the Contractor to calculate two (2) performance percentages: a.) the total Payments in CMS LAN APM Categories 2C – 4B as a percent of total Provider Payments for the Contractor for the Plan Year, and b.) the total Payments in CMS LAN APM Categories 3A – 4B as a percent of total Provider Payments for the Contractor for the Plan Year. Each performance percentage will be compared to the Threshold VBP Adoption Scores set out in Table AC2.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Table AC2 |  |  |  |  |
| Value Based Payment Strategies Tied to PGs | 2020 | 2021 | 2022 | 2023 |
| Minimum % of total annual Provider Payments that meets the requirements of CMS LAN APM Categories 2c-4b (see Table 8, below) as self-reported by Contractor.  Metrics tied to payment must be from the Common Measure Set. | 70% | 75% | 80% | 85% |
| Minimum % subset of the above percentage of total Provider Payments that meets the requirements of CMS LAN APM Categories 3A-4B as self-reported by Contractor.  Metrics tied to payment must be from the Common Measure Set. | 20%  (14% of total) | 25%  (18.5% of total) | 35%  (28% of total) | 45%  (38.25% of total) |

1. If the Contractor meets both thresholds set out in Table AC2 then the VBP Adoption Component of the MLR Incentive Adjustment shall be set at one (1) percentage point. If one (1) threshold is met but not the other then the VBP Adoption Component of the MLR Incentive Adjustment shall be set at one half (.5) of a percentage point. If neither threshold is met for the Plan Year then the VBP Adoption Component of the MLR Incentive Adjustment shall be set at zero (0) percentage points.
2. HCA may use a third-party assessment organization to review and validate Contractor’s results. Contractor must pay for the audit performed by the third-party assessment organization, if requested by HCA.
   1. **VBP Significance Component**

The VBP Significance Component of the MLR Incentive Adjustment shall contribute up to one (1) percentage point to the MLR Incentive Adjustment. The VBP Significance Component may be reduced by establishing Payment Incentives and Payment Disincentives tied to quality and financial attainment. The VBP Significance Component of the MLR Incentive Adjustment will be calculated as set out below.

1. Contractor shall report to HCA the total statewide Provider Payments that the Contractor made to providers for the Plan Year, and the amount of statewide Payment Incentives and Payment Disincentives for the Plan Year (us Table SC1 for data reporting). Contractor must report results to HCA within ninety (90) Calendar Days after the end of each reporting period. Failure to provide the report by the deadline may result in the application of the default zero (0) value for the VBP Significance Component of the MLR Incentive Adjustment.
2. HCA will use the data supplied by the Contractor to calculate the total Provider Incentives for the Plan Year as a percent of the Contractor’s total Provider Payments for the Plan Year. This percentage shall be referred to herein as the “VBP Significance Score.” This “VBP Significance Score” shall be compared to the VBP Significance Threshold Score, which is set at one percent (1%) to determine the VBP Significance Component of the MLR Incentive Adjustment.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Table SC1** | **Payment Incentives** | | **Payment Disincentives** | | **Total Payments** |
| Total Amount | Describe\* | Total Amount | Describe\* |
| **Statewide Provider Payments** |  |  |  |  |  |

*\*For example: “Downside risk arrangement whereby providers make payments to contracted payers from an existing reimbursement structure based on quality reporting and performance.”*

1. Provider Incentives should be reported in the period in which they are paid or accrue in the Contractor’s financial statements. The method of reporting should be consistent to ensure that amounts are not duplicated year-to-year.
2. If, for the Plan Year, the VBP Significance Score is equal to or exceeds the VBP Significance Threshold Score, then the VBP Significance Component of the MLR Incentive Adjustment shall be set at one (1) percentage point. If the VBP Significance Score is less than then VBP Significance Threshold Score for the Plan Year, then the VBP Significance Component of the MLR Incentive Adjustment shall be set at zero (0) percentage points.
   1. **Reporting and Reconciliation of MLR**
3. MLR Incentive Adjustment will occur annually under the Contract.
4. HCA intends to reconcile the Premium Rebates relating to the MLR Incentive Threshold concurrently with the final Federal reconciliation of the MLR rebate. Any incentive based Premium Rebate should not be considered a premium adjustment for the MLR year.
5. All rules and regulations pertaining to the financial accounting and reporting of 45 CFR §158 will continue to apply to this Contract.
6. Timing of the performance model will be such that the performance score will be available around June following the close of the Calendar Year, with the MLR being reported around that August.
7. HCA reserves the right to use a third-party to validate any of the Contractor’s reported components.

## Exhibit 5 – OCIO Policies







## Exhibit 6 – Implementation Plan

Placeholder for Contractor’s implementation plan.

## Exhibit 7– Provider Adequacy and Service Areas

Placeholder for Contractor’s provider adequacy and approved Service Area(s).

## Exhibit 8 - SEBB Clinical Performance Measures

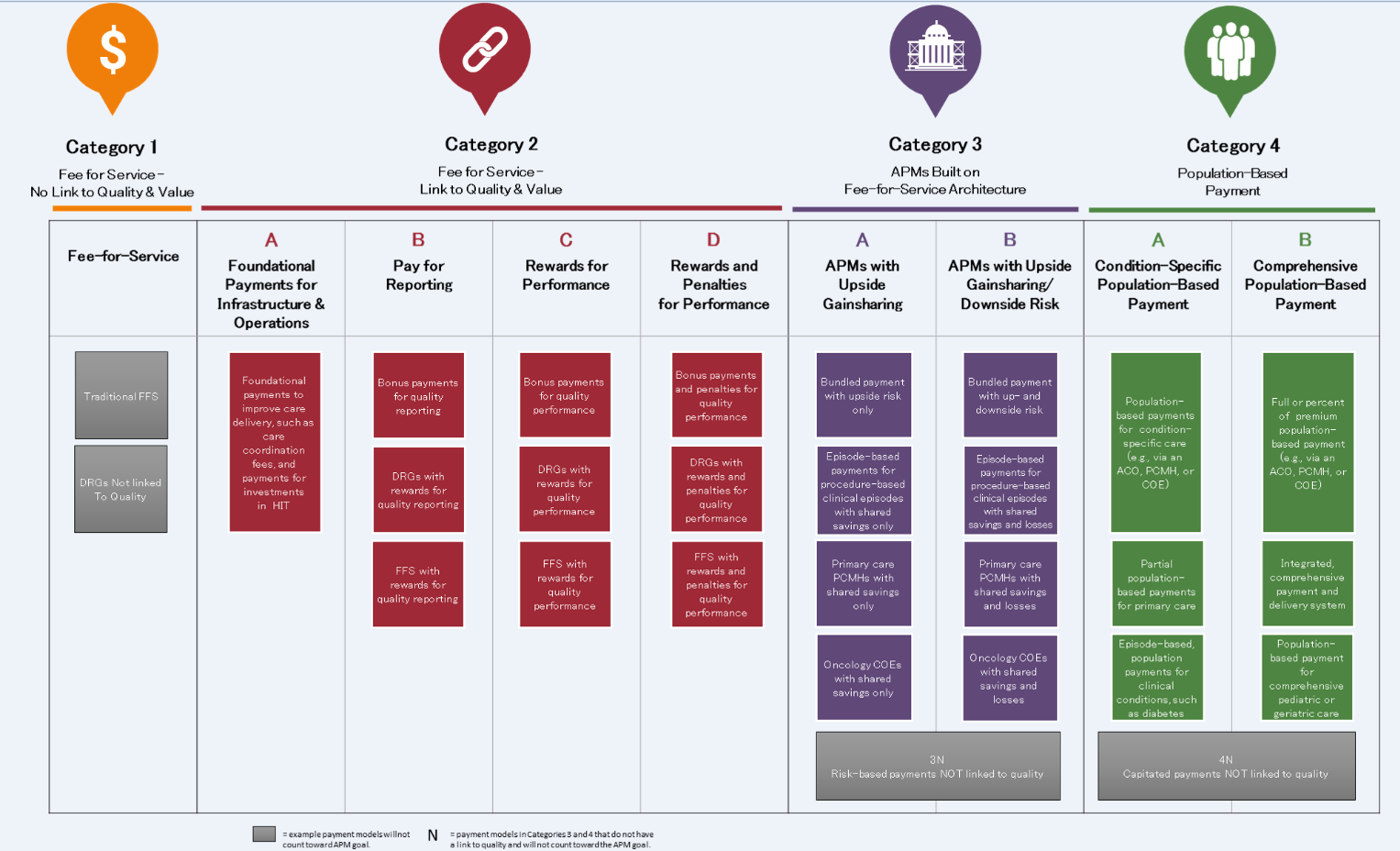
Contractor agrees to calculate and report the Statewide Common Measure Set (SCMS) on an annual basis within required timelines (see section 5.12.C, Quality and Outcomes Data, subsection III). The measures can be found here: <https://www.hca.wa.gov/assets/Washington-State-Common-Measure-Set-2018.pdf>.

In addition to the SCMS measures, the Contractor will be notified of any additional measures requiring calculation and reporting annually, as part of the Request for Renewal process. All measures will require an audit conforming to audit standards and business processes defined by the National Committee for Quality Assurance for the calculation and reporting of HEDIS measures.

## Exhibit 9 – Paid Claims and Risk Assessment Data

Placeholder for paid Claims and risk assessment data specifications, which will be provided during Contract negotiations.

## Exhibit 10 - CMS Framework for Value‐based Payments or Alternative Payment Models



For more information, see LAN APM Framework White Paper, here: https://hcp-lan.org/workproducts/apm-whitepaper.pdf

## Exhibit 11 - Paying for Value Survey

Contractor’s annually updated Paying for Value Survey will be incorporated here as Exhibit 11.

## Exhibit 12 - Clinical Management Programs

Placeholder for Clinical Management programs offered by Contractor and included within the scope of this Contract.

Clinical Management programs may be changed through the RFR process. Each amended Clinical Management program will be maintained in the Contract as programs that have been phased out by the Contractor.

## Exhibit 13 – ERB HIPAA 834 Eligibility File Format



## Exhibit 14 – Data Share Agreement

Placeholder for Data Share Agreement.

## Exhibit 15 – HCA’s Opioid Policy

1. **Prescribing Opioids**

EFFECTIVE JANUARY 2, 2018

**Acute use of opioids for the treatment of non-cancer, non-palliative care, non-hospice, non-end of life paid (applies to both short-acting and long-acting formulas):**

1. Grandfathering criteria:
2. Patients who have filled at least one opioid prescription in three (3) of the last four (4) months (other than methadone) will be grandfathered. The attestation is not needed for these patients.
   1. The dose, quantity, and forty two (42) Calendar Day supply limits do not apply.
   2. These patients may be identified electronically by looking back at claims data prior to January 2, 2018.
3. In general, only short-acting opioids will be approved for acute use. Long-acting opioids for acute use will be approved only under the exception criteria listed in (4) below.
4. Short and long-acting opioid prescriptions are covered without prior authorization to treat non-cancer, non-palliative care, non-hospice, and non-end of life related pain when the limits listed in (3a) and (3b) below are followed or when one of the exceptions listed in (4) applies. Limits apply as follows:
5. For short acting opioids only:
6. A quantity limit of eighteen (18) dosages per prescription for children (≤ 20 years of age); [Note: Prescriber indicating EXEMPT overrides quantity limit] **OR**
7. ii) A quantity limit of forty two (42) dosages per prescription for adults (≥ 21 years of age); [Note: Prescriber indicating EXEMPT overrides the quantity]; **AND**
8. For both long and short acting opioids:
9. No more than forty two (42) Calendar Days of opioid use within a rolling 90-day period. Use of any opioid for more than forty two (42) Calendar Days within a 90-day period is considered chronic use of opioids and requires prior authorization. See the **chronic use of opioids section** below; **AND**
10. **Exceptions** (Quantity limits in Table 1 below apply) (4a and 4b require separate codes):
11. Patient with a diagnosis or pharmacy claim for active cancer treatment, hospice, palliative care, or end-of-life care and pharmacy documents this on the prescription and submits the claim with an **expedited authorization code** used for this criteria; [Note: quantity limits do not apply]; **OR**
12. Provider wrote/typed “EXEMPT” on the prescription or the pharmacist has contacted the provider and the provider confirmed verbally the patient has an “EXEMPT” medical condition.
13. By indicating “EXEMPT” the provider is attesting that the patient has a medically necessary need that requires the prescribed long or short acting opioid (other than pain related to active cancer, hospice, palliative care, or end-of-life care) and it is documented in the medical record
14. The pharmacy may submit the claim with the **expedited authorization code** used for this criteria; **OR**
15. New Members are exempted for the first one hundred and twenty (120) Calendar Days of enrollment.
16. Documentation from the pharmacist or prescriber is not required
17. Quantity limits and forty two (42) Calendar Day supply limit do not apply.
18. Current prior authorization on file.
19. Opioid prescriptions exceeding the limits in (3a) and (3b) that do not have an exception listed in (4) are not authorized unless provider submits attestation.

**Chronic use of opioids for the treatment of non-cancer pain (applies to both short-acting and long-acting formulations):**

1. Use of opioids for more than forty two (42) Calendar Days may be authorized in twelve (12) month intervals or to the provider’s indicated expiration date [“End Date”] when the prescriber signs the attestation below.

Attestation:

“I [Doctor’s Name] attest that all of the below criteria are met, or there is documentation in the chart for why one or more are not applicable:

1. The patient has an on-going clinical need for chronic opioid use at the prescribed dose (more than forty two (42) Calendar Days per ninety (90) Calendar Day period) that is documented in the medical record.
2. The patient is using appropriate non-opioid medications, and/or non-pharmacologic therapies; OR
3. The patient has tried and failed non-opioid medications and non-pharmacologic therapies for the treatment of this pain condition; AND
4. For long-acting opioids, the patient must be using or had trials of short-acting opioid therapy for at least forty two (42) Calendar Days; OR
5. The reason for inadequate response to short-acting opioid therapy is documented in the medical record; OR
6. Justification of beginning an opiate naïve patient on a long-acting opioid is documented in the medical record;
7. The provider has recorded baseline and ongoing assessments of measurable, objective pain scores and function scores. These should be tracked serially in order to demonstrate clinically meaningful improvements in pain and function; AND
8. The patient has been screened for mental health disorders, substance use disorder, naloxone use; AND
9. The provider will conduct periodic urine drug screens; AND
10. The provider has checked the PDMP for any other opioid use and concurrent use of benzodiazepines and other sedatives; AND
11. The provider has discussed with the patient the realistic goals of pain management therapy and has discussed discontinuation as an option during treatment; AND
12. The provider confirms that the patient understands and accepts these conditions and the patient has signed a pain contract or informed consent document.

By signing this attestation, I hereby certify that the above information is true, accurate and complete. That the requested treatment is medically necessary, does not exceed the medical needs of the Member, and is clinically supported in the Member’s medical record [Insert Attestation End Date].

1. Definitions:

**“Short-acting opioid”** meansan opioid that is FDA-approved to manage pain severe enough to require opioid treatment and for which alternative treatment options are inadequate (includes tramadol and tapentadol; excludes trans-mucosal fentanyl and all buprenorphine products).

**“Long-acting opioid”** meansan extended release opioid that is FDA-approved to manage pain severe enough to require daily, around-the-clock, long-term opioid treatment for opioid-tolerant patients and for which alternative treatment options are inadequate (includes fentanyl patches and tramadol ER; excludes methadone and buprenorphine patches).

**“Dosage”** means one dosage equals one (1) tablet, one (1) capsule, one (1) suppository, or five (5) ml.

**“Opioid”** means drugs containing the following ingredients

* + - Codeine
    - Fentanyl
    - Hydrocodone
    - Hydromorphone
    - Meperidine
    - Morphine
    - Oxycodone
    - Oxymorphone
    - Tapentadol
    - Tramadol

**“MED”** means morphine equivalent doses per the calculator published on the Washington State Agency Medical Directors’ Group website(<http://agencymeddirectors.wa.gov/opioiddosing.asp>)

**Table 1: Quantity and Days’ Supply Limits**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACUTE USE** | | | |
|  | | **Short acting opioids** | **Long acting opioids** |
| Standard limits when exceptions are not met | Quantity limits for children ≤ 20 years old | 18 tablets or capsules, or 90 ml per prescription | No allowed for acute use unless exempt |
| Quantity limits for adults ≥21 years old | 42 tablets or capsules, or 210 ml per prescription |
| Limits when exceptions are met | Dosage | No MED limits at this time. | |
| Day Supply | 30 days maximum in a single fill. Use of opioids not to exceed 42 calendar days within a rolling 90 day period. Greater than 42 days require attestation or prior authorization. | |
| **CHRONIC USE** | | | |
| Limits | Dosage | No Med limit at this time. | |
| Day Supply | 30 day supply | |

1. **Treatment for Opioid Use Disorder**

Prescriptions for opioid treatment medications for the treatment of Opioid Use Disorder do **not** require a prior authorization.

## Exhibit 16 – Business Interruption and Disaster Management Plan

Placeholder for Contractor’s business interruption and disaster management plan.

## Attachment 1 – Confidential Information Security Requirements

1. Definitions

In addition to the definitions set out in Section 2 of this Contract K      for Fully Insured Group Medical Plan, 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. HCA's 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.

## Attachment 2 – Performance Guarantees and Credits



## Attachment 3 – APM Whitepaper

The HCP LAN Alternative Payment Model whitepaper can be found at this link: <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>.

1. https://www.irs.gov/government-entities/federal-state-local-governments/faqs-for-government-entities-regarding-cafeteria-plans [↑](#footnote-ref-1)
2. https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm [↑](#footnote-ref-2)