Washington State Health Care Authority	**CONTRACT**	HCA Contract Number: K1101 Contractor/Vendor Contract Number:

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

CONTRACTOR NAME [Organization]		CONTRACTOR doing business as (DBA)	
CONTRACTOR ADDRESS [Mailing Address] [City, State, Zip]		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)	
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE		CONTRACTOR E-MAIL ADDRESS

HCA PROGRAM Washington Medicaid Integration Project (WMIP)	HCA DIVISION/SECTION Health Care Services	HCA CONTRACT CODE N/A
HCA CONTACT NAME AND TITLE Alison Robbins	HCA CONTACT ADDRESS P.O. Box 45530, Olympia, WA 98504-5530	
HCA CONTACT TELEPHONE (360) 725-1634	HCA CONTACT E-MAIL ADDRESS Alison.robbins@hca.wa.gov	
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? ☐YES ☒NO	CFDA NUMBER(S)	FFATA Form Required ☐YES ☒NO
CONTRACT START DATE January 1, 2014	**CONTRACT END DATE** June 30, 2014	**TOTAL MAXIMUM CONTRACT AMOUNT** per member/per month

PURPOSE OF CONTRACT:
The purpose of this Contract is to provide an integrated managed care program that offers Medical, Mental Health, Chemical Dependency and Long Term Care services, along with Health Integration Services, to categorically needy, aged, blind and disabled Medicaid clients, aged 21 and over, living in Snohomish County.

ATTACHMENTS/EXHIBITS. When the box below is marked with an X, the following Exhibits/Attachments are attached and are incorporated into this Contract Amendment by reference:

☐ Exhibit(s) (specify):

☒ Attachment(s) (specify): Attachment 1, WMIP rates (Exhibit 1 and Exhibit 2 from Milliman rate letter dated December 17, 2013; and Attachment 2, WMIP Mental Health Rates

☐ Schedule(s) (specify):

This terms and conditions of this Contract are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise, regarding the subject matter of this Contract. The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract shall be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

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1 Definitions

1.1 Access to Care Standards (ACS)

"Access to Care Standards (ACS)" means minimum eligibility requirements for Medicaid eligible persons to access mental health services through the publically funded system.

1.2 Action

"Action" means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services or act in a timely manner as required herein, failure of the Contractor to act within the timeframes for disposition, resolution, and notification of appeals and grievances, or, for a rural area resident with only one Managed Care Organization (MCO) available, the denial of an enrollee's request to obtain services from outside the Contractor's network:

1.2.1 From any other provider (in terms of training, experience, and specialization) not available within the network;

1.2.2 From a provider not part of the network that is the main source of a service to the enrollee, provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within sixty (60) calendar days;

1.2.3 Because the only Contractor or provider available does not provide the service because of moral or religious objections;

1.2.4 Because the enrollee's provider determines that the enrollee needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the Contractor's network;

1.2.5 The HCA determines that other circumstances warrant out-of network treatment. (42 C.F.R. § 438.400(b)).

1.3 Actuarially Sound Capitation Rates

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

1.4 Acute Detoxification Services

"Acute Detoxification Services" means medical care and physician supervision for withdrawing from alcohol or other drugs.

1.5 Administrative Hearing

"Administrative Hearing" means an adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by Chapter 34.05 RCW, the agency's hearings rules found in Title 388 or 182 WAC, or other law.

1.6 **Advance Directive**

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of Washington, relating to the provision of health care when an individual is incapacitated (WAC 182-501-0125, 42 C.F.R. § 438.6, 438.10, 422.128, and 489.100).

1.7 **Aging and Long-Term Support Administration (ALTSA)**

"Aging and Long-Term Support Administration (ALTSA)" means the administration within the state Department of Social and Health Services (DSHS) responsible for administering Medicaid funded long-term care and supportive services to clients statewide, including those provided by ALTSA-contracted Area Agencies on Aging (AAAs).

1.8 **Allegation of Fraud**

"Allegation" means an unproved assertion: an assertion, especially relating to wrongdoing or misconduct on the part of the individual. An allegation has yet to be proved or supported by evidence.

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

1.8.1 Fraud hotline complaints;

1.8.2 Claims data mining;

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

1.9 **Alternative Benefit Plan (ABP)**

"Alternative Benefit Plan (ABP)" means the new, mandatory Medicaid benefits for the newly eligible Medicaid expansion group of non-pregnant adults between 19-64 with modified adjusted gross income that does not exceed 138% or less of the Federal Poverty Level (FPL) established by the federal Patient Protection and Affordable Care Act (ACA) of 2010. For the purposes of this Contract, we refer to this population as Apple Health Adult Coverage – Medicaid Expansion.

1.10 **American Society of Addiction Medicine (ASAM)**

"American Society of Addiction Medicine (ASAM)" means an international organization of physicians dedicated to improving the treatment of persons with substance abuse disorders.

1.11 **Ancillary Services**

"Ancillary Services" means health care services which are auxiliary, accessory, or secondary to a primary health care service.

1.12 **Anniversary Date**

"Anniversary Date" means the first day of January.

1.13 **Appeal**

"Appeal" means a request for review of an action (42 C.F.R. § 438.400(b)).

1.14 **Appeal Process**

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

1.15 **Area Agency on Aging (AAA)**

"Area Agency on Aging (AAA)" means the agency responsible for providing ongoing case management including assessments for fee for service Medicaid clients who live in their own homes. The AAAs also provide assistance with applying for Medicaid services, as well as information and referral for programs such as the Family Caregiver Support Program, Living Well with Chronic Conditions, Senior Nutrition including the Senior Farmer's Market Nutrition program, Veterans Directed HCBS, LTC Ombudsman, Transportation, Legal Services, Elder Abuse Prevention and Care Transitions Services. For WMIP clients, the AAAs provide ongoing functional assessments for clients living in their own homes and assist clients in transitioning onto and off of WMIP program enrollment.

1.16 **Behavioral Health and Service Integration Administration (BHISA)**

"Behavioral Health and Service Integration Administration (BHISA)" means the administration of the Department of Social and Health Services that provides prevention, intervention, inpatient treatment, outpatient treatment and recovery support to people with addition and mental health needs.

1.17 **CARE Tool**

"CARE Tool" means the tool used by DSHS's Aging and Long Term Support Administration (ALTSA) staff to assess and determine functional eligibility for individuals who are potentially eligible for ALTSA services.

1.18 **Care Coordination**

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

1.19 **Care Coordinator**

"Care Coordinator" means a health care professional or group of professionals, licensed in the state of Washington, who is responsible for providing care coordination services to enrollees. Care Coordinators may be:

1.19.1 A Registered Nurse or Social Worker employed by the Contractor or primary care provider; and/or

1.19.2 Individuals or groups of licensed professionals, or individuals working under their licenses, subcontracted by the primary care provider/clinic.

Nothing in this definition precludes the Contractor or care coordinator from using allied health care staff, such as community health workers and others to facilitate the work of the care coordinator.

1.20 **Care Management**

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

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

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

1.20.3 Coordination of care across the continuum of medical, behavioral health and long term services and supports, including tracking referrals and outcomes of referrals;

1.20.4 Ready access to behavioral health services that are, to the extent possible, integrated with primary care; and

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

1.21 **Centers for Medicare and Medicaid Services (CMS)**

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

1.22 **Chemical Dependency**

"Chemical Dependency" means an alcohol or drug addiction, or dependence on alcohol and one or more other psychoactive chemicals.

1.23 **Chemical Dependency Assessment**

Chemical Dependency Assessment" means a comprehensive evaluation of an individual's risk for substance abuse by a certified chemical dependency professional (CDP) or chemical dependency professional trainee (CDPT) under the supervision of a CDP, including evaluating treatment needs and making necessary referrals and completing release of information forms to enable the CDP or CDPT to provide information to the care coordinator.

1.24 **Chemical Dependency Intensive Inpatient Treatment**

"Chemical Dependency Intensive Inpatient Treatment" means a residential inpatient primary alcohol/drug treatment program in a facility up to a 30-day stay. Includes a concentrated intervention program that consists of therapy, education, and activities for detoxified alcoholics and addicts and their families and the development of community support systems and referrals.

1.25 **Chemical Dependency Professional (CDP)**

"Chemical Dependency Professional (CDP)" means a person certified as a chemical dependency professional by the Washington State Department of Health under Chapter 18.205 RCW.

1.26 **Chemical Dependency Professional Trainee (CDPT)**

"Chemical Dependency Professional Trainee (CDPT)" means a person registered as a chemical dependency professional trainee by the Washington State Department of Health under Chapter 18.205 RCW.

1.27 **Chemical Dependency Residential/Long Term Treatment**

"Chemical Dependency Residential/Long Term Treatment" means chemical dependency residential treatment program with personal care services for individuals with chronic histories of addiction and impaired self-maintenance capabilities. Long-term services are provided up to 180 days.

1.28 **Chemical Dependency Screening**

"Chemical Dependency Screening" means a short questionnaire, selected in conjunction with the Department, to determine a client's risk for substance abuse and need for further assessment. The chemical dependency screening does not have to be conducted by a Chemical Dependency Professional.

1.29 **Chemical Dependency Treatment Agency**

"Chemical Dependency Treatment Agency" means an agency certified by DSHS's Behavioral Health and Service Integration Administration (BHSIA) to provide chemical dependency treatment services and listed in BHSIA's service directory.

1.30 **Code of Federal Regulations (CFR)**

"Code of Federal Regulations (CFR)" means the codification of the general and permanent rules and regulations (Sometimes called administrative law) published in the Federal Register by the executive departments and agencies of the federal government of the United States.

1.31 **Cold Call Marketing**

"Cold Call Marketing" means any unsolicited personal contact by the Contractor or its designee, with a potential enrollee or an enrollee with another Contracted managed care organization for the purposes of marketing (42 C.F.R. § 438.104(a)).

1.32 **Community Mental Health Agency**

"Community Mental Health Agency (CMHA) means a state licensed facility that provides mental health services.

1.33 **Comparable Coverage**

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

1.34 **Confidential Information**

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state law. Confidential Information includes, but is not limited to, Personal Information.

1.35 **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**

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

1.36 **Continuity of Care**

"Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through enrollee transitions between: facility to home; facility to facility; providers or service areas; managed care Contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings to home or other health care settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; and from substance use care to primary and/or mental health care.

1.37 **Contract**

"Contract" means the entire written agreement between HCA and the Contractor, including any Exhibits, documents, and materials incorporated by reference.

1.38 **Contractor**

"Contractor" means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted subcontract, "Contractor" includes any subcontractor and its owners, officers, directors, partners, employees, and/or agents. In this Contract "Contractor" means any managed care organization contracting with HCA for the same services as the Contractor.

1.39 **Contracted Services**

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

1.40 **Covered Services**

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

1.41 **Credible Allegation of Fraud**

"Credible Allegation of Fraud" means an allegation, which has been verified by the state, from any source. Allegations are considered credible when they have evidence to support the allegation. HCA reviews the allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. (42 C.F.R. § 455.2).

1.42 **Debarment**

"Debarment" means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

1.43 **Department of Social and Health Services (DSHS)**

"Department of Social and Health Services (DSHS)" means the Washington State agency responsible for providing a broad array of health care and social services.

1.44 **Detoxification Services**

"Detoxification Services" means the care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

1.45 **Developmental Disabilities Administration (DDA)**

"Developmental Disabilities Administration (DDA)" means the administration with the Department of Social and Health Services responsible for administering Medicaid services to clients with developmental disabilities statewide.

1.46 **Director**

"Director" means the Director of HCA. At his or her sole discretion, the Director may designate a representative to act on the Director's behalf. Any designation may include the representative's authority to hear and/or determine any matter.

1.47 **Dual Eligible**

"Dual Eligible" or dually eligible, means individuals who have been determined eligible for both Medicare and Medicaid services.

1.48 **Duplicate Coverage**

"Duplicate Coverage" means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under this Contract.

1.49 **Eligible Clients**

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

1.50 **Emergency Fill**

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

1.51 **Emergency Medical Condition**

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 C.F.R. § 438.114(a)).

1.52 **Emergency Services**

"Emergency Services" means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 C.F.R. § 438.114(a)).

1.53 **Emergent Care for Mental Health**

"Emergent Care for Mental Health" means services provided for an individual, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to Chapter 71.05 RCW.

1.54 **Encrypt**

"Encrypt" means to encipher or encode electronic data using software that generates a minimum key length of 128 bits.

1.55 **Enrollee**

"Enrollee" means an individual who is enrolled in managed care through a Managed Care Organization (MCO) having a Contract with HCA (42 C.F.R. § 438.10(a)).

1.56 **External Quality Review (EQR)**

"External Quality Review" means the analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that the Contractor or its subcontractors furnish to enrollees (42 C.F.R. § 438.320).

1.57 **External Quality Review Organization (EQRO**)

"External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. § 438.358, or both (42 C.F.R. § 438.320).

1.58 **Family**

"Family" means those the enrollee defines as family or those legally appointed or assigned to provide support to the enrollee, such as parents, foster parents, guardians, siblings, caregivers and significant others.

1.59 **Fraud**

"Fraud" means an intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law (42 C.F.R § 455.2).

1.60 **Grievance**

"Grievance" means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 C.F.R. § 438.400(b)).

1.61 **Grievance Process**

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

1.62 **Grievance System**

"Grievance System" means the overall system that includes grievances and appeals handled by the Contractor and access to the hearing system (42 C.F.R. § 438, Subpart F).

1.63 **Hardened Password**

"Hardened Password" means a string of at least eight characters containing at least one alphabetic character, at least one number and at least one special character such as an asterisk, ampersand or exclamation point.

1.64 **Health Care Authority**

"Health Care Authority" means the State of Washington Health Care Authority and its employees and authorized agents. The Health Care Authority is the state's Medicaid agency with responsibility for oversight of all Medicaid-funded programs.

1.65 **Health Care Professional**

"Health Care Professional" means a physician or any of the following acting within their scope of practice; a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, pharmacist and certified respiratory therapy technician (42 C.F.R. § 438.2).

1.66 **Healthcare Effectiveness Data and Information Set (HEDIS®)**

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

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

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

1.68 **Health Technology Assessment (HTA)**

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

1.69 **Individual with Special Health Care Needs**

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

1.69.1 Has a biologic, psychologic, or cognitive basis;

1.69.2 Has a chronic disease or disabling healthcare condition that is likely to continue for more than

one year; and

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

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

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

1.70 **Managed Care**

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

1.71 **Managed Care Organization (MCO)**

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

1.72 **Marketing**

"Marketing" means any communication, whether written, oral, in-person (telephonic or face-to-face) or electronic, and includes promotional activities intended to increase a Contractor's membership or to "brand" a Contractor's name or organization. Marketing is communication from the Contractor to a potential enrollee or enrollee with another HCA-Contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or to either not enroll or end enrollment with another HCA-contracted MCO.

1.73 **Marketing Materials**

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the Contractor that can be reasonably interpreted as intended as marketing (42 C.F.R. § 438.104(a)).

1.74 **Material Provider**

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

1.75 **Medicaid Fraud Control Unit (MFCU)**

"Medicaid Fraud Control Unit" or "MFCU" means the Washington State Medicaid Fraud Control Unit which investigates and prosecutes fraud by health care providers. The unit is part of the Criminal Justice Division of the Attorney General's Office.

1.76 **Medically Necessary Services**

"Medically Necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting

the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

1.77 **Mental Health Care Provider (MHCP)**

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

1.78 **Mental Health Professional**

"Mental Health Professional" means:

1.78.1 A physician or osteopath licensed under Chapter 18.57 or 18.71 RCW or is board eligible in psychiatry;

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

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

1.78.4 A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;

1.78.5 A person who has an approved exception to perform the duties of a Mental Health Professional that was requested by the regional support network and granted by the DSHS Division of Behavioral Health and Recovery prior to July 1, 2002; or

1.78.6 A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional by the DSHS Division of Behavioral Health and Recovery consistent with WAC 388-865-0265.

1.79 **Mental Health Specialist**

"Mental Health Specialist" means a Mental Health Professional with additional training and experience in the areas of child, geriatric, ethnic minority or disability mental health services, as defined in Chapter 388-865 WAC.

1.80 **National CAHPS® Benchmarking Database – (NCBD)**

"National CAHPS® Benchmarking Database – (NCBD)" means a national repository for data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The database facilitates comparisons of CAHPS® survey results by survey sponsors. Data is compiled into a single national database, which enables NCBD participants to compare their own results to relevant benchmarks (i.e., reference points such as national and regional averages). The NCBD also offers an important source of primary data for specialized research related to consumer assessments of quality as measured by CAHPS®.

1.81 **National Committee for Quality Assurance (NCQA)**

"National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

1.82 **Non-Participating Provider**

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

1.83 **Participating Rebate Eligible Manufacturer**

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

1.84 **Participating Provider**

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

1.85 **Peer Counselor**

"Peer Counselor" means an individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by DSHS; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check and has been certified by DSHS.

1.86 **Peer-Reviewed Medical Literature**

"Peer-Reviewed Medical Literature" means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

1.87 **Personal Information**

"Personal Information" means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.

1.88 **Physically Secure**

"Physically Secure" means that access is restricted through physical means to authorized individuals only.

1.89 **Physician Group**

"Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

1.90 **Physician Incentive Plan**

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

1.91 **Physician's Orders for Life Sustaining Treatment (POLST)**

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

1.92 **PITA**

"PITA" means Prevention, Intervention, Treatment and Aftercare. PITA is a chemical dependency model utilized to develop chemical dependency treatment programs along a continuum of care.

1.93 **Post-stabilization Services**

"Post-stabilization Services" means contracted services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition (42 C.F.R. § 438.114 and 422.113).

1.94 **Potential Enrollee**

"Potential Enrollee" means any individual eligible for enrollment in Managed Care under this Contract who is not enrolled with a health care plan having a Contract with HCA (42 C.F.R. § 438.10(a)).

1.95 **Primary Care Provider (PCP)**

"Primary Care Provider (PCP)" means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Naturopathic physicians, medical residents (under the supervision of a teaching physician), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor. The definition of PCP is inclusive of primary care physician as it is used in 42 C.F.R. § 438. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Contract.

1.96 **Predictive Risk Intelligence System (PRISM)**

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

1.97 **Professional Services Supplemental Program (PSSP)**

"Professional Services Supplemental Program (PSSP)" means a federally funded program that provides additional payments for professional services to eligible public hospitals and University of Washington Hospital's affiliated practice plans.

1.98 **Provider**

"Provider" means an individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

1.99 **Quality**

"Quality" means the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge (42 C.F.R. § 438.320).

1.100 **Recovery**

"Recovery" means the process by which people with mental health diagnoses are able to live, work, learn and participate fully in their communities.

1.101 **Resiliency**

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

1.102 **Referral Provider**

"Referral Provider" means a provider, who is not the enrollee's PCP, to whom an enrollee is referred for covered services.

1.103 **Regional Support Network**

"Regional Support Network" means a single or multiple-county authority or other entity operating as a prepaid health plan through which the agency or the agency's designee contracts for the delivery of community outpatient and inpatient mental health services system in a defined geographic area to enrollees who meet Access to Care Standards.

1.104 **Regulation**

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

1.105 **RCW**

"RCW" means the Revised Code of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at http://www.leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx.

1.106 **Risk**

"Risk" means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a physician incentive plan, as defined in this Contract.

1.107 **Routine care for Mental Health**

"Routine Care for Mental Health" means evaluation and mental health services provided to consumers on a regular basis. These services are intended to stabilize sustain, and facilitate consumer recovery within his or her living situation.

1.108 **Safety Net Assessment Fund (SNAF)**

"Safety Net Assessment Fund (SNAF)" means a program that increases payment for hospital claims for Medicaid clients, authorized under Chapter 74.60 RCW.

1.109 **Screening, Brief Intervention and Referral for Treatment (SBIRT)**

"Screening, Brief Interventions and Referral to Treatment (SBIRT)" means a comprehensive, evidenced-based public health practice designed to identify people who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. SBIRT services are provided in a wide variety of medical and community health care settings: primary care centers, hospital emergency rooms, and trauma centers.

1.110 **Secured Area**

"Secured Area" means an area to which only authorized representatives of the entity possessing the Confidential Information have access. Secured Areas may include buildings, rooms or locked storage containers (such as a filing cabinet) within a room, as long as access to the Confidential Information is not available to unauthorized personnel.

1.111 **Service Areas**

"Service Areas" means the geographic areas in which the Contractor serves eligible clients as described in this Contract.

1.112 **Sub-acute Detoxification Services**

"Sub-acute Detoxification Services" means the non-medical detoxification or patient self-administration of withdrawal medications ordered by a physician and provided in a home-like environment.

1.113 **Subcontract**

"Subcontract" means any separate agreement or Contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Contract.

1.114 **Substantial Financial Risk**

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

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

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

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

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

1.114.5 Capitation arrangements if the difference between the minimum and maximum possible payments is more than twenty-five percent (25%) of the maximum possible payments, or the

minimum and maximum possible payments are not clearly explained in the Contract.

1.115 **Tracking**

"Tracking" means a record keeping system that identifies when the sender begins delivery of Confidential Information to the authorized and intended recipient, and when the sender receives confirmation of delivery from the authorized and intended recipient of Confidential Information.

1.116 **Transitional Healthcare Services (THS)**

"Transitional Healthcare Services" means the mechanisms to ensure coordination and continuity of care as enrollees transfer between different locations or different levels of care within the same location. Transitional Healthcare Services are intended to prevent secondary health conditions or complications, re-institutionalization or re-hospitalization, including recidivism following substance use disorder treatment.

1.117 **Transport**

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

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

1.117.2 Is accomplished other than via a Trusted System.

1.118 **Trusted Systems**

"Trusted Systems" means methods of delivering confidential information in such a manner that confidentiality is not compromised. Trusted Systems include only the following methods of physical delivery:

1.118.1 Hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; and

1.118.2 United States Postal Service (USPS) delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail.

Any other method of physical delivery will be deemed not be a Trusted System.

1.119 **Unique User ID**

"Unique User ID" means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase or other mechanism, authenticates a user to an information system.

1.120 **Validation**

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

1.121 **Washington Administrative Code (WAC)**

"Washington Administrative Code (WAC)" means the rules adopted by agencies to implement legislation and RCWs. All references in this Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation. Pertinent WAC chapters or sections can be accessed at http://www.leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx

1.122 **Washington Apple Health**

"Washington Apple Health" means a title that expresses the rebranding of the Washington State Medicaid Program.

1.123 **Washington Medicaid Integration Partnership (WMIP)**

"Washington Medicaid Integration Partnership (WMIP)" means a program that incorporates a strong care management and health integration component into a managed care program that integrates medical, mental health, chemical dependency and long term care services into a single, well-coordinated whole.

2 GENERAL TERMS AND CONDITIONS

2.1 Amendment

Any amendment to this Contract shall require the approval of both HCA and the Contractor. Any amendment shall be in writing and shall be signed by a Contractor's authorized officer and an authorized representative of HCA. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

HCA reserves the right to issue unilateral amendments which provide corrective or clarifying information.

2.2 Assignment

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

2.3 Billing Limitations

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

2.3.2 HCA shall not pay any claims for payment for services submitted more than twelve (12) months after the calendar month in which the services were performed.

2.3.3 The Contractor shall not bill and HCA shall not pay for services performed under this Contract, if the Contractor has charged or will charge another agency of the state of Washington or any other party for the same services.

2.4 Compliance with Applicable Law

In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal, state and local laws and regulations, and all amendments thereto, that are in effect when the Contract is signed or that come into effect during the term of this Contract (42 C.F.R. § 438.6(f)(1) and 438.100(d)). The provisions of this Contract that are in conflict with applicable state or federal laws or regulations are hereby amended to conform to the minimum requirements of such laws or regulations. A provision of this Contract that is stricter than such laws or regulations will not be deemed a conflict. Applicable laws and regulations include, but are not limited to:

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

2.4.2 Title VI of the Civil Rights Act of 1964;

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

2.4.4 The Age Discrimination Act of 1975;

2.4.5 The Rehabilitation Act of 1973;

2.4.6 The Budget Deficit Reduction Act of 2005;

2.4.7 The False Claim Act;

2.4.8 The Health Insurance Portability and Accountability Act (HIPAA);

2.4.9 The American Recovery and Reinvestment Act (ARRA);

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

2.4.11 The Health Care and Education Reconciliation Act;

2.4.12 Chapter 70.02 RCW and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews; and

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

2.4.13.1 All applicable standards, orders, or requirements issued under Section 306 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 C.F.R. Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to HCA, DHHS, and the EPA.

2.4.13.2 Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.

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

2.4.13.4 Those specified in Title 18 RCW for professional licensing.

2.4.13.5 Industrial Insurance – Title 51 RCW.

2.4.13.6 Reporting of abuse as required by RCW 26.44.030.

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

2.4.13.8 EEO Provisions.

2.4.13.9 Copeland Anti-Kickback Act.

2.4.13.10 Davis-Bacon Act.

2.4.13.11 Byrd Anti-Lobbying Amendment.

2.4.13.12 All federal and state nondiscrimination laws and regulations.

2.4.13.13 Americans with Disabilities Act: The Contractor shall make reasonable accommodation for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit enrollees with disabilities from obtaining contracted services.

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

2.5 **Confidentiality**

2.5.1 The Contractor will protect and preserve the confidentiality of HCA's data or information that is

defined as confidential under state or federal law or regulation or data that HCA has identified as confidential.

2.5.2 The Contractor shall comply with all applicable federal and state laws and regulations concerning collection, use, and disclosure of Personal Information set forth in Governor Locke's Executive Order 00-03 and Protected Health Information (PHI), defined at 45 C.F.R. § 160.103, as may be amended from time to time. Personal Information or PHI collected, used, or acquired in connection with this Agreement shall be used solely for the purposes of this Contract. The Contractor shall not release, divulge, publish, transfer, sell, or otherwise make known to unauthorized third parties Personal Information or PHI without the advance express written consent of the individual who is the subject matter of the Personal Information or PHI or as otherwise required in this Contract or as permitted or required by state or federal law or regulation. The Contractor shall implement appropriate physical, electronic, and managerial safeguards to prevent unauthorized access to Personal Information and PHI. The Contractor shall require the same standards or confidentiality of all its Subcontractors.

2.5.3 The Contractor agrees to share Personal Information regarding enrollees in a manner that complies with applicable state and federal law protecting confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 USC 1320(d) et. seq. and 45 C.F.R. parts 160, 162, and 164., the HIPAA regulations, 42 C.F.R. § 431 Subpart F, 42 C.F.R. § 438.224, RCW 5.60.060(4), and RCW 70.02). The Contractor and the Contractor's subcontractors shall fully cooperate with HCA efforts to implement HIPAA requirements.

2.5.4 The Contractor shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss.

2.5.4.1 This duty requires that Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:

2.5.4.1.1 Encrypting electronic Confidential Information during Transport;

2.5.4.1.2 Physically Securing and Tracking media containing Confidential Information during Transport;

2.5.4.1.3 Limiting access to staff that have an authorized business requirement to view the Confidential Information;

2.5.4.1.4 Using access lists, Unique User ID and Hardened Password authentication to protect Confidential Information;

2.5.4.1.5 Physically Securing any computers, documents or other media containing the Confidential Information; and

2.5.4.1.6 Encrypting all Confidential Information that is stored on portable devices including but not limited to laptop computers and flash memory devices.

2.5.4.2 Upon request by HCA the Contractor shall return the Confidential Information or certify in writing that the Contractor employed a HCA approved method to destroy the information. Contractor may obtain information regarding approved destruction methods from HCA contact identified in this Contract.

2.5.5 In the event of a breach, meaning an acquisition, access, use, or disclosure of PHI in a manner not permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule which compromises the security or privacy of an enrollee's PHI, the Contractor shall notify HCA in writing, as described in the Notices section of the General Terms and

Conditions, within two (2) business days after determining notification must be sent to enrollees. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirement imposed by law (42 C.F.R. § 164.102, WAC 284-04-625, RCW 19.255.010).

2.5.6 HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Enrollees collected, used, or acquired by Contractor during the term of this Agreement. All HCA representatives conducting onsite audits of Contractor agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

2.5.7 Any material breach of this confidentiality provision may result in termination of this Contract. The Contractor shall indemnify and hold HCA harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of enrollees.

2.5.8 This section does not preclude the Contractor and HCA, DSHS and/or DSHS's delegated authority from communicating about an enrollee in common for the purposes of continuity of care and appropriate care transitions.

2.6 Covenant Against Contingent Fees

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

2.7 Debarment Certification

The Contractor, by signature to this Contract, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded in any Washington State or Federal department or agency from participating in transactions (debarred). The Contractor agrees to include the above requirement in any and all Subcontracts into which it enters, and also agrees that it will not employ debarred individuals or subcontract with any debarred providers, persons, or entities. The Contractor shall immediately notify HCA if, during the term of this Contract, the Contractor becomes debarred. HCA may immediately terminate this Contract by providing Contractor written notice in accord with subsection 2.38 of this Contract if the Contractor becomes debarred during the term hereof.

2.8 Defense of Legal Actions

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

2.9 Disputes

When a dispute arises over an issue that pertains in any way to this Contract, the parties agree to the following process to address the dispute:

2.9.1 Except as otherwise provided in this Contract, when a bona fide dispute arises between HCA and the Contractor and it cannot be resolved, the Contractor may request a dispute resolution

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

2.9.1.1 The disputed issue(s);

2.9.1.2 An explanation of the positions of the parties; and

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

2.9.2 Requests for a dispute resolution conference must be mailed to the Director, Washington State HCA, P.O. Box 42700, Olympia, WA 98504-2700. Any such requests must be received by the Director within fifteen (15) calendar days after the Contractor receives notice of the disputed issue(s).

The Director, in his or her sole discretion, will determine a time for the parties to present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's discretion. The Director will provide written notice of the time, format, and location of the conference. The conference is informal in nature and is not governed in any way by the Administrative Procedure Act, chapter 34.05 RCW.

The Director will consider all of the information provided at the conference and will issue a written decision on the disputed issue(s) within thirty (30) calendar days after the conclusion of the conference. However, the Director retains the option of taking up to an additional sixty (60) calendar days to consider the disputed issue(s) or taking additional steps to attempt to resolve them. If the Director determines, in his or her sole discretion, that an additional period of up to sixty (60) calendar days is needed for review, he or she will notify the Contractor, in writing, of the delay and the anticipated completion date before the initial thirty-day period expires.

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

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

2.10 **Force Majeure**

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

2.11 Governing Law and Venue

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

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

2.12 Independent Contractor

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

2.13 Insolvency

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

2.13.1 The State of Washington and enrollees shall not be in any manner liable for the debts and obligations of the Contractor (42 C.F.R. § 438.106(a) and 438.116(a)(1)).

2.13.2 In accord with the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge enrollees for Contracted services (42 C.F.R. § 438.106(b)(1))).

2.13.3 The Contractor shall, in accord with RCW 48.44.055 or 48.46.245, provide for the continuity of care for enrollees.

2.14 Inspection

The Contractor and its subcontractors shall cooperate with audits performed by duly authorized representatives of the State of Washington, the federal Department of Health and Human Services, auditors from the federal Government Accountability Office, federal Office of the Inspector General and federal Office of Management and Budget. With reasonable notice, generally thirty (30) calendar days, the Contractor and its subcontractors shall provide access to its facilities and the records pertinent to this Contract to monitor and evaluate performance under this Contract, including, but not limited to, claims payment and the quality, cost, use, health and safety and timeliness of services, provider network adequacy, including panel capacity or willingness to accept new patients, and assessment of the Contractor's capacity to bear the potential financial losses. The Contractor and its subcontractors shall provide immediate access to facilities and records pertinent to this Contract for State or Federal fraud investigators (42 C.F.R. § 438.6(g)).

2.15 Insurance

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

2.15.1 Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance,

including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. The State of Washington, HCA, its elected and appointed officials, agents, and employees shall be named as additional insured's expressly for, and limited to, Contractor's services provided under this Contract.

2.15.2 Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000.

2.15.3 Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The State of Washington and HCA shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.

2.15.4 Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.

2.15.5 Subcontractors: The Contractor shall ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for subcontractors, to HCA if requested.

2.15.6 Separation of Insured's: All insurance Commercial General Liability policies shall contain a "separation of insured's" provision.

2.15.7 Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the State of Washington, with a "Best's Reports'' rating of A-, Class VII or better. Any exception must be approved by HCA. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.

2.15.8 Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accord with the Notices section of the General Terms and Conditions, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

2.15.9 Material Changes: The Contractor shall give HCA, in accord with the Notices section of the General Terms and Conditions, forty-five (45) calendar days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give HCA ten (10) calendar days advance notice of cancellation.

2.15.10 General: By requiring insurance, the State of Washington and HCA do not represent that the coverage and limits specified will be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and HCA in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.

2.15.11 The Contractor may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers and Evidence of Coverage provisions of this Section if self-insured. In the event the Contractor is self-insured, the Contractor must send to HCA by the third Wednesday of January in each Contract year, a signed written document, which certifies that the Contractor is self-insured, carries coverage adequate to meet the

requirements of this Section, will treat HCA as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA.

2.16 Records

2.16.1 The Contractor and its subcontractors shall maintain financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.

2.16.2 All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of six (6) years after final payment is made under this Contract. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action (RCW 40.14.060). The Contractor acknowledges the HCA is subject to the Public Records Act (chapter 42.56 RCW). This Contract will be a “public record” as defined in chapter 42.56 RCW. Any documents submitted to HCA by the Contractor may also be construed as “public records” and therefore subject to public disclosure under chapter 42.56 RCW.

2.17 Mergers and Acquisitions

If the Contractor is involved in an acquisition of assets or merger with another HCA Contractor after the effective date of this Contract, HCA reserves the right, to the extent permitted by law, to require that each Contractor maintain its separate business lines for the remainder of the Contract period.

2.18 Notification of Organizational Changes

The Contractor shall provide HCA with ninety (90) calendar days’ prior written notice of any change in the Contractor’s ownership or legal status. The Contractor shall provide HCA notice of any changes to the Contractor’s key personnel including, but not limited to, the Contractor’s Chief Executive Officer, the Contractor’s Chief Financial Officer, HCA government relations contact, HCA Account Executive, and Medical Director as soon as reasonably possible.

2.19 Order of Precedence

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

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

2.19.2 State of Washington statues and regulations concerning the operation of HCA programs participating in this Contract.

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

2.19.4 General Terms and Conditions of this Contract.

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

2.19.6 Any other material incorporated herein by reference.

2.20 Severability

If any term or condition of this Contract is held invalid by any court, such invalidity shall not affect the validity of the other terms or conditions of this Contract.

2.21 Survivability

The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: Confidentiality, Indemnification and Hold Harmless, Inspection and Maintenance of Records. After termination of this Contract, the Contractor remains obligated to:

2.21.1 Cover hospitalized enrollees until discharge consistent with this Contract.

2.21.2 Submit reports required in this Contract.

2.21.3 Provide access to records required in accord with the Inspection provisions of this Section.

2.21.4 Provide the administrative services associated with Contracted services (e.g. claims processing, enrollee appeals) provided to enrollees prior to the effective date of termination under the terms of this Contract.

2.22 Waiver

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

2.23 Contractor Certification Regarding Ethics

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

2.24 Health and Safety

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

2.25 Indemnification and Hold Harmless

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

waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees.

2.26 **Industrial Insurance Coverage**

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

2.27 **No Federal or State Endorsement**

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

2.28 **Notices**

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

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

[Contact Name]
[Organization's name]
[Address]
[City, State, Zip]

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

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

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

2.28.4 Either party may at any time change its address for notification purposes by mailing a notice in accord with this Section, stating the change and setting for the new address, which shall be effective on the tenth (10th) day following the effective date of such notice unless a later date is specified.

2.29 **Notice of Overpayment**

If the Contractor receives a vendor overpayment notice or a letter communicating the existence of an overpayment from HCA, the Contractor may protest the overpayment determination by requesting an

adjudicative proceeding. For purposes of this Contract, the term "overpayment" is the same as the definition given in RCW 41.05A.010. The Contractor's request for an adjudicative proceeding must:

2.29.1 Be received by the Office of Financial Recovery (OFR) at Post Office Box 9501, Olympia, Washington 98507-9501, within twenty-eight (28) calendar days of service of the notice;

2.29.2 Be sent by certified mail (return receipt) or other manner that proves OFR received the request;

2.29.3 Include a statement as to why the Contractor thinks the notice is incorrect; and

2.29.4 Include a copy of the overpayment notice.

2.29.4.1 Timely and complete requests will be scheduled for a formal hearing by the Office of Administrative Hearings. The Contractor may be offered a pre-hearing or alternative dispute resolution conference in an attempt to resolve the overpayment dispute prior to the hearing.

2.29.4.2 Failure to provide OFR with a written request for a hearing within twenty-eight (28) calendar days of service of a vendor overpayment notice or other overpayment letter will result in an overpayment debt against the Contractor. HCA may charge the Contractor interest and any costs associated with the collection of this overpayment. HCA may collect an overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; or any other collection action available to HCA to satisfy the overpayment debt.

2.30 **Proprietary Data or Trade Secrets**

2.30.1 Except as required by law, regulation, or court order, data identified by the Contractor as proprietary trade secret information shall be kept strictly confidential, unless the Contractor provides prior written consent of disclosure to specific parties. Any release or disclosure of data shall include the Contractor's interpretation.

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

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

2.31 **Ownership of Material**

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

2.32 Solvency

2.32.1 The Contractor shall have a Certificate of Registration as a Health Maintenance Organization (HMO), Health Care Service Contractor (HCSC) or Life and Disability Insurance Carrier, from the Washington State Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of chapters 48.21, 48.21a, 48.44 or 48.46 RCW, as amended.

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

2.32.3 The Contractor shall deliver to HCA copies of any financial reports prepared at the request of the OIC. The Contractor's routine quarterly and annual statements submitted to the OIC are exempt from this requirement. The Contractor shall also deliver copies of related documents and correspondence (including, but not limited to, Risk-Based Capital [RBC] calculations and Management's Discussion and Analysis), at the same time the Contractor submits them to the OIC.

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

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

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

2.33 Conflict of Interest Safeguards

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

2.34 Reservation of Rights and Remedies

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

2.35 **Termination Default**

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

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

2.36 **Termination for Convenience**

Except as otherwise provided in this contract, the HCA may, by giving thirty (30) days written notice, beginning on the second day after the mailing, terminate this contract in whole or in part when it is in the best interest of HCA. If this contract is so terminated, HCA shall be liable only for payment in accordance with the terms of this contract for services rendered prior to the effective date of termination.

2.37 **Termination due to Federal Impact**

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

2.38 **Terminations: Pre-termination Processes**

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

HCA shall provide written notice to the Contractor's enrollees of the decision to terminate the Contract and indicate whether the Contractor may appeal the decision.

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

2.38.2 If the Contractor disagrees with a HCA decision to terminate this Contract and the dispute process is not successful, HCA shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 C.F.R. § 438.708. HCA shall:

2.38.2.1 Give the Contractor written notice of the intent to terminate, the reason for

termination, and the time and place of the hearing;

2.38.2.2 Give the Contractor (after the hearing) written notice of the decision affirming or reversing the proposed termination of this Contract, and for an affirming decision the effective date of termination; and

2.38.2.3 For an affirming decision, give enrollees notice of the termination and information consistent with 42 C.F.R. § 438.10 on their options for receiving Medicaid services following the effective date of termination.

2.39 Savings

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

2.40 Post Termination Responsibilities

The following requirements survive termination of this Contract. The Contractor shall:

2.40.1 Cover Enrollees hospitalized on the date of termination until discharge, consistent with the terms of this Contract;

2.40.2 Submit all data and reports required in this Contract;

2.40.3 Provide access to records, related to audits and performance reviews; and

2.40.4 Provide administrative services associated with services (e.g., claims processing and Enrollee appeals) to be provided to Enrollees under the terms of this Contract.

2.41 Termination - Information on Outstanding Claims

In the event this Contract is terminated, the Contractor shall provide HCA, within three hundred and sixty-five (365) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to enrollees (42 C.F.R. § 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions Section of this Contract.

2.42 Administrative Simplification

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

2.42.1 To maximize understanding, communication, and administrative economy among all managed care Contractors, their Subcontractors, governmental entities, and Enrollees, Contractor shall use and follow the most recent updated versions of:

- Current Procedural Terminology (CPT)
- International Classification of Diseases (ICD)
- Healthcare Common Procedure Coding System (HCPCS)
- CMS Relative Value Units (RVUs)
- CMS billing instructions and rules
- NCPDP Telecommunication Standard D.O.

- Medi-Span® Master Drug Data Base

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

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

2.43 Background Checks

2.43.1 This requirement applies to any employees, volunteers and subcontractor employees who may have unsupervised access to children and/or Vulnerable Adults served under this Contract.

2.43.2 The Contractor shall ensure a criminal history background check pursuant to RCW 43.43.832, 43.43.834, RCW 43.20A.710 and WAC 388-06 has been completed through the Background Check Central Unit, Administrative Services Division, Financial Services Administration, Washington State Department of Social and Health Services (bccuinquiry@dshs.wa.gov) for all current employees, volunteers, and subcontractors, and that a criminal history background check shall be initiated for all prospective employees, volunteers and subcontractors who may have unsupervised access to children and/or vulnerable adults served under this Contract.

2.43.3 The Contractor shall assist in obtaining additional state or national criminal history and/or child and/or vulnerable adult abuse/neglect history, if requested by the HCA Contract Contact.

2.43.4 The Contractor shall ensure that no employee, volunteer or subcontractor, including those provisionally hired pursuant to RCW 43.43.832(7), has unsupervised access to children and/or Vulnerable Adults served under this Contract, until a full and satisfactory background check is completed and documentation, qualifying the individual for unsupervised access, is returned to the Contractor.

2.43.5 All Individual Providers are subject to background checks prior to providing services under this contract. The DSHS Background Check Central Unit shall conduct all background checks to ensure all disqualifying crimes are being addressed and are known to the Contractor. The Contractor will apply the disqualifying crimes list per population served per WAC 388-71-0540.

2.44 Treatment of Client Property

Unless otherwise provided, the Contractor shall ensure that any adult client receiving services from the Contractor has unrestricted access to the client's personal property. The Contractor shall not interfere with any adult client's ownership, possession, or use of the client's property. The Contractor shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon termination of the Contract, the Contractor shall immediately release to the client and/or the client's guardian or custodian all of the client's personal property.

2.45 Treatment of Property

All property purchased or furnished by DSHS for use by the Contractor during this Contract term shall remain with DSHS. Title to all property purchased or furnished by the Contractor for which the Contractor is entitled to reimbursement by DSHS under this Contract shall pass to and vest in DSHS. The Contractor shall protect, maintain, and insure all DSHS property in its possession against loss or damage and shall return DSHS property to DSHS upon Contract termination or expiration.

2.46 Washington Public Disclosure Act

The Contractor acknowledges that HCA is subject to the Public Records Act (the Act, which is codified at RCW 42.17.250, et seq.). This Contract will be a 'public record' as defined in RCW 42.17.020. Any documents submitted to HCA by the Contractor may also be construed as 'public records' and therefore subject to public disclosure under the Act. The Contractor may label documents submitted to HCA as 'confidential' or 'proprietary' if it so chooses; however, the Contractor acknowledges that such labels are not determinative of whether the documents are subject to disclosure under the Act. If HCA receives a public disclosure request that would encompass any Contractor document that has been labeled by the Contractor as 'confidential' or 'proprietary,' then HCA will notify the Contractor pursuant to RCW 42.17.330. The Contractor then will have the option, under RCW 42.17.330, of seeking judicial intervention to prevent the public disclosure of the affected document(s).

2.47 Collective Bargaining Agreements

The Contractor shall comply with all current and future collective bargaining agreements by and between the Governor of the State of Washington and the Service Employees International Union, Local 775, AFL-CIO in accordance with RCW 74.39A.270. DSHS shall provide the Contractor with copies of any new collective bargaining agreements or amendments to existing agreements no less than 60 days prior to the effective date of the new agreement or amendment. Should the terms of any new agreements or amendments be materially different than the 2005-2007 Agreement, Contractor shall have the right to discontinue its responsibility for services upon effective date of such agreement or amendment. DSHS reserves the right to terminate the Long Term Care portion of this program in accordance with Section 2.36, Termination for Convenience, of the General Terms and Conditions of this Contract, should the Contractor discontinue provision of services.

3 MARKETING AND INFORMATION REQUIREMENTS

3.1 Marketing

3.1.1 All marketing materials must be reviewed by and have written approval of HCA prior to distribution (42 C.F.R. § 438.104(b)(1)(i)). Marketing materials must be developed and submitted in accordance with the Marketing Guidelines developed and distributed by the HCA. Marketing materials include any items developed by the Contractor for distribution to enrollees or potential enrollees that are intended to provide information about the Contractor's benefit administration, including:

3.1.1.1 Print media;

3.1.1.2 Websites; and

3.1.1.3 Electronic Media (Television/Radio/Internet).

3.1.2 Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information (42 C.F.R. § 438.104(b)(2)).

3.1.3 Marketing materials must be distributed in all service areas the Contractor serves (42 C.F.R. § 438.104(b)(1)(ii)).

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

3.1.4.1 Marketing materials in English must give directions for obtaining understandable

materials in the population's primary languages, as identified by HCA.

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

3.1.5 The Contractor shall not offer anything of value as an inducement to enrollment.

3.1.6 The Contractor shall not offer the sale of other insurance to attempt to influence enrollment (42 C.F.R. § 438.104(b)(1)(iv)).

3.1.7 The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment (42 C.F.R. § 438.104(b)(1)(v)).

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

3.1.9 The Contractor shall not make any assertion or statement, whether written or oral, in marketing materials that the Contractor is endorsed by CMS, the Federal or State government or similar entity (42 C.F.R. § 438.104(b)(2)(ii)).

3.2 Information Requirements for Enrollees and Potential Enrollees

3.2.1 The Contractor shall provide to potential enrollees and new enrollees sufficient, accurate information needed to understand benefit coverage and obtain care in accord with the provisions of this Section (42 C.F.R. § 438.10(b)(3) and 438.10(f)(3)). The information shall be provided at least once a year, or upon request and within fifteen (15) working days of enrollment. The Contractor shall coordinate with the enrollee or potential enrollee to provide the information in an alternative format that the enrollee can understand.

3.2.2 Information provided by the Contractor must include contact numbers for Contractor's customer service, information about the Contractor's authorization processes, network providers and/or Value Added Benefits that the Contractor may provide.

3.2.2.1 If the enrollee is not able to understand written information provided by the Contractor or only understands a language that is not translated, the Contractor shall provide the necessary information in an alternative format that is understandable to the enrollee.

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

3.2.4 Changes to State or Federal law shall be reflected in information to enrollees no more than ninety (90) calendar days after the effective date of the change and enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of HCA, the change is significant in regard to the enrollees' quality of or access to care, which may include changes to: enrollment rights, grievance and hearing procedures, benefits, authorizations or coverage of emergency services. HCA shall notify the Contractor in writing of any significant change (42 C.F.R. § 438.6(i)(4) and 438.10(f)(4)).

3.2.5 The Contractor shall provide to enrollees and potential enrollees written information about:

3.2.5.1 Choosing a PCP, including general information on available PCPs and how to obtain specific information including a list of PCPs that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

3.2.5.2 How to change PCPs.

3.2.5.3 How to access services outside the Contractor's service area.

3.2.5.4 How to access Emergency, after hours and urgent services.

3.2.5.5 How to access hospital care and how to get a list of hospitals that are available to enrollees.

3.2.5.6 Specialists available to enrollees, including mental health providers and how to obtain specific information including a list of specialists, their identity, location, languages spoken, qualifications, practice restrictions and availability.

3.2.5.7 Pharmacies available to enrollees and how to obtain specific information including a list of pharmacies that includes their identity, location, and hours of operation.

3.2.5.8 To assist the enrollee in selecting a PCP, what limitations on the availability of or referral to specialists there are including any medical group restrictions.

3.2.5.9 How to get direct access to a Woman's Healthcare specialist within the Contractor's network.

3.2.5.10 How to get information about Physician Incentive Plans (42 C.F.R. § 422.208 and 422.210).

3.2.5.11 How to get information on the Contractor's structure and operations (42 C.F.R. § 438.10(g)).

3.2.5.12 Informed consent guidelines.

3.2.5.13 Conversion rights under RCW 48.46.450 or RCW 48.44.370.

3.2.5.14 How to request a termination of enrollment.

3.2.5.15 Information regarding advance directives to include (42 C.F.R. § 422.128 and 438.6(i)(1 and 3)):

3.2.5.15.1 A statement about an enrollee's right to make decisions concerning an enrollee's medical care, accept or refuse surgical or medical treatment, execute an advance directive, and revoke an advance directive at any time.

3.2.5.15.2 The Contractor's written policies and procedures concerning advance directives, including any policy that would preclude the Contractor or subcontractor from honoring an enrollee's advance directive.

3.2.5.15.3 An enrollee's rights under state law, including the right to file a grievance with the Contractor or HCA regarding compliance with advance directive requirements in accord with the Advance Directive provisions of the Enrollee Rights and Protections Section of this Contract.

3.2.5.16 How to recommend changes in the Contractor's policies and procedures.

3.2.5.17 What health promotion, health education and preventive health services are available.

3.2.5.18 Information on the Contractor's Grievance System including (42 C.F.R. § 438.10(f)(2), 438.10(f)(6)(iv), 438.10(g)(1) and SMM2900 and 2902.2):

3.2.5.18.1 How to obtain assistance from the Contractor in using the grievance, appeal and independent review processes (must assure enrollees that

information will be kept confidential except as needed to process the grievance, appeal or independent review).

3.2.5.18.2 The enrollee's right to and how to initiate a grievance or file an appeal, in accord with the Contractor's HCA approved policies and procedures regarding grievances and appeals.

3.2.5.18.3 The enrollees' right to and how to request a hearing after the Contractor's appeal process is exhausted, how to request a hearing and the rules that govern representation at the hearing.

3.2.5.18.4 The enrollees' right to and how to request an independent review in accord with RCW 48.43.535 and Chapter 246-305 WAC after the hearing process is exhausted and how to request an independent review.

3.2.5.18.5 The enrollees' right to appeal to the Board of Appeals and how to request such an appeal.

3.2.5.18.6 The requirements and timelines for grievances, appeals, hearings, independent review and Board of Appeals.

3.2.5.18.7 The enrollees' rights and responsibilities, including potential payment liability, regarding the continuation of services that are the subject of appeal or a hearing.

3.2.5.18.8 The availability of toll-free numbers for information about grievances and appeals and to file a grievance or appeal.

3.2.5.19 The enrollee's rights and responsibilities with respect to accessing contracted services.

3.2.5.20 Information about covered benefits and how to contact HCA regarding services that may be covered by HCA, but are not covered benefits under this Contract.

3.2.5.21 Information regarding the availability of and how to access or obtain interpretation services and translation of written information at no cost to the enrollee (42 C.F.R. § 438.10(c)(5)(i and ii)).

3.2.5.22 How to obtain information in alternative formats (42 C.F.R. § 438.10(d)(2)).

3.2.5.23 The enrollee's right to and procedure for obtaining a second opinion.

3.2.5.24 The prohibition on charging enrollees for contracted services, the procedure for reporting charges the enrollee receives for contracted services to the Contractor, and circumstances under which an enrollee might be charged for services.

3.2.5.25 Information regarding appointment wait-time standards.

3.2.5.26 How to access dental benefits through the Medicaid fee for service system.

3.3 Equal Access for Enrollees & Potential Enrollees with Communication Barriers

The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access for enrollees and potential enrollees with communication barriers (42 C.F.R. § 438.10).

3.3.1 Oral Information

3.3.1.1 The Contractor shall assure that interpreter services are provided for enrollees and potential enrollees with a primary language other than English, free of charge (42

C.F.R. § 438.10(c)(4)). Interpreter services shall be provided for all interactions between such enrollees or potential enrollees and the Contractor or any of its providers including, but not limited to:

3.3.1.1.1 Customer service.

3.3.1.1.2 Face-to-face care plan development, implementation and ongoing consultation.

3.3.1.1.3 All appointments with any provider for any covered service.

3.3.1.1.4 Emergency services.

3.3.1.1.5 All steps necessary to file grievances and appeals.

3.3.1.2 The Contractor is responsible for payment for interpreter services for Contractor administrative matters including, but not limited to handling enrollee grievances and appeals.

3.3.1.3 HCA is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient medical visits and hearings.

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

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

3.3.1.6 Interpreter services include the provision of interpreters for enrollees and potential enrollees who are deaf or hearing impaired at no cost to the enrollee or potential enrollee (42 C.F.R. § 438.10(c)(4)).

3.3.2 Written Information

3.3.2.1 The Contractor shall provide all generally available and client-specific written materials in a language and format which may be understood by each individual enrollee and potential enrollee (42 C.F.R. § 438.10(c)(3) and 438.10(d)(1)(ii)).

3.3.2.1.1 If five percent (5%) or more of the Contractor's enrollees speak a specific language other than English, generally available materials will be translated into that language.

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

3.3.2.1.2.1 Translating the material into the enrollee's or potential enrollee's primary reading language.

3.3.2.1.2.2 Providing the material in an audio format in the enrollee's or potential enrollee's primary language.

3.3.2.1.2.3 Having an interpreter read the material to the enrollee or potential enrollee in the enrollee's primary language.

3.3.2.1.2.4 Providing the material in another alternative medium or format acceptable to the enrollee or potential enrollee. The Contractor shall document the enrollee's or potential enrollee's acceptance of the material in an alternative medium or format (42 C.F.R. § 438.10(d)(1)(ii)).

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

3.3.2.2 The Contractor shall ensure that all written information provided to enrollees or potential enrollees is accurate, is not misleading, is comprehensible to its intended audience, designed to provide the greatest degree of understanding, and is written at the sixth grade reading level and fulfills other requirements of the Contract as may be applicable to the materials (42 C.F.R. § 438.10(b)(1)).

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

3.3.2.4 Educational materials about topics such as Disease Management preventative services or other information used by the Contractor for health promotion efforts must be submitted to HCA, but do not require HCA approval as long as they do not specifically mention WMIP or the benefits provided under this contract.

3.3.2.5 Educational materials that are not developed by the Contractor of developed under contract with the Contractor are not required to meet the sixth grade reading level requirement and do not require HCA approval.

3.3.2.6 All other written materials must have the written approval of HCA prior to use. For client-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved materials in final form.

3.4 Electronic Outbound calls

The Contractor may use an interactive, automated system to make certain outbound calls to enrollees.

3.4.1 The Contractor must submit call scripts to HCA no less than thirty (30) calendar days prior to the date the automated calls will begin. Approvable reasons for automated calls include:

3.4.1.1 Outreach to new enrollees;

3.4.1.2 Reminders of events such as flu clinics;

3.4.1.3 Initial Health Screening;

3.4.1.4 Surveys;

3.4.1.5 Disease management information and reminders;

3.4.1.6 Appointment reminders/immunizations/well child appointments; and

3.4.1.7 Notification of new programs or assistance offered.

3.4.2 Under no circumstances will the Contractor use automated calls for assistance in eligibility recertification, care coordination activities, behavioral health-related calls or prescription verifications.

3.4.3 The Contractor shall ensure that if this service is provided by a third party, that either a subcontract or a Business Associate Agreement is in place and is submitted to HCA for review.

4 ENROLLMENT

4.1 Service Area

4.1.1 The Contractor shall provide the services described in this Contract to clients who are determined by HCA to reside in Snohomish County and to be eligible for WMIP or who live on Camano Island in zip code 98282.

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

4.2 Service Area Changes

4.2.1 The Contractor may decrease its service area by giving HCA ninety (90) calendar days' written notice. The decrease shall not be effective until the first day of the month that falls after the ninety (90) calendar days has elapsed.

4.2.2 The Contractor shall notify enrollees affected by any service area decrease at least sixty (60) calendar days prior to the effective date. Notices shall be approved in advance by HCA. If the Contractor fails to notify affected enrollees of a service area decrease at least sixty (60) calendar days prior to the effective date, the decrease shall not be effective until the first day of the month, which falls sixty (60) calendar days from the date the Contractor notifies enrollees.

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

4.2.4 HCA shall determine, in its sole judgment, which zip codes fall within the service area.

4.2.5 HCA shall determine whether potential enrollees reside within the service area.

4.2.6 If the Contractor increases or decreases the service area, HCA may recalculate the Contractor's rate to account for the change.

4.3 Eligible Client Group

HCA shall determine eligibility for enrollment under this Contract. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract, and may enroll in the Washington Medicaid Integration Partnership (WMIP). For information about eligibility groups, please go to: www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx

4.3.1 Clients who are 21 years of age or older, who are Aged, Blind, or Disabled, with these exclusions:

4.3.1.1 Medically needy;

4.3.1.2 Dual eligibles that are not entitled to Medicaid services (Qualified Medicare Beneficiary (QMB)-only, Qualified Disabled and Working Individual (QDWI), Special Low-Income Medicare Beneficiary (SLMB)-only, and Qualified Individual (QI)-1).

4.4 Client Notification

HCA shall notify eligible clients of their eligibility for the WMIP and of their rights and responsibilities as WMIP enrollees at the time of initial eligibility determination and again at least annually. The Contractor shall provide enrollees with additional information as described in this Contract.

4.5 Enrollment Period

Subject to the Enrollment provisions of this Contract, enrollment is continuously open.

4.6 Enrollment Process

4.6.1 HCA shall automatically enroll an adequate number of eligible Medicaid-only clients in the WMIP in order to maintain a steady state of enrollment at 3500, with the exception of:

4.6.1.1 American Indian/Alaska Natives,

4.6.1.2 Clients who are receiving long term care services, and

4.6.1.3 Clients who, at time of enrollment, reside in Granite Falls, WA; Arlington, WA; or Darrington, WA.

4.6.2 Individuals in the categories in subsection 4.6.1 of this section must take action to enroll. Dual-eligible clients who are eligible to participate in the WMIP may enroll at their option.

4.6.3 The Contractor and participating WMIP providers may assist a potential enrollee who receives long term care services to complete the WMIP enrollment form, including submission of the enrollment form, if the potential enrollee requests assistance. If the contractor assists the client in enrolling in WMIP, the Contractor shall ensure the potential enrollee makes an informed choice of whether to enroll. This process does not prevent a client from enrolling by calling the HCA customer service line.

4.6.4 Auto-enrolled clients may disenroll from the WMIP at any time after 60 days, without cause, by submitting the request in writing or calling HCA's Medical Assistance Customer Service Center's toll-free number. Eligible clients may re-enroll at any time by calling the MACSC toll-free number, or submitting an enrollment form signed by the enrollee or his/her representative. Such enrollments and disenrollments shall be effective prospectively for the following month.

4.7 Effective Date of Enrollment:

4.7.1 Enrollment with the Contractor shall be effective on the later of the following dates:

4.7.1.1 If the enrollment is processed on or before the HCA cut-off date for enrollment, enrollment shall be effective the first day of the month following the month in which the enrollment is processed; or

4.7.1.2 If the enrollment is processed after the HCA cut-off date for enrollment, enrollment shall be effective the first day of the second month following the month in which the enrollment is processed.

4.7.2 Retroactive coverage is provided under this Contract if a client is retro-enrolled and retro-premium paid when agreed to by HCA, DSHS and the Contractor for continuity of care.

4.8 Enrollment Data and Requirements for Contractor's Response

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

4.8.1 Data files will be sent to the Contractor at intervals specified within the HCA 834 Benefit Enrollment and Maintenance Companion Guide, published by HCA and incorporated by reference.

4.8.2 The data file will be in the Health Insurance Portability and Accountability Act (HIPAA) compliant 834, Benefit Enrollment and Maintenance format (45 C.F.R. § 162.1503).

4.8.3 The data file will be transferred per specifications defined within HCA Companion Guides.

4.8.4 The Contractor shall have ten (10) calendar days from the receipt of the data files to notify HCA in writing of the refusal of an application for enrollment or any discrepancy regarding HCA's

proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by the HCA. The effective date of enrollment specified by the Health Care Authority shall be considered accepted by the Contractor and shall be binding if the notice is not timely or HCA does not agree with the reasons stated in the notice. Subject to HCA approval, the Contractor may refuse to accept an enrollee for the following reasons:

4.8.4.1 HCA has enrolled the enrollee with the Contractor in a service area where the Contractor is not contracted; or

4.8.4.2 The enrollee is not eligible for enrollment under the terms of this Contract.

4.9 **Enrollment of Newborns**

Newborns whose mothers are WMIP enrollees shall be automatically enrolled in the Contractor's Apple Health Managed Care program, beginning from the newborn's date of birth, or the mother's date of enrollment, whichever is later. If the mother is disenrolled before the newborn receives a separate client identifier, the newborn's coverage shall end when the mother's coverage ends except as provided in Enrollee in Facility at Termination of Enrollment.

4.10 **Termination of Enrollment**:

4.10.1 Voluntary Termination of Enrollment

4.10.1.1 Enrollees may request termination of enrollment by submitting a written request to terminate enrollment to HCA or by calling HCA toll-free customer service number (42 C.F.R. § 438.56(d)(1)(i)). Except as provided in Chapter 182-538 WAC or WAC 388-542, the enrollment for enrollees whose enrollment is terminated will be prospectively ended. The Contractor may not request voluntary termination of enrollment on behalf of an enrollee.

4.10.1.2 If the Contractor becomes aware of a voluntary termination by a long-term care enrollee, the Contractor shall notify DSHS (HCS/AAA) to ensure care coordination and continuity of care in the transition between managed care and fee for service.

4.10.2 Involuntary Termination of Enrollment Initiated by HCA for Ineligibility.

4.10.2.1 The enrollment of any enrollee under this Contract shall be terminated if the enrollee becomes ineligible for enrollment due to a change in eligibility status.

4.10.3 When an enrollee's enrollment is terminated for ineligibility, the termination shall be effective:

4.10.3.1 The first (1st) day of the month following the month in which the enrollment termination is processed HCA if it is processed on or before HCA cut-off date for enrollment or the Contractor is informed by HCA of the enrollment termination prior to the first (1st) day of the month following the month in which it is processed by HCA.

4.10.3.2 Effective the first (1st) day of the second month following the month in which the enrollment termination is processed if it is processed after HCA cut-off date for enrollment and the Contractor is not informed by HCA of the enrollment termination prior to the first (1st) day of the month following the month in which it is processed by HCA.

4.10.4 Involuntary Enrollment Termination Initiated by HCA for Comparable Coverage or Duplicate Coverage:

4.10.4.1 The Contractor shall notify HCA, in accord with the Notices provision of the General

Terms and Conditions Section of this Contract, when an enrollee has health care insurance coverage with the Contractor or any other carrier:

4.10.4.1.1 Within fifteen (15) working days of the date when the Contractor becomes aware that an enrollee has any health care insurance coverage with any other insurance carrier. The Contractor is not responsible for the determination of comparable coverage, as defined herein.

4.10.4.1.2 Within fifteen (15) working days of the date when the Contractor becomes aware that an enrollee has any health care insurance coverage with any other insurance carrier. The Contractor is not responsible for the determination of comparable coverage, as defined herein.

4.10.4.1.3 HCA will involuntarily terminate the enrollment of any enrollee with duplicate coverage or comparable coverage as follows:

4.10.4.1.3.1 When the enrollee has duplicate coverage that has been verified by HCA, HCA shall terminate enrollment retroactively to the beginning of the month of duplicate coverage and recoup premiums as describe in the Recoupments provisions of the Payment and Sanctions Section of this Contract.

4.10.4.1.3.2 When the enrollee has comparable coverage which has been verified by HCA, HCA shall terminate enrollment prospectively.

4.10.5 Involuntary Termination Initiated by the Contractor

4.10.5.1 To request involuntary termination of enrollment, the Contractor shall send written notice to HCA as described in Notices provision of the General Terms and Conditions Section of this Contract.

4.10.5.1.1 HCA shall review each involuntary termination request on a case-by-case basis. The Contractor shall be notified in writing of an approval or disapproval of the involuntary termination request within thirty (30) working days of HCA's receipt of such notice and the documentation required to substantiate the request. HCA shall approve the request for involuntarily termination of the enrollee when the Contractor has substantiated in writing all of the following (42 C.F.R. § 438.56(b)(1)):

4.10.5.1.1.1 The enrollee purposely puts the safety or property of the Contractor, or the Contractors' staff, providers, patients, or visitors at risk; or

4.10.5.1.1.2 The enrollee refuses to follow procedures or treatment recommended by the enrollee's provider and determined by the Contractor's medical director to be essential to the enrollee's health and safety and the enrollee has been told by the provider and/or the Contractor's medical director that no other treatment is available; or

4.10.5.1.1.3 The enrollee engages in intentional misconduct, including refusing to provide information to the Contractor about third party insurance coverage; or

4.10.5.1.1.4 The enrollee received written notice from the Contractor of its intent to request the enrollee's termination of enrollment, unless the requirement for notification has been waived HCA because the enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the enrollee shall include the enrollee's right to use the Contractor's grievance process to review the request to end the enrollee's enrollment.

4.10.5.2 The Contractor shall continue to provide services to the enrollee until HCA has notified the Contractor in writing that enrollment is terminated.

4.10.5.3 HCA will not terminate enrollment of an enrollee solely due to a request based on an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or mental health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b)(2)).

4.10.6 An enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive contracted services, at the Contractor's expense, through the end of that month.

4.10.7 In no event will an enrollee be entitled to receive services and benefits under this Contract after the last day of the month, in which their enrollment is terminated, except:

4.10.7.1 When the enrollee is hospitalized or in another inpatient facility covered by this contract at termination of enrollment and continued payment is required in accord with the provisions of this Contract.

4.10.7.2 For the provision of information and assistance to transition the enrollee’s care with another provider.

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

4.10.8 Regardless of the procedures followed or the reason for termination, if an enrollment request is granted, or the enrollee’s enrollment is terminated by HCA for one of the reasons described in Section 4.10 of this Contract, the effective date of the disenrollment will be no later than the first day of the second month following the month the request was made.

5 PAYMENT AND SANCTIONS

5.1 **Rates/Premiums**:

5.1.1 Subject to the Sanctions provisions of this Section, HCA shall pay a monthly premium for each enrollee, in full consideration of the work to be performed by the Contractor under this Contract.

5.1.2 HCA shall pay the Contractor, on or before the fifteenth (15th) working day of the month based on the HCA list of enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by the Centers for Medicare and Medicaid Services

(CMS) under 42 C.F.R. 438.726(b) or 42 C.F.R. 438.730(e).

5.1.3 The Contractor shall reconcile the electronic benefit enrollment file with the premium payment information and submit differences it finds to HCA for resolution within sixty (60) calendar days of the first day of the subject month.

5.1.4 HCA shall make a full monthly payment to the Contractor for the month in which an enrollee's enrollment is terminated except as otherwise provided herein.

5.1.5 The Contractor shall be responsible for contracted services provided to the enrollee in any month for which HCA paid the Contractor for the enrollee's care under the terms of this Contract.

5.1.6 HCA shall establish separate rate cells for enrollees who are placed in a Long Term Acute Care (LTAC) Hospital.

5.2 Annual Fee on Health Insurance Providers

5.2.1 The parties acknowledge that Contractor is subject to a fee (the "Annual Fee") imposed by the federal government under Section 9010 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (124 Stat. 1029 (2010)) (collectively, "PPACA").

5.2.2 The Contractor is responsible for payment of a percentage of the Annual Fee for all health insurance providers. The Contractor's obligation is determined by the ratio of the Contractor's net written premiums for the preceding year compared to the total net written premiums of all covered entities subject to the Annual Fee for the same year. This fee will be assessed on the HCA and DASA portions of the rate. The MHD and ADSA portions of the rate are not subject to the fee.

5.2.3 The amount of the Annual Fee attributable to the Contractor and attributable specifically to the Contractor's premiums under this Contract ("Contractor's Allocated Fee") could affect the actuarial soundness of the premiums received by the Contractor from HCA for the contract year during which the Annual Fee is assessed.

5.2.4 A dollar amount reflecting the Contractor's Allocated Fee, which shall also include an adjustment for the impact of non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"), shall be payable to the Contractor under this Contract.

5.2.5 Because of the uncertainty as of the date of the execution of this Contract regarding the actual amount of the Contractor's Adjusted Fee, HCA shall consult with the Contractor and determine an estimated amount of the Contractor's Adjusted Fee based on the pro rata share of the preliminary notice of the fee amount, as transmitted by the United States Internal Revenue Service to the Contractor, attributable to the Contractor's net written premiums under this Contract. HCA shall make a good-faith effort to make the estimated payment to the Contractor thirty (30) calendar days prior to the deadline for payment by the Contractor. This adjustment shall be reconciled, no later than ninety (90) calendar days following the receipt of the final notice of the fee from the United States Internal Revenue Service, through an additional payment to the Contractor, or a refund from the Contractor, as applicable, once the complete data is available to calculate the Contractor's Adjusted Fee.

5.2.6 The Contractor agrees to not pursue any legal action whatsoever against HCA or its officers,

employees, or agents with respect to the amount of the Contractor's Allocated Fee or Contractor's Adjusted Fee.

5.3 Nursing Facility Payments

5.3.1 All Nursing Facility (NF) claims will be billed to HCA, without regard to whether the enrollee is in the NF for a short stay or custodial stay, at the established DSHS rates.

5.3.2 HCA will recoup the cost of claims using current procedures outlined in the Nursing Facility payment Policies and Procedures.

5.3.3 The Contractor will continue to pay directly for medically necessary ancillary services, such as Physical/Occupational or Speech Therapy, IV therapy and wound care and any other service billed using a CPT code.

5.3.4 Nursing Facility Risk Period: A portion of six months' worth of per member/per month nursing facility costs have been preloaded into the Contractor's monthly premium payments. If the Contractor places an enrollee to a nursing facility during the WMIP enrollment and their stay in the nursing facility is equal to or less than six months, the Contractor shall be responsible for the nursing facility costs.

5.3.5 The Contractor shall track, within the limitations of available data, all nursing facility costs for which the Contractor is at risk and coordinate with HCA and DSHS to complete the nursing facility risk reconciliation process. Once these claims are reconciled at the dollar amount initially incurred, the Contractor shall take responsibility for working with the nursing facility to determine any nursing facility claims adjustments.

5.4 Western State Hospital Payments

The Contractor shall, in consultation with DSHS and HCA staff, shall coordinate discharge planning and shall process a retro-premium to the Contractor, if necessary, for the month of enrollment back into WMIP using current enrollment procedures.

5.5 Renegotiation of Rates

The base rate set forth herein shall be subject to renegotiation during the Contract period only if HCA, in its sole judgment, determines that it is necessary due to a change in federal or state law or other material changes, beyond the Contractor's control, which would justify such a renegotiation.

5.6 Reinsurance/Risk Protection

The Contractor may obtain reinsurance for coverage of enrollees provided that the Contractor remains ultimately liable to HCA for the services rendered.

5.7 Recoupments

5.7.1 Unless mutually agreed by the parties in writing, HCA shall only recoup premium payments and retroactively terminate enrollment for individual enrollees who are:

5.7.1.1 Covered by the Contractor with duplicate coverage.

5.7.1.2 Deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the enrollee's date of death.

5.7.1.3 Retroactively have their enrollment terminated consistent with the Termination of Enrollment provisions of the Enrollment Section of this Contract.

5.7.1.4 Found ineligible for enrollment with the Contractor, provided HCA has notified the Contractor before the first day of the month for which the premium was paid.

5.7.1.5 Incarcerated for any full month of enrollment.

5.7.2 The Contractor may recoup payments made to providers for services provided to enrollees during the period for which HCA recoups premiums for those enrollees. If the Contractor recoups said payments, providers may submit appropriate claims for payment to HCA through its fee-for-service program.

5.7.3 When HCA recoups premiums and retroactively terminates the enrollment of an enrollee, HCA will not recoup premiums and retroactively terminate the enrollment of any other family member, except for newborns whose mother's enrollment is terminated for duplicate coverage.

5.8 Information for Rate Setting and Methodology

For rate setting only, the Contractor shall annually provide information regarding its cost experience related to the provision of the services required under this Contract. The experience information shall be provided directly to an actuary designated by HCA. The designated actuary will determine the timing, content, format and medium for such information. HCA sets actuarially-sound managed care rates.

5.9 State-Only Funding:

5.9.1 Mental Health Funding: The State shall pay the Contractor a maximum of $13,900.00 per month for room and board costs associated with Evaluation and Treatment Centers, crisis beds, and basic supervision for residential beds. The Contractor shall track all expenditures using these funds separately from expenditures made with Medicaid funds and provide a report to the WMIP program manager in the Office of Quality and Care Management upon request.

5.9.2 Residential Care Discharge Allowance: If funding is not available through Community Transition Services (CTS), or the enrollee is not eligible for CTS funds, the enrollee may be eligible to receive funds through the Residential Care Discharge Allowance (RCDA). RCDA funds may be used for rent, utilities or other costs involved in establishing an enrollee in his or her own home after a nursing home stay. Funds may NOT be used for recreational equipment such as TV, DVD, stereo, or computer equipment. Project Requests for funding are submitted by the Contractor to the ADSA program manager and are limited to one payment per nursing facility visit. Subject to prior approval by the Aging and Disability Services Administration's WMIP Program Manager.

5.10 Payments to Critical Access Hospitals (CAH)

For services provided by CAH to enrollees, the Contractor shall pay the CAH the prospective Inpatient and Outpatient Departmental Weighted Cost-to-Charge rates published by HCA for the fee-for-service program. See CAH link at: http://www.hca.wa.gov/medicaid/hospitalpymt/pages/inpatient_cah.aspx

5.11 Encounter Data

5.11.1 For purposes of this Subsection:

5.11.1.1 “Encounter” means a single health care service or a period of examination or treatment.

5.11.1.2 “Encounter data” means records of health care services submitted as electronic data files created by the Contractor’s system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format.

5.11.2 The Contractor shall comply with the all of the following:

5.11.2.1 Submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA;

5.11.2.2 Submit its encounter data to HCA at a minimum monthly, and no later than thirty (30) calendar days from the end of the month in which the Contractor paid the financial liability; and

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

5.11.3 Effective April 1, 2014, the Contractor must report the paid date and amount paid for each encounter. The “amount paid” data is considered the Contractor’s proprietary information and is protected from public disclosure under RCW 42.56.270(11). Amount paid shall not be utilized in the consideration of a Contractor’s assignment percentage or in the evaluation of a Contractor’s performance.

5.11.4 HCA shall perform encounter data quality reviews and shall define data quality standards to ensure receipt of complete and accurate encounter data for program administration and rate setting. These standards shall be closely monitored. The Contractor shall make changes or corrections to encounter data and/or any systems, processes or data transmission formats as needed to comply with HCA’s data quality standards as defined and subsequently amended.

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

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

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

5.11.5.3 The Contractor’s Chief Executive Officer, Chief Financial Officer, or authorized staff attest that based on best knowledge, information, and belief as of the date indicated, all information submitted to HCA in the submission is accurate, complete, truthful, and they hereby certify that no material fact has been omitted from the certification and submission.

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

5.11.6.1 Within sixty (60) days of the end of each calendar quarter, the Contractor shall provide aggregate totals of all encounters submitted during that quarter, and shall reconcile the cumulative encounter data submitted for the quarter and contract year with the year-to-date general ledger paid claims. The Contractor shall provide justification for any discrepancies.

5.11.7 HCA collects and uses this data for many reasons such as: federal reporting (42 C.F.R. § 438.242(b)(1)), rate setting and risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care; HCA hospital rate setting; pharmacy rebates and research studies.

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

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

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

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

5.12 Payment for Services by Non-Participating Providers

5.12.1 The Contractor shall limit payment for emergency services furnished by any provider who does not have a contract with the Contractor to the amount that would be paid for the services if they were provided under HCA's, Medicaid Fee-For-Service (FFS) program (Deficit Reduction Act of 2005, Public Law No. 109-171, Section 6085).

5.12.2 Except as provided herein for emergency services, the Contractor shall coordinate with and pay a non-participating provider that provides a service to enrollees under this Contract no more than the lowest amount paid for that service under the Contractor's contracts with similar providers in the state. For the purposes of this subsection, "contracts with similar providers in the state" means the Contractor's contracts with similar providers to provide services under the managed care program when the payment is for services received by a managed care enrollee.

5.12.3 The Contractor shall track and record all payments to participating providers and non-participating providers in a manner that allows for the reporting to HCA the number, amount, and percentage of claims paid to participating providers and non-participating providers separately. The Contractor shall also track, document and report to HCA any known attempt by non-participating providers to balance bill enrollees.

5.12.4 The Contractor shall provide annual reports to the HCA for the preceding state fiscal year July 1st through June 30th. The reports shall indicate the proportion of services provided by the Contractor's participating providers and non-participating providers, by county, and including hospital-based physician services in a format provided by HCA. Contractor shall submit the report to the HCA no later than November 1st of each year, or as required by the HCA.

5.13 Data Certification Requirements

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

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

5.13.1.1 The Contractor's Chief Executive Officer.

5.13.1.2 The Contractor's Chief Financial Officer.

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

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

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

5.13.4 HCA will identify the specific data that requires certification.

5.14 **Sanctions**

5.14.1 If the Contractor fails to meet one or more of its obligations under the terms of this Contract or other applicable law, HCA may impose sanctions by withholding from the Contractor up to five percent of its scheduled payments or may hold assignments and re-enrollments.

5.14.2 HCA shall notify the Contractor of any default in writing, and shall allow a cure period of up to 30 calendar days, depending on the nature of the default. If the Contractor does not cure the default within the prescribed period, HCA may withhold payment from the beginning of the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

5.14.2.1 HCA will notify the Contractor in writing of the basis and nature of any sanctions, and if, applicable, provide a reasonable deadline for curing the cause for the sanction before imposing sanctions. The Contractor may request a dispute resolution, as described in the Disputes provisions of the General Terms and Conditions Section of this Contract, if the Contractor disagrees with HCA's position.

5.14.3 HCA, CMS, or the Office of the Inspector General (OIG) may impose intermediate sanctions in accord with applicable law, including but not limited to 42 C.F.R. § 438.700, 42 C.F.R. § 438.702, 42 C.F.R. § 438.704, 45 C.F.R. § 92.36(i)(1), 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210 against the Contractor for:

5.14.3.1 Failing to provide medically necessary services that the Contractor is required to provide, under law or under this Contract, to an enrollee covered under this Contract.

5.14.3.2 Imposing on enrollee's premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.

5.14.3.3 Acting to discriminate against enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll an enrollee, except as permitted under law or under this Contract, or any practice that would reasonably be expected to discourage enrollment by enrollees whose medical condition or history indicates probable need for substantial future medical services.

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

5.14.3.5 Failing to comply with the requirements for physician incentive plans.

5.14.3.6 Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by HCA or that contain false or

materially misleading information.

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

5.14.3.8 Intermediate sanctions may include:

5.14.3.8.1 Civil monetary penalties in the following amounts:

5.14.3.8.1.1 A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or healthcare providers; failure to comply with physician incentive plan requirements; or marketing violations.

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

5.14.3.8.1.3 A maximum of $15,000 for each potential enrollee HCA determines was not enrolled because of a discriminatory practice subject to the $100,000 overall limit.

5.14.3.8.1.4 A maximum of $25,000 or double the amount of the charges, whichever is greater, for charges to enrollees that are not allowed under managed care. HCA will deduct from the penalty the amount charged and return it to the enrollee.

5.14.3.8.2 Appointment of temporary management for the Contractor as provided in 42 C.F.R. § 438.706. HCA will only impose temporary management if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Temporary management will be imposed in accord with RCW 48.44.033 or other applicable law.

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

5.14.3.8.4 Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

5.15 **Payment of Physician Services for Trauma Care**

The Contractor shall pay physician services for trauma care at the same rate as HCA for corresponding dates of service as set forth in WAC 183-531-2000 and published provider notices.

5.16 Nonpayment for Provider Preventable Conditions

The Contractor shall comply with the requirements of WAC 182-550-1650 related to Adverse Events, hospital-acquired conditions, and present on admission indicators. The Contractor shall comply with the requirements of WAC 182-502-0022, on Provider Preventable Conditions (PPCs) – Payment Policy, which replaces WAC 182-550-1650. In complying with these rules, the Contractor will deny or recover payments to healthcare professionals and inpatient hospitals for care related only to the treatment of the consequences of Healthcare Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC), also known as Serious Adverse Events.

5.17 Affordable Care Act: Primary Care Physician Adjustment

5.17.1 In accordance with sections 1902(a)(13), 1902(jj), 1905(dd), and 1932(f) of the Social Security Act, as amended by the Affordable Care Act (ACA), physicians who meet the following requirements may be eligible for enhanced payments for certain Evaluation and Management (E&M) and vaccine administration codes for calendar years 2013 and 2014 as determined by an attestation process administered by HCA.

5.17.1.1 These enhanced payments are separate and apart from the risk-based capitation payments made to the Contractor by HCA. The full amount of the enhanced payment must be paid to eligible providers who have provided eligible services to the Contractor's enrollees regardless of the existing payment arrangements between the Contractor and any subcontractors.

5.17.2 The Contractor is responsible for disbursement of the enhanced payment to all eligible providers both in and out of its network who provided eligible services to enrollees.

5.17.3 The enhanced payment applies to primary care services delivered by a physician (or under the personal supervision of a physician) who attests to having a specialty designation of family medicine, general internal medicine, or pediatric medicine or a subspecialty within those designations recognized by the American Board of Physician Specialties (ABPS), the American Board of Medical Specialties (ABMS), or the American Osteopathic Association (AOA). To be eligible for enhanced payment:

5.17.3.1 Physicians must first self-attest to a covered specialty or sub-specialty designation;

5.17.3.2 Physicians may self-attest that they are eligible to receive the enhanced payments. In order to receive the enhanced payments, each eligible physician is required to complete, sign, and submit the attestation form to HCA.

5.17.4 HCA shall calculate payments on a quarterly basis for providers who serve managed care enrollees.

5.17.4.1 HCA shall produce reconciliation payments based on the Contractor's submission of encounter data for providers who have submitted attestation forms that have been accepted by HCA.

5.17.4.2 HCA shall provide the Contractor with payment due to each eligible provider for eligible services provided. HCA shall base its calculation on the Contractor's encounter data. Calculations shall utilize the state's CPT-4 code list and the state's eligible provider list.

5.17.5 All eligible providers who submit attestation forms that have been accepted by HCA shall be eligible for the increased payments for claims for eligible services provided for the period January 1, 2013 throughJune 30, 2014. Physicians whose attestation form is accepted by HCA will receive the increased payment beginning the date the form was accepted.

5.17.5.1 Payments to eligible providers shall be made for the Evaluation and Management (E&M) codes 99201 through 99499 and adjusted to the Medicare rate established by HCA. Eligible services also include vaccine and toxoid administration procedures. HCA shall post the applicable codes and rates for these codes on HCA's secure website.

5.17.5.2 HCA shall make payment for the Vaccines for Children (VFC) administration fee, for eligible providers that qualify and attest, at the lesser of the regional maximum administration fee or Medicare rate. Any other provider that qualifies and attests but is not enrolled in the Vaccines for Children program shall receive the Medicare rate for the administration of vaccines if the provider is contracted to cover this service by the Contractor.

5.17.5.3 If an enrollee receives eligible services out of network from an eligible provider, the reimbursement rate must also align with the requirements of the ACA, and HCA shall also calculate and pass the enhancement on to the Contractor for that quarter.

5.17.6 The Contractor shall ensure the entire amount of the payment enhancement is passed to the eligible provider of eligible services, whether billed by the provider or billed by a group entity within forty-five (45) calendar days of the Contractor's receipt of the payment enhancement from HCA. The ACA requires that eligible providers receive direct benefit of the payment increase for each of the primary care services specified in this amendment. The Contractor must meet this requirement regardless of whether a provider is salaried or receives a fee-for-service or capitated payment. The structure of the Contractor's provider network does not mitigate this responsibility.

5.17.7 The Contractor shall maintain documentation of all payments made to subcontracted and out of network providers in a format determined by HCA and will make this documentation available to HCA during the annual monitoring visit or upon request. The Contractor's liability will be satisfied upon disbursement of all calculated payments from HCA.

5.17.8 For calendar years 2013 and 2014, HCA shall review a statistically valid sample of providers who received enhanced payments to verify that eligible providers meet the requirements for enhanced payments. If HCA identifies a provider who was paid in error, HCA shall notify the Contractor and the Contractor must recoup only the amount of the rate increase in the adjusted payment and remit the amount to the State.

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

5.18 Billing for Services Provided by Residents

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

6 ACCESS AND CAPACITY

6.1 Network Capacity

6.1.1 The Contractor shall maintain and monitor an appropriate provider network, supported by written agreements, sufficient to serve enrollees enrolled under this Contract (42 C.F.R. § 438.206(b) (1)).

6.1.2 The Contractor shall provide contracted services through non-participating providers, at a cost to the enrollee that is no greater than if the contracted services were provided by participating providers, if its network of participating providers is insufficient to meet the needs of enrollees in a manner consistent with this Contract. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor's network is inadequate to provide them (42 C.F.R. § 438.206(b)(4)). This provision shall not be construed to require the Contractor to cover such services without authorization except as required for emergency services.

6.1.3 The Contractor may decrease capacity by giving HCA sixty (60) calendar days' written notice. The decrease shall not be effective until the first day of the month which falls after the sixty (60) calendar days has elapsed.

6.1.4 The Contractor must submit documentation regarding its maintenance, monitoring and analysis of the network to include full provider network submissions to determine compliance with the requirements of this Section, at any time upon HCA request or when there has been a change in the Contractor's network or operations that, in the sole judgment of HCA, would affect adequate capacity and/or the Contractor's ability to provide services (42 C.F.R. § 438.207(b & c)).

6.1.4.1 The Contractor shall submit updated provider network information as requested by HCA within fourteen (14) business days of the request. This information will be reviewed by HCA staff for:

6.1.4.1.1 Completeness and accuracy;

6.1.4.1.2 Removal of providers who no longer contract with the Contractor.

6.1.5 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network of providers in any contracted service area including all essential provider types: Primary Care Providers, Hospitals, Pharmacy, Obstetrician/Gynecologist, and Pediatrician, for two consecutive quarters, HCA reserves the right to immediately terminate the Contractor's services for that service area.

6.1.6 The Contractor shall maintain an online provider directory. The directory shall include primary and specialty providers. This directory shall be updated no less than quarterly, or whenever there is a change in the Contractor's network that would affect adequate capacity or the Contractor's ability to provide services.

6.2 Service Delivery Network:

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

6.2.1.1 Expected enrollment.

6.2.1.2 Adequate access to all services covered under this Contract.

6.2.1.3 The expected utilization of services, taking into consideration the characteristics and health care needs of the Medicaid population represented by the Contractor's enrollees.

6.2.1.4 The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services.

6.2.1.5 The number of network providers who are not accepting new Medicaid enrollees.

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

6.2.1.7 The cultural, ethnic, race and language needs of enrollees.

6.2.2 The Contractor shall make a good faith effort to contract with existing DSHS-contracted networks of providers for mental health, Long-Term Care, and chemical dependency services to ensure continuity of care for those clients who choose enrollment in the WMIP.

6.3 Timely Access to Care

The Contractor shall have contracts in place with all subcontractors that meet state standards for access, taking into account the urgency of the need for services (42 C.F.R. § 438.206(b) & (c)(1)(i))). The Contractor shall ensure that:

6.3.1 Network providers offer access comparable to that offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Contractor serves only Medicaid enrollees (42 C.F.R. § 438.206(b)(1)(iv) & (c)(1)(ii))).

6.3.2 Mechanisms are established to ensure compliance by providers.

6.3.3 Providers are monitored regularly to determine compliance.

6.3.4 Corrective action is initiated and documented if there is a failure to comply.

6.4 Hours of Operation for Network Providers

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

6.5 24/7 Availability

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

6.5.1 Medical advice for enrollees from licensed health care professionals concerning the emergent, urgent or routine nature of the enrollee's condition including the ability to connect with mental health crisis services when necessary.

6.5.2 Triage concerning the emergent, urgent or routine nature of medical conditions by licensed health care professionals.

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

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

6.5.5 Medically necessary mental health services. Emergent mental health care must be available for response within two (2) hours of the request for mental health services from any source.

6.6 Customer Service

The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8:00 a.m. to 5:00 p.m., Pacific Standard Time or Daylight Savings Time (depending on the season), Monday through Friday, year round and shall provide customer service on all dates that are recognized as work days for state employees. HCA may authorize exceptions to this requirement if the Contractor provides HCA with written assurance that its providers will accept enrollment information from HCA. Toll free numbers shall be provided at the expense of the Contractor.

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

6.6.2 The Contractor must notify HCA five business days in advance of any non-scheduled closure during scheduled business days, except in the case when advanced notification is not possible due to emergency conditions.

6.6.3 The Contractor shall comply with the following customer service performance standards:

6.6.3.1 Call abandonment rate – standard is less than 3%.

6.6.3.2 Call response time - average speed of answer less than 30 seconds

6.7 Appointment Standards

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

6.7.1 Transitional healthcare services by a primary care provider shall be available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

6.7.2 Transitional healthcare services by a home care nurse or home care registered counselor within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the enrollee's primary care provider or as part of the discharge plan.

6.7.3 Non-symptomatic (i.e., preventive care) office visits shall be available from the enrollee's PCP

or another provider within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

6.7.4 Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the enrollee's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

6.7.5 Urgent, symptomatic office visits shall be available from the enrollee's PCP or another provider within twenty-four (24) hours for medical or mental health services. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

6.7.6 Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.

6.7.7 Offer of an appointment for the initial mental health intake assessment by a Mental Health Professional shall take place within ten (10) working days of the request for mental health services. A request for mental health services can be made by telephone, referral, clinic walk-in, or in writing.

6.7.7.1 Offer of an appointment by a Contracted private practice mental health provider will be as soon as reasonably possible given individual wait times.

6.7.8 After initial assessment has been completed, routine mental health services must be offered to occur within 14 calendar days of a determination to initiate mental health services. The time from request for mental health services to first routine appointment must not exceed 28 days unless the Contractor documents a reason for the delay.

6.7.9 Comprehensive chemical dependency assessment and treatment services shall be provided to injection drug users no later than 14 days after the services have been requested by the enrollee. If the enrollee cannot be placed in treatment within 14 days, interim services must be made available to the enrollee.

6.7.10 Urgent and Emergent Care for Mental Health Services: Enrollees may access urgent and emergent medically necessary mental health services (e.g. crisis mental health services, stabilization services) without completing an intake evaluation, as referenced in Section16.10.2.7. The Contractor shall ensure that timelines for accessing urgent and emergent services are met. Enrollees have access to following services prior to completing an intake evaluation:

6.7.10.1 Crisis Services;

6.7.10.2 Freestanding Evaluation and Treatment;

6.7.10.3 Stabilization;

6.7.10.4 Rehabilitation Case Management.

6.7.11 Failure to meet appointment standards may, at the HCA's sole discretion, result in withholding of payments, assignments and/or re-enrollments as described in the Sanctions Subsection of

this Contract.

6.8 **Provider Database**

The Contractor shall have, maintain and provide to HCA upon request an up-to-date database of its provider network, which includes the identity, location, languages spoken, qualifications, practice restrictions, and availability of all current contracted providers, including specialty providers (42 C.F.R. § 438.242(b)(1)).

6.9 **Provider Network - Distance Standards**:

6.9.1 The Contractor network of providers shall meet the distance standards below in every service area.

6.9.1.1 PCP

Urban: 2 within 10 miles for 90% of enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

6.9.1.2 Obstetrics

Urban: 2 within 10 miles for 90% of enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

6.9.1.3 Hospital

Urban/Rural: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

6.9.1.4 Pharmacy

Urban: 1 within 10 miles for 90% of enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

6.9.1.5 Mental Health Service Sites

Urban: 1 within 10 miles for 90% of WMIP enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of WMIP enrollees in the Contractor's service area.

6.9.1.6 Chemical Dependency Treatment Facilities:

Urban/Rural: 1 within 25 miles for 90% of WMIP enrollees in the Contractor's service area.

6.9.2 HCA may, in its sole discretion, grant exceptions to the distance standards. HCA's approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall

provide evidence as HCA may require supporting the request. If the closest provider of the type subject to the standards in this section is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest provider may be a provider not participating with the Contractor.

6.10 Distance Standards for High Volume Specialty Care Providers

The Contractor shall establish, analyze and meet measurable distance standards for high volume specialty care providers. At a minimum the Contractor shall establish, analyze and meet distance standards for Cardiologists, Oncologists, Ophthalmologists, Orthopedic Surgeons, General Surgery, Gastroenterologists, Pulmonologists, Neurologists, Endocrinologists, Otolaryngologists, and Specialists in Physical Medicine, Rehabilitation and Mental Health providers. The Contractor shall analyze performance against standards at minimum, annually and provide a report to HCA detailing the outcomes of this analysis along with the Contractor's analysis of Primary Care Providers. Analyses and documentation for the standards shall be available to HCA upon request.

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

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

6.12 Access to Specialty Care

6.12.1 The Contractor shall provide all medically necessary specialty care for enrollees in a service area. If an enrollee needs specialty care from a type of specialist who is not available within the Contractor's provider network, the Contractor shall arrange for the necessary services with the nearest qualified specialist outside the Contractor's provider network, who is willing to see the enrollee.

6.12.2 The Contractor shall maintain, and make readily available to providers, up-to-date information on the Contractor's available network of specialty providers and shall provide any required assistance to providers in obtaining timely referral to specialty care.

6.13 Capacity Limits and Order of Acceptance:

6.13.1 The Contractor shall provide care to all enrollees who voluntarily choose the Contractor. The Contractor shall accept assignments up to the capacity limits described in this Contract.

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

6.13.3 HCA shall enroll WMIP-eligible clients with the Contractor to maintain a steady state of enrollment, unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.

6.13.4 The Contractor may request in writing that HCA temporarily suspend enrollment in the service area. HCA will approve the temporary suspension when the Contractor presents evidence to HCA, of the network limitations that demonstrate the Contractor's inability to accept additional enrollees.

6.13.5 The Contractor shall accept clients who are enrolled by HCA in accord with this Contract, Chapter 182-538 WAC, except as specifically provided in the Enrollment Data and Requirements for Contractor's Response provisions in the Enrollment Section of this Contract.

6.13.6 No eligible client shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, the existence of a pre-existing physical or mental condition, including pregnancy and/or hospitalization, or the expectation of

the need for frequent or high cost care (42 C.F.R. § 438.6(d)(1 and 3)).

6.14 Provider Network Changes:

6.14.1 The Contractor shall give HCA a minimum of ninety (90) calendar days' prior written notice, in accord with the Notices provisions of the General Terms and Conditions Section of this Contract, of the loss of a material provider. A material provider is one whose loss would impair the Contractor's ability to provide continuity of and access to care for the Contractor's current enrollees and potential enrollees.

6.14.2 The Contractor shall make a good faith effort to provide written notification to enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 C.F.R. § 438.10(f)(5)). Enrollee notices shall have prior approval of HCA. If the Contractor fails to notify affected enrollees of a provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected enrollees to continue to receive services from the terminating provider, at the enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies enrollees or the enrollee's effective date of enrollment with another plan.

6.14.3 HCA reserves the right to reduce the premium to recover any expenses incurred by HCA as a result of the withdrawal of a material Subcontractor from a Service Area. This reimbursable expense shall be in addition to any other provisions of this Contract.

6.14.4 HCA reserves the right to impose Sanctions, in accordance with Subsection 5.14 of this Contract, if the Contractor was notified by the terminating provider in a timely manner and does not comply with the notification requirements of this section.

6.14.4.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor shall provide documentation of the date of notification along with the notice of loss of a material provider.

6.15 Medicaid Enrollment, Non-Billing Providers

The Contractor shall ensure that all of its contracted providers have a signed Core Provider Agreement with HCA. A provider may enroll with HCA as a "non-billing" provider if he or she does not wish to serve fee-for-service Medicaid clients, but the provider must have an active NPI number with HCA.

7 QUALITY OF CARE

7.1 Quality Assessment and Performance Improvement (QAPI) Program:

7.1.1 The Contractor shall have and maintain a quality assessment and performance improvement (QAPI) program for the physical, mental health, chemical dependency and long-term care services it furnishes to its enrollees that meets the provisions of 42 C.F.R. § 438.240.

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

7.1.1.2 The QAPI program structure shall include the following elements:

7.1.1.2.1 A written description of the QAPI program including identification and description of the roles of designated geriatric, mental health, chemical

dependency representatives, that are consistent with existing standards published by the respective HCA and DSHS Administrations, the Medicaid State Plan and applicable WAC. The QAPI program description shall include:

7.1.1.2.1.1 Have in effect mechanisms to detect both underutilization and over utilization of services;

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

7.1.1.2.1.3 Descriptions of committee responsibilities;

7.1.1.2.1.4 Contractor staff and practicing provider committee participant titles;

7.1.1.2.1.5 Meeting frequency; and

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

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

7.1.1.2.2.1 Recommend policy decisions;

7.1.1.2.2.2 Analyze and evaluate the results of QI activities;

7.1.1.2.2.3 Institute actions; and

7.1.1.2.2.4 Ensure appropriate follow-up.

7.1.1.2.3 The Quality Improvement Committee will be comprised of:

7.1.1.2.3.1 A Mental Health Professional with substantial involvement in the implementation of mental health care aspects of the QAPI;

7.1.1.2.3.2 A Chemical Dependency Professional with substantial involvement in the implementation of chemical dependency health care aspects of the QAPI; and

7.1.1.2.3.3 A geriatric specialist with substantial involvement in the implementation of the long term care aspects of the QAPI.

7.1.1.2.4 An annual quality work plan, including objectives for serving individuals with special health care needs and enrollees from diverse communities. The work plan shall contain:

7.1.1.2.4.1 Goals and objectives for the year, including objectives for patient safety;

7.1.1.2.4.2 Timeframe to complete each activity;

7.1.1.2.4.3 Identification of a responsible person for each activity; and

7.1.1.2.4.4 Monitoring plans to assure implementation of the work plan.

7.1.1.2.5 An annual written report of the overall evaluation of the effectiveness of the Contractor QAPI program. (42 C.F.R. § 438.240(e)(2)). The report shall include at minimum:

7.1.1.2.5.1 HEDIS and non-HEDIS contractually required performance measure and utilization data pictorially displayed using charts and graphs, trended over time and compared against the Medicaid National Committee for Quality Assurance 75th or 25th percentile for performance or other comparable, published Benchmarks.

7.1.1.2.5.2 Accompanying written analysis of performance, including data comparisons to national and/or other benchmarks.

7.1.1.2.5.3 Interventions undertaken and/or planned during the review period to address underutilization, overutilization or misutilization patterns.

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

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

7.1.1.2.6 Upon request, the Contractor shall make available to providers, enrollees, or the Department, the QAPI program description, and information on the Contractor's progress towards meeting its quality plans and goals.

7.1.1.2.7 The Contractor shall provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities shall include evidence of:

7.1.1.2.7.1 A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity;

7.1.1.2.7.2 Evaluation of the delegated organization prior to delegation;

7.1.1.2.7.3 An annual evaluation of the delegated entity;

7.1.1.2.7.4 Evaluation of regular delegated entity reports; and

7.1.1.2.7.5 Follow-up on issues out of compliance with delegated agreement or HCA contract specifications.

7.1.1.2.8 The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. (42 C.F.R. § 438.240 (b)(4)).

7.2 **Performance Improvement Projects (PIPs)**:

7.2.1 The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas. The Contractor shall conduct at least three (3) PIPS, of which at least two are clinical and one is non-clinical as described in 42 C.F.R. § 438.240 (b)(1) and as specified in the CMS protocol.

7.2.2 The projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Through implementation of performance improvement projects, the Contractor shall:

7.2.2.1 Measure performance using objective, quality indicators of health outcomes and enrollee satisfaction.

7.2.2.2 Implement system interventions to achieve improvement in quality.

7.2.2.3 Evaluate the effectiveness of the interventions.

7.2.2.4 Plan and initiate activities for increasing or sustaining improvement.

7.2.2.5 Report the status and results of each project to HCA (42 C.F.R. § 438.240(d)(2)).

7.2.2.6 Complete projects in a reasonable time period as to allow aggregate information on the success of the projects to produce new information on the quality of care every year (42 C.F.R. § 438.240(d)(2)).

7.3 **Performance Measures using Health Employer Data & Information Set (HEDIS)**

7.3.1 In accord with the Notices provisions of the Special Terms and Conditions Section of this Contract, the Contractor shall report to HCA HEDIS® measures using the current HEDIS® Technical Specifications and official corrections published by NCQA, unless directed otherwise in writing by HCA. For the 2008 and 2009 HEDIS® measures listed below, the Contractor shall use the administrative or hybrid data collection methods, specified in the current HEDIS® Technical Specifications, unless directed otherwise by HCA (42 C.F.R. § 438.240(b)(2)). The Contractor shall make reasonable effort to maximize data collection.

7.3.2 No later than June 15 of each year, HEDIS® measures shall be submitted electronically to HCA using the NCQA Interactive Data Submission System (IDSS) or other NCQA-approved method.

7.3.2.1 Comprehensive Diabetes Care;

7.3.2.2 Inpatient Utilization – General Hospital/Acute Care;

7.3.2.3 Ambulatory Care;

7.3.2.4 Inpatient Utilization – Nonacute care;

7.3.2.5 Anti-depression Medication Management;

7.3.2.6 Follow-up after hospitalization for mental Illness;

7.3.2.7 Drugs to be avoided in the elderly;

7.3.2.8 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;

7.3.2.9 Identification of Alcohol and Other Drug Services; and

7.3.2.10 Mental Health Utilization.

7.4 **Process and Outcome measure**

The Contractor shall implement the following process and outcome measures:

7.4.1 Process Measures:

7.4.1.1 Increase percentage of enrollees who receive PCP annual visit;

7.4.1.2 Increase percentage of enrollees receiving initial and follow-up screenings;

7.4.1.3 Increase the number of enrollees who are contacted;

7.4.1.4 Increase the number of contacted enrollees with Integrated Care Plans (ICP); and

7.4.1.5 Increase percent of enrollees receiving Integrated Health Management (IHM) resources;

7.4.2 Outcome Measures:

7.4.2.1 Improve HEDIS quality scores;

7.4.2.2 Increase percentage of enrollees receiving outpatient office visits for primary care and mental health;

7.4.2.3 Increase prescription refills, (monitor as appropriate for controlled substances);

7.4.2.4 Increase percentage of enrollees receiving chemical dependency treatment for all ASAM levels of care;

7.4.2.5 Decrease inpatient stays, readmissions, and Skilled Nursing Facility placements;

7.4.2.6 Decrease preventable emergency room utilization; and

7.4.2.7 Decrease early mortality rate.

7.4.3 All HEDIS® measures, including the CAHPS® sample frame shall be audited, by a designated certified HEDIS® Compliance Auditor, a licensed organization in accord with methods described in the current HEDIS® Compliance Audit™ Standards, Policies and Procedures. HCA will fund and the HCA designated EQRO will conduct the audit.

7.4.4 The Contractor shall cooperate with HCA' designated EQRO to validate the Contractor's Health

Employer Data and Information Set (HEDIS®) performance measures and CAHPS® sample frame.

7.4.4.1 If the Contractor does not have NCQA accreditation for WMIP from the National Committee for Quality Assurance (NCQA), the Contractor shall receive a partial audit.

7.4.4.2 If the Contractor has NCQA accreditation for WMIP managed care or is seeking accreditation with a scheduled NCQA visit during the contract term, the Contractor shall receive a full audit.

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

7.4.5 The Contractor shall provide evidence of trending of measures to assess performance in quality and safety of clinical care and quality of non-clinical or service-related care.

7.4.6 The Contractor shall collect and maintain data on ethnicity, race and language markers as established by HCA on all enrollees. The Contractor shall record and maintain enrollee self-identified data as established by the Contractor and maintain unique data fields for self-identified data. HCA will monitor compliance with this requirement in 2014.

7.5 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

7.5.1 In 2014, the Contractor shall conduct the CAHPS® Adult survey to Medicaid and Medicare enrollees enrolled in WMIP.

7.5.2 The Contractor shall contract with an NCQA certified HEDIS® survey vendor qualified to administer the CAHPS® survey and conduct the survey according to NCQA protocol. The Contractor shall submit the following information to the HCA designated EQRO:

7.5.2.1 Contractor CAHPS® survey staff member contact, CAHPS® vendor name and CAHPS® primary vendor contact.

7.5.2.2 Timeline for implementation of vendor tasks.

7.5.3 The Contractor shall ensure that all survey questions, including Contractor-determined and HCA-determined supplemental questions are approved by the HCA WMIP contract manager prior to submission to the Contractor's contracted survey vendor.

7.5.4 The Contractor shall ensure the survey sample frame consists of all non-commercial adult plan enrollees (not just subscribers) 21 (twenty-one) years and older with Washington State addresses. The Contractor shall submit the survey sample frame to the contracted survey vendor for approval prior to conducting the survey.

7.5.5 The Contractor and it's contracted survey vendor shall coordinate to develop the questionnaire format, questions and question placement, using the most recent HEDIS® version of the Medicaid adult questionnaire (currently 4.0H), plus approved supplemental and/or custom questions as determined by HCA.

7.5.6 Conduct the mixed methodology (mail and phone surveys) for CAHPS® survey administration.

7.5.7 Submit the final disposition report by June 10 for every year that the CAHPS survey is administered.

7.5.8 Submit a copy of the Washington State adult Medicaid response data set according to the most current NCQA/CAHPS® standards to the HCA-contracted EQRO, Accumentra, by June, 2015.

7.5.9 The Contractor is required to include performance guarantee language in their vendor subcontracts that require a vendor to achieve at least a thirty-five percent (35%) response rate.

7.5.10 The Contractor shall notify HCA in writing whether they have a physician or physician group at substantial financial risk in accord with the physician incentive plan requirements under the Subcontracts Section of this Contract.

7.6 **External Quality Review**:

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

7.6.2 The following required activities will be validated (42 C.F.R. § 438.358(b)(1)(2)(3)):

7.6.2.1 Performance improvement projects;

7.6.2.2 Performance measures; and

7.6.2.3 A monitoring review of standards established by HCA and included in this Contract to comply with 42 C.F.R. § 438.204 (g) and a comprehensive review conducted within the previous three-year period.

7.6.3 The following optional activity will be validated annually:

7.6.3.1 Administration and/or validation of consumer or provider surveys of quality of care, i.e., the CAHPS® survey (438.358(c)(2).

7.6.3.2 HCA reserves the right to include additional optional activities described in 42 C.F.R. § 438.358 if additional funding becomes available and as mutually negotiated between HCA and the Contractor.

7.6.4 The Contractor shall submit to annual HCA Contract Monitoring and EQRO monitoring reviews. The monitoring review process uses standard methods and data collection tools and methods found in the CMS EQR Managed Care Organization Protocol and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by Medicaid MCOs (42 C.F.R. § 438.204). In addition, the Contract Monitoring tool shall include specific contract regulations relating to mental health, long-term care, and chemical dependency.

7.6.5 The Contractor shall, during an annual monitoring review of the Contractor's compliance with contract standards or upon request by HCA or its External Quality Review Organization (EQRO) contractor(s), provide evidence of how external quality review findings, agency audits and contract monitoring activities, enrollee grievances, HEDIS®, CAHPS®, outcome and process measurement results are used to identify and correct problems and to improve care and services to enrollees.

7.6.6 The Contractor will provide data requested by the EQRO for purposes of completing the External Quality Review Report (EQRR). The EQRR is a detailed technical report that

describes the manner in which the data from all activities described in External Quality Review provisions of this Section and conducted in accord with 42 C.F.R. § 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness and access to the care furnished by the Contractor.

7.6.7 HCA will provide a copy of the EQRR to the Contractor, through print or electronic media and to interested parties such as participating health care providers, enrollees and potential enrollees of the Contractor, recipient advocacy groups, and members of the general public. HCA must make this information available in alternative formats for persons with sensory impairments, when requested.

7.6.8 If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to HCA. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with HCA, Department of Health (DOH), and Health Care Authority (HCA) as needed to reduce duplicated work for both the Contractor and the state.

7.7 Enrollee Mortality

The Contractor shall maintain a record of known enrollee deaths, including the enrollee's name, date of birth, age at death, location of death, and cause(s) of death. This information shall be available to HCA upon request. The Contractor shall assist HCA in efforts to evaluate and improve the availability and utility of selected mortality information for quality improvement purposes.

7.8 Practice Guidelines

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

7.8.1 The Contractor shall adopt physical, mental health, chemical dependency and long-term care practice guidelines. The Contractor may develop or adopt guidelines developed by organizations such as the American Diabetes Association or the American Lung Association. Practice guidelines shall meet the following requirements (42 C.F.R. § 438.236):

7.8.1.1 Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

7.8.1.2 Consider the needs of enrollees and support client and family involvement in care plans;

7.8.1.3 Are adopted in consultation with contracting health care professionals;

7.8.1.4 Are reviewed and updated at least every two years and as appropriate;

7.8.1.5 Are disseminated to all affected providers and, upon request, to HCA, enrollees and potential enrollees (42 C.F.R. § 438.236(c)); and

7.8.1.6 Are the basis for and are consistent with decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply (42 C.F.R. § 438.236(d)).

7.8.2 Practice guidelines must be distributed to affected providers within 60 days of adoption or revision. If distributed via the Internet, written notification of the availability of adopted or revised guidelines must be mailed to providers. If the Contractor has added new providers, there must be evidence that it distributed the guidelines to new providers.

7.8.3 Practice guidelines must:

7.8.3.1 Include at least two mental health-specific guidelines, including documentation of why the guidelines were adopted;

7.8.3.2 Include at least two long-term care specific guidelines including documentation of why the guidelines were adopted; and

7.8.3.3 Use the American Society of Addiction Medicine (ASAM) Guidelines for Chemical Dependency to determine appropriate levels of care for chemically dependent enrollees in accordance with Chapter 388-805 WAC.

7.9 Drug Formulary Review and Approval

The Contractor shall submit its drug formulary to HCA for review and approval.

7.9.1 The term "Formulary" as used in this subsection includes lists of products and their formulary status available through a retail pharmacy, "Specialty Pharmacy" products, and drugs paid by the Contractor under the medical rather than retail pharmacy benefits.

7.9.2 If the formulary differs from the Apple Health Managed Care formulary, or if there have been substantive changes to the formulary, it and any formulary and related materials must be submitted:

7.9.2.1 In an electronic format and according to the HCA specifications;

7.9.2.2 No later than February 1, 2014 or upon HCA's request;

7.9.2.3 Via secure email to: hcamcprograms@hca.wa.gov.

7.9.3 In order to be approved by HCA, the Contractor's formulary shall include all therapeutic classes in the Health Care Authority's fee-for-service drug file and a variety of drugs in each therapeutic class determined by HCA to be sufficient to meet enrollees' medically necessary health care needs.

7.9.3.1 To be found sufficient to meet enrollees' medically necessary health care needs the Contractor's formulary must include at a minimum:

7.9.3.1.1 The same number of prescription drugs in each US Pharmacopeia (USP) category and class as Washington State's selected Essential Health Benefit (EHB) benchmark plan;

7.9.3.1.2 At least one drug in any USP category and class for which the EHB benchmark plan has no covered drugs;

7.9.3.1.3 Additional drugs as determined necessary by HCA to meet enrollees' medically necessary health care needs; and

7.9.3.1.4 Indefinite continuation of therapy for antidepressants which a client has been previously prescribed, regardless of the drug's status on the Contractor's formulary.

7.9.3.2 If HCA determines that the formulary does not contain a sufficient variety of drugs in each therapeutic class, the Contractor shall amend and update its formulary and related materials as required by HCA.

7.9.3.3 Upon request by HCA, the Contractor shall submit any additional materials required to determine the sufficiency of the formulary within five (5) business days of the request.

7.9.3.4 HCA shall notify the Contractor of either the approval of their formulary or any required changes, no later than April 1, 2014.

7.9.3.5 If HCA notifies the Contractor of required changes, all such changes must be completed and resubmitted no later than May 1, 2014.

7.9.3.6 After final approval of the Contractor's formulary by HCA, the Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs.

7.9.3.7 HCA may require changes to Contractor formulary after initial approval. Any such required change shall be communicated to the Contractor no less than sixty (60) calendar days prior to required implementation.

7.10 Rebate Eligible Manufacturers

7.10.1 The Contractor shall ensure that:

7.10.1.1 Products in the Contractor's drug formulary are purchased from a participating rebate eligible manufacturer. Participating manufacturers are defined in Subsection 1.83 of this Contract and a list can be found at: **http://www.hca.wa.gov/medicaid/pharmacy/Documents/rebate_customer_list.pdf**;

7.10.1.2 The Contractor has a Drug Use Review program that ensures providers screen for allergies, idiosyncrasies, chronic conditions that may relate to drug utilization, potential drug therapy problems, and provide counseling to the enrollee in accordance with existing state pharmacy laws and federal regulations; and

7.10.1.3 Drug Rebate records are kept in accord with the Records Retention section of this contact and that they are made available to HCA upon request, to resolve disputes by drug manufacturers of their rebate obligations.

7.11 Health Information Systems

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

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

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

7.11.2.1 Verifying the accuracy and timeliness of reported data;

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

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

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

7.12 Technical Assistance

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

7.13 Critical Incident Reporting

The Contractor shall notify HCA of any critical incident as described in this Subsection:

7.13.1 Examples of incidents to report include but are not limited to: homicide, attempted homicide, completed suicide, the unexpected death of a consumer, abuse or neglect of an enrollee by an employee or volunteer, loss of crisis lines, loss of service or residential sites.

7.13.2 Notification must be made to the WMIP Program Manager in the Office of Quality and Care Management (OQCM), or his/her designee during the business day in which the Contractor becomes aware of such an event. If the event occurs after business hours, notice must be given as soon as possible during the next business day.

7.13.3 Notification must include a description of the event, any actions taken in response to the incident, the purpose for which any action was taken, and any implications to the service delivery system.

7.13.4 When requested by HCA, the Contractor shall submit a written report within two weeks of the original notification to provide information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

7.14 Long Term Care Utilization Reports

7.14.1 To comply with the requirements of the Department's COPES waivers, the Contractor must provide an annual report on long term care service utilization data for WMIP enrollees. The report shall cover the period of April 1 – March 31 and shall be submitted to the ALTSA WMIP program manager no later than August 31 of the following year.

7.14.2 The report must include all WMIP enrollees receiving COPES services as noted in the CARE tool, and must provide unduplicated counts in the following categories in dollars and the total number of unduplicated clients across categories.

7.14.2.1 Personal Care Agency

7.14.2.2 Environmental Modification

7.14.2.3 Personal Emergency Response System Installation and Service

7.14.2.4 Adult Day Care

7.14.2.5 Adult Day Health

7.14.2.6 Home Delivered Meals

7.14.2.7 Home Health Aide

7.14.2.8 Skilled Nursing

7.14.2.9 Client Training

7.14.2.10 Specialized Medical Equipment and Supplies

7.14.2.11 Nurse Delegation (In Home)

7.14.2.12 Adult Family Home

7.14.2.13 Enhanced Residential Care

7.14.2.14 Community Transition Services

7.14.2.15 Assisted Living

7.15 LTC Provider Network Capacity Report

To comply with requirements set forth by the Washington State Legislature, the Contractor shall track and provide an annual report of service days paid for all WMIP enrollees to licensed facilities that have an Assisted Living contract with the Department.

The report must be broken down by total service days per month per facility. The report shall cover the period of July 1 through December 31st of each year and be submitted to the Department on later than March 31st of the following year.

7.16 Reporting of Enrollee Abuse

The Contractor shall report all instances of suspected abuse, abandonment, neglect and/or exploitation to one of the following toll free numbers:

7.16.1 If the enrollee or other alleged victim resides in Snohomish County, call: 1-866-221-4909.
7.16.2 For all others, call 1-866-END-HARM.

On an annual basis, the Contractor shall report all instances of suspected abuse, abandonment, neglect or exploitation to the ALTSA Program Manager, including enrollee name, nature of the abuse, abandonment, neglect or exploitation and any action taken by the contractor in addition to calling the toll free number.

The Contractor shall have in place a standard process and effective training on reporting to Adult Protective Services when fraud adversely affects the health and safety of a vulnerable adult as defined by RCW 74.34.095, regardless of whether the vulnerable adult is a WMIP enrollee.

7.17 Reporting of Deduction of Payment for Services paid for by DSHS

DSHS shall provide to Contractor a client detail report identifying all dollars paid to Individual Providers (IPs) on behalf of Contractor in the previous month. The Contractor shall identify any payment errors and submit those to HCA. HCA shall subtract from the following month's capitation payment the amount paid to IPs, less the amount of any error payments to IPs identified by Contractor. DSHS shall have full responsibility for pursuing IPs for any overpayments.

DSHS shall submit to Contractor a client detail report identifying all dollars paid to Nursing Facilities (NFs) on behalf of Contractor in the previous month. Contractor shall identify any payment errors and submit those to DSHS. DSHS shall subtract from the following month's capitation payment, the amount paid to NFs, less the amount of any error payments to NFs identified by Contractor. DSHS shall have full responsibility for pursuing NFs for any overpayments.

8 POLICIES AND PROCEDURES

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

8.1 The Contractor's policies and procedures shall:

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

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

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

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

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

8.2 Assessment of Policies and Procedures

The Contractor shall complete a self-assessment of its policies and procedures related to this Contract to HCA for review and approval. The self-assessment will be developed by HCA. The Contractor shall complete and submit the self-assessment in response to corrective action and any time there is a new policy and procedure or a change to an existing policy and procedure. The Contractor shall also submit copies of policies and procedures upon request by HCA.

9 SUBCONTRACTS

9.1 Contractor Remains Legally Responsible

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

9.2 Solvency Requirements for Subcontractors

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

9.3 Provider Nondiscrimination

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

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

9.3.3 The Contractor’s policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 C.F.R. § 438.214(c)).

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

9.3.4.1 Contract with providers beyond the number necessary to meet the needs of its enrollees.

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

9.3.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs (42 C.F.R. § 438.12(b)(1)).

9.4 Required Provisions

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

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

9.4.2 Procedures and specific criteria for terminating the subcontract.

9.4.3 Processing and maintenance of ensuring background checks are completed and current and

providers meet all qualifications and training to be a qualified provider.

9.4.4 Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor.

9.4.5 Reimbursement rates and procedures for services provided under the subcontract.

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

9.4.7 Reasonable access to facilities and financial and medical records for duly authorized representatives of HCA or DHHS for audit purposes, and immediate access for Medicaid fraud investigators (42 C.F.R. § 438.6(g)).

9.4.8 The requirement to completely and accurately report encounter data to the Contractor. Contractor shall ensure that all subcontractors required to report encounter data have the capacity to submit all HCA required data to enable the Contractor to meet the reporting requirements in the Encounter Data Transaction Guide published by HCA.

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

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

9.4.11 The subcontractor shall comply with the applicable state and federal statutes, rules and regulations as set forth in this Contract, including but not limited to the applicable requirements of 42 U.S.C. § 1396a(a)(43), 1396d(r), 42 C.F.R. § 438.6(i).

9.4.12 Subcontracts shall set forth and require the subcontractor to comply with any term or condition of this Contract that is applicable to the services to be performed under the subcontract (42 C.F.R. § 438.6(1)).

9.4.13 The Contractor shall provide the following information regarding the grievance system to all subcontractors (42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(1)):

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

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

9.4.13.3 The enrollee’s right to request continuation of benefits during an appeal or hearing and, if the Contractor’s action is upheld, that the enrollee may be responsible to pay for the continued benefits.

9.4.13.4 The enrollee’s right to file grievances and appeals and their requirements and timeframes for filing.

9.4.13.5 The enrollee’s right to a hearing, how to obtain a hearing and representation rules at a hearing.

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

9.4.15 A process for monitoring the subcontractor's performance and a schedule for formally evaluating performance, consistent with industry standards or State managed care laws and regulations. This process shall include an element that ensures any deficiencies identified in the evaluation are subjected to corrective action.

9.4.16 The process whereby the subcontractor evaluates and ensures that services furnished to individuals with special health care needs are appropriate to the enrollee's needs;

9.4.17 The Contractor shall evaluate any prospective subcontractor's ability to perform the activities for which that subcontractor is contracting, including the subcontractor's ability to perform delegated activities described in the subcontracting document.

9.5 Health Care Provider Subcontracts

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

9.5.1 A quality improvement system tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this Contract.

9.5.2 A statement that primary care and specialty care provider subcontractors shall cooperate with Quality Improvement (QI) activities.

9.5.3 A means to keep records necessary to adequately document services provided to enrollees for all delegated activities including Quality Improvement, Utilization Management, Member Rights and Responsibilities, and Credentialing and Recredentialing.

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

9.5.4.1 Assigned responsibilities

9.5.4.2 Delegated activities

9.5.4.3 A mechanism for evaluation

9.5.4.4 Corrective action policy and procedure

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

9.5.6 The subcontractor accepts payment from the Contractor as payment in full and shall not request payment from HCA or any enrollee for contracted services performed under the subcontract.

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

contractors (42 C.F.R. § 438.230(b)(2)).

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

9.5.9 A ninety (90) day termination notice provision.

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

9.5.11 The subcontractor agrees to comply with the appointment wait time standards of this Contract. The subcontract must provide for regular monitoring of timely access and corrective action if the subcontractor fails to comply with the appointment wait time standards (42 C.F.R. § 438.206(c)(1)).

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

9.6 **Health Care Provider Subcontracts Delegating Administrative Functions**

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

9.6.1.1 For those subcontractors at financial risk, that the subcontractor shall maintain the Contractor's solvency requirements throughout the term of the Contract.

9.6.1.2 Clear descriptions of any administrative functions delegated by the Contractor in the subcontract. Administrative functions are any obligations of the Contractor under this Contract other than the direct provision of services to enrollees and include, but are not limited to, utilization/medical management, claims processing, enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.

9.6.1.3 How frequently and by what means the Contractor will monitor compliance with solvency requirements and requirements related to any administrative function delegated in the subcontract.

9.6.1.4 Provisions for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate (42 C.F.R. § 438.230(b)(2)).

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

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

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

9.7 Home Health Providers

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

9.8 Physician Incentive Plans

Physician incentive plans, as defined herein, are subject to the conditions set forth in this Section in accord with federal regulations (42 C.F.R. § 438.6(h), 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210).

9.8.1 Prohibited Payments: The Contractor shall make no payment to a physician or physician group, directly or indirectly, under a physician incentive plan as an inducement to reduce or limit medically necessary services provided to an individual enrollee.

9.8.2 Disclosure Requirements: Risk sharing arrangements in subcontracts with physicians or physician groups are subject to review and approval by HCA. Prior to entering into, modifying or extending the risk sharing arrangement in a subcontract at any tier, the Contractor shall provide the following information about its physician incentive plan, and the physician incentive plans of its subcontractors to HCA:

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

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

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

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

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

9.8.2.2.4 The panel size and, if commercial members and enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or physician group's panel may be pooled provided the terms of risk for the pooled enrollees and commercial members are comparable, and the incentive payments are not calculated separately for pooled enrollees. Commercial members include military members.

9.8.3 If the Contractor, or any subcontractor, places a physician or physician group at substantial financial risk, the Contractor shall assure that all physicians and physician groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or physician group.

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

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

9.8.3.2.1 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional services, or $6,000 for combined services.

9.8.3.2.2 1,001 - 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

9.8.3.2.3 5,001 - 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

9.8.3.2.4 8,001 - 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

9.8.3.2.5 10,001 - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

9.8.3.2.6 25,001 members or more, there is no risk threshold.

9.8.3.3 For a physician or physician group at substantial financial risk, the Contractor shall conduct surveys of enrollee satisfaction with the physician or physician group on an annual basis. The survey shall:

9.8.3.3.1 Be approved by HCA.

9.8.3.3.2 Be conducted according to commonly accepted principles of survey design and statistical analysis.

9.8.3.3.3 Address enrollee satisfaction with the physician or physician group, quality of services provided; and degree of access to services.

9.8.3.3.4 Report survey results to the HCA and, upon request, to enrollees.

9.9 **Provider Education**

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

9.9.1 The Contractor shall maintain a system for keeping participating providers informed about:

9.9.1.1 Covered services for enrollees served under this Contract.

9.9.1.2 Coordination of care requirements.

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

9.9.1.4 Health Homes.

9.9.1.5 Interpretation of data from the Quality Improvement program.

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

9.9.1.7 Mental health services through the Contractor.

9.9.1.8 Mental health services through DSHS Regional Support Networks including a list of Regional Support Networks and contact information in counties served by the Contractor.

9.9.1.9 DSHS substance use disorder services, including a list of Substance Use Disorder Clinics and contact information located in the counties served by the Contractor.

9.9.1.10 Contractor care management staff for assistance in care transitions and care management activity.

9.9.1.11 Program Integrity requirements.

9.9.1.12 DSHS long-term care services including availability of home and community based care.

9.9.1.13 Educational opportunities for primary care providers, such as those produced by the Washington State Department of Health Collaborative, the Washington State Medical Association or the Washington State Hospital Association, etc.

9.10 Claims Payment Standards

The Contractor shall meet the timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a)(37)(A) of the Social Security Act, 42 C.F.R. § 447.46 and specified for health carriers in WAC 284-43-321. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, ninety-five percent (95%) of clean claims within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) of receipt and ninety-nine percent (99%) of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

9.10.1 A claim is a bill for services, a line item of service or all services for one enrollee within a bill.
9.10.2 A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.
9.10.3 The date of receipt is the date the Contractor receives the claim from the provider.
9.10.4 The date of payment is the date of the check or other form of payment.

9.11 Provider Credentialing

The Contractor's policies and procedures shall follow the state's requirements related to the credentialing and recredentialing of health care professionals who have signed contracts or participation agreements with the Contractor (Chapter 246-12 WAC). The Contractor shall ensure compliance with the requirements described in this Contract.

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

9.11.1.1 The Contractor's medical director or other designated physician shall have direct

responsibility for and participation in the credentialing program.

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

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

9.11.2.1 Identification of the type of providers credentialed and recredentialed.

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

9.11.2.3 Prohibition against employment or contracting with providers excluded from participation in Federal health care programs under federal law and as described in the Excluded Individuals and Entities provisions of this Contract.

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

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

9.11.2.6 Verification that the provider is considered a qualified provider under Title 388 WAC.

9.11.3 The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials shall include communication of the provider's rights to:

9.11.3.1 Review materials.

9.11.3.2 Correct incorrect or erroneous information.

9.11.3.3 Be informed of their credentialing status.

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

9.11.5 An appeal process for providers for quality reasons and reporting of quality issues to the appropriate authority and in accord with the Program Integrity requirements of this Contract.

9.11.6 The Contractor's process to ensure confidentiality.

9.11.7 The Contractor's process to ensure listings in provider directories for enrollees are consistent with credentialing file content, including education, training, certification and specialty designation.

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

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

9.11.10 The Contractor's system for monitoring sanctions, limitations on licensure, complaints and

quality issues or information from identified adverse events and provide evidence of action, as appropriate based on defined methods or criteria.(42 C.F.R. § 455.101).

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

9.11.12 The criteria used by the Contractor to credential and recredential practitioners shall include (42 C.F.R. § 438.230(b)(1)):

9.11.12.1 Evidence of a current valid license to practice;

9.11.12.2 A valid DEA or CDS certificate if applicable;

9.11.12.3 Evidence of appropriate education and training;

9.11.12.4 Board certification if applicable;

9.11.12.5 Evaluation of work history;

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

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

9.11.12.7.1 The lack of present illegal drug use;

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

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

9.11.12.7.4 Current malpractice coverage;

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

9.11.12.7.6 Accuracy and completeness of the application.

9.11.13 The Contractor shall ensure that all subcontracted providers defined as "high categorical risk" in 42 C.F.R. § 424.518, are enrolled through the Medicare system, which requires a criminal background check as part of the enrollment process. The Contractor shall ensure that each provider defined as "high categorical risk" provide an enrollment verification letter from Medicare issued after March 23, 2011 as part of the credentialing process. The contractor shall ensure that contracted providers defined as "high categorical risk" revalidate their Medicare enrollment every three (3) years in compliance with 42 C.F.R. § 424.515.

9.11.14 The Contractor shall terminate any provider where HCA or Medicare has taken any action to revoke the provider's privileges for cause, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. For cause may include, but is not limited to, fraud; integrity; or quality (42 C.F.R. § 455.101).

9.11.15 The Contractor shall notify HCA in accord with the Notices section of this contract, within three (3) business days of receipt of information relating to disciplinary action against the accreditation, certification, license and/or registration of the Contractor, an employee,

subcontractor or subcontractor employee.

9.11.16 The Contractor shall require providers defined as "high categorical risk" for potential fraud as defined in 42 C.F.R. § 424.518 to be enrolled and screened by Medicare.

9.11.17 The Contractor's policies and procedures shall be consistent with 42 C.F.R. § 438.12, and the process shall ensure the Contractor does not discriminate against particular health care professionals that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination.

10 ENROLLEE RIGHTS AND PROTECTIONS:

10.1 General Requirements:

10.1.1 The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees (42 C.F.R. § 438.100(a)(2)).

10.1.2 The Contractor shall guarantee each enrollee the following rights (42 C.F.R. § 438.100(b)(2)):

10.1.2.1 To be treated with respect and with consideration for their dignity and privacy (42 C.F.R. § 438.100(b)(2)(ii)).

10.1.2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's ability to understand (42 C.F.R. § 438.100(b)(2)(iii)).

10.1.2.3 To participate in decisions regarding their health care, including the right to refuse treatment (42 C.F.R. § 438.100(b)(2)(iv)).

10.1.2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 C.F.R. § 438.100(b)(2)(iv)).

10.1.2.5 To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. § 164 (42 C.F.R. § 438.100(b)(2)(iv)).

10.1.2.6 Each enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its subcontractors treat the enrollee (42 C.F.R. § 438.100(c)).

10.2 **Cultural Considerations**

The Contractor shall participate in and cooperate with HCA efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds (42 C.F.R. § 438.206(c)(2)).

10.3 **Advance Directives and Physician Orders for Life Sustaining Treatment (POLST):**

10.3.1 The Contractor shall meet the requirements of WAC 182-501-0125, 42 C.F.R. § 438.6, 438.10, 422.128, 489.100 and 489 Subpart I as described in this section.

10.3.2 The Contractor's advance directive policies and procedures shall be disseminated to all affected providers, enrollees, HCA, and, upon request, potential enrollees (42 C.F.R. § 438.6(i)(3)).

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

10.3.3 The Contractor's written policies respecting the implementation of advance directive rights shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience (42 C.F.R. § 422.128). At a minimum, this statement must do the following:

10.3.3.1 Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.

10.3.3.2 Identify the state legal authority permitting such objection.

10.3.3.3 Describe the range of medical conditions or procedures affected by the conscience objection.

10.3.4 If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the Contractor may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accord with State law. The Contractor is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

10.3.5 The Contractor must require and ensure, that the enrollee's medical record documents, in a prominent part, whether or not the individual has executed an advance directive.

10.3.6 The Contractor shall not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an advance directive.

10.3.7 The Contractor shall ensure compliance with requirements of State and Federal law (whether statutory or recognized by the courts of the State) regarding advance directives.

10.3.8 The Contractor shall provide for education of staff concerning its policies and procedures on advance directives.

10.3.9 The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and Federal law concerning advance directives. The Contractor shall document its community education efforts (42 C.F.R. § 438.6(i)(3)).

10.3.10 The Contractor is not required to provide care that conflicts with an advance directive; and is not

required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or any subcontractor providing services under this Contract to conscientiously object.

10.3.11 The Contractor shall inform enrollees that they may file a grievance with the Contractor if the enrollee is dissatisfied with the Contractor's advance directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform enrollees that they may file a grievance with DSHS if they believe the Contractor is non-compliant with advance directive requirements and that the enrollee may file complaints concerning noncompliance with advance directives for psychiatric care requirements with the Contractor or by contacting the DSHS, Behavioral Health and Integrated Services Administration's Quality Improvement and Assurance staff.

10.4 **Enrollee Choice of PCP:**

10.4.1 The Contractor must implement procedures to ensure each enrollee has a source of primary care appropriate to their needs (42 C.F.R. § 438.207(c)).

10.4.2 The Contractor shall allow, to the extent possible and appropriate, each new enrollee to choose a participating PCP (42 C.F.R. § 438.6(m)).

10.4.3 In the case of newborns, the parent shall choose the newborn's PCP.

10.4.4 If the enrollee does not make a choice at the time of enrollment, the Contractor shall assign the enrollee to a PCP or clinic, within reasonable proximity to the enrollee's home, no later than fifteen (15) working days after coverage begins.

10.4.5 The Contractor shall allow an enrollee to change PCP or clinic at any time with the change becoming effective no later than the beginning of the month following the enrollees request for the change (WAC 388-538-060 and 284-43-251(1)).

10.4.6 The Contractor may limit enrollees' ability to change PCP's in accord with the Patient Review and Coordination provisions of the Benefits Section of this Contract.

10.5 **Direct Access for Enrollees with Special Health Care Needs**

The Contractor shall allow enrollees with special health care needs who utilize a specialist frequently to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care. The Contractor shall also allow enrollees with special health care needs as defined in WAC 388-538-050 to retain a specialist as a PCP or be allowed direct access to a specialist if the assessment required under the provisions of this Contract demonstrates a need for a course of treatment or regular monitoring by such specialist (42 C.F.R. § 438.208(c)(4) and 438.6(m)).

10.6 **Prohibition on Enrollee Charges for Contracted Services**:

10.6.1 Under no circumstances shall the Contractor, or any providers used to deliver services under the terms of this Contract, including non-participating providers, charge enrollees for covered services as described in the (SSA 1932(b)(6), SSA 1128B(d)(1)), 42 C.F.R. § 438.106(c), 438.6(1), 438.230, 438.204(a) and WAC 182-502-0160).

10.6.2 Prior to authorizing services with non-participating providers, the Contractor shall assure that non-participating providers fully understand and accept the prohibition against balance billing enrollees.

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

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

10.6.5 The Contractor shall have a separate and specific policy and procedure that fully articulates how the Contractor will protect enrollees from being billed for contracted services.

10.6.6 The Contractor shall coordinate benefits with other insurers in a manner that does not result in any payment by or charges to the enrollee for covered services including other insurer's copayments and coinsurance.

10.7 Provider/Enrollee Communication

The Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient, for the following (42 C.F.R. § 438.102(a)(1)(i)):

10.7.1 The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered (42 C.F.R. § 438.102(a)(1)(i)).

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

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

10.7.4 The enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions (42 C.F.R. § 438.102(a)(1)(iv)).

10.8 Enrollee Self-Determination

The Contractor shall ensure that all providers: obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning advance directives (WAC 182-501-0125 and 42 C.F.R. § 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (Chapter 68.64 RCW).

10.9 Women's Health Care Services

The Contractor must provide female enrollees with direct access to a women's health practitioners within the Contractors network for covered care necessary to provide women's routine and preventive health care services, including prescriptions for pharmaceutical or medical supplies ordered by a directly accessed women's health care practitioner, and which are in the practitioner's scope of practice in accord with the provisions of WAC 284-43-250 and 42 C.F.R. § 438.206(b)(2).

10.10 **Maternity Newborn Length of Stay**

The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

10.11 **Enrollment Not Discriminatory**

10.11.1 The Contractor will not discriminate against enrollees or potential enrollees based on health status or need for health care services (42 C.F.R. § 438.6 (d) (3)).

10.11.2 The Contractor will not discriminate against enrollees due to an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of medical services, diminished mental capacity, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b)(2)).

10.11.3 No eligible person shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, including the existence of a pre-existing physical or mental condition, functional impairment or chemical dependency, pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 C.F.R. § 438.6(d)(1 and 3)).

10.11.4 The Contractor will not discriminate against enrollees or those eligible to enroll on the basis of race, color, or national origin, sex, age, veteran or military status, sexual orientation, or the presence of any sensory, mental or physical disability, or the use of a trained dog guide or service animal by a person with a disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin (42 C.F.R. § 438.6(d)(4)).

11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 Utilization Management Requirements

The Contractor shall follow the Utilization Management requirements described in this section.

11.1.1 The Contractor’s policies and procedures related to Utilization Management (UM) shall comply with, and require the compliance of subcontractors with delegated authority for Utilization Management, the requirements described in this section.

11.1.2 The Contractor shall have and maintain a Utilization Management Program (UMP) description for the physical and behavioral services it furnishes its enrollees (WAC 284-43-410(2)).

11.1.3 The Contractor shall define its UMP structure and assign responsibility for UMP activities to appropriate individuals.

11.1.4 Upon request the Contractor shall provide HCA with meeting minutes and a written description of the UMP that includes identification of designated physician and behavioral health practitioners and evidence of the physician and behavioral health practitioner’s involvement in program development and implementation.

11.1.5 The UMP program description shall include:

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

11.1.5.2 Descriptions of committee responsibilities

11.1.5.3 Contractor staff and practicing provider committee participant title(s)

11.1.5.4 Meeting frequency

11.1.5.5 Maintenance of meeting minutes reflecting decisions made by each committee, as appropriate

11.1.6 UMP behavioral health and non-behavioral health policies and procedures at minimum, shall address the following requirements:

11.1.6.1 Documentation of use and periodic review of written clinical decision-making criteria based on clinical evidence, including policies and procedures for appropriate application of the criteria (WAC 284-43-410(2)).

11.1.6.2 Mechanisms for providers and enrollees on how they can obtain the UM decision-making criteria upon request, including UM action or denial determination letter template language reflecting same (WAC 284-43-410(2)).

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

11.1.6.4 Written job descriptions with qualification for providers who review denials of care based on medical necessity that requires education, training or professional experience in medical or clinical practice and current non-restricted license.

11.1.6.5 Mechanisms to verify that claimed services were actually provided.

11.1.6.6 Mechanisms to detect both underutilization and over-utilization of services, including pharmacy underutilization and over-utilization.

11.1.6.7 Production of a yearly report which identifies and reports findings on utilization measures and includes completed or planned interventions to address under or over-utilization patterns of care (42 C.F.R. § 438.240(b)(3)).

11.1.6.8 Identification of the type of personnel responsible for each level of UM decision-making.

11.1.6.9 A physician or behavioral health practitioner or pharmacist as appropriate reviews any behavioral health denial of care based on medical necessity.

11.1.6.10 The use of board certified consultants to assist in making medical necessity determinations.

11.1.6.11 Appeals of adverse determinations evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person’s condition or disease (PBOR, WAC 284-43-620(4)).

11.1.6.12 Documentation of timelines for appeals in accord with the Appeal Process provisions of the Grievance System Section of this Contract.

11.1.7 Follow the coverage decisions of the Health Technology Assessment (HTA) program promulgated by HCA (Chapter 182-55 WAC) and, upon HCA's request, provide documentation demonstrating compliance.

11.1.8 Annually evaluate and update the UMP.

11.1.9 The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee (42 C.F.R. § 438.210(e)).

11.1.10 The Contractor shall not penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the Contractor's determination with respect to coverage or payment for health care service (PBOR, WAC 284-43-210(6)).

11.2 **Medical Necessity Determination**

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

11.3 **Authorization of Services**

The Contractor shall follow the authorization of services requirements described in this section.

11.3.1 The Contractor shall follow the authorization of services requirements described in this section. The Contractor shall not have or implement authorization policies that inhibit enrollees from obtaining medically necessary contracted services and supplies. Authorizations for contracted services and supplies that are needed on an ongoing basis shall not be required any more frequently than semi-annually. Services and supplies needed on an ongoing basis include, but are not limited to, insulin pens, incontinence supplies, ongoing medications or medications for chronic conditions.

11.3.2 The Contractor's policies and procedures related to authorization of services shall include compliance with 42 C.F.R. § 438.210, WAC 284-43-410 and Chapter 182-538 WAC, and require compliance of subcontractors with delegated authority for authorization of services with the requirements described in this section and shall include a definition of "service authorization" that includes an enrollee's request for services.

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

11.3.4 The Contractor shall consult with the requesting provider when appropriate (42 C.F.R. § 438.210(b)(1)(ii)).

11.3.4.1 The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease (42 C.F.R. § 438.210(b)(3)).

11.3.4.2 Any decision to deny a mental health service authorization request or to authorize a service in an amount, duration, or score that is less than requested must be determined by a healthcare professional having appropriate clinical expertise to make such a decision. (42 C.F.R. § 438.210(b)(3)).

11.3.4.3 A decision to deny inpatient mental health care must be made by a psychiatrist, Doctoral-level clinical psychologist (Psy.D., Ph.D.), or another healthcare professional at the Doctoral-level (Ph.D., M.D.).

11.3.4.4 The Contractor shall submit to HCA a list of providers who are authorized to make denials of inpatient mental health care. For non-psychiatric MDs, the contractor will verify that Behavioral Health InterQual training has been provided and that mental health consultation is available.

11.3.4.5 The Contractor shall notify the requesting provider, and give the enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the following requirements, except that the notice to the provider need not be in writing (42 C.F.R. § 438.210(c) and 438.404):

11.3.4.5.1 The notice to the enrollee shall be in writing and shall meet the requirements of the, Information Requirements for Enrollees and Potential Enrollees, provisions of the Marketing and Information Requirements Section, of this Contract to ensure ease of understanding.

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

11.3.4.5.2.1 The action the Contractor has taken or intends to take.

11.3.4.5.2.2 The reasons for the action, in easily understood language.

11.3.4.5.2.3 The enrollee and providers right to request and receive free of charge a copy of the rule, guideline, protocol or other criterion that was the basis for the decision.

11.3.4.5.2.4 A statement whether or not an enrollee has any liability for payment.

11.3.4.5.2.5 A toll free telephone number to call if the enrollee is billed for services.

11.3.4.5.2.6 The enrollee's right to file an appeal.

11.3.4.5.2.7 The availability of Washington’s designated ombudsman’s office as referenced in the Affordable Care Act (Public Law 111-148).

11.3.4.5.2.8 If services are denied as non-covered, inform enrollees how to access the Contractor's Exception to Rule or Limitation Extension process.

11.3.4.5.2.9 The procedures for exercising the enrollee's rights.

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

11.3.4.5.4 The enrollee's rights to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay for these services.

11.3.4.5.5 In denying services and notices to enrollees, the Contractor will only deny a service as non-covered if HCA has determined that the service is non-covered under the fee-for-service program. For services that are excluded from this Contract, but are covered by HCA, the Contractor will direct the enrollee to those services and coordinate receipt of those services.

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

11.3.5.1 For denial of payment that may result in payment liability for the enrollee, at the time of any action affecting the claim.

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

11.3.5.3 For standard authorization, determinations are to be made within five (5) calendar days of the receipt of necessary information, but may not exceed fourteen (14) calendar days following receipt of the request for services (42 C.F.R. § 438.210(d)(1) and WAC 284-43-410).

11.3.5.3.1 Beyond the fourteen (14) calendar day period, a possible extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances (42 C.F.R. § 438.210(d)(1)(i-ii)):

11.3.5.3.1.1 The enrollee or the provider requests extensions;

11.3.5.3.1.2 The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest; or

11.3.5.3.1.3 If the Contractor extends that timeframe, it shall (42 C.F.R. § 438.210(d)(4) give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and issue and carry out

its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

11.3.5.4 For standard authorization decisions, notification of the decision shall be made to the attending physician, ordering provider, facility and enrollee within two (2) business days (PBOR, WAC 284-43-410).

11.3.5.5 For cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires. If the lack of treatment may result in an emergency visit or emergency admission the decision must be made no later than twenty-four (24) hours after receipt of the request for service. For all other urgent requests for service the decision must be made within forty-eight (48) hours. The Contractor may extend the time period by up to fourteen (14) calendar days under the following circumstances (42 C.F.R. § 438.210(d)(2)):

11.3.5.5.1 The enrollee requests the extension; or

11.3.5.5.2 The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

11.3.5.6 For all adverse determinations, the Contractor must notify the ordering provider, facility, and the enrollee. The Contractor must inform the parties, other than the enrollee, in advance whether it will provide notification by phone, mail, fax, or other means. The Contractor must notify the enrollee in writing of the decision. For an adverse authorization decisions involving an expedited authorization request the Contractor may initially provide notice orally. For all adverse authorization decisions, the Contractor shall provide written notification within seventy-two (72) hours of the decision. (PBOR, WAC 284-43-410).

11.3.5.6.1 The Contractor shall give notice at least five (5) calendar days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services when enrollee fraud has been verified.

11.3.5.7 The Contractor shall provide notification in accord with the timeframes described in Subsection 11.3.5.2 in the following circumstances:

11.3.5.7.1 The enrollee dies;

11.3.5.7.2 The Contractor has a signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services (where the enrollee understands that termination, reduction or suspension of services is the result of supplying this information;

11.3.5.7.3 The enrollee is admitted to an institution where he or she is ineligible for services;

11.3.5.7.4 The enrollee's address is unknown and mail directed to him or her has no forwarding address;

11.3.5.7.5 The enrollee has moved out of the Contractor's service area;

11.3.5.7.6 The enrollee's PCP prescribes the change in the level of medical care;

11.3.5.7.7 An adverse determination made with regard to the preadmission screening for nursing facility was made by Home and Community Services;

11.3.5.7.8 The safety or health of individuals in the nursing facility would be endangered, the enrollee's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the enrollee's urgent medical needs, or an enrollee has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse actions for nursing facility transfers).

11.4 Untimely Service Authorization Decisions

When the Contractor does not reach service authorization decisions within the timeframes for either standard or expedited service authorizations it is considered a denial and thus, an adverse action.

11.5 Experimental and Investigational Services for Managed Care Enrollees

11.5.1 In determining whether a service that the Contractor considers experimental or investigational is medically necessary for an individual enrollee, the Contractor must have and follow policies and procedures that mirror the process for HCA's medical necessity determinations for its fee-for-service program described in WAC 182-501-0165. Medical necessity decisions are to be made by a qualified healthcare professional and must be made for an individual enrollee based on that enrollee's health condition. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to HCA upon request.

11.5.2 Criteria to determine whether an experimental or investigational service is medically necessary shall be no more stringent for Medicaid enrollees than that applied to any other members.

11.5.3 An adverse determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, hearing process and independent review in accordance with Section 13 of this Contract.

11.6 Compliance with Office of the Insurance Commissioner Regulations

The Contractor shall comply with all Office of the Insurance Commissioner (OIC) regulations regarding utilization management and authorization of services unless those regulations are in direct conflict with Federal regulations. Where it is necessary to harmonize Federal and state regulations, HCA will direct such harmonization. If an OIC regulation changes during the Period of Performance of this Contract, HCA will determine whether and when to apply the regulation.

12 PROGRAM INTEGRITY

12.1 General Requirements

12.1.1 The Contractor shall have policies and procedures that guide and require the Contractor's and the Contractor's officers, employees, agents and subcontractors compliance with the requirements of this section.

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

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

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

12.1.3.2 42 C.F.R. § 438.610

12.1.3.3 42 C.F.R. § 455

12.1.3.4 42 C.F.R. § 1000 through 1008

12.2 **Program Integrity**

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

12.2.1 The Contractor shall have a staff person dedicated to working collaboratively with HCA on program integrity issues. This will include the following:

12.2.1.1 Participation in MCO-specific, quarterly program integrity meetings with HCA following the submission of the quarterly allegation log defined in Subsection 12.7, Reporting. Discussion at these meetings shall include case development and monitoring.

12.2.1.2 Participation in a bi-annual Contractor-wide forum to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned.

12.2.1.3 Quality control and review of encounter data submitted to HCA.

12.2.2 The Contractor shall work with HCA to perform individual and corporate extrapolation audits of the Contractor's provider billings. This may include audits against all State-funded claims including Medicaid, CHIP, Basic Health Plan, and state employee health plans.

12.3 **Disclosure by Managed Care Organization: Information on Ownership and Control**

12.3.1 The Contractor must provide the following disclosures (42 C.F.R. § 455.104):

12.3.1.1 The name and address of any person (individual or corporation) that has 5% or more ownership or control interest in the managed care organization. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

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

12.3.1.3 Other tax identification number (in the case of a corporation) with an ownership or

control interest in the managed care organization or in any subcontractor in which the managed care organization has a five percent (5%) or more interest.

12.3.2 Whether the person (individual or corporation) with an ownership or control interest in the managed care organization is related to another person with ownership or control interest in the managed care organization as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care organization has a 5 percent or more interest is related to another person with ownership or control interest in the managed care organization as a spouse, parent, child, or sibling.

12.3.3 The name of any other managed care organization in which an owner of the managed care organization has an ownership or control interest.

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

12.3.5 Disclosures from the managed care entity are due at any of the following times:

12.3.5.1 Upon the managed care organization submitting the proposal in accordance with HCA’s procurement process.

12.3.5.2 Upon the managed care entity executing the Contract with HCA.

12.3.5.3 Upon renewal or extension of the Contract.

12.3.5.4 Within thirty-five (35) calendar days after any change in ownership of the managed care entity.

12.3.5.5 Upon request by HCA.

12.4 **Fraud and Abuse**

The Contractor’s Fraud and Abuse program shall have:

12.4.1 A process to inform officers, employees, agents and subcontractors regarding the False Claims Act.

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

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

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

12.4.5 Effective training for all affected parties.

12.4.6 Effective lines of communication between the compliance officer and the Contractor’s staff and subcontractors.

12.4.7 Enforcement of standards through well-publicized disciplinary guidelines.

12.4.8 Provision for internal monitoring and auditing.

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

12.4.10 Provision of detailed information to employees and subcontractors regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(68) of the Social Security Act.

12.4.11 Provision for full cooperation with any federal, HCA or Attorney General Medicaid Fraud Control Unit (MFCU) investigation including promptly supplying all data and information requested for the investigation.

12.4.12 Verification that services billed by providers were actually provided to enrollees. The Contractor may use explanation of benefits (EOB) for such verification only if the Contractor suppresses EOBs that would be a violation of enrollee confidentiality requirements for women's healthcare, family planning, and behavioral health services (42 C.F.R. § 455.20).

12.5 **Provider Payment Suspensions**

The Contractor shall establish policies and procedures for suspending a provider's payments when HCA determines a credible allegation of fraud exists and there is a pending investigation (42 C.F.R. § 455.23).

12.5.1 When the Contractor's investigation indicates a potentially credible allegation of fraud, the Contractor shall make a fraud referral to HCA within five (5) business days of the determination. The referral must:

12.5.1.1 Indicate whether the provider is subcontracted with the Contractor;

12.5.1.2 Indicate whether a good cause exception is requested and the grounds for the exception; and

12.5.1.3 Include a recommendation of whether or not a payment suspension should occur, in whole or part.

12.5.2 If HCA confirms there is a credible allegation of fraud, HCA shall make a referral to the Medicaid Fraud Control Unit (MFCU). If the MFCU accepts the allegation for investigation, HCA shall notify the Contractor's compliance officers within two (2) business days of MFCU's acceptance notification, along with a directive to suspend payment to the affected provider(s). HCA shall notify the Contractor if the MFCU or other law enforcement agency declines to accept the fraud referral for investigation.

12.5.3 Upon receipt of notification from HCA, the Contractor shall send notice of the decision to suspend program payments to the provider within the following timeframes:

12.5.3.1 Within five (5) calendar days of taking such action unless requested in writing by HCA, the Medicaid Fraud Control Unit (MFCU), or law enforcement agency to temporarily withhold such notice.

12.5.3.2 Within thirty (30) calendar days if requested by HCA, MFCU, or law enforcement in writing to delay sending such notice. The request for delay may be renewed in writing no more than twice and in no event may the delay exceed ninety (90) calendar days.

12.5.4 The notice must include or address all of the following (42 C.F.R. § 455.23(2):

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

12.5.4.2 Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation;

12.5.4.3 State that the suspension is for a temporary period and cite the circumstances under which the suspension will be lifted;

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

12.5.4.5 Where applicable and appropriate, Inform the provider of any appeal rights available to this provider, along with the provider's right to submit written evidence for consideration by the Contractor.

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

12.5.5.1 HCA determines that there is insufficient evidence of fraud by the provider; or

12.5.5.2 Legal proceedings related to the provider's alleged fraud are completed and the allegation of fraud was not upheld.

12.5.6 The Contractor must document in writing the termination of a suspension.

12.5.7 The Contractor and/or HCA may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

12.5.7.1 Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

12.5.7.2 Other available remedies are implemented by the Contractor, after HCA approves remedy, that more effectively or quickly protect Medicaid funds.

12.5.7.3 The Contractor determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, there is no longer a credible allegation of fraud and that the suspension should be removed. The Contractor shall review evidence submitted by the provider and submit it with a recommendation to HCA. HCA shall direct the Contractor to continue, reduce or remove the payment suspension within thirty (30) calendar days of having received the evidence.

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

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

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

12.5.7.5 Law enforcement declines to certify that a matter continues to be under investigation.

12.5.7.6 HCA determines that payment suspension is not in the best interests of the Medicaid program.

12.5.8 The Contractor shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

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

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

12.5.9 If the Contractor fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of fraud without good cause, and HCA directed the Contractor to suspend payments, HCA may impose sanctions in accord with Subsection 5.14 of this Contract.

12.6 **Excluded Individuals and Entities**

The Contractor is prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction or on the prescription of an excluded person (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 C.F.R. § 455.104, 42 C.F.R. § 455.106, and 42 C.F.R. § 1001.1901(b)).

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

12.6.1.1 Screening Contractor and subcontractor individuals and entities with an ownership or control interest during the initial provider application, credentialing and recredentialing processes and prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract and payable by a federal health care program.

12.6.1.2 Screening individuals during the initial provider application, credentialing and recredentialing process and before entering into a contractual or other relationship where the individual would benefit directly or indirectly from funds received under this Contract or payable by a federal health care program.

12.6.1.3 Screening monthly all Contractor and subcontractor individuals and entities with an ownership or control interest and individuals that would benefit from funds received under this Contract for newly added excluded individuals and entities.

12.6.2 The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

12.6.3 The Contractor shall immediately terminate any employment, contractual and control relationships with any excluded individual or entity discovered during its provider screening processes, including the provider application, credentialing and recredentialing, and shall report these individuals and entities within ten (10) business days of discovery.

12.6.4 Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees. (SSA section 1128A(a)(6) and 42 C.F.R. § 1003.102(a)(2)).

12.6.5 An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 C.F.R. § 455.104(a), and 42 C.F.R. § 1001.1001(a)(1)).

12.6.6 In addition, if HCA notifies the Contractor that an individual or entity is excluded from participation by HCA, the Contractor shall terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately (WAC 182-502-0030).

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

12.7 **Reporting**

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

12.7.2 Quarterly Allegation Log: On a quarterly basis (first week of April, July, October, and January) the Contractor shall submit to HCA in a format determined by HCA, a report of all allegations of fraud received and reviewed by the Contractor during the previous quarter. The report shall include:

12.7.2.1 All cases being actively pursued by the Contractor;

12.7.2.2 All cases that did not warrant opening a case for investigation; and

12.7.2.3 All allegations that were reported to the Office of the Attorney General

12.7.3 The report required by subsection 12.7.2 of this section shall contain the following information for each case, submitted on a template provided by HCA:

12.7.3.1 Date complaint or referral received;

12.7.3.2 Date the complaint was opened as a case;

12.7.3.3 Last date case was updated with additional information;

12.7.3.4 Subject(s) of complaint by name and provider/subcontractor type, member or employee position;

12.7.3.5 Source of complaint (i.e., provider/subcontractor type, member, employee, vendor, hotline call, etc.), if applicable;

12.7.3.6 Nature of complaint;

12.7.3.7 Estimate of the amount of funds involved;

12.7.3.8 Legal and administrative disposition of the case; and

12.7.3.9 If actual recoveries were made by the Contractor as the result of the investigation.

12.7.4 On a quarterly basis, the Contractor shall submit to HCA, on an HCA generated reporting format, a report of any recoveries made by the Contractor during the course of its claims review/analysis.

12.7.5 On an annual basis, the Contractor shall report to HCA summary information on each of the following:

12.7.5.1 Suspension of payment, including the nature of the suspected fraud, the basis for suspension, any known progress on the investigation, date the suspension was implemented, the outcome of the suspension, and total amount being withheld, if any, from the provider.

12.7.5.2 Situations in which the Contractor determined good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.

12.7.5.3 The Contractor is responsible for investigating enrollee fraud, waste and abuse. The Contractor shall provide a report of initial allegations, investigations and resolutions of enrollee fraud, waste and abuse to HCA during the annual monitoring review.

12.7.6 The Contractor shall notify the Washington State Department of Social and Health Services (DSHS) Office of Fraud and Accountability (OFA) of any cases in which the Contractor believes there a serious likelihood of enrollee fraud by:

12.7.6.1 Calling the Welfare Fraud Hotline at 1-80-562-6906 and pressing option”1” to report Welfare Fraud by leaving a detailed voice mail message;

12.7.6.2 Mailing a written complaint to:

Welfare Fraud Hotline
P.O. Box 45817
Olympia, WA 98504-5817

12.7.6.3 Entering the complaint online at:
https://fortress.wa.gov/dshs/dshsroot/fraud/index.asp;

12.7.6.4 Faxing the written complaint to Attention Hotline at 360-664-0032; OR

12.7.6.5 Emailing the compliant electronically to the DSHS OFA Hotline at Hotline@dshs.wa.gov.

12.7.7 The Contractor shall report in writing to HCA all potentially credible cases of fraud within thirty (30) calendar days of the date the Contractor first becomes aware of the allegation. The Contractor may request an additional thirty (30) calendar days to complete the investigation if

the Contractor determines the case is potentially credible. The request must be in writing and sent to HotTips@hca.wa.gov with a copy to the managed care mail box (hcamcprograms@hca.wa.gov). The report must include the following information:

12.7.7.1 Subject(s) of compliant by name and either provider/subcontractor type or employee position;

12.7.7.2 Source of compliant by name and provider/subcontractor type or employee position, if applicable;

12.7.7.3 Nature of Complaint;

12.7.7.4 Estimate of the amount of funds involved;

12.7.7.5 Legal and administrative disposition of case.

12.7.8 Any excluded individuals and entities discovered in the screening, including the provider application, credentialing and recredentialing processes, within ten (10) business days of discovery.

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

12.7.9.1 The ownership of any subcontractor with whom the Contractor or subcontractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

12.7.9.2 Any significant business transactions between the Contractor or subcontractor and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

13 GRIEVANCE SYSTEM

Access to the Grievance System: Enrollees may access the grievance process related to services determined by the Contractor to be a Medicaid only benefit or services determined by the Contractor to be under both Medicare and Medicaid in accordance with applicable federal and state laws and regulations. If Enrollee elects to use the Medicaid appeal process, the Contractor must abide by the process as follows.

13.1 General Requirements

The Contractor shall have a grievance system which complies with the requirements of 42 C.F.R. § 438 Subpart F and Chapters 182-538, 182-526, and 284-43 WAC, insofar as those WACs are not in conflict with 42 C.F.R. § 438 Subpart F. The grievance system shall include a grievance process, an appeal process, and access to the hearing process. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

13.1.1 The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Contract. HCA must approve, in writing, all grievance system policies and procedures and related notices to enrollees regarding the grievance system.

13.1.2 The Contractor shall give enrollees any assistance necessary in completing forms and other procedural steps for grievances and appeals (42 C.F.R. § 438.406(a)(1) and WAC 284-43-615(2)(e)).

13.1.3 The Contractor shall acknowledge receipt of each grievance, either orally or in writing, within two (2) business days and appeals, in writing, within seventy-two (72) hours (42 C.F.R. § 438.406(a)(2) and (WAC 284-43-620).

13.1.4 The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making (42 C.F.R. § 438.406(a)(3)(i)).

13.1.5 Decisions regarding grievances and appeals shall be made by health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply (42 C.F.R. § 438.406(a)(3)(ii)):

13.1.5.1 If the enrollee is appealing an action concerning medical necessity.

13.1.5.2 If an enrollee grievance concerns a denial of expedited resolution of an appeal.

13.1.5.3 If the grievance or appeal involves any clinical issues.

13.2 **Grievance Process**

The following requirements are specific to the grievance process:

13.2.1 Only an enrollee or the enrollee's authorized representative may file a grievance with the Contractor; a provider may not file a grievance on behalf of an enrollee (42 C.F.R. § 438.402(b)(3)) unless the provider is acting on behalf of the enrollee and with the enrollee's written consent.

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

13.2.3 The Contractor shall assist the enrollee with all grievance and appeal processes (WAC 284-43-615(2)(d)).

13.2.4 The Contractor shall cooperate with any representative authorized in writing by the covered enrollee (WAC 284-43-615(2)(e)).

13.2.5 The Contractor shall consider all information submitted by the covered person or representative (WAC 284-43-615(2)(f).

13.2.6 The Contractor shall investigate and resolve all grievances whether received orally or in writing (WAC 284-43-615(2)(g)). The Contractor shall not require an enrollee or his/her authorized representative to provide written follow-up for a grievance or appeal the Contractor received orally.

13.2.7 The Contractor shall complete the disposition of a grievance and notice to the affected parties as expeditiously as the enrollees health condition requires, but no later than forty-five (45) calendar days from receipt of the grievance.

13.2.8 The Contractor shall provide information on the covered person's right to obtain a second opinion (WAC 284-43-615(2(h)).

13.2.9 The Contractor must notify enrollees of the disposition of grievances within five (5) business days of determination. The notification may be orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

13.2.10 Enrollees do not have the right to a hearing in regard to the disposition of a grievance.

13.3 **Appeal Process**

The following requirements are specific to the appeal process:

13.3.1 An enrollee, the enrollee's authorized representative, or a provider acting on behalf of the enrollee and with the enrollee's written consent, may appeal a Contractor action (42 C.F.R. § 438.402(b)(1)(ii)).

13.3.2 If HCA receives a request to appeal an action of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the enrollee.

13.3.3 For appeals of standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety (90) calendar days of the date on the Contractor's notice of action. This also applies to an enrollee's request for an expedited appeal (42 C.F.R. § 438.402(b)(2) and WAC 182-538-110).

13.3.4 For appeals for termination, suspension, or reduction of previously authorized services when the enrollee requests continuation of such services, an enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the notice of action. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for appeals of standard resolution apply (42 C.F.R. § 438.420 and WAC 182-538-110).

13.3.5 Oral inquiries seeking to appeal an action shall be treated as appeals and be confirmed in writing, unless the enrollee or provider requests an expedited resolution (42 C.F.R. § 438.406(b)(1)). The appeal acknowledgement letter sent by the MCO to an enrollee shall serve as written confirmation of an appeal filed orally by an enrollee.

13.3.6 The appeal process shall provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the enrollee of the limited time available for this in the case of expedited resolution (42 C.F.R. § 438.406(b)(2)).

13.3.7 The appeal process shall provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process (42 C.F.R. § 438.406(b)(3)).

13.3.8 The appeal process shall include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate (42 C.F.R. § 438.406(b)(4)).

13.3.9 The Contractor shall resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following timeframes (42 C.F.R. § 438.408(b)(2)-(3)):

13.3.9.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the appeal, unless the Contractor notifies the enrollee that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty (30) calendar days of the request for appeal, without the informed written consent of the enrollee. In all circumstances the appeal determination must not be extended beyond forty-five (45) calendar days from the day the Contractor receives the appeal request.

13.3.9.2 For expedited resolution of appeals, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the appeal.

13.3.10 The notice of the resolution of the appeal shall:

13.3.10.1 Be in writing. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice (42 C.F.R. § 438.408(d).

13.3.10.2 Include the date completed and reasons for the determination in easily understood language (42 C.F.R. § 438.408(e).

13.3.10.3 Include a written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the Utilization Management clinical review or decision-making criteria.

13.3.10.4 For appeals not resolved wholly in favor of the enrollee (42 C.F.R. § 438.408(e)(2)):

13.3.10.4.1 Include information on the enrollee's right to request a hearing and how to do so.

13.3.10.4.2 Include information on the enrollee's right to receive services while the hearing is pending and how to make the request.

13.3.10.4.3 Inform the enrollee that the enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending, if the hearing decision upholds the Contractor's action.

13.4 **Expedited Appeal Process**

13.4.1 The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines, for a request from the enrollee, or the provider indicates, in making the request on the enrollee's behalf or supporting the enrollee's request, that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function (42 C.F.R. § 438.410(a)).

13.4.2 The Contractor shall make a decision on the enrollee's request for expedited appeal and provide written notice, as expeditiously as the enrollee's health condition requires, within three (3) calendar days after the Contractor receives the appeal. (42 C.F.R. § 438.408(b)(3)). The Contractor shall also make reasonable efforts to provide oral notice.

13.4.3 The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal (42 C.F.R. § 438.410(b)).

13.4.4 If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice (42 C.F.R. § 438.410(c)).

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

13.5 **Administrative Hearing**

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

13.5.2 If an enrollee does not agree with the Contractor's resolution of the appeal, the enrollee may file a request for a hearing within the following time frames (see WAC 182-526-0200):

13.5.2.1 For hearings regarding a standard service, within ninety (90) calendar days of the date of the notice of the resolution of the appeal (42 C.F.R. § 438.402(b)(2)).

13.5.2.2 For hearings regarding termination, suspension, or reduction of a previously authorized service, if the enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for a hearing regarding a standard service apply (42 C.F.R. § 438.420).

13.5.3 If the enrollee requests a hearing, the Contractor shall provide to HCA and the enrollee, upon request, and within three (3) working days, all Contractor-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

13.5.4 The Contractor is an independent party and is responsible for its own representation in any hearing, independent review, Board of Appeals and subsequent judicial proceedings.

13.5.5 The Contractor's medical director or designee shall review all cases where a hearing is requested and any related appeals, when medical necessity is an issue.

13.5.6 The enrollee must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a hearing with HCA.

13.5.7 HCA will notify the Contractor of hearing determinations. The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision. Implementation of the final order shall not be the basis for termination of enrollment by the Contractor.

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

13.5.9 The hearings process shall include as parties to the hearing, the Contractor, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate and HCA.

13.6 Independent Review

After exhausting both the Contractor's appeal process and the administrative hearing, an enrollee has a right to request an independent review in accord with RCW 48.43.535, WAC 182-526-0200, and Chapter 284-43 WAC.

13.7 Petition for Review

Any party may appeal the initial order from the administrative hearing to HCA Board of Appeals in accord with Chapter 182-526 WAC. Notice of this right will be included in the Initial Order from the administrative hearing or the written decision of the Independent Review Organization.

13.8 Continuation of Services

13.8.1 The Contractor shall continue the enrollee's services if all of the following apply (42 C.F.R. § 438.420):

13.8.1.1 An appeal, hearing, or independent review is requested on or before the later of the following:

13.8.1.1.1 Within ten (10) calendar days of the Contractor mailing the notice of action, which for actions involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.

13.8.1.1.2 The intended effective date of the Contractor's proposed action.

13.8.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

13.8.1.3 The original period covered by the original authorization has not expired.

13.8.1.4 The enrollee requests an extension of services.

13.8.2 If, at the enrollee's request, the Contractor continues or reinstates the enrollee's services while the appeal, hearing, independent review or HCA Board of Appeals is pending, the services shall be continued until one of the following occurs (42 C.F.R. § 438.420 and WAC 182-526-0200 and WAC 182-538-110):

13.8.2.1 The enrollee withdraws the appeal, hearing, or independent review request.

13.8.2.2 Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the appeal and the enrollee has not requested a hearing (with continuation of services until the hearing decision is reached) within the ten (10) calendar days.

13.8.2.3 Ten (10) calendar days pass after HCA mails the initial hearing decision and the enrollee has not requested an independent review (with continuation of services until the independent review decision is reached) within the ten (10) calendar days.

13.8.2.4 Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the independent review and the enrollees has not requested a HCA Board of Appeals (with continuation of services until HCA Board of Appeals decision is reached) within ten (10) calendar days.

13.8.2.5 The time period or service limits of a previously authorized service has been met.

13.8.2.6 When a state hearing decision adverse to the enrollee is rendered such that benefits are terminated.

13.8.3 If the final resolution of the appeal upholds the Contractor's action, the Contractor may recover from the enrollee the amount paid for the services provided to the enrollee for the first sixty (60) calendar days during which the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

13.9 **Effect of Reversed Resolutions of Appeals and Hearings**

13.9.1 If the Contractor, or through a final order of the Office of Administrative Hearings (OAH) or Board of Appeals (BOA), or an independent review organization (IRO) reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the

Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires (42 C.F.R. § 438.424(a)).

13.9.2 If the Contractor, or through a final order of OAH or the Board of Appeals, or an IRO reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Contractor shall pay for those services. (42 C.F.R. § 438.424(b)).

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

The Contractor shall maintain records of all actions, grievances, appeals and independent reviews.

13.10.1 The records shall include actions, grievances and appeals handled by delegated entities.

13.10.2 The Contractor shall provide a report of all actions, grievances, appeals and independent reviews to HCA in accord with the Grievance System Reporting Requirements published by HCA.

13.10.3 The Contractor is responsible for maintenance of records for and reporting of any grievance, actions, and appeals handled by delegated entities.

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

13.10.5 Data shall be reported in HCA and Contractor agreed upon format. Reports that do not meet the Grievance System Reporting Requirements shall be returned to the Contractor for correction. Corrected reports will be resubmitted to HCA within 30 calendar days.

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

13.10.7 Reporting of actions shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers unless the enrollee is liable for payment in accord with WAC 182-502-0160 and the provisions of this Contract.

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

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

14 Care Coordination

The Contractor shall provide care coordination services that ensure integration of and access to preventive, primary, acute, post-acute, mental health, chemical dependency and long term care services into a well-coordinated system. In addition to coordinating the services covered by this contract, the Contractor shall coordinate contracted services with services enrollees receive from other care systems.

The Contractor's Care Coordination system shall:

- Ensure communication and coordination of an enrollee's care across network provider types and settings;

- Ensure smooth transitions for enrollees who move among various care settings and Medicaid programs; and

- Assist enrollees in maintaining program eligibility, within the limitations of available data. This includes collecting and reviewing all DSHS ACES system letters to monitor each enrollee's eligibility as well as any enrollee responsibility for payment toward the cost of their care. The Contractor shall assist enrollees to contact their Medicaid financial and social services workers as necessary to maintain Medicaid eligibility.

The Contractor shall provide each enrollee with a primary contact person who will assist the enrollee in accessing services and information. The system shall promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, and culturally appropriate care.

The Contractor shall ensure that all enrollees have access to a Chemical Dependency Professional (CDP) if the enrollee requests, or, if during the initial assessment it is determined that the enrollee needs the services. Referral to a certified and/or contracted CD agency is sufficient to meet this requirement.

14.1 **Continuity of Care**

The Contractor shall ensure Continuity of Care, as defined herein, for enrollees in an active course of treatment for a chronic or acute medical condition. The Contractor shall ensure that medically necessary care for enrollees is not interrupted and that transitions from one setting or level of care to another are promoted (42 C.F.R. § 438.208).

14.1.1 For changes in the Contractor's provider network or service areas, the Contractor shall comply with the notification requirements identified in the Service Area and Provider Network Changes provisions found in the Access to Care and Provider Network Section of this Contract.

14.1.2 If possible and reasonable, the Contractor shall preserve enrollee provider relationships through transitions.

14.1.3 Where preservation of provider relationships is not possible and reasonable, the Contractor shall provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the enrollee's medical condition requires.

14.1.4 The Contractor shall allow new enrollees with the Contractor to fill prescriptions written prior to enrollment until the first of the following occurs:

14.1.4.1 The enrollee's prescription expires.

14.1.4.2 A participating provider examines the enrollee to evaluate the continued need for the prescription. If the enrollee refuses an evaluation by a participating provider the Contractor may refuse to fill the prescription.

14.1.5 The following continuity of care requirements apply for all enrollments beginning January 1, 2014. The Contractor shall:

14.1.5.1 Continue, renew and fill all prescriptions held by the enrollee on the date of enrollment for ninety (90) calendar days or until a participating provider examines the enrollee to evaluate the enrollee's medication needs, whichever is later, and, if necessary, oversees medically appropriate changes that do not threaten the health of the enrollee. If the enrollee refuses an evaluation by a participating provider the Contractor may refuse to fill prescriptions until the enrollee is evaluated as long as the enrollee's safety is considered in the decision. In accord with the requirements of

pharmacists under RCW 69.41.190(3) the Contractor must approve payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medication

14.1.5.2 Allow enrollees to continue to receive care from non-participating providers with whom an enrollee has documented established relationships. The Contractor shall take the following steps:

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

14.1.5.2.2 If transition is necessary, the Contractor shall facilitate collaboration between the established non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care.

14.1.5.2.3 If the established non-participating provider or the enrollee will not cooperate with a necessary transition, the Contractor may transfer the enrollee's care to a participating provider within ninety (90) calendar days of the enrollee's enrollment effective date.

14.1.5.2.4 The Contractor may choose to pay the established non-participating provider indefinitely to provide care to the enrollee if the non-participating provider will accept payment rates the Contractor has established for non-participating providers as payment in full.

14.1.5.2.5 The Contractor shall apply utilization management decision-making standards no more stringent than standards for participating providers.

14.2 **Screening**

14.2.1 Initial Health Screen (IHS): The Contractor shall conduct an initial, brief health screen containing behavioral, developmental and physical health questions within sixty (60) calendar days of enrollment for all new enrollees including reconnects.

14.2.1.1 To assist in the screening process, the Contractor may review administrative data, such as PRISM, diagnoses of chronic conditions, indicators of potential for high risk pregnancy, social complexity (history of homelessness, language barriers, substance use disorder or chronic mental health conditions, domestic violence or arrests), enrollees with unmet care needs or evidence of being underserved or through enrollee responses to Contractor interviews or surveys.

14.2.1.2 The Contractor shall make at least three (3) reasonable attempts on different days and times of day to contact an enrollee to complete the IHS and document these attempts. This information shall be considered evidence of meeting the three contacts requirement.

14.2.2 If the Contractor's contact information for the enrollee is incorrect, the Contractor shall maintain documentation evidencing its attempt to obtain correct information.

14.2.3 The Contractor shall document the results of the screening and, based on the results of the initial screening, the Contractor conduct an Initial Health Assessment (IHA within sixty (60) calendar days of the identification of special needs or IHS that indicates the need for care coordination. The assessment shall determine ongoing need for care coordination services and the need for clinical and non-clinical services, including referrals to specialists and community

resources.

14.2.3.1 The assessment shall be based on medical necessity and take into account the client's goals and preferences. If the assessment determines that the enrollee needs services covered under this Contract, the Contractor shall ensure coordination of referrals to the appropriate provider. If the service is covered by DSHS or HCA on a fee for service basis, the Contractor shall coordinate with appropriate service provider to ensure the enrollee receives the needed service. If the Contractor is unable to conduct the assessment, the Contractor shall document efforts to do so in the enrollee's file.

14.2.3.2 The assessment shall include, at minimum, an evaluation of the enrollee's physical and behavioral health status, health services history, including receipt of preventive care services, current medications, and an evaluation of the need for or use of supportive services and resources, such as those described in the Coordination of Care provisions of this Contract.

14.2.3.3 The primary care provider and care coordinator shall ensure that arrangements are made for follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or substance use disorder providers.

14.2.3.4 The IHA shall be maintained in the enrollees' medical record and in the Contractor's care coordination file and available during subsequent preventive health visits.

14.2.4 The Contractor shall establish business rules regarding screening, referral and co-management of individuals with both behavioral health and physical health conditions. Both behavioral health and physical health care managers or Disease Management coaches will be trained on the protocols.

14.2.5 Client records for enrollees who screen as high risk for chemical dependency and are referred for a chemical dependency assessment shall reflect that the referral was made and the reasons for making the referral for an assessment. Client records for enrollees who have screened as high risk for chemical dependency but are not referred for a chemical dependency assessment shall reflect the reason that the referral for chemical dependency services was not made.

14.3 **Integrated Care Plan**:

The Contractor shall develop an Integrated Care Plan (ICP) based on issues or needs identified by the initial assessment, medical records and/or prior utilization data to the extent they are available, enrollee and/or family input, PCP input if the enrollee has a PCP, along with other appropriate health care professionals the enrollee may be seeing. If the enrollee does not have a PCP, the Contractor shall assist the enrollee in finding one.

The ICP shall incorporate an interdisciplinary/holistic and preventive focus, address any barriers to care and accommodate the specific cultural and linguistic needs of the enrollee. For enrollees who have been assessed to have mental health needs, the Contractor shall incorporate portions of the mental health treatment plan from the treating provider into the ICP as needed. The Contractor shall ensure that the enrollee's plan is updated based on periodic assessments, information received by DSHS case managers who work with the enrollee, or information received by one or more of the enrollee's providers.

14.3.1 The ICP must include, at a minimum:

14.3.1.1 Enrollee self-management goals.

14.3.1.2 Short- and long-term treatment goals, identification of barriers to meeting goals.

14.3.1.3 Identification of barriers to achieving self-management goals and how these were addressed.

14.3.1.4 Time schedule for follow-up treatment and communication with the enrollee.

14.3.1.5 Clinical and non-clinical services accessed by the enrollee or recommended by the primary care provider or care manager.

14.3.1.6 Integration and coordination of clinical and non-clinical services, including follow-up to ensure services are accessed (42 C.F.R. § 438.208(c)(2)).

14.3.1.7 Modifications as needed to address emerging needs of the enrollee.

14.3.1.8 Progress or reason for lack of progress on self-management goals.

14.3.1.9 Communication with primary and specialty care providers including mental health and substance use disorder providers.

14.3.2 The Contractor shall ensure provision of care coordination services including assistance with accessing needed mental health, substance use disorder, physical health services or community resources.

14.3.2.1 Care coordinators shall monitor, provide education, and facilitate and encourage adherence to recommended treatment. Nothing in this requirement should be construed to limit in any way the enrollee's right to refuse treatment.

14.3.2.2 ICP initiation/updates, screening assessment scores and interpretation and recommendations for improved care coordination and additional services needed. Chemical Dependency will be included only if a signed Release of Information (ROI) from the enrollee is on file with the Contractor. The Contractor shall work with the enrollee's providers to ensure that they are aware of changes in the enrollee's health condition. The Contractor shall coordinate its assessment with required assessments conducted by DSHS staff.

14.3.2.3 Enrollees determined to have mental health needs will be provided access to an intake evaluation by a Mental Health Professional (MHP). The Contractor shall also ensure reassessment at a minimum of every 180 days for enrollees with mental health needs, annually for enrollees receiving Long Term Care services, or as determined necessary by a significant change in the enrollee's condition. The reassessment will include an evaluation of supports and services, based on the Enrollee's strengths, needs, choices, and preferences for care.

14.3.3 Care Coordination staff shall:

14.3.3.1 Have authority to approve referrals and request for services and equipment within the care plan.

14.3.3.2 Provide the enrollee with information about advance directives and assist the enrollee in advance directive planning if the enrollee requests, based on enrollee needs and cultural considerations. The Contractor shall initiate discussion with the enrollee and/or the enrollee's family or guardian when the lack of a documented advance directive is identified through the assessment process. The advance directive or a record of the enrollee's refusal of assistance shall be kept on file in the enrollee's case management record.

14.3.3.2.1 Arrange and coordinate the provision of supports and services identified in the enrollee's care plan, including the early intervention services and preventive care, skilled specialty services and community-based services.

14.3.3.2.2 Assist the enrollee and his or her family or legal representatives, if any, to maximize informed choices of services and control over services and supports.

14.3.3.2.3 Monitor the enrollee's progress toward achieving the outcomes identified in the enrollee's care plan on a regular basis, in order to evaluate and adjust the timeliness and adequacy of services.

14.3.3.2.4 Coordinate with DSHS and local agency case managers, financial workers and other staff. This includes developing working agreements with DSHS, Division of Vocational Rehabilitation (DVR) local offices to coordinate supported employment activities for enrollees receiving mental health benefits.

14.3.3.2.5 Communicate on an ongoing basis, with the enrollee and with other individuals participating in the enrollee's care plan.

14.3.3.2.6 Educate and communicate with the enrollee about good health care practices and behaviors.

14.3.3.2.7 Have knowledge of basic enrollee protection requirements, including data privacy.

14.3.3.2.8 Inform, educate, and assist the enrollee in identifying available service provider and accessing needed resources and services, including those that are beyond the limitations of this Contract.

14.3.3.3 The Contractor shall ensure access to a toll free line to primary care providers and other health care specialists to call for technical assistance when behavioral health or developmental delays are suspected or identified. Available information shall include assistance in arranging for exams and treatment by providers with appropriate expertise and experience in behavioral health/substance use disorders and/or developmental issues.

14.4 **Integrated Case Management**

The Contractor shall provide enrollees with Integrated Case Management, whereby WMIP staff work with enrollees to address the underlying principles of disease management (treatment and prescription adherence, self-management, self-efficacy, prevention, etc.). Staff will also provide disease specific education, both verbally and through printed materials that are appropriate for the WMIP population. All diseases will be addressed, but the following diseases will be emphasized: Mental Illness, Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD) and Substance Abuse.

14.5 **Long-Term Care**

For enrollees who have been determined eligible for Long-Term Care services by the Aging and Long-Term Support Administration/Area Agency on Aging (ALTSA/AAA), the Contractor shall provide the following:

14.5.1 An initial screening and assessment within thirty (30) days of the enrollee's enrollment into the WMIP, OR determination of eligibility for long term care services. The assessment provided to long term care-eligible enrollees shall include all the components described in Section 14.4.2.2 and must be face-to-face assessment unless the Contractor can document that all efforts to provide the assessment on a face-to-face assessment within the 30 day timeframe failed. DSHS shall provide assistance to the Contractor in locating and/or contacting the enrollee if the Contractor is unable to locate the enrollee. Once the client is located the assessment must be completed.

14.5.1.1 The initial screen shall include:

14.5.1.1.1 A screening for dementia using the Contractor's Department-approved dementia screening tool. The Contractor shall document in the enrollee's care plan the steps taken once an enrollee is found to have a positive dementia screening result.

14.5.1.1.2 A screening for risk of falls using the Contractor's Department-approved falls screening tool. The Contractor shall document in the enrollee's care plan the steps taken once the enrollee is found to have fallen and/or to be at risk of falls.

14.5.1.1.3 Assessment for risk of skin breakdown. If risk factors are met, completion of the DSHS-approved Skin Observation Protocol or other nationally recognized tool.

14.5.1.1.4 A Functional Status Assessment and creation of a unique client-centered service plan, approved by the enrollee, at initial enrollment and thereafter at least annually or when there is a significant change in the enrollee's condition.

14.5.1.1.5 The Contractor shall offer at least the number of personal care hours authorized in the CARE assessment or a significant change review completed by the Home and Community Services/Area Agency on Aging (HCS/AAA) or the Developmental Disabilities Administration (DDA), including any approved Exceptions to Policy, unless the enrollee chooses an alternative proposed by the Contractor. The enrollee's choice must be documented in writing in the enrollee's file and must include the enrollee's signature or that of the enrollee's authorized representative.

14.5.1.2 The Contractor shall:

14.5.1.2.1 Assist enrollees in providing the necessary information to allow Home and Community Services financial staff to determine if the enrollee is eligible for a Medical Institutional Income Exemption (MIIE). The MIIE provides money for rent or bills to keep an enrollee's residence if the enrollee is admitted to a nursing or other residential facility for a short period of time;

14.5.1.2.2 Ensure Pre-Admission Screening and Resident Reviews (PASRR) are completed prior to all nursing facility admissions for WMIP enrollees. The PASRR determines whether the nursing facility can appropriately manage the enrollee being admitted; and

14.5.1.2.3 Notify DSHS, HCS/AAA/DDA staff when the Contractor's staff becomes aware of enrollee address changes, income or asset changes, and moves from one living environment to another. DSHS shall make every effort to notify the Contractor when these changes are discovered or reported to DSHS or AAA staff.

14.5.1.3 Both DSHS and the Contractor shall make every effort to notify the other party when either party discovers that an enrollee who is receiving LTC services through the WMIP ends enrollment from the program for any reason. DSHS and the Contractor shall coordinate to ensure continuity of care in the enrollee's LTC services.

14.6 **Transitional Care**

The Contractor shall ensure that transitional care services described in this section are provided to all enrollees who are transitioning from one setting to another. The Contractor shall develop written operational agreements with State and community physical and behavioral health hospitals, Regional Support Networks, long-term care facilities and inpatient and outpatient substance use disorder treatment programs to facilitate enrollee care transitions. The written agreements shall define the responsibility of each party in meeting the following requirements:

14.6.1 Completion of a standardized discharge screening tool. The tool shall encompass a risk assessment for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism.

14.6.2 Enrollee permission to share information with clinical and non-clinical providers to facilitate care transitions.

14.6.3 An individual enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include:

14.6.3.1 Enrollee education that supports discharge care needs including medication management, purchase of services or equipment that support independence, interventions to ensure follow-up appointments are attended and follow-up for self-management of the enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Formal or informal caregivers shall be included in this process when requested by the enrollee;

14.6.3.2 Written discharge plan provided to both the enrollee and the primary care provider at enrollee discharge;

14.6.3.3 Systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage enrollees that do not receive post discharge care;

14.6.3.4 Scheduled follow-up appointments at enrollee discharge;

14.6.3.5 Organized post-discharge services, such as home care services, social services, after-treatment services and therapy services;

14.6.3.6 Telephonic or face-to-face meetings to reinforce of the discharge plan and problem-solving two (2) to three (3) business days following enrollee discharge;

14.6.3.7 Information on what to do if a problem arises following discharge;

14.6.3.8 For enrollees at high risk of re-hospitalization, a visit by a Contractor designee at the facility before discharge to coordinate transition;

14.6.3.9 For enrollees at high risk of re-hospitalization, primary care provider or Contractor designee visit at the enrollee's residence or secondary facility, such as a skilled nursing facility or residential mental health facility within seven (7) calendar days post-discharge to support: discharge instructions, assess the environment for safety issues, conduct medication reconciliation, assess adequacy of support network and services, and linkage of the enrollee to appropriate referrals;

14.6.3.10 Scheduled outpatient mental health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge; and

14.6.3.11 Planning and follow up that actively includes the patient and family caregivers and support network in assessing needs.

14.7 **Coordination with State Hospital re: Discharge and Planning**

14.7.1 Work with staff at Western State Hospital and BHSIA for discharge planning, coordination of care and treatment planning and hospital census alerts. The Contractor shall submit a copy of policies and procedures to the DSHS BHSIA program manager for review and approval prior to final execution.

14.7.1.1 Respond to state hospital census alerts by working with hospital staff and community providers to ensure the availability of services using alternative community resources and other covered mental health services.

14.7.1.2 Ensure that contact with the state hospital occurs within three working days of notification for all enrollee admissions and provide the hospital with all available information regarding the enrollee's case, including intake documentation, case notes, and all known healthcare benefits.

14.7.1.3 Implement mechanisms that promote rapid and successful reintegration of WMIP enrollees back into the community from the state hospital, including those patients who were WMIP enrollees prior to their admission to the hospital and require assistance with resuming eligibility and enrollment into the WMIP. The Contractor shall:

14.7.1.3.1 Designate staff with primary responsibility for coordination of the mental health aftercare services that the enrollee receives, based on medical necessity.

14.7.1.3.2 Provide staff the information necessary for effective access to continuity of care for enrollees returning to the community, to promote successful community reintegration and recovery.

14.7.1.3.3 Ensure the enrollee is discharged to a safe location.

14.8 Care Coordination Protocols

14.8.1 The Contractor shall develop policies and procedures to govern coordination of assessments and evaluations with mental health, chemical dependency, long-term care, and other providers, and if an enrollee chooses to change enrollment to an Apple Health managed care plan, the Contractor's care management staff will coordinate transition of the enrollee to the new plan's care management system to ensure services are not duplicated. The Contractor must also ensure that enrollee confidentiality and enrollee rights are protected (42 C.F.R. § 438.208 (b)(3)).

14.8.2 The Contractor shall have written protocols in place for:

14.8.2.1 Tracking referrals;

14.8.2.2 Providing or arranging for second opinions, whether in or out of network;

14.8.2.3 Sharing clinical information with other entities and providers serving the enrollee, including, when appropriate, the results of the contractor's identification and assessment of enrollees with special health care needs, so that services provided to enrollees will not be missed or duplicated.

14.8.2.4 Tracking and coordination or enrollee transfers from one setting to another (for example, hospital to home and nursing home to adult family home) and ensuring continuity of care.

14.8.2.5 Development of transition plans for enrollees when the enrollee is receiving services from a CMHA and the CMHA's contract with the Contractor is terminated for any reason.

14.9 Co-Occurring Disorder Screening and Assessment

The Contractor shall ensure the provision of an integrated, comprehensive screening and assessment for chemical dependency and mental health disorders such as the GAIN-SS or another DSHS-approved tool.

14.10 Care Coordination Oversight

14.10.1 The Contractor shall have internal monitoring processes in place to ensure compliance with the Care Coordination requirements and the quality and appropriateness of care furnished to individuals with special health care needs. (42 C.F.R. § 438.240 (b)(4)).

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

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

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

14.10.2.3 Effective enrollee monitoring, including management of barriers;

14.10.2.4 Referral management; and

14.10.2.5 Effective coordination of care.

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

14.11 Direct Access for Individuals with Special Health Care Needs

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

14.12 Coordination with Centers of Excellence

14.12.1 For enrollees who receive services through Centers of Excellence (COE) for hemophilia and other bleeding disorders, the Contractor shall coordinate care with the COE to avoid duplication or delays in service provision and factor replacement products and medications to WMIP enrollees. The Contractor shall provide all care coordination and care management services other than those related to management of the enrollee's hemophilia, but will ensure exchange of information necessary to coordinate these services.

15 GENERAL PROVISONS REGARDING BENEFITS

15.1 Second Opinions

15.1.1 The Contractor must authorize a second opinion regarding the enrollee's health care from a qualified health care professional within the Contractor's network, or provide authorization for the enrollee to obtain a second opinion outside the Contractor's network, if the Contractor's network is unable to provide for a qualified health care professional.

15.1.2 This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider (42 C.F.R. § 438.206(b)(3)).

15.2 Sterilizations and Hysterectomies

The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are in compliance with 42 C.F.R. § 441 Subpart F, and that HCA Sterilization Consent Form (HCA 13-364)) or its equivalent is used.

15.3 Narcotic Review

A Contractor's Medical Director or representative shall participate in the Washington HCA Managed Care Medical Director's meeting to develop a process to identify and manage enrollees with a diagnosis of chronic, non-cancer pain taking opioids at a combined daily dose of greater than 120 Med/day. Contractor activities developed in collaboration with peer managed care organizations to address this health and safety concern may include, but is not limited to: prescriber and enrollee education about the risk of using high dose opioids, including the provision of opioid dosing guidelines to the prescriber, requesting second opinions from a pain management specialist, preauthorization of all opioid medication, negotiating taper plans with the prescriber resulting in safer dosing levels and referrals to mental health services and/or substance use disorder programs for assessment.

15.4 **Special Provisions for American Indians and Alaska Natives**

In accord with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating Indian health care providers for contracted services provided to American Indian and Alaska Native enrollees at a rate equal to the rate negotiated between the Contractor and the Indian health care provider. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an Indian health care provider.

16 BENEFITS

16.1 Scope of Services

16.1.1 The Contractor is responsible for covering medically necessary services sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished (42 C.F.R. § 438.210(a)(3)(ii). The Contractor shall cover services related to the following (42 C.F.R. § 438.210(a)(4))::

16.1.1.1 The prevention, diagnosis, and treatment of health impairments.

16.1.1.2 The achievement of age-appropriate growth and development.

16.1.1.3 The attainment, maintenance, or regaining of functional capacity.

16.1.2 If a service is covered by HCA under its fee-for-service program, or by DSHS for behavioral health or Long Term Services and Supports, that service is a contracted service, and shall be provided by the Contractor when medically necessary, including all specific procedures and elements, unless it is specifically excluded under this Contract. Covered services are described in HCA's Medicaid Provider Guidelines, incorporated by reference.

16.1.3 For services that HCA or DSHS determines are non-covered or limited in its fee-for-service program, that are not specifically excluded by this Contract, excluded from coverage under Federal regulations or excluded from coverage by HCA, the Contractor will have policies and procedures for Exception to Rule (ETR) and Limitation Extension (LE) that are equivalent to the procedures described in WAC 182-501-0160 and 182-501-0169. The Contractor is responsible for providing a service when the Contractor's ETR or LE results in approval of the service.

16.1.4 If the coverage of services is modified in the fee-for-service program, the modification will be effective for the Contractor on the same date as it is effective in the fee-for-service program.

16.1.5 HCA and DSHS make all decisions about what is and is not a covered service in the WMIP program, both for the fee-for-service program (FFS) and services provided by a managed care program. This Contract does not in any manner delegate coverage decisions to the Contractor. The Contractor must provide the same amount, duration and scope of services as HCA fee-for-service program unless a service is specifically excluded. Covered services that are not excluded are contracted services. The Contractor makes the decision whether or not a contracted service is medically necessary; Medical necessity decisions are to be made based on an individual enrollee's healthcare needs by a health care professional with expertise appropriate to the enrollee's condition. The Contractor may not make global medical necessity decisions, since that is a coverage decision. The Contractor is allowed to have guidelines, developed and overseen by appropriate health care professionals, for approving services. All

denials of contracted services are to be individual medical necessity decisions made by a health care professional without being limited by such guidelines.

16.1.6 Except as otherwise specifically provided in this Contract, the Contractor shall provide contracted services in the amount, duration and scope described in the Medicaid State Plan (42 C.F.R. § 438.210(a)(1 & 2)).

16.1.7 The amount and duration of contracted services that are medically necessary depends on the enrollee's condition (42 C.F.R. § 438.210(a)(3)(i)).

16.1.8 The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the enrollee's diagnosis, type of illness or condition (42 C.F.R. § 438.210(a)(3)(ii).

16.1.9 Except as specifically provided in the provisions of the Authorization of Services Section, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary contracted services to enrollees nor unduly burden providers or enrollees. The Contractor's utilization control measures are not required to be the same as those in the Medicaid fee-for-service program (42 C.F.R. § 438.210(a)(3)(iii).

16.1.10 For specific contracted services, the requirements of this Section shall also not be construed as requiring the Contractor to provide the specific items provided by HCA under its fee-for-service program or under a DSHS program, but shall rather be construed to require the Contractor to provide at least the same scope of services.

16.1.11 Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of contracted services (42 C.F.R. § 438.6(e)).

16.1.12 The Contractor may limit the provision of contracted services to participating providers except as specifically provided in this Contract; and the following provisions of this subsection:

16.1.12.1 Emergency services;

16.1.12.2 Outside the Service Areas as necessary to provide medically necessary services; and

16.1.12.3 Coordination of Benefits, when an enrollee has other primary comparable medical coverage as necessary to coordinate benefits.

16.1.13 Within the Service Areas:

16.1.13.1 Within the Contractor's service areas, as defined in the Service Areas provisions of the Enrollment Section of this Contract, the Contractor shall cover enrollees for all medically necessary services included in the scope of services covered by this Contract.

16.1.14 Outside the Service Areas:

16.1.14.1 For the enrollees still enrolled with the Contractor who are temporarily outside of the service areas or who have moved to a service area not served by the Contractor, the Contractor shall cover the following services until the last day of the month in which the 90th day after the enrollee has left the service area falls:

16.1.14.1.1 Emergency and post-stabilization services.

16.1.14.1.2 Urgent care services associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require prior-authorization for urgent care services as long as the wait times specified in the, Appointment Standards provisions of the Access Section of this Contract, are not exceeded.

16.1.14.1.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area. The Contractor may require prior-authorization for such services as long as the wait times specified in the Appointment Standards provision of the Access Section of this Contract are not exceeded.

16.1.14.1.4 Except for the six (6) month risk period for Nursing Facility care and coordination for Western State Discharges, the Contractor's obligation for services outside the service area is limited to ninety (90) calendar days beginning with the first of the month following the month in which the enrollee leaves the service area or changes residence, except when the enrollee is sent out of the service area by the Contractor to receive services.

16.1.14.1.5 The Contractor is not responsible for coverage of any services when an enrollee is outside the United States of America and its territories and possessions.

16.2 **Enrollee in Facility at Enrollment**

16.2.1 If an enrollee is in a facility at the time of enrollment and was receiving services through the fee-for-service system on the day he or she was admitted to the facility, the HCA shall be responsible for payment of all facility and professional services provided from the date of admission until the date the enrollee is discharged from a facility to home or a community residential setting.

16.2.2 For newborns, born while their mother is hospitalized, the party responsible for the payment of contracted services for the mother's hospitalization shall be responsible for payment of all covered inpatient facility and professional services provided to the newborn from the date of admission until the date the newborn is no longer confined to an acute care hospital.

16.2.3 For newborns, who are removed from the enrollment with the Contractor retroactive to the date of birth and whose premiums are recouped as provided herein, HCA shall be responsible for payment of all covered inpatient facility and professional services provided to and associated with the newborn. This provision does not apply for services provided to and associated with the mother.

16.2.4 The payer responsible for payment under this Subsection remains responsible for medical necessity determinations and service authorizations.

16.2.5 For the purposes of this Section, "facility" means but is not limited to: a hospital, an inpatient rehabilitation center, long-term and acute care (LTAC), skilled nursing facility, and nursing home.

16.3 **Enrollee in Facility at Termination of Enrollment**

If an enrollee is in a facility at the time of termination of enrollment and the enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered facility and professional services from the date of admission until one of the following occurs:

16.3.1 The enrollee is discharged from a facility to home or a community residential setting.

16.3.2 The enrollee's eligibility to receive Medicaid services ends. The Contractor's obligation for payment ends at the end of the month the enrollees Medicaid eligibility ends.

16.4 **Enrollee in Nursing Facility at Termination of Enrollment**

If an enrollee is in a skilled nursing facility at the time of termination of enrollment, and the enrollee was placed in the skilled nursing facility during his or her enrollment in the WMIP, the Contractor is responsible for payment from the date of admission until one of the following occurs:

16.4.1 The Enrollee is no longer confined to a skilled nursing facility;

16.4.2 The Contractor's six (6) month obligation to pay for skilled nursing facility services, as described in Section5.3, has ended, in compliance with Section5.3.4;

16.4.3 The enrollee's eligibility to receive Medicaid services ends. The Contractor's obligation for payment ends at the end of the month the enrollee's Medicaid eligibility ends.

16.5 **General Description of Contracted Services**

This section is a general description of services covered under this Contract and is not intended to be exhaustive.

16.5.1 The Contractor shall provide a wellness exam to each enrollee that documents the enrollee's baseline health status and allows the enrollee's PCP to monitor health improvements and outcome measures.

16.5.2 When an enrollee has an alcohol and/or chemical dependency and/or mental health diagnosis, the Contractor is responsible for contracted services whether or not the enrollee is also receiving alcohol and/or chemical dependency and/or mental health treatment.

16.5.3 Inpatient Services provided by acute care hospitals (licensed under Chapter 70.41 RCW) or in a Nursing Facility, Skilled Nursing Facility or other acute care setting.

16.5.4 Outpatient Hospital Services: Provided by acute care hospitals (licensed under Chapter 70.41 RCW).

16.5.5 Emergency Services and Post-stabilization Services:

16.5.5.1 Emergency Services: Emergency services are defined in this Contract.

16.5.5.1.1 The Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 C.F.R. § 438.114.

16.5.5.1.2 The Contractor shall cover all emergency services provided by a licensed provider, acting within their scope of practice, regardless of diagnosis, without regard to whether the provider is a participating or non-participating provider (42 C.F.R. § 438.114 (c)(1)(i)).

16.5.5.1.3 The Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or the Contractor of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services (42 C.F.R. § 438.114 (c)(1)(ii)).

16.5.5.1.4 The only exclusions to the Contractor's coverage of emergency services are:

16.5.5.1.4.1 Dental services only if provided by a dentist or an oral surgeon to treat a dental diagnosis, covered under HCAs' fee-for-service program.

16.5.5.1.5 Emergency services shall be provided without requiring prior authorization.

16.5.5.1.6 What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 C.F.R. § 438.114 (d)(1)(i)).

16.5.5.1.7 The Contractor shall cover treatment obtained under the following circumstances:

16.5.5.1.7.1 An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition (42 C.F.R. § 438.114(c)(1)(ii)(A)).

16.5.5.1.7.2 A participating provider or other Contractor representative instructs the enrollee to seek emergency services (42 C.F.R. § 438.114(c)(1)(ii)(B)).

16.5.5.1.7.3 The enrollee presents at the emergency room with a psychiatric diagnosis but is not admitted for inpatient treatment. The Contractor is responsible for all covered psychotropic medications prescribed as a part of the emergency room visit.

16.5.5.1.8 If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor (42 C.F.R. § 438.114 (d)(3)).

16.6 **Urgent and Emergent Care for Mental Health**

Enrollees may access urgent and emergent medically necessary mental health services (e.g. crisis mental health services, stabilization services) without completing an intake evaluation. The Contractor shall ensure that timelines for accessing urgent and emergent services are met. Enrollees have access to the following services prior to completing an intake evaluation:

16.6.1 Crisis Services;

16.6.2 Freestanding Evaluation and Treatment;

16.6.3 Stabilization;

16.7 **Post-stabilization Services**:

16.7.1 The Contractor shall limit post-stabilization services for non-emergent conditions in accord with the Health Care Authority's Medicaid Provider Guidelines for coverage of non-emergent condition.

16.7.2 The Contractor will provide all inpatient and outpatient post-stabilization services in accord with the requirements of 42 C.F.R. § 438.114 and 42 C.F.R. § 422.113(c).

16.7.3 The Contractor shall cover all post-stabilization services provided by a licensed provider, acting within their scope of practice, without regard to whether the provider is a participating or non-participating provider.

16.7.4 The Contractor shall cover post-stabilization services under the following circumstances (42 C.F.R. § 438.114 (e) and 42 C.F.R. § 438.113(c)(2)(iii)):

16.7.4.1 The services are pre-approved by a participating provider or other Contractor representative.

16.7.4.2 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain the enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further post-stabilization care services.

16.7.4.3 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain, improve, or resolve the enrollee's stabilized condition and the Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d)), the Contractor cannot be contacted or the Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the enrollee until a Contractor physician is reached or one of the criteria identified in 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.133(c)(3) is met.

16.7.4.3.1 The Contractor's responsibility for post-stabilization services it has not pre-approved ends when (42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.133(c)(3)):

16.7.4.3.1.1 A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

16.7.4.3.1.2 A participating provider assumes responsibility for the enrollee's care through transfer;

16.7.4.3.1.3 A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

16.7.4.3.1.4 The enrollee is discharged.

16.7.5 Ambulatory Surgery Center: Services provided at ambulatory centers.

16.7.6 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, naturopathic physicians, and certified dietitians. Provider services include, but are not limited to:

16.7.6.1 Medical examinations, including wellness exams.

16.7.6.2 Immunizations including the shingles vaccine for enrollees over age sixty (60).

16.7.6.3 Maternity care. The Contractor shall ensure that, to the extent possible, contracted provider refer all pregnant women to a local Maternity Support Services program.

16.7.6.4 Family planning services provided or referred by a participating provider or practitioner.

16.7.6.5 Performing and/or reading diagnostic tests.

16.7.6.6 Surgical services.

16.7.6.7 Services to correct defects from birth, illness, or trauma, medically necessary surgery to correct complications of weight loss surgeries after 30 calendar days post-surgery, and mastectomy reconstruction.

16.7.6.8 Anesthesia.

16.7.6.9 Administering pharmaceutical products.

16.7.6.10 Fitting prosthetic and orthotic devices.

16.7.6.11 Rehabilitation services.

16.7.6.12 Enrollee health education.

16.7.6.13 Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia.

16.7.6.14 Biofeedback training when determined medically necessary specifically for, perineal muscles, anorectral or urethral sphincter, including EMG and/or manometry for incontinence.

16.7.6.15 Genetic services, including testing, counseling and laboratory services, when medically necessary for diagnosis of a medical condition.

16.7.7 Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel, and peripheral blood stem cell.

16.7.8 Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy.

16.7.9 Vision Care: Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The Contractor may restrict non-emergent care to participating providers.

16.7.10 Neurodevelopmental Services, Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability when provided by a facility that is not a Department of Health (DOH) recognized neurodevelopmental center.

16.7.11 Pharmaceutical Products:

16.7.11.1 Covered drug products shall include products from participating rebate eligible manufacturers for medically accepted indications:

16.7.11.1.1 All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies, including over-the-counter (OTC) products and contraceptive methods which require administration or insertion by a healthcare professional in a medical setting;

16.7.11.1.2 Antigens and allergens;

16.7.11.1.3 Therapeutic vitamins and iron prescribed for prenatal and postnatal care;

16.7.11.1.4 Auto-approval of insulin pens for pregnant women; and

16.7.11.1.5 Psychotropic medications when prescribed by a medical or mental health professional, when he or she is prescribing medications within his or her scope of practice with appropriate authorization.

16.7.11.2 Prescription drug products according to a Health Care Authority approved formulary from participating rebate eligible manufacturers. The Contractor's formulary shall include all therapeutic classes in the Health Care Authority' fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet enrollees' medically necessary health care needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs.

16.7.11.3 All prescription and over the counter family planning drugs, supplies and devices, including emergency contraception provided at a pharmacy of by the Family Planning Clinic at the time of a family planning visit. Drugs, supplies and devices must be dispensed in a one year supply unless otherwise prescribed by the clinician or requested by the enrollee.

16.7.11.4 All long acting reversible contraception (LARC).

16.7.11.5 The Contractor shall have in place a mechanism to deny prescriptions written:

16.7.11.5.1 By excluded providers;

16.7.11.5.2 From non-rebate eligible manufacturers;

16.7.11.5.3 For non-medically accepted indications.

16.7.11.6 The Contractor's policies and procedures for the administration of the pharmacy benefit shall ensure compliance with the following requirements described in this section:

16.7.11.6.1 Formulary exceptions:

16.7.11.6.1.1 The Contractor shall approve or deny all requests for prior authorization or non-formulary drugs by the business day following the day of request.

16.7.11.6.2 Emergency fill:

16.7.11.6.2.1 The Contractor shall have a process for providing an emergency drug supply to enrollees when a delay in authorization would interrupt a drug therapy that must be continuous or when the delay would pose a threat to the enrollees' health and safety. The drug supply provided must be sufficient to bridge the time until an authorization determination is made.

16.7.11.7 Birth Control methods/contraceptive drugs authorized in one-year supplies, dispensed at one time unless an enrollee requests a smaller supply or the prescribing physician instructs that the patient must receive a smaller supply. The Contractor shall authorize on-site dispensing of the prescribed birth control methods\contraceptive drugs at family planning clinics. Dispensing practices must follow clinical guidelines for appropriate prescribing and dispensing to ensure the health of the enrollee while maximizing access to effective birth control methods\contraceptive drugs.

16.7.12 Enteral and parenteral nutritional supplements and supplies prescribed by the enrollee's PCP or other provider.

16.7.13 Home Health Services: Home health services through state-licensed agencies.

16.7.14 Durable Medical Equipment (DME) and Supplies: Including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the enrollee agrees.

16.7.15 Respiratory Care: Equipment, services and supplies.

16.7.16 Hospice Services: Includes hospice services provided in Skilled Nursing Facilities/Nursing Facilities, hospitals, hospice care centers and the enrollee's home.

16.7.17 Blood, Blood Components and Human Blood Products: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products, the Contractor shall cover the cost of the blood or blood products.

16.7.18 Treatment for Renal Failure: Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

16.7.19 Ambulance Transportation: The Contractor shall cover ground ambulance transportation for

emergency medical conditions, as defined herein, including, but not limited to, Basic and Advanced Life Support Services, and other required transportation costs, such as tolls and fares. In addition, the Contractor shall cover ambulance services under two circumstances for non-emergencies:

16.7.19.1 When it is necessary to transport an enrollee between facilities to receive a contracted service; and

16.7.19.2 When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

16.7.20 Smoking Cessation Services without primary care provider referral or Contractor prior authorization.

16.7.21 Services to Inmates of Correctional Facilities: The Contractor shall provide inpatient hospital services to enrollees who were inmates of correctional facilities, and are admitted to the hospital for an overnight stay. When an enrollee who was an inmate of a correctional facility is admitted to the hospital, the Contractor will submit all necessary information to HCA regarding the admission. HCA will determine if the enrollee is eligible for coverage of the hospital stay. If HCA determines that the enrollee is eligible for coverage, the Contractor is responsible for the hospital stay and all associated services.

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

16.8.1 Screening, Brief Intervention and Referral to Treatment (SBIRT) services for enrollees know to have or at high risk for substance abuse, to include alcohol and drugs with or without anxiety or depression.

16.9 Chemical Dependency Treatment

The Contractor shall provide Outpatient Chemical Dependency treatment services to Enrollees as follows. Outpatient treatment services must meet the criteria in the specific modality provisions set forth in Chapter 388-877B WAC.

16.9.1 Chemical dependency treatment services must be directed and/or provided in accordance with the American Society of Addiction Medicine (ASAM) Patient Placement Criteria 2-Revised (ASAM PPC2-R) or its successor.

16.9.2 The Contractor shall ensure a sufficient number, mix and geographic distribution of community chemical dependency treatment agencies to provide chemical dependency treatment services in the geographic area to all enrollees.

16.9.3 The Contractor shall ensure that chemical dependency treatment services are provided in accordance with applicable portions of the Washington Administrative Code (WAC) 388-805 or its successor.

16.9.4 The Contractor shall ensure that chemical dependency treatment services are provided by agencies certified DSHS and reported in the TARGET information system.

16.9.5 The Contractor shall ensure that the following services are available to its enrollees:

16.9.6 The Contractor shall ensure a screening for alcohol and/or drug dependency is included in the comprehensive assessment required for each enrollee. The Contractor may conduct the chemical dependency screening or allow a member of the Contractor's provider network to conduct the chemical dependency screening. The results of the screening shall be documented

in the Contractor's or subcontractor's client chart and shared within the Molina network upon request.

16.9.6.1 The Contractor shall refer the high risk enrollee for an assessment or allow a member of the Contractor's provider network to refer the high risk enrollee for an assessment. Client records for enrollees who have screened as high risk for Chemical Dependency and are referred for a chemical dependency assessment shall reflect that the referral was made and the reasons for making the referral. Client records for enrollees who have screened as high risk for chemical dependency but are NOT referred for a chemical dependency assessment shall reflect the reason that the referral for chemical dependency assessment/treatment was NOT made.

16.9.6.2 In accordance with Section9.5.5, the Contractor shall require its contracted Chemical Dependency providers to offer the enrollee a consent form for release of information (ROI) to sign if one is not already on record. To ensure that enrollees needing CD services are receiving treatment, the contractor will cross reference those enrollees who screened positive for CD with the utilization data from the TARGET database on a quarterly basis. If an enrollee who has screened positive is not represented in the utilization data, the Contractor shall contact the enrollee for reassessment and another attempt to provide a referral. The Contractor shall also cross-reference the TARGET database list with the signed releases of information forwarded by the CD subcontractors. When an enrollee is receiving CD services from a subcontractor, but the Contractor has not received a signed ROI, the Contractor shall contact the subcontractor to encourage obtaining the ROI and will exercise its right to enforce the "limitations on re-disclosure" agreement with the provider to audit enrollee charts.

16.9.6.3 The Contractor shall ensure enrollee access to a Chemical dependency assessment by a chemical dependency professional (CDP) certified by the Department of Health, or a chemical dependency professional trainee (CDPT) under the supervision of a CDP, to determine a patient diagnosis supported by criteria of substance dependency per DSM IV, followed by placement and retention assessment according to ASAM PP C2-R.

16.9.6.4 Crisis intervention in accordance with the RCW 70.96A.140, Involuntary Treatment Act (ITA) through existing community systems.

16.9.6.5 Alcohol/Drug detoxification services (acute and sub-acute) to provide care and treatment of enrollees while the enrollee recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. Services may be provided in a hospital or DSHS-certified free-standing 24-hour care facility setting.

16.9.6.6 Outpatient treatment services that provide non-domiciliary/non-residential chemical dependency services to enrollees. Includes services to family and significant others of enrollees in treatment. Includes intensive outpatient services, and services authorizing the use of the medications Suboxone (buprenorphine HCI and naloxone HCI dehydrate) and ReVia (naltrexone) when the person is enrolled in a state certified chemical dependency treatment program and meets the criterion for use of either medication.

16.9.6.7 The Contractor will ensure enrollee referral to the chemical dependency treatment system for residential treatment services that provide chemical dependency treatment for patients and includes room and board in a twenty-four-hour-a-day supervised facility if the assessment determines that the patient meets the ASAM PPC2-R placement criteria for residential treatment. Where appropriate, the

Contractor may purchase residential treatment services from a DSHS-certified residential treatment provider.

16.10 **Mental Health Services**

The Contractor shall provide inpatient and outpatient mental health services in accordance with Chapters 70.02, 71.05, and 71.24 RCW or any of their successors. The Contractor shall provide uninterrupted linkage through the range of contracted services with the goal of moving the enrollee toward Resiliency and Recovery. All enrollees requesting covered mental health services must be offered an intake evaluation as defined in the Medicaid State Plan.

16.10.1 **Outpatient Mental Health Services**: The Contractor shall provide Outpatient Mental Health services to enrollees when they are determined to be medically necessary. Mental Health services must be directed towards helping the enrollee to live successfully in the community, must be culturally appropriate and be based on the initial assessment. Services are provided by or under the supervision of a Mental Health Professional.

The Contractor shall ensure a sufficient number, mix and geographic distribution of community mental health agencies (CMHA) and/or qualified personnel, including mental health care providers (MHCPs) to meet the requirements of this section and provide access to an Intake Evaluation in accordance with Section 6.7.7 and an age-appropriate and culturally appropriate range of medically necessary mental health services as described in this Section.

16.10.2 The Contractor shall provide the following outpatient mental health services:

16.10.2.1 **Brief Intervention**: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the enrollee to previous higher levels of general functioning. Enrollees must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

16.10.2.2 **Day Support**: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality

may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

16.10.2.3 **Family Treatment**: Psychological counseling provided for the direct benefit of the enrollee. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the enrollee and his or her family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will offer family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the enrollee present in the room but service must be for the benefit of attaining the goals identified for the enrollee in his or her individual service plan. This service is provided by or under the supervision of a mental health professional.

16.10.2.4 **High Intensity Treatment**: Intensive levels of services furnished under this contract, provided to enrollees who require a multi-disciplinary treatment team that is available 24 hour-per-day, seven-days-per-week, based on the enrollee's need. Goals for High Intensity Treatment include the reinforcement of safety, promotion of stability and the independence of the enrollee in the community, and restoration to a higher level of functioning. These services are designed to rehabilitate enrollees who are experiencing severe symptoms in the community, and avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The multi-disciplinary team consists of the enrollee, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the enrollee (e.g., family, guardian, friends and/or neighbors). Other community agency members may include probation/parole officers, teacher, minister, physician, chemical dependency counselor, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the enrollee's individual service plan. The team's intensity varies among enrollee's and for each enrollee across time. The enrollee's symptoms and functioning will be continuously assessed by the team, allowing for the prompt implementation of needed modifications to the enrollee's individual service plan or crisis plan. Team members provide immediate feedback to the enrollee and to other team members. The staff to enrollee ratio for this service is no more than 1:15.

16.10.2.5 **Group Treatment Services:** Counseling in a group setting to assist the enrollee in meeting goals described in the ITP by learning from the experiences and perspective of others in the group. Services are provided to groups of 24 or fewer enrollees, with a staff to enrollee ration of no more than 1:12. Group Treatment may include counseling and /or psychotherapy to help the enrollee establish and/or maintain stability in living, work and educational surroundings and should assist the enrollee to:

16.10.2.5.1 Develop self-care and/or life skills;

16.10.2.5.2 Improve interpersonal skills;

16.10.2.5.3 Reduce results of traumatic experience and alleviate symptoms of mental illness.

16.10.2.6 **Individual Treatment Services**: Age and culturally appropriate services designed to assist individual enrollees to build strengths and maintain stability in daily life. Individual treatment services may include the enrollee's family and others the enrollee wants involved. Services provided may include: self-care/life skills training, counseling, psychotherapy and monitoring the enrollee's functional level. When feasible, Individual Treatment Services may be provided at a location preferred by the enrollee.

16.10.2.7 **Intake Evaluation**: The Contractor shall ensure that an age and culturally appropriate evaluation takes place before delivery of any mental health service other than crisis services, stabilization and free-standing evaluation and treatment. The evaluation must take place within 10 working days of the request for evaluation and be completed within 30 working days and must be conducted by a Mental Health Professional. The purpose of the evaluation is to establish medical necessity for services; once medical necessity has been established, the Contractor may begin provision of services even if the intake evaluation has not yet been completed.

16.10.2.8 **Medication Management**: Is the prescribing, administering and review of medications and their side effects. The Contractor shall ensure that this service is provided by a provider licensed to provide medication management. Medication Management may be provided in consultation with other providers, such as the enrollee's primary therapist and/or case manager, but includes only minimal psychotherapy.

16.10.2.9 **Medication Monitoring**: Face-to-face, one-on-one cueing, observing, and encouraging an enrollee to take medications as prescribed. Medication monitoring also includes reporting back to persons licensed to perform medication management services for the direct benefit of the enrollee. This service may take place at any location and for as long as it is clinically necessary. This service is designed to facility medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a Mental Health Professional.

16.10.2.10 **Peer Support**: Peer Support is provided by peer counselors to enrollees under the consultation, facilitation or supervision or a Mental Health Professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Enrollees actively participate in decision-making and the operation of the programmatic supports.

16.10.2.10.1 Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur at locations where mental health consumers are known to gather (i.e., churches, parks, community centers, etc.). Drop-in centers are required to maintain a log documenting identification of the enrollee including Medicaid eligibility.

16.10.2.10.2 Services provided by peer counselors to enrollees are noted in the enrollee's ISP, which delineates specific goals that are flexible, tailored to the enrollee and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the ISP and indicate where treatment goals have not yet been achieved.

16.10.2.10.3 Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

16.10.2.11 **Psychological Assessment**: Shall be provided by a licensed psychologist to assist the enrollee's provider in treatment planning. The psychological assessment includes all psychometric services provided for evaluations, diagnostic or therapeutic purposes by or under the supervision of a licensed psychologist.

16.10.2.12 **Rehabilitation Case Management**: Are activities conducted at or in coordination with, an inpatient facility to assist an enrollee in transitioning from an inpatient to a community setting. Rehabilitation Case Management activities include assessment for discharge, planning for integrated mental health treatment, resource identification, and linkage to mental health rehabilitation services, and collaborative development of individualized services that promote continuity of care to enable the enrollee to stay in the least restrictive setting possible. Rehabilitation Case Management may be provided prior to completion of an intake evaluation.

16.10.2.13 **Special Population Evaluation**: Age and culturally appropriate evaluation by a Mental Health Specialist (child, geriatric, disabled, or ethnic minority specialist) to gather enrollee-specific information to assist in treatment planning; the evaluation occurs after intake and is specific to one of the four Mental Health Specialist categories above.

16.10.2.14 **Therapeutic Psychoeducation**: Informational and experiential services designed to aid enrollees, their family members (e.g., spouse, parents), and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are included in the Individual Service Plan and are provided at locations

convenient to the enrollee, by or under the supervision of a mental health professional.

The primary goal of therapeutic Psychoeducation is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem solving skills; etc.

16.10.2.15 **Mental Health Services provided in Residential Settings**: **A** specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Enrollees receiving this service present with severe impairment in psychosocial functioning or have apparent symptoms with unclear contributing factors due to their mental illness. Treatment cannot be safely provided in a less restrictive environment but the enrollee's symptoms do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to the enrollee.

Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed to stabilize the enrollee and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

16.10.2.16 **Freestanding Evaluation and Treatment** means services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Division of Behavioral Health and Recovery of Behavioral Health and Recovery to provide medically necessary evaluation and treatment to enrollees who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family and significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to: performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of

mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for enrollees who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self, due to the onset or exacerbation of a psychiatric disorder. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

16.10.2.17 **Inpatient Hospital Services**: The Contractor shall cover inpatient mental health services for both voluntary and involuntary admissions in community settings and shall develop communications plans with contracted hospitals to ensure notification in the event that an enrollee is admitted for psychiatric evaluation and/or treatment.

16.10.3 **Court Ordered Services**: The Contractor shall respond to requests for participation, implementation, and monitoring of enrollees in the provision of mental health outpatient services to enrollees who are:

16.10.3.1 On a Less Restrictive Alternative court order in accordance with RCW 71.05.320 and WAC 388-865-0466;

16.10.3.2 On a Conditional Release under RCW 72.05.340; or

16.10.3.3 On a Conditional Release under RCW 10.77.150.

16.11 Long-Term Care Services

The Contractor shall provide the following long-term care services including, but not limited to:

16.11.1 **Adult Day Care**: A supervised daytime program for adults with medical or disabling conditions that do not require the level of care provided by a registered nurse or licensed rehabilitative therapist. Services include personal care, social services and activities, education, routine health monitoring, general therapeutic activities, a nutritious meal and snacks, supervision and/or protection for adults who require it, coordination of transportation, and first aid and emergency care.

16.11.2 **Adult Day Health**: A supervised daytime program that provides skilled nursing and rehabilitative therapy services in addition to adult day care. An adult day health center provides skilled nursing services, rehabilitative therapy such as physical therapy, occupational therapy or speech-language therapy and brief psychological and/or counseling services and all of the services listed for adult day care above. Adult day health services shall only be authorized for in-home clients.

16.11.3 **Caregiver/Recipient Training Services**: Training services are mandated for each COPES paid caregiver and provide instruction in either a one-to-one situation or in a group setting. Each caregiver shall receive a two (2) hour orientation and additional twenty-eight (28) hours basic training, and ten (10) hours continuing education. Contractor is responsible for payment of Training Services for those Caregivers who are providing care solely to Contractor's

enrollees. Contractor is responsible for continuing education of Caregivers providing at least 50% of employed caregiver services to Contractors' enrollees.

The caregiver training curriculum includes: use of special or adaptive equipment or medically related procedures required to maintain the recipient in the home or community-based setting; and, activities of daily living. In addition, caregiver training teaches critical care giving skills including: client rights and abuse reporting; observation and reporting changes in client condition; infection control, accident prevention, food handling and other tips on providing a safe environment; emergency procedures and problem solving.

Recipient training needs are identified in the comprehensive assessment or in a professional evaluation. This service is provided in accordance with a therapeutic goal in the plan of care and includes e.g., adjustment to serious impairment; maintenance or restoration of physical functioning and management of personal care needs, i.e., the development of skills to deal with care providers.

16.11.4 **Environmental Modifications/Assistive Technology**: Physical adaptations, for example: ramp installation, grab-bars, widening doorways, modifying bathrooms, or installing special systems to accommodate medical equipment. Assistive Technology includes any item, piece of equipment, or product system whether acquired commercially off the shelf, modified, or customized that is used to increase, maintain, or improve the functional capabilities of a client.

16.11.5 **Home Health Care**: In-home health care (monitoring, treatment, therapies, medications, exercises) as authorized by a physician and provided by nurses, therapists, or trained aides.

16.11.6 **Minor Household Repairs**: Home or apartment repairs/modifications made to maintain the enrollee's health and safety.

16.11.7 **Nurse Delegation:** Training and supervision of a nursing assistant to do routine health care tasks by a registered nurse delegator. The trained nursing assistant shall provide care in the enrollee's home setting. The nursing assistant shall only perform those tasks described in RCW 18.88A.210 and shall successfully complete Nurse Delegate training prior to providing delegated services.

16.11.8 **Personal Care Services**: Services provided for enrollees who are functionally unable to perform all or part of such tasks, or for enrollees who cannot perform the tasks without specific instructions. Personal care services do not include assistance with tasks that are performed by a licensed health professional. Personal Care Services may include physical assistance, and/or prompting and supervising the enrollee in performance of direct personal care tasks and household tasks. Individual or agency providers perform these duties.

Personal Care services must be provided by qualified home care agency workers or individual providers who meet background check and training requirements outlined in Chapters 388-112 and 388-71 WAC.

16.11.9 Personal Care tasks include, but are not limited to:

16.11.9.1 Assistance with walking/locomotion;

16.11.9.2 Bathing;

16.11.9.3 Bed Mobility, i.e. repositioning enrollee in chair or bed;

16.11.9.4 Body Care;

16.11.9.5 Dressing;

16.11.9.6 Eating;

16.11.9.7 Essential shopping;

16.11.9.8 Housework;

16.11.9.9 Laundry;

16.11.9.10 Meal preparation;

16.11.9.11 Personal Hygiene;

16.11.9.12 Self-medication administration;

16.11.9.13 Supervision;

16.11.9.14 Toileting;

16.11.9.15 Transfer; i.e. assisting enrollee to move from bed to chair, etc.;

16.11.9.16 Travel to medical services; and

16.11.9.17 Wood supply.

16.11.10 **Personal Emergency Response System (PERS)**: An electronic device is provided that allows clients to get help in an emergency. The system is connected to a phone or the enrollee may also wear a portable "help" button. When activated, staff at a response center will call 911 and/or take whatever action has been set-up ahead of time.

16.11.11 **Self-Directed Care**: An adult with a functional disability, living in his/her own home can direct and supervise a paid personal care aide to help them with health care tasks that he/she can't do because of his or her disability. Examples of self-directed care tasks include medications, bowel programs, bladder catheterization, and wound care. Self-directed care supports an individual's autonomy and choice and often allows him/her to stay in his/her own home longer.

16.11.12 **Home Delivered Meals**: Nutritious meals and other dietary services are provided in a group setting or delivered to home-bound persons.

16.11.13 **Residential Programs**: The Contractor shall provide the following Long Term Care residential programs to enrollees who have been determined eligible.

16.11.14 **Adult Family Homes**: Adult family homes are residential, neighborhood homes licensed by Washington State to care for two to six people. Adult family homes provide lodging, meals, laundry, and organized social activities or outings. If it is needed, they also provide necessary supervision, assist with personal care (getting dressed, bathing, etc.) and help with medications. Some provide nursing care or may specialize in serving people with mental health problems, developmental disabilities, or dementia.

16.11.15 **Assisted Living Facilities**: Assisted living facilities are larger facilities licensed by

Washington State to care for seven or more people. Assisted Living Facilities provide lodging, meal services, assistance with personal care, and general supervision of residents. Some provide limited nursing care or may specialize in serving people with mental health problems, developmental disabilities, or dementia.

Assisted Living Facilities that provide care for state-funded clients are contracted under the following categories:

16.11.15.1 **Adult Residential Care (ARC)**: services include lodging, meal services, general supervision of residents, and assistance with personal care.

16.11.15.2 **Enhanced Adult Residential Care (EARC)**: Includes everything provided through an ARC contract (See above) plus limited nursing services.

16.11.15.3 **Assisted Living (AL)**: Includes everything provided through an EARC contract (see above) plus offering residents private apartment-like units with a private bath and kitchen area.

16.11.16 **Nursing facilities (Homes)**: Provide 24-hour a day supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board, and laundry. Nursing facilities also offer short-term rehabilitation services. The Contractor shall notify DSHS if the rehabilitation stay exceeds 30 days.

16.11.17 **Individual Providers**: The Contractor shall ensure that all Individual Providers (IPs) meet the minimum qualifications and training requirements for care providers in home settings as described in Chapters 388-71 and 388-112 WAC before they provide the following services to enrollees:

16.11.17.1 Assist, as specified by the client, with those personal care services, authorized household tasks, and/or nurse delegated or self-directed health care tasks, which are included in the enrollee's service plan.

16.11.17.2 Perform all services in a manner consistent with protecting and promoting the client's health, safety and well-being.

16.11.17.3 No Individual Provider will perform any task requiring a registration, certificate or license unless he or she is registered, certified or licensed to do so, is a member of the enrollee's immediate family, or is performing self-directed health care tasks. Chapters 18.79, 19.88 and 74.39 RCW provide more information about regulations related to nursing care, Registered Nurse Delegation and self-directed health care tasks.

16.11.18 **Community Transition Services**: Services designed to assist enrollees who are returning to the community on waiver services from institutional settings such as hospital or nursing homes. These services may include one-time expenses required to set up a home or apartment in the community, such as safety deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for living in a community setting. Community transition services do not include rent or recreational items such as TV, cable or VCRs.

16.11.19 **Skilled Nursing: Services described in the plan of care that are within the scope of the** State's Nurse Practice Act and that are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse licensed to practice in the State of Washington. Services may be provided in the enrollee's home or in an Adult Family Home setting.

16.11.20 **Clients receiving services through the Developmental Disabilities Administration (DDA):**

16.11.20.1 The Contractor shall be responsible for providing all services under this contract to DDA clients who receive Medicaid Personal Care (MPC) services from DDA. Other services provided by DDA, such as supported employment, will be covered by DSHS on a fee for service basis.

16.11.20.2 DDA clients who receive services through DDA's Basic Waiver, Basic Plus Waiver, or Core Waiver shall be eligible to receive medical, mental health and chemical dependency services through the WMIP but will receive all long term care and other DDA services on a fee for service basis via the appropriate waiver.

16.12 **Enrollee Participation in Cost of Care**

The Contractor shall collect, or deduct from the enrollee's long-term Care provider's rate the amount determined by HCS staff to be the enrollee's contribution to his or her cost of care. HCS staff shall determine what, if any, amount the enrollee must pay towards his or her cost of care. This determination is completed during the initial eligibility process and at least annually thereafter. The enrollee participation amount shall be used as the first payment source for long-term care services. DSHS shall notify the Contractor of the participation amount via a copy of the ACES award letter or other mutually agreeable method of communication.

If the amount for which the enrollee is responsible has not been exhausted prior to the enrollee's death the Contractor can only collect or deduct the amount up to the amount of long-term care services that had been provided at the time of the enrollee's death.

16.13 **Enrollee Self-Referral**

16.13.1 Enrollees have the right to self-refer for certain services to local health departments and family planning clinics paid through separate arrangements with the State of Washington.

16.13.2 The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

16.13.3 The enrollees also may choose to receive such services from the Contractor.

16.13.4 The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor, the Contractor shall pay the local health department or family planning facility for services provided to enrollees up to the limits described herein.

16.13.5 Contractor shall offer a provider subcontract to all family planning agencies contracted with the Health Care Authority and make a reasonable and fair effort to subcontract with such agencies for contracted services that are provided by the family planning agencies.

16.13.6 If the Contractor subcontracts with local health departments or family planning clinics as

participating providers or refers enrollees to them to receive services, the Contractor shall pay the local health department or family planning facility for services provided to enrollees up to the limits described herein.

16.13.7 The services to which an enrollee may self-refer are:

16.13.7.1 Family planning services and sexually-transmitted disease screening and treatment services provided at family planning agencies, such as Planned Parenthood.

16.13.7.2 Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through the local health department.

16.14 **Exclusions**

16.14.1 The following services and supplies are excluded from coverage under this Contract.

16.14.2 Unless otherwise required by this Contract, ancillary services resulting from or ordered in the course of non-contracted services are also non-contracted services.

16.14.3 Complications resulting from an excluded service are also excluded for a period of thirty (30) calendar days following the occurrence of the excluded service not counting the date of service. Thereafter, complications resulting from an excluded service are a covered service when they would otherwise be a covered service under the provisions of this Contract.

16.14.4 The following covered services are provided by the State as described in the Medicaid Provider Guides and are not contracted services. The Contractor is responsible for coordinating these services for the enrollee. Some services are only provided to children under the age of 21.

16.14.4.1 Eyeglass frames, lenses, and fabrication services covered under the Health Care Authority's selective contract for these services, and associated fitting and dispensing services;
16.14.4.2 Voluntary Termination of Pregnancy;
16.14.4.3 Transportation Services other than ambulance including but not limited to taxi, cabulance, voluntary transportation, public transportation and common carriers;
16.14.4.4 Air ambulance services. The Contractor remains responsible for all ground ambulance transportation services as described in this Contract;
16.14.4.5 Services provided by dentists and oral surgeons for dental diagnoses, and anesthesia for dental care;
16.14.4.6 Hearing aid devices, including fitting, follow-up care and repair;
16.14.4.7 Maternity Support Services/Infant Case Management;
16.14.4.8 Sterilizations for enrollees under age twenty-one (21), or those that do not meet other federal requirements (42 C.F.R. § 441 Subpart F);
16.14.4.9 Health care services provided by a neurodevelopmental center recognized by the Department of Health;
16.14.4.10 Services provided by a health department when a client self-refers for care if the health department is not contracted with the Contractor;
16.14.4.11 Pharmaceutical products prescribed by any provider related to services provided under a separate contract with the Health Care Authority or DSHS;
16.14.4.12 Surgical procedures for weight loss or reduction, when approved by the Health Care Authority in accord with WAC 182-531-0200. Except as provided in this Contract, the Contractor has no obligation to cover surgical procedures for weight loss or reduction;

16.14.4.13 Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing;

16.14.4.14 Health care services covered through the DSHS, Developmental Disabilities Administration (DDA) for institutionalized clients;

16.14.4.15 Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the pharmacy benefit;

16.14.4.16 Services Excluded by HCA by rule; and

16.14.4.17 Any service provided to an enrollee, while an inmate of a correctional facility, except as provided herein.

16.15 Coordination of Benefits and Subrogation of Rights of Third Party Liability

16.15.1 Coordination of Benefits:

16.15.1.1 Until HCA ends the enrollment of an enrollee who has comparable coverage as described in the Enrollment Section of this Contract, the services and benefits available under this Contract shall be secondary to any other medical coverage.

16.15.1.2 Nothing in this Section negates any of the Contractor's responsibilities under this Contract including, but not limited to, the requirement described in the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract. The Contractor shall:

16.15.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in Chapter 284-51 WAC.

16.15.1.2.2 Attempt to recover any third-party resources available to enrollees (42 C.F.R. § 433 Subpart D) and shall make all records pertaining to coordination of benefits collections for enrollees available for audit and review.

16.15.1.2.3 Pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties (42 C.F.R. § 433.139(b)(3)).

16.15.1.2.4 Pay claims for contracted services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 C.F.R. § 433.139(c)).

16.15.1.2.5 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

16.15.2 **Services Not Covered by HCA, DSHS or the Contractor in accord with WAC 388-501-070:**

16.15.2.1 Any ancillary services provided in association with services not covered by either HCA, DSHS, or the Contractor.

16.15.2.2 Medical examinations for Social Security Disability.

16.15.2.3 Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.

16.15.2.4 Physical examinations required for obtaining continuing employment, insurance or governmental licensing.
16.15.2.5 Sports physicals.
16.15.2.6 Reversal of voluntary induced sterilization.
16.15.2.7 Personal Comfort Items, including but not limited to guest trays, television and telephone charges.
16.15.2.8 Massage Therapy.
16.15.2.9 Acupuncture.
16.15.2.10 TMJ for Adults.
16.15.2.11 Diagnosis and treatment of infertility, impotence, and sexual dysfunction.
16.15.2.12 Tissue or organ transplants that are not specifically listed as covered.
16.15.2.13 Immunizations required for international travel purposes only.
16.15.2.14 Court-ordered services.
16.15.2.15 Gender dysphoria surgery and other services not covered by HCA for gender dysphoria.
16.15.2.16 Any service provided to an incarcerated enrollee, beginning when a law enforcement officer takes the enrollee into legal custody and ending when the enrollee is no longer in legal custody.
16.15.2.17 Pharmaceutical products prescribed by any provider related to a service not covered by either HCA or the Contractor.
16.15.2.18 Biofeedback training except when determined medically necessary as described in Section 16.7.6.14.
16.15.2.19 Any non-covered service under HCA's fee-for-service program (WAC 182-501-0070), except when the service is provided by the Contractor under the Contractor's Exception to Rule and Limitation Extension policies and procedures as described in this Contract.

16.16 Coordination of Benefits and Subrogation of Rights of Third Party Liability

16.16.1 Coordination of Benefits

16.16.1.1 Until the Health Care Authority ends the enrollment of an enrollee who has comparable coverage as described in the Enrollment Section of this Contract, the services and benefits available under this Contract shall be secondary to any other medical coverage.

16.16.1.2 Nothing in this Section negates any of the Contractor's responsibilities under this Contract including, but not limited to, the requirement described in the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract. The Contractor shall:

16.16.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in Chapter 284-51 WAC.

16.16.1.2.2 Attempt to recover any third-party resources available to enrollees (42 C.F.R. § 433 Subpart D) and shall make all records pertaining to coordination of benefits collections for enrollees available for audit and review.

16.16.1.2.3 Pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties (42 C.F.R. § 433.139(b)(3)).

16.16.1.2.4 Pay claims for contracted services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 C.F.R. § 433.139(c)).

16.16.1.2.5 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

16.16.2 **Subrogation Rights of Third-Party Liability:**

16.16.2.1 Injured person means an enrollee covered by this Contract who sustains bodily injury.

16.16.2.2 Contractor's medical expense means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accord with the Contractor's fee-for-service schedule.

16.16.2.3 If an enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.

16.16.2.4 The HCA specifically assigns to the Contractor HCA's rights to such third party payments for medical care provided to an enrollee on behalf of HCA, which the enrollee assigned to HCA as provided in WAC182-503-0540.

16.16.2.5 HCA also assigns to the Contractor its statutory lien under RCW 43.20B.060. The Contractor shall be subrogated to HCA's rights and remedies under RCW 74.09.180 and 43.20B.040 through 43.20B.070 with respect to medical benefits provided to enrollees on behalf of HCA under Chapter 74.09 RCW.

16.16.2.6 The Contractor may obtain a signed agreement from the enrollee in which the enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.

16.16.2.7 The Contractor shall notify HCA of the name, address, and other identifying information of any enrollee and the enrollee's attorney who settles a claim without protecting the Contractor's interest in contravention of RCW 43.20B.050.

16.17 **Patient Review and Coordination (PRC)**

16.17.1 The Contractor shall have a PRC program that meets the requirements of WAC 182-501-0135. PRC is authorized by 42 U.S.C. § 1396n(a)(2) and 42 C.F.R. § 431.54.

16.17.2 If either the Contractor or HCA places an enrollee into the PRC program, both parties will honor that placement.

16.17.3 The Contractor's placement of an enrollee into the PRC program shall be considered an action, which shall be subject to appeal under the provisions of the Grievance System section of this Contract. If the enrollee appeals the PRC placement the Contractor will notify HCA of the appeal and the outcome.

16.17.4 When an enrollee is placed in the Contractor's PRC program, the Contractor shall send the enrollee a written notice of the enrollee's PRC placement, or any change of status, in accord with the requirements of WAC 182-501-0135.

16.17.5 The Contractor shall send HCA a written notice of the enrollee's PRC placement, or any change of status, in accord with the required format provided in the Patient Review and Coordination Program Guide published by HCA.

16.17.6 The Contractor shall ensure PRC clients and providers have direct access to the Contractor's PRC-trained program staff to make needed changes to assigned providers during regular business hours. The Contractor may also subcontract to provide this service.

16.17.7 In accord with WAC 182-501-0135, HCA will limit the ability of an enrollee placed in the PRC program to change their enrolled contractor for twelve months after the enrollee is in the PRC program by HCA or the Contractor unless the PRC enrollee moves to a residence outside the Contractor's service areas.

16.17.8 If HCA limits the ability of an enrollee to change their enrolled contractor family members may still change enrollment as provided in this Contract.