HealthPathWashington

3-way Contract

DRAFT
Version 3

IMPORTANT NOTE: All specifications, terms and requirements in the model contract are for informational purposes only, and have not been reviewed nor approved by CMS. All specifications, terms and requirements will be finalized during the Memorandum of Understanding process and completion of the 3-Way contract between CMS, the State of Washington and MMI Plans.

TABLE OF CONTENTS

Appendices

Appendix C - Home and Community Based Services Waiver

1 DEFINITIONS

1.1 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, 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:

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

1.1.2 From a provider not part of the network who 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 qualification, the enrollee is given a choice of participating providers and is transitioned to a participating provider within sixty (60) calendar days;

1.1.3 Because the Contractor does not provide the service because of moral or religious objections;

1.1.4 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;

1.1.5 The HCA determines that other circumstances warrant out-of network treatment. (42 CFR 438.400(b)).

1.2 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 CFR 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 CFR 438.6(c)).

1.3 Administrative Hearing

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

1.4 Advance Directive

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

1.5 Ancillary Services

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

1.6Annual Notice of Changes (ANOC)

"CMS standardized model document for outreach and educational materials for Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans and 1876 Cost Plans."

1.7Appeal

"Appeal" means a request for review of an action (42 CFR 438.400(b)).

1.8Appeal Process

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

1.9 Care Manager

"Care Manager" means an individual who is responsible for providing care management services to beneficiaries. Care Managers may be:

1.9.1 Staff employed or contracted by a Primary Care Provider;

1.9.2 Staff employed or contracted by the Medicare/Medicaid Integrated Health Plan who have relevant credentials such as health or behavioral sciences degree and applicable experience;

1.9.3 A Care Coordinator employed or contracted by the Medicare/Medicaid Integrated Health Plan or Primary Care Provider.

1.9.4 Nothing in this definition precludes the Health Plan, primary care provider or Care Manager from using allied health care staff, such as community health workers and others to support and facilitate the work of the Care Manager.

1.10 Comprehensive Assessment Report and Evaluation (CARE)

"Comprehensive Assessment Report and Evaluation (CARE)" means is a person centered, automated assessment tool used for determining Medicaid functional eligibility, level of care for budget and comprehensive care planning, as defined in WAC 388-106 or any successor provisions thereto.

1.11 Care Management

"Care Management" means the practice and procedures to improve overall health care and assist beneficiaries and their support system to become engaged in a collaborative process designed to manage medical/social/behavioral health conditions more effectively. Care management involves identifying beneficiaries who will most benefit from planning and coordinating interventions tailored to meet the individual's needs, respecting the role of the individual to be a decision maker in the care planning process, evaluating the results of interventions and implementing necessary adjustments, and aligning payment/financing to reward consumers and providers for participating in interventions/evaluations and establishing accountability for quality and cost of health

care service delivery to complete a specified course of treatment or regular care monitoring.

For beneficiaries identified to have special health care needs, intensive care management is employed to address complex conditions and includes comprehensive health assessment, care planning and monitoring of enrollee status, implementation and coordination of services, ongoing reassessment and consultation and crisis intervention and case conferencing as needed to facilitate improved outcomes and appropriate use of health services, including case closure as warranted by enrollee improvement and stabilization.

1.12 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) with primary responsibility for the Medicaid and Medicare programs.

1.13 Certified Peer Counselor

"Certified Peer Counselor" means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Division of Behavioral Health and Recovery; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Division of Behavioral Health and Recovery; and is registered as a counselor with the Department of Health.

1.14 Children with Special Health Care Needs

"Children with Special Health Care Needs" means children under 19 years of age who are any one of the following:

1.14.1 Eligible for SSI under Title XVI;

1.14.2 Eligible under section 1902(e)(3) of the Act;

1.14.3 In foster care or other out-of-home placement;

1.14.4 Receiving foster care or adoption assistance; and/or

1.14.5 Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V.

1.15 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 CFR 438.104(a)).

1.16 Comparable Coverage

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

1.17 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.

1.18 Contract

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

1.19 Contractor

"Contractor" means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, officers, directors, partners, employees, and/or agents.

1.20 Contracted Services

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

1.21 Coordination of Care

"Coordination of Care" or "Care Coordination" means the deliberate organization of health care activities between two or more participants (including the enrollee) involved in the enrollee's care to facilitate the appropriate delivery of medical, chemical dependency, mental health and long term services and supports.

1.22 Covered Services

"Covered Services" means health care, behavioral health and long term services and supports that HCA and CMS determine are covered for Medicare and Medicaid enrollees.

1.23 Chronic Condition

"Chronic Condition" means a prolonged condition and includes, but is not limited to:

1.24.1 A mental health condition;

1.24.2 A substance use disorder;

1.24.3 Asthma;

1.24.4 Diabetes;

1.24.5 Heart failure;

1.24.6 Coronary artery disease;

1.24.7 Cerebrovascular disease;

1.24.8 Fibromyalgia;

1.24.9 Renal failure;

1.24.10 Chronic pain associated with musculoskeletal conditions;

1.24.11 Dementia;

1.24.12 Being overweight, as evidenced by a body mass index over twenty-five.

1.24 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.

1.25 Designated Provider

"Designated Provider" means a primary care provider, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency or interdisciplinary health care team that has the systems and infrastructure in place to provide coordinated services for enrollees with special health care needs.

1.26 Director

"Director" means the Director of HCA. The Director may designate a representative to act on the Director's behalf. Any designation may include the representative's authority to hear and determine any matter.

1.27 Disease Management

"Disease management" means an approach to healthcare that teaches beneficiaries how to manage their chronic disease(s). Disease Management consists of a group of interventions designed to prevent or manage one or more chronic conditions so that beneficiaries may learn to take responsibility for management of their health condition(s).

1.28 Dual Eligible Beneficiary

"Dual Eligible Beneficiary" means a Medicare managed care recipient who is also eligible for Medicaid, and for whom the State has a responsibility for payment of Cost Sharing Obligations under the Washington State Plan. For purposes of this Agreement, Dual Eligible Enrollees are limited to the following categories of recipients:

1.28.1 **"**QMB Plus" -- QMBs who also meet the financial criteria for full Medicaid coverage. QMB Plus individuals are entitled to QMB Medical Benefits, plus all benefits available under the Washington State Plan for fully eligible Medicaid recipients.

1.282 **"**SLMB Plus" – SLMBs who also meet the financial criteria for full Medicaid Coverage. SLMB Plus individuals are entitled to payment of Medicare Part B premiums, plus all benefits available under the Washington State Plan for fully eligible Medicaid recipients.

1.29 Duplicate Coverage

"Duplicate Coverage" means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under HealthPath Washington (HPW).

1.30 Early, Periodic Screening, Diagnostic and Treatment (EPSDT)

"EPSDT (Early, Periodic Screening, Diagnostic and Treatment)" means a package of services in a preventive (well child) screening covered by Medicaid for children under the age of twenty-one (21) as defined in the Social Security Act (SSA) Section 1905(r) and HCA EPSDT program policy and billing instructions. Screening services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance use, mental health and hearing. The Contractor shall be responsible for all services found to be medically necessary services during the EPSDT exam. HCA has determined that EPSDT is available to all children eligible for any of its medical programs, except for the Medical Care Services program.

1.31 Eligible Enrollees

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

1.32 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 CFR 438.114(a)).

1.33 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 CFR 438.114(a)).

1.34 Encrypt

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

1.35 Enrollee

"Enrollee" means an individual who is enrolled in HealthPath Washington through a Managed Care Organization (MCO) having a Contract with HCA and CMS (42 CFR 438.10(a)). For the purposes of this program, the term "enrollee" also includes the term "enrollee" as it appears in informational materials developed by the Contractor and the State.

1.36 Enrollee with Special Health Care Needs

"Enrollee with Special Health Care Needs" means an enrollee who has a chronic or disabling condition that meets all of the following conditions:

a) Have a biological, psychological, or cognitive basis;

b) Have lasted or are virtually certain to last for at least a year;

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

d) Significant limitation in areas of physical, cognitive, or emotional function; and

e) Have a risk score of 1.5 or greater using the Predictive Risk Intelligence SysteM (PRISM) scoring method.

1.37 Evidence of Coverage (EOC)

"Evidence of Coverage (EOC)" means the CMS standardized model document for outreach and educational materials for Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans and 1876 Cost Plans.

1.38 External Quality Review (EQR)

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

1.39 External Quality Review Organization (EQRO)

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

1.40 External Quality Review Protocols

"External Quality Review Protocols" means a series of nine (9) procedures or guidelines for validating performance. Two of the nine protocols must be used by state Medicaid agencies. These are: 1) Determining Contractor compliance with federal Medicaid managed care regulations; and 2) Validation of performance improvement projects undertaken by the Contractor. The current External Quality Review Protocols can be found at the Centers for Medicare and Medicaid Services (CMS) website.

1.41 External Quality Review Report (EQRR)

"External Quality Review Report (EQRR)" means a technical report that describes the manner in which the data from all EQR activities are aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to the care furnished by the Contractor. HCA will provide a copy of the EQRR to the Contractor, through print or electronic media.

1.42 File and Use

"File and Use" means a CMS process for selected marketing materials as defined by CMS. File and Use materials are general advertising materials, the provider directory (including combined provider directory and model directory), the combined Annual Notice of Changes and Evidence of Coverage (ANOC/EOC), as well as the following model marketing documents, if used without modification 1) pharmacy directories; 2) formularies; 3) certain CMS enrollment/disenrollment letters, and 4) certain claims,

grievance, organization/coverage determinations, (including exceptions) and appeals model letters.

1.43 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 rights (42 CFR 438.400(b)).

1.44 Grievance Process

"Grievance Process" means the procedure for addressing enrollees' grievances (42 CFR 438.400(b)).

1.45 Grievance System

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

1.46 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.

1.47 Health Action Plan

"Health Action Plan**"** means an enrollee-prioritized plan identifying what the enrollee plans to do to improve their health and/or self-management of health conditions. The health action plan should contain at least one enrollee-developed and prioritized goal; identify what actions the beneficiary is taking to achieve the goal(s); and includes the actions of the Intensive Care Coordinator, including use of health care or community resources and services that support the enrollee's action plan.

1.48 Health Care Authority

"Health Care Authority" means the State of Washington's single state Medicaid Agency and its employees and authorized agents. For the purposes of this contract, HealthCare Authority also includes HealthPath Washington project staff employed by the Washington Department of Social and Health Services' Aging and Disability Services Administration (ADSA).

1.49 Health Care Professional

"Health Care Professional" means a physician or any of the following acting within their scope of practice, including; 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, For the purposes of this project, "health care professional" also includes chemical dependency professional, licensed mental health counselor, mental health professionals, and mental health care providers..

1.50 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).

1.51 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).

1.52 HealthPath Washington

"HealthPath Washington" is the demonstration program developed by a partnership of the Washington Department of Social and Health Services. The Health Care Authority and the Centers for Medicare and Medicaid Services (CMS) Innovations Office, to provide integrated managed care services to dually eligible Medicare/Medicaid enrollees.

1.53 Health Technology Assessment (HTA)

"Health Technology Assessment (HTA)" means a program that determines if health services purchased 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.

1.54 Individualized Care Plan

"Individualized Care Plan" means an integrated, individualized, person-centered care plan jointly created and managed by the beneficiary, his or her selected support system, his or her health plan care management team, and his or her interdisciplinary team of care providers. The plan incorporates a holistic, preventative, and recovery focus and is based on a comprehensive assessment of clinical and non-clinical needs and addresses identified gaps in care and barriers to care.

1.55 Intensive Care Management

"Intensive Care Management" means an approach to integrating care across existing care systems. Intensive Care Management is a person-centered system of care that provides a means of integrating and coordinating services across systems of care including institutions, acute medical care, preventive and wellness care, behavioral health care, community-based long-term services and supports, and community-based social services and supports for both children and adults with chronic conditions.

Intensive Care Management is the central point for directing person-centered care and is accountable for the following:

- Reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits;
- Providing timely post discharge follow-up; and
- Improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health, and long-term care services and supports.

The Intensive Care Management incorporates the following six activities:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care between care settings, including appropriate follow-up;
4. Individual and family support (including authorized representatives);
5. Referral to community and social support services, if relevant; and
6. Use of health information technology to link services, as feasible and appropriate.

1.56 Intensive Care Management Organization

"Intensive Care Management Organization" means various providers such as a primary care, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, AAA, or other community based management organizations that has the systems and infrastructure in place to provide Intensive Care Management services for enrollees with special health care needs. The (IHMO)may bring together in one location large and diverse teams of care providers to meet the needs of the beneficiary or may build virtual teams linking themselves and the beneficiary to care providers and services in their communities.

1.57 Intensive Care Coordinator

"Intensive Care Coordinator" means an individual that has successfully completed specialized training directly related to the Intensive Care Management Model for Service Delivery and meets at a minimum one or more of the following requirements:

- Registered Nurse
- Licensed Practical Nurse
- Physician's Assistant
- BSW or MSW prepared Social Worker
- Chemical Dependency Professional
- Professionals with significant experience working with special populations

1.58 Interdisciplinary Health Care Team

"Interdisciplinary Health Care Team" means a consistent groping of people from relevant clinical and non-clinical disciplines, inclusive of the enrollee and individuals of his or her choice, whose interaction are guided by specific team functions and processes to achieve team-defined favorable outcomes for the enrollee. The team may include, but is not limited to, medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, doctors of chiropractic, physical therapists, licensed complementary and alternative medicine practitioners, home care and other long-term care providers, and physician assistants.

1.59

1.60 Long Term Services and Supports (LTSS)

"Long Term Services and Supports (LTSS)" means a wide range of consumer directed assistance, services or devices provided and designed to meet medical, personal and social needs in a variety of settings or locations to enable a person to live as independently as possible.

1.61 Managed Care

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

1.62 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 and CMS under a comprehensive risk contract to provide prepaid health care, behavioral health and long term services and supports services to eligible enrollees.

1.63 Marketing

"Marketing" means any communication from the Contractor to a potential enrollee or enrollee with another MCO contracted for HealthPathWashington, 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 contracted MCO (42 CFR 438.104(a)).

1.64 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 CFR 438.104(a)).

1.65 Material Provider

"Material Provider" means a Participating Provider whose loss would degrade access to care in the Service Area.

1.66 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, behavioral health and long term supports and services providers. The unit is part of the Criminal Justice Division of the Attorney General's Office.

1.67 "Medically Necessary Services"

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 or 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 purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

1.68 "Medicare"

"Medicare" means Title XVIII of the Social Security Act, federal health insurance program for people age 65 and older, certain younger disabled people, and people with kidney failure. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies, Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare enrollees with the option of receiving Part A and Part B services through a private health plan.

1.69 Mental Health Advance Directive

"Mental Health Advance Directive" means a written document in which the principal makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both, and that is consistent with the provisions of Revised Code of Washington (RCW) 71.32.020.

1.70 Mental Health Care Provider

"Mental Health Care Provider "means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years' experience in the mental health or related fields.

1.71 Mental Health Professional

"Mental Health Professional "means:

(A) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;

(B) 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 of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(C) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(E) A person who has been granted a time limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388 865 265.

Within the definition above are the following:

1.71.1 "Psychiatrist" means a person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

1.71.2 "Psychologist" means a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW;

1.71.3 "Social worker" means a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary;

1.71.4 “Child psychiatrist" means a person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

1.71.5 "Psychiatric nurse" means a registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years of experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

1.71.6 "Counselor" means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

1.72 Model of Care

“Model of Care” means a CMS required written care management plan for Dual Eligible Medicare Advantage Special Needs Plans (DESNP) with eleven model of care elements and 4 State specific elements

1.72.1 Targeted population;

1.72.2 Measurable goals;

1.72.3 Staff structure and care management roles;

1.72.4 Interdisciplinary care team;

1.72.5 Provider network having special expertise and use of clinical practice guidelines;

1.72.6 Model of care training;

1.72.7 Health risk assessment;

1.72.8 Individualized care plan;

1.72.9 Communication network;

1.72.10 Care management for most vulnerable subpopulations;

1.72.11 Performance and health outcome measurement.

1.72.12 Integrated Delivery System and Care Coordination

1.72.13 Health Action Plan (HAP)

1.72.14 Person-Centered Care

1.72.15 Transitional Care

1.73 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 enrollees receive.

1.74 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.

1.75 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.

1.76 Person-Centered

"Person-Centered" means an orientation toward the whole person that is relation-based and involves partnering with beneficiaries and people of their choosing to understand and respect each individual's unique needs, culture, values, and preferences. The beneficiary and their representatives are recognized as core members of the care team and are fully informed partners in establishing care plans and making decisions about the management of their health status and utilization of available health care benefits.

1.77 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.

1.78 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.

1.79 Physically Secure

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

1.80 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.

1.81 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.

1.82 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 CFR 438.114 and 422.113).

1.83 Potential Enrollee

"Potential Enrollee" means any individual eligible for enrollment in HealthPath Washington under this Contract who is not enrolled with a health care plan having a contract with HCA and CMS (42 CFR 438.10(a)).

1.84 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, 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 CFR 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.

1.85 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 enrollee's disease profile and pharmacy utilization.

1.86 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, behavioral health or long term services and supports, or products.

1.87 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, behavioral health, long term services and supports that are consistent with current professional knowledge (42 CFR 438.320).

1.88 Referral Provider

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

1.89 Regional Support Network (RSN)

"Regional Support Network (RSN)" means a county, a combination of counties, or a private nonprofit entity that administers and provides publicly funded mental health services for a designated geographic area within the state.

1.90 Regulation

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

1.91 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://slc.leg.wa.gov/.

1.92 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 herein.

1.93 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.

1.94 Service Areas

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

1.95 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.

1.96 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:

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

1.96.2 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

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

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

1.96.5 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.

1.97 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.

1.98 Transitional Continuity of Care

"Transitional Continuity of Care" means the provision of continuous care, including prescription medication, 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.

1.99 Transport

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

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

1.99.2 Is accomplished other than via a Trusted System.

1.100 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.

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

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

1.101 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.

1.102 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 CFR 438.320).

1.103 WAC

"WAC" means the Washington Administrative Code. 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://slc.leg.wa.gov/.

2 GENERAL TERMS AND CONDITIONS

2.1 Amendment

Any amendment to this Contract shall require the approval of CMS, HCA and the Contractor. Any amendment shall be in writing and shall be signed by a Contractor's authorized officer and authorized representatives of CMS and 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.

2.2Assignment

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

2.3Billing Limitations

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

2.3.2 Neither HCA nor CMS shall 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 neither HCA nor CMS shall 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.

2.4Compliance 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 CFR 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:

2.4.1.1 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 CFR 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.

2.4.1.2 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.

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

2.4.1.4 Those specified in Title 18 RCW for professional licensing.

2.4.1.5 Industrial Insurance – Title 51 RCW.

2.4.1.6 Reporting of abuse as required by RCW 26.44.030.

2.4.1.7 Federal Drug and Alcohol Confidentiality Laws in 42 CFR Part 2.

2.4.1.8 EEO Provisions.

2.4.1.9 Copeland Anti-Kickback Act.

2.4.1.10 Davis-Bacon Act.

2.4.1.11 Byrd Anti-Lobbying Amendment.

2.4.1.12 All federal and state nondiscrimination laws and regulations.

2.4.1.13 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.

Any other requirements associated with the receipt of federal funds.

2.4.1.14 Collective Bargaining: The Contractor shall comply with all current and future collective bargaining agreements.

2.4.1.15 The Contractor shall establish a mechanism to directly communicate and/or respond to Union employment-related inquiries made by worker/provider representatives when acting on the enrollee's behalf. Such information shall exclude specific and/or confidential personal information of consumers unless the Contractor has the written

permission of the consumer in question.

2.5 Confidentiality

2.5.1 The Contractor will protect and preserve the confidentiality of HCA/CMS's data or information that is defined as confidential under state or federal law or regulation or data that HCA/CMS has identified as confidential.

2.5.2 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 CFR Sec. 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 CFR parts 160, 162, and 164., the HIPAA regulations, 42 CFR 431 Subpart F, 42 CFR 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. This duty requires the Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:

2.5.4.1 Encrypting electronic Confidential Information during Transport;

2.5.4.2 Physically securing and tracking media containing Confidential Information during Transport;

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

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

2.5.4.5 Physically securing any computers, documents or other media containing the Confidential Information; and

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

2.5.5 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.

2.5.6 In the event of a theft, loss, unauthorized disclosure, or other potential or known compromise of Confidential Information, the Contractor shall notify HCA in writing, as described in accord with the Notices section of the General Terms and Conditions, within one (1) business day of the discovery of the event. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirement imposed by law.

2.5.7 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.

2.5.8 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.

2.6 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 and CMS 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 by any 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. The Contractor shall immediately notify HCA or CMS if, during the term of this Contract, Contractor becomes debarred. HCA/CMS may immediately terminate this Contract by providing Contractor written notice if 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

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 hearing shall be mailed to the Director, Washington State HCA, P.O. Box 42700, Olympia, WA 98504-2700 within fifteen (15) calendar days after the Contractor receives notice of the disputed issue(s). The Director will determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's reasonable discretion, but it is understood that such presentations will be informal in nature. The Director will provide written notice of the time, format, and location of the presentations. At the conclusion of the presentations, the Director will consider all of the evidence available and shall render a written recommendation as soon as practicable, but in no event more than thirty (30) calendar days after the conclusion of the presentations. The Director may appoint a designee to hear and determine the matter.

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

2.11.1 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.

2.11.2 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 or CMS. 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 or of CMS 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, nor CMS 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 CFR 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 CFR 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, 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 CFR 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.

2.14.4 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 Certificates of Insurance: 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 January 15th, of 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. Medical records and supporting management systems shall include all pertinent information related to the medical management of each enrollee. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.

2.16.2 All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of Ten (10) years after final payment is made under this Contract. However, when an 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).

2.16.3 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 or CMS contractor after the effective date of this Contract, HCA and CMS reserve 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/CMS with ninety (90) calendar days' prior written notice of any change in the Contractor's ownership or legal status. The Contractor shall provide HCA/CMS 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, the MCO contact person for HealthPath Washington, the HCA/CMS Account Executive, and the HCA 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 Exhibit A – HCA's Request for Proposal 2013-XXX Dated

2.19.6 Exhibit B – Contractors Response to RFP 2013-XXX Dated

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

2.19.8 Any other material incorporated herein by reference.

2.20 Severability

If any term or condition of this Contract is held invalid by any court, 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 designee has the authority to waive any term or condition of this Contract on behalf of HCA, and for CMS.

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 dually eligible beneficiary with whom the Contractor has contact. The Contractor shall require participating hospitals, ambulatory care surgery centers, nursing facilities 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

CMS, 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 parties, or any of the other parties' 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 other parties. The Contractor shall indemnify and hold harmless HCA and CMS 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 parties in writing of any claim and provide the other parties 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 others 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:

«Contractor_Contact»

«Contractor_Name»

«Contractor_Address»

«City_State_Zip»

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

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

2.28.3 In the case of notice to CMS, send notice to:

2.28.4 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.

2.2.8.5 Any 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 forth 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.

2.28.6 The Contractor shall notify the State of any suspected cases of enrollee fraud to the Department of Social and Health Services (DSHS) Office of Fraud and Accountability (OFA) (http://www.dshs.wa.gov/fraud/index.shtml) by:

2.28.6.1 Calling the Welfare Fraud Hotline at 1-800-562-6906 and pressing option “1” to report Welfare Fraud via leaving a detailed voice mail message;

2.28.6.2 Mailing a written complaint to:

Welfare Fraud Hotline

P.O. Box 45817

Olympia, WA 98504-5817

2.28.6.3 Entering the complaint online at: https://fortress.wa.gov/dshs/dshsroot/fraud/index.asp

2.28.6.4 Faxing the written complaint to Attention Hotline at 360-664-0032 OR

2.28.6.5 Emailing the complaint electronically to the DSHS OFA Hotline at Hotline@dshs.wa.gov.

2.29 Notice of Overpayment

If the Contractor receives a vendor overpayment notice or a letter communicating the existence of an overpayment from HCA or CMS, the Contractor may protest the overpayment determination by requesting an adjudicative proceeding. 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 and CMS recognize that nothing in this Contract shall give HCA or CMS 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 or CMS 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 or CMS 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 and CMS 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 and CMS 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 and CMS 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 and CMS 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 or CMS 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 including intensive care coordinators and Care Managers (41 USC 423).

2.34 Termination

2.34.1 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.

2.34.2 Termination by the Contractor for Default

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.

2.34.3 Termination by HCA

2.34.3.1 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.

2.34.3.2 Except as otherwise provided in this contract, the HCA may, by giving thirty (30) days' written notice, terminate this contract in whole or in part when the HCA determines, in its sole discretion, that termination would be in the Authority's best interest. If this contract is so terminated, the 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.

2.35 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.

2.35.1 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.

2.35.2 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 CFR 438.708. HCA shall:

2.35.2.1 Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;

2.35.2.2 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

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

2.36 Termination for Withdrawal or Reduction of Funds

In the event funding from any state, federal, or other sources is withdrawn, substantially reduced, or limited in any way after the date this Contract is signed and prior to the termination date, HCA and/or CMS may terminate this Contract upon 60 calendar days' prior written notice to Contractor or upon the effective date of withdrawn or reduced funding, whichever occurs earlier. If this Contract is so terminated, HCA and CMS 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 Post Termination Responsibilities

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

2.37.1 Cover enrollees hospitalized or in a nursing facility or other residential facility on the date of termination until discharge, consistent with the terms of this Contract;

2.37.2 Submit all data and reports required in the Contract;

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

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

2.38 Termination - Information on Outstanding Claims

In the event this Contract is terminated, the Contractor shall provide HCA and CMS, 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 CFR 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions Section of this Contract.

2.39 Treatment of Enrollee Property

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

2.40 Administrative Simplification

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

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

2.40.1.1 Current Procedural Terminology (CPT)

2.40.1.2 International Classification of Diseases (ICD)

2.40.1.3 Healthcare Common Procedure Coding System (HCPCS)

2.40.1.4 CMS Relative Value Units (RVUs)

2.40.1.5 CMS billing instructions and rules

2.40.1.6 Minimum Data Set

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

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

3 CMS AND HCA ADMINISTRATIVE RESPONSIBILITIES

3.1 Contract Management Team

CMS and HCA will designate a Contract Management Team that will include at least one contract manager from CMS, and at least two contract managers from the HCA project team (one each from HCA and DSHS). These contract managers shall be authorized and empowered to represent CMS and the State about all aspects of the Contract. The CMS contract manager and the HCA/DSHS contract managers shall act as liaisons between the Contractor, and CMS and the State for the duration of the Contract. The Contract Management Team shall:

3.1.1 Monitor Contractor compliance with the terms of the Contract. HCA shall be responsible for the day-to-day monitoring of the Contractor's performance and shall periodically report to CMS and the Director of HCA and ADSA. HCA and Contractor staff may also meet on a regular basis to discuss issues involved in implementation of the program. CMS shall communicate directly with the Contractor as necessary;

3.1.2 Receive and respond to all inquiries and requests made by the Contractor under this Contract in a timely manner;

3.1.3 Meet with the Contractor's Project Director on a periodic or as-needed basis, resolving issues that arise;

3.1.4 Coordinate requests for assistance from the Contractor, and assign CMS and HCA staff with appropriate expertise to provide technical assistance to the Contractor;

3.1.5 Make every effort to resolve any issues applicable to the HealthPath Washington Contract identified by the Contractor, CMS and/or HCA,

3.1.6 Inform the Contractor of any discretionary action by CMS or HCA under the provisions of the Contract,

3.1.7 Review and approve Contractor policies, guidelines, notices and other materials, including the Contractor's Outreach and orientation materials as described in Section 3.1.7.1, generated or disseminated by the Contractor, as required by this Contract.

3.1.7.1 Review, approve, and monitor the Contractor's Outreach and orientation materials and procedures, and the Contractor's Outreach activities and distribution of such materials, including:

3.1.7.1.1 Approval of all outreach materials, in all forms, prior to use;

3.1.7.1.2 Onsite review of outreach forums, products, and activities;

3.1.7.1.3 Review of actual outreach pieces as they are used in or by the media; and

3.1.7.1.4 Conduct additional review of materials and activities when complaints are made by any source. If CMS or HCA find that the Contractor is violating outreach requirements, monitor the development and implementation of a corrective action plan.

3.1.8 Review, approve and monitor the Contractor's Complaint and Appeals procedures;

3.1.9 Apply one or more of the sanctions described in the Contract, including monetary penalties, if CMS and HCA determine that the Contractor is in violation of any of the Contract terms stated herein;

3.1.10 Conduct onsite monitoring visits annually, or as determined necessary by CMS and HCA to verify the accuracy of reported data;

3.1.11 Develop documentation to support contract termination if the Contractor does not correct contract violations in the timeframe specified by CMS and HCA for corrective action; and

3.1.12 Coordinate the Contractor's external quality reviews conducted by the External Quality Review Organization.

3.2 Performance Evaluation

CMS and HCA will, at their discretion:

3.2.1 Evaluate, via onsite monitoring visits, reports as required by the Contract, external quality review activities and other means, the Contractor's compliance with the terms of this Contract, including evaluation of the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and HCA shall provide the Contractor with at least thirty (30) calendar days written notice of such monitoring activities.

3.2.2 Meet with the Contractor at least quarterly to assess the Contractor's performance and discuss areas of interest and discuss and resolve ongoing issues.

4 MARKETING, OUTREACH AND INFORMATION REQUIREMENTS

4.1 Marketing

4.1.1 All marketing materials must be reviewed by and have written approval of HCA and CMS prior to distribution (42 CFR 438.104(b)(1)(i)).

4.1.2 Such material shall include, but not be limited to:

4.1.2.1 Outreach, advertising, enrollment and disenrollment materials;

4.1.2.2 Benefit coverage information (e.g., Member handbooks, Summary of Benefits);

4.1.2.3 Operational letters (e.g., for enrollment, claims denials, appeals); and

4.1.2.4 Provider-related materials (e.g. provider directory, primary care network list).

4.1.3 In accordance with 42 CFR 422.80 (Medicare Advantage regulations), the review period for marketing materials by CMS and HCA shall be as follows:

4.1.3.1 Ten (10) days before the date of distribution if the marketing materials use, without modification, proposed model language as specified by CMS;

4.1.3.2 At least 45 days prior to use if the language in the proposed

materials is not the model language specified by CMS;

4.1.3.3 Five (5) days prior to use if the materials are “file and use” documents.

4.1.4 The Contractor shall submit all marketing material electronically to HCA as the single point of entry.

4.1.5 Missing or incorrect information will be returned to the Contractor for correction and the submission pended until resubmitted to HCA.

4.1.6 After approval of the material by HCA, (but no later than 20 days after plan submission of the complete materials), HCA will forward the material to the CMS Region X Office for review.

4.1.7 CMS will review the material per the Standard Medicare Advantage review within the 45 day timeframe and a joint letter detailing the review (approve, disapprove) will be sent to the Contractor.

4.1.8 Material requiring edits (i.e. that were denied pending submission of edits) will be resubmitted by the Contactor and 4.5 through 4.6 will be followed until the submission is approved or withdrawn.

4.1.9 Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information (42 CFR 438.104(b)(2)).

4.1.10 Marketing materials must be distributed in all service areas in which the Contractor provides services under this contract (42 CFR 438.104(b)(1)(ii)).

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

4.1.11.1 Marketing materials in English must give directions for obtaining understandable materials in the population's primary languages, as described in Subsection 4.4.2.2 of this Contract.

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

4.1.11.3 All translated marketing materials must be posted on the Contactor’s website.

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

4.1.13 The Contractor shall not offer the sale of other insurance to attempt to influence enrollment (42 CFR 438.104(b)(1)(iv)).

4.1.14 Neither the Contractor nor its subcontractors shall directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment (42 CFR 438.104(b)(1)(v)).

4.1.15 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 CFR 438.104(b)(2)(i)).

4.1.16 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 CFR 438.104(b)(2)(ii)).

4.2 Outreach Standards:

4.2.1 The Contractor shall submit to CMS and HCA a quarterly comprehensive outreach plan that includes:

4.2.1.1 Proposed activities for the coming quarter, including a schedule of planned events and activities, including the proposed audience;

4.2.1.2 Events, materials and approaches the Contractor intends to utilize for culturally diverse populations. If the Contractor has developed materials for a specific audience, CMS and HCA must approve the materials prior to distribution;

4.2.2 The Contractor shall:

4.2.2.1 Submit an outreach plan and materials for CMS and HCA approval before conducting any outreach activities or distributing such materials; Materials must take the intended audience into consideration, including translation of materials and terminology used in materials.

4.2.2.2 Refer Enrollees and Potential Enrollees with questions about HealthPath Washington eligibility or enrollment to HCA;

4.2.2.3 Make available to CMS and HCA, upon request, current schedules of all activities initiated or promoted by the Contractor to provide information or to encourage enrollment, and

4.2.2.4 Convene all promotional events at sites within the Contractor's Service Area that meet the requirements of the Americans with Disabilities Act.

4.2.3 Optional Outreach Activities. The Contractor MAY:

4.2.3.1 Post written outreach and promotional materials approved by CMS and HCA at provider sites and other sites throughout the Contractor's service area;

4.2.3.2 Access television, radio, and print media, including free newspapers, for the purpose of outreach or promotion in accordance with the requirements set forth in this Contract. All text, scripts, and materials developed by the Contractor for this purpose require review and approval by CMS and HCA prior to use;

4.2.3.3 Distribute approved outreach and promotional materials by mail to potential enrollees throughout the Contractor's service area;

4.2.3.4 Provide nonfinancial promotional items only if they are offered to everyone to attends an event, regardless of whether they enroll with the Contractor, and only if items are of a retail value of $15.00 or less;

4.2.3.5 Conduct nursing facility and residential facility visits and home visits for interested enrollees only if the Contractor has documented a request to visit by a potential enrollee, a caregiver or other authorized representative.

4.3 Information Requirements for Enrollees and Potential Enrollees

4.3.1 As determined by HCA, either HCA or the Contractor shall provide sufficient, accurate written information to potential enrollees to assist them in making an informed decision about enrollment in accord with the provisions of this Section (SSA 1932(d)(2) and 42 CFR 438.10 and 438.104(b)(1)(iii)). If the enrollee is not able to understand written information or only understands a language that is not translated, the Contractor will provide the necessary information in an alternative format that is understandable to the enrollee.

4.3.2 The Contractor shall provide enrollees, and potential enrollees upon request, informational materials designed to describe HealthPath Washington. All informational materials must meet the requirements of this contract section. If the enrollee or potential enrollee is not able to understand written information or only understands a language that is not translated, the Contractor will provide the necessary information in an alternative format that is understandable to the enrollee or potential enrollee.

4.3.3 At least forty-five (45) calendar days prior to distribution, all enrollee information shall be submitted to CMS and HCA for written approval. CMS and HCA may waive the forty-five day requirement if, in the judgment of CMS and HCA, it is in the best interest of CMS, HCA and their enrollees.

4.3.4 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 judgment of CMS and HCA, the change is significant in regard to the enrollees' quality of or access to care. CMS and/or HCA shall notify the Contractor of any significant change in writing (42 CFR 438.6(i)(4) and 438.10(f)(4)).

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

4.3.5.1 Covered Services, including those covered by HealthPath Washington, and those covered by DSHS, HCA or CMS outside the Contract;

4.3.5.2 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.

4.3.5.3 Changing PCPs.

4.3.5.4 Accessing services outside the Contractor's service area.

4.3.5.5 Accessing Emergency, after hours and urgent services.

4.3.5.6 Accessing hospital care and how to get a list of hospitals that are available to enrollees.

4.3.5.7 Specialists available to enrollees, including mental health and chemical dependency providers and providers of long term care services and supports, and how to obtain specific information including a list of specialists, their identity, location, languages spoken, qualifications, practice restrictions and availability.

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

4.3.5.9 Limitations to the availability of or referral to specialists to assist the enrollee in selecting a PCP, including any medical group restrictions.

4.3.5.10 Direct access to a Woman's Healthcare specialist within the Contractor's network.

4.3.5.11 Obtaining information regarding Physician Incentive Plans (42 CFR 422.208 and 422.210).

4.3.5.12 Obtaining information on the Contractor's structure and operations (42 CFR 438.10(g)).

4.3.5.13 Informed consent guidelines.

4.3.5.14 Conversion rights under RCW 48.46.450 or RCW 48.44.370.

4.3.5.15 Requesting a termination of enrollment.

4.3.5.16 Information regarding health care and mental health advance directives to include (42 CFR 422.128 and 438.6(i)(1 and 3)):

4.3.5.16.1 A statement about an enrollee's right to make decisions concerning his or her medical care, accept or refuse surgical, medical or psychiatric treatment, execute a healthcare or mental health advance directive, and revoke a healthcare or mental health advance directive at any time.

4.3.5.16.2 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.

4.3.5.16.3 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.

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

4.3.5.17 Health promotion, health education and preventive health services available.

4.3.5.18 Information on the Contractor's Grievance System including (42 CFR 438.10(f)(2), 438.10(f)(6)(iv), 438.10(g)(1) and SMM2900 and 2902.2):

4.3.5.18.1 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).

4.3.5.18.2 The enrollees' 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.

4.3.5.18.3 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.

4.3.5.18.4 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.

4.3.5.18.5 The enrollees' right to appeal an independent review decision to the Board of Appeals and how to request such an appeal.

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

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

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

4.3.5.18.9 Availability of ombuds-services through the Long Term Care, Mental Health system, and the Office of Insurance Commissioner.

4.3.5.19 The enrollee's rights and responsibilities with respect to receiving contracted services.

4.3.5.20 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.

4.3.5.21 Specific information regarding EPSDT and childhood immunizations as described in the Contract.

4.3.5.22 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 CFR 438.10(c)(5)(i and ii)).

4.3.5.23 How to obtain information in alternative formats (42 CFR 438.10(d)(2)).

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

4.3.5.25 The prohibition on charging enrollees for contracted services, except for enrollee participation in the cost of care as described in this Contract, 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.

4.3.5.26 Information regarding the Contractor's appointment wait-time standards.

4.3.5.27 A description of the options Enrollees have to enroll, dis-enroll and change plans on a monthly basis.

4.3.5.28 Upon request by an enrollee, the Contractor shall provide:

4.3.5.28.1 Information regarding Mental Health Care Providers (MHCPs) including: Those who are not accepting new enrollees and information regarding licensure and certification status of MHCPs and Mental Health Professionals.

4.3.5.28.2 Information regarding Chemical Dependency Providers including: Those who are not accepting new enrollees, and information regarding licensure and certification status of Chemical Dependency Providers and Chemical Dependency Professionals (CDPs).

4.4 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 CFR 438.10).

4.4.1 Oral Information

4.4.1.1 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 CFR 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:

4.4.1.1.1 Customer service;

4.4.1.1.2 The Contractor is responsible for payment for interpreter services for care coordination and care planning activities conducted by Contractor's staff:

4.4.1.1.3 All appointments with any provider for any covered service;

4.4.1.1.4 Emergency services;

4.4.1.1.5 All steps necessary to file grievances and appeals.

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

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

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

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

4.4.1.6 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 CFR 438.10(c)(4)).

4.4.2 Written Information

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

4.4.2.1.1 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.

4.4.2.1.2 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:

4.4.2.1.2.1 Translating the material into the enrollee's

or potential enrollee's primary reading language.

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

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

4.4.2.1.2.4 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 CFR 438.10(d)(1)(ii)).

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

4.4.2.2 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 CFR 438.10(b)(1)).

4.4.2.3 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.

4.4.2.4 Disease Management materials, preventative services or other education materials used by the Contractor for health promotion efforts that are not developed by the Contractor or developed under contract with the Contractor are not required to meet the sixth grade reading level requirement.

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

5 ENROLLMENT

5.1Service Areas

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

5.1.1 The Contractor's services areas are either King or Snohomish County or both. The Health Care Authority may modify the service areas if there are changes as described in this section.

5.1.2 Clients in the eligibility groups described in this Section are eligible to enroll with the Contractor if they reside in the Contractor's service areas.

5.1.3 The Health Care Authority will use the enrollee's residential zip code to determine whether an enrollee resides within a service area.

5.2Eligible Client Groups

The Health Care Authority shall determine eligibility for enrollment under this Contract. The Health Care Authority will provide the Contractor a list of Recipient Aid Categories (RACs) that are eligible to enroll in HealthPathWashington. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract:

5.2.1 "Dual Eligible Beneficiary" means a Medicare managed care recipient who is also eligible for Medicaid, and for whom the State has a responsibility for payment of Cost Sharing Obligations under the Washington State Plan. For purposes of this Agreement, Dual Eligible Enrollees are limited to the following categories of recipients:

5.2.1.1 "QMB Plus" -- QMBs who also meet the financial criteria for full Medicaid coverage. QMB Plus individuals are entitled to QMB Medical Benefits, plus all benefits available under the Washington State Plan for fully eligible Medicaid recipients.

5.2.1.2 "SLMB Plus" – SLMBs who also meet the financial criteria for full Medicaid Coverage. SLMB Plus individuals are entitled to payment of Medicare Part B premiums, plus all benefits available under the Washington State Plan for fully eligible Medicaid recipients.

5.3 Client Notification

The Health Care Authority shall notify eligible clients of their rights and responsibilities as enrollees at the time of initial eligibility determination, after a break in eligibility greater than twelve 12 months or at least annually.

5.4 Enrollment Period

Subject to the Effective Date of Enrollment provisions of this Section, enrollment is continuously open.

5.5 Enrollment Process

5.5.1 HCA shall automatically enroll all Dual Eligible clients who are eligible for HealthPath Washington in accordance with the requirements of Section 5.2, with the exception of American Indian/Alaska Natives (AI/AN), Program for All inclusive Care for the Elderly (PACE) and those receiving Hospice. AI/AN individuals must take action to enroll in the program. PACE enrollees may enroll in HealthPath Washington, but must first disenroll from PACE.

5.5.2 After a 60-day retention period, an enrollee may disenroll for HealthPath Washington or change plans. The enrollee, the enrollee's representative or responsible parent or guardian must notify the Health Care Authority if the enrollee wants to disenroll from HealthPath Washington, or choose another health plan.

5.5.3 An enrollee or his/her representative may request disenrollment from HealthPath Washington at any time for any reason by calling the Health Care Authority's Customer Service Center. Former enrollees or their representatives may request re-enrollment into the program at any time if he or she still meets eligibility requirements. Enrollment in the program or disenrollment from the program shall be made prospectively for the month following the month in which the request was made.

5.6 Effective Date of Enrollment

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

5.6.1 If the enrollment is processed on or before the Health Care Authority cut-off date for enrollment, enrollment shall be effective the first (1st) day of the month following the month in which the enrollment is processed; or

5.6.2 If the enrollment is processed after the Health Care Authority cut-off date for enrollment, enrollment shall be effective the first (1st) day of the second month following the month in which the enrollment is processed.

5.7Newborns Effective Date of Enrollment

Newborns whose mothers are enrollees of a HealthPath Washington plan that also provides Healthy Options managed care on the date of birth shall be deemed Healthy Options enrollees and enrolled in the same plan as the mother as follows:

5.7.1 Retrospectively for the month(s) in which the first twenty-one (21) days of life occur and prospectively, beginning the first (1st) of the month after the newborn is reported to the Health Care Authority.

5.7.2 If the newborn does not receive a separate client identifier from the Health Care Authority the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) Days of life occur.

5.7.3 If the mother's enrollment is ended before the newborn receives a separate client identifier from the Health Care Authority, the newborn's enrollment shall end the last day of the month in which the twenty first (21st) day of life occurs or when the mother's enrollment ends, whichever is later, except as provided in the provisions of the Enrollee Hospitalized at Termination of Enrollment of the Benefits Section of this Contract.

5.7.3.1 Adopted children shall be covered consistent with the provisions of Title 48 RCW.

5.7.3.2 No retroactive coverage is provided under this Contract, except as described in this section or by mutual agreement by both parties to this Contract.

5.7.3.3 Newborns born to mothers who are not enrolled in a plan that also provides Healthy Options will be assigned to a Healthy Options plan according to current Healthy Options assignment criteria.

5.8Enrollment Data and Requirements for Contractor's Response

The Health Care Authority will provide the Contractor with data files with the information needed to perform the services described in this Contract.

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

5.8.2 The data file will be in the Health Insurance Portability and Accountability Act (HIPAA) compliant 834, Benefit Enrollment and Maintenance format (45 CFR 162.1503).

5.8.3 The data file will be transferred per specifications defined within the Health Care Authority Companion Guides.

5.8.4 The Contractor shall have ten (10) calendar days from the receipt of the data files to notify the Health Care Authority in writing of the refusal of an application for enrollment or any discrepancy regarding the Health Care Authority's proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by the Health Care Authority. 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 the Health Care Authority does not agree with the reasons stated in the notice. Subject to the Health Care Authority approval, the Contractor may refuse to accept an enrollee for the following reasons:

5.8.4.1 The Health Care Authority has enrolled the enrollee with the Contractor in a service area the Contractor is not contracted for.

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

5.9Termination of Enrollment

5.9.1 Voluntary Termination of Enrollment

5.9.1.1 Enrollees may request termination of enrollment by submitting a written request to terminate enrollment to the Health Care Authority or by calling the Health Care Authority toll-free enrollment number (42 CFR 438.56(d)(1)(i)). Except as provided in WAC 182-538 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.

5.9.2 Involuntary Termination of Enrollment Initiated by the Health Care Authority for Ineligibility

5.9.2.1 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.

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

5.9.3.1 The first (1st) day of the month following the month in which the enrollment termination is processed by the Health Care Authority if it is processed on or before the Health Care Authority cut-off date for enrollment or the Contractor is informed by the Health Care Authority of the enrollment termination prior to the first (1^{st}) day of the month following the month in which it is processed by the Health Care Authority.

5.9.3.2 Effective the first (1^{st}) day of the second month following the month in which the enrollment termination is processed if it is processed after the Health Care Authority cut-off date for enrollment and the Contractor is not informed by the Health Care Authority of the enrollment termination prior to the first(1^{st}) day of the month following the month in which it is processed by the Health Care Authority.

5.9.4 Newborns placed in foster care prior to discharge from their initial birth hospitalization shall have their enrollment terminated effective their date of birth.

5.9.5 Involuntary Enrollment Termination Initiated by the Health Care Authority for Comparable Coverage or Duplicate Coverage:

5.9.5.1 The Contractor shall notify the Health Care Authority, 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:

5.9.5.2 Within fifteen (15) working days when an enrollee is verified as having duplicate coverage with the Contractor, as defined herein.

5.9.5.3 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.

5.9.5.3.1 The Health Care Authority will involuntarily terminate the enrollment of any enrollee with duplicate coverage or comparable coverage as follows:

5.9.5.3.1 When the enrollee has duplicate coverage that has been verified by the Health Care Authority, the Health Care Authority 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.

5.9.5.3.1 When the enrollee has comparable coverage which has been verified by the Health Care Authority, the Health Care Authority shall terminate enrollment prospectively.

5.9.6 Involuntary Termination Initiated by the Contractor

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

5.9.6.1.1 The Health Care Authority 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 the Health Care Authority's receipt of such notice and the documentation required to substantiate the request. The Health Care Authority shall approve the request for involuntary termination of the enrollee when the Contractor has substantiated in writing evidence of the following (42 CFR 438.56(b)(1)):

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

5.9.6.1.1 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

5.9.6.1.1 The Enrollee engages in intentional misconduct, including refusing to provide information to the Contractor about third party insurance coverage; and

5.9.6.1.1 The enrollee received written notice from the Contractor of its intent to request the enrollee's termination of enrollment, unless the requirement for notification has been waived by the Health Care Authority 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.

5.9.6.2 The Contractor shall continue to provide services to the enrollee until the Health Care Authority has notified the Contractor in writing that enrollment is terminated.

5.9.6.3 The Health Care Authority 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 CFR 438.56(b)(2)).

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

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

5.9.8.1 When the enrollee is hospitalized at termination of enrollment and continued payment is required in accord with the provisions of the Enrollee Hospitalized at Enrollment and Enrollee Hospitalized at Termination of Enrollment in the

Benefits Section of this Contract.

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

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

5.9.9 Regardless of the procedures followed or the reason for termination, if an enrollment request is granted, or the enrollee's enrollment is terminated by the Health Care Authority for one of the reasons described in 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.

6 PAYMENT AND SANCTIONS

From the contract effective date, through March 31, 2014, any costs incurred by the Contractor in preparation for providing service are the responsibility of the Contractor.

6.1Rates/Premiums

6.1.1 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. HCA shall pay the Contractor, on or before the fifteenth (15th) calendar day of the month based on HCA list of enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 438.726(b) or 42 CFR 438.730(e).

6.1.2 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.

6.1.3 HCA will make a reasonable effort to provide the Contractor program specific premiums for any renewal period one hundred and twenty (120) calendar days prior to the beginning of that renewal period. If the Contractor will not continue to provide services to HCA in the renewal period, the Contractor shall notify HCA no later than thirty (30) calendar days after the publication of the rates and factors as required under the Notices provisions of the General Terms and Conditions Section of this Contract. If the Contractor notifies HCA, this Contract shall terminate, without penalty to either party, effective midnight at the end of the current term of the Contract. Neither party shall have the right to assert a claim for costs.

6.2 Medical Loss Ratio Limitation

The Contractor medical loss ratio for each program is limited to eighty-three percent (83%) in calendar year2014. Medical loss ratio shall be as defined by the Office of the Insurance Commissioner (OIC) in RCW 48.43.049 with the additional inclusion of any quality incentive payments made directly to Participating Providers prior to the end of the year. If the Contractor's actual medical loss ratio as determined by HCA and its

actuaries using the Contractor's financial information, is less than eighty-three percent (83%), HCA will calculate an amount due from the Contractor by subtracting the Contractor's actual medical loss ratio related to its performance under this Contract in the calendar year from eighty-three percent (83%) and multiplying the result by the total premiums paid to the Contractor for the calendar year, including the Delivery Case Rate. The Contractor shall remit to HCA the amount due within ninety (90) calendar days of the date that HCA provides notice to the Contractor of that amount. This provision shall survive the expiration or termination of this Contract.

6.3 Western State Hospital Payments

This work is in progress and will be incorporated at a later date.

6.4 Renegotiation of or Changes in Rates

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

6.4.2 The Contractor shall report to HCA on its coordination of benefits activities and its data collection methods in a format provided by HCA. The Contractor shall provide semi-annual reports to the HCA on February 1st for July through December of the preceding calendar year and August 1st for January through June of the current calendar year.

6.5Reinsurance/Risk Protection

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

6.6Experience Data Reporting

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

6.7Payments to Hospitals

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

6.7.1.1 HCA will recalculate claims payments to hospitals subject to the Hospital Safety Net Assessment for the period July 1, 2009 through April 30, 2011 based on restored and increased fee-for-services rates and hospital claims information provided to HCA. HCA will then use the results of the recalculation to calculate the change in premium payment rates for July 1, 2009 through April 30,2011. HCA will provide amended rates and make

payments to the Contractor for the difference between those amended premium payment rates and premium payment rates that were paid for that time period.

6.7.1.2 HCA will provide information to the Contractor to facilitate its payments to the hospitals subject to the Hospital Safety Net Assessment in compliance with Chapter 74.60 RCW.

6.7.1.3 The Contractor shall pay all hospitals at least the Inpatient and Outpatient rates published by HCA for its fee-for-service program.

6.7.2 Treatment of Inpatient Hospital Claims for Certified Public Expenditure (CPE) Hospitals.

6.7.2.1 Because HCA can leverage additional federal funds for fee-for-service inpatient claims at CPE facilities, these expenditures are being carved out of the premium payments for dually eligible populations being moved from fee-for-service (FFS) to HealthPath Washington beginning January 1, 2014. HCA will separately identify the enrollees subject to the carve-out.

6.7.2.2 While premiums are net of CPE inpatient hospital claims, the Contractor does remain at risk for these fee-for-service claims if they exceed expectations. CPE inpatient hospital expenditure benchmarks will be computed on a per-member-per month (PMPM) basis, and will vary by category, age, gender and region.

6.7.3 After the end of each calendar year, HCA will compute aggregate CPE hospital FFS expenditures attributable to the Contractor, based upon actual enrollment. Actual CPE hospital expenditures for all Contractor enrolled member months will be compared to the Contractor specific benchmarks. If actual expenditures exceed the established benchmarks, the Contractor will reimburse the State for the amount of the excess. The State will not make payments to any MCO if expenditures are below benchmark amounts. The following is a list of CPE Hospitals:

6.7.3.1 University of Washington Medical Center

6.7.3.2 Harborview Medical Center

6.7.3.3 Cascade Valley Hospital

6.7.3.4 Evergreen Hospital and Medical Center

6.7.3.5 Kennewick General Hospital

6.7.3.6 Olympic Medical Center

6.7.3.7 Samaritan Hospital – Moses Lake

6.7.3.8 Skagit County Hospital District #2 – Island

6.7.3.9 Skagit Valley Hospital

6.7.3.10 Valley General Hospital – Monroe

6.7.3.11 Valley Medical Center - Renton

6.7.3.12 The Contractor will be authorizing inpatient claims at CPE hospitals. HCA will honor the Contractor's authorization for the Contractor's provision of services related to inpatient claims.

6.8Payment for Services by Non-Participating Providers

6.8.1 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).

6.8.2 Except as provided herein for emergency services, the Contractor shall 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 HealthPath Washington program when the payment is for services received by a HealthPath Washington enrollee.

6.8.3 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.

6.8.3.1 The Contractor shall also track, document and report to HCA any known attempt by non-participating providers to balance bill enrollees.

6.8.3.2 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 September 1st of each year

and HCA shall forward the reports to CMS as necessary.

6.9 Payment to FQHCs/RHCs

The Contractor shall not pay a federally qualified health center (FQHC) or a rural health clinic (RHC) less than the Contractor would pay non-FQHC/RHC providers for the same services (42 USC 1396(m)(2)(A)(ix)).

6.10 Payment of Physician Services for Trauma Care

The Contractor shall pay physician services for trauma care at the same rate as HCA.

6.11 Data Certification Requirements

6.11.1 Data Certification Requirements: Any information and/or data required by this Contract and submitted to CMS and/or HCA shall be certified by the Contractor as follows (42 CFR 438.242(b)(2) and 438.600 through 438.606).

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

6.11.2.1 The Contractor's Chief Executive Officer.

6.11.2.2 The Contractor's Chief Financial Officer.

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

6.11.2.4 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.

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

6.11.2.6 HCA will identify the specific data that requires certification.

6.12 Sanctions

6.12.1 If the Contractor fails to meet one or more of its obligations under the terms of this Contract or other applicable law, CMS and/or HCA may impose sanctions by withholding up to five percent of its scheduled payments to the Contractor.

6.12.1.1 CMS and/or HCA may withhold payment from the end of the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

6.12.1.2 CMS and 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 CMS' and HCA' position.

6.12.2 HCA, CMS, or the Office of the Inspector General (OIG) may impose intermediate sanctions in accord with 42 CFR 438.700, 42 CFR 438.702, 42 CFR 438.704, 45 CFR 92.36(i)(1), 42 CFR 422.208 and 42 CFR 422.210 against the Contractor for:

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

6.12.2.2 Imposing on enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.

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

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

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

6.12.2.6 Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by CMS and HCA or that contain false or materially misleading information.

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

6.12.3 Intermediate sanctions may include:

6.12.3.1 Civil monetary penalties in the following amounts:

6.12.3.1.1 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.

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

6.12.3.1.1 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.

6.12.3.1.1 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.

6.12.3.2 Appointment of temporary management for the Contractor as provided in 42 CFR 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.

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

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

7 ACCESS TO CARE AND PROVIDER NETWORK

7.1Network Capacity

7.1.1 The Contractor shall maintain and monitor an appropriate provider network, supported by written agreements, sufficient to serve enrollees enrolled under this Contract and to provide the full range of services included in covered benefits (42 CFR 438.206(b)(1)).

7.1.2 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 medical, behavioral health or long term services and supports 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 CFR 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.

7.1.3 The Contractor must submit documentation regarding its maintenance, monitoring and analysis of the network 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 CFR 438.207(b & c)).

7.1.4 To assure adequate access to services, in the event the Contractor, by February 19, 2014, and in HCA's sole opinion, fails to secure an adequate network of providers in any contracted service area, HCA reserves the right to immediately terminate the Contractor's services for that area.

7.2Direct Services Provider Network

In the maintenance and monitoring of its network, the Contractor must consider the following (42 CFR 438.206(b)):

7.2.1 Expected enrollment.

7.2.2 Adequate access to all services covered under this Contract.

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

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

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

7.2.6 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.

7.2.7 The age, gender, cultural, ethnic, race and language needs of enrollees.

7.2.8 Continuity of care between existing provider relationships and potential new relationships.

7.3Direct Service Provider Network 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 CFR 438.206(b) & (c)(1)(i))). The Contractor shall ensure that:

7.3.1 Network providers offer access comparable to that offered to commercial enrollees or, if the Contractor serves only Medicaid and dual eligible enrollees, comparable to fee-for-service Medicaid and other care options available to Medicare enrollees(42 CFR 438.206(b)(1)(iv) & (c)(1)(ii))).

7.3.2 Mechanisms are established to ensure compliance by providers.

7.3.3 Providers are monitored regularly to determine compliance.

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

7.4Direct Service Provider Network Hours of Operation

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

7.524/7 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 CFR 438.206(c)(1)(iii)).

7.5.1 Health and behavioral health care 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.

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

7.5.3 Authorization of services.

7.5.4 Emergency drug supply, as described in the General Description of Contracted Services provisions in this Contract.

7.5.5 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

7.6Customer Service

The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8 a.m. to 5 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. Work

days for state employees shall include days designated as “temporary lay-off” or “furlough” days under state law.

7.6.1 Toll free numbers shall be provided at the expense of the Contractor.

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

7.6.3 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.

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

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

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

7.6.4.3 Average call “hold time” no longer than 3 minutes.

7.7 Appointment Standards

The Contractor shall comply with appointment standards that are no longer than the following, including priority appointments for HealthPath Washington enrollees (42 CFR 438.206(c)(1)(i)):

7.7.1 Transitional care:

7.7.1.1 The Contractor shall ensure that a Care Manager/Intensive Care Coordinator works with the hospital or other facility discharge planner to ensure that an enrollee being discharged from inpatient care has a follow-up medical appointment within seven days of release from the facility. If the enrollee requests it, the Care Manager/Intensive Care Coordinatorshall accompany the enrollee to the appointment, and shall work with the enrollee to ensure that all prescriptions and follow up instructions are followed by the enrollee and that any additional appointments are scheduled and attended. The Care Manager/Intensive Care Coordinator shall also ensure that a clinical assessment is provided and a care plan developed after discharge from one of these facilities.

7.7.1.2 The Contractor shall also ensure follow up activities described above are provided for enrollees who are discharged from inpatient or institutional care for mental 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. The Care Manager/Intensive Care Coordinator shall also ensure that a clinical assessment is provided and a care plan developed after discharge from one of these facilities.

Follow up appointment for mental health or chemical dependency treatment shall be offered within seven days of discharge.

7.7.1.3 The Contractor shall ensure that a Care Manager/Intensive Care Coordinator works with Residential Care Services when there is a licensing action against the a residential/licensed facility. If the violation is such that the enrollee must move to another setting, the Contractor will ensure that the enrollee's assigned Care Manager/Intensive Care Coordinator works with the enrollee and those designated by the enrollee to find another appropriate setting of their choice. Once the enrollee has chosen a new residence, the Care Manager/Intensive Care Coordinator will see the enrollee face-to-face, assist the enrollee to move themselves and their belongings and accompany the enrollee to their new setting. The Care Manager/Intensive Care Coordinator shall also ensure that a follow up contact is made within three days of the move to ensure the enrollee's needs are being met.

7.7.2 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.

7.7.3 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.

7.7.4 Urgent, symptomatic office visits shall be available from the enrollee's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

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

7.7.6 Offer of an appointment for the initial mental health intake assessment by a Mental Health Professional 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.

7.7.7 After initial mental health intake 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 Contract documents a reason for the delay.

7.7.8 Comprehensive chemical dependency assessment and treatment services shall be provided to enrollees 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.

7.7.9 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 Section 16.1.

7.7.10 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:

7.7.10.1 Crisis Services;

7.7.10.2 Freestanding Evaluation and Treatment;

7.7.10.3 Stabilization;

7.7.10.4 Rehabilitation Case Management

7.7.10.5 Psychiatric hospitalization

7.7.11 Contractor shall make a referral to DSHS or its designee within five (5) days of identification through the care coordination process or by the enrollee that the enrollee has unmet long term service and support need, in accordance with the requirements of Section 15 of this Contract.

7.8Provider 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, mental health, level 3 (Intensive Care Coordinator), chemical dependency and long term services and supports providers.

7.9Provider Network - Distance Standards

The Contractor's network of providers shall meet the distance standards below in every service area. HCA will designate a zip code in a service area as urban or non-urban for purposes of measurement. HCA will provide to the Contractor a list of service areas, zip codes and their designation.

7.9.1 PCP

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

7.9.1.2 Non-urban: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

7.9.2 Obstetrics

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

7.9.2.2 Non-urban: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

7.9.3 Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

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

7.9.3.2 Non-urban: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

7.9.4 Hospital

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

7.9.5 Pharmacy

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

7.9.5.2 Non-urban: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

7.9.6 Mental Health Service Sites

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

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

7.9.7 Chemical Dependency Treatment Facilities:

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

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

7.9.8 Long Term Services and Supports

7.9.8.1 Residential Services: The Contractor will maintain contracts sufficient to ensure enough bed capacity that 90% of enrollees would be able to move into a residential placement within one (1) week of referral or request and have the choice of three (3) different residential options within at least two (2) residential licensed categories (AFH, AL) in a 10 mile radius (Urban) or 25 miles (Rural) of their preferred location.

7.9.8.2 Skilled Nursing Facilities: The Contractor will maintain contracts sufficient enough to ensure that 90% of enrollee

would be able to move into a skilled nursing facility within 20 miles of their location of choice..

7.9.9 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.

7.10 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, Otolaryngologist, and Specialists in Physical Medicine and Rehabilitation. The Contractor shall analyze performance against standards at least annually. Analyses and documentation for the standards shall be available to HCA upon request.

7.11 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.

7.12 Standards for LTSS Providers

7.12.1 Residential Providers: The Contractor must ensure the percentage of residential providers who hold specialty designations is proportionate to the number of enrollees whose diagnoses would require the specialty Mental Health, Dementia, or Developmental Disability placement to ensure enrollees would not experience a delay in placement due to lack of specialty providers. For example, if 60% of the enrollees served have diagnoses that require a placement with mental health specialty, then the Contractor will ensure that at least 60% of residential providers have the specialty designation for mental health.

7.12.2 In-Home Personal Care Provider Network: The Contractor will develop contract with both agency and individual providers. The network will be sufficient to ensure 90% of enrollees will receive services through the provider type of their choice within five (5) business days or referral for in-home services. The provider network will be sufficient enough to allow enrollees a choice between at least two (2) different providers for each of the services for which they qualify.

7.12.3 Other LTSS Providers: The Contractor will provide or contract for services as listed in Appendix A, and will have access to at least two (2) of each provider type in the geographic areas or enough contractors of high use services to ensure enrollees receive the service within 10 calendar days of referral in the setting most appropriate to their need or to the service.

7.13 Access to Specialty Care

7.13.1 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 provide the necessary services with a qualified specialist outside the Contractor's provider network.

7.13.2 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.

7.14 Order of Acceptance

7.14.1 The Contractor shall provide care to all enrollees who voluntarily choose to enroll with the Contractor.

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

7.14.3 HCA shall enroll all eligible enrollees with the Contractor of their choice except as provided herein, unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.

7.14.4 HCA may suspend enrollment in any service area if, in judgment of CMS and HCA, it is in the best interest of CMS, HCA and/or their enrollees. The Contractor shall present any information CMS and or HCA require within thirty (30) calendar days of the Contractor's receipt of the request for information.

7.14.5 The Contractor shall accept enrollees who are enrolled by HCA in accord with this Contract and Chapter 182-538 WAC.

7.14.6 No eligible enrollee 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 , mental condition, functional impairment and chemical dependency, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 CFR 438.6(d)(1 and 3)).

7.15 Provider Network Changes

7.15.1 The Contractor shall give CMS and 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.

7.15.2 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 CFR 438.10(f)(5)). Enrollee notices shall have prior approval of CMS and 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.

7.15.3 CMS and HCA reserve the right to reduce premiums to recover any expenses incurred by CMS and/or 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.

8 QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

8.1 Quality Assurance and Performance Improvement (QAPI) Program

8.1.1 The Contractor shall have and maintain a quality assessment and performance improvement (QAPI) program for the long term services and supports, physical and behavioral health services it furnishes to its enrollees that meets the provisions of 42 CFR 438.240.

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

8.1.1.2 The QAPI program structure shall include the following elements:

8.1.1.2.1 A written description of the QAPI program including identification and description of the roles of designated physician, behavioral health practitioners, which includes chemical dependency treatment professionals, geriatric specialists, and specialists with disability expertise. The QAPI program description shall include:

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

8.1.1.2.1.1 Descriptions of committee responsibilities;

8.1.1.2.1.1 Contractor staff and practicing provider committee participant titles;

8.1.1.2.1.1 Meeting frequency; and

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

8.1.1.2.1 A Quality Improvement (QI) Committee that oversees the quality functions of the Contractor. The Quality Improvement Committee will:

8.1.1.2.1.2 Recommend policy decisions;

8.1.1.2.1.2 Analyze and evaluate the results of QI activities including annual review of the results of performance measures, utilization data and performance improvement;

8.1.1.2.1.2 Institute actions to address performance deficiencies;

8.1.1.2.1.2 Ensure appropriate follow-up and,

8.1.1.2.1.2 Ensure Model of Care is included in description

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

8.1.1.2.1.3 Goals and objectives for the year, including objectives for enrollee safety;

8.1.1.2.1.3 Timeframe to complete each activity;

8.1.1.2.1.3 Identification of a responsible person for each activity; and

8.1.1.2.1.3 Strategies for ensuring culturally competent services are provided including services provided to enrollees with developmental disabilities, substance abuse, mental health conditions;

8.1.1.2.1.3 Monitoring plans to assure implementation of the work plan;

8.1.1.2.1.3 Inclusion of Model of Care elements that represent under-performance;

8.1.1.2.1 An annual written report of the overall evaluation of the effectiveness of the Contractor QAPI program. (42 CFR 438.240(e)(2)). The report shall include at minimum:

8.1.1.2.1.4 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.

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

8.1.1.2.1.4 Interventions undertaken and/or planned during the review period to address underutilization, overutilization or mis-utilization patterns.

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

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

8.1.1.2.1.4 A written assessment of the Intensive Care Management program, including evaluation, monitoring, analysis and performance objectives;

8.1.1.3 The Quality Improvement Committee must include

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

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

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

8.1.1.3.1 A specialist with disability expertise with substantial involvement in the implementation of the long term care aspects of the QAPI.

8.1.2 Upon request, the Contractor shall make available to providers, enrollees, CMS or the HCA, the QAPI program description, and information on the Contractor's progress towards meeting its quality

plans and goals.

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

8.1.3.1 A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity.

8.1.3.2 Evaluation of the delegated entity prior to delegation.

8.1.3.3 An annual evaluation of the delegated entity.

8.1.3.4 Evaluation of regular delegated entity reports.

8.1.3.5 Follow-up on issues out of compliance with delegated agreement or HPW contract specifications.

8.2Performance Improvement Projects

8.2.1 The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas. The Contractor shall conduct the following PIPs:

8.2.1.1 One clinical PIP of the Contractor's choosing;

8.2.1.2 One non-clinical PIP, as described in Section 7.2.4.

8.3 By April 15, 2015, the Contractor shall evaluate their performance measurements as described in Section 8.2 and choose a third clinical or non-clinical PIP for a total of three PIPs.

8.3.1 The PIPs 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:

8.3.1.1 Measure performance using objective quality indicators.

8.3.1.2 Implement system interventions to achieve improvement in quality.

8.3.1.3 Evaluate the effectiveness of the interventions.

8.3.1.4 Plan and initiate activities for increasing or sustaining improvement.

8.3.1.5 Report the status and results of each project to HCA (42 CFR 438.240(d)(2)).

8.3.1.6 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 CFR 438.240(d)(2)).

8.3.2 Annually, the Contractor shall submit to HCA all required clinical and non-clinical performance improvement projects. Each project shall be documented on a performance improvement project worksheet found in the CMS protocol entitled "Conducting Performance Improvement Projects".

8.3.3 The Contractor shall conduct one non-clinical PIP on Comprehensive Transitional Care focused on dual eligible enrollees at risk for re-institutionalization, re-hospitalization, or substance use disorder recidivism. The Contractor will collaborate with primary care providers, regional support networks, state institutions, long-term care providers, hospitals, and substance use disorder programs to plan, execute and evaluate the project. The project shall include the following:

8.3.3.1 Appointment or hiring of a leader to manage the PIP including development of a project plan, budget, intervention activities and a plan for evaluating the impact of the PIP.

8.3.3.2 Coordinate with existing state efforts to improve care transitions such as projects led by the Washington State Hospital Association, Qualis Health, and grantees of the Community-based Care Transitions Program.

8.3.3.3 Evaluate the success of interventions at reducing re-institutionalization, re-hospitalization, and substance use disorder recidivism.

8.3.3.4 Submit quarterly progress reports providing an update on the status of the Transitional Healthcare Services PIP shall be submitted by the Project Leader to CMS and HCA beginning January 2014 and quarterly thereafter.

8.4Performance Measures using Healthcare Effectiveness Data & Information Set (HEDIS®) and Non-HEDIS Measures®)

8.4.1 In accord with the Notices provisions of the General 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 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 CFR 438.240(b)(2)). The Contractor shall make its best effort to maximize data collection.

8.4.2 In addition, the Contractor shall collect and report the non-HEDIS® measures, identified as such, following specifications provided by HCA.

8.4.3 No later than June 15 of each year, HEDIS® and non- HEDIS® measures shall be submitted electronically to HCA using the NCQA Interactive Data Submission System (IDSS) or other NCQA-approved method and methods provided by HCA to the Contractor for non-HEDIS® measures.

8.4.4 The following HEDIS® and non-HEDIS® measures shall be submitted to HCA in reporting year 2015; for the data collection period January 1, 2014 through December 31, 2014.

8.4.4.1 Care Transition Record transmitted to health care professional

8.4.4.2 Influenza Immunization

8.4.4.3 Percent of members with care plans by specific timeframe

8.4.4.4 Increase depression screening and follow-up care

8.4.4.5

8.4.4.6 Plan All Cause Readmission

8.4.4.7 Inpatient Utilization – General Hospital/Acute Care

8.4.4.8 Ambulatory Care (Outpatient and Emergency Department visits)

8.4.4.9 Preventable Non-Emergent Emergency Room Rates – non-HEDIS®

8.4.4.10 Initiation and engagement of alcohol and substance use treatment for program enrollees

8.4.4.11 Controlling High Blood Pressure

8.4.4.12 Use of Imaging Studies for Low Back Pain

8.4.4.13 Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol - non-HEDIS®

8.4.4.14 Follow-up after hospitalization for mental illness

8.4.4.15 Screening for Falls Prevention

8.4.5 DSHS, through the Division of Behavioral Health and Recovery (DBHR), shall provide technical assistance to the Contractor on use of the DSHS Treatment Analyzer. Contractor shall use TARGET (DSHS' chemical dependency information system) data and other sources to generate these reports.

8.4.6 The Contractor shall submit raw de-identified HEDIS® and non-HEDIS® data to HCA electronically for all measures, no later than June 30 of each year. The Contractor shall submit the raw HEDIS® data according to specifications provided by HCA.

8.4.7 All HEDIS® and non-HEDIS® measures 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 and the Centers for Medicare and Medicaid (CMS) Validating Performance Measures Protocol found at http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/ for non-HEDIS®

measures. HCA will fund and the designated EQRO will conduct the audit.

8.4.8 The Contractor shall cooperate with HCA's designated EQRO to validate the Contractor's Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures.

8.4.8.1 If the Contractor does not have NCQA accreditation for its Medicaid/CHIP product from the National Committee for Quality Assurance (NCQA), the Contractor shall receive a partial audit.

8.4.8.2 If the Contractor has NCQA accreditation for its Medicare or Medicaid product or is seeking accreditation with a scheduled NCQA visit during the Contract term, the Contractor shall receive a full audit.

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

8.4.9 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.

8.4.10 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.

8.5Training for Cultural Competency and Care Planning

The Contractor shall conduct and report on disability and cultural competence and care planning training attendance for 100% staff within 6 months of hire.

8.6 Behavioral Health Utilization Data

8.6.1 The Contractor shall report behavioral health utilization data annually for enrollees who are screened and/or assessed for Behavioral Health services. Data must be reported noting gender and age:

8.6.1.1 Number of enrollees who were screened for Chemical Dependency and/or Mental Health issues within 90 days of enrollment;

8.6.1.2 Number of enrollees whose initial screening results lead to further evaluation/assessments;

8.6.1.3 Number of enrollees who received treatment and the range of covered services provided.

8.7 Long Term Services and Supports

8.7.1 Contractor shall report enrollee discharge from a Nursing Home data annually: Percent of Enrollees with the following length of stay at date of discharge and the disposition after discharge, whether home, assisted living, another institution, or death.

8.7.1.1 Less than 30 calendar days

8.7.1.2 30-90 calendar days

8.7.1.3 90 calendar days to 6 months

8.7.1.4 6 months to 1 year

8.7.1.5 Longer than 1 year

8.7.2 LTSS Utilization: Contractor must report LTSS utilization data annually for Enrollees specified below by gender and age.

8.7.2.1 Percent of enrollees whose face-to-face appointments were made by the Contractor's Care Manager/Intensive Care Coordinator within seven (7) days from date DSHS or its designee informed the Contractor of their eligibility approval.

8.7.2.2 Percent of enrollees whose individual care plans were completed within 30 days of their care planning meeting.

8.7.2.3 Percent of enrollees who transitioned to the community for which the Care Manager/Intensive Care Coordinator conducted a face-to-face visit within 30 days.

8.8 LTSS Reports shall be sent to the HCA's Managed Care Mailbox at hcamcprograms@hca.wa.gov and titled LTSS Duals Contract enrollee reports, Section 7.9.

8.9 LTSS Waiver Utilization

8.9.1 To comply with the requirements of the Department of Social and

Health Services (DSHS) COPES waiver, the Contractor must provide an annual report on long term care service utilization data for enrollees. The report shall cover the period of April 1, 2014 – March 31, 2015 and shall be submitted to the DSHS program manager no later than August 31, 2015. Subsequent reports shall be submitted using the same timeframes.

8.9.2 The report must include all enrollees eligible for 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 enrollees across categories:

8.9.2.1 Personal Care Agency/IP

8.9.2.2 Environmental Modification

8.9.2.3 Personal Emergency Response System Installation and Service

8.9.2.4 Adult Day Care

8.9.2.5 Home Delivered Meals

8.9.2.6 Home Health Aide

8.9.2.7 Skilled Nursing

8.9.2.8 Enrollee Training

8.9.2.9 Specialized Medical Equipment and Supplies

8.9.2.10 Nurse Delegation (in Home)

8.9.2.11 Adult Family Home

8.9.2.12 Transportation

8.9.2.13 Enhanced Residential Care

8.9.2.14 Community Transition Services

8.9.2.15 Assisted Living.

8.10 LTSS 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 enrollees to licensed Assisted Living contract with the Department. The report is due April 30th of each year.

8.11 Enrollee Mortality

The Contractor must report mortality data annually, and within (10) business days upon request of HCA. The data will be reported by gender and age in the following categories:

8.11.1 Name

8.11.2 Location of death, and

8.11.3 Cause(s) of death

8.12 Enrollee Abuse

8.12.1 The Contractor shall report all instances of suspected abuse, abandonment, neglect and/or exploitation to 1-866-END-HARM.

8.12.2 On an annual basis, the Contractor shall report all instances of suspected abuse, abandonment, neglect or exploitation to the 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.

8.13 Incident Reporting

8.13.1 The Contractor must have a designated incident manager responsible for meeting the requirements under this section. The Contractor must maintain policies and procedures for both mandatory and serious and emergent incident reporting and referrals. Policies and procedures must be consistent with RCW 74.34, RCW 26.44 and other applicable state and federal laws. Policies and procedures must address the Contractor's oversight and review of the requirements in this section.

8.13.2 Contractors must report and follow up on a Category 1 incident involving enrollees who have been served anytime in the past 365 days. The Contractor must report incidents using the HCS/DDD CARE system and DBHR's electronic incident reporting system. If the DBHR electronic incident reporting system is unavailable for use, a DBHR standardized form shall be provided with instructions. The report must contain:

8.13.2.1 A description of the incident;

8.13.2.2 The date and time of the incident;

8.13.2.3 Incident location;

8.13.2.4 Incident type;

8.13.2.5 Names and ages, if known, of all individuals involved in the incident;

8.13.2.6 The nature of each individual's involvement in the incident;

8.13.2.7 The service history with the Contractor, if any, of individuals involved;

8.13.2.8 Steps taken or safeguards identified by the Contractor to promote the safety of the individual; and

8.13.2.9 Any legally required notifications made by the Contractor.

8.13.3 The Contractor must report the following serious and emergent incidents as defined in the table below. In addition, the Contractor shall use professional judgment in reporting incidents not listed herein.

Phone call to HCA/DSHS **within one hour** or once safety has been ensured. Follow	Electronic notification to HCA/DSHS **during business hours,** once enrollee safety has been ensured. **No later than one**

with electronic notification. **Category 1**	**business day.** **Category 2**
1. Death of enrollee when suspicious or unusual 2.. Enrollee is missing 3. Injuries of unknown origin requiring hospital admission 4. Any event involving known media interest or litigation 5. Any violent act to include rape or sexual assault, as defined in RCW 71.05.020 and RCW 9.94A.030, or any homicide or attempted homicide committed by a enrollee.	1. Death of any enrollee not reported under Column A 2. Alleged or suspected abandonment, abuse, exploitation, financial exploitation, neglect, or self-neglect of a enrollee 3. Alleged or suspected physical or sexual assault of a enrollee 4. Alleged or suspected criminal activity perpetrated against a enrollee 5. Alleged or suspected criminal activity by a enrollee that results in a case number or detainment 6. Injuries resulting from alleged or suspected enrollee to enrollee altercations that require medical treatment beyond First Aid 7. Mental health crisis resulting in inpatient admission to a state or community psychiatric facility 8. Life-threatening medically emergent condition 9. All injuries to a enrollee resulting from the use of restrictive procedures 10. Serious injuries of known cause, not otherwise defined, that require medical treatment beyond First Aid 11. Hospital or nursing facility admission not otherwise defined 12. Medication errors(s) that have or may result in injury/harm as assessed by a medical professional 13. Suicide gestures or attempts

8.13.4 Notification to the HCA/DSHS program manager within 1 business day:

8.13.4.1 Any event involving: a credible threat towards a staff member that occurs at a DSHS facility, a facility that DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community. A credible threat towards staff is defined as "A communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family, which resulted in a report to Law Enforcement, a Restraining/Protection order, or a workplace safety/personal protection plan.

8.13.4.2 Any breach or loss of enrollee data in any form that is considered as reportable in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act and that would allow for the unauthorized use of enrollee personal information. In addition to the standard elements of an incident report, contractor will document and/or attach: 1) the Police report, 2) any equipment that was lost, and 3) specifics of the beneficiary information.

8.13.4.3 Any incident that was referred to the Medicaid Fraud Control Unit.

8.13.4.4 Natural disaster or other conditions threatening the operations of the program or facility (to include earthquake, volcanic eruption, tsunami, fire, flood, an outbreak of communicable disease, etc.).

8.13.4.5 Death or serious injury of, staff, or public citizens at a DSHS facility or a facility that DSHS licenses, contracts with, or certifies;

8.13.4.6 Unauthorized leave of a mentally ill offender or a sexual violent offender from a mental health facility. This includes Evaluation and Treatment centers (E&T) Crises Stabilization Units (CSU) and Triage Facilities that accept involuntary enrollees.

8.13.5 Investigation: HCA/DSHS may require the Contractor to initiate an investigation of an incident.

8.13.5.1 The Contractor will fully cooperate with any investigation initiated by DSHS and provide any information requested by DSHS within the timeframes specified within the request.

8.13.5.2 DSHS may obtain information directly from any involved party and

8.13.5.3 DSHS may request medication management information.

8.13.5.4 DSHS may also investigate or may require the Contractor to investigate incidents that involve enrollees who have

received services from the Contractor more than 365 days prior to the incident.

8.13.6 Incident Review and Follow-up: the Contractor will review and follow-up on all incidents reported. The Contractor will provide sufficient information, review, and follow-up to take the process and report to its completion. An incident will not be categorized as complete until the following information is provided:

8.13.6.1 A summary of any incident debriefings or review process dispositions;

8.13.6.2 The present physical location of the enrollee if known. If the beneficiary cannot be located, the Contractor will document using the HCS/DDD CARE system and DBHR's electronic incident reporting system the steps that the Contractor took to attempt to locate the enrollee by using available local resources;

8.13.6.3 Documentation of whether the enrollee is receiving or not receiving LTSS or DBHR services from the Contractor at the time the incident is being closed.

8.13.6.4 In the case of a death of the enrollee, the Contractor must provide either a telephonic verification from an official source or via a death certificate.

8.13.6.5 In the case of a telephonic verification, the Contractor will document the date of the contact and both the name and official duty title of the person verifying the information.

8.13.7 If this information is unavailable, the attempt to retrieve it will be documented.

8.14 Plan Disenrollment Rate

8.14.1 The Contractor must report annually voluntary disenrollment rates and reasons (add reasons here).

8.14.2 The Contractor must track such information and develop interventions to address opportunities for improvement identified through the analysis of voluntary disenrollments.

8.15 External Quality Review

8.15.1 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.

8.15.2 The following required activities will be validated (42 CFR 438.358(b)(1)(2)(3)):

8.15.2.1 Performance improvement projects.

8.15.2.2 Performance measures.

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

8.15.3 HCA reserves the right to include additional optional activities described in 42 CFR 438.358 if additional funding becomes available and as mutually negotiated between HCA and the Contractor.

8.15.4 The Contractor shall submit reports, findings, and other results obtained from a Medicare or private accreditation review (e.g., CMS, NCQA, EValue8, URAC, etc.) if requested by HCA. HCA may, at its sole option, use the accreditation review results in lieu of an assessment of compliance with any Federal or State standards and the review conducted by TEAMonitor of those standards.

8.15.5 The Contractor shall submit to annual HCA TEAMonitor and EQRO monitoring reviews. The monitoring review process uses standards developed by HCA and methods and data collection tools and methods found in the CMS EQR Managed Care Organization Protocol and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by Medicaid MCOs (42 CFR 438.204).

8.15.5.1 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® results are used to identify and correct problems and to improve care and services to enrollees.

8.15.5.2 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 CFR 42 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness and access to the care furnished by the Contractor.

8.15.5.3 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, enrollee advocacy groups, and members of the general public. HCA must make this information available in alternative formats for

persons with sensory impairments, when requested.

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

8.15.6 The Contractor shall submit an annual update to HCA about currently held Medicare contracts in the State of Washington, including county-level coverage information under part C of title XVIII or under section 1876 of the Act.

8.16 Practice Guidelines

8.16.1 The Contractor shall adopt physical, behavioral health and long term care practice guidelines. The Contractor may develop or adopt guidelines developed by organizations such as the American Diabetes Association, American Medical Directors Association or the American Lung Association. Practice guidelines shall meet the following requirements (42 CFR 438.236):

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

8.16.1.2 Consider the needs of enrollees and support enrollee and family involvement in care plans.

8.16.1.3 Are adopted in consultation with contracting health care professionals within the State of Washington.

8.16.1.4 Are reviewed and updated at least every two years and as appropriate.

8.16.1.5 Are disseminated to all affected providers and, upon request, to HCA, enrollees and potential enrollees (42 CFR 438.236(c)).

8.16.1.6 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 CFR 438.236(d)).

8.16.1.7 Are distributed to affected providers within sixty (60) calendar days of adoption or revision.

8.16.1.8 Are distributed to new providers.

8.16.1.9 If distributed via the Internet, notification of the availability of adopted or revised guidelines must be provided to providers.

8.16.1.10 Include evidence-based mental health-specific guidelines, including documentation of why the guidelines were adopted;

8.16.1.11 Include evidence-based long-term care-specific guidelines including documentation of why the guidelines were adopted;

8.16.1.12 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.

8.16.2 The Contractor must maintain a record of notification and distribution of guidelines.

8.16.3 The Contractor shall adopt common practice guidelines on the use of standardized screening tools for:

8.16.3.1 Development in young children and

8.16.3.2 Mental health and substance use disorders in children, adolescents and adults/geriatric enrollees.

8.16.4 The Contractor shall develop health promotion and preventive care educational materials for enrollees using both print and electronic media. In developing these materials, the Contractor shall:

8.16.4.1 Conduct outreach to enrollees to promote timely access to preventive care according to Contractor-established preventive care guidelines.

8.16.4.2 Report on preventive care utilization through required performance measure reporting.

8.17 Deduction of payment for Services paid for by DSHS

8.17.1 DSHS shall provide to Contractor a enrollee detail report identifying all dollars paid to Individual Providers (IPs) on behalf of the Contractor in the previous month. The 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 IPs, less the amount of any error payments to IPs identified by the Contractor. DSHS shall have full responsibility for pursuing IPs for any overpayments.

8.17.2 DSHS shall submit to Contractor a enrollee detail report identifying all dollars paid to Nursing Facilities (NFs) on behalf of the 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 the Contractor. DSHS shall have the full responsibility for pursuing NFs for any overpayments.

8.18 Drug Formulary Review and Approval

The Contractor shall submit its drug formulary, for use with enrollees covered under the terms of this Contract, to HCA for review and approval by January 31 of each year of this Contract or upon HCA's request. HCA shall ensure that the formulary is adequate to meet the needs of enrollees, including adequate coverage of psychotropic medications which shall be at least as comprehensive as the HCA formulary (preferred drug list). The formulary shall be submitted to:

Pharmacy Policy Manager
Health Care Authority
Health Care Benefits and Utilization Management
P.O. Box 45506
Olympia, WA 98504-5506

8.19 Health Information Systems

8.19.1 The Contractor shall maintain, and shall require subcontractors to maintain, a health information system that complies with the requirements of 42 CFR 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:

8.19.1.1 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.

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

8.19.1.2.1 Verifying the accuracy and timeliness of reported data;

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

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

8.19.1.3 Include the Electronic Data Interchange (EDIE) for Emergency Room Notification.

8.19.1.4 Include the ability to store the Health Action Plan (HAP).

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

8.20 Technical Assistance

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

9 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 all policies and procedures to the HCA for review and approval in accordance with Subsection 8.2 Assessment of Policies and Procedures.

9.1 The Contractor's policies and procedures shall:

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

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

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

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

9.2 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 no later than April 30, 2014 and, thereafter, in response to corrective action and any time there is a new policy and procedure or a change to an existing policy and procedure.

10 SUBCONTRACTS

10.1 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 CFR 434.6 (c) & 438.230(a)).

10.2 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.

10.3 Provider Nondiscrimination

10.3.1 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 CFR 438.12(a)(1)).

10.3.2 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 CFR 438.12(a)(1)).

10.3.3 The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42CFR 438.214(c)).

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

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

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

10.3.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs (42 CFR 438.12(b)(1)).

10.4 Required Provisions

Subcontracts shall be in writing, consistent with the provisions of 42 CFR 434.6. All subcontracts shall contain the following provisions, in addition to those contained in subsection 9.5 and 9.6 of this contract:

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

10.4.2 Procedures and specific criteria for terminating the subcontract.

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

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

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

10.4.6 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 CFR 438.6(g)).

10.4.7 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.

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

10.4.9 No assignment of the subcontract shall take effect without HCA's written agreement.

10.4.10 The subcontractor shall comply with the applicable state and federal rules and regulations as set forth in this Contract, including the applicable requirements of 42 CFR 438.6(i).

10.4.11 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 CFR 438.6(1)).

10.4.12 The Contractor shall provide the following information regarding the grievance system to all subcontractors (42 CFR 438.414 and 42 CFR 438.10(g)(1)):

10.4.12.1 The toll-free numbers to file oral grievances and appeals.

10.4.12.2 The availability of assistance in filing a grievance or appeal.

10.4.12.3 The enrollee's right to request continuation of benefits during an appeal or hearing and, if the Contractor's action is upheld, the enrollee's responsibility to pay for the continued benefits for a maximum of the first sixty (60) days during which such benefits were continued.

10.4.12.4 The enrollee's right to file grievances and appeals and their requirements and timeframes for filing.

10.4.12.5 The enrollee's right to a hearing, how to obtain a hearing and representation rules at a hearing.

10.4.12.6 The process for revoking delegation or imposing other

sanctions if the subcontractor's performance is inadequate.

10.4.12.7 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.

10.4.12.8 The process whereby the subcontractor evaluates and ensures that services furnished to enrollees with special health care needs are appropriate to the enrollee's needs;

10.4.12.9 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.

10.5 Health Care Provider Subcontracts

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

10.5.1 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.

10.5.2 A statement that primary care, long term services and supports, chemical dependency and mental health and specialty care provider subcontractors shall cooperate with QI activities.

10.5.3 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.

10.5.4 Delegated activities are documented and agreed upon between Contractor and subcontractor. The document must include:

10.5.4.1 Assigned responsibilities

10.5.4.2 Delegated activities

10.5.4.3 A mechanism for evaluation

10.5.4.4 Corrective action policy and procedure

10.5.5 Information about enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws

and regulations.

10.5.6 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.

10.5.7 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 CFR 438.230(b)(2)).

10.5.8 If the subcontract includes physician services, provisions for compliance with the PCP requirements stated in this Contract.

10.5.9 A ninety (90) day termination notice provision.

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

10.5.11 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 CFR 438.206(c)(1)).

10.5.12 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 CFR 438.230(b)).

10.6 Health Care Provider Subcontracts Delegating Administrative Functions

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

10.6.1.1 For those subcontractors at financial risk, that the subcontractor shall maintain the Contractor's solvency requirements throughout the term of the Contract.

10.6.1.2 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.

10.6.1.3 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.

10.6.1.4 Provisions for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate (42 CFR 438.230(b)(2)).

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

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

10.6.2 The Contractor shall submit a report of all current delegated entities, activities delegated and the number of enrollees assigned or serviced by the delegated entity to HCA for review by February 28th of each year.

10.7 Intensive Care Management Providers

The Contractor shall provide intensive care management services or may enter into subcontracts for delivery of intensive care management services for enrollees with special health care needs. If services are provided by subcontractors, the Contractor must maintain a network of providers sufficient in quantity and type to provide the services defined in Section 15 of this contract.

10.7.1 Subcontracts shall contain elements defined by the State and which may include:

10.7.1.1 A requirement for subcontractor pre-delegation assessments conducted in accord with delegation requirements. Pre-delegation assessments shall include examination of:

10.7.1.1.1 The subcontractor's health information system and its ability to provide timely and efficient population-based and individual enrollee information on quality, cost and utilization-based performance data;

10.7.1.1.1 If delegated, the adequacy of staff resources, including an assessment of staff skills and abilities to provide care management services to enrollees with special health care needs;

10.7.1.1.1 If delegated, the tools used by Intensive Care Coordinator to document enrollee assessments, care plans, and care management described in this Contract; and

10.7.1.1.1 Adequacy of a supportive infrastructure beyond the health information system that promotes optimal enrollee outcomes and care experiences that may include, but is not limited to:

10.7.1.1.1.4 Care management for child and adult enrollees with special health care needs;

10.7.1.1.1.4 Care teams that facilitate high quality health care services delivery;

10.7.1.1.1.4 Enrollee reminder systems for primary care and specialist visits;

10.7.1.1.1.4 Open access scheduling;

10.7.1.1.1.4 Group visits for enrollees with common disease states such as diabetes, heart disease, asthma, etc.;

10.7.1.1.1.4 Use of disease registries to track patients individually and as a population;

10.7.1.1.1.4 Pre-visit planning and outreach to assess enrollee needs and gaps in care and facilitate improved care planning and primary care provider preparation;

10.7.1.1.1.4 Co-location of behavioral health, dental preventive, visual health or community-based social services; and

10.7.1.1.1.4 Enhanced access to care provided through alternative hours of care, 24-7 access or nurse call centers that facilitate both appropriate use of services and receipt of evidence-based preventive and illness care.

10.7.1.2 Evidence of adoption and use of evidence-based guidelines;

10.7.1.3 Established relationships with home care providers and community resources to facilitate the care of the enrollee; and

10.7.1.4 Established relationships with emergency room, urgent care and hospital facilities that support timely sharing of information about services accessed; and which promotes transitional health care services.

10.7.2 If validated by the pre-delegation assessment, the Contractor shall delegate care management responsibilities as defined in Contract to the subcontractor.

10.7.3 The Contractor shall pay intensive care management payments to

qualified providers commensurate with the functions provided. At minimum payment shall be made for:

10.7.4 Care management services (if delegated) and a description of the funding mechanism for such services;

10.7.5 Performance on reducing preventable emergency room and avoidable hospitalization utilization, and re-hospitalization within thirty (30) calendar days of hospital discharge; and

10.7.5.1 Performance on a subset of other performance measures defined in contract.

10.7.6 Provision for routine (at minimum, quarterly) Intensive care management utilization reports on performance against established performance measures compared to performance goals, including information on enrollees with special health care needs that require specific outreach or interventions to address under-, over- or mis-utilization of health care services;

10.7.7 Established business process relationships between Contractor-managed care departments and intensive care management subcontractors, such as hospital admission notification and pre-authorization programs contained within utilization management, Intensive Care Coordinators serving enrollees without chronic conditions to assist with case problem-solving including consideration of services beyond those covered by the contract, pharmacy reports of enrollee under, over or mis-utilization of medications including medications that threaten the health and safety of the enrollee, and quality improvement;

10.7.8 Requirement for at least annual subcontractor reporting on performance measures, including those linked to incentive payments, if funded; and

10.7.9 Requirement for conduct of periodic surveys; or cooperation with the State conduct of surveys of child and adult enrollees with special needs served by the subcontractor to assess enrollee satisfaction with health care services delivered or coordinated by a Intensive Care Management provider.

10.8 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 CFR 441.16).

10.9 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 CFR 438.6(h), 42 CFR 422.208 and 42 CFR 422.210).

10.9.1 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.

10.9.2 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:

10.9.2.1 A description of the incentive plan including whether the incentive plan includes referral services.

10.9.2.2 If the incentive plan includes referral services, the information provided to HCA shall include:

10.9.2.2.1 The type of incentive plan (e.g. withhold, bonus, capitation).

10.9.2.2.1 For incentive plans involving withholds or bonuses, the percent that is withheld or paid as a bonus.

10.9.2.2.1 Proof that stop-loss protection meets the requirements identified within the provisions of this Section, including the amount and type of stop-loss protection.

10.9.2.2.1 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.

10.9.3 If the Contractor, or any subcontractor (e.g. IPA, PHO), 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.

10.9.4 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.

10.9.5 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.

10.9.5.1 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.

10.9.5.2 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.

10.9.5.3 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.

10.9.5.4 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.

10.9.5.5 10,001 - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

10.9.5.6 25,001 members or more, there is no risk threshold.

10.9.6 For a physician or physician group at substantial financial risk, the Contractor shall annually, commencing in 2013, conduct surveys of enrollee satisfaction with the physician or physician group. The survey shall:

10.9.6.1 Be approved by HCA.

10.9.6.2 Be conducted according to commonly accepted principles of survey design and statistical analysis.

10.9.6.3 Address enrollee satisfaction with the physician or physician group, quality of services provided; and degree of access to services.

10.10 Provider Education

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

10.10.1 The Contractor shall maintain a system for keeping participating providers informed about:

10.10.1.1 Covered services for enrollees served under this Contract.

10.10.1.2 Coordination of care requirements.

10.10.1.3 HCA and the Contractor's policies and procedures as

related to this Contract.

10.10.1.4 Intensive Care Management

10.10.1.5 Interpretation of data from the Quality Improvement program.

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

10.10.1.7 Coverage of Mental health and chemical dependency services.

10.10.1.8 Contractor care management staff for assistance in care transitions and care management activity.

10.10.1.9 Program Integrity requirements.

10.10.1.10 Long-term services and supports including availability of home and community based care.

10.10.1.11 Educational opportunities for primary care and other 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.

10.11 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 CFR 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.

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

10.11.2 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.

10.11.3 The date of receipt is the date the Contractor receives the claim from the provider.

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

10.12 Federally Qualified Health Centers / Rural Health Clinics Report

The Contractor shall provide HCA with information related to subcontracted federally qualified health centers (FQHC) and rural health clinics (RHC), as required by HCA

Federally Qualified Health Center and Rural Health Center Billing Guides, published by HCA and incorporated by reference.

10.13 Provider Credentialing

The Contractor's policies and procedures shall follow the requirements related to the credentialing and re-credentialing of health care professionals who have signed contracts or participation agreements with the Contractor (42 CFR 438.12(a)(2), 438.206(a) and (b), and 438.214; 42 CFR 455.410 through 455.412; 42 CFR 455.416 through 455.432; 42 CFR 455.436 through 455.450). The Contractor shall ensure compliance with the requirements described in this Contract.

10.13.1 The Contractor's policies and procedures shall ensure compliance with the following requirements described in this section.

10.13.1.1 The Contractor's medical director or other designated physician shall have direct responsibility for and participation in the credentialing program.

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

10.13.2 The Contractor's credentialing and re-credentialing program shall include:

10.13.2.1 Identification of the type of providers credentialed and re-credentialed.

10.13.2.2 Specification of the verification sources used to make credentialing and re-credentialing decisions, including any evidence of provider sanctions.

10.13.2.3 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.

10.13.2.4 A detailed description of the Contractor's process for delegation of credentialing and re-credentialing.

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

10.13.3 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:

10.13.3.1 Review materials.

10.13.3.2 Correct incorrect or erroneous information.

10.13.3.3 Be informed of their credentialing status.

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

10.13.5 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.

10.13.6 The Contractor's process to ensure confidentiality.

10.13.7 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.

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

10.13.9 The Contractor's process to ensure that offices of all health care professionals meet office site standards established by the Contractor.

10.13.10 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 CFR 455.101).

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

10.13.12 The criteria used by the Contractor to credential and re-credential practitioners shall include (42 CFR 438.230(b)(1)):

10.13.12.1 Evidence of a current valid license to practice;

10.13.12.2 A valid DEA or CDS certificate if applicable;

10.13.12.3 Evidence of appropriate education and training;

10.13.12.4 Board certification if applicable;

10.13.12.5 Evaluation of work history;

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

10.13.12.7 A signed, dated attestation statement from the provider

that addresses:

10.13.12.7.1 The lack of present illegal drug use;

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

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

10.13.12.7.1 Current malpractice coverage;

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

10.13.12.7.1 Accuracy and completeness of the application.

10.13.13 The Contractor shall ensure that all subcontracted providers defined as "high categorical risk" in 42 CFR 424.515, 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 enrollment every three (3) years in compliance with 42 CFR 424.515.

10.13.14 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 CFR 455.101).

10.13.15 The Contractor shall require providers defined as "high categorical risk" for potential fraud as defined in 42 CFR 424.518 to be enrolled and screened by Medicare.

10.13.16 The Contractor's policies and procedures shall be consistent with 42 CFR 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.

10.13.17 The Contractor shall ensure that facilities providing LTSS meet licensing, certification and qualifications as set forth by the DSHS Residential Care Services Division, the Department of Health (DOH) or Washington Administrative Code (WAC).

11 ENROLLEE RIGHTS AND PROTECTIONS

11.1 General Requirements

11.1.1 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 CFR 438.100(a)(2)).

11.1.2 The Contractor shall guarantee each enrollee the following rights (42 CFR 438.100(b)(2)):

11.1.2.1 To be treated with respect and with consideration for their dignity and privacy (42 CFR 438.100(b)(2)(ii)).

11.1.2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's ability to understand (42 CFR 438.100(b)(2)(iii)).

11.1.2.3 To participate in decisions regarding their health care, including the right to refuse treatment (42 CFR 438.100(b)(2)(IV)).

11.1.2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 CFR 438.100(b)(2)(IV)).

11.1.2.5 To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 CFR 164 (42 CFR 438.100(b)(2)(iv)).

11.1.2.6 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 CFR 438.100(c)).

11.2 Cultural Considerations

The Contractor shall provide services that are appropriate to the culture of the enrollee receiving services, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and enrollees with physical and mental disabilities (42 CFR 438.206(c)(2)).

11.3 Advance Directives

11.3.1 The Contractor shall meet the requirements of WAC 182-501-0125, 42 CFR 438.6, 438.10, 422.128, 489.100 and 489 Subpart I as described in this section.

11.3.2 The Contractor's health and mental health advance directive policies and procedures shall be disseminated to all affected providers, enrollees, HCA, and, upon request, potential enrollees (42 CFR 438.6(i)(3)).

11.3.3 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 a health or mental health advance directive as a matter of conscience (42 CFR 422.128). At a minimum, this statement must do the following:

11.3.3.1 Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.

11.3.3.2 Identify the state legal authority permitting such objection.

11.3.3.3 Describe the range of medical conditions or procedures affected by the conscience objection.

11.3.4 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 health and mental health 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.

11.3.5 The Contractor must require and ensure, that the enrollee's medical record documents, in a prominent part, whether or not the individual has executed a health or mental health advance directive.

11.3.6 The Contractor shall not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed a health or mental health advance directive.

11.3.7 The Contractor shall ensure compliance with requirements of State and Federal law (whether statutory or recognized by the courts of the State) regarding health or mental health advance directives.

11.3.8 The Contractor shall provide for education of staff concerning its policies and procedures on health or mental health advance directives.

11.3.9 The Contractor shall provide for community education regarding health or mental health 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 a health or mental health 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 CFR 438.6(i)(3)).

11.3.10 The Contractor is not required to provide care that conflicts with a health or mental health advance directive; and is not required to

implement a health or mental health 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.

11.3.11 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 HCA if they believe the Contractor is non-compliant with advance directive requirements.

11.4 Enrollee Choice of PCP

11.4.1 The Contractor must implement procedures to ensure each enrollee has a source of primary care appropriate to their needs (42 CFR 438.207(c)).

11.4.2 The Contractor shall allow, to the extent possible and appropriate, each new enrollee to choose a participating PCP (42 CFR 438.6(m)).

11.4.3 In the case of newborns, the parent shall choose the newborn's PCP.

11.4.4 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) business days after coverage begins.

11.4.5 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 enrollee's request for the change (WAC 182-538-060 and WAC 284-43-251(1)).

11.5 Prohibition on Enrollee Charges for Covered Services

11.5.1 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, except enrollee participation in cost of care, and spend down payments required for certain eligibility groups.

11.5.2 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.

11.5.3 Except for allowable copayments and coinsurance, the Contractor shall require providers to report, and will maintain a central record of the charged amount, enrollee's agreement to pay, if any, and actions taken regarding the billing by the Contractor and 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.

11.5.4 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.

11.5.5 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.

11.5.6 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 that are not allowed under this Contract, including other insurer's copayments and coinsurance.

11.6 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 CFR 438.102(a)(1)(i)):

11.6.1 The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered (42 CFR 438.102(a)(1)(i)).

11.6.2 Any information the enrollee needs in order to decide among all relevant treatment options (42 CFR 438.102(a)(1)(ii)).

11.6.3 The risks, benefits, and consequences of treatment or non-treatment (42 CFR 438.102(a)(1)(iii)).

11.6.4 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 CFR 438.102(a)(1)(iv)).

11.7 Enrollee Self-Determination

The Contractor shall ensure that all providers: obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning advance directives (WAC 182-501-0125 and 42 CFR 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (Chapter 68.64 RCW).

11.8 Women's Health Care Services

The Contractor must provide female enrollees with direct access to a women's health specialist within the Contractors network for covered care necessary to provide women's routine and preventive health care services in accord with the provisions of WAC 284-43-250 and 42 CFR 438.206(b)(2).

11.9 Maternity Newborn Length of Stay

The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

11.10 Enrollment Not Discriminatory

11.10.1 The Contractor will not discriminate against enrollees due to an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of

medical services, diminished mental capacity, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition (WAC 182-538-130 and 42 CFR 438.56(b)(2)).

11.10.2 No eligible person shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, 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 CFR 438.6(d)(1 and 3)).

11.10.3 The Contractor will not discriminate against enrollees on the basis of race, color, national origin, sex, age, honorably discharged veteran or military status, sexual orientation, or the presence of any sensory, mental or physical disability, including chemical dependency issues, 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 any of these factors (42 CFR 438.6(d)(4), RCW 48.60.030).

12 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

12.1 Utilization Management Requirements

The Contractor shall follow the Utilization Management requirements described in this section.

12.1.1 The Contractor's policies and procedures related to Utilization Management shall comply with, and require the compliance of subcontractors with delegated authority for Utilization Management, the requirements described in this section.

12.1.2 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)).

12.1.3 The Contractor shall define its UMP structure and assign responsibility for UMP activities to appropriate individuals.

12.1.4 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.

12.1.5 The UMP program description shall include:

12.1.5.1 A written description of all UM-related committee(s)

12.1.5.2 Descriptions of committee responsibilities

12.1.5.3 Contractor staff and practicing provider committee participant title(s)

12.1.5.4 Meeting frequency

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

12.1.6 UMP behavioral health and non-behavioral health policies and procedures at minimum, shall address the following requirements:

12.1.6.1 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)).

12.1.6.2 The Contractor shall review and follow the recommendations of the Health Technology Assessment (HTA) program promulgated by HCA (Chapter 182-55 WAC).

12.1.6.3 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)).

12.1.6.4 Mechanisms for at least annual assessment of inter-rater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions.

12.1.6.5 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.

12.1.6.6 Mechanisms to verify that claimed services were actually provided.

12.1.6.7 Mechanisms to detect both underutilization and over-utilization of services, including pharmacy and LTSS.

12.1.6.8 Produce an annual report of the findings on quality and utilization measures and completed or planned interventions to address under or over-utilization patterns of care (42 CFR 438.240(b)(3)).

12.1.6.9 Specify the type of personnel responsible for each level of UM decision-making.

12.1.6.10 A physician, doctoral level psychologist, certified addiction medicine specialist, geriatrician or pharmacist, as appropriate, reviews any behavioral health denial of care based on medical necessity.

12.1.6.11 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.

12.1.6.12 Use of board certified consultants to assist in making medical necessity determinations.

12.1.6.13 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 or relevant area of expertise that encompasses the enrollee's condition or disease (WAC 284-43-620(4)).

12.1.6.14 Documentation of timelines for appeals in accord with the Appeal Process provisions of the Grievance System Section of this Contract.

12.1.7 Annually evaluate and update the UMP.

12.1.8 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 CFR 438.210(e)).

12.1.9 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.

12.2 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.

12.3 Decisions based on Functional Impairment

For enrollees receiving LTSS, the contractor shall not deny services for enrollees who are eligible for services based on their functional impairment WAC 388-106-0300 through 388-106-0335). 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 Division of Developmental Disabilities (DDD), including any approved Exceptions to Policy, unless the enrollee chooses an alternative proposed by the Contractor. However, the Contractor has the discretion to authorize LTSS more broadly in terms of criteria, amount, duration and scope, if the Contractor determines that such authorization would provide sufficient value to the Enrollee's care. Value shall be determined in light of the full range of service included in the care plan. 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.

12.4 Authorization of Services

The Contractor shall follow the authorization of services requirements described in this section.

12.4.1 The Contractor's policies and procedures related to authorization of services shall include compliance with 42 CFR 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.

12.4.2 The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (42 CFR 438.210(b)(1)(i)).

12.4.3 The Contractor shall not require pre-authorization for Behavioral Health assessments when the enrollee screening triggers a possible need for services.

12.4.4 The Contractor shall consult with the requesting provider when appropriate (42 CFR 438.210(b)(1)(ii)).

12.4.4.1 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, including those specializing in mental health, chemical dependency, LTSS and disability issues in treating the enrollee's condition or disease (42 CFR 438.210(b)(3)).

12.4.4.2 The Contractor shall notify the requesting provider and the enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the following requirements (42 CFR 438.210(c) and 438.404):

12.4.4.2.1 The notice to the enrollee shall meet the requirements of the, Information Requirements for Enrollees and Potential Enrollees of this Contract to ensure ease of understanding.

12.4.4.2.1 The notice to the enrollee and provider shall explain the following (42 CFR 438.404(b)(1-3)(5-7)):

12.4.4.2.1.2 The action the Contractor has taken or intends to take.

12.4.4.2.1.2 The reasons for the action, in easily understood language.

12.4.4.2.1.2 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.

12.4.4.2.1.2 A statement whether or not an enrollee has any liability for payment.

12.4.4.2.1.2 A toll free telephone number to call if the enrollee is billed for services.

12.4.4.2.1.2 The beneficiary's right to file an appeal.

12.4.4.2.1.2 The availability of Washington's designated ombudsman's office as referenced in the Affordable Care Act (Public Law 111-148).

12.4.4.2.1.2 If services are denied as non-covered, inform enrollees how to access the Contractor's Exception to Rule or Limitation Extension process.

12.4.4.2.1.2 The procedures for exercising the enrollee's rights.

12.4.4.3 The circumstances under which expedited resolution is available and how to request it.

12.4.4.4 The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay for these services.

12.4.4.5 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.

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

12.4.5.1 For denial of payment that may result in payment liability for the enrollee, at the time of any action affecting the claim.

12.4.5.2 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 CFR 431.213 and 431.214 are met.

12.4.5.3 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 CFR 438.210(d)(1) and WAC 284-43-410).

12.4.5.3.1 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 CFR 438.210(d)(1)(i-ii)):

12.4.5.3.1.1 The enrollee, or the provider, requests extension; or

12.4.5.3.1.1 The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

12.4.5.3.1 If the Contractor extends that timeframe, it shall (42 CFR 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.

12.4.5.4 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 CFR 438.210(d)(2)):

12.4.5.4.1 The enrollee requests the extension; or

12.4.5.4.1 The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

12.4.5.5 For all adverse determinations, the Contractor must notify the ordering provider, facility, and the enrollee. The Contractor must inform the parties in advance whether it will provide notification by phone, mail, fax, or other means. 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).

12.4.6 If enrollee fraud has been verified, the period of advance notice is five (5) calendar days.

12.4.6.1 The Contractor shall provide notification by the date of action in the following circumstances:

12.4.6.1.1 The enrollee dies;

12.4.6.1.1 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;

12.4.6.1.1 The enrollee is admitted to an institution where he or she is ineligible for services;

12.4.6.1.1 The enrollee's address is unknown and mail directed to him or her has no forwarding address;

12.4.6.1.1 The enrollee has moved out of the Contractor's service area;

12.4.6.1.1 The enrollee's PCP prescribes the change in the level of medical care;

12.4.6.1.1 An adverse determination made with regard to the preadmission screening for nursing facility was made by Home and Community Services;

12.4.6.1.1 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).

12.5 Experimental and Investigational Services

12.5.1 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.

12.5.2 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.

12.5.3 An adverse determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, hearing process and independent review.

12.6 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.

13 PROGRAM INTEGRITY

13.1 General Requirements

13.1.1 The Contractor's 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.

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

13.1.3 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.

13.1.3.1 Section 1902(a)(68) of the Social Security Act

13.1.3.2 42 CFR 438.(610)

13.1.3.3 42 CFR 455

13.1.3.4 42 CFR 1000 through 1008

13.2 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.

13.2.1 The Contractor shall work with HCA to perform individual and corporate extrapolation audits of the plan's providers' billings. This may include audits against all State-funded claims including Medicaid, CHIP, Basic Health Plan, and state employee health plans.

13.2.2 Recoveries from any identified and collected overpayments resulting from joint Contractor/HCA audit or post-payment review activities shall be split between HCA and the Contractor at a rate determined and developed by the purchaser-wide program integrity forum.

13.3 Disclosure by Managed Care Organization: Information on Ownership and Control

13.3.1 The Contractor must provide the following disclosures (42 CFR 455.104):

13.3.1.1 The name and address of any person (individual or corporation) with an 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.

13.3.1.2 Date of birth and Social Security Number (in the case of an individual).

13.3.1.3 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 5 percent or more interest.

13.3.1.4 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 five percent (5%) 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.

13.3.2 The name of any other managed care organization in which an owner of the managed care organization has an ownership or control interest.

13.3.3 The name, address, date of birth, and Social Security Number of any managing employee of the managed care organization.

13.3.4 Disclosures from the managed care entity are due at any of the following times:

13.3.4.1 Upon the managed care organization submitting the proposal in accordance with HCA's procurement process.

13.3.4.2 Upon the managed care entity executing the Contract with HCA.

13.3.4.3 Upon renewal or extension of the Contract.

13.3.4.4 Within thirty-five (35) calendar days after any change in ownership of the managed care entity.

13.4 Fraud and Abuse

The Contractor's Program Integrity, Fraud and Abuse program shall have:

13.4.1 In effect a process to inform officers, employees, agents and subcontractors regarding the False Claims Act.

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

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

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

13.4.5 Effective training for all affected parties.

13.4.6 Effective lines of communication between the compliance officer and the Contractor's staff and subcontractors.

13.4.7 Enforcement of standards through well-publicized disciplinary guidelines.

13.4.8 Provision for internal monitoring and auditing.

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

13.4.10 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.

13.4.11 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 their investigation.

13.4.12 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.

13.5 Provider Payment Suspensions

The Contractor shall establish policies and procedures for suspending a provider's payments when the Contractor determines a credible allegation of fraud exists and there is a pending investigation (42 CFR 455.23).

13.5.1 The Contractor must send notice of its suspension of program payments to the provider within the following timeframes:

13.5.1.1 Five (5) calendar days of taking such action unless requested in writing by the Medicaid Fraud Control Unit (MFCU) or law enforcement agency to temporarily withhold such notice.

13.5.1.2 Thirty (30) calendar days if requested by law enforcement in writing to delay sending such notice, which request for delay may be renewed in writing up to twice and in no event may exceed ninety (90) calendar days.

13.5.2 The notice must include or address all of the following:

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

13.5.2.2 Set forth the general allegations as to the nature of the

suspension action, but need not disclose any specific information concerning an ongoing investigation;

13.5.2.3 State that the suspension is for a temporary period and cite the circumstances under which the suspension will be terminated;

13.5.2.4 Specify, when applicable, to which type or types of claims or business units of a provider suspension is effective; and

13.5.2.5 Inform the provider of the right to submit written evidence for consideration by the Contractor.

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

13.5.3.1 The Contractor or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider; or

13.5.3.2 Legal proceedings related to the provider's alleged fraud are completed.

13.5.4 The Contractor must document in writing the termination of a suspension including, where applicable and appropriate, any appeal rights available to a provider.

13.5.5 Whenever the Contractor's investigation leads to the initiation of a payment suspension in whole or part, the Contractor must make a fraud referral to the Medicaid Fraud Control Unit (MFCU) and notify HCA.

13.5.6 The fraud referral must be made in writing and provided to the MFCU no later than the next business day after the suspension is enacted.

13.5.7 If the MFCU or other law enforcement agency accepts the fraud referral for investigation, the payment suspension may be continued until the investigation and any associated enforcement proceedings are completed.

13.5.8 On a quarterly basis, the Contractor must request a certification from the MFCU or other law enforcement agency that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of the suspension.

13.5.9 If the MFCU or other law enforcement agency declines to accept the fraud referral for investigation the payment suspension must be discontinued.

13.5.10 A Contractor's decision to exercise the good cause exceptions in this contract not to suspend payments or to suspend payments only in part does not relieve the Contractor of the obligation to refer any credible allegation.

13.5.11 A Contractor may find that good cause exists not to suspend payments, 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:

13.5.11.1 Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

13.5.11.2 Other available remedies implemented by the Contractor more effectively or quickly protect Medicaid funds.

13.5.11.3 The Contractor determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.

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

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

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

13.5.11.5 Law enforcement declines to certify that a matter continues to be under investigation.

13.5.11.6 The Contractor determines that payment suspension is not in the best interests of the Medicaid program.

13.5.12 The Contractor may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

13.5.12.1 Enrollee access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:

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

13.5.12.1.1 The individual or entity serves a large number of enrollees within a federal HRSA designated medically underserved area.

13.5.12.2 The Contractor determines based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such

suspension should be imposed only in part.

13.5.12.3 The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and the Contractor determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

13.5.12.4 Law enforcement declines to certify that a matter continues to be under investigation.

13.5.12.5 The Contractor determines that payment suspension only in part is in the best interests of the Medicaid program.

13.5.13 The Contractor must meet the following documentation and record retention requirements:

13.5.13.1 Maintain for a minimum of 6 years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part, including the following:

13.5.13.1.1 All notices of suspension of payment in whole or part.

13.5.13.1.1 All fraud referrals to the MFCU or other law enforcement agency.

13.5.13.1.1 All quarterly certifications of continuing investigation status by law enforcement.

13.5.13.1.1 All notices documenting the termination of a suspension.

13.5.13.2 Maintain for a minimum of six (6) years from the date of issuance all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause.

13.5.13.3 This type of documentation must include, at a minimum, detailed information on the basis for the existence of the good cause not to suspend payments, to suspend payments only in part, or to discontinue a payment suspension and, where applicable, must specify how long the Contractor anticipates such good cause will exist.

13.5.13.4 Annually report to HCA summary information on each of the following:

13.5.13.4.1 Suspension of payment, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension.

13.5.13.4.1 Situation 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.

13.5.14 If the Contractor fails to suspend payments to an entity or individual for which there is a pending investigation of a credible allegation of fraud, without good cause, HCA may withhold monthly payments.

13.6 Excluded Individuals and Entities

The Contractor is prohibited from paying with funds received under this Contract for goods and services furnished, ordered or prescribed by excluded individuals and entities (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b)).

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

13.6.1.1 Screening Contractor and subcontractor individuals and entities with an ownership or control interest for excluded individuals and entities during the 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.

13.6.1.2 Screening monthly newly added Contractor and subcontractor individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from funds received under this Contract.

13.6.1.3 Screening monthly Contractor and subcontractor individuals

and entities with an ownership or control interest that would benefit from funds received under this Contract for newly added excluded individuals and entities.

13.6.2 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.

13.6.3 The Contractor will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.

13.6.4 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 CFR 1003.102(a)(2)).

13.6.5 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 CFR 455.104(a), and 42 CFR 1001.1001(a)(1)).

13.6.6 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).

13.6.7 The list of excluded individuals will be found at: http://www.oig.hhs.gov/fraud/exclusions.asp

13.6.8 SSA section 1128 will be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm

13.7 Reporting

13.7.1 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.

13.7.2 The Contractor shall report in writing to HCA all alleged cases of fraud and abuse regardless of funding source (Medicaid/Medicare), including fraud and abuse by the Contractor's employees, subcontractors, and subcontractor's employees, within seven (7) calendar days of the date the Contractor first becomes aware of the allegation. The report shall include the following information:

13.7.2.1 Subject(s) of complaint by name and either provider/subcontractor type or employee position.

13.7.2.2 Source of complaint by name and provider/subcontractor type or employee position, if applicable.

13.7.2.3 Nature of complaint.

13.7.2.4 Estimate of the amount of funds involved.

13.7.2.5 Legal and administrative disposition of case.

13.7.3 Any excluded individuals and entities discovered in the screening, including the provider application, credentialing and recredentialing processes, within ten (10) business days of discovery.

13.7.4 Any actions taken by the Contractor to terminate relationships with Contractor and subcontractor individuals with an ownership or control interest discovered in the screening.

13.7.5 Any payments made by the Contractor that directly or indirectly benefit excluded individuals and entities and the recovery of such payments within ten (10) business days of discovery.

13.7.6 Any Contractor and subcontractor individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 within ten (10) business days of the Contractor becoming aware of the conviction, including any discovered in the course of provider application, credentialing, and recredentialing.

13.7.7 Any subcontractor terminated for cause within ten (10) business days of the effective date of termination to include full details of the reason for termination.

13.7.8 In the course of provider application, credentialing and re-credentialing, and subcontracting the Contractor shall require detailed disclosure of all individuals and entities with an ownership or control interest. The Contractor shall maintain a list of Contractor and subcontractor individuals and entities with an ownership or control interest. The Contractor must provide the up-to-date list to HCA within ten (10) business days upon request.

13.7.9 Upon request the Contractor and the Contractor's subcontractor's shall furnish to HCA, with thirty-five (35) calendar days of the request, full and complete business transaction information as follows:

13.7.9.1 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.

13.7.9.2 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.

13.8 Incentives for Program Integrity for Compliance and Penalties for Non-Compliance

13.8.1 The Contractor shall work with HCA to develop payment incentives for compliance with program integrity activities developed by the purchaser-wide forum defined in this Contract.

13.8.2 The Contractor shall work with HCA to develop penalties for non-compliance with program integrity items identified in this Contract, as well as those newly developed by the purchaser-wide forum.

14 GRIEVANCE SYSTEM

14.1 General Requirements

The Contractor shall have a grievance and appeal system which complies with the requirements of 42 CFR 438 Subpart F, Chapters 182-538 WAC, and Chapter 284-43 WAC, insofar as those WACs are not in conflict with 42 CFR 438 Subpart F. The grievance and appeal system shall include a blended Medicare and Medicaid grievance and internal appeal process. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

14.1.1 The Contractor shall have policies and procedures addressing the grievance and appeal system, which comply with the requirements of this Contract. CMS and HCA must approve, in writing, all grievance and appeal system policies and procedures and related notices to enrollees regarding the grievance and appeal system.

14.1.2 The Contractor shall give enrollees any assistance necessary in completing forms and other procedural steps for grievances and appeals (42 CFR 438.406(a)(1).

14.1.3 A grievance may be called a grievance or complaint and may be an expression of dissatisfaction with the manner in which the Contractor or delegated entity provides health care services, such as quality of care received or rudeness. In addition, a grievance may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item.

14.1.4 The Contractor shall acknowledge receipt of each grievance, either orally or in writing, within five (5) working days. The Contractor shall acknowledge receipt of each appeal in writing within five (5) business days. (WAC 182-538-110).

14.1.5 The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making (42 CFR 438.406(a)(3)(i) and WAC 182-538-110).

14.1.6 Decisions regarding grievances and appeals shall be made by health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply (42 CFR 438.406(a)(3)(ii) and WAC 182-538-110):

14.1.6.1 If the enrollee is appealing an action concerning medical necessity.

14.1.6.2 If an enrollee grievance concerns a denial of expedited resolution of an appeal.

14.1.6.3 If the grievance or appeal involves any clinical issues.

14.2 Grievance Process

The following requirements are specific to the Contractor's grievance process:

14.2.1 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 (WAC 182-538-110).

14.2.2 The Contractor shall accept, document, record, and process grievances forwarded by CMS or HCA.

14.2.3 The Contractor shall assist the enrollee with all grievance and appeal processes (WAC 182-538-110).

14.2.4 The Contractor shall cooperate with any representative authorized in writing by the covered enrollee.

14.2.5 The Contractor shall consider all information submitted by the covered person or representative.

14.2.6 The Contractor shall investigate and resolve all grievances whether received orally or in writing.

14.2.7 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.

14.2.8 The Contractor shall provide the enrollee information about their right to obtain a second opinion as provided in WAC 182-538-120.

14.2.9 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.

14.2.10 Enrollees do not have the right to a hearing in regard to the disposition of a grievance.

14.3 Internal Appeal Process

The following requirements are specific to the Contractor's internal appeal process:

14.3.1 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 CFR 438.402(b)(1) and WAC 182-538-110).

14.3.2 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.

14.3.3 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 CFR 438.402(b)(2) and WAC 182-538-110).

14.3.4 For appeals relating to 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 CFR 438.402(2)(b) and WAC 182-538-110).

14.3.5 For purposes of this contract and if timeframes for continuation of

services are met, the service under appeal will be continued during the Contractor's internal appeal process.

14.3.6 Once the enrollee has exhausted the Contractor's internal appeal process and is engaged in the external appeal/hearing processes, Medicaid only services will continue so long as the enrollee meets the requirements found in WAC 182-538-110 and WAC 182-526-0200 for continuation of services. If the service on appeal is a Medicare only service, it will not continue past the Contractor's internal appeal process.

14.3.7 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 CFR 438.406(b)(1) and WAC 182-538-110).

14.3.8 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 CFR 438.406(b)(2) and WAC 182-538-110).

14.3.9 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 CFR 438.406(b)(3) and WAC 182-538-110).

14.3.10 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 CFR 438.406(b)(4) and WAC 182-538-110).

14.3.11 The Contractor shall resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following timeframes (42 CFR 438.408(b)(2)-(3)):

14.3.11.1 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.

14.3.11.2 For expedited resolution of appeals, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the appeal. This timeframe may not be extended.

14.3.12 The notice of the resolution of the appeal shall (42 CFR 438.408(d) and WAC 182-538-110):

14.3.12.1 Be in writing. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

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

14.3.12.3 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.

14.3.12.4 For appeals not resolved wholly in favor of the enrollee (42 CFR 438.408(e)(2)):

14.3.12.4.1 Include information on the enrollee's right to request a state administrative hearing and how to do so, or for Medicare only service appeals, how to appeal to a CMS independent review entity.

14.3.12.4.1 For Medicaid only services, explain that the appeal will be automatically advanced to a state Independent Review Organization (IRO) for a determination. For Medicare only and Medicare/Medicaid cross over services, that the appeal will be automatically advanced to a federal Independent Review Entity.

14.3.12.4.1 Except for Medicare only service appeals, include information on the enrollee's right to receive services while the Independent Review Organization review is pending and the timeframe the enrollee has for appealing to the state administrative hearing if the IRO decision is not fully in favor of the enrollee, and the enrollee seeks continuation of services.

14.3.12.4.1 Except for Medicare only service appeals, inform the enrollee that the enrollee may be held liable for the amount the Contractor pays for services received while the state administrative hearing is pending, if the hearing decision upholds the Contractor's action.

14.4 Expedited Internal Appeal Process

14.4.1 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 CFR 438.410(a)).

14.4.2 The Contractor shall make a decision on the enrollee's request for expedited appeal and provide notice, as expeditiously as the enrollee's

health condition requires, within three (3) calendar days after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice.

14.4.3 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 CFR 438.410(b)).

14.4.4 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 CFR 438.410(c)).

14.4.5 The enrollee has a right to file a grievance regarding the Contractors 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.

14.5 Independent Review

14.5.1 Any appeal not resolved fully in favor of the enrollee shall be automatically advanced to:

14.5.2 The state Independent Review Organization (IRO), if the appeal relates to a Medicaid only service, or

14.5.3 The federal Independent Review Entity (IRE), if the appeal relates to a Medicare only service or a Medicare/Medicaid cross over service.

14.6 Medicaid: State Administrative Hearing and Review Process

14.6.1 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.

14.6.2 If an enrollee does not agree with the Contractor's resolution of the appeal after receiving the Independent Review Organization determination, the enrollee may request a state administrative hearing:

14.6.2.1 For hearings regarding a standard service, within ninety (90) calendar days of the date on the Independent Review Organization's mailing of the notice of the resolution of the appeal. (WAC 182-526-####).

14.6.2.2 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 Independent Review Organization'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 CFR 438.420, WAC 182-526-####, and WAC 182-538-

110).

14.6.2.3 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, Independent Review Organization decision letter, or written decision(s) from participating providers or delegated entities.

14.6.2.4 The Contractor is an independent party and is responsible for its own representation in any hearing, Board of Appeals and subsequent judicial proceedings.

14.6.2.5 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.

14.6.2.6 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 (42 CFR 438.402(b)(2)(ii) and WAC 182-526-0200).

14.6.2.7 HCA will notify the Contractor of hearing determinations. All parties to a state fair hearing can appeal the initial hearing decision ("initial order") in accordance with the rules found in Chapter 182-526 WAC. The Contractor will be bound by the hearing decision when it becomes a final order as defined in WAC 182-526-0010. Implementation of a final order shall not be the basis for termination of enrollment by the Contractor.

14.6.2.8 If the hearing decision as set forth in the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the hearing decision.

14.6.3 Petition for Review

If an enrollee, the Contractor, or HCA disagrees with the results of the administrative hearing, any party may appeal the decision to HCA Board of Appeals in accordance with 182-526 WAC.

14.6.4 Effect of Reversed Resolutions of Appeals and Hearings

14.6.4.1 If the Contractor on appeal or a final order, as defined in WAC 182-526-0010, 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 CFR 438.424(a)(b)).

14.6.4.2 If the Contractor on appeal or a final order, as defined in

WAC 182-526-0010 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.

14.7 Medicaid Appeals: Continuation of Services

14.7.1 The Contractor shall continue the enrollee's services in accordance with WAC 182-538-110, WAC 182-526-####, and 42 CFR 438.420 if all of the following apply:

14.7.1.1 An appeal, or hearing is requested on or before the later of the following:

14.7.1.1.1 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.

14.7.1.1.1 The intended effective date of the Contractor's proposed action.

14.7.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

14.7.1.3 The services were ordered by an authorized provider.

14.7.1.4 The original period covered by the original authorization has not expired.

14.7.1.5 The enrollee requests an extension of services.

14.7.2 If, at the enrollee's request, the Contractor continues or reinstates the enrollee's services while the appeal, hearing or HCA Board of Appeals review is pending, the services shall be continued until one of the following occurs (42 CFR § 438.420, WAC 182-526-0200, and WAC 182-538-110):

14.7.2.1 The enrollee withdraws the appeal, hearing, or request for Board of Appeals review..

14.7.2.2 Ten (10) calendar days pass after the Independent Review Organization 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.**13.7.2.3** Ten (10) calendar days pass after the HCA's Presiding Officer or the Office of Administrative Hearings mails the Initial Order from the state administrative hearing and the enrollees has not requested a HCA Board of Appeals review (with continuation of services until HCA Board of Appeals decision is reached) within ten (10) calendar days of the Initial Order.

14.7.2.3 The time period or service limits of a previously authorized service has been met.

14.7.3 If the final resolution of the appeal (i.e., final order) upholds the Contractor's action, the Contractor may recover from the enrollee the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services (WAC 182-538-110).

14.8 Medicare Appeals: Appeals, Administrative Hearings, and Review

14.8.1 Internal Appeal Process. Enrollee appeals of actions related to Medicare only services follow the internal appeal process as set forth in sections 13.3 and 13.4 except, continuation of services does not continue after the internal appeal resolution for Medicare-only services.

14.8.2 CMS Independent Review Entity. If on internal appeal, the Contractor does not decide fully in the Enrollee's favor within the relevant time frame, the Contractor shall automatically forward the case file to the CMS Independent Review Entity for a new and impartial review.

14.8.2.1 For standard external Appeals, the CMS Independent Review Entity will send the enrollee and the Contractor a letter with its decision within 30 calendar days after it receives the case from the Contractor, but may grant up to a 14 calendar day extension.

14.8.2.1.1 If the CMS Independent Review Entity decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute within 72 hours from the date the Contractor receives the review entity's notice reversing the Contractor's decision, or provide the service under dispute as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from the date of the notice.

14.8.2.2 For expedited external Appeals, the CMS Independent

Review Entity will send the Enrollee and the Contractor a letter with its decision within 72 hours after it receives the case from the Contractor, or at the end of up to a 14 calendar day extension.

14.8.2.2.1 If the CMS Independent Review Entity decides in the Enrollee's favor, the Contractor must authorize or provide the service under dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the Contractor receives the notice reversing the decision.

14.8.3 Federal Administrative Hearing and Review. If the Contractor or the Enrollee disagrees with the CMS Independent Review Entity's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review in accordance with federal rules and statutes. The Contractor shall comply with any requests for information or participation from such further Appeal entities.

14.9 Medicare Appeals: Hospital Discharge

14.9.1 When an Enrollee is being discharged from the hospital, the Contractor must assure that the Enrollee receives a written notice of explanation called a Notice of Discharge and Medicare Appeal Rights (NODMAR).

14.9.2 The Enrollee has the right to request a review by a QIO of any hospital discharge notice. The notice includes information on filing the QIO Appeal. Such a request must be made by noon of the first workday after the receipt of the notice.

14.9.3 If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described in Sections 13.3-13.4 and 13.7. Note: an Enrollee may file an oral or written request for an expedited 72-hour Contractor Appeal if the Enrollee has missed the deadline for requesting the QIO review.

14.9.4 The QIO will make its decision within one full working day after it receives the Enrollee's request, medical records and any other information it needs to make its decision.

14.9.5 If the QIO agrees with the Contractor's decision, the Contractor is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Enrollee of its decision.

14.9.6 If the QIO overturns the Contractor's decision, the Contractor must pay for the remainder of the hospital stay.

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

The Contractor shall maintain records of all actions, grievances, appeals and independent reviews.

14.10.1 The records shall include actions, grievances and appeals handled by delegated entities.

14.10.2 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.

14.10.3 The Contractor is responsible for maintenance of records for and reporting of any grievance, actions, and appeals handled by delegated entities.

14.10.4 Delegated actions, grievances, and appeals are to be integrated into the Contractor's report.

14.10.5 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.

14.10.6 The report medium shall be specified by HCA and shall be in accord with the Grievance System Reporting Requirements published by HCA.

14.10.7 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.

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

14.10.9 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.

15 PRIMARY CARE AND COORDINATION OF HEALTH CARE SERVICES

15.1 System for Coordination and Continuity of Care

15.1.1 The Contractor shall have in place a three tiered care coordination and care integration system designed to ensure all enrollees have access to integrated delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, behavioral health and long term supports and services, including Medicaid, Behavioral Health services, State Plan Home Care services and HCBS waiver services as provided for in this Contract.

15.1.2 For all enrollees, the system must promote and ensure service accessibility, attention to individual needs, transitional continuity of care, comprehensive and coordinated service delivery, culturally appropriate care and fiscal and professional accountability.

15.1.3 For each enrollee, the system must ensure communication and coordination among the enrollee, providers of service to the enrollee, and the enrollee's designated Care Manager/Intensive Care Manager in the settings in which the enrollee receives services, and facilitate and maximize the level of enrollee self-determination and enrollee choice of services, providers and living arrangements.

15.1.4 For enrollees with special health care needs, the system must provide additional services to address increased complexity and intensity of service needs. Eligible enrollees with special health care needs will have access to whole-person integrated care management and care coordination through the service delivery system described in Section 15. This integrated care management approach expands the traditional medical care delivery system to build stronger linkages to other community and social supports, and to enhance coordination of medical, behavioral health, chemical dependency, and long-term care services and supports.

15.1.5 Enrollee characteristics for inclusion in whole-person integrated care management and care coordination are encompassed within the definition of Enrollees with Special Health Care Needs and shall include at minimum: presenting diagnoses, such as complex physical and/or behavioral health conditions, predictive risk scores, and examination of durable medical equipment, pharmacy, inpatient and emergency department utilization.

15.2 System Tiers

As a result of Contractor completion of initial screenings, health risk assessments, or other identification methods, enrollees will be identified and placed into one of the following Care Management categories:

15.2.1 Level One Supported Self-Care Management;

15.2.2 Level Two Disease/Episodic Care Management; or

15.2.3 Level Three – Intensive Care Management for Enrollees with Special Health Care Needs

15.3 Level One Supported Self-Care Management

15.3.1 The Contractor shall ensure that all enrollees who have less intensive needs based upon their Health Risk Assessment will:

15.3.1.1 Have an ongoing source of primary care appropriate to his or her needs;

15.3.1.2 Have a person or entity formally designated as the Care Manager primarily responsible for coordinating health care services provided to the enrollee;

15.3.1.3 Have an Individualized care plan (ICP) when the enrollee is determined to need a course of treatment or regular care monitoring;

15.3.1.4 Receive referral assistance to arrange for transportation to ensure access to providers of services that are identified on their ICP.

15.3.1.5 Receive educational materials specific to chronic conditions and care planning.

15.3.1.6 At a minimum be evaluated annually to determine if the ICP is meeting identified needs and if it is necessary to update the plan.

15.3.2 The Contractor shall include the ICP in the enrollee's centralized record.

15.3.3 Supported Self-Care Management services for enrollees who are identified to need long term services and supports must comply with the requirements set forth in Section 18: Coordination with the Department of Social and Health Services, of this Contract.

15.4 Level Two Disease/Episodic Care Management

15.4.1 Enrollees in Level Two include individuals who have chronic diseases that pose low to moderate risks for acute episodes, cognitive deficits, traumatic brain injury, no informal resources, are homeless, an anxiety diagnosis, frequently call 911 for assistance, have frequent hospitalizations/ER use, have had a psychological hospitalization in the past year or are receiving paid assistance with ADL's.

15.4.2 The Contractor shall ensure that all enrollees who have moderate needs based upon their Health Risk Assessment :

15.4.2.1 Have an ongoing source of primary care appropriate to his or her needs;

15.4.2.2 Have a person or entity formally designated as the Care Manager primarily responsible for coordinating health care services provided to the enrollee;

15.4.2.3 Have an Individualized care plan (ICP) when the enrollee is

determined to need a course of treatment or regular care monitoring;

15.4.2.4 Receive educational materials specific to chronic conditions and care planning;

15.4.2.5 Have access to a interdisciplinary care team that may include individuals providing direct service to the enrollee, such as primary care providers, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, family members or housing representative.

15.4.3 The Care Manager will have at least quarterly contact with the enrollee and be evaluated every 6 months or more often if progress notes indicate a change in condition or circumstances which will result in the worsening of the enrollee's condition.

15.4.4 The Contractor shall include the ICP in the enrollee's centralized record.

15.4.5 The Contractor shall establish policies and criteria for Level Two case load ratios for I Care Managers serving all Level Two enrollees.

15.4.6 Episodic Care Management Services provided to enrollees who are identified to need long term services and supports must comply with the requirements set forth in Section 16: Coordination with the Department of Social and Health Services, of this Contract.

15.5 Level Three Intensive Care Management for Enrollees with Special Health Care Needs

15.5.1 Enrollees with special health care needs have one or more eligible chronic conditions and a PRISM risk score of 1.5 or higher. Eligible chronic conditions include but are not limited to:

15.5.1.1 A mental health condition

15.5.1.2 A substance use disorder

15.5.1.3 Asthma

15.5.1.4 Diabetes

15.5.1.5 Heart disease

15.5.1.6 Heart failure

15.5.1.7 Coronary artery disease

15.5.1.8 Cerebrovascular disease

15.5.1.9 Fibromyalgia

15.5.1.10 Renal failure

15.5.1.11 Chronic pain associated with musculoskeletal conditions

15.5.1.12 Dementia

15.5.1.13 Being overweight, as evidenced by a body mass index over twenty-five.

15.5.2 The Contractor shall identify potential enrollees with special health care needs through the following mechanisms:

15.5.2.1 Receive and use risk score information from DSHS-PRISM, if known at the time of enrollment in the MCO; and provide quarterly risk indicator health reports of select indicators of risk to the primary care provider.

15.5.2.2 Require the primary care provider to identify child or adult enrollees with special health care needs in the course of any contact or enrollee initiated health care visit and report to the Contractor.

15.5.2.3 Community provider referrals.

15.5.2.4 Review of the enrollees' use of health care services, such as:

15.5.2.4.1 Overuse of preventable emergency room services

15.5.2.4.1 Opioid prescription use exceeding 120 MED/day

15.5.2.4.1 Inconsistent medication prescribing or refills for the management of chronic disease

15.5.2.4.1 Frequent hospitalizations

15.5.2.4.1 Underuse of preventive care

15.5.2.4.1 Underuse of services considered standard for treatment of chronic conditions, such as diabetes, cardiovascular disease or serious and persistent mental illness

15.5.3 The Contractor shall ensure that all enrollees who are identified to have special health care needs will:

Have an ongoing source of primary care appropriate to his or her needs;

15.5.3.1 Have a person or entity formally designated as the Intensive Care Coordinators primarily responsible for coordinating all health care services provided to the enrollee;

15.5.3.2 Have an Individualized care plan (ICP) when the enrollee is determined to need a course of treatment or regular care monitoring;

15.5.3.3 Have access to a Interdisciplinary care team that may include individuals providing direct service to the enrollee, such as primary care providers, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, family members or housing representative.

15.5.3.4 Have a Health Action Plan;

15.5.3.5 The Contractor shall use and abide by the Intensive Care Management Assurances as noted under Appendix B of this contract.

15.5.4 The Contractor shall establish policies and criteria for Level Three case load ratios for Intensive Care Coordinators serving the respective Level Three enrollees and ensure through monitoring that care management and care coordination fulfills the requirements of this contract.

15.5.5 The Contractor shall use and abide by the Intensive Care Management Assurances as noted under Appendix B of this contract.

15.6 Coordination of Health Care Services

15.6.1 For all enrollees the Contractor shall ensure that health care services are coordinated as follows:

15.6.1.1 The Contractor shall ensure that the Care Manager/Intensive Care Coordinator assigned to the enrollee provides high touch intensive care management services in relationship to identified special health care needs, consistent with the results of the HRA, claims, or other data sources.

15.6.1.2 The Contractor shall ensure that PCPs, in consultation with

other appropriate health care professionals, such as Care Managers, and Intensive Care Coordinators, are responsible for the provision, coordination, and supervision of overall health care to meet the needs of each enrollee, including initiation and coordination of referrals for medically necessary specialty care.

15.6.1.3 The Contractor shall ensure that enrollee health information is shared between providers in a manner that facilitates coordination of care while protecting confidentiality and enrollee privacy (42 CFR 438.208(b)(2)(4) and 45 CFR 160 and 164 subparts A and E).

15.6.1.4 The Contractor must implement procedures to share information regarding the physical and behavioral health care of enrollees with other contractors and RSNs serving the enrollees so that those activities are not duplicated while protecting confidentiality and enrollee rights (42 CFR 438.208 (b)(3)).

15.6.2 The Contractor shall facilitate care management and coordination between the PCP and the Care Manager/Intensive Care Coordinator, or case manager(s) assigned to the enrollee as necessary if it is not provided directly by the Contractor.

15.6.2.1 For all enrollees, care management and coordination services shall include assistance with accessing needed mental health, substance use disorder, physical health services, long term services and supports, community resources, or developmental disability services.

15.6.2.2 For all enrollees, care management and coordination services shall include monitoring, providing education, facilitating and encouraging adherence to recommended treatment. Nothing in this requirement should be construed to limit in any way the enrollee's right to refuse treatment.

15.6.3 The Contractor shall coordinate and ensure PCPs coordinate with community-based and Department of Social and Health Services, Department of Health, local health jurisdictions and HCA services/programs including but not limited to services/programs described in this Section:

15.6.3.1 First Steps Maternity Support Services/Infant Case Management

15.6.3.2 Transportation and Interpreter Services

15.6.3.3 Patient Review and Coordination (PRC) program, for enrollees who meet the criteria identified in WAC 182-501-0135

15.6.3.4 Dental services

15.6.3.5 Foster Care – Fostering Well-Being

15.6.3.6 Early Support for Infants and Toddlers

15.6.3.7 Department of Health and Local Health Jurisdiction services, including Title V services for children with special health care needs

15.6.3.8 Hospitals

15.6.4 The Contractor shall participate with, cooperate with and coordinate with regional health alliances.

15.6.5 The Contractor will have an operational agreement with the local Regional support Network (RSN), crisis lines, emergency departments, and Counties that addresses coordination of Crisis/ITA services between the parties, including real time data, data sharing agreements, and care transitions.

15.6.6 The Contractor shall execute an MOU with the Area Agencies on Aging and DSHS Home and Community Services for the purposes of coordination, participation and cooperation to ensure seamless service delivery to enrollees. This includes information sharing when Enrollees' move, are admitted to the hospital or other institutional settings, exchange of information related to eligibility determinations, and advocacy concerns for Enrollees receiving LTSS.

15.6.7 The Contractor shall ensure care coordination informs interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting an enrollee's health and health care choices.

15.6.8 The Contractor shall ensure that communication is fostered between the providers of care, including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports, the enrollee and the assigned Care Manager/Intensive Care Coordinator .

15.7 Health Risk Assessment and Screening

To determine the enrollee's appropriate assignment within the three-tier system and required level of care management and care coordination, the Contractor shall use HCA pre-approved screening tools and a standardized Health Risk Assessment (HRA).

15.7.1 Initial Health Screen (IHS): To evaluate the enrollee's level of need

and to identify potential Enrollees with Special Health Care Needs, the Contractor shall conduct an initial, brief health screen containing behavioral, developmental and physical health questions, including questions appropriate to capture LTSS needs, within thirty (30) calendar days of enrollment for new enrollees.

15.7.1.1 The IHS screening can be completed in a variety of methods (written, telephonic or in person). If the Contractor is unable to conduct the initial screening within 30 days, the Contractor shall continue to make efforts to conduct the screening for up to 60 days after enrollment. If the Contractor is unsuccessful in contacting the enrollee, the Contractor shall document efforts made to contact the enrollee and conduct the screening.

15.7.1.2 The Contractor shall document the results of the screening and, based on the results of the initial screening, and if warranted by the screening process, conduct a secondary screening within 30 days to further determine treatment needs.

15.7.1.3 Enrollee 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 for an assessment. Enrollee 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.

15.7.1.4 For those new and current enrollees who have at least one chronic condition and a risk score of 1.5 or greater using PRISM methods, the Initial Health Screen shall be bypassed and a Health Risk Assessment (HRA) shall be conducted. Current enrollees' means those enrollees enrolled with the Contractor under prior contracts with HCA and transitioned to enrollment with the Contractor under this Contract.

15.7.2 Initial Health Risk Assessment (HRA): The Contractor shall ensure that the HRA is conducted within 90 days of enrollment when the initial and secondary screening indicates the need for a HRA. The HRA shall determine ongoing need for care coordination services and the need for clinical and non-clinical services, including referrals to clinical consultant services and community resources. The HRA tool and content shall be pre-approved by HCA and all information gathered in the HRA shall be entered into the Care Coordination Enrollee Record.

15.7.2.1 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.

15.7.2.2 The Contractor shall ensure that arrangements are made for follow-up services that reflect the findings in the HRA, such as consultations with primary care providers, specialty providers, mental health and/or substance use disorder providers, or Home and Community Services (HCS) for further evaluation for LTSS.

15.7.2.3 To conduct the HRA:

15.7.2.3.1 The Contractor shall use current contact information, using search methods that confirm address and phone contact information.

15.7.2.3.1 The Contractor shall make at least three (3) reasonable attempts on different days and times of the day to contact an enrollee and complete an HRA.

15.7.2.3.1 If the Contractor's contact information for an enrollee is incorrect, the Contractor shall have procedures to make a reasonable attempt to resolve incorrect contact information.

15.7.2.3.1 The Contractor shall document all attempts to contact an enrollee for the HRA, including dates and times of attempted contacts. This information shall be considered evidence in meeting this requirement.

15.7.2.4 The HRA shall be maintained in the enrollees' individualized care plan and available during subsequent preventive health visits.

15.7.3 Ongoing Health Risk Assessments: The Contractor must:

15.7.3.1 Perform Ongoing Assessments of each enrollee's needs:

15.7.3.1.1 At least once every six months, or

15.7.3.1.1 For enrollees with special health care needs, at least quarterly, or

15.7.3.1.1 Whenever an enrollee experiences a major change that:

15.7.3.1.1.3 Impacts more than one area of health status; and

15.7.3.1.1.3 Requires interdisciplinary review or revision of the Individualized plan of Care.

15.7.3.2 Record the results of all enrollee assessments and updates in the Care Coordination Enrollee Record;

15.7.3.3 Communicate the results to the enrollee's provider network in a timely manner.

15.7.4 The Contractor shall establish business rules regarding screening, referral and co-management of individuals with both behavioral health and physical health conditions, including enrollees that have long term services and supports. Both behavioral health and physical health Care Manager/Intensive Care Coordinator or Disease Management coaches will be trained on the protocols.

15.7.4.1 The Care Manager/Intensive Care Coordinator shall be trained on common screening tools and HRA appropriate to the enrollee's age for at least:

15.7.4.1.1 Delays in child development.

15.7.4.1.1 Behavioral health conditions.

15.7.4.2 When behavioral health or developmental needs are suspected or identified, the Contractor will provide a toll free line for primary care providers and other medical specialists to call for technical assistance, including arranging for exams and treatment by providers with appropriate expertise and experience in behavioral health/substance use or developmental issues.

15.7.4.3 The Contractor shall ensure that Care Manager/Intensive Care Coordinatorare trained on HCA approved common screening tools when evaluating the enrollee's health care needs.

15.8 Screening Tools

15.8.1 The contractor shall adopt HCA standardized screening tools, interventions, protocols and procedures, including standardized screening tools to assess:

15.8.1.1 Development in young children;

15.8.1.2 Mental health conditions and alcohol and substance use disorder in children, adolescents, and adults.

15.8.2 The contractor will adopt HCA protocols related to Brief Intervention and Referral to Treatment techniques for mitigating risk in individuals with drug or alcohol use concerns. Protocols include:

15.8.2.1 The mechanism developed for implementing screening in the course of conducting health history and physical examinations or in the course of care for urgent or emergency health condition;

15.8.2.2 HCPCS or CPT or other coding to allow for ongoing Contractor assessment on the use and uptake of screening tools;

15.8.2.3 Publishing the screens with sufficient background information on the use, reliability and validity of the various instruments used to screen enrollees by February 1, 2014;

15.8.2.4 Making the information available on the Contractor's provider website by February 1, 2014;

15.8.3 CD treatment services will also include utilization of the Screening and Brief Intervention and Referral to Treatment (SBIRT) tool designed to improve the effectiveness of early detection of at risk or harmful substance abuse and to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. The SBIRT may be offered in a primary care or emergency care setting.

15.8.4 Additionally, the MCO agrees to participate in a workgroup that will focus on the implementation of Screening, Evaluation, and Treatment (SET) for alcohol abuse and dependence, that may be used in combination with SBIRT in primary care clinic settings by providing immediate treatment options and using the NIAAA Clinician's Guide entitled Helping Patients Who Drink Too Much, and associated tools.

15.9 Health Action Plan

The Contractor shall ensure that Level Three enrollees develop a Health Action Plan with assistance from the Intensive Care Coordinator

15.9.1 The Health Action Plan is shared with the enrollee and others identified as assisting the enrollee in achieving health action goals, either as a hard copy or shared electronically via secure email. This may include family, caregivers, primary care providers, mental health treatment providers, chemical dependency treatment providers, and authorizers of long term services and supports.

15.9.2 The Health Action Plan is reviewed and updated to include reassessment of the enrollee's progress towards meeting clinical and patient-centered health action plan goals.

15.9.3 The Contractor shall ensure that changes to the Health Action Plan will be based upon changes in the enrollee's need or preferences.

15.9.4 The Contractor shall ensure the Health Action Plan includes enrollee self-identified goals, needed interventions and outcomes, transitional care planning, supports and interventions.

15.9.5 The Contractor shall ensure that health education begins for level 3 enrollees with the commencement of the Health Action Plan.

15.9.6 The Contractor shall ensure that all Health Action Plans are

maintained electronically, can be shared externally with other providers, family members or care givers through a release of consent form, and are updated at minimum every six months. Progress or case notes should be added to the Health Action Plan as needed by a change in circumstances.

15.9.7 The Contractor shall ensure that the Health Action Plan includes participation of the enrollee and their family or caregiver in the development of the Health Action Plan.

15.9.8 Contents of the Health Action Plan shall include, but are not limited to:

15.9.8.1 A brief introductory statement about the enrollee; which may include preferences, and demographics;

15.9.8.2 Enrollee diagnosis;

15.9.8.3 Patient Activation Measure (PAM) survey and Caregiver Activation Measure (CAM) survey (if enrollee has a caregiver);

15.9.8.4 Survey date;

15.9.8.5 Survey score;

15.9.8.6 PAM/CAM level;

15.9.8.7 Enrollee self-management goals;

15.9.8.8 Short- and long-term treatment goals, identification of barriers to meeting goals or complying with treatment;

15.9.8.9 Enrollee prioritized action items;

15.9.8.10 If the enrollee has a personal care worker, the HAP will include action steps for them;

15.9.8.11 Time schedule for follow-up treatment and communication with the enrollee.

15.9.9 The Intensive Care Coordinator shall update and modify the Health Action Plan quarterly, and as needed to support:

15.9.10 Care transitions;

15.9.11 A change in the enrollee's condition;

15.9.12 New immediate goals;

15.9.13 Resolution of goals or action steps.

15.10 Individualized Treatment Plan

The Contractor shall assure an individualized treatment plan is developed for each enrollee who is determined through assessment to need a course of treatment or regular care monitoring.

15.10.1 The enrollee's primary care provider will develop, document and

maintain an individualized treatment plan in the enrollee's medical record.

15.10.1.1 The individualized treatment plan will be developed with enrollee participation and in consultation with any specialists caring for the enrollee.

15.10.1.2 The individualized treatment plan will incorporate all the elements of the enrollee's Health Action Plan as applicable.

15.10.1.3 If the Contractor requires approval of the treatment plan, approval must be provided in a timely manner appropriate to the enrollee's health condition.

15.10.2 For enrollees with special health care needs, including children with special health care needs, the primary care provider, in consultation with the Intensive Care Coordinator, other treating providers and other appropriate health care professionals, will develop, document and maintain an individualized treatment plan in the enrollee's medical record. Elements required in the treatment plan include, at minimum:

15.10.2.1 Enrollee self-management goals;

15.10.2.2 Short and long-term treatment goals, identification of barriers to meeting goals or complying with the treatment plan;

15.10.2.3 Time schedule for follow-up treatment and communication with the enrollee;

15.10.2.4 Clinical and non-clinical services accessed by the enrollee or recommended by the primary care provider or I Care Manager/Intensive Care Coordinator;

15.10.2.5 Integration and coordination of clinical and non-clinical services, including follow-up to ensure disciplines and services are accessed;

15.10.2.6 Modifications as needed to address emerging needs of the enrollees;

15.10.2.7 Participation of the enrollee in the development of the treatment plan;

15.10.2.8 Progress or reason for lack of progress on self-management or treatment plan goals;

15.10.2.9 Communication with primary and specialty care providers including mental health and substance abuse providers;

15.10.2.10 Identification of barriers to achieving self-management or treatment planning goals and how these were addressed;

15.10.2.11 Health promotion activities, including scheduling of appointments for preventive care.

15.10.3 The primary care provider treatment plan content will be coordinated with the health action plan to assure all necessary information is included while minimizing administrative duplication in preparing the two documents.

15.10.4 Direct Access for Enrollees with Special Health Care Needs: When the required treatment plan of enrollees 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 those enrollees to retain the specialist as a PCP, or alternatively, be allowed direct access, with prior authorization, to specialists for needed care (42 CFR 438.208(c)(4) and 438.6(m)).

15.10.5 Treatment Plans for Enrollees with Mental Health Needs: 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.

15.10.6 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.

15.10.7 For enrollees provided long-term services and supports, an Individual Care Plan will be developed.

15.10.8 The Contractor shall ensure enrollees at high risk of re-hospitalization and/or substance use disorder treatment recidivism have a documented, individual plan for interventions to mitigate risk. ICPs shall include scheduled outpatient mental health and/or primary care visits within seven (7) calendar days of discharge; and/or physical or mental health, home health services delivered within forty-eight (48) hours of discharge.

15.11 Continuity of Care

The Contractor shall ensure the 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 CFR 438.208).

15.11.1 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 Enrollment and Access and Capacity Sections of this Contract.

15.11.2 If possible and reasonable, the Contractor shall preserve enrollee provider relationships through transitions.

15.11.3 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.

15.11.4 For new enrollees, during the 90 day retention period, the Contractor shall:

15.11.4.1 Continue, renew and fill all prescriptions held by the enrollee on the date of enrollment until a participating provider examines the enrollee to evaluate the enrollee's medication needs 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.

15.11.4.2 Allow enrollees to continue to receive care from non-participating providers, including long term service and support providers, with whom an enrollee has

documented established relationship. The Contractor shall take the following steps:

15.11.4.2.1 The Contractor must make a good faith effort to subcontract with the established non-participating provider.

15.11.4.2.1 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.

15.11.4.2.1 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 ninety (90) calendar days from the enrollee's enrollment effective date.

15.11.4.2.1 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.

15.11.5 The Contractor shall have written operational agreements, which include data sharing, with State and community physical and behavioral health hospitals, Regional Support Networks, long-term care facilities and inpatient and outpatient Drug and Alcohol Treatment programs for the purpose of facilitating transitions of care for enrollees. The written operational agreements shall include at minimum:

15.11.5.1 Use of a standardized discharge screening tool pre-approved by HCA and developed in collaboration with institutional providers, hospitals, and substance use disorder treatment programs. The tool shall encompass a risk assessment for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism.

15.11.5.2 An individual enrollee plan for interventions to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include:

15.11.5.2.1 Enrollee education about the presenting diagnosis(es) throughout the care stay;

15.11.5.2.1 Written discharge plan provided to both the enrollee and the primary care provider at enrollee discharge;

15.11.5.2.1 Scheduled follow-up appointments at enrollee discharge;

15.11.5.2.1 Organized post-discharge services, such as long term services and supports, home care services, after-treatment services, and therapy services;

15.11.5.2.1 Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following enrollee discharge;

15.11.5.2.1 Information on what to do if a problem arises following discharge;

15.11.5.2.1 Care Manager/Intensive Care Coordinator or Contractor designee visit at facility prior to discharge to assess readmission risk and coordinate transition;

15.11.5.2.1 For enrollees at high risk of re-hospitalization the Care Manager/Intensive Care Coordinator, or other Contractor designee shall 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 ensure the enrollee has appropriate referrals and is able to get to appointments;

15.11.5.2.1 Scheduled outpatient mental health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health care services delivered within seven (7) calendar days of discharge;

15.11.5.2.1 Planning that actively includes the patient and family

Notifications to the Contractor and primary care provider shall be made when the enrollee is:

15.11.5.2.1.10 Admitted to a State or community physical or behavioral health hospital, Regional Support Network facility, skilled nursing facility and if appropriate patient releases signed, to a substance use disorder treatment facility.

15.11.5.2.1.10 Discharged from a State or community hospital, Regional Support Network facility, skilled nursing facility and if appropriate patient releases signed, from a substance use disorder treatment facility.

15.11.5.3 The Contractor shall obtain releases from enrollees to allow sharing of information to facilitate transitions in care.

16 PERSON-CENTERED INTEGRATED CARE COORDINATION AND CARE MANAGEMENT

16.1 Intensive Care Management Service Delivery System

16.1.1 The Contractor shall ensure that integrated care management services are available to all enrollees have been determined to need level 3 care management services and that the Contractor's delivery system includes adequate resources to deliver the full array of needed services to all participating enrollees, including individual Intensive Care Coordinators with demonstrated competency across the disciplines of physical health, behavioral health, chemical dependency, long-term care, and home and community-based long–term services and supports.

16.1.1.1 Intensive Care Coordinators may be employed through a combination of the Contractor and subcontracted providers.

16.1.1.2 The specific distribution of Intensive Care Coordinators shall be determined by the size, demographic makeup, disease burden, and geographic distribution of the enrollee population, the types and numbers of entities available to participate, and the structure of the local public and private health delivery systems.

16.1.2 The Contractor shall maintain a list of Intensive Care Coordinators and their assigned enrollees.

16.1.3 The Contractor shall maintain Memoranda of Agreement (MOA) with the intensive care management provider network that provide services to program enrollees that are outside the contracted benefits available to enrollees to ensure coordination and continuity of care. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved and that care coordination services are not duplicated. MOAs will contain information related to enrollee privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.

16.1.4 The Contractor shall collect and reports encounters to the HCA for tracking and reporting purposes.

16.1.5 The Contractor shall disburse payment to subcontracted entities in accordance with terms negotiated in subcontracts and based upon documented encounters.

16.1.6 The Contractor that intensive care management organizations and other providers coordinate to provide high touch care management; such as meeting the required enrollee-to-Intensive Care Coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the Intensive Care Coordinator.

16.1.7 The Contractor shall collect, analyze, and report financial, health status

and performance and outcome measures to objectively determine progress towards meeting project goals and outcomes.

16.1.8 The Contractor shall initially assign each eligible enrollee to a Intensive Care Coordinator to initiate intensive care management services and incorporates the following:

16.1.8.1 Use of PRISM or other data systems to match the enrollee to the Intensive Care Coordinator that is knowledgeable about the type of services they receive; or

16.1.8.2 Optimizes enrollee choice in selecting an Intensive Care Coordinator.

17 Comprehensive Care Management

The Contractor shall ensure that Level 3 enrollees are assigned to an Intensive Care Coordinator, and that comprehensive care management services are delivered primarily in-person with periodic follow-up in-person and by phone.

17.1.1 The Contractor shall ensure that care management services include standardized screens, demonstrate the ability to provide continuity and coordination of care through in-person visits, and the ability to accompany enrollees to health care provider appointments, as needed.

17.1.2 The Contractor shall ensure that Intensive Care Coordinators assess enrollee readiness for self-management and promote self-management skills so the enrollee is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning.

17.1.3 The Contractor shall ensure that comprehensive care management includes clinical, functional, and resource use screens, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual.

17.1.4 The Contractor shall ensure that standardized screens will support referrals for assessment of need for physical health services, mental health services, chemical dependency treatment, depression management or long term services and supports.

17.1.5 The Contractor shall ensure the enrollee's, parents or caregivers activation level will be assessed using the Patient Activation Measure (PAM) tool, or when appropriate, the Caregiver Activation Measure (Insignia products). The enrollee's activation level shall be reassessed every 6 months while receiving Level 3 services. PAM uses engagement, coaching and advocacy strategies that assist enrollees to develop and implement Health Action Plans.

17.1.6 The Contractor shall utilize other screens and assessments that may supplement the HAP, including their contractually required health risk assessments for enrollees with special health care needs, mental health treatment plans, chemical dependency treatment plans, and/or other pre-existing care plans which include assessment results.

17.1.7 The Contractor shall ensure that Intensive Care Coordinators communicate and coordinate with the enrollee, but do not duplicate the functions of other Medicaid care or case managers involved in the enrollee's care, including those that assess and authorize physical health services, long term services and supports, services for individuals with developmental disabilities and provide mental health interventions.

17.1.8 The Contractor shall share critical data with Intensive Care Coordinators to ensure coordination of services. Data may include institutional admissions and discharge readiness for transitional health care services management and facilitation, lapses in pharmaceutical payments that may indicate need for enrollee outreach and education regarding medication use and over-use patterns, such as emergency room use that may suggest a need for a home visit or intervention to address the clinical and Health Action Plan goals.

17.2 Care Coordination & Health Education

The Contractor shall ensure that the Intensive Care Coordinator:

17.2.1 Plays a central and active role in development and execution of cross-system care coordination to assist the enrollee to access needed services.

17.2.2 Fosters communication between the providers of care including the treating primary care provider and medical specialists, behavioral health providers and entities authorizing long-term services and supports.

17.2.3 Maintains a case load that achieves fidelity in providing required Level 3 services, including interventions to deliver high-touch, in-person care coordination.

17.2.4 The Contractor shall ensure that care coordination is based on informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting a enrollee's health and health care choices.

17.2.5 The Contractor shall ensure that Intensive Care Coordinators promote:

17.2.5.1 Optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;

17.2.5.2 Outreach and engagement activities that support the enrollee's participation in their care and promotes continuity of care;

17.2.5.3 Health education and coaching designed to assist enrollees to increase self-management skills and improve health outcomes; and

17.2.6 Use of peer supports, support groups and self-care programs to increase the enrollee's knowledge about their health care conditions and improve adherence to prescribed treatment.

17.2.7 The Contractor shall ensure self-management, recovery and resiliency principles using person-identified supports including family members, and paid and unpaid caregivers are demonstrated in the Health Action Plan and in care management activities;

17.2.8 The Contractor shall ensure the Intensive Care Coordinator uses the enrollee's PAM score and level (1-4) to determine the coaching methodology for each enrollee to develop a teaching and support plan.

17.2.9 The Contractor shall ensure educational materials are customized and introduced according to the enrollee's readiness for change and appropriate to the enrollee's level of confidence and self-management abilities.

17.2.10 The Contractor shall ensure the opportunities for mentoring and modeling communication with health care providers are provided through joint office visits and communications with health care providers by the enrollee and the Intensive Care Coordinator.

17.2.11 The Contractor shall ensure that the Intensive Care Coordinator provides wellness and prevention education specific to the enrollee's chronic conditions, Health Action Plan, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks and linking enrollees with resources that support a health promoting lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing, based on individual needs and preferences.

17.2.12 The Contractor shall have a process to enable enrollees to request and be offered the Intensive Care Coordinator of their choice within the complement of the Contractor's available Intensive Care Coordinators.

17.2.13 The Contractor shall have in place a process to evaluate the performance of individual Intensive Care Coordinators, including Enrollee input.

17.3 Comprehensive Transitional Care

Comprehensive transitional care, including appropriate follow-up from inpatient to other settings, shall be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting) and to ensure proper and timely follow-up care.

17.3.1 The enrollee's Health Action Plan shall include transitional care planning.

17.3.2 Transitional care planning includes:

17.3.2.1 A notification system with managed care plans, hospitals, nursing homes and residential/rehabilitation facilities to provide the Contractor prompt communication of an enrollee's admission and/or discharge from an emergency

room, inpatient, nursing home or residential/rehabilitation and if proper permissions are in place, a substance use disorder treatment setting. Progress notes or a case file will document the notification and the Health Action Plan should be updated with transition planning.

17.3.2.2 Intensive Care Coordinator as an active participant in all phases of care transition; including discharge planning visits during hospitalizations or nursing home stays post hospital/institutional stay home visits and telephone calls.

17.3.2.3 Enrollee education that supports discharge care needs including medication management, encouragement and intervention to assure follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of formal or informal caregivers shall be facilitated when requested by the enrollee.

17.3.2.4 A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage enrollees that do not receive post discharge care.

17.4 Individual and Family Support Services

The Contractor shall ensure recognition of the unique role the enrollee may give family, identified decision makers and caregivers in assisting the enrollee to access and navigate the health care and social service delivery system as well as support health action planning.

17.4.1 The Contractor shall ensure peer supports, support groups, and self-management programs will be used by the Intensive Care Coordinator to increase enrollee and caregiver's knowledge of the enrollee's chronic conditions, encourage the enrollee's engagement and self-management capabilities and help the enrollee improve adherence to their prescribed treatment.

17.4.2 The Contractor shall ensure the Intensive Care Coordinator and enrollee:

17.4.2.1 Identify the role that families, informal supports and paid caregivers provide to achieve self-management and optimal levels of physical and cognitive function;

17.4.2.2 Educate and support self-management; self-help recovery and other resources necessary for the enrollee, their family and their caregivers to support the enrollee's individualized health action goals;

17.4.2.3 Discuss advance directives with enrollees and their families; and

17.4.2.4 Communicate and share information with individuals and

their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

17.5 Referral to Community and Social Support Services

17.5.1 The Contractor shall ensure the Intensive Care Coordinator identifies available community based resources, if appropriate, and actively manages referrals, assists the enrollee in advocating for access to care, and engagement with community and social supports related to goal achievement documented in the Health Action Plan.

17.5.2 The Contractor shall ensure that, when needed and not provided through other case management systems, the Intensive Care Coordinator provides assistance to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services. These services are coordinated with appropriate departments of local, state and federal governments and community based organizations. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers needed to support the enrollee in support of health action goals.

17.5.3 The Contractor shall ensure that the Intensive Care Coordinator documents referrals to and access by the enrollee of community based and other social support services.

17.6 The use of health information technology to link services, as feasible and appropriate**.**

18 COORDINATION WITH DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Coordination of LTSS (level 2 or 3 enrollees)

18.1.1 The Contractor shall ensure that the enrollee's assigned Care Manager/Intensive Care Coordinator has primary responsibility for coordination of all enrollee's physical health, behavioral health, and long term services and supports.

18.1.2 The Contractor shall provide or arrange for enrollees to have assistance to obtain a needed service or accomplish a necessary task that, due to physical or cognitive limitations, they cannot obtain independently, such as completing forms, arranging for transportation, gaining access to community resources, or locating a personal care provider.

18.1.3 DSHS or its designee will be responsible to determine enrollee's financial and functional eligibility for long term services and supports using the Comprehensive Assessment Review Evaluation (CARE) tool DSHS or its designee will make the CARE assessment available to the Contractor.

18.1.4 The Contractor shall make a referral to DSHS or its designee within five (5) days of notification through the care coordination process or by the enrollee that the enrollee has unmet long term service and support needs.

18.1.5 Within seven (7) days after notification of eligibility from DSHS or its designee the Contractor shall contact the enrollee schedule an initial face-to-face visit to assess the enrollee's functional needs and develop a care plan to address the needs. The visit must include a comprehensive needs assessment, and development of the Individual Care Plan (ICP).

18.1.6 The Contractor must use the CARE assessment and results as part of the care planning process. If the Contractor chooses to use another comprehensive needs assessment tool to determine long term service and support needs it must first be approved by DSHS.

18.1.7 As part of the initial face-to-face visit the Care Manager/Intensive Care Coordinator shall verify the enrollee's interest in the program, provide enrollee education regarding choice of personal care providers including their ability to hire friends or family, subject to the provider's availability and willingness to deliver timely services, provide information about grievance and appeal process and determine the care plan for the enrollee.

18.1.8 The Care Manager/Intensive Care Coordinator shall include other individuals, such as the enrollee's family and/or caregiver in the care planning process if the enrollee requests and/or approves the inclusion, and such persons are willing and able to participate.

18.1.9 The services to be provided must be incorporated into the Individual Care Plan within 30 days of the care planning meeting.

18.1.10 The Care Manager/Intensive Care Coordinator shall confirm services identified in the ICP have been implemented within 60 days of the care planning meeting.

18.1.11 Upon the scheduled implementation of services identified in the ICP,

the enrollee's Care Manager/Intensive Care Coordinator shall begin monitoring to ensure the services have been initiated and continue to be provided as authorized.

18.1.12 If at any time the Contractor becomes aware of an increase or decrease in the enrollee's needs, the Intensive Coordinator shall contact the DSHS case manager to coordinate a updated CARE assessment, and upon completion of the assessment will review the and implement the updated services within ten (10) days of the enrollee's approval.

18.1.13 At minimum the Contractor shall consider the following a significant change in need or circumstances for enrollees living in the community:

18.1.13.1 Change of residence or primary caregiver or loss of essential social supports

18.1.13.2 Significant change in health and/or functioning;

18.1.13.3 An event that significantly increase the perceived risk to an enrollee; or

18.1.13.4 Enrollee has been referred to CPS, APS or RCS because of abuse, neglect or exploitation.

18.1.14 The Contractor shall inform DSHS or its designee within seven (7) business of the Contractor becoming aware that the enrollee's functional or medical status has changed in a way that may affect level of care eligibility and necessitates a review of the enrollee's need for mental health treatment or long term care services and supports.

18.2 Individual Care Plans (ICP) for Enrollees who have Long Term Services and Supports

For enrollees receiving long term services and supports, an Individual Care Plan will be developed.

18.2.1 The content of the individual care plan will include at a minimum:

18.2.1.1 Pertinent demographic information regarding enrollee name, contact information of any authorized representative, and a list of other persons authorized by the enrollee to have access to health care information;

18.2.1.2 Care to be provided, including specific tasks and functions that will be performed by family and other caregivers;

18.2.1.3 Home health and long term services and supports, including the amount, frequency, and duration of each service to be provided and the schedule at which such care is needed, and other related information; and

18.2.1.4 A detailed back-up plan for situation when regularly scheduled providers are unavailable.

18.2.2 The Care Manager/Intensive Care Coordinator shall verify that the decisions made by the care planning team are documented in the enrollee record.

18.2.3 The Care Manager/Intensive Care Coordinator ensure that the enrollee reviews, signs and dates the ICP as well as any updates. The Care Manager/Intensive Care Coordinator shall also sign and date the ICP.

18.2.4 The enrollee's Care Manager/Intensive Care Coordinator provide a copy of the enrollee's completed ICP in the language of their choice, including any updates, to the enrollee, their representative, as applicable, and the enrollee's community residential/personal care providers.

18.2.5 The Contractor shall develop policies and procedures that describe the measures taken by the Contractor to address instances when an enrollee refused to sign the ICP, including actions taken to resolve any disagreements with the ICP and shall involve the consumer advocate in helping to facilitate resolution.

18.3 Transition of Providers for Enrollees Receiving LTSS in the Community

18.3.1 The Contractor shall actively assist enrollees who receive LTSS in transitioning to new providers of their choice when necessary. The Contractor shall have transition policies that, at minimum, include the following:

18.3.1.1 A schedule which ensures the change in provider does not create a lapse in service;

18.3.1.2 A requirement in the Contractor's contract with the LTSS provider, that the LTSS provider who is no longer willing or able to provide services to an enrollee must cooperate with the enrollee's Care Manager/Intensive Care Coordinator to facilitate a seamless transition to another LTSS provider and that the original provider continue to provide services to an enrollee until he/she has transitioned to another provider;

18.3.1.3 A process for which the Contractor will follow when an

Assisted Living facility or AFH's license is revoked or is closed to ensure timely and smooth transition (even after regular business hours) to another setting, including coordination of transportation of the enrollee, their belongings, and medications.

18.3.1.4 A mechanism for assuring confidentiality;

18.3.1.5 A mechanism for allowing a member to request and be granted a change of provider; and

18.3.1.6 An appropriate schedule for transitioning enrollees from one residential setting to another.

18.3.2 The Contractor shall facilitate a seamless transition to new services and/or providers, as applicable, in the ICP.

18.3.3 The Contractor shall not transition nursing facility residents or residents of community-based residential alternatives from one facility to another unless:

18.3.3.1 The enrollee or his/her representative specifically request the transition. This request must be documented in the enrollees file;

18.3.3.2 The enrollee or his/her representative provides consent to the transition based on quality or concerns other than the nursing facility's rate of reimbursement, raised by the Contractor; or

18.3.3.3 If the Community based residential facility where the enrollee is currently residing is not a contracted provider, the Contractor shall provide continuation of services in such facility for at least sixty (60) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the Contractor or the enrollee's transition to a contracted facility. If the member is transitioned to a contracted facility, the Contractor shall facilitate a seamless transition to the new facility.

18.4 Nursing Home Diversion

If an enrollee is ready for discharge from a skilled nursing facility, the Contractor shall coordinate with the skilled nursing facility as necessary to facilitate a smooth transition at discharge.

18.4.1 The Contractor shall develop and implement a nursing facility diversion process. The diversion process shall not prohibit or delay an enrollee's access to nursing facility services when these services are medically necessary and requested by the enrollee.

18.4.2 At minimum the nursing facility diversion process shall include a detailed description of how the Contractor will work with providers to ensure appropriate communication among providers and between

staff, early identification of enrollees who may be candidates for diversion, and follow up activities to help sustain community living.

18.4.3 The Contractor shall develop and implement methods for identifying enrollees who may have the ability and/or desire to transition from a nursing facility to the community.

18.4.4 For transition referrals by or on behalf of a nursing facility resident, regardless of referral source, the Contractor shall ensure that within five (5) days of the referral a Care Manager/Intensive Care Coordinator conducts an in-facility visit with the enrollee to determine the enrollee's interest in and potential ability to transition to the community, and provide orientation and information to the enrollee regarding transition activities.

18.4.5 The Care Manager/Intensive Care Coordinator shall document in the enrollee's case file that transition was discussed with the enrollee and indicate the enrollee's wishes as well as their potential for transition.

18.4.6 If the enrollee wishes to pursue transition to the community, within fourteen (14) days of the initial visit or within fourteen (14) days of identification through the care coordination process, the Care Manager/Intensive Care Coordinator shall conduct an in-facility assessment and develop a transition plan which will include identification of any barriers to a safe transition to be included in the transition plan.

18.4.7 The Care Manager/Intensive Care Coordinator shall include other individuals such as the enrollee's family and/or caregiver in the transition planning process if the enrollee requests and/or approves the request, and such persons are willing and able to participate.

18.4.8 The transition plan shall address all services necessary to safely transition the enrollee to the community and include at minimum enrollee needs related to housing, transportation, need for caregivers, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.

18.4.9 For enrollee's who have transitioned to the community, the Care Manager/Intensive Care Coordinator shall conduct a face–to-face visit with the enrollee within thirty (30) days to ensure the ICP is being followed, that the plan meets the enrollee's needs, and the enrollee has successfully transitioned to the new setting.

18.4.10 The Contractor shall monitor hospitalization and nursing facility re-admission for enrollees who transition from a nursing facility to the community to identify and implement strategies to improve transitions outcomes.

18.4.11 The Contractor shall be permitted to coordinate or subcontract with local community-based organization to assist in the identification, planning and facilitation processes relate to nursing facility-to-community transitions that are not specifically assigned to the Care Manager/Intensive Care Coordinator.

18.4.12 The Contractor shall inform DSHS of any enrollee who is discharged, who has resided in the a nursing facility for over 3 months, is

discharged to a qualified residence, and chooses to be a part of the Money Follows the Person (MFP) efforts.

18.4.12.1 Enrollee participation in MFP is voluntary and may withdraw consent to participate at any time without affecting their enrollment.

18.4.12.2 If the enrollee chooses to be in MFP they will sign the enrollment form provided by DSHS. This form shall be maintained in the enrollee record.

18.4.12.3 The Care Manager/Intensive Care Coordinator shall verify and document in the enrollee record that the enrollee will transition into a qualified residence.

18.4.12.4 A qualified residence for the MFP is a private residence or an Adult Family Home with four or fewer residents at the time of transition.

18.4.12.4.1 The Contractor will contact DSHS 2 weeks prior to the transition to the new residence.

18.4.12.4.1 The transition period for MFP is 365 days. This includes all days during which the enrollee resides in the community. Days are counted consecutively except for days during which the enrollee is admitted to an institutional setting at which time participation in MFP is suspended.

18.4.12.4.1 The enrollee will be reinstated in MFP upon return to a qualified residence in the community.

18.4.12.4.1 The Contractor shall track the enrollee's residency throughout the 365-day MFP period.

18.4.12.4.1 The Contractor shall contact DSHS 2 weeks prior to the end of the 365-day period.

18.4.12.4.1 Upon conclusion of the enrollee's 365-day period in MFP, long term services and supports shall continue to be provided in accordance with the covered benefits described in Appendix A.

18.4.12.5 An enrollee who successfully completes 365-day period for MFP and is subsequently re-institutionalized may qualify to participate in MFP again but must first meet the eligibility requirements.

18.5 Individual Providers

The Contractor will be responsible for collecting, processing and maintaining employment related forms for all IPs employed by enrollees/representatives. These

tasks include:

18.5.1 Complying with all IP requirements outlined in RCW 43.20A.710 and WAC 388-71. Individuals who do not meet these requirements are not eligible for payment for Participant directed personal assistance services.

18.5.2 Developing standard policies and procedures for the IP contracting process.

18.5.3 Verifying the individuals' right to work by reviewing a completed Provider Eligibility Verification form as an authorizing representative.

18.5.4 Processing an initial Name/Birthdate background check through the DSHS Background Check Central Unit (BCCU) as part of the contracting process to be used to presumptively hire an individual provider. The cost for this service will be billed at $15.00 per background check to the Contractor. This cost cannot be billed to the enrollee or Individual Provider.

18.5.5 Processing an FBI fingerprint background through LOne, (DSHS contracted provider). The cost for this service will be billed at negotiated rate per fingerprint process. This cost cannot be billed to the enrollee or Individual Provider.

18.5.6 Executing IP contracts as required and approved by the DSHS.

18.5.7 Collection and review of IP time sheets to ensure accurate payment.

18.5.8 Verifying the completion of required training as specified in WAC 388-71.

18.5.9 Providing written due process notification to the IP and enrollee at least ten days prior to the training deadline when training has not been completed and termination of payment will occur in accordance with DSHS policy.

18.5.9.1 If the IP does not successfully complete the training within the required timelines notify the enrollee, and terminate payment by closing the service authorization immediately.

18.6 Payment for LTSS

The Contractor shall only pay qualified long term services and support providers per qualification noted in the WA states approved HCBS waiver.

18.7 Behavioral Health Services - Coordination with State Hospital re: Discharge and Planning

The Contractor shall:

18.7.1 Work with staff at Western State Hospital and outpatient mental health providers 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 Contract Management Team for review and approval prior to final contract execution.

18.7.2 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.

18.7.3 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.

18.7.4 Implement mechanisms that promote rapid and successful reintegration of HPW enrollees back into the community from the state hospital, including those patients who were HPW enrollees prior to their admission to the hospital and require assistance with resuming eligibility and enrollment into the HPW. The Contractor shall:

18.7.5 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.

18.7.6 Designate staff with primary responsibility for coordination of the mental health aftercare services that the enrollee receives, based on medical necessity.

18.8 ELECTRONIC HEALTH RECORD

To ensure coordination of care, the Contractor must maintain a single, centralized, comprehensive Electronic Health Record (EHR), as follows:

18.9 Record Content

18.9.1 The Contractor must ensure that the PCP, Interdisciplinary care team, Care Manager/Intensive Care Coordinator, and any other appropriate providers, including subcontracted providers, have access to the EHR.

18.9.2 The Contractor shall make appropriate and timely entries describing the care provided, diagnoses determined, medications prescribed, and treatment plans developed.

18.9.3 The organization and documentation included in the EHR must meet all applicable professional requirements.

18.9.4 The EHR must contain the following:

18.9.4.1 Enrollee identifying information;

18.9.4.2 Interdisciplinary assessments, including diagnoses, prognoses, reassessments, planning documents, and treatment and progress notes, signed and dated by the appropriate provider;

18.9.4.3 Laboratory and radiology reports;

18.9.4.4 Prescribed medications, including dosages and any known drug contraindications;

18.9.4.5 Documentation of contacts with family members and persons giving informal support, if any;

18.9.4.6 Physician orders;

18.9.4.7 Disenrollment agreement, if applicable;

18.9.4.8 Enrollee's individual advance directives and health care proxy, recorded and maintained in a prominent place;

18.9.4.9 Plan for Emergency Conditions and Urgent Care, including identifying information about any emergency contact persons;

18.9.4.10 Allergies and special dietary needs;

18.9.4.11 Health Action Plan;

18.9.4.12 Individual Care Plan.

18.10 Coordination of Electronic Health Record Information

Systems must be implemented to ensure that the EHR is:

18.10.1 Updated in a timely manner by the Contractor;

18.10.2 Shareable and available upon request 24 hours per day, seven days per week, either in its entirety or in a current summary of key clinical information, to triage and acute care providers for Emergency Conditions and Urgent Care; and

18.10.3 Shareable and available to all providers involved in the enrollee's care.

18.11 Confidentiality of EHR Information

The Contractor must have and comply with written policies to ensure the confidentiality of EHR information. Such policies must include the following:

18.11.1 At a minimum, compliance with all federal and State legal requirements as they pertain to confidentiality of Enrollee records, including without limitation the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 C.F.R. parts 160 and 164.

18.11.2 Information for Enrollees on how to obtain a copy of their centralized Enrollee Records and how to request that it be amended or corrected at no cost;

18.11.3 Require all subcontractors to abide by the confidentiality protections established by the Contractor;

18.11.4 Ensure that documentation of mental health and substance abuse treatment in the EHR includes only documentation of behavioral health assessment, diagnosis, treatment plan, therapeutic outcome or disposition, and any medications prescribed (psychotherapeutic session notes must not be recorded in the EHR);

18.11.5 Provide records at the request of HCA, DSHS or CMS, for monitoring the quality of care provided by the Contractor in accordance with federal law (for example, 42 USC 1396a (a) (30)) and conducting performance evaluation activities;

18.11.6 Audit all access to records to ensure that only authorized individuals have access to information to prevent misuse.

19 PERFORMANCE MEASUREMENT

19.1 Care Management Processes and Outcomes

19.1.1 Care management process and outcome measures shall be calculated annually and reported to HCA. The measures shall include, at minimum:

19.1.1.1 Average time from referral to conduct of the initial health screen of new enrollees.

19.1.1.2 Average time from the initial health screen to conduct of the initial health assessment of new enrollees and from enrollment to assessment if no screen required for new and current enrollees.

19.1.1.3 Avoidable hospitalizations.

19.1.1.4 Hospital readmission rates within seven (7) and thirty (30) calendar days of hospital discharge.

19.1.1.5 Preventable emergency room utilization.

19.1.1.6 Annual primary care history and physical examination or other appropriate frequency of PCP visits dependent on age and/or EPSDT periodicity schedule.

19.1.1.7 Documentation of annual mental health and substance use disorder screening; and developmental screen as defined by peer managed care Contractors.

19.2 Home and Community Based Services (HCBS) Waiver Performance Measures

The Contractor will be responsible for all HCBS quality assurance performance measures as noted in Appendix C.

19.3 Pay for Performance Incentives

The Contractor will be required to report on all HEDIS, CHAPS and other performance measure for specific of populations as required in 7.3.

20 GENERAL PROVISONS REGARDING BENEFITS

20.1 Second Opinions

20.1.1 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.

20.1.2 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 CFR 438.206(b)(3)).

20.2 Sterilizations and Hysterectomies

The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are in compliance with 42 CFR 441 Subpart F, and that HCA Sterilization Consent Form (HCA 13-364)) or its equivalent is used.

20.3 Narcotic Review

The Contractor shall have a process in place 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 to address this health and safety concern may include: 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.

20.4 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.

Appendix A

Benefit Package

1. BENEFITS

1.1. Scope of Services:

1.1.1. The Contractor is responsible for covering medically necessary services relating to (42 CFR 438.210(a)(4)):

1.1.1.1. The prevention, diagnosis, and treatment of health impairments.

1.1.1.2. The achievement of age-appropriate growth and development.

1.1.1.3. The attainment, maintenance, or regaining of functional capacity.

1.2. If a service is covered by HCA under its fee-for-service program, 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 billing instructions, incorporated by reference. For services that HCA determines are non-covered or limited in its fee-for-service program, that are not specifically excluded by this Contract or excluded from coverage under Federal regulations, 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.

HCA and CMS will make all decisions about what is and is not a covered service in Healthpath Washington. 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 the HCA FFS 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 a global medical necessity decision, since that is a coverage decision. The Contractor may 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 healthcare professional without being limited by such guidelines.

1.2.1. Except as otherwise specifically provided in this Contract, the Contractor shall provide contracted Medicaid (need Medicare Benefits) services in the amount, duration and scope described in the Medicaid State Plan (42 CFR 438.210(a)(1 & 2)).

1.2.2. The amount and duration of contracted services that are medically necessary depends on the enrollee's condition (42 CFR 438.210(a)(3)(i)).

1.2.3. 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 CFR 438.210(a)(3)(ii).

1.2.4. 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. The Contractor's utilization control measures are not required to be the same as those in the Medicaid fee-for-service program (42 CFR 438.210(a)(3)(iii).

1.2.5. For specific contracted services, the requirements of this Section shall also not be construed as requiring the Contractor to cover the specific items covered by HCA under its fee-for-service program, but shall rather be construed to require the Contractor to cover the same scope of services.

1.2.6. Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of services covered under this Contract (42 CFR 438.6(e)).

1.2.7. The Contractor may limit of the provision of contracted services to participating providers except as specifically provided in the Access and Capacity Section of this Contract; and the following provisions of this Section:

1.2.7.1. Emergency services;

1.2.7.2. Outside the Service Areas as necessary to provide medically necessary services; and

1.2.7.3. Coordination of Benefits, when an enrollee has other medical coverage as necessary to coordinate benefits.

1.2.8. **Within the Service Areas**: 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.

1.2.9. **Outside the Service Areas**: 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:

1.2.9.1. Emergency and post-stabilization services.

1.2.9.2. 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 and Capacity Section of this Contract, are not exceeded.

1.2.9.3. 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 pre-authorization for such services as long as the wait times specified in the Appointment Standards provision of the Access and Capacity Section of this Contract, are not exceeded.

1.2.10. 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.

1.3. 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.

1.4. Enrollee Self-Referral:

1.4.1. 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.

1.4.2. The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

1.4.3. The enrollees also may choose to receive such services from the Contractor.

1.4.4. 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.

1.4.5. 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.

1.4.6. The services to which an enrollee may self-refer are:

1.4.6.1. Family planning services and sexually-transmitted disease

screening and treatment services provided at family planning facilities, such as Planned Parenthood.

1.4.6.2. 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.

1.5. Women's Health Care Services: The Contractor must provide female enrollees with direct access to a women's health specialist within the Contractors network for covered care necessary to provide women's routine and preventive health care services in accord with the provisions of WAC 284-43-250 and 42 CFR 438.206(b)(2).

1.6. Maternity Newborn Length of Stay: The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

1.7. Experimental and Investigational Services:

1.7.1. In determining whether a service that the Contractor considers experimental or investigational is medically necessary for an individual enrollee, the Contractor must have and follow policies and procedures that mirror the process for HCA's medical necessity determinations for its 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.

1.7.2. Criteria to determine whether an experimental or investigational service is medically necessary shall be no more stringent for HPW enrollees than that applied to any other members.

1.7.3. An adverse determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, hearing process and independent review.

1.8. Enrollee Hospitalized at Enrollment:

1.8.1. If an enrollee is in an acute care hospital at the time of enrollment and was not enrolled in HPW on the day the enrollee is admitted to the hospital, HCA shall be responsible for payment of all inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer confined to an acute care hospital.

1.8.2. If the enrollee is re-admitted into the hospital with the same diagnosis within the seven (7) day readmission period as outlined in the Inpatient Hospital Services billing guidelines, HCA shall be responsible for payment of all inpatient facility and professional services provided from the date of readmission until the date the enrollee is no longer confined to an acute care hospital.

1.8.3. If an enrollee is enrolled on the day the enrollee was admitted to an acute care hospital, then the plan the enrollee is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer confined to an acute care hospital.

1.8.4. 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.

1.8.5. 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.

1.8.6. If HCA is responsible for payment of all covered inpatient facility and professional services provided to a mother, HCA shall not pay the Contractor a Delivery Case Rate under the provisions of the Payment and Sanctions Section of this Contract.

Comment [RA(1]: CMS discussion needed

1.9. Enrollee Hospitalized at Termination of Enrollment: If an enrollee is in an acute care hospital 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 inpatient facility and professional services from the date of admission until one of the following occurs;

1.9.1. The enrollee is no longer confined to an acute care hospital.

1.9.2. The Contractor's obligation to pay for services has ended based on the Contractor's obligation for covering services outside the service area as identified in this Section.

1.9.3. 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.

1.10. 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, the Contractor is responsible for payment from the date of admission until one of the following occurs:

1.10.1. The Enrollee is no longer confined to a skilled nursing facility;

1.10.2. The enrollee's eligibility to receive Medicare/Medicaid services ends. The Contractor's obligation for payment ends at the end of the month the

enrollee's eligibility ends.

1.11. General Description of Contracted services: This Section is a general description of services covered under this Contract and is not intended to be exhaustive.

1.11.1. Inpatient Services: Provided by acute care hospitals (licensed under RCW 70.41).

1.11.2. Outpatient Hospital Services: Provided by acute care hospitals (licensed under RCW 70.41).

1.11.3. Emergency Services and Post-stabilization Services:

1.11.3.1. Emergency Services: Emergency services are defined herein.

1.11.3.2. The Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 CFR 438.114.

1.11.3.3. The Contractor shall cover all emergency services provided by a licensed provider, acting with in their scope of practice, without regard to whether the provider is a participating or non-participating provider (42 CFR 438.114 (c)(1)(i)).

1.11.3.4. 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 CFR 438.114 (c)(1)(ii)).

1.11.3.5. The only exclusions to the Contractor's coverage of emergency services are dental services only if provided by a dentist or an oral surgeon to treat a dental diagnosis, covered under HCA's fee-for-service program.

1.11.3.6. Emergency services shall be provided without requiring prior authorization.

1.11.3.7. What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 CFR 438.114 (d)(1)(i)).

1.11.4. The Contractor shall cover treatment obtained under the following circumstances:

1.11.4.1. 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 CFR 438.114(c)(1)(ii)(A)).

1.11.4.2. A participating provider or other Contractor representative

instructs the enrollee to seek emergency services (42 CFR 438.114(c)(1)(ii)(B)).

1.11.4.3. 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 CFR 438.114 (d)(3)).

1.11.5. Post-stabilization Services: Post-stabilization services are defined herein.

1.11.5.1. The Contractor will provide all inpatient and outpatient post-stabilization services in accord with the requirements of 42 CFR 438.114 and 42 CFR 422.113(c).

1.11.5.2. 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.

1.11.6. The Contractor shall cover post-stabilization services under the following circumstances (42 CFR 438.114 (e) and 42 CFR 438.113(c)(2)(iii))):

1.11.6.1. The services are pre-approved by a participating provider or other Contractor representative.

1.11.6.2. 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 1 hour of a request to the Contractor for pre-approval of further post-stabilization care services.

1.11.6.3. 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:

1.11.6.4. The Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d));

1.11.6.5. The Contractor cannot be contacted; or

1.11.6.6. 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 CFR 438.114(e) and 42 CFR 422.133(c)(3) is met.

1.11.7. The Contractor's responsibility for post-stabilization services it has not pre-approved ends when (42 CFR 438.114(e) and 42 CFR 422.133(c)(3)):

1.11.7.1. A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

1.11.7.2. A participating provider assumes responsibility for the enrollee's care through transfer;

1.11.7.3. A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

1.11.7.4. The enrollee is discharged.

1.11.8. 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. 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:

1.11.8.1. Crisis Services;

1.11.8.2. Freestanding Evaluation and Treatment;

1.11.8.3. Stabilization;

1.11.8.4. Rehabilitation Case Management.

1.11.9. Ambulatory Surgery Center: Services provided at ambulatory surgery centers.

1.11.10. 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, and certified dietitians. Provider Services include, but are not limited to:

1.11.10.1. Medical examinations, including wellness exams for adults and EPSDT for children;

1.11.10.2. Immunizations;

1.11.10.3. Maternity care;

1.11.10.4. Family planning services provided or referred by a participating provider or practitioner;

1.11.10.5. Performing and/or reading diagnostic tests;

1.11.10.6. Surgical services;

1.11.10.7. Services to correct defects from birth, illness, or trauma, or for mastectomy reconstruction;

1.11.10.8. Anesthesia;

1.11.10.9. Administering pharmaceutical products;

1.11.10.10. Fitting prosthetic and orthotic devices;

1.11.10.11. Rehabilitation services;

1.11.10.12. Enrollee health education;

1.11.10.13. Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia;

1.11.10.14. Bio-feedback training when determined medically necessary specifically for, perineal muscles, anorectral or urethral sphincter, including EMG and/or manometry for incontinence; and

1.11.10.15. Genetic services when medically necessary for diagnosis of a medical condition.

1.11.11. Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel, and peripheral blood stem cell.

1.11.12. Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy.

1.11.13. 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. Enrollees may self-refer to participating providers for these services.

1.11.14. Orthoptic (eye training) care for eye conditions

1.11.15. Pharmaceutical Products: Prescription drug products according to a DSHS approved formulary, which includes both legend and over-the-counter (OTC) products. The Contractor's formulary shall include all therapeutic classes in DSHS' fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet medically necessary health needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs. The Contractor shall have policies and procedures for the administration of the pharmacy benefit including formulary exceptions. The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request.

1.11.16. Covered drug products shall include all of the following products not covered by the Medicare Prescription Drug Plan:

1.11.16.1. Oral, enteral and parenteral nutritional supplements and supplies prescribed by the enrollee's PCP or other provider.

1.11.16.2. All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies;

1.11.16.3. Antigens and allergens;

1.11.16.4. Therapeutic vitamins and supplements prescribed for prenatal and postnatal care;

1.11.17. The Contractor must ensure that procedures for pharmaceutical management promote clinically appropriate use of pharmaceuticals.

1.11.17.1. Procedures must include criteria used for adoption of pharmaceutical management procedures.

1.11.17.2. Procedures must include the process for using external organization's clinical evidence for pharmaceutical management.

1.11.18. 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.

1.11.19. Oxygen and Respiratory Services: Oxygen, and respiratory therapy equipment and supplies.

1.11.20. Hospice Services: When the enrollee elects hospice care. Includes facility services.

1.11.21. 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 an HCA recognized neurodevelopmental center. The Contractor may refer children to an HCA recognized neurodevelopmental center for the services as long as appointment wait time standards and access to care standards of this Contract are met.

1.11.22. 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.

1.11.23. Treatment for Renal Failure: Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of

treatment.

1.11.24. Ambulance Transportation: The Contractor shall cover ground and air 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:

1.11.24.1. When it is necessary to transport an enrollee between facilities to receive contracted services; and,

1.11.24.2. 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.

1.11.25. Smoking Cessation Services: As determined medically necessary by the Care Coordinator.

1.12. Chemical Dependency Treatment: The Contractor shall provide Chemical Dependency treatment services to Enrollees as follows. Outpatient treatment services must meet the criteria in the specific modality provisions set forth in WAC 388-805.

1.12.1. 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.

1.12.2. 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.

1.12.3. 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.

1.12.4. The Contractor shall ensure that chemical dependency treatment services are provided by DSHS-certified agencies and reported in the TARGET information system.

1.12.5. In accordance with Section XXX of this Contract, the Contractor shall ensure that contracted Chemical Dependency providers offer the enrollee a consent form for release of information (ROI) to sign if one is not already on record. The Contractor shall ensure that enrollees who need CD services are receiving them by cross referencing enrollee data with utilization contained in the TARGET database on a quarterly basis.

If an enrollee who 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.

1.12.6. The Contractor shall ensure provision of the following services:

1.12.6.1. Screening for alcohol and/or drug dependency shall be included in the required comprehensive assessment for each enrollee. Either a member of the Contractor's staff or a contracted provider may conduct the chemical dependency screening. The results of the screening shall be documented in the Contractor's or subcontractor's client chart and shared with the enrollee's providers as appropriate and in compliance with confidentiality rules.

When the screening indicates that the enrollee is at risk of a substance use disorder, the contractor's staff member or the provider who conducted the screening shall conduct a brief intervention (if trained to do so). When the screening indicates the enrollee is at high risk for substance dependence, the contractor's staff member or the provider who conducted the screening should refer the enrollee for an assessment.

1.12.6.1.1. Clinical records for those enrollees who have screen as high risk for Chemical Dependency and who are referred for an assessment as the result of the screening shall reflect that the referral was made and the reasons for making the referral. If the enrollee is NOT referred for a chemical dependency assessment, the Contractor's staff or the contracted provider shall document the reasons that the referral was not made.

1.12.6.2. 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.

1.12.6.3. Individual and Group Therapy as determined necessary by the chemical dependency assessment:

1.12.6.3.1. Individual Therapy is a planned therapeutic or counseling activity provided by a CDP or CDP-T under supervision of a CDP. Individual therapy includes treatment provided to a family or couple when the primary patient is present or the family group without the primary patient present.

1.12.6.3.2. Group Therapy is a planned therapeutic or counseling activity conducted by one or more certified CHPs or CDP-Ts to a group of three or more unrelated individuals and lasting at least 45 minutes.

1.12.6.4. Crisis intervention in accordance with the RCW 70.96A.140, Involuntary Treatment Act (ITA), through existing community systems.

1.12.6.5. 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.

1.12.6.6. 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.

1.12.6.7. Opiate Substitution Treatment providing a combination of chemical dependency counseling along with adjunctive medication reviewed and administered by medical staff. The Contractor shall ensure that each enrollee is evaluated by medical staff prior to initial medication administration.

1.13. Mental Health Services. The Contractor shall provide inpatient and outpatient mental health services in accordance with RCW 70.02, 71.05, and 71.24 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 HPW enrollees requesting covered mental health services must be offered an intake evaluation as defined in the Medicaid State Plan.

1.13.1. 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 17.7.5 and an age-appropriate and culturally appropriate range of medically necessary mental health services as described in this Section.

1.13.2. The Contractor shall provide the following outpatient mental health services:

1.13.2.1. 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.

1.13.2.1.1 Crisis Services: Evaluation and treatment of enrollees who are experiencing a mental health crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis.

1.13.2.1.2 Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the enrollee and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

1.13.2.2. 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.

1.13.2.3. 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.

1.13.2.4. **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.

1.13.2.5. **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:

1.13.2.5.1. Develop self care and/or life skills;

1.13.2.5.2. Improve interpersonal skills;

1.13.2.5.3. Reduce results of traumatic experience and alleviate symptoms of mental illness.

1.13.2.5.4. 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.

1.13.2.6. 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.

1.13.2.7. Intake Evaluation: The Contractor shall ensure that an age and culturally appropriate evaluation is initiated 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. Note: Rehabilitation Case Management may be provided prior to an intake in order to facilitate transition from an inpatient facility into the community.

1.13.2.8. 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.

1.13.2.9. 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.

1.13.2.10. 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.

1.13.2.10.1. 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.

1.13.2.10.2. 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.

1.13.2.10.3. Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

1.13.2.11. 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.

1.13.2.12. 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.

1.13.2.13. 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.

1.13.2.14. 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.

1.13.2.15. 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.

1.13.2.16. 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.

1.13.2.17. Inpatient Hospital Services: The Contractor will be financially responsible for state hospital placements of enrollees and will be required to contract with the Regional Support Network (RSN) to use part of the RSNs state hospital bed allocation and hospital liaison services. The Contractors state funded hospital placements will be counted against the RSN's annual state hospital allocation. Unless an alternative, mutually acceptable payment agreement is negotiated between the Contractor and the RSN, the Contractor will pay the amount called for in the RSN contract.

1.13.3. Coordination with State Hospital re: Discharge and Planning.

1.13.3.1. Work with staff at Western State Hospital for discharge planning, coordination of care and treatment planning and hospital census alerts. The Contractor shall submit a copy of policies and procedures to HPW program managers for review and approval prior to final execution.

1.13.3.2. 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.

1.13.3.3. 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.

1.13.3.4. Implement mechanisms that promote rapid and successful reintegration of HPW enrollees back into the community from the state hospital, including those patients who were HPW enrollees prior to their admission to the hospital and require assistance with resuming eligibility and enrollment into the HPW. The Contractor shall:

1.13.3.4.1. Designate staff with primary responsibility for coordination of the mental health aftercare services that the enrollee receives, based on medical necessity.

1.13.3.4.2. 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.

1.13.4. 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:

1.13.4.1. On a Less Restrictive Alternative court order in accordance with RCW 71.05.320 and WAC 388-865-0466;

1.13.4.2. On a Conditional Release under RCW 72.05.340; or

1.13.4.3. On a Conditional Release under RCW 10.77.150.

1.14. Long-Term Services and Supports: The Contractor shall provide the following long-term care services including:

1.14.1. 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; routine health monitoring with consultation from a registered nurse; general therapeutic activities; general health education; and supervision and/or protection for at least four hours a day but less than twenty-four hours a day in a group setting on a continuing, regularly scheduled basis. Services also include: provision of recipient meals as long as meals do not replace nor be a substitute for a full day's nutritional regimen; and, programming and activities designed to meet clients' physical, social and emotional needs.

1.14.2. 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.

1.14.3. Dental: Adult dental services are provided to individuals age 21 years and older. Dental Services, as defined in WAC 182-535, are available through the Medicaid State Plan for clients through the age of 20.

1.14.4. Enrollee/Caregiver Training: Provided in accordance with a therapeutic goal in the plan of care and includes for example, adjustment to serious impairment, maintenance or restoration of physical functioning, self-management of chronic disease, acquisition of skills to address minor depression, management of personal care, and development of skills to work with care providers including behavior management.

1.14.5. Environmental Modifications/Assistive Technology: Physical adaptations to a private residence of the enrollee or enrollee's family that are necessary to ensure the health, welfare and safety of the enrollee of that enable the enrollee to function with greater independence in the home. Such adaptions include: ramp installation, grab-bars, widening doorways, modifying bathrooms,

or installing special electric and plumbing systems to accommodate medical equipment

1.14.6. Home Delivered Meals: Nutritious meals and other dietary services are provided in a group setting or delivered to home-bound persons.

1.14.7. Home Health Aide: In-home health care (monitoring, treatment, therapies, medications, exercises) as authorized by a physician and provided by nurses, therapists, or trained aides. Home health aide services may be provided without a physician order and the tasks in the care plan performed by the aide are supervised by an RN as needed and in coordination with the client's case manager. Home health aide services under the HCBS waiver differ in nature, scope, supervision arrangement, or provider type (including provider training and qualifications) from home health aide services in the State Plan.

1.14.8. Minor Household Repairs: Home or apartment repairs/modifications made to maintain the enrollee's health and safety.

1.14.9. Nurse Delegation Training and supervision of a nursing assistant to perform specific designated routine health care tasks by a registered nurse. The trained nursing assistant shall provide care in the enrollee's home setting. The nursing assistant shall only perform those tasks allow in rule and shall successfully complete a class before doing a delegated task. A registered nurse delegator assesses a client for program suitability; and teaches, evaluates competency and supervises the performance of a nursing assistant. The nursing assistant has met additional educational requirements performs the delegated nursing tasks for a client.

1.14.10. Supplemental Roads to Community Living (RCL) Services – A service option for intensive one on one relocation support for individuals moving from institutional settings to community settings. Services may include the following:

1.14.10.1. Community Choice Guide

1.14.10.2. Community Housing Specialist (locating, setting up, maintaining affordable housing),

1.14.10.3. Challenging Behavior Consultant: services include training, education, and consulting services which benefit individuals with traumatic brain injury as well as those with a diagnosis of mental illness. It targets direct interventions to decrease aggressive, destructive, sexually inappropriate, or other behaviors that compromise a participant's ability to remain in the community.

1.14.10.4. Informal Caregiver Respite: the provision of hourly services for the caregiver for the purpose of time-limited, intermittent respite from caregiver responsibilities. Services may be provided through IP or Agency Care in the enrollee's home.

1.14.10.5. Life Skills: services impact directly on enrollee's ability to access community settings or health services. It also helps individuals and their caregivers with personal skill development related to the individual's plan of care.

1.14.10.6. Professional Therapy Services: covers a range of services for enrollees whose needs include therapeutic services not otherwise covered by Medicaid. It covers supports and services that are typically performed or provided by people with specialized skill, certification or licenses.

1.14.10.7. Transitional Mental Health and Substance Service: include mental health and/or substance abuse services for participants whose needs are not otherwise covered by Medicaid. Services are for participants transitioning from institutional to community settings only and may include mental health services for instances in which the authorized level of services do not meet the participant's transition needs.

1.14.10.8. Service Animals: provided only as authorized in the enrollee's plan of care.

1.14.11. 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 tasks include, but are not limited to:

1.14.11.1. Assistance with walking/locomotion;

1.14.11.2. Bathing;

1.14.11.3. Bed Mobility, i.e. repositioning enrollee in chair or bed;

1.14.11.4. Body Care;

1.14.11.5. Dressing;

1.14.11.6. Eating;

1.14.11.7. Essential shopping;

1.14.11.8. Housework;

1.14.11.9. Laundry;

1.14.11.10. Meal preparation;

1.14.11.11. Personal Hygiene;

1.14.11.12. medication management;

1.14.11.13. Toileting;

1.14.11.14. Transfer; i.e. assisting enrollee to move from bed to chair, etc;

1.14.11.15. Travel to medical services; and

1.14.11.16. Wood supply.

1.14.12. Individual Providers: The Contractor shall ensure that all potential Individual Providers (IPs) meet the minimum qualifications for care providers in home settings as described in WAC 388-71 and are therefore qualified to perform the following services to enrollees:

1.14.12.1. 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.

1.14.12.2. Perform all services in a manner consistent with protecting and promoting the client's health, safety and well-being.

1.14.12.3. An individual provider may perform tasks identified in the enrollee's service plan for which the provider is registered, certified or licensed. An individual provider may also perform these tasks if he/she is a member of the enrollee's immediate family, or is performing self-directed health care tasks. RCW 18.79, 19.88 and 74.39 provide more information about regulations related to nursing care, Registered Nurse Delegation and self-directed health care tasks.

1.14.13. 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. The system is programmed to signal a response center once a "help" button is activated. When activated, staff at a response center will call 911 and/or take whatever action has been set-up ahead of time. Some PERS systems can also include medication reminders or other more complex interventions.

1.14.14. Residential Programs: The Contractor shall provide the following Long Term Care residential programs to enrollees who have been determined eligible.

1.14.14.1. 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 have are designate to provide nursing care or may specialize in serving people with mental health problems, developmental disabilities, or dementia.

:

1.14.14.2. 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:

1.14.14.2.1. Adult Residential Care (ARC): services include lodging, meal services, general supervision of residents, and assistance with personal care.

1.14.14.2.2. Enhanced Adult Residential Care (EARC)**:** Includes everything provided through and ARC contract (See above) plus limited nursing services.

1.14.14.2.3. 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.

1.14.15. 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.

1.14.16. Skilled Nursing: Skilled nursing service is used for treatment of chronic, stable, long-term conditions that cannot be delegated or self-directed. Services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State.

1.14.17. Skilled 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 will notify DSHS if the rehabilitation stay exceeds 30 days.

1.14.18. Skilled Nursing Facility Relocation Services:

Community Transitional Services – Services are non-recurring set-up expenses for enrollees to assist institutionalized enrollees to reintegrate into the community by providing assistance to enable a move to their own home or a residential setting. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may

include:

1.14.18.1. Security deposits that are required to obtain a lease on an apartment or home;

1.14.18.2. Essential household furnishings and moving expense required to occupy and use a community domicile such as furniture, window coverings, food preparation items, and bed/bath linens;

1.14.18.3. Set-up fees or deposits for utility or service access;

1.14.18.4. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;

1.14.18.5. Moving expenses;

1.14.18.6. Necessary home accessibility adaptations; and

1.14.18.7. Activities to assess need, arrange for and procure need resources. This service includes the training of participants and caregivers in the maintenance or upkeep of equipment purchased under the service.

1.14.19. Specialized Medical Equipment and Supplies:

Specialized medical equipment and supplies to include devices, controls, or appliances whether acquired commercially off the shelf, modified, or customized that is used to increase, maintain, or improve the functional capabilities of the individual. This service also includes maintenance and upkeep of items covered under the service and training for the participant/caregivers in the operation and maintenance of the item.

1.14.20. Clients receiving services through the Developmental Disabilities Administration (DDA):

1.14.20.1. The Contractor shall be responsible for providing all services under this contract to DDA clients who receive Medicaid Personal Care (MPC) services from DDA and the Division of Behavioral Health and Recovery. Other services provided by DDD, such as supported employment, will be covered by DSHS on a fee for service basis.

1.14.21. 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.

1.15. Demonstration Specific: Intensive Care Management Services

Intensive Care Management provides a means of integrating and coordinating services across systems of care including acute medical care, preventive and wellness care, behavioral health care, community-based long-term services and supports, and community-based social services and supports for both children and adults with chronic conditions.

The Intensive Care Management incorporates the following six activities:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care between care settings, including appropriate follow-up;
4. Individual and family support (including authorized representatives);
5. Referral to community and social support services, if relevant; and
6. Use of health information technology to link services, as feasible and appropriate.

1.16. Exclusions: The following services and supplies are excluded from coverage under this Contract.

1.16.1. Unless otherwise required by this Contract, ancillary services resulting from excluded services are also excluded.

1.16.1.1. Complications resulting from an excluded service are also excluded for a period of ninety (90) 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.

1.16.2. Services Covered By HCA Fee-For-Service Or Through Other Contracts:

1.16.2.1. Voluntary Termination of Pregnancy.

1.16.2.2. Transportation Services other than Ambulance: including but not limited to Taxi, cabulance, voluntary transportation, public transportation and common carriers.

1.16.2.3. Services provided by dentists and oral surgeons for dental diagnoses, including physical exams required prior to hospital admissions for oral surgery and anesthesia for dental care.

1.16.2.4. First Steps Child Care, Infant Case Management and Maternity Support Services as described in the HCA program billing instructions.

1.16.2.5. Health care services provided by a neurodevelopmental center recognized by HCA.

1.16.2.6. Services provided by a health department or family planning clinic when a client self-refers for care.

1.16.2.7. Pharmaceutical products prescribed by any provider related to services provided under a separate contract with HCA or DSHS.

1.16.2.8. Surgical procedures for weight loss or reduction, when approved by HCA in accord with WAC 182-531-0200. The Contractor has no obligation to cover surgical procedures for weight loss or reduction.

1.16.2.9. Urinalysis for the purpose of drug screening for Pregnant and Parenting women and clients receiving opiate substitution treatment.

1.16.2.10. Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing.

1.16.3. Services Covered By the Department of Social and Health Services (DSHS):

1.16.3.1. Health care services covered through the Division of Developmental Administration for individuals who are receiving services under the DD Home and Community Based Waiver.

1.16.3.2. Twenty-four-hour crisis intervention services which remain under the Regional Support Network's responsibility.

1.16.3.3. ITA-related transportation for judicial oversight.

1.16.4. Services Not Covered by Either DSHS or the Contractor in accord with WAC 182-501-0070:

1.16.4.1. Any ancillary services provided in association with services not covered by either DSHS or the Contractor.

1.16.4.2. Medical examinations for Social Security Disability.

1.16.4.3. Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.

1.16.4.4. Physical examinations required for obtaining continuing employment, insurance or governmental licensing.

1.16.4.5. Sports physicals

1.16.4.6. Reversal of voluntary induced sterilization.

1.16.4.7. Personal Comfort Items, including but not limited to guest trays, television and telephone charges.

1.16.4.8. Massage Therapy

1.16.4.9. Acupuncture

1.16.4.10. TMJ for Adults

1.16.4.11. Diagnosis and treatment of infertility, impotence, and sexual dysfunction.

1.16.4.12. Naturopathy

1.16.4.13. Tissue or organ transplants that are not specifically listed as covered.

1.16.4.14. Immunizations required for international travel purposes only.

1.16.4.15. Court-ordered services with the exception of those services provided under ITA or as part of a Conditional Release (CR) or Least Restrictive Agreement (LRA)

1.16.4.16. Gender dysphoria surgery and other services not covered by HCA for gender dysphoria.

1.16.4.17. 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.

1.16.4.18. Pharmaceutical products prescribed by any provider related to a service not covered by either DSHS or the Contractor.

1.16.4.19. Biofeedback training except when determined medically necessary as described in Section 23.14.10.15.

1.16.4.20. 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.

Appendix B

INTENSIVE CARE MANAGEMENT ASSUMPTIONS

1. Intensive Care Management. The Health Action Plan development process will include:

   A. Engagement and outreach activities which could be by mail/phone/face to face;
   B. In person screening and assessment visit, which include prior work to include examining PRISM data (presenting dx, pharmacy, utilization, claims data, etc.) and other screening materials that are available such as patient activation measure if available;
   C. Be completed within 60 days of assignment to a Care coordination Organization;
   D. Be updated as needed but no less than every 6 months for intensive-level;
   E. Updated annually for low-level (if beneficiary declines participation in the HAP it should be reflected in the plan including what other HH services are being provided); and
   F. Updated ideally prior to discharge from an institutional setting or at least within 7 days of discharge.

2. Situations for which an in person contact should be considered:
   PAM score (lower the score more intense contact needed);
   Medication changes;
   A. New diagnosis;
   B. Emergency room visit;
   C. Significant change in functioning;
   D. Change in living environment;
   E. Inability to communication over the phone; or
   F. Inconsistent use of prescription medications.

3. Contacts with the beneficiary can be in person and by telephone dependent on the needs of the beneficiary. The Intensive Care coordinator should take into consideration their PAM, severity and stability of their chronic conditions. Services may be provided in the following settings:
   A. The beneficiary's home;

B. The beneficiary's PCP office or other healthcare setting (hospital, skilled nursing facility, residential settings); or
C. Another setting selected by the beneficiary.

4. The Intensive Care coordinator is required to maintain contact with the beneficiary's primary providers and other health care specialists to exchange information and updates on the beneficiary's conditions. This can be accomplished in the following ways:
   A. Mentoring and modeling the beneficiary to improve health literacy and communication with their health care providers related to self-management of their chronic conditions;
   B. Support the beneficiary to navigate the health care system to received disease and age appropriate health promotion and disease prevention services; and
   C. Engaging beneficiary and family supports to assist in ways to make positive progress to meeting health action goals.
   D. Maintaining telephonic or other forms of contact with services and support providers to ensure that all key parties are aware of changes in the beneficiaries' condition or treatment plan.
   E. Making referrals to community support providers, and other health care providers.

APPENDIX C

HOME AND COMMUNITY BASED SERVICE (HCBS)

WAIVER ASSURANCE

Indicator	Proposed Measure	Numerator and Denominator	Data Source	Frequency of Measuring
Administrative Authority	Percent and number of service plans completed for waiver participants that address their assessed needs and personal goals by the provision of waiver services or other. (100% remediation)	means N=Number of service plans reviewed that address all assessed needs and personal goals D=Number of service plans reviewed	Quality Review Instrument	12 months
Administrative Authority	Percent and number of records reviewed where services identified in the POC are authorized (100% remediation)	N=Number of records reviewed where all services identified in the POC are authorized D=Number of records where the POC identifies services	Quality Review Instrument	12 months
Administrative Authority	The percent and number of contracted providers determined to meet qualifications prior to service authorization (100% remediation)	N=Number of contracted providers reviewed that were determined to meet provider qualifications D=Number of contracted providers reviewed.	Quality Review Instrument	12 months
Administrative Authority	Percent and number of correctly executed	N= Number of correctly executed	Quality Review	12 months

	Medicaid provider agreements (100% remediation)	Medicaid provider agreements D=Number of provider agreements reviewed	Instrument	
Qualified Providers	The percent and number of AFH providers that meet licensing requirements at time of initial Medicaid contracting (100% remediation)	N=Adult Family Home providers that initially meet licensing requirements at contracting D=All Adult Family Home providers contracted	Administrative Data	12 months
Qualified Providers	The percent and number of AFH providers that continue to meet licensing requirements at time of Medicaid contract renewal (100% remediation)	N=Adult Family Home providers that continue to meet licensing requirements at contract renewal D=All Adult Family Home providers contracted	Administrative Data	12 months
Qualified Providers	The percent and number of Enhanced Adult Residential Care (EARC) providers that initially meet licensing requirements at time of Medicaid contract (100% remediation)	N=The number of EARC providers that initially meet licensing requirements at time of contracting D=All EARC providers contracted	Administrative Data	12 months
Qualified Providers	The percent and number of Enhanced Adult Residential Care (EARC) providers that continue to meet licensing requirements at time of	N=EARC providers that continue to meet licensing requirements at time of contract renewal D=All EARC	Administrative Data	12 months

	Medicaid contract renewal (100% remediation)	providers contracted		
Qualified Providers	The percent and number of Assisted Living (AL) providers that initially meet licensing requirements at time of Medicaid contract (100% remediation)	N=AL providers that initially meet licensing requirements at initial contracting D=All AL providers contracted	Administrative Data	12 months
Qualified Providers	The percent and number of Assisted Living (AL) providers that continue to meet licensing requirements at time of Medicaid contract renewal (100% remediation)	N=AL providers that continue to meet licensing requirements at time of contract renewal D=All AL providers contracted	Administrative Data	12 months
Qualified Providers	The percentage and number of waiver service providers that require licensure and/or certification that initially meet ADSA contract standards (100% remediation)	Numerator: All waiver service providers that required licensure and/or certification initially meet contract standards Denominator: All waiver service providers that require licensure and/or certification	Administrative Data	12 months
Qualified Providers	The percentage and number of waiver service	. Numerator: All waiver service	Administrative Data	12 months

	providers that require licensure and/or certification that continues to meet ADSA contract standards (100% remediation)	providers that required licensure and/or certification continue to meet contract standards Denominator: All waiver service providers that require licensure and/or certification		
Qualified Providers	The percent and number of Home Care Agency providers that meet licensing requirements at time of initial Medicaid contracting (100% remediation)	N=Home Care Agency providers that meet licensing requirements at initial contracting D=All Home Care Agency providers contracted	Administrative Data	12 months
Qualified Providers	The percent and number of Home Care Agency providers that meet continue to meet licensing requirements at time of Medicaid contract renewal (100% remediation)	N=Home Care Agency providers that continue to meet licensing requirements at time of contract renewal D=All Home Care Agency providers contracted	Administrative Data	12 months
Qualified Providers	The percent and number of individual providers that meet waiver requirements (100% remediation)	N= # of contracted individual providers that meet waiver requirements D=# of contracted individual providers	Quality Review Instrument	12 months
Qualified Providers	The percentage and number of individual providers providing	Numerator: Number of Individual Providers providing	Quality Review Instrument	12 months

	services that meet training requirements (100% remediation)	services that meet training requirements Denominator: Number of Individual Provider providing services Percent of Home Care Agency providers that meet training requirements Numerator: Number of Home Care Agency providers reviewed that meet training requirements Denominator: Number of Home Care Agency providers reviewed		
Qualified Providers	Percent and number of RNs providing Nurse Delegation that have met training requirements (100% remediation)	Numerator: Number of RNs reviewed that provide nurse delegation and have met training requirements Denominator: Number of RNs reviewed that provide nurse delegation	Quality Review Instrument	12 months
Qualified Providers	Percent and number of boarding homes that meet training requirements	Numerator: Number of boarding homes that meet training requirements Denominator:	Quality Review Instrument	12 months

	(100% remediation)	Number of boarding homes		
Qualified Providers	Percent and number of adult family homes that completed specialty training (100% remediation)	Numerator: Number of adult family homes that completed specialty training Denominator: Number of adult family homes that care for waiver residents with dementia, mental health, or developmental disabilities	Quality Review Instrument	12 months
Service Plan Assurance	The percentage and number of Service Plans for waiver participants that address their assessed needs and personal goals by the provision of waiver services or other means (100% remediation)	Numerator: Number of service plans reviewed that address all assessed needs and personal goals Denominator: Number of service plans reviewed	Quality Review Instrument	12 months
Service Plan Assurance	Percentage and number of service plans completed within 30 days of referral (100% remediation)	Numerator: Number of service plans completed within 30 days of referral Denominator: Number of service plans	Quality Review Instrument	12 months
Service Plan Assurance	Percent and number of service plans that address all needs identified in the	N: number of service plans that address all identified needs D: Number of	Quality Review Instrument	12 months

	assessment (100% remediation)	number of service plans reviewed		
Service Plan Assurance	Percent and number of service plans where services were delivered as authorized (100% remediation)	N:Number of service plans where all authorized services were delivered D:Number of service plans reviewed	Quality Review Instrument	12 months
Service Plan Assurance	Percent and number of signed service plans that indicate client choice of provider and services (100% remediation)	N: Number of signed service plans that indicate client choice of provider and services D: Number of signed service plans	Quality Review Instrument	12 months
Health and Welfare	Percent and number of critical incidents that should have been reported (100% remediation)	Numerator: Number of records reviewed where a referral for APS/CRU/CPS was required and not completed Denominator: Number of records reviewed	Administrative	12 months
Financial Accountability	Percentage and number of clients for whom inappropriate payments were made after death (100% remediation)	N= Number of deceased clients for whom inappropriate payments were made D= Number of deceased clients	Administrative Data	12 months