Table of Contents

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 8-K

Current Report
Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934
Date of Report (Date of earliest event reported): January 3, 2008

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware	**1-31719**	**13-4204626**
(State of incorporation)	**(Commission File Number)**	**(I.R.S. Employer Identification Number)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)

Registrant's telephone number, including area code: (562) 435-3666

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

o Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

o Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

o Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

o Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

TABLE OF CONTENTS

Item 1.01. Entry into a Material Definitive Agreement.

Molina Healthcare of Washington, Inc., a health plan subsidiary of the Company, has executed a one-year extension of its Basic Health Plan contract with the Washington State Health Care Authority. The contract extends through December 31, 2008 the same general terms and conditions of the parties' existing Basic Health Plan contract. Based upon the health plan's membership mix, the contract increases the blended per member per month rate from under the previous contract by approximately 5% as of January 1, 2008. As of September 30, 2007, there were approximately 34,000 Medicaid members covered under the contract, and revenues under the contract represented approximately 3.6% of the Company's consolidated premium revenues through the first nine months of the Company's 2007 fiscal year. A copy of the new contract is attached hereto as Exhibit 10.1.

Molina Healthcare of Washington has also executed a one-year extension of its Healthy Options Program contract with the State of Washington Department of Social and Health Services. The contract extends through December 31, 2008 the same general terms and conditions of the parties' existing Healthy Options Program contract. Based upon the health plan's membership mix, the contract increases the blended per member per month rate from under the previous contract by approximately 5% as of January 1, 2008. As of September 30, 2007, there were approximately 246,000 Medicaid members covered under the contract, and revenues under the contract represented approximately 22.4% of the Company's consolidated premium revenues through the first nine months of the Company's 2007 fiscal year. A copy of the new contract is attached hereto as Exhibit 10.2.

Molina Healthcare of California Partner Plan, Inc., a subsidiary of the Company and an affiliate of Molina Healthcare of California, has executed a one-year contract renewal with the California Department of Health Services with respect to the Sacramento Geographic Managed Care (GMC) program. The contract renewal extends through December 31, 2008 the same general terms and conditions of the parties' previous contract covering Medi-Cal (California Medicaid) members in Sacramento County, California. Based upon the membership mix in Sacramento, the GMC contract also increases the blended per member per month rate from under the previous contract by approximately 14% as of January 1, 2008. As of September 30, 2007, there were approximately 16,000 Medi-Cal members covered under the contract, and revenues under the contract represented approximately 1% of the Company's consolidated premium revenues through the first nine months of the Company's 2007 fiscal year.

Although Molina Healthcare of Washington has not yet been provided a fully countersigned copy of the Basic Health Plan contract and Molina Healthcare of California Partner Plan has not yet been provided a fully countersigned copy of the Sacramento GMC contract, the Company believes that its health plan subsidiaries have entered into the respective contracts, that the contracts are enforceable in accordance with their terms, and that fully countersigned copies of the contracts will be provided to the health plans in the ordinary course of business and without amendment following standard processing by the relevant state financing agencies and the Centers for Medicare and Medicaid Services (CMS).

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: This current report contains "forward-looking statements" identified by words such as "believes" and "anticipates." In addition, any statements that explicitly or implicitly refer to the underlying assumptions of our expectations are forward-looking statements. All of our forward-looking statements are subject to risks and uncertainties that may cause actual results to differ materially, including the risk that a state financing agency or CMS may disapprove of or wish to amend the form of a contract already executed by the relevant state health agency. The reader is urged to review the risk factors and other cautionary language found in our periodic reports and filings with the Securities and Exchange Commission and available for viewing on its website at www.sec.gov.

Item 9.01. Financial Statements and Exhibits.

(d) Exhibits:

Exhibit No.	Description
10.1	Basic Health Plan and Basic Health Plus contract with Washington State Health Care Authority (HCA).
10.2	Healthy Options Program contract with State of Washington Department of Social and Health Services.

Table of Contents

SIGNATURE

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

MOLINA HEALTHCARE, INC.

Date: January 8, 2008

By: /s/ Mark L. Andrews
Mark L. Andrews
Chief Legal Officer, General Counsel, and Corporate Secretary

Table of Contents

EXHIBIT INDEX

Exhibit No.	Description
10.1	Basic Health Plan and Basic Health Plus contract with Washington State Health Care Authority (HCA).
10.2	Healthy Options Program contract with State of Washington Department of Social and Health Services.

Table of Contents

Exhibit 10.1

Contract Number: 4000-002089

This Agreement has been entered into between
MOLINA HEALTHCARE OF WASHINGTON, INC.
(Hereinafter referred to as "CONTRACTOR")
and the
WASHINGTON STATE HEALTH CARE AUTHORITY
(Hereinafter referred to as "HCA") For the
Washington Basic Health Plan

In consideration of the payment of monthly fees to be made by HCA and the conditions specified in this Agreement, CONTRACTOR agrees to provide services and benefits, as herein specified, for enrollees in the Washington Basic Health Plan (BH), consistent with Chapter 70.47 Revised Code of Washington (RCW) and Chapter 182-25 Washington Administrative Code (WAC) as amended. This Agreement is subject to all of the terms and conditions set forth herein, including the Exhibits attached hereto and included in this Agreement by this reference.

This Agreement is effective January 1, 2008, at 12:01 A.M., Pacific Standard Time, at Olympia, Washington, and will remain in effect through December 31, 2008, unless terminated earlier or renewed. HCA reserves the right to negotiate annual renewals of this Agreement.

In Witness Whereof, CONTRACTOR and HCA have caused this Agreement to be signed by their respective officers who are duly authorized as of the effective date.

MOLINA HEALTHCARE
OF WASHINGTON, INC.

By: _____

Title: President

Date: _____

Address for Notice Purposes:
Claudia St. Clair
Contract Manager
P O Box 4004
Bothell, Washington 98041-4004

WASHINGTON STATE
HEALTH CARE AUTHORITY

By: _____

Title: Deputy Administrator

Date: _____

Address for Notice Purposes:
Bevin Hansell
Director of Basic Health Purchasing
P O Box 42685
Olympia, Washington 98504-2685

This Contract is approved as to form by the Office of the Attorney General.

Contract Number: 4000-002089

This Agreement has been entered into between
Molina Healthcare of Washington, Inc.
(hereinafter referred to as “CONTRACTOR”)
and the
WASHINGTON STATE HEALTH CARE AUTHORITY
(hereinafter referred to as “HCA”)
for the Washington Basic Health Plan

SUBSTITUTE FINAL SIGNATURE PAGE

TABLE OF CONTENTS

Exhibits

1. DEFINITIONS

For purposes of this Agreement, including all exhibits and amendments, the following terms shall have the meanings indicated:

1.1. Administrator

"Administrator" means the Administrator of Health Care Authority (HCA). The Administrator may designate a representative to act on his behalf. Any designation may include the representative's authority to hear and determine any matter.

1.2. Anniversary Date

"Anniversary Date" means the first day of January.

1.3. Basic Health Plus

"Basic Health Plus" means the federal aid medical care program jointly administered by HCA and Washington State Department of Social and Health Services (DSHS) for children under age 19 who qualify for Medical Assistance as defined under Title XIX of the federal social security act.

1.4. Certificate of Coverage (COC) or Member Handbook

"Certificate of Coverage" or "COC" means the Member Handbook, Exhibit 2 of this Agreement, published by HCA, which describes requirements for eligibility and enrollment, Covered Services, and other terms and conditions that apply to Enrollee participation.

1.5. CONTRACTOR

"CONTRACTOR" means the entity contracting with HCA to provide a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services set forth in the COC (Exhibit 2).

1.6. Coordination of Benefits (COB)

"Coordination of Benefits" or "COB" means the rules for administering HCA health contracts, whose hospital, medical, or surgical benefits may be reduced because of other existing coverages.

1.7. Covered Services

"Covered Services" means services set forth in the COC (Exhibit 2).

1.8. Dependent

"Dependent" means family members defined as eligible for Basic Health Covered Services in the COC (Exhibit 2).

1.9. Enrollee

"Enrollee" means an individual eligible for Covered Services according to the eligibility and enrollment criteria set forth in the COC (Exhibit 2).

1.10. HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 (as codified at 42 USC 1320(d) et seq.

1.11. Material Provider

"Material Provider" means a Participating Provider whose loss would degrade access to care in the Service Area. In evaluating whether a degradation of access has occurred, HCA will consider the effect on appointment wait times, accessibility of services, continuity of care, and the accessibility of Providers in relation to the Quality Improvement Standards set forth in Exhibit 4 and the Network Accessibility Guidelines set forth in Exhibit 7.

1.12. Maternity Benefits Program

"Maternity Benefits Program" means the federal aid medical care program (also known as BH S-Medical Program) jointly administered by the HCA and Department of Social and Health Services for pregnant women who qualify for Medical Assistance as defined under Title XIX of the federal social security act.

1.13. Medical Assistance

"Medical Assistance" means the federal aid medical care program provided to categorically needy persons as defined under Title XIX of the federal social security act.

1.14. Medicare

"Medicare" means the programs of medical care coverage set forth in Title XVIII of the social security act as amended by Public Law 89-97 or as hereafter amended.

1.15. Participating Provider

"Participating Provider" means a person, practitioner (as defined in the Quality Improvement Standards, Exhibit 4), or entity having a written agreement with

CONTRACTOR or employed by the CONTRACTOR to provide health care services to Enrollees during the term of this Agreement.

1.16. 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 that may be exempt from disclosure to the public or other unauthorized persons under chapter 42.17 RCW or other applicable state and federal statutes.

1.17. Primary Care Physician (PCP)

"Primary Care Physician" or "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 may 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 CONTRACTOR.

1.18. Privacy Rule

"Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E.

1.19. Provider

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

1.20. Referral Provider

"Referral Provider" means a provider, who is not the Enrollee's PCP, to whom an Enrollee is referred for Covered Services.

1.21. Service Area

"Service Area" means the geographic area covered by this Agreement set forth at Exhibit 6.

1.22. Subcontract

"Subcontract" means a written agreement between CONTRACTOR and a Subcontractor, or between a Subcontractor and another Subcontractor, to perform all or a portion of the duties and obligations CONTRACTOR is obligated to perform under the terms of this Agreement.

1.23. Subscriber

"Subscriber" means that person or those persons defined in the COC (Exhibit 2) as the person on a BH account who is responsible for payment of premiums and copayments and to whom BH sends all notices and communications.

1.24. Consumer Assessment of Health Plans Survey (CAHPS)

"Consumer Assessment of Health Plans Survey (CAHPS) means a commercial and Medicaid standardized survey instrument used to measure client experience of health care.

1.25. External Quality Review (EQR)

"External Quality Review (EQR) means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to health care services that a managed care organization or their contractors furnish to Medicaid recipients.

1.26. External Quality Review Organization (EQRO)

"External Quality Review Organization (EQR0)" 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.

1.27. Partial HEDIS® Compliance Audit ™ Standards, Policies, and Procedures

"Partial HEDIS® Compliance Audit ™ Standards, Policies and Procedures" means the methods used to validate the accuracy and reliability of HEDIS® data by conducting a thorough assessment of MCO information systems, coupled with an assessment of compliance with production of HEDIS® performance measures. The compliance audit includes an audit of the survey sample for the CAHPS survey.

1.28. Health Employer Data and Information Set (HEDIS®)

"Health Employer Data and Information Set (HEDIS®) is a set of performance measures used in the managed care industry. HEDIS® is developed and

maintained by the National Committee for Quality Assurance, a not-for-profit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

1.29. Managed Care Organization (MCO)

"Managed Care Organization" means a health carrier that contracts with the state of Washington to provide managed health care services.

2. ELIGIBILITY AND ENROLLMENT

2.1. Eligibility

Eligibility of Subscribers and their Dependents and the terms of their coverage shall be as set forth in the COC (Exhibit 2), subject to amendment in accordance with current and future provisions of chapter 70.47 RCW and Title 182 WAC.

2.2. Enrollment

Each applicant for enrollment must file an application form and must fulfill all conditions of enrollment described in the COC (Exhibit 2). Coverage begins for Enrollees as described in the COC (Exhibit 2).

At the direction of HCA, CONTRACTOR shall enroll any person for whom HCA pays monthly fees on a retroactive basis for Covered Services, even though the person may not have complied with the prescribed time limits for obtaining coverage. When a person has been retroactively enrolled, services covered during that retroactive period may be limited to those provided by Participating Providers, or emergency care services. In addition, with regard to services that require preauthorization, retroactive coverage may be limited to services that would have been preauthorized had the Enrollee been actively enrolled at the time services were provided.

2.3. Limited Enrollment

Upon at least 90 days' prior written notice, and with prior agreement in writing by HCA, CONTRACTOR may limit enrollment or set priorities for acceptance of new applications for enrollment. Said limitations shall be based on a determination by CONTRACTOR that its capacity, in relation to its total enrollment, is not adequate to provide services to additional persons. The consent of HCA will not be unreasonably withheld.

2.4. Identification Cards and CONTRACTOR Information

HCA shall:

2.4.1. Publish and distribute the COC to all persons enrolled in BH as of January 31 of each calendar year.

2.4.2. Issue a notice to all new Enrollees and Enrollees requesting a change of BH CONTRACTORS, providing the following information: (1) the name(s) or other identification of the Enrollee(s) eligible for coverage; (2) the effective date of coverage for each Enrollee; and (3) the BH CONTRACTOR selected by the Enrollee(s). This notice will serve as temporary membership identification pending issuance of identification cards by CONTRACTOR. An Enrollee's out-of-pocket maximum liability begins on the effective date of coverage with CONTRACTOR.

CONTRACTOR shall:

2.4.3. Respond promptly and courteously to inquiries from Enrollees and candidates for enrollment in BH coverage. CONTRACTOR shall provide sufficient, accurate oral and written information to assist Enrollee to make informed decisions about enrollment. CONTRACTOR shall provide Enrollees with a summary of benefits, including an Enrollee's rights and obligations related to the administration of deductibles, coinsurance, and out-of-pocket maximums. CONTRACTOR shall ensure Enrollees have written information about how to obtain care in CONTRACTOR'S health care system and network and the role of the PCP in providing and authorizing care. Upon request from Enrollee, CONTRACTOR shall provide adequate and timely information to Enrollees or potential Enrollees so that they are informed as to how they can access care and choose an appropriate PCP for coverage prior to their effective date of enrollment with the CONTRACTOR.

2.4.4. Submit any materials intended primarily for use by BH Enrollees or candidates for enrollment in BH coverage for approval by HCA prior to distribution. In addition, CONTRACTOR must submit to BH a courtesy copy of all other materials sent to BH Enrollees or candidates for enrollment in BH coverage.

2.4.5. Distribute the COC to Enrollees enrolled for coverage effective on or after February 1 within 15 business days of receipt of confirmation of enrollment from HCA.

2.4.6. Distribute to Enrollees, upon request, a copy of CONTRACTOR'S drug formulary or list used for Enrollees covered under the terms of this Agreement. CONTRACTOR shall ensure Enrollees know how to request a copy of the formulary and that they have timely access to the formulary upon request.

2.4.7. Distribute to Enrollees in writing, at the time of enrollment, or at any time upon request, information about the CONTRACTOR'S complaint and appeal procedures.

2.4.8. Assist HCA in the distribution of any disclosure forms, benefits descriptions or other material that may be required by HCA, or by any provision of Washington or federal law or by regulation.

2.4.9. Send identification cards to Enrollees. This information must be sent to the Enrollees within 15 business days of receipt of enrollment verification from HCA.

2.4.10. Ensure that Participating Providers accept the HCA-issued notice detailed at Section 2.4.2. of this Agreement as verification of enrollment until an official identification card is issued to the Enrollee by CONTRACTOR.

2.4.11. Provide all Participating Providers with timely information so that adequate care for Enrollees can be reasonably assured. Timely information includes, but is not limited to, enrollment information and, where appropriate, preauthorizations for Covered Services or referrals to non-Participating Providers. Enrollment data must be available to Participating Providers within 5 business days after receipt from HCA.

2.4.12. Issue Explanation of Benefits (EOB) reflecting patient's responsibility for claims and accumulated amount toward deductibles and out-of-pocket maximums. CONTRACTOR'S appropriate staff must have electronic access to an Enrollee's benefit history in order to provide timely response to Enrollee queries related to benefit usage.

2.5. Medical Assistance Recipients

Pursuant to RCW 70.47.110, DSHS will determine if a BH Plus or Maternity Benefits Program applicant is eligible for Medical Assistance under chapter 74.09 RCW. DSHS will make payments to HCA on behalf of any BH Plus or Maternity Benefits Program Enrollee. Any Enrollee on whose behalf HCA makes such payments to CONTRACTOR, will be entitled to the BH Plus or the Maternity Benefits Program services set forth in the BH Plus and Maternity Benefits Program Agreement signed by CONTRACTOR and HCA, effective January 1, 2008. CONTRACTOR agrees to cooperate with HCA in effecting the smooth transfer of Enrollees from BH to BH Plus or the Maternity Benefits Program. CONTRACTOR is required to cooperate with DSHS to ensure compliance with the BH Plus and Maternity Benefits Program contract terms.

2.6. Service Area

2.6.1. CONTRACTOR'S Service Area includes those counties and partial counties set forth at Exhibit 6. Enrollees are eligible to enroll with CONTRACTOR if they reside in CONTRACTOR'S Service Area. If the U.S. Postal Service alters the ZIP codes within CONTRACTOR'S Service Area, HCA shall redetermine the boundaries of the Service Area.

2.6.2. HCA may require CONTRACTOR to cover full ZIP codes that cross county borders served by CONTRACTOR in order to assure continuity of care or ready access to health care services. Enrollees may be required by CONTRACTOR to access care in the county where CONTRACTOR has been awarded a contract even though the Enrollee's residence may be in the portion of the ZIP code which crosses the county line.

2.6.3. CONTRACTOR shall not change its Service Area without prior approval of the HCA. CONTRACTORS must have a sufficient number of Participating Providers in a Service Area before requesting a Service Area expansion. HCA shall apply the Network Accessibility Guidelines (Exhibit 7) when evaluating the adequacy of the network.

2.6.4. HCA reserves the right to request full reimbursement for any costs incurred by HCA as a result of a CONTRACTOR'S withdrawal from a Service Area. HCA may reduce CONTRACTOR'S final December premium or final mid-year premium, whichever occurs earliest, to recover those costs. This reimbursable expense will be in addition to any other provision of this Agreement.

2.6.4.1. The Network Accessibility Guidelines for rural access (Exhibit 7) for Asotin County are waived based on the demonstrated lack of provider access. If provider access should improve, either through the CONTRACTOR'S reporting methods, or through the HCA's reporting methods, the Network Accessibility Guidelines for rural access will be required within 30 days from date once agreed to and confirmed by both parties.

3. TERMINATION AND RELATED PROVISIONS

3.1. Reservation of Rights and Remedies

A material default or breach in this Agreement will cause irreparable injury to HCA. In the event of any claim for default or breach of this Agreement, no provision in this Agreement 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 Agreement or to exercise or delay

the exercise of any right or remedy provided in this Agreement 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 Agreement 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 Agreement. In addition to any other remedies that may be available for default or breach of this Agreement, in equity or otherwise, HCA may seek injunctive relief against any threatened or actual breach of this Agreement without the necessity of proving actual damages. HCA reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as a result of any threatened or actual breach.

3.2. Termination By HCA

HCA may terminate this Agreement upon occurrence of any of the following:

3.2.1. Any threatened or actual material breach by CONTRACTOR. Upon HCA's knowledge of a material breach by CONTRACTOR, HCA shall provide an opportunity for CONTRACTOR to cure the breach or end the violation. HCA reserves the right to terminate this Agreement if CONTRACTOR does not cure the breach or end the violation within the time specified by HCA, or immediately terminate this Agreement if CONTRACTOR has breached a material term of this Agreement and cure is not possible.

3.2.2. HCA has reasonably determined that management practices adopted by CONTRACTOR or the current financial condition of CONTRACTOR present a substantial material risk of interrupting or interfering with the delivery of Covered Services or the quality of such services.

3.2.3. Receipt of notice of change in ownership or other material change in organization pursuant to Section 12.24. of this Agreement, "Notification of Organizational Changes," if HCA reasonably determines that such change presents a risk of interrupting or interfering with the delivery or quality of Covered Services.

3.2.4. HCA has informed CONTRACTOR in writing of its continuing failure to arrange for the provision of Covered Services or of other continuing unsatisfactory performance by CONTRACTOR and CONTRACTOR has not taken reasonable, effective, and prompt steps to correct the alleged failures or unsatisfactory performance or to demonstrate that the concerns of HCA are not justified.

3.2.5. Any anniversary date of this Agreement.

3.2.6. Any violation of the State Ethics Law, chapter 42.52 RCW.

3.3. Termination By CONTRACTOR

If HCA fails to pay the monthly fees in the amounts and manner specified at Section 4 (Monthly Fees) of this Agreement, CONTRACTOR may terminate this Agreement by giving advance written notice received by HCA of not less than 60 days prior to termination.

3.4. Termination Procedure

3.4.1. A party seeking to terminate this Agreement pursuant to Sections 3.2. or 3.3. of this Agreement shall give not less than 60 days' advance written notice to the other party of the intent to terminate. The notice shall explain the reason for termination and shall include an explanation of any alleged breach. Notwithstanding anything herein provided to the contrary, the breaching party shall have the right to cure the breach during the 60 day notice period. The party seeking to terminate this Agreement shall review any efforts to cure the alleged breach and determine whether such efforts are sufficient to cure the breach. Failure of a party to cure the breach within the 60 day time period shall allow the other party to terminate this Agreement upon the delivery of a written notice declaring a termination.

3.4.2. Termination shall be in addition to any other remedies that may be available by law or under this Agreement. Termination of this Agreement will not terminate the rights or liabilities of either party arising out of performance for any period prior to such termination.

3.5. Termination for Withdrawal or Reduction of Funding

In the event funding from any state, federal, or other sources is withdrawn, substantially reduced, or limited in any way after the effective date of this Agreement and prior to the termination date, HCA may terminate this Agreement upon 60 days' prior written notice to CONTRACTOR or upon the effective date of withdrawn or reduced funding, whichever occurs earlier. If this Agreement is so terminated, HCA shall be liable only for payment in accordance with the terms of this Agreement for services rendered prior to the effective date of termination.

3.6. Termination of Enrollee Coverage

3.6.1. Enrollee coverage may be terminated by HCA in accordance with the eligibility provisions set forth in WAC 182-25-030 and as described in the COC (Exhibit 2).

3.6.2. In the event that an Enrollee appeals a disenrollment decision through the HCA appeals process, HCA may require CONTRACTOR to continue to provide services to the Enrollee under the terms of this Agreement pending the final decision. CONTRACTOR agrees to continue to provide services, provided HCA continues to pay the monthly fee to CONTRACTOR for such Enrollee according to the

terms of this Agreement. With prior approval of HCA, CONTRACTOR may discontinue providing services to an Enrollee during the appeals process if the Enrollee has demonstrated a danger or threat to the safety or property of the CONTRACTOR, its staff, Providers, patients, or visitors.

3.6.3. CONTRACTOR may request that HCA immediately terminate an Enrollee's coverage for repeated failure to pay copayments, coinsurance or other cost-sharing in full on a timely basis; abuse, intentional misconduct, danger or threat to the safety of the CONTRACTOR, its staff, Providers, patients, or visitors; or refusal to accept or follow procedures or treatment determined by CONTRACTOR to be essential to the health of the Enrollee, when CONTRACTOR has advised the Enrollee and demonstrated to the satisfaction of BH that no professionally acceptable alternative form of treatment is available from CONTRACTOR.

Prior to requesting disenrollment for abuse, intentional misconduct, or posing an imminent danger or threat, CONTRACTOR shall ensure CONTRACTOR'S Medical Director has reviewed the circumstances to ensure the Enrollee has been appropriately evaluated and offered all appropriate Covered Services.

Prior to requesting disenrollment under the terms of this Section, CONTRACTOR must: (a) afford the Enrollee with notice of the action CONTRACTOR intends to take; (b) ensure the Enrollee is afforded an opportunity to be heard; and (c) in the case of non-payment, the Enrollee is given an opportunity to make payments prior to the disenrollment request. Involuntary termination of an Enrollee under this Section will be considered a "Special Circumstance" and HCA shall approve or disapprove CONTRACTOR'S request for termination as soon as reasonably possible but no later than 30 business days after receipt of such request and CONTRACTOR'S supporting documentation.

3.6.4. If an Enrollee is confined in a hospital or skilled nursing facility for which benefits are provided when Basic Health coverage ends and the Enrollee is not immediately covered by other health care coverage, benefits will be extended until the earliest of the following events: (1) the Enrollee is discharged from the hospital or from a hospital to which the Enrollee is directly transferred; (2) the Enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization; (3) the Enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the Enrollee is directly transferred; (4) the Enrollee is covered by another health plan which will provide benefits for the services; or (5) benefits are exhausted.

4. MONTHLY FEES

4.1. Remittance

Subject to the provisions of Section 12.18. of this Agreement (Intermediate Sanctions), HCA shall remit a monthly fee to CONTRACTOR on behalf of each Enrollee in full consideration of the work to be performed by CONTRACTOR under this Agreement. The "Monthly Fee" specified in Exhibit 1, shall be based on HCA's then current enrollment information. Payment shall be remitted to CONTRACTOR on or before the 15th day of the month during which Covered Services are to be provided to eligible Enrollees. Monthly fees for BH Plus and the Maternity Benefits Program are set forth in the separate Agreement between HCA and CONTRACTOR.

4.2. Retroactive Payment or Refund

Retroactive payment or refund of monthly fees to reflect additions or deletions of Enrollees added or omitted based on HCA's enrollment records will be made by HCA.

4.3. Responsibility for Enrollment Data

4.3.1. HCA will furnish current enrollment information to CONTRACTOR upon which CONTRACTOR may rely without further verification. HCA may provide enrollment verification by telephone, which will be followed by written or electronic confirmation.

4.3.2. CONTRACTOR shall perform a full file enrollment match not less frequently than twice a year, shall report resulting mismatches to HCA within 30 days of the receipt of HCA enrollment file, and shall resolve reconciliation discrepancies within 90 days of receipt of the HCA enrollment file. It is the responsibility of CONTRACTOR to contact the HCA Information Services Quality Assurance Manager to coordinate transmittal of the full file match and mismatch report.

4.4. Renegotiation of Rates

The Monthly Fees set forth in Exhibit 1 shall be subject to negotiation during the Agreement period if HCA determines that changes in federal or state law or regulations materially affect the risk to CONTRACTOR or its costs of doing business.

5. SERVICES, BENEFITS, EXCLUSIONS, AND LIMITATIONS

5.1. Plan Description

The services, benefits, exclusions, and limitations applicable to Enrollees are set forth in the COC (Exhibit 2).

5.2. Self-Referral for Women's Health Care

5.2.1. Pursuant to WAC 284-43-250, access to women's health care Providers may not be restricted based solely on a woman's choice of PCP. If CONTRACTOR restricts access for other services to a subnetwork of fewer than the entire panel of Participating Providers available to all Enrollees, access to women's health care services may not be restricted to the same subnetwork, but Enrollees may be required to use a Participating Provider.

5.2.2. If an Enrollee is required to use facilities (such as hospitals) affiliated with her PCP or the PCP's subnetwork for services generally, this limitation may not be imposed for women's health care services. Enrollees may be required to use a Participating Provider facility within CONTRACTOR'S network.

5.3. Preventive Care

5.3.1. Primary and secondary preventive care services shall be provided in accordance with the edition of the "Guide to Clinical Preventive Services" of the U.S. Preventive Services Task Force as of the effective date of this contract and as follows:

5.3.1.1. Those services rated "A" shall be covered and CONTRACTOR shall take active steps to assure their provision.

5.3.1.2. Those services rated "B" shall be covered.

5.3.1.3. Those services rated "D" shall not be covered.

5.3.1.4. Those services rated "I" shall not be covered, and CONTRACTOR shall take steps to determine that if those services are provided, there is informed consent.

5.3.1.5. Those services rated "C" and those services not rated shall be provided at the discretion of CONTRACTOR to determine the appropriate level of care for the Enrollee consistent with the terms of the COC (Exhibit 2) and this Agreement.

5.3.2. CONTRACTOR may substitute generally recognized accepted guidelines, such as those developed by the American Academy of Pediatrics or the Canadian Task Force on the Periodic Health Examination, as a basis to define the content and periodicity of coverage of preventive services, as long as such substitution is approved in advance, in writing, by HCA.

5.3.3. CONTRACTOR shall provide the Enrollee with a description of preventive care benefits to be used by CONTRACTOR in the materials required by Section 2.4. (Identification Cards and CONTRACTOR Information).

6. COORDINATION OF BENEFITS

6.1. Benefits Subject To This Provision

Benefits under this Agreement shall be coordinated as prescribed in this Section.

6.2. "Plan" Defined

6.2.1. "Plan," as used in this Section 6. only, means any of the following sources of benefits or services:

6.2.1.1. Group or blanket disability insurance policies and health care service contractor and health maintenance organization group agreements, issued by insurers, health care service contractors, and health maintenance organizations, respectively;

6.2.1.2. Labor-management trustee Plans, labor organization Plans, employer organization Plans or employee benefit organization Plans;

6.2.1.3. Governmental programs; and

6.2.1.4. Coverage required or provided by any statute.

6.2.2. "Plan" shall be construed separately with respect to each health contract or other arrangement for benefits or services, and separately with respect to the respective portions of any such health contract or other arrangement which do and which do not reserve the right to take the benefits or services of other health contracts or other arrangements into consideration in determining its benefits.

6.3. "Allowable Expense" Defined

6.3.1. "Allowable Expense," as used in this Section 6., means the customary and reasonable charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the Plans involved. When a Plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense unless the Enrollee's stay in a

private hospital room is considered medically necessary under at least one of the Plans involved.

6.3.2. In the case where coverage is provided through internal maximums in the contract, CONTRACTOR shall coordinate benefits in such a manner as to allow coverage for the internal maximums provided for in both the primary contract and this Agreement. If internal maximums are provided for by a specified maximum dollar amount, then CONTRACTOR must coordinate benefits as secondary Plan until benefits under the primary contract are exhausted, then pay BH benefits (up to BH internal maximum dollar amount) until BH benefits are exhausted. If internal maximums are provided for by a specified maximum number of visits, then CONTRACTOR must coordinate benefits as secondary Plan until benefits under the primary contract are exhausted, then pay BH benefits (up to BH maximum) until BH benefits are exhausted.

6.4. "Claim Determination Period" Defined

"Claim Determination Period," as used in this Section 6., means a calendar year.

6.5. Facility of Payment

Whenever payments which should have been made under this Agreement in accordance with this provision have been made under any other Plan, CONTRACTOR shall have the right, exercisable alone and in its sole discretion, to pay over to any Plan making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be considered benefits paid under this Plan and, to the extent of such payments, CONTRACTOR shall be fully discharged from liability under this Plan. This provision shall not apply to the extent it conflicts with the requirements of RCW 48.44.026.

6.6. Right of Recovery

Whenever payments have been made by CONTRACTOR with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Agreement, CONTRACTOR shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as CONTRACTOR shall determine: (1) any persons to or for or with respect to whom such payments were made, (2) any other insurers, (3) any service Plans, or (4) any other organizations or other Plans.

6.7. Effect on Benefits

6.7.1. This Section shall apply in determining the benefits for a person covered under this Agreement for a particular claim determination period if, for the allowable expenses incurred as to such person during such period, the sum of: (1) the benefits that would be payable under

this Agreement in the absence of this provision, and (2) the benefits that would be payable under all other health Plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable expenses.

6.7.2. As to any claim determination period with respect to which this Section is applicable, the benefits that would be payable under this Agreement in the absence of this provision for the allowable expenses incurred as to such person during the applicable claim determination period shall be reduced to the extent necessary so that the sum of reduced benefits and all the benefits payable for allowable expenses under all other health Plans, except as provided elsewhere in this Section, shall not exceed the total of allowable expenses. Benefits payable under another health Plan include the benefits that would have been payable had claim been duly made therefore.

6.7.3. Except where in conflict with federal or state law, or regulations promulgated thereunder, the benefits of any other health Plan which covers the Enrollee shall be determined before the benefits of BH.

6.7.4. When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

7. DATA REPORTING

CONTRACTOR shall submit the following data to HCA:

7.1. Integrated Provider Network Database (IPND)

Contractor shall submit a report of Providers currently under contract. This report shall be submitted to DSHS through the designated data management contractor in accord with the Provider Network Reporting Requirements published by DSHS at http://maa.dshs.wa.gov/healthyoptions/IPND

7.2. Health Plan Employer Data and Information Set (HEDIS®)

CONTRACTOR is required to submit audited HEDIS® information on the BH non-Medicaid population. CONTRACTOR and HCA agree that the HEDIS® audit will be performed by a third party vendor under contract with the Department of Social and Health Services. CONTRACTOR agrees that HCA shall reduce CONTRACTOR'S monthly premium in accordance with the terms set forth in this agreement, to pay the cost of such audit, as described in Exhibit 9.

All BH CONTRACTORS must comply with the HEDIS® requirements set forth in the BH Plus and Maternity Benefits Program contract.

7.2.1 CONTRACTOR shall provide raw HEDIS® data for the following three measures: Childhood Immunizations, Use of Appropriate Medication for People with Asthma, and Children and Adolescents' Access to Primary Care Practitioners. This data shall be submitted to the HCA electronically no later than June 30th of each year according to the specifications communicated by the HCA to the CONTRACTOR no later than May of each year.

7.3. Consumer Assessment of Health Plans (CAHPS™) Survey

CONTRACTOR shall submit a set of data from its commercial CAHPS™ 4.0 survey by June 30 each year. (See Exhibit 5 for instructions.)

7.4. Experience Data Reports

7.4.1. CONTRACTOR shall provide health experience data (utilization and costs) for services rendered during the term of this Agreement. CONTRACTOR shall provide this data for the current year, as well as all outstanding data from any previous Agreement year, whether or not this Agreement is renewed for any subsequent term. Experience data shall be submitted on a yearly basis consistent with the instructions in Exhibit 8.

7.4.2. Should CONTRACTOR merge, be acquired by, or otherwise become affiliated with another health plan, whether or not that health plan is under contract with HCA at the time of the merger, acquisition, or other affiliation, CONTRACTOR shall provide the required health experience data for the entire calendar year as well as data from any previous calendar year for which data is outstanding as of the date of the merger, acquisition, or other affiliation. HCA reserves the right to modify or clarify the data request at that time.

7.4.3. CONTRACTOR shall reimburse HCA for the reasonable cost of obtaining CONTRACTOR'S experience data in the event CONTRACTOR does not provide data in accordance with the terms of this Agreement.

- CONTRACTOR shall also provide the same health experience data (utilization and costs), consistent with instructions as described in Exhibit 8, for enrolled Health Coverage Tax Credit enrollees.

The data set for Health Coverage Tax Credit enrollees is to be collected and submitted separate and distinct from Basic Health enrollment data.

7.5 Data Reporting — Paid Claims Data

7.5.1. CONTRACTOR shall submit Basic Health and Health Coverage Tax Credit paid claims electronically as per the following requirements:

Encounter and Eligibility Data Submission Obligations: The CONTRACTOR will provide the Health Care Authority with detailed encounter and eligibility for the Basic Health and Health Care Tax Credit populations on a monthly basis with the data elements listed in Exhibit 10. The data will include:

i) A one time historical load of data that includes encounters and eligibility from January 1, 2006 to December 31, 2007, paid through December 31, 2007.

ii) The most granular service lines for each claim or encounter should be provided. Data should not be rolled up into aggregate stays or visits.

iii) Beginning with January 1, 2008 data, data will be submitted monthly, not more than 30 days after the end of the next month (i.e. for enrollment in and claims paid in January 1, 2008 to January 31, 2008, data will be received by February 28, 2008).

iv) Data will be submitted in a file format agreed upon by the HCA and the CONTRACTOR, including but not limited to DVD, USB Drive, FTP site, or other electronic media that is mutually agreeable.

v) Data, to be transferred, will be encrypted in a mutually agreed upon method.

vi) The CONTRACTOR will provide all identifiers necessary to link providers and members to HCA identifiers.

vii) The data files will be comma separated or tab delimited.

viii) The CONTRACTOR will supply control totals with the files that include the total number of records, the total number of enrollees for each month, and the total amount billed for each month. These totals should balance to CONTRACTOR financial reports.

7.6. Denials, Appeals, Grievances, and Independent Reviews

CONTRACTOR shall maintain a record of all grievances, denials, appeals, and decisions from independent review organizations (IRO) of any adverse decisions by the health plan. CONTRACTOR shall provide a report of

complete denials, appeals, grievances, and IRO decisions to HCA four times a year. The fourth quarter of 2007 shall be due to the HCA on February 1, 2008. The first quarter of 2008 shall be due to the HCA on May 1, 2008. The second quarter of 2008 shall be due to the HCA on September 1, 2008; and third quarter of 2008 shall be reported to the HCA on November 1, 2008. CONTRACTOR is responsible for maintenance of records for and reporting of any grievances, denials, appeals, and IRO decisions handled by delegated entities. Delegated denials, appeals, grievances, and IRO decisions are to be integrated into CONTRACTOR'S report. The report shall contain all of the data elements formatted as specified in the Grievance System Reporting Requirements, Exhibit 11.

8. QUALITY OF CARE

8.1. Quality Improvement Program

8.1.1. CONTRACTOR shall maintain a quality improvement program that meets or exceeds the requirements of the HCA's Quality Improvement Standards, a subset of the National Committee for Quality Assurance (NCQA) Standards (Exhibit 4). If NCQA updates the standards for a July 1, 2008 effective date, the HCA will permit any CONTRACTOR seeking accreditation to administer the updated standards, to the extent they do not conflict with federal or state regulations. HCA will not require a mid-year contract amendment requiring CONTRACTOR to comply with mid-year updated NCQA standards. If HCA determines that a standard adopted by NCQA mid-year should be included in the future, that new standard may be added in a subsequent contract.

8.1.2. CONTRACTOR shall use data provided by HCA and its own data (including external quality review findings, agency audits, contract monitoring activities, and Enrollee complaint and satisfaction survey findings), to identify and correct problems and to improve care and service to Enrollees.

8.1.3. If CONTRACTOR has had an accreditation review or visit by NCQA or another accrediting body, CONTRACTOR shall provide the complete report from that organization to HCA. If permitted by the accrediting body, CONTRACTOR shall allow a Washington State representative to accompany any accreditation review team during the site visit in an official observer status. CONTRACTOR must provide the HCA with adequate prior notice of any scheduled accreditation review in order that HCA might observe the review. The state representative is allowed to share information with HCA, Department of Health (DOH), and DSHS as needed, to reduce duplicated work for both CONTRACTOR and the State.

8.1.4. CONTRACTOR shall encourage its participating hospitals to self-report on the Leapfrog web site.

8.2. Clinical Outcomes Assessment Program (COAP)

CONTRACTOR shall require Participating Providers of selected cardiac services (CPTs: 33400 -33401, 33403, 33405-33406, 33410-33411, 33413, 33425-33427, 33430, 33460, 33464-33465, 33472, 33474, 33475, 33510-33536, 92980-92984, and 92974) to provide demographic and clinical registry information to the ongoing Clinical Outcomes Assessment Program (COAP), a Certified Quality Improvement Program protected at RCW 43.60.510.

Additionally, when the Foundation establishes its abdominal surgical procedures (SCOAP) program, carriers are encouraged to participate. The selected abdominal surgical CPT codes are: Appendectomy 44950, 44960, 44970; Bariatric Surgery 43644, 43645, 43842-43848, Colon or rectal resection 44140-44147, 44150-44156, 44160, 44204-44208, 44210-44212, 44116, 45123, 45110, 45111, 45112, 45113, 45114, 45116, 45119-45121, 45123, 45126, 45130, 45135, 45136.

8.3. Patient Safety

CONTRACTOR shall require participating hospitals, ambulatory care surgery centers, and office-based surgery sites to endorse and adopt procedures for verifying the correct patient, the correct procedure, and the correct surgical site that meets or exceeds those set forth in the Universal Protocol TM developed by JCAHO.

8.4 Claims Payment

CONTRACTOR shall comply with the claims payment provisions set forth in WAC 284-43-321, and WAC 284-43-200(7), as amended.

9. DATA RECORDS

9.1. Confidential Personal Information

9.1.1. CONTRACTOR shall undertake all reasonable efforts to protect and preserve the confidentiality of HCA's data or information which is defined as confidential under state or federal law or regulation or data that HCA has identified as confidential.

9.1.2. HCA and 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 Agreement. 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 Agreement or as permitted or required by state or federal law or regulation. CONTRACTOR shall implement appropriate physical, electronic, and managerial safeguards to prevent unauthorized access to Personal Information and PHI. CONTRACTOR shall require the same standards or confidentiality of all its Subcontractors.

9.1.3. The 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, including TEAMonitor, agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

9.1.4. Any material breach of this confidentiality provision may result in termination of this Agreement. CONTRACTOR shall indemnify and hold HCA harmless from any damages related to CONTRACTOR'S or Subcontractor's unauthorized use or release of Personal Information or PHI of Enrollees. In the event of termination of this Agreement, HCA and CONTRACTOR agree that it may not be feasible for CONTRACTOR to return or destroy all Personal Information or PHI concerning HCA Enrollees. Thus, if CONTRACTOR is not able to return or destroy all Personal Information or PHI of Enrollees, CONTRACTOR agrees to continue to apply privacy protections contained in this Section, or as are then in effect, to all Personal Information or PHI retained by CONTRACTOR after termination and for as long as such Personal Information or PHI is in its possession. If CONTRACTOR is able to return or destroy Personal Information or PHI of Enrollees or if CONTRACTOR ceases to do business with HCA, HCA will provide advice on how to transfer information to HCA or to destroy it.

9.2. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

CONTRACTOR and its Subcontractors shall comply with the applicable provisions of the HIPAA Privacy Rule and shall fully cooperate with HCA efforts to implement all applicable HIPAA requirements.

9.3. Proprietary Data or Trade Secrets

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

9.3.2. CONTRACTOR shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. HCA will

notify CONTRACTOR upon receipt of any request under the Public Disclosure Law (chapter 42.17 RCW) or otherwise for data or Claims Data identified by CONTRACTOR as proprietary trade secret information and will not release any such information until 5 business days after it has notified CONTRACTOR of the receipt of such request.

9.3.3. If CONTRACTOR files legal proceedings within the aforementioned 5 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, CONTRACTOR dismisses its lawsuit, or CONTRACTOR agrees that the data may be released.

9.3.4. Nothing in this Section shall prevent HCA from filing its own lawsuit or joining any lawsuit filed by 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 CONTRACTOR of the filing of any such lawsuit.

9.4. Data Ownership

9.4.1. All original material and data, either written or readable by machine, prepared for or with HCA solely for the purposes of this Agreement, except for Claims Data, shall belong to and be the property of CONTRACTOR.

9.4.2. All Claims Data is the property of HCA. For the purpose of this Section, “Claims Data” means event level cost and utilization data, including, but not limited to, hospital, facility, professional, dental, and prescription drug services. “Event Level Data” includes, but is not limited to, the cost of Covered Services provided to the Enrollee in accordance with the terms of this Agreement, including, but not limited to, vendor discounts, rebates, capitation payments, or other similar payments made or revenues received for the purpose of administering the health care services under this Agreement. HCA will withhold from public inspection all such data as “cost and utilization data” as provided for at RCW 41.05.026.

9.4.3. CONTRACTOR shall retain custody, possession, and control of all data and will provide it to HCA upon reasonable request in a mutually acceptable form. CONTRACTOR in its sole discretion may attach its interpretation to any data provided to HCA, and any such interpretation shall become a permanent part of such data.

10. PERFORMANCE EXPECTATIONS

10.1. General Expectations

10.1.1. Throughout the period of this Agreement and any subsequent renewals thereof, CONTRACTOR shall maintain a Certificate of Registration as either a Health Maintenance Organization or a Health Care Service Contractor from the Insurance Commissioner. CONTRACTOR shall be in good standing with the Insurance Commissioner and comply with the applicable solvency provisions of Title 48 RCW, as amended and regulations promulgated thereunder.

10.1.2. CONTRACTOR shall provide access to consistently high-quality, cost-effective care which is designed to improve the health of Enrollees, through efficient, stable networks or delivery systems. Throughout the period of this Agreement, HCA will review and assist CONTRACTOR, where appropriate, to develop or refine its risk management plan to address the performance expectations. CONTRACTOR'S ability to address the performance expectations of this Agreement will be considered when evaluating any renewal offer of this Agreement.

10.2. Demonstrated Superior Quality in Health Care Delivery

CONTRACTOR shall provide evidence that it has and uses the following:

10.2.1. Programs to reach out to Enrollees to ensure appropriate detection of disease, illness, or injury and preventive care services are available and effectively delivered.

10.2.2. A plan that considers community health issues, including, but not limited to, collaboration with other local health plans or health departments.

10.2.3. A plan which provides for all aspects of Enrollee health, including minimizing Enrollee disability and absenteeism. CONTRACTOR shall be able to demonstrate how its plan incorporates disease management standards which reinforce quality of care.

10.2.4. A plan to support the efforts of Providers to improve quality, service, safety, and effectiveness of care. CONTRACTOR shall be able to demonstrate how its efforts incorporate information sharing, Provider development programs, and regular feedback on performance.

10.2.5. A plan to hold all components of the delivery system accountable for the appropriateness of care delivered to Enrollees, for patient outcomes, and for Enrollee satisfaction.

10.2.6. Programs that focus on Enrollee safety. CONTRACTOR shall be able to describe its use of up-to-date standards for patient safety and Provider feedback, including a description for evaluating safety concerns.

10.2.7. A plan to improve its quality, care delivery and satisfaction scores, and other standard measures; for example, HEDIS® and CAHPS™.

10.2.8. A plan (including timelines) to meet or exceed the transaction, security and privacy requirements of state and federal law (including chapter 70.02 RCW, the Washington State Patient Bill of Rights, HIPAA, and to protect the Personal Information and PHI of Enrollees.

10.2.9. CONTRACTOR's formulary must reflect an evidence-based formulary that includes all therapeutic classes of drugs and meets or exceeds the recommendations set forth by the Academy of Managed Care Pharmacists. Additionally, CONTRACTOR is encouraged to expand its Pharmacy & Therapeutics Committee to include at least one voting professional provider who is not employed by CONTRACTOR.

10.3. Access to Health Care Services

CONTRACTOR shall ensure that an adequate network of Providers that deliver high quality health care services is available to Enrollees. HCA will apply the Quality Improvement Standards (Exhibit 4) and the Network Accessibility Guidelines (Exhibit 7) when evaluating a CONTRACTOR'S network adequacy. Upon request, CONTRACTOR shall demonstrate that it ensures the following, for the benefit of HCA Enrollees:

10.3.1. A comprehensive, organized system of care that is accountable for delivery, development, and performance throughout the period of the Agreement.

10.3.2. Accessible, high quality PCPs, specialists, hospitals, and pharmacies. CONTRACTOR shall be able to demonstrate how its network is of sufficient size and distribution to meet Enrollee needs, and meets or exceeds the network accessibility guidelines of HCA.

10.3.3. Long-term relationships with Providers. CONTRACTOR shall be able to demonstrate that its Provider relationships are designed to ensure that continuity and coordinated care are available to Enrollees.

10.3.4. Adequate and timely access to medically appropriate Providers outside the contracted network if there is an insufficient number of Participating Providers.

10.4. Accountability for Delivery of Affordable Health Care

In its demonstration of fiscal accountability to HCA, Enrollees, and Providers, CONTRACTOR shall provide for and ensure that CONTRACTOR has and uses the following:

10.4.1. Financial contracts and agreements with Providers which focus on efficiency and effectiveness of health care.

10.4.2. A plan to improve administrative systems that promote CONTRACTOR'S performance and efficiencies, including information management systems to support HCA's expectations and objectives and, in particular, the ability of CONTRACTOR to monitor and promote continuous quality improvements. Upon request, CONTRACTOR shall demonstrate how such programs reinforce quality of care and do not impede access to or the delivery of care.

10.4.3. Financial arrangements with Providers that are designed to ensure Enrollees receive appropriate and cost-effective care.

10.4.4. A risk management plan that is designed to anticipate and reduce threats to continued Enrollee access to care.

10.4.5. A system to incorporate disease management, use of clinical guidelines, and evidence-based medicine.

10.4.6. Policies and procedures to prevent and detect fraud and abuse activities related to the BH program. These may include, but not be limited to: claims prior authorization, utilization management and quality review, Enrollee complaint and grievance resolution, Provider credentialing and contracting, Provider and staff education to prevent fraud and abuse, and corrective action plans to remedy situations where fraud and abuse have been detected.

10.5. Performance Measures

10.5.1. CONTRACTOR agrees to comply with the performance measures as outlined in Exhibit 3. CONTRACTOR agrees to maintain adequate records, satisfactory to HCA, documenting compliance with these measures.

10.5.2. CONTRACTOR shall self-report compliance with the performance measures as described in Exhibit 3 on July 31 for the contract period January 1 through June 30 and on January 31 of the following year for the period July 1 through December 31 of the contract period. If HCA determines that it is not feasible for CONTRACTOR to report compliance with a measure on a BH-specific basis, then CONTRACTOR may report compliance with that measure for their total book of business.

11. APPEALS AND COMPLAINTS

11.1. Enrollee Complaints and Appeals Procedure

CONTRACTOR shall establish and maintain a procedure for the timely resolution of complaints and appeals from Enrollees that meets the requirements in the Quality Improvement Standards (Exhibit 4), any other applicable provision of this Agreement, or as required by federal or state law or regulation.

11.2. Grievance Timelines

CONTRACTOR will provide written notice of its resolution of a grievance (as defined in 48.43.005 (14) RCW) to an Enrollee within 30 days of the receipt of the grievance, unless CONTRACTOR notifies the Enrollee that an extension is necessary to complete the grievance review process and the Enrollee gives informed, written consent to an extension.

11.3. Dispute and Dispute Resolution Hearings

11.3.1. Except as otherwise provided in this Agreement, when a bona fide dispute arises between HCA and CONTRACTOR and it cannot be resolved, CONTRACTOR may request a dispute resolution hearing with the Administrator. The request for a dispute resolution hearing must be in writing and shall clearly state all of the following:

(1) The disputed issue(s),

(2) An explanation of the positions of the parties, and

(3) Any additional facts necessary to explain completely and accurately the nature of the dispute.

11.3.2. Requests for a dispute resolution hearing shall be mailed to the Administrator, Washington State Health Care Authority (HCA), P.O. Box 42700, Olympia, WA 98504-2700 within 15 days after CONTRACTOR receives notice of the disputed issue(s). The Administrator 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 Administrator's reasonable discretion, but it is understood that such presentations will be informal in nature. The Administrator will provide written notice of the time, format, and location of the presentations. At the conclusion of the presentations, the Administrator will consider all of the evidence available to him and shall render a written recommendation as soon as practicable, but in no event more than 30 days after the conclusion of the presentations. The Administrator may designate an employee of HCA or an Administrative Law Judge to hear and determine the matter.

11.3.3. The parties hereby agree that this dispute process shall precede any judicial or quasi-judicial proceeding.

12. GENERAL PROVISIONS

12.1. Accessibility of Covered Services

CONTRACTOR shall ensure Enrollees have access to Covered Services defined in the COC (Exhibit 2) by the medically appropriate Provider.

12.1.1. Network Adequacy. CONTRACTOR shall maintain the support services and a Provider network sufficient to serve Enrollees, consistent with the requirements of this Agreement. CONTRACTOR will provide the Covered Services required by this Agreement through non-Participating Providers if its network of Participating Providers is insufficient to meet the medical needs of Enrollees in a manner consistent with this Agreement. CONTRACTOR shall make services accessible consistent with the provisions of this Agreement, including, but not limited to, the Quality Improvement Standards (Exhibit 4) and the Network Accessibility Guidelines (Exhibit 7). CONTRACTOR shall make Covered Services as accessible to Enrollees under this Agreement as under its other state, federal, or private contracts.

12.1.2. 24/7 Availability of Services. CONTRACTOR shall have the following services available to Enrollees on a 24 hour-a-day, 7 days a week basis. These services may be provided directly by the CONTRACTOR or may be delegated to Subcontractors, provided that all Subcontractors perform subject to the applicable terms and conditions of this Agreement:

12.1.2.1. Medical advice for Enrollees from licensed health care professionals concerning the emergent, urgent, or routine nature of a medical condition.

12.1.2.2. Authorization of emergency services, out-of-area urgent care, or authorizing care at other facilities when the use of participating facilities is not practical.

12.1.3. Office Appointment Standards. CONTRACTOR shall comply with appointment standards that are no longer than the following:

12.1.3.1. Non-symptomatic (e.g., preventive care) office visits shall be available from the Enrollee's PCP or an alternative provider within 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 children and adult immunizations.

12.1.3.2. Non-urgent, symptomatic (e.g., routine care) office visits shall be available from the Enrollee's PCP or an alternative practitioner within 7 calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

12.1.3.3. Urgent, symptomatic office visits shall be available within 24 hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

12.1.3.4. Emergency medical care shall be available 24 hours per day, 7 days per week.

12.1.4. Access to Specialty Care. CONTRACTOR shall provide for availability of necessary covered specialty care for Enrollees in a Service Area. If an Enrollee needs specialty care from a specialist who is not available within CONTRACTOR'S Participating Provider network, CONTRACTOR shall provide the necessary services with a qualified specialist outside CONTRACTOR'S Participating Provider network without additional expense (except applicable coinsurance or copayment amounts) to the Enrollee and to HCA.

12.1.5. Equal Access for Enrollees with Communications Barriers. CONTRACTOR shall assure equal access of Covered Services, as described in the COC (Exhibit 2), for all Enrollees when oral or written language creates a barrier to such access.

12.1.6. Americans with Disabilities Act. CONTRACTOR shall make reasonable accommodation for Enrollees with disabilities, in accord with the Americans with Disabilities Act, for all Covered Services and

shall assure physical and communication barriers shall not inhibit Enrollees with disabilities from obtaining Covered Services.

12.2. Administrative Simplification

12.3.1. To maximize understanding, communication, and administrative economy among all BH CONTRACTORS, their Subcontractors, governmental entities, and Enrollees, CONTRACTOR shall use and follow the most recent updated versions of:

- Current Procedural Terminology (CPT)
- International Classification of Diseases (ICD-9 CM)
- Healthcare Common Procedure Coding System (HCPCS)
- CMS Relative Value Units (RVUs)
- CMS billing instructions and rules, including HCFA 1500 & UB-92 instructions

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

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

12.3. Assignment

Responsibilities and rights under this Agreement may not be assigned by either CONTRACTOR or HCA without the prior written consent of the other party, which consent will not be unreasonably withheld.

12.4. Audits and Performance Reviews

12.4.1. HCA may undertake periodic audits or performance reviews at its expense regarding any aspect of the provision of Covered Services or CONTRACTOR'S administration of this Agreement. Such audits or reviews will be designed not to interfere with the delivery of health care services by Participating Providers of CONTRACTOR. Audits or reviews may be undertaken directly by HCA, by third parties engaged by HCA, the Interagency Contract Review Team (currently referred to as TEAMonitor), or the State of Washington Auditor's Office. With reasonable advance written notice, CONTRACTOR and its Subcontractors shall provide access to its facilities and the financial and medical records pertinent to this Agreement to monitor and evaluate performance under this Agreement, including, but not limited to, the quality, cost, use, and timeliness of services, and assessment of the CONTRACTOR'S capacity to bear the potential financial losses.

12.4.2. CONTRACTOR agrees to provide HCA the results of final financial, market conduct, or special examinations performed by OIC and any final audit report produced by the U. S. Department of Health and Human Services.

12.4.3. CONTRACTOR shall submit a business or corrective action plan, including timelines for remediation, in response to any final audit or performance review recommendations identified by HCA or its agent. Such action plan is due to the HCA within 60 calendar days after the date on the final report.

12.5. Clerical Error

No clerical error on the part of HCA or CONTRACTOR, which is discovered within 12 months of its occurrence, shall operate to defeat any of the rights, privileges, or benefits of any Enrollee.

12.6. Compliance With All Applicable Laws and Regulations

12.6.1. In the provision of services under this Agreement, the HCA, CONTRACTOR, and its Subcontractors shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the Agreement is signed or that come into effect during the term of the Agreement or any renewals thereof. The provisions of this Agreement which 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.

12.6.2. CONTRACTOR and HCA shall comply with all the applicable provisions of the HIPAA

12.6.3. CONTRACTOR shall comply with all the applicable provisions of 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.

12.7. Covenant Against Contingent Fees

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

12.8. Customer Service

12.8.1. 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 will authorize exceptions to this requirement if CONTRACTOR provides HCA with written assurance that its Participating Providers will accept enrollment information from the BH Provider Line or HCA's system-generated notice to the Enrollee that acknowledges his or her enrollment with CONTRACTOR.

12.8.2. Toll free numbers shall be provided at the expense of CONTRACTOR for out-of-state and in-state lines.

12.8.3. CONTRACTOR shall provide a list of known dates that are not considered business days for CONTRACTOR, but are considered work days for state employees no later than March 1, 2008. Throughout the period of this Agreement, CONTRACTOR shall give HCA not less than 30 days' prior notice of any additional dates that subsequently are identified where customer service representation will be unavailable to BH Enrollees.

12.9. Defense of Legal Actions

Each party to this Agreement 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 Agreement by providing without additional fee all reasonably available information relating to such actions and by providing necessary testimony.

12.10. Financial Solvency

12.10.1. CONTRACTOR shall deliver to HCA copies of any financial reports prepared at the request of the Office of the Insurance Commissioner (OIC). CONTRACTOR'S routine quarterly and annual statements submitted to the OIC are exempt from this requirement. 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 CONTRACTOR submits them to the OIC.

12.10.2. CONTRACTOR shall notify HCA within 10 business days after the end of any month in which 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 Agreement or which may otherwise materially affect the relationship of the parties under this Agreement.

12.10.3. CONTRACTOR shall notify HCA within 24 hours after any action by the Insurance Commissioner which may affect the relationship of the parties under this Agreement.

12.10.4. CONTRACTOR shall notify HCA if the OIC requires enhanced reporting requirements within 14 calendar days after CONTRACTOR'S notification by the OIC. CONTRACTOR agrees that HCA may, at any time, access any financial reports submitted to the Insurance Commissioner in accordance with any enhanced reporting requirements and consult with OIC staff concerning information contained therein.

12.10.5. If CONTRACTOR, any Subcontractor, or any Participating Provider becomes insolvent during the term of this Agreement:

12.10.5.1. The state of Washington, HCA, and its Enrollees shall not be liable in any manner for the debts and obligations of the CONTRACTOR.

12.10.5.2. Under no circumstances shall CONTRACTOR, or any Provider who delivers Covered Services under the terms of this Agreement, charge Enrollees more than the Enrollee cost share set forth in the COC (Exhibit 2).

12.10.5.3. CONTRACTOR shall provide for the continuity of care for Enrollees in accordance with RCW 48.44.055.

12.11. Force Majeure

If CONTRACTOR is prevented from performing any of its obligations hereunder, in whole or in part, as a result of major epidemic, act of God, act of war (declared or undeclared), civil disturbance, court order, labor dispute, or any other cause beyond its control, CONTRACTOR shall make a good faith effort to perform such obligations through its then-existing Participating Providers and personnel. Upon the occurrence of any such event, if CONTRACTOR is unable to fulfill its obligations either directly or through Participating Providers, CONTRACTOR shall make a good faith effort to arrange for the provision of alternate and comparable performance.

12.12. Governing Law and Venue

This Agreement shall be governed by the laws of the state of Washington. In the event of a lawsuit involving this Agreement, venue shall be proper only in the Superior Court of Thurston County.

12.13. HCA and Enrollee Protection

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

12.13.2. Under no circumstances shall CONTRACTOR, or any Provider used to deliver Covered Services under the terms of this Agreement, charge an Enrollee more than the Enrollee cost share set forth in the COC (Exhibit 2) including, but not limited to, emergent care or Covered Services administered by a Provider referred by CONTRACTOR or referred by CONTRACTOR'S Participating Providers.

12.14. Indemnification

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

12.15. Independent Parties

CONTRACTOR acknowledges and certifies that its directors, officers, partners, employees, and agents are not officers, employees, or agents of HCA or the state of Washington. CONTRACTOR shall not hold itself out as or claim to be an officer, employee, or agent of HCA or the state of Washington by reason of this Agreement. CONTRACTOR shall not claim any rights, privileges, or benefits that would accrue to a civil service employee under chapter 41.06 RCW.

12.16. Industrial Insurance Coverage

CONTRACTOR shall provide or purchase industrial insurance coverage prior to performing work under this Agreement. HCA will not be responsible for payment of industrial insurance premiums or for any other claim or benefit for CONTRACTOR, or any Subcontractor or employee of CONTRACTOR, which might arise under the industrial insurance laws during performance of duties and services under this Agreement.

12.17. Integration and Modification of Agreement

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

12.18. Intermediate Sanctions

12.18.1. If CONTRACTOR fails to meet a material obligation under the terms of this Agreement, HCA may impose intermediate sanctions by withholding up to 5 percent of payments to the CONTRACTOR rather than terminate this Agreement. CONTRACTOR agrees that any intermediate sanction assessed by HCA shall not be regarded as a waiver of any requirements contained in this Agreement or any provision therein, nor as a waiver by HCA of any other remedy available in law or in equity.

12.18.2. HCA will notify CONTRACTOR in writing of any default and provide a reasonable deadline for curing the default before imposing intermediate sanctions. CONTRACTOR may request a dispute resolution hearing, as described at Section 11.2. of this Agreement (Disputes and Dispute Resolution Hearings). CONTRACTOR agrees that any intermediate sanction assessed under this Section shall be in addition to any other legal or equitable remedies allowed by this Agreement or awarded by a court of law, including injunctive relief.

12.18.3. If the dispute is resolved in favor of CONTRACTOR, HCA shall immediately pay to CONTRACTOR any and all withheld payments. Interest shall not accrue on any amount withheld as an intermediate sanction. If the dispute is resolved in favor of HCA, HCA may withhold said amounts until such breach is cured.

12.19. Licensing, Registration, Certification, and Authorization

CONTRACTOR shall comply with all applicable local, state, and federal licensing, certification, accreditation, and registration standards and requirements necessary for the performance of this Agreement, including, but not limited to, licensing, registration, certification, or authorization as a health maintenance organization, health care service contractor, or disability insurer under Title 48 RCW.

12.20. Marketing and Written Communication Materials

12.20.1. CONTRACTOR shall not engage in any marketing activity related to this Agreement without the prior written approval of HCA.

12.20.2. CONTRACTOR will not use identifying marks of BH, HCA, or the state of Washington on any materials produced or issued by CONTRACTOR without the prior written consent of HCA. This contract term includes, but is not limited to marketing, advertising or other direct communications to members, terminated members or potential members.

12.20.3. CONTRACTOR agrees not to represent itself as endorsed, supported by, or affiliated with the state of Washington.

12.20.4. CONTRACTOR agrees to submit all written communications and marketing materials, developed and used by CONTRACTOR to communicate specifically with BH Enrollees at any time during the contract period, to HCA for review and approval. This subsection does not refer to such items as Provider directories and plan-wide newsletters as long as they do not contain information on eligibility, enrollment, benefits, rates, etc., which HCA must review.

12.20.5. CONTRACTOR agrees that it will not advertise or distribute any information to BH Enrollees, terminated BH Enrollees, and candidates for BH enrollment or Providers that contains false or misleading information. Violation of this subsection is subject to the Rights and Remedies defined in Sections 3.1. and 12.18. of this Agreement. CONTRACTOR further agrees that if erroneous or misleading information is sent to an Enrollee or Subcontractors (including contracted Providers) regarding any matter related to this Agreement, HCA may require CONTRACTOR to mail a correction or clarification to correctly inform the recipients of such written materials.

12.20.6. Nothing in this Section shall be construed to prohibit CONTRACTOR from acknowledging that it has entered into this Agreement with HCA.

12.21. Mergers and Acquisitions

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

12.22. Nondiscrimination

During the performance of this Agreement, CONTRACTOR, and any of its Subcontractors performing any of the obligations of CONTRACTOR set forth in this Agreement, shall comply with all federal and state laws, regulations, and Executive Orders regulating discrimination. These include, but are not limited to, the following and any amendments thereto: Titles VI and VII of the Civil Rights Act of 1964, Executive Order 11246 as amended by Executive Order 11375, Sections 503 and 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the 1974 Vietnam Era Veterans Readjustment Assistance Act, the Americans with Disabilities Act of 1990, as amended, including the provisions of Title II as if they were a public entity, the Civil Rights Act of 1991, and the Washington State Law Against Discrimination (chapter 49.60 RCW).

12.23. Noncompliance with Nondiscrimination Laws

In the event of noncompliance with any nondiscrimination law, regulation, or policy by CONTRACTOR, HCA may rescind, cancel, or terminate this Agreement in whole or in part, and CONTRACTOR may be declared ineligible for further contracts or agreements with HCA for a period of up to 2 years. CONTRACTOR shall be given a reasonable time, not to exceed 60 days, in which to cure this noncompliance. Any dispute may be addressed in accordance with Section 11.2. (Disputes and Dispute Resolution Hearings).

12.24. Notification of Organizational Changes

CONTRACTOR shall provide HCA with 90 days' prior written notice of any change in CONTRACTOR'S ownership or legal status. CONTRACTOR shall provide HCA notice of any changes to CONTRACTOR'S key personnel including, but not limited to, CONTRACTOR'S Chief Executive Officer, HCA government relations contact, and Medical Director as soon as reasonably possible.

12.25. Subcontracts

12.25.1. Subcontracts, as defined at Section 1.22., may be used by CONTRACTOR for the provision of any service under this

Agreement; however, no Subcontract shall act to terminate CONTRACTOR'S legal responsibility to HCA for any work required to be performed under this Agreement. If the terms or conditions of an agreement between CONTRACTOR and its Subcontractors conflict with this Agreement, the terms and conditions of this Agreement shall prevail for purposes of administration of this Agreement.

12.25.2. CONTRACTOR is responsible for ensuring that all terms, conditions, assurances, and certifications set forth in this Agreement are carried forward to any Subcontractors, including, but not limited to, those contract terms set forth in Section 9. (Data Records), Section 12.1. (Accessibility of Covered Services), Section 12.13. (HCA and Enrollee Protection), and Section 12.27. (Records Maintenance and Retention). CONTRACTOR shall be responsible for educating its Subcontractors on the nature and purpose of CONTRACTOR'S relationship with HCA, including Covered Services for Enrollees under this Agreement, coordination of care requirements, and HCA policies as they relate to this Agreement.

12.25.3. If a Subcontractor is at financial risk and CONTRACTOR imposes solvency requirements on the Subcontractor, the terms of the solvency requirement and how frequently and by what means CONTRACTOR will monitor compliance with solvency requirements must be in writing and enforced throughout the term of the Subcontract agreement.

12.25.4. Contracts or Subcontracts with Providers, including those for facilities, must ensure the terms and conditions of this Agreement apply to the Subcontractor. The Subcontract must also contain the following provisions:

12.25.4.1. 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 Covered Services in accordance with the terms and conditions set forth in this Agreement, and which provides a free exchange of information with CONTRACTOR to assist CONTRACTOR in complying with Sections 8. and 10. of this Agreement.

12.25.4.2. A 90 day termination notice provision for Participating Providers and a specific “short term” notice of termination when a Provider is excluded from participation due to quality of care concerns.

12.25.4.3. Whether referrals for Enrollees will be restricted to Providers affiliated with a specific network group and, if so, a description of those restrictions.

12.25.4.4. The Subcontractor accepts payment from CONTRACTOR as payment in full and shall not request payment from HCA or any Enrollee for any services performed under the Subcontract.

12.26. Provider Network Changes

12.26.1. CONTRACTOR shall furnish health care services at its health care facilities or through its Participating Providers throughout the term of this Agreement.

12.26.2. CONTRACTOR shall provide HCA not less than 90 calendar days’ advance written notice of termination of a Material Provider.

12.26.2.1. In the event CONTRACTOR receives fewer than 90 days’ notice of termination from a Material Provider, CONTRACTOR shall provide written notice of the termination to HCA within 5 business days after CONTRACTOR’S receipt of the termination notice from the Provider.

12.26.2.2. If CONTRACTOR gives HCA fewer than 90 days’ termination notice to a Material Provider due to the Provider’s loss of accreditation or Medicare or Medicaid certification, or because of serious concerns about service delivery or quality of care, CONTRACTOR shall notify HCA within 5 business days after such termination.

12.26.2.3. If HCA receives fewer than 90 days’ notice of termination of a Participating Provider determined by HCA to be material to the performance of this Agreement and the access goals of HCA, HCA may, at its sole discretion, require CONTRACTOR to continue providing services through the Material Provider for a period not to exceed 90 days. CONTRACTOR shall cooperate with HCA to ensure continuity of care and that treatment protocols are not materially affected by Provider terminations. CONTRACTOR shall cooperate with HCA to effect the orderly transition of Enrollees to

other Participating Providers or programs of health care coverage for which such Enrollees may be eligible.

12.26.3. If CONTRACTOR requires a Participating Provider to accept a revised structure or method of reimbursement (e.g., moving from a fee schedule reimbursement methodology to full-risk capitation payment) during the period of this Agreement as a condition of continued participation with CONTRACTOR and the change is rejected by the Provider, CONTRACTOR shall extend the terms of the existing Subcontract to continue service for BH Enrollees until the end of the calendar year in which the change is proposed.

12.26.4. CONTRACTOR shall notify Enrollees affected by any Provider termination which occurs without cause, 60 calendar days prior to the effective date. Notices to Enrollees of Provider termination shall have prior approval of HCA. If CONTRACTOR fails to notify affected Enrollees of a Provider termination 60 calendar days prior to the effective date, CONTRACTOR shall allow affected Enrollees to continue to receive services from the terminating Provider, at the Enrollees' option, and administer benefits to the lesser of a period of 60 calendar days from the date CONTRACTOR notifies Enrollees of the termination or the Enrollee's effective date of enrollment with another Provider or another BH CONTRACTOR.

12.26.5. If because of changes in the Participating Provider network, the network becomes so changed that Enrollees are unable to obtain services from Participating Providers, or if in the sole judgment of HCA the change in network adversely impacts Enrollees, HCA may transfer the affected Enrollees to another CONTRACTOR.

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

12.27. Records Maintenance and Retention

12.27.1. CONTRACTOR and its Subcontractors shall maintain financial, medical, and other records relevant to this Agreement. Medical records and supporting management systems shall include all relevant information related to the medical management of each Enrollee. Other records shall be maintained as necessary to clearly reflect all actions taken by CONTRACTOR related to this Agreement.

12.27.2. All records and reports relating to this Agreement, and any subsequent amendments extending the effective date of this Agreement, shall be retained by CONTRACTOR and its

Subcontractors for a minimum of six (6) years after final payment is made under this Agreement. 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.

12.28. Post Termination Responsibilities

The following requirements survive termination of this Agreement. CONTRACTOR shall:

12.28.1. Cover Enrollees hospitalized on the date of termination until discharge, consistent with subsections 3.6.4. and 12.10.5.3. of this Agreement.

12.28.2. Submit all data and reports required in Section 7. of this Agreement.

12.28.3. Provide access to records, as required in Section 12.4. of this Agreement.

12.28.4. Provide administrative services associated with Covered Services (e.g., claims processing and Enrollee appeals) provided to Enrollees under the terms of this Agreement.

12.29. Required Notices

Any notice required hereunder shall be deemed to be sufficient if mailed to the addresses appearing on the signature page of this Agreement.

12.30. Services Non-Transferable

No person other than the Enrollee is entitled to receive services and benefits furnished under this Agreement. Rights to services and benefits are not transferable.

12.31. Severability

If any provision of this Agreement or any provision of any document, law, or regulation incorporated by reference shall be held invalid, such invalidity shall not affect the other provisions of this Agreement which can be given effect without the invalid provision, and to this end the provisions of this Agreement are declared to be severable.

12.32. Waiver

Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of this Agreement unless stated to be such in writing, signed by the parties, and attached to the original Agreement.

Table of Contents

Molina Healthcare of Washington, Inc — Exhibit 1 Monthly Fees

Basic Health CY 08 Final Rate Summary

Changes to monthly fees because of the addition of a newborn or adoptive child will be effective the first of the month following the date of birth, or date of placement of a child for purposes of adoption.

Monthly fees are determined by an enrollee's age as of January 1 of each calendar year regardless of the date when Basic Health coverage began. Monthly fees will not increase for an enrollee at any date

other than January 1. Student dependents and disabled dependents who are less than 23 years old will be assigned the "child" monthly fee. Enrollees who are less than age 19 and are not dependents will be assigned the 0—39 year old monthly fee. "Monthly fee" means the amount paid on a monthly basis to an MHCS by the HCA.

Monthly fees paid for enrollees in Basic Health Plus and Maternity Benefits Program will be the Medicaid fees set forth by the Department of Social and Health Services and described in the Basic Health Plus and Maternity Benefits Program contract.

	2008 Tiered Bid Rates for Subsidized BH							2008 Tiered Bid Rates for HCTC BH						
County	One child	2 children	3+ children	Adult 0-39	Adult 40-54	Adult 55-64	Adult 65+	One child	2 children	3+ children	Adult 0-39	Adult 40-54	Adult 55-64	Adult 65+
Adams	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
Asotin	$99.54	$199.08	$298.62	$215.66	$276.49	$472.80	$597.22	$106.85	$213.70	$320.55	$231.52	$296.82	$507.56	$641.12
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Chelan	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
Clallam														
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Columbia	$99.54	$199.08	$298.62	$215.66	$276.49	$472.80	$597.22	$106.85	$213.70	$320.55	$231.52	$296.82	$507.56	$641.12
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Douglas	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
Ferry	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
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Garfield	$99.54	$199.08	$298.62	$215.66	$276.49	$472.80	$597.22	$106.85	$213.70	$320.55	$231.52	$296.82	$507.56	$641.12
Grant	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
Grays Harbor	$95.27	$190.54	$285.81	$206.42	$264.64	$452.53	$571.62	$102.50	$205.00	$307.50	$222.09	$284.72	$486.88	$615.00
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King	$82.95	$165.90	$248.85	$179.73	$230.42	$394.02	$497.71	$ 89.93	$179.86	$269.79	$194.85	$249.81	$427.17	$539.58
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Kittitas	$82.95	$165.90	$248.85	$179.73	$230.42	$394.02	$497.71	$ 89.93	$179.86	$269.79	$194.85	$249.81	$427.17	$539.58
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Lewis	$95.27	$190.54	$285.81	$206.42	$264.64	$452.53	$571.62	$102.50	$205.00	$307.50	$222.09	$284.72	$486.88	$615.00
Lincoln	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
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Okanogan	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
Pacific	$99.54	$199.08	$298.62	$215.66	$276.49	$472.80	$597.22	$106.85	$213.70	$320.55	$231.52	$296.82	$507.56	$641.12
Pend Oreille	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
Pierce	$95.27	$190.54	$285.81	$206.42	$264.64	$452.53	$571.62	$102.50	$205.00	$307.50	$222.09	$284.72	$486.88	$615.00
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Spokane	$82.95	$165.90	$248.85	$179.73	$230.42	$394.02	$497.71	$ 89.93	$179.86	$269.79	$194.85	$249.81	$427.17	$539.58
Stevens	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
Thurston	$95.27	$190.54	$285.81	$206.42	$264.64	$452.53	$571.62	$102.50	$205.00	$307.50	$222.09	$284.72	$486.88	$615.00
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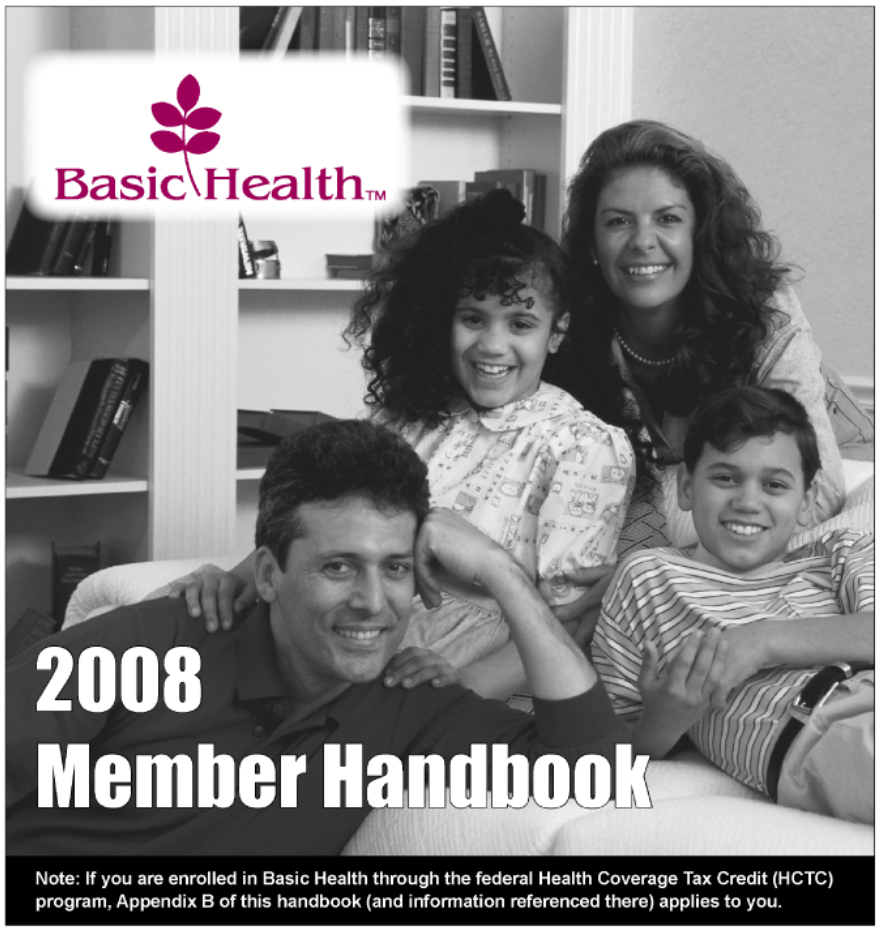
Walla Walla	$82.95	$165.90	$248.85	$179.73	$230.42	$394.02	$497.71	$ 89.93	$179.86	$269.79	$194.85	$249.81	$427.17	$539.58
Whatcom	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
Whitman	$87.28	$174.56	$261.84	$189.10	$242.44	$414.57	$523.67	$ 94.35	$188.70	$283.05	$204.42	$262.07	$448.14	$566.07
Yakima	$82.95	$165.90	$248.85	$179.73	$230.42	$394.02	$497.71	$ 89.93	$179.86	$269.79	$194.85	$249.81	$427.17	$539.58

Table of Contents

Keep this book handy for quick reference.



Note: If you are enrolled in Basic Health through the federal Health Coverage Tax Credit (HCTC) program, Appendix B of this handbook (and information referenced there) applies to you.

Basic Health ID #: _____

Health plan ID #: _____

Health plan phone #: _____

HCA 22-405 (1/08)

Basic Health	24-hour self-service	**1-800-842-7712**
	Mon.-Fri. 8 a.m.-5p.m.	**1-800-660-9840**
TTY:	Mon.-Fri. 8 a.m.-5p.m.	**1-888-923-5622**
Spanish:	Mon.-Fri. 8 a.m.-5p.m.	**1-800-321-0291**
Korean:	Mon.-Fri. 8 a.m.-5p.m.	**1-800-324-1658**
Vietnamese:	Mon.-Fri. 8 a.m.-5p.m.	**1-800-423-2231**
Russian:	Mon.-Fri. 8 a.m.-5p.m.	**1-800-387-8224**

Table of Contents

Contact Information

	Customer Service Hours	Customer Service Phone Numbers	Web Site Address
Basic Health	24-hour self-service Mon. – Fri. 8 a.m. – 5 p.m.	1-800-842-7712 1-800-660-9840 TTY: 1-888-923-5622	www.basichealth.hca.wa.gov
Spanish	8 a.m. – 5 p.m.	1-800-321-0291	
Korean	8 a.m. – 5 p.m.	1-800-324-1658	
Vietnamese	8 a.m. – 5 p.m.	1-800-423-2231	
Russian	8 a.m. – 5 p.m.	1-800-387-8224	
Internal Revenue Service (to request federal income tax information)	Mon. – Fri.	1-800-829-1040	www.irs.gov
Health Coverage Tax Credit (HCTC) Program	Mon. – Fri. 5 a.m. – 5 p.m.	1-866-628-4282 TTY: 1-866-626-4282	www.irs.gov (Keyword: HCTC)
Columbia United Providers, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-315-7862 or 360-891-1520 TDD: 1-866-287-9962	www.cuphealth.com
Community Health Plan of Washington	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-440-1561 TTY: 1-800-833-6388	www.chpw.org
Group Health Cooperative	Mon. – Fri. 8 a.m. – 5 p.m.	1-888-901-4636 TTY: 1-800-833-6388	www.ghc.org
Kaiser Foundation Health Plan of the Northwest	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-813-2000 TTY: 1-800-324-8010	www.kaiserpermanente.org
Molina Healthcare of Washington, Inc.	Mon. – Fri. 7:30 a.m. – 5:30 p.m.	1-800-869-7165 TTY: 1-877-665-4629	www.molinahealthcare.com

Premium payments are due by the 5th day of the month before the actual month of coverage; the amount and due date are shown on each month's bill. Your bill is sent about six weeks before the month to be covered by that payment. For example, the bill for August coverage is sent mid-June and payment is due July 5.

Basic Health	Mailing Addresses
Premium payments	P.O. Box 34270, Seattle, WA 98124-1270
General correspondence	P.O. Box 42683, Olympia, WA 98504-2683
Basic Health appeals (see page 20)	P.O. Box 42690, Olympia, WA 98504-2690

Table of Contents

If you have any questions about...	Contact...
• **Adding and/or dropping coverage** • **Address changes** • **Income changes**	Basic Health at 1-800-842-7712 to get forms or hear recorded information, go to **www.basichealth.hca.wa.gov** or call 1-800-660-9840 to talk to a Basic Health representative.
• **A bill for medical care** • **Choosing a provider** • **Covered services** • **Services received from providers** • **Waiting period**	Your health plan. (See the phone number on the previous page.)
• **Your medical care** • **Referrals to specialists**	Your primary care provider.
• **Your monthly premium** • **Your bill from Basic Health** • **Refunds**	Basic Health at 1-800-842-7712 for 24-hour, self-service payment information; or 1-800-660-9840, then follow the instructions to talk to an accounting representative.
• **Your family's enrollment** • **Your health plan** • **Your premium**	Visit **www.hca.wa.gov/ecoverage.shtml** or call 1-800-660-0840.

When you call or write to us...

Include your **name, Basic Health ID number, address,** and a **daytime phone number.** Be sure to note the date of the call, the name of the person you talked to, and the organization you contacted. If you have Basic Health through your employer, a home care agency, or a financial sponsor, first contact your representative (usually your payroll officer or financial sponsor representative). Your representative may have the information you need, or may need to know about the change you're making.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Si desea ayuda en español, llame al 1-800-321-0291. Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.

한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오. Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.

Table of Contents

Table of Contents

Introduction

Basic Health offers quality, low-cost health coverage to eligible people who live in Washington State. It is a state program managed by the Washington State Health Care Authority (HCA). The HCA contracts with health plans to offer Basic Health and Basic Health *Plus* coverage. Each health plan works with hospitals, clinics, pharmacies, physicians, and other providers to serve Basic Health and Basic Health *Plus* members.

If any of your family members are enrolled in Basic Health *Plus* or the Maternity Benefits Program, you should have received *A Guide to Basic Health Plus and the Maternity Benefits Program*, with specific information about these programs.

You must give Basic Health the information needed to determine your continued eligibility for the program. You must also give your health plan all information they need to process claims, including medical records.

You must follow your health plan's rules to get the benefits described in this handbook. Rules may be different between health plans. Be sure to read your health plan's materials for details, and call them if you have questions about your benefits.

This handbook is your "certificate of coverage." It describes what Basic Health covers, and the rules you must follow when using your coverage. This handbook is subject to state laws governing Basic Health (Chapter 70.47 RCW) and the administrative rules of Basic Health (Chapter 182-25 of the Washington Administrative Code). If there are any conflicts between this handbook and the law, the law governs.

Keep this *Member Handbook* handy, and look at it when you have a question about your benefits. Basic Health may send other important documents, such as *Hot Policy Pages* and open enrollment materials. These may include updates to this handbook. Always keep them with your *Member Handbook*.

If you are enrolled in Basic Health as a Health Coverage Tax Credit (HCTC) enrollee, read Appendix B of this handbook, starting on page 41, first.

Throughout this handbook, "you" generally refers to the main subscriber on the Basic Health account or to an adult who will be reading and referring to coverage information on behalf of an enrolled child.

Chapter One:

Eligibility for Basic Health Programs

Basic Health is available to anyone who lives in Washington and:

- **Meets income guidelines (see pages 5–6).**
- **Is not eligible for free or purchased Medicare.**
- **At the time of enrollment, is not confined in or living in a government-funded institution that has historically provided health care.**
- **Is not attending school full-time in the United States on a student visa.**

Specific programs may have additional eligibility requirements. Basic Health is also available to people eligible for the Health Coverage Tax Credit through the Internal Revenue Service (IRS), whether or not they meet the above criteria.

Family members who should be listed as dependents on your account (even if they are not enrolling for coverage) include:

- **Your spouse living in the same house and not legally separated from you.**
- **Your unmarried child, including stepchild, legally adopted child, and a child placed in your home for purposes of adoption or under your legal guardianship, who is:**
  - Under age 19; or
  - Under age 23 and a full-time student at an accredited school. You are required to send proof from the school each year when your dependent is age 19 through 22, to show that he or she is a full-time student. If your dependent over age 18 is no longer a full-time student, you must notify Basic Health within 30 days of this change.
- **Your unmarried child under age 19, enrolling for Basic Health coverage, and in your custody under an informal guardianship agreement that is signed by the child's parent(s) and allows you to get medical care for the child. To request coverage for a child living with you under such an agreement, you must provide a copy of the guardianship agreement and proof that you are providing at least 50 percent of the child's support. You cannot list a child who is in your home under a foster care agreement.**
- **Your unmarried child, stepchild, legally adopted child, or legal dependent of any age who cannot take care of him-or herself due to disability. You must provide proof of disability. If the dependent with a disability is not your birth or adopted child, you must also provide proof of legal guardianship.**

Family members who are not eligible for coverage on your account may be able to enroll separately—for example, a child who reaches age 19 and is not disabled or attending school full time. This family member must complete a separate Basic Health application.

Family enrollment

Individuals may apply for Basic Health, Basic Health *Plus*, the Maternity Benefits Program, or other programs for themselves and qualified family members. You and your family members may be enrolled in different programs. For example, you may enroll in Basic Health, your spouse in the Maternity Benefits Program, and your child in Basic Health *Plus.*

Premiums

Premium payments are due by the 5th day of each month before the actual month of coverage; the amount and due date are shown on each month's bill. Your bill is sent about six weeks before the month to be covered by that payment. For example, the bill for August's coverage is sent mid-June and payment is due July 5.

If the entire premium is not paid on time, Basic Health will send you a late notice. This notice will include the bill for both the past due amount (called the delinquent balance) and the premium for the

following month's coverage. Basic Health must receive payment for each amount due by the due date given, or your coverage will be suspended for one month. Partial payment or checks that cannot be processed (for example, insufficient funds or missing a signature) will be considered nonpayment and may cause you to lose coverage. For more information, refer to page 13.

Basic Health *Plus*

This Basic Health and Department of Social and Health Services (DSHS) program is for children under age 19. With Basic Health *Plus*, children receive additional health care coverage such as dental care, vision care, and physical therapy. Children enrolled in Basic Health *Plus* receive services through the same health plan that provides your Basic Health coverage.

Your family will have to meet DSHS's income guidelines, available at http://fortress.wa.gov/dshs/maa/eligibility/OVERVIEW/MedicalOverview.htm. The children must be your legal dependents, live in your home, and be:

- **Under age 19.**
- **U.S. citizens, or immigrants who have legally lived in the U.S. for five years.**
- **Not enrolled in any other managed care plan, including TRICARE.**
- **Not receiving Temporary Assistance for Needy Families (TANF) grants from DSHS.**

For some Basic Health *Plus* services, such as dental and vision care, the state pays the provider directly.

If you would like to transfer your child's coverage from Basic Health to Basic Health *Plus*, call 1-800-842-7712 or visit our Web site (**www.basichealth.hca.wa.gov**) to request a Basic Health *Plus* application.

Maternity Benefits Program

This Basic Health and DSHS program provides pregnant women with full maternity coverage, usually through the same providers and health plan chosen for Basic Health coverage. See pages 23–24 for more information on maternity coverage.

Basic Health for personal care workers

If you are working for DSHS as a personal care worker, and meet Basic Health income guidelines, you may be able to pay even less for Basic Health coverage.

For more information or to request a personal care worker application, call 1-800-660-9840 or check Basic Health's Web site.

Basic Health for foster parents

If you have a current foster parent license issued by DSHS, you may be eligible for lower premium rates through our foster parent program. For information or to request a foster parent application call 1-800-660-9840 or visit our Web site.

The licensed foster parents in your family may qualify for coverage even if they exceed income limits for Basic Health. See chart on page 6 for income guidelines.

Basic Health through your employer, financial sponsor, or home care agency

Employers, home care agencies, and financial sponsors may enroll their employees or sponsored members in Basic Health. Your employer or sponsor pays your premium, but may collect part of it from you. Your main contact with Basic Health will be through your employer or sponsor.

If your employer, home care agency, or financial sponsor doesn't pay the premium on time, or if you no longer qualify for coverage through them, you may be disenrolled. If your entire organization is disenrolled, Basic Health will offer you individual coverage; however, you may have a break in coverage.

Health Coverage Tax Credit

If you are enrolled in Basic Health through the federal Health Coverage Tax Credit (HCTC) program, please read Appendix B of this handbook. If you are not enrolled in HCTC-Basic Health, but think you may qualify, call 1-866-628-4282, or visit **www.irs.gov** (keyword: HCTC).

Chapter Two:

Income Guidelines

How your income is calculated

Basic Health requires current pay stubs and a copy of your IRS Form 1040 for the most recent tax year, with all schedules fled. We will look at your income from both sources and use the one that gives the best picture of your income.

If you cannot provide IRS documentation (you were not required to file a tax return), we will use your most recent income documentation, unless your income is seasonal. If Basic Health determines that your income is seasonal, we will use an average of your income over several months. We may require you to provide additional documents.

If you are reporting self-employment or rental income, Basic Health will use a 12-month average of that income, unless you have had the business or rental property for less than 12 months. When figuring your self-employment income, Basic Health will not deduct depreciation or amortization, and may not deduct business use of your home. A net loss from this calculation will not be used to offset other income sources (a loss equals zero).

If you paid for child care or for the care of a disabled dependent so either you or your spouse could work or go to school, you may be allowed to deduct expenses, up to a maximum of $1,025 per month per child or disabled

dependent. We require proof showing the amount you paid and to whom. (Tis will not count if paid to the child's parent or stepparent, or to another dependent of the main subscriber.) If the expenses were for the care of a disabled dependent, we will require you to provide documents of the disability and proof that the dependent cannot care for himself/herself and, if the care is during school hours, that (s)he cannot attend public schools.

Eligibility and premiums for most Basic Health programs are based on your family's gross income, which is adjusted according to the number of people in the family (the "income band" for the family). The following table shows the income bands used for determining eligibility and premiums through June 2008. After June 30, 2008, please check our Web site(**www.basichealth.hca.wa.gov**) or call 1-800-660-9840 for information. To find your income band, find your family size and your family's **gross** monthly income (before taxes and other deductions).

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

Income Table

Number of People in Your Family

Gross Monthly Income

1	2	3	4	5	6	7	Income Band
$0 – $553.04	$0 – $741.54	$0 – $930.04	$0 – $1,118.54	$0 – $1,307.04	$0 – $1,495.54	$0 – $1,684.04	**A**
553.05 – 850.83	741.55 – 1,140.83	930.05 – 1,430.83	1,118.55 – 1,720.83	1,307.05 – 2,010.83	1,495.55 – 2,300.83	1,684.05 – 2,590.83	**B**
850.84 – 1,063.54	1,140.84 – 1,426.04	1,430.84 – 1,788.54	1,720.84 – 2,151.04	2,010.84 – 2,513.54	2,300.84 – 2,876.04	2,590.84 – 3,238.54	**C**
1,063.55 – 1,191.16	1,426.05 – 1,597.16	1,788.55 – 2,003.16	2,151.05 – 2,409.16	2,513.55 – 2,815.16	2,876.05 – 3,221.16	3,238.55 – 3,627.16	**D**
1,191.17 – 1,318.79	1,597.17 – 1,768.29	2,003.17 – 2,217.79	2,409.17 – 2,667.29	2,815.17 – 3,116.79	3,221.17 – 3,566.29	3,627.17 – 4,015.79	**E**
1,318.80 – 1,446.41	1,768.30 – 1,939.41	2,217.80 – 2,432.41	2,667.30 – 2,925.41	3,116.80 – 3,418.41	3,566.30 – 3,911.41	4,015.80 – 4,404.41	**F**
1,446.42 – 1,574.04	1,939.42 – 2,110.54	2,432.42 – 2,647.04	2,925.42 – 3,183.54	3,418.42 – 3,720.04	3,911.42 – 4,256.54	4,404.42 – 4,793.04	**G**
1,574.05 – 1,701.75	2,110.55 – 2,281.78	2,647.05 – 2,861.80	3,183.55 – 3,441.83	3,720.05 – 4,021.86	4,256.55 – 4,601.89	4,793.05 – 5,181.92	**H**
Foster Parent Income Lim its*							
1,701.76 – 2,127.16	2,281.79 – 2,852.19	2,861.81 – 3,577.22	3,441.84 – 4,302.25	4,021.87 – 5,027.28	4,601.90 – 5,752.31	5,181.93 – 6,477.34	**I**
2,127.17 – 2,552.58	2,852.20 – 3,422.61	3,577.23 – 4,292.64	4,302.26 – 5,162.67	5,027.29 – 6,032.70	5,752.32 – 6,902.73	6,477.35 – 7,772.75	**J**

* I & J apply only to licensed Foster Parent

Valid through June 30, 2008

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

Chapter Three:

Making Changes and Maintaining Eligibility

Changes to your account could affect your Basic Health coverage. Report changes to Basic Health within the timelines noted in this chapter. You may use the *Change Form* included with your monthly bill to make some account changes. To get other forms, call our 24-hour, automated, self-service phone line at 1-800-842-7712 or visit our Web site. You may also write to Basic Health at PO Box 42683, Olympia, WA 98504-2683.

If you are enrolled through your employer or a financial sponsor, make sure the sponsor knows about changes in your income or family, too, because it may affect the amount you pay for your coverage. Contact your financial sponsor, employer, or payroll office if you have questions.

Changing health plans

Open enrollment is the time each year when you can change your health plan (if you have more than one plan available in your area), except as noted elsewhere in this section. During open enrollment, Basic Health will send you information about any changes to your coverage, and will tell you about health plans in your area and their monthly premiums. You'll be notified before each open enrollment and given instructions for making changes.

Other than during open enrollment, you may only change health plans under certain conditions. These are explained later in this chapter. You cannot change health plans because your provider is no longer with your health plan. (An exception may be made in some cases if you can prove that you need to continue a current course of treatment with a specific provider.) When you change health plans, remember each health plan contracts with different providers and has its own list of prescription drugs. Call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription drugs, contact the health plan to see if they will be covered.

If you change health plans, any services you had approved under your previous health plan will need to be reviewed and approved again by your new health plan. Also, your deductible and out-of-pocket maximum will start over. Check with your health plan for further information.

Basic Health will do its best to make sure your health plan is available throughout the year. However, if your health plan becomes unavailable, you will be asked to choose one of the plans in your county. If only one health plan remains, you will be assigned to that plan.

Address changes

You must give Basic Health your new address within 30 days of a change. You may call Basic Health at 1-800-660-9840, complete and return the *Change Form* included with your bill, or write to Basic Health at PO Box 42683, Olympia, WA 98504-2683. Include your Basic Health ID number, your name, new address and county, your old address, and your new phone number. Be sure to say if your new address is permanent or temporary (less than three months), and if your mailing address is different from your street address.

If you move out of Washington State, you will be disenrolled from Basic Health. If you move out of your health plan's service area, you will have to

The information in chapters 2-4 dose not apply to HCTC-Basic Health members.

select a new health plan. If your current health plan is still available to you, but would cost more, or you have plan choices that weren't available before you moved, you may request a plan change. While you are waiting to be transferred to your new health plan, you will need to keep using your old health plan for anything except emergency services. When you change health plans, your deductible and out-of-pocket maximum will start over.

Please note: Basic Health double-checks addresses with the U.S. Postal Service, so be sure to file any change of address with your post office.

Dependent living away from home

If your dependent is living away from home, as described below, Basic Health will cover only emergency care while the dependent is out-of-state or staying in a county that is not served by your health plan. Routine services should be scheduled when the dependent is home.

Out-of-county

If your child lives in a different county, you may be able to choose a health plan that provides service to both your home county and the county the dependent lives in. When necessary, Basic Health allows your dependent to enroll in a different health plan under a separate account so the dependent may receive services in the county where the dependent lives. You will be sent a separate bill for their account.

Out of state

If your child is a Washington State resident, but lives away from home part of the time (to attend college, for example), (s) he may be eligible to receive Basic Health coverage as long as (s) he remains a Washington State resident and returns to Washington State during scheduled breaks. You may be required to provide proof of out-of-state tuition or that the child's residence is in Washington State.

Family changes

Eligible family members may enroll in Basic Health during open enrollment. You will get information telling you how to enroll a family member at that time.

Family members may be added, removed, or enrolled at other times during the year, based on the guidelines below, by completing and submitting a *Family Changes Form.* Adding, enrolling, or removing a family member may change your monthly premium. You will get written verification of any changes to your account. Also, if the number of family members living in your home goes down, you may no longer be eligible for Basic Health. If you do not report changes to your account in the required timeframe, you may be disenrolled. To make any family changes to your account, call 1-800-842-7712 or visit Basic Health's Web site to request the *Family Changes Form.* When you notify Basic Health of a change in family size (such as birth, marriage, divorce, or death), you will be required to submit proof of your current income and Washington State residence.

- **Loss of or transfer from other continuous coverage:** If you or a family member either left

The information in chapters 2-4 dose not apply to HCTC-Basic Health members.

or chose not to enroll in Basic Health coverage because you or they had other health care coverage, and then that person loses or wants to transfer from that coverage, the request must be received by Basic Health within 30 days of the loss of coverage. You must show proof of the other continuous coverage.

- **Enrolling a new family member:** To enroll a new spouse, child, or dependent, Basic Health must receive the appropriate application within the timeframes below. Otherwise, the family member will be counted for family size when figuring your monthly premium, but will not have coverage.
  - **Marriage:** Within 30 days of the date of your marriage.
  - **Newborn or newly adopted child:** Within 60 days of the birth or placement for adoption.
  - **Other dependents** (students age 19 through 22, adult with disability): Within 30 days of the date they become your dependent or move into your home. See page 3 for details.

Removing a family member: Basic Health needs notice of the following changes within the required timeframes.

- **Divorce or separation:** We must receive notice within 30 days of the divorce or separation. If you get back together and are living in the same home, you must tell Basic Health, in writing, and we will stop the separation of your account.
- **Transfer of a former student to separate account:** You must notify Basic Health within 30 days of the date the person stops attending school full time. A former student who is taken off the parents' account because the child is no longer a full-time student, may apply for coverage on a separate account.

When coverage begins for added family members

If you get married and follow the procedures explained in "Family changes" (above), coverage for your new family members will begin on the first day of the month after eligibility has been determined and full payment is received.

Your newborn or adopted child is covered from the date of birth or placement in your home if you or a family member is enrolled in Basic Health or Basic Health *Plus*, and if Basic Health receives the application for the child within 60 days of the birth or placement. If Basic Health receives your application more than 60 days after the child's birth or placement, your child will be included for family size only when calculating your premium (this usually reduces your premium), but will not have medical coverage. See page 8 for more information.

Income changes

If your income changes, your monthly premium or eligibility for Basic Health may change, too. You must report any income change to Basic Health within 30 days of the end of the first month at the new income. You must continue paying your premium as billed until we tell you the new premium amount. (See additional information on pages 10-11.)

If you begin receiving Social Security Disability Benefits, you must notify Basic Health immediately. This may affect your eligibility for Basic Health.

When sending income information to Basic Health, use the list below. If this list changes, we will send you an update. Keep all updates with this handbook.

***Include* proof of all income received from the following sources:**

- Salaries, wages, commissions, tips, work-study training stipends, or assistantships, including overtime and bonuses
- Self-employment
- Rental property
- Unemployment
- Strike benefits
- Social Security retirement, survivor, disability, or supplemental security income (including money received by dependent children)
- Retirement and pensions
- Child support or alimony
- Insurance benefits and compensation for an injury

The information in chapters 2-4 dose not apply to HCTC-Basic Health members.

(other than reimbursement for a loss or medical costs), including workers' compensation

- Interest, dividends, periodic receipts from a trust, and royalties
- Net short-term capital gains
- Veterans' benefits and military allotments
- Public assistance (DSHS cash assistance)
- Estate income
- Net gambling or lottery winnings, unless you received them more than one month before you apply for coverage
- All other income that's not specifically in the "Income does not include" list, below

Income does *not* include:

- Income, such as wages, earned by dependent children (however, you must include distributions from a corporation, partnership, or business, even if distributed to a child)
- Any assets drawn down as withdrawals from a bank, or proceeds from the sale of personal property, such as a car
- Tax refunds, gifts, or loans
- Income from a family member who lives in another household, when that income is not available to you or eligible dependents
- University scholarships, grants, VA education grants, or fellowships
- Non-cash benefits (such as food stamps, school lunches, or housing instead of wages)
- Payments for adoption support received from the Department of Social and Health Services (DSHS)
- Individual Retirement Account (IRA) distributions
- Crime victims' compensation
- L&I (Labor and Industries) one-time payments
- Long-term capital gains

Reporting income changes

Send a *Family Income Reporting Form*, along with proof of current income and IRS documentation for the most current tax year. You may get this form by calling 1-800-842-7712, or visiting our Web site. (See "Recertification" for acceptable IRS and income documentation.)

- Include proof of childcare expenses up to $1,025 per child, if the childcare was necessary for both parents to work or attend school

Basic Health will send you a *Personal Eligibility Statement*. It will show any changes to your account that affect your monthly premium or eligibility for the program. It may include a bill for an additional amount you must pay as a result of the change.

Recertification

State law requires Basic Health to periodically review members' income and eligibility for this program. This is called "recertification." Under this process, Basic Health members must send in proof of income, benefits, and Washington State residency. Being selected for recertification does not mean Basic Health believes you have given us the wrong information; it is a legal requirement for all of our members. If you have to wait for Basic Health coverage because the program is full, you may be recertified soon after your coverage begins.

If you get a recertification notice, Basic Health must receive all documentation requested by the due date given. Otherwise, you and your covered family members will lose your coverage for at least 12 months. If you reapply for Basic Health at the end of the 12 months, you will have to provide proof of income and eligibility at that time. Even if you are found eligible, if Basic Health is full, you will have to wait until space is available.

To complete your recertification, you must send all of the following:

- **Proof that you live in Washington State.**
- **The *Recertification Form*** sent to you, signed by any enrolled family members age 18 and over.
- **A copy of one of the following** for the most current tax year:
  - Your IRS Form 1040 (federal income tax form) and all schedules
  - IRS transcript of your return, if you do not have a copy of your IRS Form 1040

The information in chapters 2-4 dose not apply to HCTC-Basic Health members.

- Verification of non-filing from the IRS if you were not required to file a tax return (non-filing status)
- **Copies of pay stubs** for the last 30 days for you and your spouse.
- **Written proof of all other income and benefits** received by your family for the last 30 days.
- **If you are self-employed or have rental income,** a copy of all business forms and schedules filed with the IRS, a complete copy of your Schedules K-l (if applicable), and a *Self-Employment/Rental Income Reporting Form* if you:
  - Were not required to file a tax return; or
  - Have been in business for less than 12 months.

We will send you more details when we select you for recertification.

What if I don't report a change in income?

We base your monthly premium in part on your income; you must report all changes in your income to Basic Health. We check with other sources to make sure your this information is accurate. If we find you have not reported an income change, you must pay the difference between the premium you paid and the premium you should have paid.

If this happens, Basic Health will send you a notice showing the amount we believe you owe the state. If you believe you do not owe the amount shown on that notice, you must follow the instructions in the notice. If you do not respond, or if you are unable to prove that the amount of income you reported to us was correct, Basic Health will bill you for the amount you owe.

What if I don't repay the amount I owe?

If you are billed, you must pay based on the billing schedule we provide. If you do not pay your full bill on time, you will lose your Basic Health coverage. (See page 13 for more information.) If you do not repay the total amount, your account will be sent to a collection agency and you will also have to pay any fees charged by the collection agency.

Legal penalties

Basic Health may bill you for twice the amount due if you:

- Intentionally provide misleading or false income information.
- Withhold information about income.

If you intentionally provide false or misleading information or withhold information, Basic Health may take additional legal action, such as:

- Prosecution for perjury.
- Immediate disenrollment back to the date your coverage would have been affected. This means we will bill you for the total cost of your health coverage since that date.

In addition, if your health plan has paid for services during a time you were enrolled through fraud, they may demand you repay them.

The information in chapters 2-4 dose not apply to HCTC-Basic Health members.

Chapter Four:

Suspension, Disenrollment, and Reenrollment

Suspension

If you (or your financial sponsor or employer, if enrolled through them) do not pay your premium on time, you will lose coverage for one month (suspension). If your premium is paid in full by the due date on your notice of suspension, you will be reenrolled the next month. If you lose coverage for one month, any payments you have made toward your deductible and out-of-pocket maximums will still count.

Disenrollment

To stop Basic Health or Basic Health *Plus* coverage for yourself, a family member, or your entire family, call 1-800-660-9840, or write to Basic Health, PO Box 42683, Olympia, WA 98504-2683. You must include:

- Your name and Basic Health ID number.
- The name of each person you want to disenroll.
- The reason you want to disenroll (especially if due to other insurance, Medicare, or Medicaid).
- The date you want coverage to end. We need to receive your request to disenroll at least 10 days before the first of the month you want coverage to end.

You are no longer eligible for Basic Health and will be disenrolled if you:

- Leave Washington State with no plan to return, or if you are gone for more than three months in a row.
- Become eligible for free or purchased Medicare coverage, regardless of whether you actually have Medicare coverage.
- Have income above Basic Health's income guidelines.

If you are disenrolled because you became ineligible (as previously described) and your circumstances change, you may reapply for Basic Health coverage, but may have to wait until space is available.

You will be disenrolled from Basic Health and will not be allowed back in for at least 12 months if you:

- Are suspended for nonpayment three times in a 12-month period, or do not reenroll the month following a one-month suspension.
- Are billed for the amount Basic Health overpaid for your coverage, and you do not pay the amount based on the billing schedule we provide. (See "What if I don't report a change in income?" on page 11.)
- Do not provide documents Basic Health asks for to check your eligibility or income.
- Take part in any abuse, intentional misconduct, or fraud against Basic Health or your health plan or its providers, or knowingly give information to Basic Health that is false or misleading.
- Intentionally withhold required information, such as a change in income or family size.

You may also be disenrolled from Basic Health if you:

- Purposely put the safety or property of Basic Health or your health plan, or their staff, providers, patients, or visitors, at risk.
- Refuse to follow procedures or treatment recommended by your provider and determined by your health plan's medical director to be essential to your health or the health of your child, and you have been told by your health plan that no other treatment is available.

The information in chapters 2-4 dose not apply to HCTC-Basic Health members.

- Repeatedly fail to pay copayments, coinsurance, or other cost-sharing requirements on time.
- Intentional misconduct. This includes withholding from your health plan information you have about a legally responsible third party, or refusing to help your health plan collect from that legally responsible third party

These conditions for loss of coverage also apply to family members enrolled on your Basic Health account.

Family members enrolled in Basic Health *Plus* or the Maternity Benefits Program through DSHS may stay with these programs as long as they are eligible, even if your coverage is suspended for one month or you are disenrolled from Basic Health for failing to pay your required premium.

If your coverage ends, you will receive written notice of the reason and the date your coverage ends.

Disenrollment from employer, financial sponsor, or home care agency coverage

If you have Basic Health coverage through your employer, you may be able to continue your coverage through the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, you can continue coverage for up to 18 months; however, you will have to pay the full cost of that coverage, including any premium share that had been paid by your employer. Contact your employer to find out if you qualify for COBRA coverage.

If you are no longer eligible for employer, home care agency, or financial sponsor coverage, but still qualify for individual Basic Health, Basic Health will offer you coverage on your own account. If you get an offer from us, you must tell us right away if you want to transfer to your own account. If you do, you must pay the premium for your continued coverage.

Reenrollment

The reenrollment process depends on the reason your Basic Health coverage ended and the amount of time since you last had coverage. When you reapply for Basic Health, you may be required to send in a new application, proof of income and residency, and proof of other continuous coverage.

Generally, when you disenroll from Basic Health, you have to wait at least 12 months before you can reenroll, and may have to wait until space is available. However, the 12-month wait for reenrollment may be waived if either:

- You left for other coverage, and you reapply for Basic Health within 30 days of losing other continuous coverage (you will be required to provide proof of other continuous coverage).
- You move out of the state, then move back to stay.
- You were disenrolled because you were no longer eligible for Basic Health coverage, but you are now eligible again.

Even if the 12-month wait for reenrollment is waived, if Basic Health is full, you will have to wait until space is available.

Reenrollment after disenrollment to Medicaid coverage

If you leave Basic Health for Medicaid coverage (for example Healthy Options, SSI, or GA-U), and then lose the Medicaid coverage, you may reenroll in BH without waiting for space to be available. You must request enrollment in Basic Health within 30 days of losing Medicaid. When you re-apply to Basic Health you may be required to send a new application, proof of income, a copy of your IRS 1040 and all your schedules for the most current tax year, and proof of Washington State residency.

The information in chapters 2-4 dose not apply to HCTC-Basic Health members.

Table of Contents

Chapter Five:

Rights, Responsibilities, and Privacy

Basic Health member rights

As a Basic Health member, you have the right to:

- Get understandable notices or have the materials explained or interpreted.
- Receive timely information about your health plan.
- Get courteous, prompt answers from your health plan and Basic Health.
- Be treated with respect.
- Have your privacy protected by Basic Health, your health plan, and its providers.
- Get information about all medical services covered by Basic Health.
- Choose your health plan and primary care provider from among available health plans and their contracted networks.
- Receive proper medical care, consistent with Appendix A of this handbook, without discrimination no matter what your health status or condition, sex, ethnicity, race, marital status, or religion.
- Get all medically necessary covered services and supplies listed in the Basic Health Schedule of Benefits, subject to the limits, exclusions, and cost-sharing described in Appendix A.
- Take part in decisions about your and your child's health care, including having a candid discussion of appropriate or medically necessary treatment options, regardless of cost or coverage.
- Get medical care without a long delay.
- Refuse treatment and be told of the possible results of refusing, including if your refusal may result in disenrollment from Basic Health.
- Expect your and your child's records and conversations with providers to be kept confidential.

- Get a second opinion by another provider in your health plan when you disagree with the initial provider's recommended treatment plan.
- Make a complaint about the health plan or providers and receive a timely answer.
- File an appeal with your health plan or Basic Health if you are not satisfied with their decision (see pages 19-20).
- Receive a review of a Basic Health appeal decision, if you disagree with it.
- Change your primary care provider for a good reason (call your health plan for assistance).

Basic Health member responsibilities

As a Basic Health member, you and/or your enrolled dependents have the responsibility to:

- Understand Basic Health.
- Accurately and promptly report changes that may affect your premium or eligibility, such as an address change, or a change in family status or income, and send in the required forms and documents. (Read Chapters Two and Three for timelines and instructions.)
- Choose a health plan in your area.
- Choose a primary care provider from your health plan before receiving services.
- Work with your health plan to help get any third-party payments for medical care.
- Tell your health plan about any outside sources of health care coverage or payment, such as insurance coverage for an accident.
- Tell your or your child's primary care provider about medical problems, and ask questions about things you do not understand.
- Decide whether to receive a treatment, procedure, or service.
- Get medical services from (or coordinated by) your or your child's primary care provider, except in an emergency or in the case of a referral.
- Get a referral from the primary care provider before you or your child goes to a specialist.
- Pay copayments in full at the time of service.
- Pay your Basic Health premiums in full by the due date.
- Pay your deductible and coinsurance in full when they are due.
- Not engage in fraud or abuse in dealing with Basic Health, Basic Health *Plus*, the Maternity Benefits Program, your health plan, your primary care provider, or other providers.
- Keep appointments and be on time, or call the provider's office when you or your child will be late or can't keep the appointment.
- Keep your family members' medical I.D. cards with the family member at all times, or with you if your children are young.
- Notify the health plan or primary care provider within 24 hours, or as soon as is reasonably possible, of any emergency services provided outside the health plan.
- Use only your selected health plan and primary care provider to coordinate services for your family's medical needs.
- Comply with requests for information, including requests for medical records or information about other coverage, by the date requested.
- Cooperate with your primary care provider and referred providers by following recommended procedures or treatment.
- Work with your health plan and providers to learn how to stay healthy.

Informed consent

You have the right to give your consent to treatment or care. Be sure to ask your provider about the side effects of your or your child's care. You have the right to know about them, and give your consent before getting care.

Advance directives

"Advance directives" put your health care choices into writing. They may also name someone to speak for you if you are not able to speak. Before signing such a document, talk to a lawyer or legal counselor. Washington State law has two kinds of advance directives:

1. **Durable Power of Attorney for Health Care**- Names someone to make medical decisions for you if you are not able to make them for yourself.
2. **A Directive to Physicians (Living Will)** - A document that lets you tell your doctor what you do or do not want done if you have a terminal condition or are permanently unconscious.

Privacy

Personal health information

The Health Care Authority (HCA) will not release any personal health information that is provided verbally, electronically, or in writing to anyone but you or your health plan without your prior written authorization. Exception: Basic Health and DSHS may exchange information about your pregnancy.

Account information

Without your written permission, the HCA cannot release personal account details such as eligibility, enrollment, monthly premium, or payment to anyone but you or your health plan.

Exceptions:

- If your employer, a home care agency, or a financial sponsor is paying your premium, limited information may be released to your representative. Ask your representative for details.
- Information about a dependent minor child will be released to either parent.
- Your information may be shared with DSHS if DSHS is paying any part of your premium (for example, if you are applying for or enrolling in Basic Health *Plus* or the Maternity Benefits Program, or as a foster parent, personal care worker, or home care worker).
- Providing information to law enforcement.

If you want to let someone else (such as a friend or a relative) access or make changes to your account, you need to send written permission to Basic Health. Be sure to sign and date your letter and include the person's name, their relationship to you, and what information you want released to them or changes they can make. Only the information you specify will be released. You will also need to tell us if this permission is for a specific time period or for as long as you are enrolled in Basic Health. When this person calls, they'll need your Basic Health ID number, and will be asked for other identifying information.

The HCA privacy notice is available on request by calling 360-923-2822 or online at **www.hca.wa.gov.**

Chapter Six:

Grievances, Complaints, and Appeals

If you have a grievance or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find the toll-free numbers on the inside front cover of this book. If you disagree with the determination of your ineligibility for the Health Coverage Tax Credit, contact the HCTC Customer Contact Center for information. (See Appendix B for HCTC contact information.) If you have a complaint about an action taken by Basic Health, call 1-800-660-9840. If you call Basic Health or your health plan, be sure to note the date of the call, the name of the person you talked to, and whether that person was with Basic Health or your health plan.

Your health plan is required to give you information on its grievance and appeals process:

- When you enroll.
- Annually and/or whenever there is a change to their grievance and appeal process.
- When the health plan sends you a notice of a denial of a benefit or service, or notice of an appeal decision.

Grievances against your health plan

If you disagree with a decision made by your health plan (such as a denial of a claim or benefits interpretation) or have a grievance regarding your health plan's services, providers, or facilities, you must follow your health plan's procedures for resolving the problem. Basic Health staff are available to help you resolve the issue informally, but the matter cannot be appealed to Basic Health. You may file a grievance in writing, in person at the health plan's office, or over the phone. The health plan will help you with this process.

If you file a grievance with your health plan, the health plan must respond within 30 days after receiving it. If you file a grievance against a health plan's service, provider, or facility, Washington State law limits the information the health plan may provide you regarding the resolution of your grievance.

Appeals to your health plan

If you are denied a service, or the health plan changed a service that was already approved, you may file an appeal. An appeal is a request for the health plan to review its decision. You may file an appeal or a grievance in writing, in person at the health plan's office, or over the phone. The health plan will help you with this process.

When you file an appeal with your health plan:

- Within five working days, the health plan will send you a letter saying they've received your appeal.
- Within 14 calendar days, your health plan must respond to you in writing with either a decision or notification of a reason for a delay. However, unless you agree to an additional delay, the decision must be made within 30 calendar days after the health plan receives your appeal.

If waiting for a decision could put your health at risk, you can ask, or have your provider ask, for an expedited (quick) review. The health plan will make a decision within 72 hours after receiving an expedited appeal.

If you have gone through your health plan's appeal process and disagree with their decision, or if your health plan has not responded to you within the timelines referenced above, you have the right to request a review of the decision by an Independent Review Organization (IRO). This is done through your health plan and at no cost to you. Your health plan is required by law to give the IRO all information used in making its decision within three business days of receiving the request. You may also be required to provide additional information or documentation needed for the IRO's decision. If waiting for a decision could put your health at risk,

you can ask for an expedited (quick) review. The IRO will make a decision within 72 hours. The health plan will let you know the outcome.

You may choose someone, including an attorney or provider, to serve as your personal representative to act on your behalf for the appeal. The health plan must receive written consent from you allowing this person to represent you before the person can act on your behalf. Contact your health plan for additional information.

Complaints against Basic Health

If you have a complaint or want an explanation of an action Basic Health has taken on your account, write to Basic Health at PO Box 42683, Olympia, WA 98504-2683, or call 1-800-660-9840. A representative will try to resolve your issue.

Appeals to Basic Health

If you disagree with a Basic Health decision, such as premium calculation, premium adjustment or penalty, change of health plan, denial of Basic Health eligibility, or loss of Basic Health coverage, you may file a written appeal with Basic Health within 30 days of the notice of the decision. Write to Basic Health Appeals, PO Box 42690, Olympia, WA 98504-2690, stating you want to file an appeal. Your letter must include your name, address, Basic Health ID number, a daytime phone number, a summary of the decision you are appealing, and a statement explaining why you believe the decision was incorrect. You must also include copies of any evidence that will help explain or prove that the decision should be changed. If your appeal is not received within 30 days of the notice of the decision, you will lose your right to appeal that decision.

In your appeal, you may ask to explain in person or by phone why you believe the decision was incorrect and should be changed. Be sure to let us know if you will need an interpreter and, if so, what language and dialect you speak. Also let us know if you will need any assistance due to disability.

Basic Health will confirm that your appeal was received. If you have asked to explain your appeal over the phone or in person, our Appeals Department will contact you to schedule a conference. The conference will be recorded to ensure an accurate record, and you will be questioned as well as given an opportunity to explain your point of view. You should be prepared to give detailed information to support your opinion that the decision was in error.

Your appeal will be reviewed carefully, and Basic Health will mail a written notice of the decision to you within 60 days of receiving your appeal. If additional time is required for investigation of your appeal, you'll be notified in writing and a decision date will be set.

If you disagree with Basic Health's decision on your appeal, you may request a further review of that decision verbally or by writing to: Basic Health Appeals, PO Box 42690, Olympia, WA 98504-2690. Basic Health must receive your request for review within 30 days of the date on the notice of Basic Health's appeal decision. You should explain that you are asking for a review of Basic Health's appeal decision. You must provide additional written evidence to show why you believe the appeal decision was incorrect. Also provide a summary of the decision you are contesting, why you believe the decision was incorrect, and a daytime phone number where we can reach you. In addition, the request must include all evidence that has not yet been provided and on which you will rely to explain why you believe Basic Health acted incorrectly. If your request for a review is not received within 30 days of the notice of the appeal decision, you will lose your right for a review.

The Office of Administrative Hearings will review Basic Health's appeal decisions regarding disenrollment due to nonpayment. A presiding officer appointed by the Administrator of the Health Care Authority will review Basic Health's appeal decisions on all other issues, based on the record of the appeal and any evidence you send. Be sure to include all information you want considered. The presiding officer may contact you for further information, but you generally will not be offered an opportunity to explain in person or by phone at this point in the process. The HCA will notify you in writing of the final decision.

You may choose someone, including an attorney or provider, to serve as your personal representative to act on your behalf for the appeal. Basic Health must receive written consent from you allowing this person to represent you before the person can act on your behalf. Contact Basic Health for additional information.

Table of Contents

Chapter Seven:

Health Plans and Providers

How the health plans work

All health plans offer the same basic benefits and require you to choose a primary care provider (PGP) to coordinate or provide your care. Costs, providers and facilities, covered prescription drugs, referral practices, and other things may differ by health plan.

Each health plan contracts with a number of providers and facilities (called the health plan's "provider network"). Your health plan may refer you to a specialist or facility outside the health plan's network if you or your child needs a provider or hospital not available inside your health plan's network. You must get your health plan's approval to be treated by a provider or facility not available through your health plan's provider network, except in an emergency (see page 23).

Some health plans may contract with provider groups called subnetworks; **this may restrict your choice of providers.** You may be required to see specialists or use facilities, such as hospitals, in the same subnetwork as your PGP. This means that even if a provider is in your health plan's provider network, the provider's services may not be available to you unless the provider is also in the same subnetwork as your PCP.

Call the health plan or your PCP to find out if your PCP can refer you to a provider with that health plan's provider network, or if your PCP can refer you to only a selected group of providers within the health plan.

When does my coverage begin?

Basic Health notifies you in writing when your coverage is effective. Take note of the effective date of coverage shown in that letter. Basic Health will not cover any services received before your coverage begins.

ID cards

After you enroll in Basic Health, the health plan will send ID cards to you and your enrolled family members. Some health plans may require you to choose a PCP before they issue your ID card. The card has important information, including the number to call if you are hospitalized or have questions. If you need care before you receive the card, contact the health plan at the number listed on the inside front cover of this handbook. Don't throw your enrollment confirmation letter away from Basic Health; it can serve as your temporary identification until you receive your card(s).

The right to object to certain services

Religiously sponsored health plans, health care providers, or employers have the right to not provide benefits or services for termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your health plan or employer objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another provider, with no added cost to you. Contact your health plan for more information.

If you object to having coverage for termination of pregnancy or other services, you may notify Basic Health in writing. Benefits will not be provided to you for those services; however, your premium will not change.

Primary care provider (PCP)

Each covered family member must enroll in the same health plan, but may choose a different PCP within your health plan. Except in an emergency, your PCP and staff will provide or coordinate all your health care, including referrals to specialists. Primary care providers may be family or general practitioners, internists, pediatricians, or other providers approved by your health plan. You may change your PCP during the year. Contact your health plan for details on changing providers or for a current list of providers. You may also contact a provider you're considering and to find out if the provider contracts with your health plan for Basic Health coverage. When you call a provider, be sure to mention the health plan name and Basic Health, and ask whether the provider is accepting new patients.

To be covered by your health plan, your PCP must provide all health care services, unless:

- You are referred to another provider by your PCP (in most cases, the referral must be approved by your health plan);
- You need emergency care, as described on page 23; or
- You self-refer for women's health care services (see below) or covered chiropractic care to a provider who contracts with your health plan.

If you have questions, call your health plan at the number listed on the inside, front cover of this handbook.

Women's health care services

The following women's health care services are covered by Basic Health without a PCP referral or health plan preauthorization:

- Maternity care, including prenatal, delivery, and postnatal care.
- Routine gynecological exams.
- Examination and treatment of disorders of the female reproductive system, except as specifically excluded.
- Other health problems discovered and treated during the course of a woman's health care visit, as long as the treatment is within the provider's scope of practice, and the service provided is not excluded.

You may seek these services from any women's health care provider who contracts with your health plan. Services provided by hospitals or outpatient surgical centers may require preauthorization from your health plan. Also, any follow-up services for conditions not directly related to maternity care, routine gynecological exams, or disorders of the female reproductive system may require referral and preauthorization by your health plan.

Chapter Eight:

Covered Services and Member Costs

The list of services covered under Basic Health, called the "Schedule of Benefits," is in Appendix A of this handbook. If you have questions about a particular medical condition or Basic Health benefit, contact your health plan directly at the number listed on the inside, front cover of this handbook.

Emergency care

Emergency care is covered 24-hours a day, seven days a week. (See page 45 for the definition of "emergency.") To receive emergency care benefits, it is important to follow these steps:

- **Depending on how serious the problem is, go directly to the nearest emergency room, call 911, or call your PCP.**
- **If you are admitted to a hospital or other health care facility, call (or have a friend, family member, or staff member call) your health plan or PCP within 24 hours or as soon as is reasonably possible.**
- **See (or be referred by) your PCP for follow-up care.**

Important: If you do not follow these instructions, and the provider bills for a higher amount than your health plan would pay a contracted provider, you may be required to pay the balance. If the case is determined not to be an emergency (whether or not you follow the instructions), you will be responsible for all costs.

Preexisting condition waiting period

Generally, you must wait nine months from the day your coverage begins before Basic Health will cover preexisting conditions, except for maternity care and prescription drugs. For more information, see "Limitations and exclusions" on page 37.

A preexisting condition is defined as an illness, injury, or condition for which, in the six months immediately preceding a member's effective date of enrollment in Basic Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member;
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.

If you were enrolled in health care coverage that was similar to Basic Health at any time during the three months just before you applied for or were enrolled in Basic Health, your waiting period for treatment of a preexisting condition may be waived or shortened as described in "Limitations and exclusions" beginning on page 37.

If you had to wait for Basic Health coverage because the program was full, you may receive up to three months' credit toward the waiting period. (This does not apply to the waiting period for organ transplant services.)

Organ transplants

You must be a Basic Health member for 12 months in a row before an organ transplant for a preexisting condition will be covered. See pages 30–31 for details.

Maternity care

If you or an enrolled family member becomes pregnant, call 1-800-660-9840 right away. We will mail a *Maternity Benefits Application* for you to complete and return to us.

Basic Health only covers maternity services for 30 days after pregnancy is confirmed by a medical

provider, unless you apply for the Maternity Benefits Program. This Basic Health and DSHS program provides full maternity coverage and allows you to receive care through the same health plan you choose for your Basic Health coverage. When choosing a provider for your maternity care, make sure the PCP contracts with your chosen health plan to provide Maternity Benefits Program services through Basic Health.

The Maternity Benefits Program includes the following benefits **at no cost** during pregnancy and for two months after your pregnancy ends**:**

- Prenatal care
- Maternity support services
- Dental care
- Labor and delivery
- Family planning
- Physical therapy
- Postpartum care
- Transportation to appointments
- Hearing
- Childbirth education
- Maternity case management
- Vision (eye exams and glasses)

DSHS determines eligibility for the Maternity Benefits Program based on their eligibility criteria. Information about this program is available in a separate booklet called *A Guide to Basic Health Plus and the Maternity Benefits Program*. This document will be sent to you when you enroll in the Maternity Benefits Program.

Don't stop paying your Basic Health premiums until your effective date for your enrollment in the Maternity Benefits Program. Once you are enrolled in the Maternity Benefits Program, you will not have monthly premiums or copayments, and you will continue to receive your care from the health plan you chose through Basic Health. You still must pay the monthly premiums for any family members enrolled in Basic Health.

If you do not meet citizenship requirements for the Maternity Benefits Program, you may be eligible for other DSHS programs that cover maternity care.

To receive these benefits, you must report your pregnancy to Basic Health.

If you do not apply for the Maternity Benefits Program, Basic Health will not cover the cost of any maternity services beyond 30 days after pregnancy is confirmed by a medical provider.

Maternity services will be covered by Basic Health if DSHS finds you ineligible for maternity coverage. Refer to Appendix A for information on maternity coverage for those who are ineligible for the Maternity Benefits Program.

When your pregnancy ends

You must notify Basic Health at 1-800-660-9840 as soon as your pregnancy ends. We will mail you an application to add your newborn child to your Basic Health account. To avoid a break in coverage, Basic Health must receive your completed application to add your newborn within 60 days of the child's birth.

Your Basic Health medical coverage will resume when your maternity benefits end **only if** your family's Basic Health premiums (if any) have been paid while you were enrolled in the Maternity Benefits Program. For example, if you have a spouse and/or dependent(s) enrolled in Basic Health and they are disenrolled for nonpayment while you are covered through the Maternity Benefits Program, your coverage will continue until two months after your pregnancy ends. At that point, you will lose your coverage, and you and your family (except for children enrolled in Basic Health *Plus*) will not be able to reenroll in Basic Health for 12 months. In addition, if Basic Health is full at that time, you will have to wait until space is available.

If the pregnant family member is a child enrolled in Basic Health *Plus*, she does not need to apply for the Maternity Benefits Program, although you must notify Basic Health of the pregnancy. Her maternity benefits will be covered through Basic Health *Plus*. You must notify Basic Health within 60 days of the end of her pregnancy by completing and returning the *Family Changes Form* or the *Change Form* included with your billing statement to continue the newborn's coverage. To continue coverage for her newborn, your daughter may also need to enroll on

her own account.

Member costs

Each member enrolled in Basic Health is responsible for sharing health care cost of coverage, as follows:

Copayment – A set dollar amount you pay when receiving specific services. In most cases, this will be $15, except for prescription drugs and emergency room visits.

Deductible – The amount you pay before your health plan starts to pay for covered services. You are responsible for paying the first $150 of certain covered medical costs before your health plan pays the 80% coinsurance. The $150 deductible has to be met every calendar year for each family member enrolled in Basic Health. **Your deductible does not apply towards your out-of-pocket maximum.** You may receive a bill from your health plan and/or provider.

Coinsurance – For certain services, you will be responsible for paying 20% of the cost. Your health plan pays the remaining 80%. You may receive a bill from your health plan and/or provider.

Out-of-pocket maximum – Your coinsurance costs apply toward your out-of-pocket maximum of $1,500 per person, per calendar year. When you reach your out-of-pocket maximum, you do not have to pay any further coinsurance costs for covered benefits and services received during that year. Your health plan will pay 100% of the coinsurance for all covered benefits and services. The $1,500 out-of-pocket maximum applies to each family member enrolled in Basic Health.

If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

See the "Schedule of Benefits" on page 27.

If you receive a bill for covered services

If you receive care from a provider who contracts with your health plan, the provider will usually bill the health plan directly.

You will receive a bill from a provider who has provided services to you that require a deductible and coinsurance. In most cases, your health plan will first send you an Explanation of Benefits (EOB) that will explain what service you received, what the allowed amount is for that service, what the health plan has paid, and what you have to pay. The EOB will also provide you with information about how much you have paid toward your deductible and out-of-pocket maximum. The provider or facility where you have received services will then send you a bill. You must pay the provider or facility directly. If you receive a bill but have not yet received an EOB, or if you have questions about your bill, contact the provider's office or your health plan.

In some cases, you may receive a bill from a provider or a facility that does not contract with your health plan, or from a provider who did not know about your Basic Health coverage. (When you fill out

information for your provider, be sure to list the health plan that provides your coverage—not Basic Health.) If you receive a bill for services that you think are covered by Basic Health but that have not yet been billed to your health plan, send the bill directly to your health plan at the address on your ID card. (Call your health plan at the number listed on the inside cover of this book for details.) Benefits may be denied if your health plan receives the bill more than 12 months after the date you received services.

If a third party is responsible for your injury or illness

You or your representative are required to notify your health plan if your provider charges the health plan for treatment of an injury or illness that is the result of another person's or organization's action or failure to act (for example, a fall, an auto accident, or an accident at work). The other person or organization responsible for your injury or illness is called the "third party."

You must notify your health plan promptly, in writing, of all of the following:

- The facts of the injury or illness, including the name and address of any third party you think may be responsible for the injury or illness.
- The name and address of the third party's insurance company.
- The name and address of any attorneys who will be representing the third party.
- If you plan to file a claim or lawsuit against the third party, the name and address of the person who will be representing you.
- Adequate advance notice of any trial, hearing, or possible settlement of your claim against the third party.
- Any changes in your condition or injury.
- Any additional information reasonably requested by the health plan.

If you bring a claim or legal action against a liable third party, you must seek recovery of the benefits paid by your health plan.

After you have been fully compensated for all damages you experienced as a result of the accident, your health plan has a right to reimbursement up to the amount of the benefits the health plan has paid, from any recovery you receive. You are required to pay the health plan only the amount that is left over after you have been fully compensated for all of your damages (including pain and suffering and lost wages), up to the amount of the benefits paid.

If your health plan seeks to recover benefits directly from the third party, you must cooperate fully and not do anything to impair your health plan's right of recovery. Your health plan may bring suit against the third party in your name, or may join as a party in a lawsuit or claim you have filed. Your health plan will not be required to pay for legal costs you incur, and you will not be required to pay legal costs incurred by your health plan. However, your health plan may agree to share the cost if they choose to be represented by your attorney.

Basic Health can disenroll you for intentional misconduct if you:

- Withhold from your health plan information you have about a legally responsible third party.

  or

- Refuse to help your health plan collect from that legally responsible third party.

Appendix A:

Schedule of Benefits

This "Schedule of Benefits" lists benefits for Basic Health members. Services are subject to all provisions of this "Schedule of Benefits," including limitations, exclusions, deductibles, coinsurance, and copayments. Except as specifically stated otherwise, all services and benefits under Basic Health must be provided, ordered, or authorized by the health plan or its contracting providers. Even if your provider authorizes a service, your health plan may also need to preauthorize the care.

Services in addition to those listed in this "Schedule of Benefits" may be provided at the sole discretion of the health plan through the health plan's medical management or case management program if providing the service will result in a lower total out-of-pocket cost to the health plan. Additional services may be subject to copayments, deductibles, coinsurance, and limitations.

If you have a question about the benefits listed, or are not sure if a service is covered, you should call the health plan's customer service department.

I. Medically necessary services, supplies, or interventions

Basic Health provides coverage for services, supplies, or interventions that are otherwise included as a "covered service," as set forth in Section II, that are not excluded and are medically necessary. A covered service is "medically necessary" if it is recommended by your treating provider and your health plan's medical director or provider designee, and if all of the following conditions are met:

A. The purpose of the service, supply, or intervention is to treat a medical condition.

B. It is the most appropriate level of service, supply, or intervention considering the potential benefits and harm to the patien.

C. The level of service, supply, or intervention is known to be effective in improving health outcomes.

D. The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

E. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

A health "intervention" is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation), or to maintain or restore functional ability. For purposes of this definition of "medical necessity," a health intervention means not only the intervention itself, but also the medical condition and patient indications for which it is being applied.

"Effective" means that the intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

An intervention, supply, or level of service may be medically indicated yet not be a covered benefit or meet the standards of this definition of "medical necessity." Your health plan may choose to cover interventions, supplies, or services that do not meet this definition of "medical necessity"; however, the health plan is not required to do so.

"Treating provider" means a health care provider who has personally evaluated the patient.

Appendix A: Schedule of Benefits

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

"New interventions" for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (see "existing interventions" below).

"Scientific evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

For "existing interventions," the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of "medical necessity." If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the Basic Health definition of "medical necessity" in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

A level of service, supply, or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

II. Covered services

The following services are covered when they are medically necessary. All services, supplies, and interventions are subject to the appropriate copayment, deductible, and coinsurance. (See Section III. Copayments, deductibles, and coinsurance.)

A. Hospital care

The following hospital services are covered:

1. Semi-private room and board, including meals; private room and special diets; and general nursing services.
2. Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room when eligible for Basic Health maternity benefits, anesthesia, radiology, laboratory, and other diagnostic services.
3. Normal newborn baby care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, nursery and laboratory services.
4. Drugs and medications administered while an inpatient.
5. Special duty nursing.
6. Dressings, casts, equipment, oxygen services, and radiation and inhalation therapy.

If a member is hospitalized in a non-contracting facility, the health plan has the right to require transfer of the member to a contracting health plan facility at the health plan's expense, when the member's condition is sufficiently stable to enable safe transfer.

If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Personal comfort items such as telephone, guest trays, and television are not covered.

B. Medical and surgical care

The following medical and surgical services are covered. The health plan may require that certain medical and surgical services be provided on an outpatient basis.

1. Surgical services.
2. Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.
3. Dressings, casts, and use of cast room; anesthesia and anesthesia-related oxygen services.
4. Blood, blood components, and fractions (such as plasma, platelets, packed cells, and albumin), and their administration.
5. Provider visits, including diagnosis and treatment in the hospital, outpatient facility, or office; consultations, treatment, and second opinions by the member's PCP, or by a referral provider. Normal newborn baby care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, routine newborn exams and laboratory services.

   Pharmaceuticals that are or would normally be an intrinsic part of a provider visit (inpatient or outpatient) are covered as part of the provider visit.
6. Radiation therapy; chemotherapy.
7. Inpatient and outpatient chiropractic, occupational, and physical therapy services are covered for only post-operative treatment of reconstructive joint surgery when received within one year following surgery. A combined maximum of 12 visits per calendar year are covered, but no more than six visits can be covered for chiropractic care. Diagnostic or other imaging procedures solely for determination of therapy services are not covered. Covered chiropractic services may be referred or self-referred to contracted providers.
8. Prescription drugs and medications as defined in "Pharmacy benefit."
9. Family planning services provided by the member's PCP or women's health care provider. Contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps, and long-acting progestational agents) determined most appropriate by the PCP or women's health care provider for use by the member are also covered. Over-the-counter supplies such as condoms and spermicides are covered only when part of a health plan protocol at the health plan's discretion. Elective sterilization is covered.

C. Maternity care

For pregnant Basic Health members who are determined to be eligible for medical assistance through the Department of Social and Health Services (DSHS), Basic Health only covers maternity care services for a period not to exceed 30 days following diagnosis of pregnancy.

The following maternity care services are covered for members who are determined to be ineligible for medical assistance through DSHS. These services are not subject to copays, coinsurance, or deductibles: diagnosis of pregnancy; full prenatal care after pregnancy is confirmed; delivery; postpartum care; care for complications of pregnancy; preventive care; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; medications;

Appendix A: Schedule of Benefits

anesthesia; normal newborn care following birth, such as, but not limited to, nursery services and pediatric exams; and termination of pregnancy (including voluntary termination of pregnancy).

D. Chemical dependency

Members are eligible to receive residential and outpatient chemical dependency treatment from a health plan-contracting approved treatment program to a maximum benefit of $5,000 in a 24 consecutive calendar month period up to a lifetime benefit maximum of $10,000. Covered residential and outpatient treatment includes services such as diagnostic evaluation and education, and organized individual and group counseling. The hospital inpatient deductible and coinsurance applies to intensive inpatient services. Health plans may use lower copayments, if applicable, for group sessions.

(**NOTE:** Court-ordered treatment will be covered only if determined by the health plan to meet the Basic Health definition of "Medical Necessity.")

In determining the $5,000 limit, the health plan reserves the right to take credit for chemical dependency benefits paid by any other group medical plan on behalf of a member during the immediate preceding 24 consecutive calendar month period. In determining the $10,000 lifetime limit, the health plan reserves the right to take credit for chemical dependency benefits paid under Basic Health on behalf of the member from January 1, 1988.

E. Mental health services

Mental health services are covered as follows:

Inpatient care in a participating hospital or other appropriate licensed facility approved by the health plan is covered in full (subject to deductible and coinsurance) up to 10 days per calendar year.

Outpatient care, including individual and family counseling, is covered in full up to 12 visits per calendar year after the copayment per visit for individual sessions. Health plans may use lower copayments, if applicable, for group sessions. Visits for the sole purpose of medication management are exempted from the 12-visit limit, and are instead covered as other provider visits.

(**NOTE:** Court-ordered treatment will be covered only if determined by the health plan to meet the Basic Health definition of "Medical Necessity.")

F. Organ transplants

Services related to organ transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care, are covered. Deductible, coinsurance, and copayments apply by specific service. (See Section III. Copayments, deductible, and coinsurance.) This benefit includes covered donor expenses.

Heart, heart-lung, liver, bone marrow including peripheral stem cell rescue, cornea, kidney, and kidney-pancreas human organ transplants are covered when the Basic Health definition of "Medical Necessity" is met.

Organ transplant recipient: All services and supplies related to the organ transplant for the member receiving the organ, including transportation to and from a health plan-designated facility (beyond that distance the member would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the member has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

Organ transplant donor: The donor's initial medical expenses relating to harvesting of the organ(s), as well as the costs of treating complications directly resulting from the procedure(s), are covered, **provided the organ recipient is a member of the health plan**, and provided the donor is not eligible for such coverage under any other health care plan or government-funded program.

Waiting period: Members must be enrolled in Basic Health for 12 consecutive months before they are eligible to receive benefits for covered transplant procedures. The waiting period applies to the transplant procedure including any immediate pre- and post-operative hospital care related to the transplantation, but does not apply to ongoing follow-up care including prescription drugs.

If a member satisfies the 12 consecutive months' waiting period (no breaks in coverage for 12 consecutive months) and subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

The waiting period will not apply:

1. If the transplant is required due to a condition which is not a preexisting condition;
2. For children enrolled in and continuously covered by Basic Health from birth; or
3. For children placed in the home for purposes of adoption within 60 days of birth and continuously covered by Basic Health from the date of placement, provided one or both of the adoptive parents or family members are enrolled in Basic Health at the time of placement in the home.

If a newborn child enrolled from birth, or a newborn-adoptive child enrolled within 60 days of placement, subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

Limitations: Transplants that are not preauthorized or are not performed in a health plan-designated medical facility are not covered. No benefits are provided for charges related to locating a donor, such as tissue typing of family members.

All services are subject to the appropriate copayment, deductible, and coinsurance.

G. Emergency care

An emergency is a sudden or severe health problem that needs treatment right away; there is not time to talk to your doctor.

"Emergency" is defined as:

"The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy."

The health plan reserves the right to determine whether the symptoms indicate a medical emergency. Acute detoxification is covered for up to 72 hours.

1. In-service-area emergency. In the event a member experiences a medical emergency, care should be obtained from a health plan-contracting provider. If, as a result of such emergency, the member is not able to use a health plan-contracting provider, the member may obtain emergency services from non-contracting health care providers. Follow-up care must be provided or approved by the health plan in advance. In the case of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If you fail to meet the notification requirements, coverage will be limited to what would have been payable by the health plan to a health plan-contracting provider had notification requirements been met. The member will be financially responsible for any remaining balance.

Appendix A: Schedule of Benefits

2. **Out-of-service-area emergency.** The health plan shall bear the cost of out-of-service-area emergency care for covered conditions. In the event of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If you fail to meet the notification requirements, coverage will be limited to what would have been payable by the health plan to a health plan-contracting provider, had notification requirements been met. The member will be financially responsible for any remaining balance.

   The health plan may, at its discretion, appoint a consultant when out-of-service-area care is necessary, who will have authority to monitor the care rendered and make recommendations regarding the treatment plan. The health plan may otherwise secure information which it deems necessary concerning the medical care and hospitalization provided to the member for which payment is requested.

3. **Transfer and follow-up care.** If a member is hospitalized in a non-contracting facility, the health plan reserves the right to require transfer of the member to a health plan-contracting facility, when the member's condition is sufficiently stable to enable safe transfer. If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

   Follow-up care that is a direct result of the emergency must be obtained from a health plan-contracting provider, unless a health plan-contracting provider has authorized you to continue to receive follow-up care from another provider in advance.

4. **Prescription drugs.** Prescription drugs purchased from a non-contracting facility or pharmacy are covered subject to the applicable pharmacy copayment when dispensed or prescribed in connection with covered emergency treatment.

5. **Emergency ambulance transportation.** Medically necessary ambulance transportation is covered in an emergency, or to transfer a member when preauthorized by the health plan.

H. Skilled nursing and home health care benefits

As an alternative to hospitalization in an acute care facility, the health plan, at its discretion, may authorize benefits for the services of a skilled nursing facility or home health care agency.

I. Hospice services

Hospice services are covered.

J. Plastic and reconstructive services

Plastic and reconstructive services (including implants) will be provided only under the following conditions:

1. To correct a physical functional disorder resulting from a congenital disease or anomaly;
2. To correct a physical functional disorder following an injury or incidental to covered surgery; and
3. For a member who is receiving benefits in connection with a mastectomy:
   a. Reconstruction of the breast on which the mastectomy was performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. Prostheses (internal and external) and physical complications of all stages of mastectomy.

   Treatment of lymphedemas is covered; however, durable medical equipment and supplies used to treat lymphedemas may be covered only in limited circumstances. Please contact your health plan for specific coverage information.

K. Preventive care

Preventive care services are covered, and will be provided as described in the schedule provided to you by the health plan.

L. Pharmacy benefit

The health plan may limit the drugs covered through use of a list called a "formulary." Each health plan's formulary includes all major therapeutic classes of drugs. Drugs not in the formulary will be covered if the health plan's medical staff determines that no formulary drugs are an acceptable medication for the patient.

In addition to the formulary described above, each health plan will have the following five therapeutic classes of drugs covered under the first tier, subject to a $10 copay; inhaled short-acting beta-agonists, inhaled steroids, inhaled anticholinergic bronchodilators, beta-blockers for severe heart failure, and anti-platelet clotting inhibitors for patients after intra-arterial stent placement. The members' copay will be $10 regardless (or independent) of the drug's generic or name brand status.

If you have a question about the pharmacy benefit, are not sure if a drug is covered, or believe a nonformulary drug should be covered, call the health plan's customer service department.

Basic Health covers drugs of all types, including prescribed creams, ointments, and injections, at the copayment levels shown. Prescriptions are not subject to the deductible and will not apply towards the annual out-of-pocket maximum.

When the actual cost of the drug is less than the $10 copay, members are only responsible for the cost of the drug.

Prescriptions are limited to a 30-day supply.

Drugs for cosmetic purposes are excluded unless preauthorized.

(See table below for more pharmacy copayment information.)

Tier 1 - Copayment: $10	Tier 2 - Copayment: 50%
Covered drugs:	**Covered drugs:**

Appendix A: Schedule of Benefits

Generic drugs contained in the health plan's formulary.	Brand-name drugs in the health plan's formulary.
All oral contraceptives in the health plan's formulary.	
Diabetic supplies, including syringes and needles, diabetic test strips, lancets, and insulin.	
Inhaled short-acting beta-agonists.	
Inhaled steroids.	
Inhaled anticholinergic bronchodilators.	
Beta-blockers for severe heart failure.	
Anti-platelet clotting inhibitors for patients after intra-arterial stent placement.	

M. Oxygen

Oxygen will be covered when prescribed by a contracted provider and when authorized by a contracted health plan. The health plan, at its discretion, may require an assessment to determine if oxygen therapy is still an appropriate treatment before authorizing continued oxygen treatment.

Coverage for oxygen will include the rental of oxygen equipment, oxygen contents, and supplies for the delivery of oxygen.

Portable oxygen is not covered when provided only as a backup to a stationary oxygen system.

Oxygen is not subject to a copay or coinsurance, and is excluded from the Durable Medical Equipment exclusion.

Appendix A: Schedule of Benefits

Benefits and services NOT subject to the deductible and coinsurance

The $150 annual deductible and $1,500 out-of-pocket maximum per person, per calendar year DO NOT apply to the following benefits and services.

Benefit/service	Member's payment responsibility	Notes
Preventive care	No copay	Includes routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit.
Office visits	$15 copay	Copay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits. Copays do not apply to preventive care, laboratory, radiology services, radiation, and chemotherapy. Some services will be subject to coinsurance.
Pharmacy*		30-day supply
Tier 1	$10 copay (or cost of drug, whichever is less.)	Tier 1 includes generic drugs in health plan's preferred drug list (formulary).
Tier 2	50% of the drug cost	Tier 2 includes brand-name drugs in health plan's preferred drug list (formulary).
Emergency room visit	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Out-of-area emergency services	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Urgent care	$15 copay	Copay is for office visit only, when provided in an urgent care setting. Deductible and coinsurance apply to all other services.
Skilled nursing, hospice, and home care	No copay	Covered as an alternative to hospital care at the health plan's discretion.
Maternity care	No copay	If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services.
Oxygen	No copay	Includes equipment and supplies. Not subject to copays, coinsurance, or deductible. Requires health plan authorization.

* Different health plans have different lists of approved prescription drugs (formularies). To find out if a specific drug is covered in your pharmacy benefit, contact your health plan.

Appendix A: Schedule of Benefits

Benefits and services subject to the deductible and coinsurance

Before your health plan pays the 80% coinsurance for the following benefits, you must pay your $150 annual deductible. Once you meet your deductible, all coinsurance payments will be applied toward your $1,500 annual out-of-pocket maximum. Deductibles and out-of-pocket maximums are per person, per year. Once the $1,500 per person out-of-pocket maximum has been reached, the health plan pays for all covered benefits and services with a coinsurance. Members are only responsible for copays for benefits and services as shown on page 35. If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

Benefit/service	Member's payment responsibility	Notes
Hospital, inpatient	20% coinsurance; deductible applies. $300 maximum facility charge per admittance.	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. No charges for maternity care or when readmitted for the same condition within 90 days. If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services. See "Other professional services" below.
Hospital, outpatient	20% coinsurance; deductible applies.	
Other professional services	20% coinsurance; deductible applies.	Includes services received as an inpatient including, but not limited to, surgeries, anesthesia, chemotherapy, radiation, and other types of inpatient and outpatient services.
Mental health	20% coinsurance; deductible applies to inpatient. $300 maximum facility charge per admittance.	Limited to 10 inpatient days a year and 12 outpatient visits a year. Office visits to manage medication do not count towards 12-visit maximum. Outpatient visits are subject to $15 copay (see "Office visits").
Laboratory	No copay or coinsurance for outpatient services. 20% coinsurance for inpatient hospital-based laboratory services.	Deductible applies to services with coinsurance.
Radiology	20% coinsurance, except for outpatient x-ray and ultrasound.	Deductible applies to services with coinsurance.
Ambulance services	20% coinsurance; deductible applies.	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
Chiropractic/physical therapy/occupational therapy	20% coinsurance; deductible applies.	Up to a combined maximum of 12 visits per year. (Of those, no more than six can be for chiropractic care.) Visits qualify only when used as post-operative treatment following reconstructive joint surgery. Visits must be within one year of surgery.
Chemical dependency	20% coinsurance and deductible apply to inpatient. $300 maximum facility charge per admittance.	Limited to $5,000 every 24-month period; $10,000 lifetime maximum. Outpatient visits are subject to $15 copay (see "Office visits").
Organ transplants	Deductible, coinsurance, and copays apply by specific service.	12-month waiting period, except for newborns or for a condition that is not preexisting.

III. Copayments, deductibles, and coinsurance

Each member is responsible for paying a $150 deductible per calendar year before some benefits and services will be covered (see page 36). For those services with a coinsurance, once the deductible has been met, the health plan pays 80% of allowed charges and the member pays 20% of allowed charges. All coinsurance payments will be applied towards the annual out-of-pocket maximum. For each member, the out-of-pocket maximum is $1,500 per calendar year. No amount paid toward the $150 deductible will be applied towards the out-of-pocket maximum. Once the out-of-pocket maximum has been reached, the health plan pays 100% towards all covered benefits and services with a coinsurance.

The member is responsible for paying any required copayment, deductible, and/or coinsurance directly to the provider of a covered service unless instructed by the health plan to make payment to another party. Copayments, deductibles, and coinsurance payments must be paid in full, or service may be denied or rescheduled.

Only the cost sharing specifically listed in the following tables will be charged to members for covered services. Members may be charged a missed appointment fee by a provider if they continually fail to keep appointments, or if they repeatedly fail to give timely notice when it is necessary to cancel appointments.

IV. Limitations and exclusions

A. Limitations

1. **Preexisting condition waiting period**

a. **A preexisting condition is defined as:** "Any illness, injury, or condition for which, in the six months immediately preceding a member's effective date of enrollment in Basic Health:

(1) Treatment, consultation, or a diagnostic test was recommended for or received by the member; or

(2) Medication was prescribed or recommended for the member; or

(3) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment."

b. **Waiting period**

Basic Health will not provide benefits for services or supplies rendered for any preexisting condition during the first nine consecutive months following the member's effective date of coverage. A member will not be required to begin a new nine consecutive-month waiting period if:

(1) Coverage is suspended for not longer than one month during the waiting period, and

(2) The member does not have more than two (2) one-month breaks in coverage during the waiting period.

Coverage for preexisting conditions will not be available until the member is actually covered by Basic Health for a total of nine months.

If the member is confined in a health care facility for treatment of a preexisting condition at the time the member's nine-month waiting period ends, benefits for that condition will be provided only for covered services rendered after the end of the waiting period.

c. **Exceptions to waiting period**

(1) The following services are not subject to the waiting period:

- Maternity care.

- Prescription drugs as defined in “Pharmacy Benefit.”
- Oxygen.

(2) Children born on or after the parent’s or sibling’s effective date of coverage who are enrolled within 60 days of the date of birth, and adopted children who are placed for adoption after the adoptive parent’s or sibling’s effective date of coverage who are enrolled within 60 days of placement with the adoptive parents, are not subject to the nine-month waiting period for preexisting conditions.

d. **Credit toward the waiting period**

Credit toward the waiting period will be given:

(1) If Basic Health delays your enrollment (up to a maximum of three months) due to budgetary constraints, and you have been determined eligible.

(2) For any continuous period of time during which a member was covered under similar health coverage if:

- That coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage under Basic Health, or within the three-month period immediately preceding enrollment in Basic Health; and
- The coverage terminated not later than the first of the month following the effective date of coverage in Basic Health.

If similar coverage was in effect both prior to the date of application or reservation and the date of enrollment, credit will be given for the longer period of continuous coverage.

“Similar coverage” includes Basic Health, all DSHS programs which have the Medicaid scope of benefits, the DSHS program for the medically indigent, Indian Health Services, most coverages offered by health carriers, and most self-insured plans.

2. **Major Disaster or Epidemic**

If the health plan is prevented from performing any of its obligations hereunder in whole or part as a result of a major epidemic, act of God, war, civil disturbance, court order, labor dispute, or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing and contracting providers and personnel. Upon the occurrence of any such event, if the health plan is unable to fulfill its obligations either directly or through contracting providers, it shall arrange for the provision of alternate and comparable performance.

3. **Coordination of Benefits**

The benefits available under Basic Health shall be secondary to the benefits payable under the terms of any health plan, which provides benefits for a Basic Health member except where in conflict with Washington State or federal law.

B. Exclusions

The services listed below are not covered:

1. Services that do not meet the Basic Health definition of “Medical Necessity” for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.
2. Services not provided, ordered, or authorized by the member’s health plan or its contracting providers, except in an emergency.
3. Services received before the member’s effective date of coverage.

4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
5. Hospital charges for personal comfort items; or a private room unless authorized by the member's health plan; or services such as telephones, televisions, and guest trays.
6. Emergency facility services for nonemergency conditions.
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
8. Sleep studies, except the initial sleep study authorized by the contracted health plan. Only one sleep study per member per calendar year is covered.
9. Transportation except as specified under "Organ transplants" and "Emergency care."
10. Immunizations, except as covered under preventive care. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
11. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the "Plastic and reconstructive services" benefit.
12. Sex change operations.
13. Investigation of or treatment for infertility or impotence.
14. Reversal of sterilization.
15. Artificial insemination.
16. In-vitro fertilization.
17. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under "Preventive care."
18. Hearing aids.
19. Orthopedic shoes and routine foot care.
20. Speech and recreation therapy.
21. Medical equipment and supplies not specifically listed in this "Schedule of Benefits" except while the member is hospitalized (including, but not limited to, hospital beds, wheelchairs, and walk aids).
22. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.
23. Medical services, drugs, supplies, or surgery directly related to the treatment of obesity, including morbid obesity (such as, but not limited to, gastroplasty, gastric stapling, or intestinal bypass).
24. Weight loss programs.
25. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits."

Appendix A: Schedule of Benefits

26. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with Washington State or federal law or regulation; or the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.
27. Conditions resulting from acts of war (declared or not).
28. Direct complications arising from excluded services.
29. Replacement of lost or stolen medications.
30. Evaluation and treatment of learning disabilities, including dyslexia.
31. Any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracting provider, and authorized in advance by the health plan.

C. Changes to covered services and premiums

Basic Health may from time to time revise this "Schedule of Benefits." In designing and revising this "Schedule of Benefits," Basic Health will consider the effects of particular benefits, copayments, deductibles, coinsurance, out-of-pocket maximums, limitations, and exclusions on access to medically necessary basic health care services, as well as the cost to members and to the state. Generally accepted practices of the health insurance and managed health care industries will also be taken into account.

Basic Health will provide you with written notice of any planned revisions to your Basic Health premiums or the benefit plan at least 30 days prior to the effective date of the change. This notice may be included with your premium statement, open enrollment materials or other mailing, or may be a separate notice. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first-class postage paid, directed to you at the mailing address you provided to Basic Health.

Appendix B:

Health Coverage Tax Credit (HCTC) — Basic Health

Program overview

The Health Coverage Tax Credit (HCTC) is a federal income tax credit that pays 65 percent of the health plan premium for eligible people enrolled in "qualified health plans." In Washington State, Basic Health is a qualified health plan. However, in Basic Health materials, "health plan" refers to the company that provides your health care coverage (Columbia United Providers, Community Health Plan of Washington, Group Health Cooperative, Kaiser Foundation Health Plan of the Northwest, or Molina Healthcare of Washington). For information on other qualified plans in Washington, call the HCTC Customer Contact Center or visit the Internal Revenue Service (IRS) Web site (see "HCTC contact information" on page i).

Eligibility

To be eligible for the HCTC, you do not need to be eligible for Basic Health. You may be eligible if you are a displaced worker, enroll in a qualified health plan (such as Basic Health), and:

- Receive Trade Readjustment Allowance (TRA) under the Trade Adjustment Assistance (TAA) Act or Alternative Trade Adjustment Assistance (ATAA).
- Would be eligible to receive TRA but have not yet used all of your unemployment insurance benefits, or
- Are age 55 or over, receive pension benefits from the Pension Benefits Guaranty Corporation, and are not entitled to Medicare Part A.

To find out if you are eligible or to register for the tax credit, contact the HCTC Customer Contact Center or visit the HCTC Web site (see "HCTC contact information" on page i).

Premiums

If you are eligible for the HCTC, you may claim it as an advance credit to help pay your premiums, or you may claim it when you file your federal income tax return. Either way, the tax credit will pay 65 percent of your HCTC-Basic Health premium. You pay the other 35 percent.

HCTC-Basic Health members are billed the full cost of their coverage, plus an administrative fee. Premiums are adjusted according to age, choice of health plan, and the county where services are provided. If you are claiming the HCTC advance tax credit for your Basic Health enrollment, you will receive a monthly invoice from the IRS. You will pay the IRS your share of the premium each month, and the IRS will pay Basic Health for your coverage. **If you do not pay your share of the premium to the IRS on time, the IRS will not pay your premium and you will lose coverage for one month.** You may be able to continue your coverage by paying the full premium directly to Basic Health for up to two months or applying for subsidized Basic Health coverage. Basic Health cannot accept your direct payment prior to enrolling in HCTC-Basic Health.

Making changes

HCTC-Basic Health members must report family changes, address changes, and changes in their HCTC eligibility to Basic Health. If you ask to have members added or removed from your account, Basic Health will send you a premium change notice; you must forward that notice to the IRS. To tell us about a change to your account, call 1-800-660-9840, fax a letter to 360-923-2910, or send a letter to HCTC-Basic Health at PO Box 42703, Olympia, WA 98504-2703. Be sure to include your HCTC-Basic Health ID number on all correspondence.

Appendix B: Health Coverage Tax Credit (HCTC)-Basic Health

If you move and your current health plan is not available in your new area, you will be required to choose a health plan that serves your new area. Otherwise, you may change health plans only during open enrollment, or when you move and your current health plan will cost more or a health plan is available that was not previously available. An exception may be made in some cases if you can prove that you need to continue a current course of treatment with a specific provider. When you change health plans, remember that each health plan contracts with different providers and has its own list of covered prescription drugs. Call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription medications, you also should contact the health plan to see if your medications will be covered.

If you live outside Washington State, you will be asked to choose a county within Washington where you will receive your medical services. You must choose a health plan within that county. If you move, please call Basic Health at 1-800-660-9840 to discuss whether you will remain with the same health plan and in the same county of service. If you are covering a child who is away from home attending college, that child must also get HCTC-Basic Health services through the health plan and in the Washington State county you have chosen. Only emergency services are covered outside of the health plan's service area.

If you change health plans, any services you had approved under your previous health plan will need to be reviewed and approved again by your new health plan. Also, your deductible and out-of-pocket maximum will start over with the new health plan. Check with your health plan for further information.

Basic Health is committed to making sure your health plan is available throughout the year. However, if your health plan becomes unavailable during the year, you will be able to choose among the other plans in your county. If only one health plan remains, you will be assigned to that plan.

If you want to add or remove a family member to your HCTC-Basic Health account, please call Basic Health. We will send you an updated monthly premium notice that you can forward to the HCTC program. Please note that we will need a signature from anyone age 18 or over who is added to your account. It is important that you contact us before you want a change to be effective. Because premiums for your HCTC-Basic Health coverage are paid for by the IRS, and HCTC-Basic Health cannot cover a family member until the premium is received from the IRS, you should allow plenty of time.

Suspension, disenrollment, and reenrollment

If Basic Health does not receive your premium from the IRS by the first of the month, you will not have coverage for that month. (Any payments you have made toward your deductible and out-of-pocket maximums will remain intact.) In this case, you may pay the full cost of your own coverage. However, because nonpayment from the IRS can mean you are no longer eligible for the program, you will only be able to pay your own premium for two months before you will be disenrolled from HCTC-Basic Health. If you have not already been notified by the IRS of the reason for not paying your HCTC-Basic Health premium, call the HCTC Customer Care Center at 1-866-628-4282.

You may also be disenrolled from HCTC-Basic Health if you:

- Take part in any form of abuse, intentional misconduct, or fraud against Basic Health or your health plan or its providers, or knowingly give information to Basic Health that is false or misleading;
- Intentionally withhold information required by HCTC or Basic Health;
- Pose a risk to the safety or property of Basic Health or your health plan, or their staff, providers, patients, or visitors;
- Refuse to follow procedures or treatment recommended by your provider and determined by your health plan's medical director to be essential to your health or the health of your child, and you have been told by your health plan that no other treatment is available;
- Repeatedly do not pay copayments, coinsurance, or other payments on time; or

- Withhold from your health plan information you have about a legally responsible third party, or refuse to help your health plan collect from that legally responsible third party.

If you want to disenroll from HCTC-Basic Health, contact Basic Health. However, if you plan to change your HCTC coverage to another qualified health plan, you should contact the HCTC Customer Contact Center first.

Rights, responsibilities, and privacy

All information in Chapter Five (Rights, Responsibilities, and Privacy) applies to HCTC-Basic Health members, except as noted below.

- As an HCTC-Basic Health member, you have the right to file an appeal with your health plan or with the federal HCTC program if you are not satisfied with their decision. You will not have an appeals process with Basic Health unless you have paid 100 percent of your premium for the time in question.
- As an HCTC-Basic Health member, you do not have to provide Basic Health with information about your income.
- As an HCTC-Basic Health member, you are not required to pay your premium directly to Basic Health, unless notified. The IRS will send your monthly premium to Basic Health. You will pay 35 percent of that amount directly to the HCTC program.

HCTC-Basic Health grievances and appeals

If you have a grievance or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find the toll-free numbers on the inside front cover of this book. For more information on grievances with your health plan, read “Grievances against your health plan” on page 19.

If you disagree with a decision that you are not eligible for the HCTC program, contact the HCTC Customer Contact Center.

If you have paid 100 percent of your Basic Health premium, and have a complaint about something Basic Health did during the time you paid your own premium, go to page 20.

Whenever you call any of these organizations, be sure you note the date of the call, the name of the person you talked to, and whether that person was with the HCTC program, your health plan, or Basic Health.

Health plans and providers

All of Chapter Seven applies to HCTC-Basic Health members.

Covered services

Benefits for HCTC-Basic Health members are the same as for all Basic Health members (see page 27), with the following exceptions:

- The nine-month waiting period for treatment of preexisting conditions will be waived if you had at least three months of creditable coverage before enrolling in Basic Health, with no more than a 62-day break in coverage when you applied for HCTC-Basic Health. If you had a break in coverage of 63 days or more at the time of your application to Basic Health, or if you did not have three

Appendix B: Health Coverage Tax Credit (HCTC)-Basic Health

months of creditable coverage, the nine-month waiting period will apply the same as for all other Basic Health members. For HCTC purposes, creditable coverage includes a group health plan (including COBRA, Temporary Continuation of Coverage [TCC], or state continuation coverage) or health insurance (including individual coverage, college or school insurance, or short-term limited duration insurance).

- HCTC-Basic Health covers maternity benefits without requiring that you apply for the DSHS Maternity Benefits Program. Covered maternity services are listed on pages 29 and 30.

Member costs

Each member enrolled in HCTC-Basic Health will share the cost for his or her health care coverage. See the sections “Member costs,” “If you receive a bill for covered services,” and “If a third party is responsible for your injury or illness” on pages 25-26 for details.

Continuation rights

If you leave Basic Health and enroll in coverage through an employer or privately purchased health plan in Washington State, the time you were enrolled through the HCTC program may be considered creditable coverage for purposes of shortening or waiving the waiting period for treatment of a preexisting condition. However, unlike COBRA coverage, if you apply for private insurance coverage in Washington State, your HCTC-Basic Health enrollment will not exempt you from the health plan’s use of the standard health questionnaire for screening applicants.

Schedule of benefits

The Schedule of Benefits in Appendix A applies to HCTC-Basic Health members, except as noted in “Covered Services” on page 43.

HCTC contact information
Customer Contact Center (toll-free):
1-866-628-4282 (TTY: 1-866-626-4282)

Web site: **www.irs.gov** (IRS keyword: HCTC)

Appendix C:

Definitions of Terms

Appeal

A formal request for the health plan or Basic Health to review its decision.

Basic Health

A health care coverage program administered by the Health Care Authority (HCA).

Basic Health *Plus*

A program jointly administered by the Department of Social and Health Services (DSHS) and Basic Health for children under age 19 from low-income families. It provides expanded benefits (such as dental and vision care). Eligibility for Basic Health *Plus* is determined by DSHS.

Certificate of coverage

A description of your health care coverage and benefits. This handbook serves as your certificate of coverage.

Coinsurance

A percentage you pay for certain services after you have paid your annual deductible.

Copayment or copay

A set dollar amount you pay when you receive specific services. Copays are not subject to a deductible and do not apply toward your deductible, coinsurance, or out-of-pocket maximum.

Department of Social and Health Services (DSHS)

The state agency that administers Medicaid and (along with the Health Care Authority) jointly administers Basic Health *Plus* and the Maternity Benefits Program.

Deductible

The amount you pay before your health plan starts to pay for services with coinsurance. The deductible will not apply toward your out-of-pocket maximum.

Dependents

Same as family members.

Disenrollment

Losing Basic Health coverage without the option of reenrolling the following month. This can be due to nonpayment by the due date given in the suspension notice; more than two suspensions in a 12-month period; loss of eligibility; or for failure to abide by any of your responsibilities as a Basic Health member.

Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

Appendix C: Definitions of Terms

Enrollment

The process of submitting completed application forms, being determined eligible, and being accepted into Basic Health, Basic Health *Plus*, or the Maternity Benefits Program.

Explanation of benefits (EOB)

Each health plan is required to send an EOB each time you receive medical services. The EOB is a detailed statement that explains the service(s) you received, the allowed amount for each service, the amount the health plan pays, and the amount you are responsible to pay. The EOB will also track the amount you have paid towards each covered family member's annual deductible and out-of-pocket maximum.

Family members

Family members who should be listed as dependents on your account (whether or not they are enrolling for coverage) include:

- Your spouse living in the same household and not legally separated from you.
- Your unmarried child, including stepchild, legally adopted child, and a child placed in your home for purposes of adoption or under your legal guardianship who is:
  - Under age 19; or
  - Under age 23 and a full-time student at an accredited school. You are required to send proof from the school each year when your dependent is age 19 through 22, to show that he or she is a full-time student. If your dependent over age 18 is no longer a full-time student, you must notify Basic Health within 30 days of this change.
- Your unmarried child under age 19, enrolling for coverage and in your custody under an informal guardianship agreement that is signed by the child's parent(s) and authorizes you to obtain medical care for the child. To request coverage for a child living with you under such an agreement, you must provide a copy of the guardianship agreement and proof that you are providing at least 50 percent of the child's support. If a child is placed in your home under a foster care agreement, DSHS is generally the guardian, so you will not be allowed to list that child.
- Your unmarried child, stepchild, legally adopted child, or other legal dependent of any age who is incapable of self-support due to disability. You must provide proof of disability. If the dependent with a disability is not your birth or adopted child, you must also provide proof of legal guardianship.

If you are a Health Coverage Tax Credit eligible enrollee, list all dependents that are eligible for coverage through that program.

Family size

The number of family members eligible to be listed on a Basic Health account. Family size is considered when determining eligibility and premiums.

Formulary

A list of approved prescription drugs developed by each health plan.

Grievance

A written or an oral complaint submitted by or on behalf of a covered person to their health plan or Basic Health.

Health Care Authority (HCA)

The state agency responsible for Basic Health administration and coordinating with DSHS to provide Basic Health *Plus* and the Maternity Benefits Program.

Health Coverage Tax Credit eligible member (or HCTC-Basic Health member)

An individual or qualified dependent enrolled in Basic Health and determined by the federal Department of Treasury to be eligible for the tax credit created by the Trade Act of 2002 (PL. 107-210).

Health plan

An organization that offers health care coverage

and contracts with the HCA to provide your care. You choose your health plan when you join Basic Health.

Income

Your and your family's gross income (before deductions).

Income band

Income levels A through H, as listed on page 6. These are updated in July of each year. (Look for a notice of the changes in May.) These levels, based on gross monthly income and family size, help determine monthly premiums.

Income guidelines

The guidelines used to determine your eligibility for Basic Health and Basic Health *Plus*, and your monthly premium payments for Basic Health coverage. These income guidelines change annually. See page 5 for more information.

Inpatient

A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

Maternity Benefits Program

The program coordinated with DSHS for eligible pregnant women. This program includes all Medicaid benefits, including maternity benefits, maternity support services, and maternity case management. Eligibility for the program is determined by DSHS.

Medicare

The federal health benefit program for people who are age 65 and over, and for some people with disabilities. (If you are eligible for free or purchased Medicare coverage, you are not eligible for Basic Health.)

Member

A person enrolled in and receiving health care coverage through Basic Health, Basic Health *Plus*, or the Maternity Benefits Program.

Non-compliance

Failure to provide documentation or information requested by Basic Health by the due date.

Out-of-pocket maximum

The most coinsurance you will have to pay each year for each covered family member. Only your coinsurance costs apply toward your out-of-pocket maximum. After you have paid the out-of-pocket maximum, you do not have to pay coinsurance costs for the remainder of the calendar year.

Outpatient

A nonhospitalized patient receiving covered services away from a hospital, such as in a physician's office or the patient's own home, or in a hospital outpatient or hospital emergency department or surgical center.

Personal eligibility statement (PES)

The notice Basic Health sends you showing the current status of your account. You will receive a PES when there is a change to your account. This statement may include a bill for additional premiums you must pay as a result of a change.

Preexisting condition

An illness, injury, or condition for which, in the six months immediately preceding a member's effective date of enrollment in Basic Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member;
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.

Premium

Your monthly payment for Basic Health coverage.

Appendix C: Definitions of Terms

Primary care provider (PCP)

Your personal health care provider. Your primary care provider can be a family or general practitioner, internist, pediatrician, or other provider approved by your health plan. To receive benefits, your primary care provider must provide or coordinate your care. If you need to see a specialist, your primary care provider will refer you.

Provider

A health care professional (such as a doctor, nurse, internist, etc.) or facility (such as a hospital, clinic, etc.).

Recertification

Periodic review of your family's income and eligibility. During recertification, you must submit current income and residency documentation to verify your eligibility and/or level of premium subsidy.

Recoupment

When Basic Health bills you for the amount you owe the state because you did not accurately report your income.

Service area

The geographic area served by a health plan that provides coverage for Basic Health members.

Specialist

A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Student

A person enrolled full time in an accredited secondary school, college, university, technical college, or school of nursing, as determined by the school registrar.

Subscriber

The person on a Basic Health account who is responsible for payment of premiums and other cost sharing, and to whom Basic Health sends all notices and communications. The subscriber may be a Basic Health member or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage.

Subsidy

The portion of the premium that Washington State pays for enrolled Basic Health members.

Suspension of coverage

The process of losing health coverage for one month after a monthly premium has not been paid or has been paid in full after the due date. If your coverage is suspended more than two times in a 12-month period, you will be disenrolled and cannot reenroll for at least 12 months.

Tier

A category of drugs related to the pharmacy benefit. Your cost for prescriptions depends on the category (or tier) the prescription falls within. Tier 1 is the category of prescriptions that costs you the least.

Washington resident

A person physically residing and maintaining a residence in the state of Washington. You must be a Washington resident to be eligible for Basic Health. To be considered a Washington resident, members who are temporarily out of Washington for any reason:

- May be required to prove their intent to return to Washington State; and
- May not be out of Washington State for more than three consecutive calendar months.

Dependent children who are attending school out of state may be considered residents if they are out of state during the school year, as long as their primary residence is in Washington State and they return to Washington State during breaks. Dependent children attending school out of state may be required to provide proof that they pay out-of-state tuition, vote in Washington, and file income taxes using a Washington address.

Your residence may be a home you own or are purchasing or renting, a shelter or other physical

Index

Index

Keep
Hot Policy Pages
and other updates here

Hot Policy Pages are important updates to this *Member Handbook* and are one way Basic Health provides you with official notice of program changes; you will receive them periodically, usually with your monthly billing statement. Keep these updates handy, along with this *Member Handbook* and other information you receive from Basic Health, so that you have the information you need to make the most of your Basic Health coverage.

Table of Contents

Washington State Health Care Authority
Basic Health
PO Box 42683
Olympia, WA 98504
HCA 22-405 (1/08)

Change Service Requested

2008 Member Handbook

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WASHINGTON STATE
DEPT OF PRINTING

Exhibit 3: Basic Health — 2008 Performance Standards

2008 Performance Standards

	Performance Standards	Standard Definition
	Claims Quality	
Standard 1	**Financial Payment (Dollar) Accuracy:** **98.5%**	The percentage of claim dollars paid accurately. Calculated as the total paid dollars minus the absolute value of over- and underpayments, divided by total paid dollars.
Standard 2	**Payment Incidence Accuracy:** **97.0%**	The percentage of claims processed without payment error. Calculated as the total number of claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of claims. Error is defined as any error, regardless of cause (e.g., coding, procedural, system) that results in an overpayment or an underpayment. Each type of error is counted as one full error but no more than one error can be assigned to one claim.
Standard 3	**Claims Rework:** **Plan will guarantee the number of claims requiring rework will be 6.0% or less.**	Rework is defined as any claim that requires an adjustment to the initial adjudication determination due to an error on the part of the carrier (e.g., incorrect plan provision) at the time the claim was processed.
	Claims Turnaround Time	
Standard 4	**Percent within 30 calendar days for clean claims and 60 calendar days for all claims:** **Plan will pay 95% of clean claims within 30 calendar days and 98% of all claims (paid or denied) within 60 calendar days.**	TAT is measured from the date a claim is received by the administrator (either via paper or electronic data interchange) to the date it is processed for payment or denied.

For Standards 1-4: If CONTRACTOR does not currently have a process in place to measure Basic Health independently from other lines of business, it will need to develop and implement such process by July 1, 2008. It is the HCA's intent to measure each CONTRACTOR's full book of business against the Basic Health line of business for the 2009 contract year.

Exhibit 3: Basic Health — 2008 Performance Standards

	Performance Standards	Standard Definition
	Customer Service	
Standard 5	**Call Abandonment Rate:** **≤ 3%**	Percentage of calls that reach the CONTRACTOR and are placed in member services queue, but are not answered because caller hangs up before a customer service representative (CSR) becomes available. Any calls that abandon within 10 seconds of being placed in queue need not be counted. Calculated as the number of calls in member services queue that are abandoned divided by number of calls placed in queue. Note: Calls that are answered by automated responses (e.g., claim status, eligibility) should not be included in measurement (i.e., added to the count of calls that reach facility and are placed in queue).
Standard 6	**Annual Member Satisfaction Survey:** **CONTRACTOR'S performance on Member Satisfaction will meet or exceed the average regional health plan performance based on the 2008 CAHPS survey** **(client-specific)**	Respondents who answer Q42 (CAHPS 4.0H) with an 8, 9, or 10. The standard will be based on calendar year 2007 data, to be reported in the summer of 2008.
Standard 7	**Account Management:** **Average score of 3.0 or better on scorecard elements**	It is the HCA's expectation that all CONTRACTORS will participate in the evaluation of account management support to the Basic Health program. Performance criteria/survey elements to be determined in 2008 for the 2009 contract.
Standard 8	**Call Quality**	Call Quality: It will be the HCA's expectation that all CONTRACTORS will be measuring and monitoring call quality. Performance measures will be identified and required with the 2009 contract. If the CONTRACTOR is currently measuring call quality, reports of those measures should be submitted with the other required customer service performance measures.

For Standards 5-7: If CONTRACTOR does not currently have a process in place to measure Basic Health independently from other lines of business, with the exception of 7) Account Management, it will need to develop and implement such process by July 1, 2008. It is the HCA's intent to measure each CONTRACTOR's full book of business against the Basic Health line of business for the 2009 contract year.

Exhibit 3: Basic Health — 2008 Performance Standards

	Administration	
Standard 10	**Identification Cards:** **97% of ID cards sent within 15 business days of receipt of eligibility.** **(client-specific)**	1. Open Enrollment 97% of ID cards mailed within 15 business days, but not later than two weeks prior to the contract effective date. In order to be counted in this measure, receipt of HCA enrollment must be received by CONTRACTOR 21 business days prior to the contract effective date. 2. On-Going Enrollments (Outside of Open Enrollment) 97% mailed within 15 business days of receipt of confirmation of enrollment from HCA.
Standard 11	**Certificates of Coverage:** **97% of the Certificates of Coverage (COC) mailed within 15 business days of receipt of confirmation of enrollment from the HCA.** **(client-specific)**	97% of the Certificates of Coverage (COC) mailed within 15 business days of receipt of confirmation of enrollment from the HCA.
Standard 12	**Enrollment Processing**	90% of enrollment data available to Participating Providers within 5 business days of receipt of enrollment confirmation from HCA.

For standards 10, 11 and 12: If CONTRACTOR does not currently have a process in place to measure Basic Health independently from other lines of business, it will need to develop and implement such process by July 1, 2008. It is the HCA's intent to measure each CONTRACTOR's full book of business against the Basic Health line of business for the 2009 contract year.

Exhibit 4
Basic Health 2008 Contract

Quality Improvement Standards

The CONTRACTOR shall comply with these Quality Improvement Program Standards. The standards are adopted primarily from NCQA's Standards for the Accreditation of Managed Care Organizations. HCA reserves the right to revise the Quality Improvement Program Standards to ensure that no standard is in conflict with the Washington State Patient Bill of Rights (PBOR), Health Insurance Portability and Accountability Act (HIPAA), or any other applicable state or federal statute or regulation. In the event of conflict between the Quality Improvement Program Standards and the standards of PBOR, HIPAA or state or federal statute or regulation, the standard which, in the sole judgment of HCA, is most favorable to enrollees shall have precedence.

HCA agrees that any CONTRACTOR that meets or exceeds a TEAMonitor score of "met" on a specific quality standard (Quality Management and Improvement, Utilization Management, Credentialing and Recredentialing, Members' Rights and Responsibilities, and Preventive Health Services) for 2 consecutive audit years will be assumed to be in compliance with that specific standard and will be "deemed" for the next audit year. Exceptions to deeming will be: Clinical and Service Quality Improvement Indicatives and the sections of Utilization Management that are related to file review of appeals, denials and complaints/grievances. If HCA has evidence that subsequent performance has been deficient, the CONTRACTOR shall be subject to audit on all standards. In determining whether a CONTRACTOR'S performance has been deficient with respect to the Quality Improvement Standards, HCA will consider NCQA Reports, enrollee complaints, appeals and denials, and any other substantial data or information.

The above process shall not apply to areas specifically required for annual review by the Federal Medicaid Act (Social Security Act, 42. US. C. Sec. 1396 et seq.), applicable federal regulations, The Healthy Options Waiver 1115b, Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care, The Balanced Budget Act of 1997 and any published, applicable BBA regulations, applicable RCWs and applicable WACs.

Managed care plans contracting with the Department of Social and Health Services and the Health Care Authority shall comply with the National Committee of Quality Assurance (NCQA) standards listed on the next pages. These standards are adopted from the NCQA Standards for the Accreditation of Managed Care Organizations, effective July 1, 2007 — June 30, 2008.

The following NCQA definitions apply to terms used in this document:

Appeal: A formal request by a practitioner or covered person for reconsideration of a decision such as a utilization review recommendation, a benefit payment, an administrative action, quality of care or service issue, with the goal of finding a mutually acceptable solution.

Practitioner: Any individual who is qualified to practice a profession. Practitioners are usually required to be licensed as defined by law.

Provider: An institution or organization that provides services for your organization's members. Examples of providers include hospitals and home health agencies.

BH 2008 QI Contract Requirements

QUALITY MANAGEMENT AND IMPROVEMENT

QI 1		**PROGRAM STRUCTURE**	
		The organization clearly defines its quality improvement (QI) structures and processes and assigns responsibility to appropriate individuals.	
		ELEMENT A: Quality Improvement Program Structure	
		The organization's QI program structure includes the following factors:	
	1	a written description of the QI program	ü
	2	behavioral health care is specifically addressed in the program description	ü
	3	patient safety is specifically addressed in the program description	ü
	4	the QI program accountable to the governing body	ü
	5	a designated physician has substantial involvement in the QI program	ü
	6	a designated behavioral health practitioner is involved in the implementation of the behavioral health care aspects of the QI program.	ü
	7	a QI committee oversees the QI functions of the organization	ü
	8	The specific role, structure, and function of the QI committee and other committees, including meeting frequency, are addressed in the program description	ü
	9	an annual work plan	ü
	10	A description of resources that the organization devotes to the needs of the QI program.	ü
		ELEMENT B: Annual Evaluation	
		There is an annual written evaluation of the QI program that includes:	
	1	a description of completed and ongoing QI activities that address the quality and safety of clinical care and quality of service	ü
	2	trending of measures to assess performance in the quality and safety of clinical care and quality of service	ü
	3	analysis of the results of QI initiatives, including barrier analysis	ü
	4	evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices.	ü
QI 2		**PROGRAM OPERATIONS**	
		The organization's quality improvement program is fully operational.	
		ELEMENT A: QI Committee Responsibilities	
		The organization's QI committee:	
	1	recommends policy decisions	ü
	2	analyzes and evaluates the results of QI activities	ü
	3	ensures practitioner participation in the QI program through planning, design, implementation or review	ü
	4	institutes needed actions	ü
	5	ensures follow-up, as appropriate.	ü
		ELEMENT B: Committee Minutes	
		QI committee meeting minutes reflect all committee decisions and actions, and are signed and dated	ü
		ELEMENT C: Notification of QI Information	
		The organization annually makes information about its QI program	ü
	1	members	ü
	2	practitioners	ü
QI 3		**HEALTH SERVICES CONTRACTING**	
		The organization's contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with the organization's QI program.	
		ELEMENT A: Practitioner Contracts	
		Contracts with practitioners specifically require that:	
	1	practitioners cooperate with QI activities	ü
	2	the organization has access to practitioner medical records, to the extent permitted by state and federal law	ü
	3	practitioners maintain the confidentiality of member information and records	ü
		ELEMENT B: Affirmative Statement	
		Contracts with practitioners and providers include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.	ü
		ELEMENT C: Provider Contracts	
		Contracts with organization providers specifically require that:	
	1	providers cooperate with QI activities	ü
	2	the organization has access to provider medical records, to the extent permitted by state and federal law.	ü
	3	providers maintain the confidentially of member information and records.	ü
		ELEMENT D: Notification of Specialist Termination	
		Contracts with specialists and specialty group practitioners require timely notification to organization members affected by the termination of a specialist or the entire specialty group.	ü
QI 4		**AVAILABILITY OF PRACTITIONERS**	
		The organization ensures that its network is sufficient in numbers and types of primary care and specialty care practitioners.	
		ELEMENT A: Cultural Needs and Preferences	
		The organization assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.	ü
		ELEMENT B: Ensuring Availability of PCP's	
		To ensure the availability of primary care practitioners (PCP) within its delivery system, the organization:	
	1	defines which practitioners serve as PCPs	ü
	2	establishes quantifiable and measurable standards for the number of PCPs	ü
	3	establishes quantifiable and measurable standards for the geographic distribution of PCPs	ü
	4	analyzes performance against the standards annually.	ü
		ELEMENT C: Ensuring Availability of SCPs	
		To ensure the availability of specialty care practitioners (SCP) within its delivery system, the organization:	
	1	defines which practitioners serve as high volume SCPs	ü
	2	establishes quantifiable and measurable standards for the number of SCPs	ü
	3	establishes quantifiable and measurable standards for the geographic distribution of SCPs	ü
	4	analyzes performance against the standards annually.	ü

		ELEMENT D: Ensuring Availability of BHPs	
		To ensure the availability of behavioral health practitioners (BHP) within its delivery system, the organization:	ü
	1	defines which practitioners serve as BHPs	ü
	2	establishes quantifiable and measurable standards for the number of BHPs	ü
	3	establishes quantifiable and measurable standards for the geographic distribution of BHPs	ü
	4	analyzes performance against the standards annually.	ü
QI 5		**ACCESSIBILITY OF SERVICES**	
		The organization establishes mechanisms to assure the accessibility of primary care services.	
		ELEMENT A: Assessment Against Access Standards	
		The organization collects and performs an annual analysis of data to measure its performance against standards for access to:	
	1	regular and routine care appointments	ü
	2	urgent care appointments;	ü
	3	after-hours care.	ü
	4	Member Services by telephone	ü
		ELEMENT B: BH Access Standards	
		Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against standards for behavioral health access to:	ü
	1	care for a non-life-threatening emergency within 6 hours	ü
	2	urgent care within 48 hours	ü
	3	an appointment for a routine office visit within 10 business days.	ü
		ELEMENT C: BH Telephone Access Standards	
		Using valid methodology, the organization collects and performs an analysis of data to measure its performance against the following behavioral health telephone access standards at least once in the past year:	ü
	1	the quarterly average for screening and triage calls shows that telephones are answered by a nonrecorded voice within 30 seconds	ü
	2	the quarterly average for screening and triage calls reflects a telephone abandonment rate within 5 percent.	ü
QI 6		**MEMBER SATISFACTION**	
		The organization implements mechanisms to assure member satisfaction.	
		ELEMENT A: Annual Assessment	
		To assess member satisfaction, the organization conducts annual evaluations of member complaints and appeals by:	
	1	identifying the appropriate population	ü
	2	drawing appropriate samples from the affected population, if a sample is used	ü
	3	collecting valid data	ü
	4	performing the assessment annually	ü
		ELEMENT B: Opportunities for Improvement	
	1	The organization identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based upon the analysis of:	
		member complaint and appeal data	ü
	2	The CAHPS® 4.0H survey.	ü
QI 7		**COMPLEX CASE MANAGEMENT**	
		The organization coordinates services for members with complex conditions and help them access needed resources.	
		ELEMENT A: Identifying Member for Case Management ~~Chronic Conditions~~	
		The organization uses the following data sources to identify member for case management:	ü
	1	claims or encounters data	ü
	2	hospital discharge data	ü
	3	pharmacy data	ü
	4	data collected through the UM management process, if applicable.	ü
		ELEMENT B — Access to Case Management	
		The organization has multiple avenues for members to be considered for case management services, including:	ü
	1	health information line referral	ü
	2	DM program referral	ü
	3	discharge planner referral	ü
	4	UM referral, if applicable	ü
	5	member self-referral	ü
	6	practitioner referral	ü
		ELEMENT C- Case Management Systems	
		The organization uses case management systems that support:	ü
		using evidence-based clinical guidelines or algorithms to conducts assessment and management	ü
		automatic documentation of individual and the date and time when the organization acted on the case or interacted with the member	ü
		automated prompts for follow-up, as required by the case management plan	ü
		ELEMENT D — Case management process	
		the organization's case management procedures address:	ü
	1	members' right to decline participation or disenroll from case management programs and services offered by the organization	ü
	2	initial assessment of members' health status, including condition-specific issues	ü
	3	documentation of clinical history, including medications	ü
	4	initial assessment of mental health status, including cognitive functioning	ü
	5	initial assessment of life planning activities	ü
	6	evaluation of cultural and linguistic needs, preferences or limitations	ü
	7	evaluation caregiver resources	ü
	8	evaluation of available benefits	ü
	9	development of a case management plan, including long- and short-term goals	ü
	10	development of a schedule for follow-up and communication with the member	ü
	11	development and communication of self management plans for members	ü
	12	process to assess progress against the case management plans for members	ü
		ELEMENT E — Initial Assessment	
		An NCQA review of a sample of the organization's case management files demonstrates that the organization follows its documented processes for:	ü
	1	initial assessment of members' health status, including condition-specific issues	ü
	2	documentation of clinical history, including medications	ü
	3	initial assessment of activities of daily living	ü
	4	initial assessment of mental health status, including cognitive function	ü
	5	evaluation of cultural and linguistic needs, preferences or limitations	ü
	6	evaluation of caregiver resources	ü
	7	evaluation of available benefits	ü
	8	assessment of life planning activities	ü

		ELEMENT F — Case Management-Ongoing Management	
		The NCQA review of a sample of the organization's case management files demonstrates that the organization follows its documented process for:	ü
	1	development of case management plans, including long- and short-term goals	ü
	2	identification of barriers to meeting goals or compliance with case management plans	ü
	3	development of schedules for follow-up and communication with members	ü
	4	development and communication of self-management plans for members	ü
	5	assessment of progress against case management plans and goals and modification	ü
		ELEMENT G — Satisfaction with Case Management	
	1	obtaining feedback from members	ü
	2	analyzing member complaints and inquiries	ü
		ELEMENT H — Measuring Effectiveness	
		the organization measures the effectiveness of its case management program using three measures. For each measure, the organization:	ü
	1	identifies a relevant process or outcome	ü
	2	uses valid methods that provide quantitative results	ü
	3	sets a performance goal	ü
	4	has clearly identified measure specifications	ü
	5	analyzes results	ü
	6	identifies opportunities for improvement, if applicable	ü
	7	develops a plan for intervention and remeasurement	ü
		ELEMENT I — Action and Remeasurement	
		Based on the results of its measurement and analysis of case management effectiveness,	ü
	1	implements at least one intervention to improve performance	ü
	2	remeasures to determine performance	ü
QI 8		**DISEASE MANAGEMENT**	
		The organization actively works to improve the health status of its members with chronic conditions	
		ELEMENT A- Identifying Chronic Conditions	
		The organization identifies two chronic conditions that its disease management (DM) programs address.	ü
		ELEMENT B — Program content	
		The content of the organization's programs address the following for each condition:	
	1	condition monitoring	ü
	2	patient adherence to the program's treatment plans	ü
	3	consideration of other health conditions	ü
	4	lifestyle issues as indicated by practice guidelines (e.g. goal-setting techniques, problem solving).	ü
		ELEMENT C: Identifying Eligible Members for DM Programs	
		The organization identifies members who qualify for DM programs using the following data sources:	ü
	1	claims or encounter data	ü
	2	pharmacy data, if applicable	ü
	3	health risk appraisal results	ü
	4	laboratory results, if applicable	ü
	5	data collected through the UM or case management process, if applicable	ü
	6	member and practitioner referral	ü
		ELEMENT D — Frequency of Member Identification	
		Annually, the organization systematically identifies members who qualify for its DM programs.	ü
		ELEMENT E: Providing Eligible Members With Information	
		The organization provides eligible members with written program information regarding:	
	1	how to use the services	ü
	2	how members become eligible to participate	ü
	3	how to opt in or opt out.	ü
		ELEMENT F: Interventions Based on Stratification	
		The organization provides interventions to members based on stratification.	ü
		ELEMENT G: Eligible Member Participation	
		The organization annually measures and reports member participation rates	ü
		ELEMENT H: Informing and Educating Practitioners	
		The organization has a documented process for providing practitioners with written program information, including:	
	1	instructions on how to use the DM services	ü
	2	how the organization works with a practitioner's members in the program.	ü
		ELEMENT I — Integrating Member Information	
		The organization integrates information from the following systems to facilitate access to member health information for continuity of care:	ü
	1	a health information line	ü
	2	a DM program	ü
	3	a case management program	ü
	4	a UM program, if applicable.	ü
		ELEMENT J — Satisfaction with Disease Management	
	1	obtaining feedback from members	ü
	2	analyzing member complaints and inquiries	ü
		ELEMENT K: Measuring Effectiveness	
		The organization employs and tracks one performance measure for each DM program. Each measurement:	
	1	addresses a relevant process or outcome	ü
	2	produces a quantitative result	ü
	3	is population based	ü
	4	uses data and methodology that are valid for the process or outcome measured	ü
	5	has been analyzed in comparison to a benchmark or goal.	ü
QI 9		**CLINICAL PRACTICE GUIDELINES**	
		The organization is accountable for adopting and disseminating nonpreventive health clinical practice guidelines relevant to its membership for the provision of non preventive health acute and chronic medical services and for nonpreventive and preventive behavioral health services.	ü
		ELEMENT A: Adoption and Distribution of Guidelines	
		The organization ensures that practitioner are using relevant clinical practice guidelines by:	ü
	1	adopting guidelines for at least two medical conditions and at least two behavioral health conditions	ü
	2	establishing the clinical basis for the guidelines	ü
	3	updating the guidelines at least every two years	ü
	4	distributing the guidelines to appropriate practitioners	ü
		ELEMENT B: Relation to Disease Management Programs	
		At least two of the organization's adopted clinical practice guidelines are the clinical basis for DM programs in QI 8: Disease Management	ü

		ELEMENT C — Performance Measurement	
		The organization has annually measured performance against at least two important aspects of:	ü
	1	a clinical practice guideline for an acute or chronic medical condition	ü
	2	a second clinical practice guideline for acute or chronic medical condition	ü
	3	a clinical practice guideline for behavioral health condition	ü
	4	a second clinical practice guideline for behavioral health condition	ü
QI 10 9		**CONTINUITY AND COORDINATION OF MEDICAL CARE**	
		The organization monitors the continuity and coordination of care that members receive and takes actions, as necessary, to ensure and improve continuity and coordination of care across the health care network.	
		ELEMENT A: Opportunities for Improvement	
		The organization identifies and acts on opportunities to improve coordination of medical care by:	
	1	collecting data	ü
	2	conducting quantitative and causal analysis of data to identify improvement opportunities	ü
	3	identifying and selecting one opportunity for improvement	ü
	4	identifying and selecting a second opportunity for improvement	ü
	5	taking action on the first opportunity	ü
	6	taking action on the second opportunity	ü
		ELEMENT B: Notification of PCP Termination	
		The organization notifies members affected by the termination of a primary care practitioner at least 30 calendar days prior to effective termination date and helps them select a new practitioner.	ü
		ELEMENT C: Continued Access to Practitioners	
		If the practitioner's contract is discontinued, the organization allows affect members continued access to the practitioner, as follows:	ü
	1	continuation of treatment through the lesser of the current period of active treatment, or for up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition	ü
	2	continuation of care through the postpartum period for members in their second or third trimester of pregnancy.	ü
		ELEMENT D — Transition to Other care	
		The organization assists with a member's transition to other care, if necessary, when benefits end.	ü
QI 11		**CONTINUITY AND COORDINATION BETWEEN MEDICAL AND BEHAVIORAL HEALTH CARE**	
		The organization collaborates with behavioral health specialists to monitor and improve coordination between medical and behavioral health care.	ü
		ELEMENT A: Data Collection	
		The organization collects data, at least once in the last two years, about the following opportunities for collaboration between medical and behavioral health care:	ü
	1	exchange of information	ü
	2	appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care	ü
	3	appropriate uses of psychopharmacological medications	ü
	4	management of treatment access and follow-up for members with coexisting medical and behavioral disorders	ü
	5	primary or secondary preventive behavioral health program implementation.	ü
		ELEMENT B: Collaborative Analysis	
		The organization collaborates with its behavioral health specialists to identify opportunities and take action to improve coordination of behavioral health care with general medical care. There is documentation of the following factors:	
	1	collaboration with behavioral health specialists	ü
	2	quantitative and causal analysis of data to identify improvement opportunities	ü
	3	identification and selection of at least one opportunity for improvement.	ü
	4	the organization takes collaborative action to address at least 1 identified opportunity for improvement	ü
QI 12 11		**CLINICAL QUALITY IMPROVEMENTS**	
		The organization demonstrates improvements in the clinical care of members.	
		ELEMENT A: Clinical Improvements	
		The organization demonstrates three clinical improvements, one of which is in the behavioral health area and each of which is of either of the following types:	
	1	significant improvement in one audited HEDIS clinical measure	ü
	2	Meaningful improvement in a QI clinical activity not addressed by a HEDIS measure in an area relevant to the organization's population.	ü
QI 13 12		**SERVICE QUALITY IMPROVEMENTS**	
		The organization demonstrates improvements in the service it renders to members.	
		ELEMENT A: Service Improvements	
		The organization demonstrates two service improvements, each of which is one of the following types:	
	1	significant improvement in a CAHPS® 4.0H composite or rating result or question	ü
	2	meaningful improvement in a QI service activity not using the CAHPS® 4.0H results in an area of service identified as an opportunity and relevant to the organization's population.	ü
QI 14 13		**STANDARDS FOR MEDICAL RECORD DOCUMENTATION**	
		The organization establishes medical record standards to facilitate communication, coordination and continuity of care and to remote efficient and effective treatment	
		ELEMENT A: Medical Record Criteria	
		The organization has policies and procedures that address the following factors, and distributes them to practice sites:	
	1	confidentiality of medical records	ü
	2	medical record documentation standards	ü
	3	an organized medical record keeping system and standards for availability of medical records	ü
	4	performance goals to assess the quality of medical record keeping.	ü
		ELEMENT B: Improving Medical Record Keeping	
		The organization has implemented a method to improve medical record keeping	ü
QI 14		**DELEGATION OF QI**	
		If the organization delegates any QI activities, there is evidence of oversight of the delegated activity.	
		ELEMENT A: Written Delegation Agreement	
		There is a written delegation document that:	
	1	is mutually agreed upon	ü
	2	describes the responsibilities of the organization and the delegated entity	ü
	3	describes the delegated activities	ü
	4	requires at least semiannual reporting to the organization	ü
	5	describes the process by which the organization evaluates the delegated entity's performance	ü
	6	describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.	ü

		ELEMENT B: Provisions for PHI	
		If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:	
	1	a list of the allowed uses of protected health information	ü
	2	a description of delegate safeguards to protect the information from inappropriate use of further disclosure	ü
	3	a stipulation that the delegate ensures that sub delegates have similar safeguards	ü
	4	a stipulation that the delegate provide individuals with access to their protected health information	ü
	5	a stipulation that the delegate informs the organization if inappropriate uses of the information occur	ü
	6	a stipulation that the delegate ensures protected health information is returned, destroyed or protected if the delegation agreement ends.	ü
		ELEMENT C: Approval of QI Program	
		The organization approves its delegates QI program annually.	ü
		ELEMENT D: Pre-Delegation Evaluation	
		For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.	ü
		ELEMENT E: Annual Evaluation	
		For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards for delegated activities.	ü
		ELEMENT F: Reporting	
		For delegation arrangements in effect 12 months or longer, the organization evaluated regular reports, as specified in Element A.	ü
		ELEMENT G: Opportunities for Improvement	
		For delegation arrangements that have been in effect for more than 12 months, at least once each of the past 2 years that delegation has been in effect, the organization has identified and followed up on opportunities for improvement, if applicable.	ü
UM			
UM 1		**Utilization Management Structure**	
		The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility appropriate individuals.	
		ELEMENT A: Written Program Description	
		The organization's UM program description includes the following factors:	
	1	program structure	ü
	2	behavioral health care aspects of the program	ü
	3	involvement of a designated senior physician in UM program implementation	ü
	4	involvement of a designated behavioral health care practitioner in the implementation of the behavioral health care aspects of the UM program	ü
	5	program scope and the processes and information sources used to make determinations of benefit coverage and medical necessity.	ü
		ELEMENT B: Physician Involvement	
		A senior physician is actively involved in implementing the organization's UM program.	ü
		ELEMENT C: Behavioral Health Practitioner Involvement	
		A behavioral health practitioner is actively involved in implementing the behavioral health aspects of the UM program.	ü
		ELEMENT D: Annual Evaluation	
		The organization annually evaluates and updates the UM program, as necessary.	ü
UM 2		**Clinical Criteria for UM Decisions**	
		To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.	
		ELEMENT A: UM Criteria	
		The organization:	
	1	has written UM decision-making criteria that are objective and based on medical evidence	ü
	2	has written policies for applying the criteria based on individual needs	ü
	3	has written policies for applying the criteria based on an assessment of the local delivery system	ü
	4	involves appropriate practitioners in developing, adopting and reviewing criteria	ü
	5	reviews the UM criteria and the procedures for apply them annually and updates the criteria when appropriate.	ü
		ELEMENT B: Availability of Criteria	
		The organization:	
	1	states in writing how practitioners can obtain UM criteria	ü
	2	makes the criteria available to its practitioners upon request	ü
		ELEMENT C: Consistency in Applying Criteria	
		At least annually, the organization:	
	1	evaluates the consistency with which health care professionals involved in UM apply criteria in decision making	ü
	2	acts on opportunities to improve consistency, if applicable.	ü
UM 3		**Communication Services**	
		The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.	ü
		ELEMENT A: Access to Staff	
		The organization provides the following communication services for practitioners and members:	ü
	1	staff are available at least eight hours a day during normal business days for inbound calls regarding UM issues	ü
	2	ability of staff to receive inbound communication after normal business hours regarding UM issues	ü
	3	staff can send outbound communication inquiries about UM during normal business hours, unless otherwise agreed upon	ü
	4	staff members identify themselves by name, title and organization name when initiating or returning calls regarding UM issues	ü
	5	a toll-free number or staff that accept collect calls regarding UM issues	ü
	6	access to staff for callers with questions about the UM process.	ü
UM 4		**Appropriate Professionals**	
		Qualified licensed health professionals assess the clinical information used to support UM decisions.	
		ELEMENT A: Licensed Health Professionals	
		The organization has written procedures:	
	1	requiring appropriately licensed professionals to supervise all medical necessity decisions	ü
	2	specifying the type of personnel responsible for each level of UM decision making.	ü
		ELEMENT B: Use of Practitioners for UM Decisions	
		The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are reuired to have:	
	1	education, training or professional experience in medical or clinical practice	ü
	2	current license to practice without restriction.	ü
		ELEMENT C: Practitioner Review of Non-BH Denials	
		The organization ensures that a physician, dentist or pharmacist, as appropriate, reviews any non-behavioral health denial of care based on medical necessity.	ü
		ELEMENT D: Practitioner Review of BH Denials	
		The organization ensures that a physician, appropriate behavioral health practitioner or pharmacist, as appropriate, reviews any behavioral health denial of care based on medical necessity.	ü
		ELEMENT E: Use of Board-Certified Consultants	
		The organization has written procedures for using board-certified consultants to assist in making medical necessity determinations.	ü
UM 5		**Timeliness of UM Decisions**	

		The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.	
		ELEMENT A: Timeliness of Non-BH UM Decision Making	
		The organization adheres to the following standards for timeliness of UM decision making:	
	1	for non-urgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request [HCA — require nonurgent, preservice decisions within 14 days}	ü
	2	for urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request	ü
	3	for urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request	ü
	4	for post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request.	ü
		ELEMENT B: Notification of Non-BH Decisions	
		The organization adheres to the following standards for notification of non-behavioral health UM decision making:	
	1	for non-urgent preservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request. [HCA — require nonurgent, preservice decisions within 14 days}	ü
	2	for urgent preservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request	ü
	6	for urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request	ü
	7	for postservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.	ü
		ELEMENT C: Timeliness of BH UM Decision Making	
		The organization adheres to the following standards for timeliness of behavioral health UM decision making:	ü
	1	for non-urgent pre-service decisions, the organization makes decisions within 15 calendar days of receipt of the request. [HCA — require nonurgent, preservice decisions within 14 days}	ü
	2	for urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request	ü
	3	for urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request	ü
	4	for post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request.	ü
		ELEMENT D: Notification of BH Decisions	
		The organization adheres to the following standards for notification of behavioral health UM decision making:	
	1	for non-urgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request	ü
	2	for urgent preservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request	ü
	3	for urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request	ü
	7	for post-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.	ü
UM 6		**Clinical Information**	
		When making a determination of coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating physician.	
		ELEMENT A: Information for UM Decision Making	
		The organization has a written description that identifies the information that is needed to support UM decision making in place for at least 12 months.	ü
		ELEMENT C: Documentation of Non-BH Information	
		There is documentation that relevant clinical information is gathered consistently to support non-behavioral health UM decision making.	ü
		ELEMENT D: Documentation of BH Information	
		There is documentation that relevant clinical information is gathered consistently to support behavioral health UM decision making.	ü
UM 7		**Denial Notices**	
		The organization clearly documents and communicates the reasons for each denial.	
		ELEMENT A: Notification of Reviewer Availability	
		The organization notifies practitioners of:	
	1	its policy for making a reviewer available to discuss any UM denial decision	ü
	2	how to contact a reviewer.	ü
		ELEMENT B: Discussing a with Reviewer	
		The organization provides practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or pharmacist reviewer.	ü
		ELEMENT C: Reason for Non-BH Denial	
		The organization provides written notification of the non-behavioral health denial that contains the following:	
	1	the specific reasons for the denial, in easily understandable language	ü
	2	a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based	ü
	3	notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.	ü
		ELEMENT D: Non-BH Notice of Appeal Rights/Process	
		The organization provides written notification of the non-behavioral health denial that contains the following:	
	1	description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal	ü
	2	explanation of the appeal process, including the right to member representation and time frames for deciding appeals	ü
	3	if a denial is an urgent preservice or urgent concurrent denial, a description of the expedited appeal process.	ü
		ELEMENT E: Discussing a BH Denial with Reviewer.	
		The organization provides practitioners with the opportunity to discuss any behavioral health UM denial decision with a physician, appropriate behavioral health or pharmacist reviewer.	ü

		ELEMENT F: Reason for BH Denial	
		The organization provides written notification of the behavioral health denial that contains the following:	
	1	the specific reasons for the denial, in easily understandable language	ü
	2	a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based	ü
	3	notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.	ü
		ELEMENT G: BH Notification of Appeals/Rights process	
		The organization provides written notification of the behavioral health denial that contains the following:	
	1	description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal	ü
	2	explanation of the appeal process, including the right to member representation and time frames for deciding appeals	ü
	3	if a denial is an urgent preservice or urgent concurrent denial, a description of the expedited appeal process.	ü
UM 8		**Policies for Appeals**	
		The organization has written policies and procedures for the thorough, appropriate, and timely resolution of member appeals. [HCA — Contractors are required to follow the Washington State “Patient Bill of Rights” (PBOR)]	
UM 9		**Appropriate Handling of Appeals**	
		The organization adjudicates member appeals in a thorough, appropriate and timely manner. [HCA — Contractors are required to follow the Washington State “Patient Bill of Rights” (PBOR)]	
UM 10		**Evaluation of New Technology**	
		The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefit plan. This includes medical and behavioral health procedures, pharmaceuticals and devices.	
		ELEMENT A: Written Process	
		The organization’s written process for evaluating new technologies and the new application of existing technologies for inclusion in its benefit plan includes an evaluation of the following factors:	
	1	medical procedures	ü
	2	behavioral health procedures	ü
	3	pharmaceuticals	ü
	4	devices.	ü
		ELEMENT B: Description of the Evaluation Process	ü
		The organization’s written evaluation process includes the following factors:	ü
	1	the process and decision variables the organization uses to make determinations	ü
	2	a review of information from appropriate government regulatory bodies	ü
	3	a review of information from published scientific evidence	ü
	4	a process for seeking input from relevant specialists and professionals who have expertise in the technology.	ü
		ELEMENT C: Implementation of New Technology	
		The organization implements a decision on coverage from its assessment of new technologies and new applications of existing technologies or from review of special cases.	ü
UM 11		**Satisfaction with the UM Process**	
		The organization evaluates member and practitioner satisfaction with the utilization management process.	ü
UM 12		**Emergency Services**	
		The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.	
		ELEMENT A: Policies and Procedures	
		The organization’s policies and procedures require:	
	1	coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed an emergency medical condition existed	ü
	2	coverage of emergency services if an authorized representative, acting for the organization, has authorized the provision of emergency services.	ü
		ELEMENT C: Organization’s Authorized Representative	
		The organization covers emergency services approved by an authorized representative.	ü
UM 13		**Procedures for Pharmaceutical Management**	
		The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.	
		ELEMENT A: Policies and Procedures	
		The organization’s policies and procedures for pharmaceutical management include:	
	1	the criteria used to adopt pharmaceutical management procedures	ü
	2	a process that uses clinical evidence from appropriate external organizations.	ü
		ELEMENT B: Pharmaceutical Restrictions/Preferences	ü
		The organization maintains a list of pharmaceuticals, including restrictions and preferences, and has policies that address:	ü
	1	how to use the pharmaceutical management process	ü
	2	an explanation of any limits or quotas	ü
	3	an explanation of how prescribing practitioners must provide information to support an exceptions request	ü
	4	the organization’s process for generic substitution, therapeutic interchange and step-therapy protocols.	ü
		ELEMENT C: Pharmaceutical Patient Safety Issues	ü
		The organization’s pharmaceutical procedures include:	ü
	1	adopting or creating a system for point-of -dispensing communicatoins identify and classify drug-to-drug interactoins by severity	ü
	2	notifying dis\pensing roviders at the point-of-dispensing of specific interactins when they meet the organization’s severity threshold.	ü
	3	identifying and notifying members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification.	ü
	4	an expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall.	ü
		ELEMENT D: Review and Update of Procedures	
		The organization reviews pharmaceutical management procedures at least annually and updates them as new pharmaceutical information becomes available.	ü
		ELEMENT E: Pharmacist and Practitioner Involvement	
		The organization involves the following in the development and periodic updates of its pharmaceutical management procedures:	
	1	pharmacists	ü
	2	appropriate practitioners	ü

		ELEMENT F: Availability of Procedures	
		Annually and when it makes changes, the organization provides pharmaceutical management procedures to practitioners.	ü
		ELEMENT G: Considering Exceptions	
		The organization has exceptions policies and procedures that describe the process for:	
	1	making an exceptions request based on medical necessity	ü
	2	obtaining medical necessity information from prescribing practitioners	ü
	3	using appropriate pharmacists and practitioners to consider exception requests	ü
	4	timely request handling	ü
	5	communicating the reason for a denial and an explanation of the appeals process when it does not approve an exception request.	ü
UM 14		**Ensuring Appropriate Utilization**	
		The organization facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under- and overutilization of services.	
		ELEMENT A: Relevant Utilization Data	
		The organization chooses at least four relevant types of utilization data, including one type related to behavioral health to monitor for each product line.	ü
		ELEMENT B: Under/Overutilization Thresholds	
		The organization sets thresholds for the four data types for each product line, including behavioral health, and annually quantitqtively analyzes data against the established thresholds to detect under- and overutilization	ü
		ELEMENT C: Qualitative Data Analysis	
		The organization conducts qualitative analysis to determine the cause and effect of all data not within thresholds.	ü
		ELEMENT D: Site-Level Monitoring	
		The organization analyzes data not within threshold by practice sites.	ü
		ELEMENT E: Interventions	
		The organization takes action to address identifies problems of under- and overutilization.	ü
		ELEMENT F: Evaluating Intervention Effectiveness	
		The organization measures the effectiveness of interventions to address under- and overutilization.	ü
UM 15		**Triage and Referral for Behavioral Health Care**	
		The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed. Note:	
		This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and nondelegated	
		ELEMENT A: Triage and Referral Protocols	
		The organization's protocols for behavioral health care triage and referral:	ü
	1	address all relevant mental health and substance abuse situations	ü
	2	define level of urgency	ü
	3	define appropriate setting of care	ü
	4	have been reviewed or revised within the past two years	ü
		ELEMENT B: Clinical Decisions	
		Licensed practitioners make decisions that require clinical judgment.	ü
		ELEMENT C: Supervision and Oversight	
		Supervision and oversight for triage and referral decisions meet the following factors:	ü
	1	staff who make clinical decisions are supervised by a licensed master's-level practitioner with five years of post-master's experience	ü
	2	A licensed psychiatrist or a licensed doctoral-level clinical psychologist oversees triage and referral decisions.	ü
UM 16		**Delegation of UM**	
		If the managed care organization delegates any UM activities, there is evidence of oversight of the delegated activity.	
		ELEMENT A: Written Delegation Agreement	
		The written delegation document:	ü
	1	is mutually agreed-upon	
	2	describes the responsibilities of the organization and the delegated entity	ü
	3	describes the delegated activities	ü
	4	requires at least semi-annual reporting to the organization	ü
	5	describes the process by which the organization evaluates the delegated entity's performance	ü
	6	describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.	ü
		ELEMENT B: Provision for PHI	
		If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:	
	1	a list of the allowed uses of protected health information	ü
	2	a description of delegate safeguards to protect the information from inappropriate use or further disclosure	ü
	3	a stipulation that the delegate will ensure that subdelegates have similar safeguards	ü
	4	a stipulation that the delegate will provide individuals with access to their protected health information	ü
	5	a stipulation that the delegate will inform the organization if inappropriate uses of the information occur	ü
	6	a stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends.	ü
		ELEMENT C: Approval of UM Program	
		Annually, the organization approves its delegate's UM program.	ü
		ELEMENT D: Predelegation Evaluation	
		For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.	ü
		ELEMENT E: Annual Evaluation	
		For delegation arrangements in effect 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.	ü
		ELEMENT F: Reporting	
		For delegation arrangements in effect 12 months or longer, the organization evaluated regular reports, as specified in Element A.	ü
		ELEMENT G: Opportunities for Improvement	
		For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identified and followed up on opportunities for improvement, if applicable.	ü

CREDENTIALING AND RECREDENTIALING

CR 1		**Credentialing Policies**	
		The organization has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.	
		ELEMENT A: Practitioner Credentialing Guidelines	
		The organization's credentialing policies and procedures specify:	
	1	types of practitioners to credential and recredential	ü
	2	verification sources used	ü
	3	criteria for credentialing and recredentialing	ü
	4	the process for making credentialing and recredentialing decisions	ü
	5	the process for managing credentialing files that meet the organization's established criteria	ü
	6	the process to delegate credentialing or recredentialing	ü
	7	the process ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner	ü
	8	the process for notifying a practitioner if information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner	ü
	9	the process to for ensuring that practitioners are notified of the credentialing or recredentialing decision within 60 calendar days of the committee's decision	ü
	10	the medical director's or other designated physician's direct responsibility and participation in the credentialing program	ü
	11	the process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law	ü
	12	the process for ensuring that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty	ü
		ELEMENT B: Practitioner Rights	
		The organization's policies and procedures include the following practitioner rights:	
	1	the right of practitioners to review information submitted to support their credentialing applications	ü
	2	the right of practitioner's to correct erroneous information	ü
	3	the right of practitioners, upon request, to be informed of the status of their credentialing or recredentialing application	ü
	4	notification of these rights.	ü
CR 2		**Credentialing Committee**	
		The organization designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.	
		ELEMENT A: Credentialing Committee	
		The Credentialing Committee includes representation from a range of participating practitioners.	ü
		ELEMENT B: Credentialing Committee Decisions	
		The organization provides evidence of:	ü
	1	Credentialilng Committee review of credentials for practitioners who do not meet established thresholds.	ü
	2	medical director or equally qualified individual review and approval of clean files.	
CR 3		**Initial Credentialing Verification**	
		The organization verifies credentialing information through primary sources, unless otherwise indicated.	
		ELEMENT A: Licensure Verification	
		the organization verifies that a current, valid license to practice is present and within the prescribed timelines	ü
		ELEMENT B: Initial Primary Source Verification	
		The organization verifies that the following factors are present and within the prescribed time limits:	
	1	a valid DEA or CDS certificate, if applicable	ü
	2	education and training including board certification, if the practitioner states on the application that he/she is board certified	ü
	3	work history	ü
	4	history of professional liability claims that resulted in settlements or judgments paid by on behalf of the practitioner.	ü
CR 4		**Application and Attestation**	
		Practitioners completes an application for network participation that includes a current and signed attestation regarding the applicant's health status and any history of loss or limitation of licensure or privileges:.	
		ELEMENT A: Contents of the Application	
		The application includes a current and signed attestation and addresses:	
	1	reasons for any inability to perform the essential functions of the position, with or without accommodation	ü
	2	lack of present illegal drug use	ü
	3	history of loss of license and felony convictions	ü
	4	history of loss or limitation of privileges or disciplinary activity	ü
	5	current malpractice insurance coverage	ü
	6	the correctness and completeness of the application.	ü
CR 5		**Initial Sanction Information**	
		The organization receives informton on practitioner sanctions before making a credentialing decision.	
		ELEMENT A: Sanction Information	
		The organization verifies the following sanction informaion for initial credentialing:	
	1	state sanctions, restrictions on licensure and/ or limitations on scope of practice	ü
	2	Medicare and Medicaid sanctions.	ü
CR 6		**Initial Credentialing Site Visits**	
		The organization has a process that ensures for ensuring that the offices of all primary care practitioners, obstetricians/gynecologists and high volume behavioral health care practitioners meet the organization's office site standards	ü
		ELEMENT A: Performance Standards and Thresholds	
		The organization:	ü
	1	sets standards and performance thresholds for office site criteria .	ü
	2	setts standards and performance thresholds for medical/treatment record keepoing criteria.	ü
		ELEMENT B: Site Visits and Medical Record-Keeping	
		For PCPs, OB/GYNs and high-volume behavioral health specialists, the organization conducts:	ü
	1	an initial site visit	ü
	2	an initial evaluation of medical/treatment record-keeping practices at each site.	ü
		ELEMENT C: Follow-Up for Initial Deficiencies	
		The organization implements ongoing monitoring and takes appropriate interventions by:	ü
	1	instituting actions for improving PCPs, OB/GYNs and high-volume behavioral health sites that do not meet the thresholds sites.	ü
	2	evaluating the effectiveness of the actions at least every six months, until deficient sites meet the thresholds	ü
	3	monitoring of all PCPs, OB/GYNs and high-volume behavioral health sites for deficiencies subsequent to the initial site visit, at least every six months.	ü
	4	documenting follow-up visits for those sites that had subsequent deficiencies.	ü

CR 7		**Recredentialing Verification**	
		The organization formally recredentials its practitioners at least every 36 months through information verified from primary sources, unless otherwise indicated.	
		ELEMENT A: Licensure Verification	
		the organization verifies that a current, valid license to practice is present and within the prescribed timelines	ü
		ELEMENT B: Recredentialing Verification	
		The organization verifies the following factors within the prescribed time limits:	
	1	a valid DEA or CDS certificate, as applicable	ü
	2	board certification, if the practitioner states that he/she is board certified	ü
	3	history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.	ü
		ELEMENT C: Contents of the Application	
		The application includes a current and signed attestation and addresses:	
	1	reasons for any inability to perform the essential functions of the position, with or without accommodation	ü
	2	lack of present illegal drug use	ü
	3	history of loss or limitation of privileges or felony convictions	ü
	4	a history of loss or limitatin of privileges or disciplinary action	
	5	current malpractice insurance coverage	ü
	6	correctness and completeness of the application.	ü
		ELEMENT D: Sanction Information	
		The organization verifies the following sanctions information for recredentialing:	ü
	1	state sanctions, restrictions on licensure and/ or limitations on scope of practice	ü
	2	Medicare and Medicaid sanctions.	ü
CR8		**Recredentialing Cycle Length**	ü
		The organization formally recredentials its practitioners at least every 36 months	ü
		ELEMENT A: Recredentialing Cycle Length	
	1	The length of the recredentialing cycle is within the required 36-month time frame.	ü
CR 9		**Ongoing Monitoring of Sanctions, Complaints and Quality Issues**	
		The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.	
		ELEMENT A: Ongoing Monitoring and Interventions	
		The organization implements ongoing monitoring and takes appropriate interventions by:	
	1	collecting and reviewing Medicare and Medicaid sanctions	ü
	2	collecting and reviewing sanctions and limitations on licensure	ü
	3	collecting and reviewing complaints.	ü
	4	collecting and reviewing information from identified adverse events	ü
	5	Implementing appropriate interventions when it identifies instances of poor quality, when appropriate	ü
CR 10		**Notification to Authorities and Practitioner Appeal Right**	
		An organization that has taken actions against a practitioner for quality reasons reports the action to the appropriate authorities and offers the practitioner a formal appeal process.	
		ELEMENT A: Written Policy and Procedures	
		The organization has policies and procedures for:	
	1	the range of actions available to the organization	ü
	2	procedures for reporting to authorities	ü
	3	a well-defined appeal process	ü
	4	making the appeal process known to practitioners.	ü
		ELEMENT B: Reporting to Appropriate Authorities	
		There is documentation that the organization reports practitioner suspension or termination to the appropriate authorities.	ü
		ELEMENT C: Practitioner Appeal Process	
		The organization has an appeal process for instances in which it chooses to alter the condition of the practitioner's participation based on issues of quality of care and/or service. The organization informs practitioners of the appeal process.	ü
CR 11		**Assessment of Organizational Providers**	
		The organization has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.	
		ELEMENT A: Review and Approval of Provider	
		The organization's policy for assessing health care delivery providers specifies that it:	
	1	confirms that the provider is in good standing with state and federal regulatory bodies	ü
	2	confirms that the provider has been reviewed and approved by an accrediting body	ü
	3	conducts an on-site quality assessment, if there is no accreditation status	ü
	4	Confirms, at least every 3 years, that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.	ü
		ELEMENT B: Medical Providers	
		The organization includes at least the following medical providers:	
	1	hospitals	ü
	2	home health agencies	ü
	3	skilled nursing facilities	ü
	4	free-standing surgical centers.	ü
		ELEMENT C: Mental Health and Substance Abuse	+
		The organization includes behavioral health facilities providing mental health or substance abuse	+
		services in the following settings:	
	1	inpatient	+
	2	residential	+
	3	ambulatory.	+
		ELEMENT D: Assessing Medical Care Providers	
		The organization has documentation of assessment of contracted medical health care delivery providers.	ü
		ELEMENT E: Assessing Behavioral Health Care Providers	+
		The organization has documentation of assessment of contracted behavioral health care delivery providers.	+
CR 12		**Delegation of Credentialing**	
		If the organizatin delegates andy NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. If the organization delegates any credentialing and recredentialing activities, there is evidence of oversight of the delegated activity.	
		ELEMENT A: Written Delegation Agreement	
		The written delegation document is:	
	1	mutually agreed-upon	ü
	2	describes the responsibilities of the organization and the delegated entity	ü
	3	describes the delegated activities	ü
	4	requires at least semi-annual reporting to the organization	ü
	5	describes the process by which the organization evaluates delegated entity's performance	ü
	6	describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.	ü

		ELEMENT B: Provisions for PHI	
		If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:	
	1	a list of the allowed uses of protected health information	ü
	2	a description of delegate safeguards to protect the information from inappropriate use or further disclosure	ü
	3	a stipulation that the delegate will ensure that subdelegates have similar safeguards	ü
	4	a stipulation that the delegate will provide individuals with access to their protected health information	ü
	5	a stipulation that the delegate will inform the organization if inappropriate uses of the information occur	ü
	6	a stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends.	ü
		ELEMENT C: Right to Approve and to Terminate	
		The organization retains the right, based on quality issues, to approve, suspend and terminate individual practitioners, providers and sites in situations where it has delegated decision making. This right is reflected in the delegation documents.	ü
		ELEMENT D: Predelegation Evaluation	
		For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.	ü
		ELEMENT E: Annual File Audit	
		For delegation arrangements in effect for 12 months or longer, the organization has audited files against NCQA standards for each year that the delegation has been in effect.	ü
		ELEMENT F: Annual Evaluation	
		For delegation arrangements in effect for more than 12 months, the organization has performed an annual substantive evaluation of delegated activities against delegated NCQA standards and organizational expectations.	ü
		ELEMENT G: Reporting	
		For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports.	ü
		ELEMENT H: Opportunities for Improvement	
		For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identifies and followed up on opportunities for improvement, if applicable.	ü
MEMBERS' RIGHTS AND RESPONSIBILITIES			
RR 1		**Statement of Members' Rights and Responsibilities**	
		The organization has a written policy that states its commitment to treating members in a manner that respects their rights and its expectations of members' responsibilities.	
		ELEMENT A ~~B~~: Statement of Members' Rights and Responsibilities	
		The organization's members' rights and responsibilities policy states that members have:	
	1	a right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities	ü
	2	a right to be treated with respect and recognition of their dignity and right to privacy	ü
	3	a right to participate with practitioners in decision-making regarding their health care	ü
	4	a right to a candid discussions of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage	ü
	5	a right to voice complaints or appeals about the organization or the care provided	ü
	6	a right to make recommendations regarding the organization's members' rights and responsibilities policies	ü
	7	a responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to care	ü
	8	a responsibility to follow plans and instructions for care that they have agreed on with their practitioners	ü
	9	a responsibility to understand their health care problems and participate in developing mutually agreed upon treatment goals to the degree possible.	ü
RR 2		**Distribution of Rights Statements to Members and Practitioners**	
		The organization distributes its policy on members' rights and responsibilities to its members and participating practitioners.	
		ELEMENT A: Distribution of Rights Statement to Members and Practitioners	
		The organization distributes its members' rights and responsibilities statement to:	
	1	existing members	ü
	2	new members	ü
	3	existing practitioners	ü
	4	new practitioners.	ü
RR 3		**Policies for Complaints and Appeals**	
		The organization has written policies and procedures for the thorough, appropriate and timely resolution of member complaints and appeals. [HCA — Contractors are required to follow the Washington State "Patient Bill of Rights" (PBOR)]	ü
RR 4		**Subscriber Information**	
		The organization provides each subscriber with information needed to understand benefit coverage and obtain care.	
		ELEMENT A: Subscriber Information	
		The organization provides written information to its subscriber addresses the following factors:	
	1	benefits and services included in, and excluded from, coverage	ü
	2	pharmaceutical management procedures, if they exist	ü
	3	copayments and other charges for which the member is responsible	ü
	4	restrictions on benefits that apply to services obtained outside the organization's system or service area	ü
	5	how to submit a claim for covered services, if applicable	ü
	6	how to obtain information about practitioners who participate in the organization	ü
	7	how to obtain primary care services, including points of access	ü
	8	how to obtain specialty care, behavioral health services and hospital services	ü
	9	how to obtain care after normal office hours	ü
	10	how too obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services	ü
	11	how to obtain care and coverage when out of the organization's service area	ü
	12	how to voice a complaint	ü
	13	how to appeal a decision that adversely affects a member's coverage, benefits or relationship to the organization	ü
	14	how the organization evaluates new technology for inclusion as a covered benefit.	ü
		ELEMENT B: Translation Services	
		The organization provides translation services within its member services telephone function based on the linguistic needs of its members.	ü
RR 5		**Physician and Hospital Directories**	
		The organization provides information to help members and prospective members choose physicians and hospitals.	ü

		Element A — Physician Directory Data	
		The organization has a Web-based physician directory that includes the following information to assist members and prospective members in choosing physicians:	ü
	1	name	ü
	2	gender	ü
	3	specialty	ü
	4	hospital affiliations	ü
	5	medical group affiliations, if applic	ü
	6	board certification with expiration date	ü
	7	acceptance of new patients	ü
	8	languages spoken by the practitioner or clinical sta	ü
	9	office locations.	ü
		Element B — Physician Directory Updates	
		The organization has a process for updating physician directory information when new information is provided by the physician.	ü
		Element D — Searchable Physician Web-based Directory	
		The organization's Web-based directory includes search functions with instructions on searching for:	ü
	1	name	ü
	2	gender	ü
	3	specialty	ü
	4	hospital affiliations	ü
	5	medical group affiliations, if applic	ü
	6	board certification with expiration date	ü
	7	acceptance of new patients	ü
	8	languages spoken by the practitioner or clinical sta	ü
	9	office locations.	ü
		Element E — Hospital Directory Data	
		The organization has a Web-based hospital directory that includes the following information to assist members and prospective members in choosing hospitals:	ü
	1	facility name	ü
	2	location	ü
	3	accreditation.	ü
		Element H — Searchable Hospital Web-based Directory	
		The organization's Web-based directory includes search functions on specific data types and instructions for searching for:	ü
	1	facility name	ü
	1	location.	ü
		Element I — Usability Testing	
		The organization evaluates its Web-based physician and hospital directories for understandability and usefulness to members and prospective members including:	ü
	1	font size	ü
	2	reading level	ü
	3	intuitive content organization	ü
	4	ease of navigation	ü
	5	directories in additional languages, if applicable to the membership.	ü
		Element J — Availability of Directories	
		The organization makes information from the Web-based physician and hospital directories available to members and prospective members through alternate media which include:	ü
	1	print	ü
	2	telephone.	ü
RR 6		**Privacy and Confidentiality**	
		The organization protects the confidentiality of member information and records.	
		ELEMENT A: Adopting Written Policies	
		The organization adopts written policies and procedures regarding protected health information (PHI) that addresses:	
	1	information included in notifications of privacy practices	ü
	2	access to PHI	ü
	3	the process for members to request restrictions on use/disclosure of PHI	ü
	4	the process for members to request amendments to PHI	ü
	5	the process for members to request an accounting of disclosures of PHI	ü
	6	internal protection of oral, written and electronic information across the organization.	ü
		ELEMENT B: Special Protection for PHI Sent to Plan Sponsors	
		The organization's policies and procedures prohibit sharing members' PHI with any sponsor without certification that the plan sponsor's documents have been amended to incorporate the following provisions and the plan sponsor agrees to:	ü
	1	not use or disclose PHI other than as permitted by the plan documents or required by law	ü
	2	ensure that agents and subcontractors of the employer or plan sponsor agree to the same restrictions and conditions as the employer or plan sponsor with regard to PHI	ü
	3	prohibit the use of PHI by the employer or plan sponsor for employment or other benefit-related decisions	ü
	4	notify the organization of any use or disclosure of PHI that is inconsistent with the uses and disclosures established in the plan documents	ü
	5	allow individuals access to PHI, including access to amend PHI	ü
	6	make necessary information available to the organization in order to provide individuals with accounting of disclosures	ü
	7	procedures for return, destruction and restrictions of further use of PHI by employers or plan sponsors	ü
	8	identify the sponsor's or employer's employees who have access to PHI	ü
	9	include provisions for actions if sponsor's or employer's employees inappropriately use or disclose PHI.	ü
		ELEMENT C: Right to Consent	
		The organization has policies and procedures that address a member's right to authorize or deny the release of PHI beyond uses for treatment, payment or health care operations.	ü
		ELEMENT D: Communication of PHI Use and Disclosure	
		The organization has informed its members, practitioners and providers of its policies and procedures regarding the collection, use and disclosure of member protected health information. Communication includes the following five factors:	ü
	1	the organization's routine uses and disclosures of PHI	ü
	2	use of authorizations	ü
	3	access to PHI	ü
	4	internal protection of oral, written and electronic PHI across the organization	ü
	5	protection of information disclosed to plan sponsors or employers.	ü
		ELEMENT E: Chief Privacy Officer/Privacy Committee	
		The organization designates either an internal staff member as chief privacy officer or an internal privacy committee. The chief privacy officer or the committee has been involved in the development and implementation of:	ü

RR 7		**Marketing Information**	
		The organization ensures that communications with prospective members correctly and thoroughly represent the benefits and operating procedures of the organization.	
		ELEMENT A: Materials and Presentations	
		All organization materials and presentations accurately describe:	
	1	covered benefits	ü
	2	noncovered benefits	ü
	3	practitioner and provider availability	ü
	4	a summary of key UM procedures the organization uses	ü
	5	potential network, services or benefit restrictions	ü
	6	pharmaceutical management procedures.	ü
		ELEMENT B: Communicating with Prospective Members	
		The organization communicates to prospective members, in easy-to-understand language, a summary of its policies and practices regarding the collection, use and disclosure of PHI:	
	1	inclusions in routine notifications of privacy practices	ü
	2	the right to approve release of information (use of authorization)	ü
	3	access to medical records	ü
	4	protection of oral, written and electronic information across the organization	ü
	5	information for employers.	ü
		ELEMENT C: Assessing Member Understanding	ü
		The organization systematically monitors new member understanding of its procedures to ensure that marketing communications are accurate and acts on opportunities for improvement.	ü
RR 8		**Delegation of RR**	
		If the managed care organization delegates any RR activities, there is evidence of oversight of the delegated activity.	
		ELEMENT A: Written Delegation Agreement	
		The written delegation document:	
	1	is mutually agreed-upon	ü
	2	describes the responsibilities of the organization and the delegated entity	ü
	3	describes the delegated activities	ü
	4	requires at least semi-annual reporting to the organization	ü
	5	describes the process by which the organization evaluates delegated entity's performance	ü
	6	describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.	ü
		ELEMENT B: Provisions for PHI	
		If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:	
	1	a list of the allowed uses of PHI	ü
	2	a description of delegate safeguards to protect the information from inappropriate use or further disclosure	ü
	3	a stipulation that the delegate will ensure that subdelegates have similar safeguards	ü
	4	a stipulation that the delegate will provide individuals with access to their PHI	ü
	5	a stipulation that the delegate will inform the organization if inappropriate uses of the information occur	ü
	6	a stipulation that the delegate will ensure PHI is returned, destroyed or protected if the delegation agreement ends.	ü
		ELEMENT C: Predelegation Evaluation	
		For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.	ü
		ELEMENT D: Reporting	
		For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element A.	ü
		ELEMENT E: Annual Evaluation	
		For delegation arrangements in effect for more than 12 months, the organization has performed an annual substantive evaluation of delegated activities against delegated NCQA standards and organizational expectations.	ü
		ELEMENT F: Opportunities for Improvement	
		For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identifies and followed up on opportunities for improvement, if applicable.	ü
Preventive Services			ü
PH 1		**Adoption of Preventive Health Guidelines**	
		The organization has preventive health (PH) guidelines for prevention and early detection of illness and disease.	ü
		ELEMENT A: Covered Groups	
		The organization's preventive health guidelines cover at least the following groups:	ü
	1	Prenatal and perinatal care	ü
	2	care for infants up to 24 months old	ü
	3	care for children and adolescents, 2-19 years old	ü
	4	care for adults, 20-64 years old	ü
	5	care for the elderly, 65 years and older.	ü
		ELEMENT B: Guideline Content	
		Each preventive health guideline addresses:	ü
	1	prevention or early detection interventions	ü
	2	the recommended frequency and conditions under which the interventions are required.	ü
		ELEMENT C: Scientific Evidence	
		The organization documents the scientific basis or recognized source on which it based the preventive health guidelines.	ü
		ELEMENT D: Guidelines form Recognized Sources or Practitioner Involvement	
		When it adopts preventive guidelines, the organization adopts guidelines from recognized sources or involves appropriate practitioners in the development or adoption of its own preventive health guidelines that are not from recognized sources.	ü
		ELEMENT F: Review and Update	
		The organization reviews and updates the guidelines at least every two years, where appropriate.	ü
PH 2		**Distribution of Guidelines to Practitioners**	
		The organization distributes preventive health guidelines and updates to its practitioners.	
		ELEMENT A: Distribution of New Guidelines	
		The organization communicates new guidelines to the appropriate existing practitioners.	ü
		ELEMENT B: Distribution of Revised Guidelines	
		The organization communicates revised guidelines to the appropriate existing practitioners.	ü
		ELEMENT C: Distribution of Existing Guidelines to New Practitioners	
		The organization communicates existing guidelines to new appropriate parctitioners.	ü
PH 3		**Health Promotion with Members**	
		The organization regularly encourages its members to use preventive health services.	
		ELEMENT A: Annual Distribution of Guidelines	
		The organization distributes all preventive health guidelines to members annually.	ü
		ELEMENT B: Encouraging Prevention	
		The organization informs and encourages members to use available health promotion, health education and preventive health services.	ü
		ELEMENT C: Targeting Members	
		The organization identifies specific members who, according to demographic and other identifiable health factors, may be at risk for specific health problems, and urges these members to use appropriate health promotion and prevention services.	ü

PH 4		**Delegation of Preventive Health**	
		ELEMENT A: Written Delegation Agreement	
		There is a mutually agreed-upon document that describes all delegated activities.	ü
		ELEMENT B: Specific Delegated Activities	
		There is a mutually agreed-upon document that describes all delegated activities.	ü
	1	the responsibilities of the organization and the delegated entity	ü
	2	the delegated activities	ü
	3	at least semi-annual reporting to the organization	ü
	4	the process by which the organization evaluates delegated entity's performance	ü
	5	the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.	ü
		ELEMENT C: Provisions for Protected Health Information	
		If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:	ü
	1	a list of the allowed uses of protected health information	ü
	2	a description of delegate safeguards to protect the information from inappropriate use or further disclosure	ü
	3	a stipulation that the delegate will ensure that subdelegates have similar safeguards	ü
	4	a stipulation that the delegate will provide individuals with access to their protected health information	ü
	5	a stipulation that the delegate will inform the organization if inappropriate uses of the information occur	ü
	6	a stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends.	ü
		ELEMENT D: Approval of the PH program	
		The organization approves its delegate's PH program annually.	ü
		ELEMENT E: Pre-Delegation Evaluation	
		For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.	ü
		ELEMENT F: Annual Evaluation	
		For delegation arrangements in effect for more than 12 months, the organization has performed an annual substantive evaluation of delegated activities against delegated NCQA standards and organizational expectations.	ü
		ELEMENT G: Reporting	
		For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element B.	ü
		ELEMENT H: Opportunities for Improvement	
		For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identifies and followed up on opportunities for improvement, if applicable.	ü

EXHIBIT 5
Consumer Assessment of Health Plans (CAHPS™)
Commercial Survey Data

Each Contractor with HCA for 2008 will provide to HCA a set of data from its 2008 commercial CAHPS™ 4.0 surveys.

The Contractor agrees to:

1. Conduct a CAHPS™ 4.0 survey of their adult commercial members in managed care products in which HCA members are enrolled (PEBB and/or BH). HCA members will be eligible to participate in the survey.
2. Ensure the survey sample frame consists of all non-Medicare and non-Medicaid adult plan members (not just subscribers) over the age of 18 with Washington State addresses. The sample frame for this survey shall exclude BH+ and S-medical (maternity benefits program) members since they are covered under the Medicaid program.
3. Contract with an NCQA certified vendor qualified to administer the CAHPS™ 4.0 survey and conduct the survey according to NCQA protocol.
4. Use the most recent HEDIS version of the commercial adult questionnaire or as instructed by NCQA for 2008 CAHPS™ 4.0 surveys.
5. Add one field at the end of each member level response record for HCA program identification. Label the field “HCA Identification.” This field will have a minimum of three values: PEBB member, BH member, Other.
6. Submit a copy of its Washington State adult commercial response data set according to NCQA/CAHPS™ standards (with the additional field described in paragraph 5 above) to both the HCA’s vendor and to the HCA’s Director of Basic Health Purchasing, Bevin Hansell (or her successor) by June 15, 2008.
7. Agree to have its data submitted to the National CAHPS™ Benchmarking Database (NCBD). HCA’s vendor will be responsible for forwarding each data set to the NCBD.
8. Agree to have its June 2008 premium reduced by the cost of the CAHPS sample audit validation.

Table of Contents

2008 Basic Health Service Area Matrix

County	CUP	CHPW	Group Health	Kaiser	Molina
Adams		B			B
Asotin					B
Benton		B			
Chelan		B			B
Clallam					BX
Clark	B	B		*B	
Columbia					B
Cowlitz		B		X	
Douglas		B			B
Ferry		B			B
Franklin		B			
Garfield					B
Grant		B			B
Grays Harbor		B			B
Island		B			
Jefferson		B			
King		B	B		B
Kitsap		B	B		
Kittitas					B
Klickitat		B			
Lewis		B			B
Lincoln		B			B
Mason		B			
Okanogan		B			B
Pacific		B			B
Pend Oreille		B			B
Pierce		B			B
San Juan		B			
Skagit		B			
Skamania		B			
Snohomish		B	B		
Spokane		B	B		B
Stevens		B			B
Thurston		B	B		B
Wahkiakum		B			
Walla Walla		B			B
Whatcom		B			B
Whitman					B
Yakima		B			B

"B" represents a county where plan will be available to enrollees at the benchmark rates for 2008.

"X" represents a county where plan will be available to enrollees above published benchmark rates for 2008.

"BX" represents a county where plan came in at a higher rate but will be available to enrollees at the benchmark rate.

The differential is paid by the HCA.

***Kaiser** continues to be frozen to new enrollment in Clark County

Contractors' 2008 Legal Names
Columbia United Providers, Inc.
Community Health Plan of Washington
Group Health Cooperative
Kaiser Foundation Health Plan of the Northwest
Molina Healthcare of Washington, Inc.

Table of Contents

EXHIBIT 7

Network Accessibility Guidelines

Report	Format	Enrollees	Provider Type	Access Guideline	Sort
1 9 17	Provider Map	none	PCPs	none	none
2 10 18	Provider Map	none	Hospitals	none	none
3 11 19	Accessibility Detail	Enrollees by Program: Urban/Suburban	PCPs Capacity: specific by PCP for each program	2 PCPs in 10 miles	County
4 12 20	Accessibility Detail	Enrollees by Program: Rural	PCPs Capacity: specific by PCP for each program	1 PCP in 25 miles	County
5 13 21	Accessibility Detail	Enrollees by Program: All	Obstetrical Practitioners Capacity <= 9999	1 Obstetric Practitioner in 25 miles	County
6 14 22	Accessibility Detail	Enrollees by Program: All	Hospitals Capacity <= 9999	1 Hospital in 25 miles	County
7 15 23	Accessibility Detail	Enrollees by Program: All	Pharmacies Capacity <= 9999	1 Pharmacy in 25 miles	County
8 16 24	Provider Count Detail	Enrollees by Program: All	Group 1 — PCPs Group 2 — OB Prac Group 3 — Hospitals Group 4 — Pharmacies	none	County/ City

Exhibit 8
Experience Data Reporting
Instructions for Basic Health and HCTC

The information that you are about to provide is vital to HCA. The Basic Health (BH) program will use this data to better understand utilization and healthcare cost trends for our population. It is essential that the data you submit be accurate. Please be sure to follow the definitions provided within this document when completing the worksheets.

General Procedures

The following are general instructions for completing the required reports. The primary objective of these instructions is to promote uniform reporting by all health plans.

Health plans will complete Experience Worksheets based on each health plan's financial and utilization experience with BH enrollees. Note that some of the reports require the information reported to be broken out between BH and HCTC.

This document also contains detailed, standardized definitions of the medical service categories contained in the worksheets. Health plans will use these standardized service category definitions to report their experience. HCA, in conjunction with their consultants, have provided health plans with sufficient detail so that the line items of the exhibits can be completed accurately. This assures that the data received will be as consistent as possible from health plan to health plan. The data reported by service category must be mutually exclusive and non-duplicating.

Each health plan must provide an Actuarial Memorandum signed by a Qualified Actuary. The memorandum must address the following issues:

1. Claim costs have been reviewed for reasonableness and reconciled to calendar year 2007 financial statements. While the reported experience will not balance exactly to the OIC financial statements for a variety of reasons, the actuary should understand and be comfortable with the sources of those differences.
2. Claim costs reflect best estimates of incurred experience for CY 2007, with no reserve margins.
3. Claim costs reflect all offsets, such as third party recoveries and pharmacy rebates.
4. Administrative expenses reflect the Basic Health block of business to the extent possible.
5. Administrative expenses include no risk margins or profits.

Reports are due March 31, 2008 for incurred experience in the prior calendar year.

Exhibit 8
Experience Data Reporting
Instructions for Basic Health and HCTC

REPORT 1 — DETAILED INCOME STATEMENT

Report revenues and expenses using the full accrual method according to GAAP.

A. Revenue

Capitation — Capitation Revenue recognized on a prepaid basis for provision of health care services for eligible participants. Capitated revenue PMPM should be calculated using the same denominator for member months that is used for all other PMPM line items.

Other Income — Revenue from sources not identified in other revenue categories such as investment income.

B. Incurred Medical Expense

All expenses must be reported, net of offsetting reimbursement, such as Medicare payments, other TPL or pharmacy rebates.

Hospital Inpatient — This expense category covers daily room and board and ancillary services in short-term hospitals. Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs and supplies. The ancillary charges do not include any professional charges (including professional charges for physicians on staff at the hospital).

Costs also include daily room and board and ancillary services in an approved nursing facility, including a skilled nursing facility. The care could be provided in either a nursing bed in a hospital or an independent skilled nursing facility. Confinements must be medically necessary; confinements related solely to custodial care are not included. Ancillary services include inpatient nursing care, pathology and radiology procedures, drugs and supplies.

Emergency Room services preceding a hospital inpatient admission should be included in the Hospital Inpatient category.

ER (Emergency Services) — This expense category covers services for outpatient emergency accident and medical care performed in the emergency area of a hospital outpatient facility. Costs include facility charges only and do not include professional charges unless performed by full-time staff of the facility and not billed separately.

Other Outpatient — This expense category covers hospital outpatient services (excluding emergency room services) performed in a hospital outpatient facility or a freestanding facility such as surgery, radiology, pathology, pharmacy and blood, cardiovascular, and PT/OT/ST. Costs include facility charges only and do not include professional charges unless performed by full-time staff of the facility and not billed separately.

Exhibit 8
Experience Data Reporting
Instructions for Basic Health and HCTC

Professional — This expense category covers the charges for medical treatments done by a qualified professional and not otherwise included above. Include all professional fees for inpatient and outpatient services when billed separately from the facility charge, services by anesthesiologists, office visits, home visits, consultations, the professional components of radiology and pathology services when performed in a hospital or freestanding facility, global radiology and pathology charges when performed in an office or clinic setting, private duty nursing, chiropractor, podiatrist, naturopathy, and PT/OT/ST services performed in an office setting.

RX (Pharmacy) — This expense category covers the charges for prescription drugs. Costs include material charges only and do not include professional charges or prescription drugs included in a facility charge.

Other (Specify) — Those outpatient expenses not specifically identified in one of the categories defined above. Note: This category should only be used if the expense cannot be allocated to one of the predefined categories. Examples include ambulance, durable medical equipment, prosthetics, and risk payments not considered as capitated payments. Capitated expenses covering services in the categories listed above should be allocated accordingly and should not be placed in the Other category.

C. Incurred Claim Allocation

The incurred claim subtotal (from Part B) should be allocated such that it equals paid claims plus ending reserves less beginning reserves for the requested experience period.

Beginning Reserves — Total medical expense reserves as of the start date of the requested experience period.

Paid Claims — Claims paid during the requested experience period. This includes capitation, fee-for-service, and provider risk payments.

Ending Reserves — Total medical expense reserves as of the end date of the requested experience period.

D. Other Claim Information

Reinsurance Premium Paid — Reinsurance Premium Expense.

Reinsurance Recoveries — Amounts recovered and recoverable from reinsurers on losses incurred during the experience period.

Third-Party Liability (TPL) Recoveries — Include all third party cost offsets.

E. Administrative Expense

Administrative expenses must include all administrative costs associated BH enrollees incurred by the contracted plan.

Exhibit 8
Experience Data Reporting
Instructions for Basic Health and HCTC

Rent — Occupancy expenses incurred, such as rent and utilities, on facilities used to deliver health care services to participants as well as administrative facilities. Deduct rent under sublease and exclude items for health care delivery.

Salaries, Wages, and Other Benefits — This includes all forms of compensating employees including salaries and wages, bonuses, benefits, payroll taxes, payments under a program for pension, stock options, purchases, etc. to personnel.

Legal Fees and Expenses — Fees paid or payable by the health plan for the current period for court costs, penalties and all fees or retainers for legal services or expenses in connection with matters before administrative or legislative bodies. Exclude salaries and expenses of company personnel, legal expenses associated with investigation, litigation and settlement of policy claims, and legal fees specifically associated with real estate transactions.

Marketing and Advertising — Expense related to any medium of exchange whereby the intent of such medium is to promote or increase a health plan's enrollment such as newspaper, magazine and trade journal advertising, television or radio broadcasting, and mailings. Exclude outreach activities designed to inform existing participants of their benefits.

Outsourced Services — Management fees paid or payable by the health plan for the current period to an outside management company as well as costs for outside data processing services during the period.

Other Expenses (Specify) — Those administrative expenses not specifically identified in the categories above such as interest expense, depreciation on assets not used to deliver health care services to participants, or internal data processing (other than compensation).

Premium Tax — Exclude any portion of allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

F. Total Expenses

Equal to total incurred medical expenses plus total administrative expense.

G. Income (Loss) Before Income Taxes

Total revenue less total expenses.

REPORT 2 — EXPERIENCE BY COUNTY

County is defined by subscriber residence.

Members — The member months should be reported on a cumulative basis by coverage group. A member (participant) is an eligible person who has been enrolled

Exhibit 8
Experience Data Reporting
Instructions for Basic Health and HCTC

with a health plan for the provision of health services. A member month is equivalent to one (1) member for whom the health plan has recognized capitation-based revenue for the month. The number of member months should correlate to the number of capitated payments received.

Revenue — Revenue includes capitation revenue. It is not necessary to allocate other revenue by county for this report.

Capitation — Includes incurred capitation expenses to providers for the requested experience period.

Fee-For-Service Paid — Includes fee-for-service expenses incurred during the requested experience period.

Other — Includes any risk or incentive payments incurred during the experience period.

REPORT 3 — TREND MONITORING REPORT

The claims included in Report 3 should be consistent with the OIC Service Categories of Medical/Hospital, Professional and Rx.

Members — A member (participant) is an eligible person who has been enrolled with a health plan for the provision of health services. The number of members should correlate to the number of capitated payments received.

Capitation — Includes incurred capitation payments to providers for the members for each given month and year.

Fee-For-Service Paid — Includes incurred fee-for-service costs the given month and year.

Other — Includes any risk or incentive payments incurred during the three year period. Please disclose any allocation method used to spread payments by month.

Estimated Incurred — Equals capitation plus fee-for-service plus other.

Estimated Incurred PMPM — Estimated Incurred divided by Members for each month.

REPORT 4 — HIGH COST MEMBERS REPORT

For the requested experience period, report all members with incurred claims in excess of $100,000 for each of the four coverage groups. Member identification must be scrambled. The individuals will not be re-identified.

Exhibit 8
Experience Data Reporting
Instructions for Basic Health and HCTC

REPORT 5 — UTILIZATION SUMMARY

Utilization statistics per 1,000 should be consistent with the incurred claims included in Report 1. Include capitated and fee-for-service experience. Separate delivery utilization from other inpatient statistics. As with Report 1, Emergency Room visits should not include encounters leading to an inpatient admission.

Exhibit 9

2008 Basic Health HEDIS® Measures

For 2008, the CONTRACTOR shall report the following audited measures in accord with the current HEDIS® Technical Specifications and official corrections published by NCQA for Basic Health.

If Basic Health is not included in the CONTRACTOR'S product line that is reported as the "commercial" rate, then the product line which includes Basic Health must be counted, audited and reported seperately.

All CONTRACTORS will report the following HEDIS® measures for 2008 using 2007 data:

1. Childhood immunization status
2. Adolescent immunization status
3. Beta-blocker treatment after a heart attack
4. Comprehensive diabetic care Hybrid *method only*
5. Follow-up after hospitilization for mental illness (30 day follow-up only)
6. Cholesterol management after acute cardiovascular events (screening rates)
7. Antidepressant medication management (all three rates)
8. Chlamydia screening

CONTRACTOR agrees to have its June 2008 premium reduced by the cost of the HEDIS audit, as required for NCQA validation.

All data will be submitted by June 15, 2008 to:

Bevin Hansell, Director of Basic Health Purchasing (or her successor)
Health Care Authority
PO Box 42683
Olympia, WA 98504-2683

Health Care Authority — Basic Health 2008 Contract

Exhibit 10: Paid Claims Data Reporting

MINIMUM REPOSITORY DATA LOADING REQUIREMENTS

Claims Data

Prefer all data tables sent as delimited text files

Prefer **all** ("Paid", "Denied", etc.) claims and service line detail information.

Required	-	Claim ID (unique claim identifier)
Required	-	Claim or Service Line Number
Required	-	Member ID (or Patient ID)
Required	-	Claim Status (overall claim status *and* claim service line status)
Required	-	Form Type (for example: UB92, HCFA, ADA, Drug, etc.)
	-	Encounter Type (identifies whether capitated or statistical claim)
Required	-	Billing Provider ID
Required	-	Attending Provider ID
	-	Referring Provider ID
	-	Admitting Provider ID
Required	-	Admit Date (for hospital claims)
Required	-	Discharge Date (for hospital claims)
Required	-	Service From Date
	-	Service To Date
	-	Length of Stay (for inpatient claims)
Required	-	Service Units (Quantity)
Required	-	DRG (for inpatient claims)
Required	-	Primary ICD-9 Diagnosis Code
	-	Additional ICD-9 Diagnosis Codes (up to 5 additional codes, if available)
	-	ICD-9 Procedure Code (up to 8, if available)
Required	-	Hospital Revenue Codes
Required	-	Procedure Code (CPT-4, HCPCS, NDC as applicable for each service line)
Required	-	Procedure Code Modifier (as applicable)
Required	-	Place of Service
Required	-	Billed Amount
	-	Discount Amount
	-	Disallowed Amount
Required	-	Allowed Amount
Required	-	COB/TPL Payment Amount
Required	-	Copayment Amount
Required	-	Coinsurance Amount
Required	-	Deductible Amount
	-	Withhold Amount
Required	-	Paid Amount
Required	-	Claim Paid/Check Date (for paid claims)
Required	-	Claim Received Date
Required	-	Claim Entry Date
Required	-	Service Post Date (for paid or denied claims)

Health Care Authority — Basic Health 2008 Contract

Exhibit 10: Paid Claims Data Reporting

MINIMUM REPOSITORY DATA LOADING REQUIREMENTS

Claims Data

- Discharge Status
- Admit Type
- Admit Source
- Claim Adjudication Code
- PCP Provider ID

Pharmacy Claims

Prefer **all** ("Paid", "Suspended", "Pended", "Denied", etc.) claims and service line detail information.

Required - Claim ID (unique claim identifier)
- Claim or Service Line Number (if available)

Required - Member ID (or Patient ID)

Required - Prescription Fill Date

Required - National Drug Code (NDC)

Required - Paid Date

Required - Number of Scripts
- New / Refill Code
- Days Supply

Required - Billed Amount

Required - Allowed Amount
- COB/TPL Payment Amount

Required - Copayment Amount
- Coinsurance Amount
- Deductible Amount
- Withhold Amount

Required - Paid Amount
- Ingredient Cost
- Dispensing Fee
- Dispense as Written (DAW) Code
- Drug Type (i.e., OTC, SSB, MSB, Generic)
- Formulary Flag

Eligibility

Include all eligibility *events* (such as change in: effective or termination date)

Required - Member ID or Patient ID (for matching to Claim)

Required - Relationship to Subscriber (for example: self, spouse, dependent)

Required - Subscriber ID

Required - Gender

Required - Birth date

	- Member Name
	- Member Address
	- PCP ID (if applicable)
Required	- Member Effective Date (beginning of coverage event)
Required	- Member Termination Date (end of coverage event, if applicable)

Reference Table Requests

Required	- Provider Specialty Codes Table
	- Claim Status Codes Table
	- Claims Adjudication Codes Table
Required	- Provider Table

Exhibit 11

Basic Health 2008 Grievance System Reporting

Grievance System Reporting Instructions

Calendar Quarter:

Quarter in which Grievances were received:
4th — October-December, 2007
2nd — April-June, 2008
1st — Jan-March, 2008
3rd — July-September, 2008

Data submission:

4th Quarter, 2007	**Due: February 1, 2008**
1st Quarter, 2008	**Due: May 1, 2008**
2nd Quarter, 2008	**Due: August 1, 2008**
3rd Quarter, 2008	**Due: November 1, 2008**

- Data must be in EXCEL and be submitted electronically through the secure HCA Valicert web site (https://sft.wa.gov). **Submitter must send an upload notification to Bevin Hansell (bevin.hansell@hca.wa.gov) for Basic Health (including HCTC data).**
- Submissions must be labeled with health plan name, reporting year and quarter, and book of business (Example: HealthPlan Q2/08 BH)
- Data must be reported and loaded separately onto secure web site by book of business to ensure compliance with HIPAA privacy requirements. (Example: Basic Health; HO/BH+-S Women/SCHIP; WMIP; GAU; MMIP)

DEFINITIONS

Denial: **For Basic Health (including HCTC) apply PBOR definition: A nonauthorization of a request for care or services.**

Appeal: An enrollee's written or oral request that the health plan reconsider: (a) Its resolution of a complaint made by an enrollee; or (b) its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility. A carrier must not require that an enrollee file a complaint prior to seeking appeal of a decision under (b) of this subsection. (RCW 48.43.530 (4))

Expedited: An appeal must be expedited if the enrollee's provider or the carrier's medical director reasonably determines that the appeal process timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours of the date the appeal is received. (RCW 48.43.530 (c))

Grievance:	**For Basic Health (including HCTC) apply PBOR definition:** "Grievance" means a written or oral **complaint** submitted by or on behalf of a covered person regarding: (a) denial of payment for medical services or non-provision of medical services included in the covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or non-provision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. (RCW 48.43.530; WAC 284-43-130; WAC 284-43-160) Grievance Example: Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights. A grievance is to be registered and counted as such whether the grievance is remedied by the plan immediately or through its grievance and quality of care and service procedures and regardless of whether it is substantiated. If an enrollee has a number of different grievances, each one is to be registered separately. Any grievance sent by a state agency (HCA/HRSA/OIC) is to be registered and counted as a grievance regardless of how it is resolved. *Inquiry: A written or verbal question or request for information posed to the plan with regards to such as issues a benefit questions, contract issues, or organization rules. Inquiries do not reflect enrollee grievance or disagreements with plan determinations. Inquiries **are not** to be counted.* *Example: An ID card request is considered an inquiry unless the enrollee has requested more than once and is making a grievance about not receiving the ID card.*
Issue:	The purpose or catalyst for the grievance, denial/action, or appeal.
Practitioner:	Practitioner involved in the appeal, denial or grievance.
Resolution:	The health plan's final decision of the grievance or appeal.

2007 — 2008 Denial /Appeals/ Grievance Contract Requirements

MCO FORMAT REPORTING GUIDELINES

1. **Column A**: Health Plan Name — Indicate reporting plan with full name or common abbreviation
2. **Column B:** Delegated Entity — Identify the health plan's delegated entity that receives denial, appeal, or grievance. The health plan is responsible to integrate the delegated entity's data into the health plan's data. There should be no separate data submission for the delegated entities.
3. **Column C**: Quarter — Indicate the reporting quarter the initial grievance is received. Reporting format: 1,2,3,4
4. **Column D**: Program Name — Specify the program for the data submitted using numbers 1-8 as follows:
    1. BH — Indicates Basic Health and HCTC enrollees, does not include BH+ or S-Women
    2. PEBB — Includes all enrollees covered by the PEBB contract
    3. HO — Includes all HRSA Healthy Options Medicaid Managed Care enrollees (also see Column E)
    4. BH+ — Includes BH+ and S-Women enrollees
    5. SCHIP — Identifies Children's Health Insurance Program enrollees
    6. GAU
    7. WMIP
    8. MMIP
5. **Column E:** ESHCN- Identify all enrollees with special health care needs by program with an "X" **(HRSA Only)**
6. **Column F:** Enrollee ID — Populate column with the enrollee's Social Security Number.
7. **Column G**: Enrollee Last Name — Identifies the enrollee. (**mandatory for HRSA only)**
8. **Column H**: Enrollee First Name — Identifies the enrollee. (**mandatory for HRSA only)**
9. **Column I**: Enrollee Middle Initial — Identifies the enrollee. (**mandatory for HRSA only)**
10. **Column J:** Enrollee Birth Date — Format: MM/DD/YYYY (Example: 12/01/1985).
11. **Column K**: Provider/Practitioner Last Name — Identifies the serving provider/practitioner, either as the source of a member's grievance, was the provider of service the plan took action upon or denied, or is addressing the enrollee's service.
12. **Column L**: Provider/Practitioner First Name — Identifies the serving provider/practitioner, either as the source of a member's grievance, was the provider of service the plan took action upon or denied, or is addressing the enrollee's service.

13. **Column M**: Provider/Practitioner Middle Initial — Identifies the serving provider/practitioner, either as the source of a member's grievance, provider of service the plan took action upon or denied, or is addressing the enrollee's service.

14. **Column N**: Provider/Practitioner Category — Identifies type of practitioner. Should be no more than thirty (30) characters.

    Examples: Family Practitioner, Chiropractor, Acupuncturist, Surgeon, General Surgeon, Orthopedist, Urologist, Internal Medicine, Certified Nurse Practitioner, Dermatologist, etc.

15. **Column O**: Facility Name — Identifies the facility or clinic the practitioner is associated or contracted with and which is associated with the grievance, denial/action, or appeal.

16. **Column P:** Type/Level — Specifies the category and the level for the data submitted as follows:

    1= Grievance

    2= Denial (**BH Only**)

    3= Action **(HRSA Only)**

    4= 1st Level Appeal

    5= 2nd Level Appeal

    6= Independent Review Organization (IRO)

    7= State Hearing **(HRSA Only)**

17. **Column Q**: Expedited — Identifies urgency of the grievance or appeal. Reporting format: "X" for yes.

18. **Column R**: Grievance, Denial/Action, Appeal, IRO, or Hearing Issue —Identifies/describes the "what" or the catalyst for the requested grievance, the service denied or MCO action taken, or issue driving the appeal by the enrollee or practitioner. **This key descriptive column must be populated for all records.**

    Issue Examples:

    Grievances: Administrative, Referrals, Waited too long on hold (or Dissatisfaction with Quality of Service), Provider was rude (Interpersonal Relationships or Dissatisfaction with Quality of Service), could not access a preferred provider (or Dissatisfaction with Plan Practices)

    Denials/Actions: Pain Management, Durable Medical Equipment, Prescription Drug, Chiropractic Benefits, PT/ST/OT, Emergency Services, Out of Area Care, Psychotherapy, Acupuncture,

    Appeals, IROs, State Hearings: Reflects what was in the initiating Denial/Action.

19. **Column S**: Grievance, Denial/Action, Appeal, IRO, or Hearing Reason: - Describes the "why" or which best describes the reason behind the member's dissatisfaction, behind the denied,

reduced, or changed service, or for causing the appeal, IRO, or hearing. **This key descriptive column must be populated for all records.**

Reason Examples:

Grievances: Referral lost or incomplete, Staff behavior, Perceived lack of caring/concern,

Denials/Actions: Not Medically Necessary, Not Medically Indicated, Partial Approval, Not a Covered Benefit, Contract Exclusion, No Benefit, Limited Benefit/Excluded, , Benefit Exceeded/Exhausted, Out of Network, Not A Contracted Provider, Non-Preferred Provider, Care Available from participating provider, No Referral, RX criteria not met, Investigational/Experimental, etc.

Appeals, IROs, State Hearings: Reflects what was in the initiating Denial/Action.

(NOTE: "Other" category should be used only as a last resort.)

20. **Column T**: Resolution of Grievance, Appeal, or IRO — — Describes the "outcome" — the grievance, appeal, IRO, or State Hearing determination. This specifies all partial approvals or a plan changes in a service request. **This key descriptive column must be populated for all records.**

    Resolution Examples:

    Grievances: Resolved, Forwarded to Admin/Mgr., Explanation Provided, Adjustment Completed

    Denials/Actions: Generally Blank.

    Appeals, IRO/State Hearing Determinations: Upheld, Overturned, Reversed, Partially Upheld, Partial Payment, Partial Approval, Withdrawn.

    Grievance — Action/Review/Response Provided, Forwarded to QI, Benefit Explained, Consulted/Advised.

21. **Column U**: Date Received — Documents the date the grievance was received, a denial or action took place, or an appeal, IRO, or State Hearing request was received. Reporting format: MM/DD/YYYY

22. **Column V**: Date Resolved — Identifies the date a grievance was responded to, dates denial notice sent, or date an appeal, IRO, or a denial determination is made. Reporting format: MM/DD/YYYY

23. **Column W**: Date written notification sent to enrollee and practitioner. Reporting format: MM/DD/YYYY

Note: Some plans requested examples of denial, appeal, grievance categories and denial reason. Plans are **not** required to use the issue and reason examples listed.

Additional Sample Grievance Issues by Category:

Access

Appointment availability with PCP-Grievance could include such issues as the inability to see a specific PCP; delay in getting an appointment to a PCP; appointment times are inconvenient; inadequate numbers of PCP, location of PCP office is inconvenient.

Appointment availability with specialist — Grievance can cover the same issues as above as they apply to physician specialists.

Appointment availability with ancillary- Grievance can cover the same issues as in above as they apply to ancillary services such as lab, radiology, etc.

Difficulty obtaining referral and/or covered services.

Difficulty obtaining after hours care- no response or delayed response; incomplete or unsatisfactory response to call made to the health plan or practitioner after normal business hours.

Network- adequacy of the practitioner network.

Quality of Care

Dissatisfaction with quality of medical care.

Dissatisfied with explanation of the problem or issue.

Dissatisfied with quality of clinical provider (such as physicians, nurses, therapists, psychologists) and /or such issues as misdiagnosis by any provider, unsatisfactory outcome of the treatment; unsatisfactory treatment methods, tests were not properly done, were lost, results, were not communicated; medical records could not be obtained; medication errors.

Hospital — dissatisfaction with length of stay; dissatisfaction with hospital treatment or discharge plans.

Dissatisfaction with substance abuse services/treatment; or dissatisfaction with substance abuse provider.

Dissatisfaction with pharmacy — generic drug problem; or the health plan's drug formulary.

Quality of Service

Dissatisfaction with provider services (non-medical): The physician or office staff behavior or appearance; office or facility appearance; wait time in the provider's office, exam room, or on the telephone.

Dissatisfaction with the health plan's service:

Health plan staff behavior, difficulty with telephone access and wait time.

Eligibility — issuance and/or receipt of I.D. cards, enrollment, disenrollment.

Telephone — Multiple transfers/calls to resolve issue.

Reimbursement/billing disputes- billing errors; enrollee is being billed directly; visits to providers are denied payment.

Pharmacy — dissatisfaction with length of prescription; dissatisfaction with type/locations of vendors; problem with mail order prescriptions.

Exhibit 12: Basic Health 2008 Contract

Report Due Dates for Basic Health — 2008 Contract

Name of Report	Report Due Date	HCA Recipient	Other Recipient
CAHPS (Exhibit 5)	June 15	Bevin Hansell	
Complaints, Grievances, Denials and Appeals 10 — 12/07	February 1	Bevin Hansell	HCA Valicert
Complaints, Grievances, Denials and Appeals 1 — 3/08	May 1	Bevin Hansell	HCA Valicert
Complaints, Grievances, Denials and Appeals 4 — 6/08	September 1	Bevin Hansell	HCA Valicert
Complaints, Grievances, Denials and Appeals 7 — 9/08	November 1	Bevin Hansell	HCA Valicert
Contractor's Non-Business Days for 2008	March 1	Bevin Hansell	
Experience Reports BH & HCTC	March 31	Bevin Hansell	Milliman
HEDIS® (Exhibit 9)	June 15	Bevin Hansell	
HEDIS® (Raw Measures)	June 30	Bevin Hansell	
Paid Claims Data — 2008 Monthly	Due within 30 days from end of each month	cc: Bevin Hansell	Milliman
Performance Measures January 1 — June 30	July 31	Bevin Hansell	
Performance Measures July 1 — December 31	January 31	Bevin Hansell	

Exhibit 10.2

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
2008 — 2009 CONTRACT

FOR
HEALTHY OPTIONS

AND
STATE CHILDREN'S HEALTH INSURANCE PLAN

APPROVED AS TO FORM BY THE ATTORNEY GENERAL'S OFFICE

TABLE OF CONTENTS

1. **GENERAL TERMS AND CONDITIONS**

The words and phrases listed below, as used in this Contract, shall each have the following definitions:

1.1 **Central Contract Services**means the DSHS central headquarters contracting office, or successor section or office.

1.2 **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.

1.3 **Contract** means the entire written agreement between DSHS and the Contractor, including any Exhibits, documents, and materials incorporated by reference.

1.4 **Contracts Administrator** means the manager, or successor, of Central Contract Services or successor section or office.

1.5 **Contractor** means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, members, 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, members, officers, directors, partners, employees, and/or agents.

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

1.7 **DSHS or the Department** means the state of Washington Department of Social and Health Services and its employees and authorized agents.

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

1.9 **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.

1.10 **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.

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

1.12 **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/.

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

1.14 **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.

1.15 **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.

1.16 **Subrecipient** means a non-federal entity that expends federal awards received from a pass-through entity to carry out a federal program, but does not include an individual that is a beneficiary of such a program. A subrecipient may also be a recipient of other federal awards directly from a federal awarding agency.

1.17 **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.

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

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

1.18.2 Is accomplished other than via a Trusted System.

1.19 **Trusted Systems** include only the following methods of physical delivery:

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

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

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

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

1.21 **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/.

1.22 **Amendment**: This Agreement may only be modified by a written amendment signed by both parties. Only personnel authorized to bind each of the parties may sign an amendment.

1.23 **Assignment**: The Contractor shall not assign this Agreement or Program Agreement to a third party without the prior written consent of DSHS.

1.24 **Billing Limitations**:

1.24.1 DSHS shall pay the Contractor only for services provided in accordance with this Contract.

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

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

1.25 **Compliance with Applicable Law**: In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal, state and local laws and regulations, and all amendments thereto, that are in effect when the Contract is signed or that come into effect during the term of this Contract (42 CFR 438.6(f)(1) and 438.100(d)). This includes, but is not limited to:

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

1.25.2 Title VI of the Civil Rights Act of 1964;

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

1.25.4 The Age Discrimination Act of 1975;

1.25.5 The Rehabilitation Act of 1973;

1.25.6 The Budget Deficit Reduction Act of 2005

1.25.7 The False Claim Act

1.25.8 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:

1.25.8.1 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 DSHS, DHHS, and the EPA.

1.25.8.2 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.

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

1.25.8.4 Those specified in Title 18 RCW for professional licensing.

1.25.8.5 Industrial Insurance — Title 51 RCW.

1.25.8.6 Reporting of abuse as required by RCW 26.44.030.

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

1.25.8.8 EEO Provisions.

1.25.8.9 Copeland Anti-Kickback Act.

1.25.8.10 Davis-Bacon Act.

1.25.8.11 Byrd Anti-Lobbying Amendment.

1.25.8.12 All federal and state nondiscrimination laws and regulations.

1.25.8.13 Americans with Disabilities Act: The Contractor shall make reasonable accommodation for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all covered services and shall assure physical and communication barriers

shall not inhibit enrollees with disabilities from obtaining covered services.

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

1.26 **Confidentiality**: The Contractor shall not use, publish, transfer, sell or otherwise disclose any, including but not limited to medical records, Confidential Information gained by reason of this Contract for any purpose that is not directly connected with Contractor's performance of the services contemplated hereunder, except:

As provided by law; or In the case of Personal Information, with the prior written consent of the person to whom the Personal Information pertains or their legal guardian.

1.26.1 The Contractor and DSHS agree 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 DSHS efforts to implement HIPAA requirements.

1.26.2 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 that Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:

1.26.3 Encrypting electronic Confidential Information during Transport;

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

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

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

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

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

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

1.26.10 In the event of a theft, loss, unauthorized disclosure, or other potential or known compromise of Confidential Information, the Contractor shall notify DSHS 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.

1.27 **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. The Contractor also agrees to include the above requirement in any and all subcontracts into which it enters.

The Contractor certifies that it does not knowingly have a director, officer, partner, or anyone with a beneficial ownership of more than five percent (5%) of the Contractor's equity, or have an employee, consultant or subcontractor who is significant or material to the provision of services under this Contract, who has been, or is affiliated with someone who has been debarred, suspended, or otherwise excluded by any federal agency (SSA 1932(d)(1)). A list of debarred, suspended or otherwise excluded parties is available on the following Internet website: www.arnet.gov/epls.

1.27.1 The Contractor is not required to consult the excluded parties list, but may instead rely on certification from directors, officers, partners, employees, contractors, or persons with beneficial ownership of more than five percent (5%) of the Contractor's equity, that they are not debarred or excluded from a federal program.

1.27.2 The Contractor is required to notify DSHS in writing, as described in the Notices section of the General Terms and Conditions, , when circumstances change that affect such certifications referenced in this Section.

1.27.3 The Contractor shall provide to DSHS in writing, as described in the Notices section of the General Terms and Conditions, a list of persons with a beneficial ownership of more than five percent (5%) of the Contractor's equity no later than February 28 of each year of this Contract. If no person has a beneficial ownership of more than five percent (5%) of the Contractor's equity, the Contractor shall so notify DSHS.

DSHS.

1.28 **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:

1.28.1 The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and the Office Chief of the DSHS, Division of Healthcare Services, Office of Quality and Care Management.

1.28.2 If the Contractor or DSHS is not satisfied with the outcome of the resolution with the Office Chief, the Contractor may submit the disputed issue in writing, for review, within ten (10) working days of the outcome to:

Director
Department of Social and Health Services
Division of Healthcare Services
P.O. Box 45502
Olympia, WA 98504-5502

The Director may request additional information from the Office Chief and/or the Contractor. The Director shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor as described in the Notices section of the General Terms and Conditions.

1.28.3 When the Contractor disagrees with the review decision of the Director, the Contractor may request independent mediation of the dispute. DSHS shall be bound by the decision of the Director if the Contractor is satisfied with the decision. The request for mediation must be submitted to the Director, in writing, within ten (10) working days of the contractor's receipt of the Director's review decision. The Contractor and DSHS shall mutually agree on the selection of the independent mediator and shall bear all costs associated with mediation equally. The results of mediation shall not be binding on either party.

1.28.4 Both parties agree to make their best efforts to resolve disputes arising from this Contract and agree that the dispute resolution process described herein shall precede any court action. This dispute resolution process is the sole administrative remedy available under this Contract.

1.29 **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 DSHS 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.

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

1.31 **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 Department. 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 Department 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 DSHS nor the State of Washington are guarantors of any obligations or debts of the Contractor.

1.32 **Insolvency**:

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

1.32.1.1 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));

1.32.1.2 In accord with the Prohibition on Enrollee Charges for Covered 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 covered services (42 CFR 438.106(b)(1))).

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

1.33 **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, 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 Medicaid fraud investigators (42 CFR 438.6(g)).

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

1.34.1 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, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds expressly for, and limited to, Contractor's services provided under this Contract.

1.34.2 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.

1.34.3 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 DSHS shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.

1.34.4 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.

1.34.5 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 DSHS if requested.

1.34.6 Separation of Insureds: All insurance Commercial General Liability policies shall contain a "separation of insureds" provision.

1.34.7 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 the DSHS. Exceptions include placement with a “Surplus Lines” insurer or an insurer with a rating lower than A-, Class VII.

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

1.34.9 Material Changes: The Contractor shall give DSHS, 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 DSHS ten (10) calendar days advance notice of cancellation.

1.34.10 General: By requiring insurance, the State of Washington and DSHS 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 DSHS 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.

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 DSHS 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 DSHS as an additional insured, expressly for, and limited to, the Contractor’s services provided under this Contract, and provides a point of contact for DSHS.

1.35 **Maintenance of Records**: 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.

All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of six (6) years after final payment is made under this Contract. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action.

1.36 **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:

1.36.1 Title XIX of the federal Social Security Act of 1935, as amended, and its implementing regulations, as well as federal statutes and regulations concerning the operation of Managed Care Organizations.

1.36.2 State of Washington statues and regulations concerning the operation of the DSHS programs participating in this Contract, including but not limited to RCW 74.09.522 and chapters 388-538 (Managed Care), 388-865 (Mental Health) and 388-805 (DASA) WAC.

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

1.36.4 General Terms and Conditions of this Contract.

1.36.5 Any other term and condition of this Contract and exhibits if any, as indicated on page one of this Contract.

1.36.6 Any other material incorporated herein by reference.

1.37 **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.

1.38 **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.

1.38.1 After termination of this Contract, the Contractor remains obligated to:

1.38.1.1 Cover hospitalized enrollees until discharge consistent with the Enrollee Hospitalized at Termination of Enrollment provisions of the Benefits Section of this Contract.

1.38.1.2 Submit reports required in this Contract.

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

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

1.39 **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 DSHS Chief Administrative Officer or designee has the authority to waive any term or condition of this Contract on behalf of DSHS.

2. **ADDITIONAL GENERAL TERMS AND CONDITIONS—CLIENT SERVICE CONTRACTS**

2.1. **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.

2.2. **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 DSHS client with whom the Contractor has contact.

2.3. **Indemnification and Hold Harmless**: Each party shall be responsible for, and shall indemnify and hold the other party harmless from, all claims and/or damages to persons and/or property resulting from its own negligent acts and omissions. The Contractor shall indemnify and hold harmless DSHS from any claims by non-participating providers related to the provision to enrollees of covered services under this Contract. 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.

2.4. **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, DSHS may collect from the Contractor the full amount payable to the Industrial Insurance accident fund. DSHS may deduct the amount owed by the Contractor to the accident fund from the amount payable to the Contractor by DSHS 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.

2.5. **No Federal or State Endorsement**: The award of this Contract does not indicate an endorsement of the Contractor by the Centers of Medicare and

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.

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

2.6.1. In the case of notice to the Contractor, notice will be sent to the Contractor Contact at the address for the Contractor on the first page of this Contract.

2.6.2. In the case of notice to DSHS, send notice to:

Office Chief
Department of Social and Health Services
Division of Healthcare Services
Office of Quality and Care Management
P.O. Box 45530
Olympia, WA 98504-5530

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

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

2.7. **Notification of Organizational Changes**:

2.7.1. The Contractor shall provide DSHS with ninety (90) calendar days prior written notice of any change in ownership or legal status.

2.7.2. The Contractor shall provide DSHS written notice of any changes to key personnel including, but not limited to, Chief Executive Officer, DSHS government relations contact, and Medical Director as soon as reasonably possible.

2.8. **Notice of Overpayment**: If the Contractor receives a vendor overpayment notice or a letter communicating the existence of an overpayment from DSHS, the Contractor may protest the overpayment determination by requesting an adjudicative proceeding. The Contractor's request for an adjudicative proceeding must:

2.8.1. 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;

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

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

2.8.4. Include a copy of the overpayment notice.

2.8.4.1. 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.

2.8.4.2. 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. DSHS may charge the Contractor interest and any costs associated with the collection of this overpayment. DSHS 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 DSHS to satisfy the overpayment debt.

2.9. **Ownership of Material**:DSHS recognizes that nothing in this Contract shall give DSHS 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 DSHS during the performance of this Contract.

2.10. **Solvency**:

2.10.1. 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.

2.10.2. The Contractor agrees that DSHS may at any time access any information related to the Contractor's financial condition, or compliance

with OIC requirements, from OIC and consult with OIC concerning such information.

2.11. **State Conflict of Interest Safeguards**: The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public contracting (41 USC 423).

2.12. **Subrecipients**:

2.12.1. General. If the Contractor is a subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Agreement, the Contractor shall:

2.12.1.1. Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity;

2.12.1.2. Maintain internal controls that provide reasonable assurance that the Contractor is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant agreements that could have a material effect on each of its federal programs;

2.12.1.3. Prepare appropriate financial statements, including a schedule of expenditures of federal awards;

2.12.1.4. Incorporate OMB Circular A-133 audit requirements into all agreements between the Contractor and its Subcontractors who are subrecipients;

2.12.1.5. Comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation;

2.12.1.6. Comply with the applicable requirements of OMB Circular A-87 and any future amendments to OMB Circular A-87, and any successor or replacement Circular or regulation; and

2.12.1.7. Comply with the Omnibus Crime Control and Safe streets Act of 1968, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and The Department of Justice Non-Discrimination Regulations, 28 C.F.R. Part 42, Subparts C.D.E. and G, and 28 C.F.R. Part 35 and 39. (Go to

www.ojp.usdoj.gov/ocr/ for additional information and access to the aforementioned Federal laws and regulations.)

2.12.2. Single Audit Act Compliance. If the Contractor is a subrecipient and expends $500,000 or more in federal awards from any and/or all sources in any fiscal year, the Contractor shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the Contractor shall:

2.12.2.1. Submit to the DSHS contact person the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor;

2.12.2.2. Follow-up and develop corrective action for all audit findings; in accordance with OMB Circular A-133, prepare a "Summary Schedule of Prior Audit Findings."

2.12.3. Overpayments. If it is determined by DSHS, or during the course of a required audit, that the Contractor has been paid unallowable costs under this or any Program Agreement, DSHS may require the Contractor to reimburse DSHS in accordance with OMB Circular A-87.

2.13. **Termination for Convenience**: Either party may terminate, upon one-hundred twenty (120) calendar days advance written notice, performance of work under this Contract in whole or in part, whenever, for any reason, either party determines that such termination is in its best interest.

2.13.1. In the event that either party terminates the Contract for convenience the other party may assert a claim for direct termini nation costs as follows:

2.13.1.1. In the event DSHS terminates this Contract for convenience, the Contractor shall have the right to assert a claim for the Contractor's direct termination costs. Such claim must be:

2.13.1.1.1. Delivered to DSHS as provided in accord with the Notices section of the General Terms and Conditions;

2.13.1.1.2. Asserted within ninety (90) calendar days of termination for convenience, or, in the event the termination was originally issued under the provisions of the, Termination by DSHS for Default provision of this Section, ninety (90) calendar days from the date the notice of termination was deemed to have been issued under this Section. DSHS may extend said ninety (90) calendar days if the Contractor makes a written request to DSHS and DSHS deems the grounds for the request to be reasonable.

2.13.1.1.3. DSHS will evaluate the claim for termination costs and either pay or deny the claim. DSHS shall notify the Contractor of DSHS' decision within sixty (60) calendar days of receipt of the claim.

2.13.1.2. In the event the Contractor terminates this Contract for convenience, DSHS shall have the right to assert a claim for DSHS' direct termination costs. Such claim must be:

2.13.1.2.1. Delivered to the Contractor as described in the Notices section of the General Terms and Conditions.

2.13.1.2.2. Asserted within ninety (90) calendar days of the date of termination for convenience. The Contractor may extend said ninety (90) calendar days if DSHS makes a written request to the Contractor and the Contractor deems the grounds for the request to be reasonable.

2.13.1.2.3. The Contractor shall evaluate the claim for termination costs and either pay or deny the claim. The Contractor shall notify DSHS of the Contractor's decision within sixty (60) calendar days of receipt of the claim.

2.13.1.3. In the event that either party disagrees with the other party's decision to pay or deny termination costs the disagreeing party shall have the right to a dispute resolution as described in the Disputes section of the General Terms and Conditions.

2.13.1.4. In no event shall the claim from termination costs exceed the average monthly amount paid to the Contractor for the twelve (12) months immediately prior to termination.

2.13.1.5. In addition to DSHS' or Contractor's direct termination costs, the Contractor or DSHS shall be liable for administrative costs incurred by the other party in procuring supplies or services similar to and/or replacing those terminated.

2.13.1.6. Neither the Contractor nor DSHS shall be liable for any termination costs if it notifies the other party of its intent not to renew this Contract at least one hundred twenty (120) calendar days prior to the renewal date.

2.13.2. In the event this Contract is terminated for the convenience of either party, the effective date of termination shall be the last day of the month in which the one hundred twenty (120) day notification period is satisfied, or the last day of such later month as may be agreed upon by both parties.

2.14. **Termination by the Contractor for Default**: The Contractor may terminate this Contract whenever DSHS 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 DSHS to meet one or more material obligations of this Contract. In the event it is determined that DSHS was not in default, DSHS may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction. The procedure for determining damages shall be as described in the Termination for Convenience section of the General Terms and Conditions.

2.15. **Termination by DSHS for Default**: The Contract Administrator 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 DSHS may allow) after receipt from DSHS 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. The procedure for determining damages shall be as stated in accord with the Termination for Convenience Section of this Contract.

2.16. **Termination — Information on Outstanding Claims**: In the event this Contract is terminated, the Contractor shall provide DSHS, 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.

2.17. **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 the intent to terminate this Contract and the reason for termination.

2.17.1. If either party disagrees with the other party's decision to terminate this Contract, other than a termination for convenience, that party will have the right to a dispute resolution as described in the Disputes section of the General Terms and Conditions.

2.17.2. If the Contractor disagrees with a DSHS decision to terminate this Contract and the dispute process is not successful, DSHS shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 CFR 438.708. DSHS shall:

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

2.17.2.2. 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

2.17.2.3. 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.

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

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

3. **DEFINITIONS**

The following definitions shall apply to this Contract:

3.1. **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; or the failure to provide services or act in a timely manner as required herein (42 CFR 438.400(b)).

3.2. **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)).

3.3. **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 388-501-0125, 42 CFR 438.6, 438.10, 422.128, and 489.100).

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

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

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

3.7. **Children with Special Health Care Needs** means children identified by DSHS to the Contractor as children served under the provisions of Title V of the Social Security Act.

3.8. **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)).

3.9. **Comparable Coverage** means an enrollee has other insurance that DSHS has determined provides a full scope of health care benefits.

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

3.11. **Continuity of Care** means the provision of continuous care for chronic or acute medical conditions through enrollee transitions in providers or service areas, between HO/SCHIP contractors and between Medicaid fee-for-service and HO/SCHIP in a manner that does not interrupt medically necessary care or jeopardize the enrollee's health.

3.12. **Coordination of Care** means the Contractor's mechanisms to assure that the enrollee and providers have access to and take into consideration, all required information on the enrollee's conditions and treatments to ensure that the enrollee receives appropriate health care services (42 CFR 438.208).

3.13. **Covered Services** means medically necessary services covered under the terms of this Contract, as set forth in the Benefits Section of this Contract,.

3.14. **Duplicate Coverage** means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under Healthy Options/SCHIP.

3.15. **EPSDT** (Early, Periodic Screening, Diagnosis and Treatment) means a package of services in a preventive (well child) exam covered by Medicaid as defined in the Social Security Act (SSA) Section 1905(r) and the DSHS EPSDT program policy and billing instructions (see Attachment A for website link). 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 abuse, mental health and hearing, as well as any medically necessary services found to be necessary during the EPSDT exam. EPSDT services covered by the Contractor are described in the Benefits Section of this Contract.

3.16. **Eligible Clients** means Medicaid recipients certified eligible by DSHS, living in the service area, and eligible to enroll for health care services under the terms of this Contract, as described in the Enrollment Section of this Contract.

3.17. **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)).

3.18. **Emergency Services** means covered inpatient and outpatient services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

3.19. **Enrollee** means a Medicaid recipient who is enrolled in Healthy Options/SCHIP managed care through a Managed Care Organization (MCO) having a Contract with DSHS (42 CFR 438.10(a)).

3.20. **Enrollee with Special Health Care Needs** means an enrollee who has chronic and disabling condition as defined in WAC 388-538-050.

3.21. **External Quality Review (EQR)** 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 Medicaid recipients (42 CFR 438.320).

3.22. **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).

3.23. **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 (see Attachment A for website link).

3.24. **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. DSHS will provide a copy of the EQRR to the Contractor, through print or electronic media.

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

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

3.27. **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).

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

3.29. **Health Employer Data and Information Set — (HEDISâ)** means a set of standardized performance measures designed to ensure that healthcare purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDISâ also includes a standardized survey of consumers' experiences that evaluates plan

performance in areas such as customer service, access to care and claims processing. HEDISâ is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

3.30. **Health Employer Data and Information Set (HEDISâ) Compliance Audit Program** means a set of standards and audit methods used by an NCQA certified auditor to evaluate information systems capabilities assessment (IS standards) and a Contractor's ability to comply with HEDISâ specifications (HD standards).

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

3.32. **Managed Care Organization (MCO)** means an organization having a certificate of authority or certificate of registration from the Office of Insurance Commissioner that contracts with DSHS under a comprehensive risk contract to provide prepaid health care services to eligible DSHS clients under the DSHS' managed care programs (WAC 388-538-050).

3.33. **Marketing** means any communication from the Contractor to a potential enrollee or enrollee with another DSHS contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or to either not enroll or end enrollment with another DSHS contracted MCO (42 CFR 438.104(a)).

3.34. **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)).

3.35. **Medically Necessary Services** means services that are "medically necessary" as is defined in WAC 388-500-0005. In addition, medically necessary services shall include services related to the enrollee's ability to achieve age-appropriate growth and development.

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

3.37. **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 commercial and Medicaid managed care clients receive.

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

3.39. **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.

3.40. **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.

3.41. **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.

3.42. **Post-stabilization Services** means covered 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).

3.43. **Potential Enrollee** means any Medicaid recipient eligible for enrollment in Healthy Options/SCHIP who is not enrolled with a health care plan having a contract with DSHS (42 CFR 438.10(a)).

3.44. **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.

3.45. **Quality** means the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational

characteristics and through the provision of health services that are consistent with current professional knowledge (42 CFR 438.320).

3.46. **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.

3.47. **Service Areas** means the geographic areas covered by this Contract as described in the Enrollment Section of this Contract.

3.48. **State Children's Health Insurance Program (SCHIP)** means a program to provide access to medical care for children whose family income exceeds the limit for Medicaid eligibility, but is not greater than two hundred fifty percent (250%) of the federal poverty level (FPL). SCHIP is authorized by Title XXI of the Social Security Act and by RCW 74.09.450 (WAC 388-542).

3.49. **Substantial Financial Risk**: 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:

3.49.1. Withholds greater than twenty-five percent (25%) of total potential payments.

3.49.2. 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.

3.49.3. Bonuses greater than thirty-three percent (33%) of total potential payments, less the bonus.

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

3.49.5. 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.

3.50. **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).

4. **ENROLLMENT**

4.1. **Service Areas**:

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

4.1.2. The Contractor's service areas are described in Exhibit A, Premiums, Service Areas, and Capacity. DSHS may modify Exhibit A, Premiums, Service Areas, and Capacity for service area changes as described in this Section.

4.1.3. 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.

4.1.4. Service Area Changes:

4.1.4.1. With the written approval of DSHS, the Contractor may expand into additional service areas at any time by giving written notice to DSHS, along with evidence, as DSHS may require, demonstrating the Contractor's ability to support the expansion. DSHS may withhold approval of a requested expansion, if, in DSHS' sole judgment, the requested expansion is not in the best interest of DSHS.

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

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

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

4.1.6. DSHS shall determine, in its sole judgment, which zip codes fall within each service area. No zip code will be split between service areas.

4.1.7. DSHS will determine whether an enrollee resides within a service area.

4.2. **Eligible Client Groups**: DSHS shall determine eligibility for enrollment under this Contract. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract, and must enroll in Healthy Options/SCHIP unless the enrollee has comparable coverage as defined herein, or is exempted pursuant to the Exemption from Enrollment provisions of this Section.

4.2.1. Clients receiving Medicaid under Social Security Act (SSA) provisions for coverage of families receiving Temporary Assistance for Needy Families and clients who are not eligible for cash assistance who remain eligible for Medicaid.

4.2.2. Children, from birth through eighteen (18) years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.

4.2.3. Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.

4.2.4. Children eligible for SCHIP (see Attachment A for website link).

4.3. **Client Notification:** DSHS shall notify eligible clients of their rights and responsibilities as Healthy Options/SCHIP enrollees at the time of initial eligibility determination and at least annually. The Contractor shall provide enrollees with additional information as described in this Contract (42 CFR 438.10).

4.4. **Exemption from Enrollment:** A client may request exemption from enrollment. Each request for exemption will be reviewed by DSHS pursuant to WAC 388-538 or WAC 388-542. When the client is already enrolled with the Contractor and wishes to be exempted, the exemption request will be treated as a termination of enrollment request consistent with the Termination of Enrollment provisions of this Section.

4.5. **Enrollment Period:** Subject to the Effective Date of Enrollment provisions of this Section, enrollment is continuously open. Enrollees shall have the right to change enrollment prospectively, from one Healthy Options/SCHIP plan to another without cause, each month except as described in the Patient Review and Restriction (PRR) provisions of the Benefits Section of this Contract.

4.6. **Enrollment Process:** To enroll with the Contractor, the client, the client's representative or responsible parent or guardian must complete and submit a DSHS enrollment form to DSHS, or call the DSHS toll-free enrollment number.

4.6.1. If the client does not exercise their right to choose a Healthy Options/SCHIP plan, DSHS will assign the client, and all eligible family

members, to the same Healthy Options/SCHIP plan in accord with the Assignment of Enrollees provisions of the Access and Capacity Section of this Contract.

4.6.2. DSHS will attempt to enroll all family members with the same Healthy Options/SCHIP plan unless the following occurs:

4.6.2.1. A family member is covered by Basic Health, and the plan contracts with DSHS, then DSHS will attempt to enroll the remainder of the family with the same managed care plan. If the plan does not contract with DSHS, the remaining family members will be enrolled with a single, but different Healthy Options/SCHIP plan of the enrollee's choice, or shall be assigned as described above if no choice is made.

4.6.2.2. A family member is placed into the Patient Review and Restriction (PRR) program by the Contractor or DSHS. The PRR placed family member shall follow the enrollment requirements described in the PRR provisions of the Benefits Section of this Contract. The remaining family members shall be enrolled with a single, Healthy Options/SCHIP plan of the choice, or shall be assigned as described above if no choice is made.

4.7. **Effective Date of Enrollment:**

4.7.1. Except for a newborn whose mother is enrolled in a Healthy Options/SCHIP plan, enrollment with the Contractor shall be effective on the later of the following dates:

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

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

4.7.2. Newborns whose mothers are enrollees shall be deemed enrollees and enrolled beginning from the newborn's date of birth or the mother's date of enrollment, whichever is later. If the mother's enrollment is ended before the newborn receives a separate client identifier from DSHS, the newborn's enrollment shall end when the mother's enrollment ends, except as provided in the provisions of the Enrollee Hospitalized at Termination of Enrollment of the Benefits Section of this Contract. If the newborn does not receive a separate client identifier by the sixtieth (60th) day of life, supplemental premiums and enrollment shall only be

available through the end of the month in which the sixtieth (60th) day of life falls in accord with Healthy Options Licensed Health Carrier Billing Instructions, published by DSHS and incorporated by reference (see Attachment A for website link).

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

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

4.8. **Enrollment Data and Requirements for Contractor's Response:** DSHS will provide the Contractor with data files with the information needed to perform the services described in this Contract.

4.8.1. Data files will be sent to the Contractor at intervals specified within the DSHS Companion Guides, published by DSHS and incorporated by reference (see Attachment A for website link).

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

4.8.3. The data file will be transferred per specifications defined within DSHS Companion Guides (see Attachment A for website link).

4.8.4. Data is sent in two files. The "update" file, in the 834 benefit enrollment and maintenance format, will list the enrollees whose enrollment is terminated by the end of that month, and the enrollees for the following month with the Contractor. The "audit" file will include all enrollees enrolled with the plan and for whom a monthly premium will be paid for the following month.

4.8.5. The data file will include but not be limited to the following enrollee personal information: Name, address, SSN, age/sex, ethnicity, race and language markers.

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

4.8.6.1. DSHS has enrolled the enrollee with the Contractor in a service area the Contractor is not contracted for.

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

4.9. **Termination of Enrollment**:

4.9.1. Voluntary Termination of Enrollment: Enrollees may request termination of enrollment by submitting a written request to terminate enrollment to DSHS or by calling the DSHS toll-free enrollment number (42 CFR 438.56(d)(1)(i)). Except as provided in WAC 388-538 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.

4.9.2. Involuntary Termination of Enrollment Initiated by DSHS for Ineligibility: The enrollment of any enrollee under this Contract shall be terminated if the enrollee becomes ineligible for enrollment due to a change in eligibility status.

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

4.9.2.1.1. The first day of the month following the month in which the enrollment termination is processed by DSHS if it is processed on or before the DSHS cut-off date for enrollment or the Contractor is informed by DSHS of the enrollment termination prior to the first day of the month following the month in which it is processed by DSHS.

4.9.2.1.2. Effective the first day of the second month following the month in which the enrollment termination is processed if it is processed after the DSHS cut-off date for enrollment and the Contractor is not informed by DSHS of the enrollment termination prior to the first day of the month following the month in which it is processed by DSHS.

4.9.2.2. Enrollees Eligible for Supplemental Security Income (SSI):

4.9.2.2.1. Newborn enrollees who are determined by the Social Security Administration (SSA) to have an SSI eligibility effective date within the first sixty (60) days of life, not counting the birth date, shall be ineligible for services under the terms of this Contract when DSHS receives the SSI eligibility information from the SSA through the State Data Exchange (SDX). Such newborn enrollees will have their enrollment terminated retroactively effective the date of

birth. DSHS shall recoup premiums paid in accord with Recoupments provisions of the Payment and Sanctions Section of this Contract.

4.9.2.2.2. Except as provided in this Section, enrollees determined by the SSA to be eligible for SSI shall be ineligible for services under the terms of this Contract when DSHS receives the SSI eligibility information from the SSA through the electronic SDX. Such enrollees will have their enrollment terminated prospectively. DSHS shall not recoup any premiums for enrollees determined SSI eligible and the Contractor shall be responsible for providing services under the terms of this Contract until the effective date of the termination of enrollment.

4.9.2.2.3. If the Contractor believes an enrollee has been determined by SSA to be eligible for SSI, the Contractor shall present documentation of such eligibility to DSHS, DSHS will attempt to verify the eligibility and, if the enrollee is SSI eligible, DSHS will act upon SSI eligibility in accord with this Section.

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

4.9.4. Involuntary Enrollment Termination Initiated by DSHS for Comparable Coverage or Duplicate Coverage:

4.9.4.1. The Contractor shall notify DSHS, in accord with the Notices provision of the General Terms and Conditions Section of this Contract, when an enrollee has health care insurance coverage with the Contractor or any other carrier:

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

4.9.4.1.2. Within forty-five (45) calendar days of the date when the Contractor becomes aware that an enrollee has any health care insurance coverage with any other insurance carrier. The Contractor is not responsible for the determination of comparable coverage, as defined herein.

4.9.4.2. DSHS will involuntarily terminate the enrollment of any enrollee with duplicate coverage or comparable coverage as follows:

4.9.4.2.1. When the enrollee has duplicate coverage that has been verified by DSHS, DSHS shall terminate enrollment

retroactively to the beginning of the month of duplicate coverage and recoup premiums as describe in the Recoupments provisions of the Payment and Sanctions Section of this Contract.

4.9.4.2.2. When the enrollee has comparable coverage which has been verified by DSHS, DSHS shall terminate enrollment effective the first day of the second month following the month in which the termination is processed if the termination is processed on or before the DSHS cut-off date for enrollment or, effective the first day of the third month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment.

4.9.4.3. When the enrollee is hospitalized outside the service area for more than ninety (90) calendar days and the Contractor's obligation to pay for services is limited to ninety (90) calendar days under the Outside the Service Areas provision of the Benefits Section of this Contract, DSHS shall terminate enrollment effective the date that the Contractors obligation for payment ends.

4.9.5. Involuntary Termination Initiated by the Contractor: To request involuntary termination of enrollment, the Contractor shall send written notice to DSHS as described in Notices provision of the General Terms and Conditions Section of this Contract.

4.9.5.1. DSHS 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 DSHS' receipt of such notice and the documentation required to substantiate the request. DSHS shall approve the request for involuntarily termination of the enrollee when the Contractor has substantiated in writing all of the following (42 CFR 438.56(b)(1)):

4.9.5.1.1. The enrollee's behavior is inconsistent with the Contractor's policies and procedures addressing unacceptable enrollee behavior.

4.9.5.1.2. The Contractor has provided a clinically appropriate evaluation to determine whether there is a treatable condition contributing to the enrollee's behavior and such evaluation either finds no treatable condition to be contributing, or, after evaluation and treatment, the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee.

4.9.5.1.3. 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 DSHS because the enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the enrollee shall include the enrollee's right to use the Contractor's grievance process to review the request to end the enrollee's enrollment.

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

4.9.5.3. DSHS 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 treatable mental health condition (WAC 388-538-130 and 42 CFR 438.56(b)(2)).

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

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

4.9.7.1. 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.

4.9.7.2. It is necessary to provide only coordination of care to transition the enrollee's care with another provider.

4.9.7.3. It is necessary to satisfy the results of an appeal or hearing.

4.10. **Enrollment Not Discriminatory**:

4.10.1. The Contractor will not discriminate against enrollees or potential enrollees on the basis of health status or need for health care services (42 CFR 438.6(d)(3)).

4.10.2. The Contractor will not discriminate against enrollees or potential enrollees on the basis of race, color, or national origin, and will not use

any policy or practice that has the effect of discriminating on the basis of race, color, or national origin (42 CFR 438.6(d)(4)).

5. **MARKETING AND INFORMATION REQUIREMENTS**

5.1. **Marketing:**

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

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

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

5.1.4. Marketing materials must be distributed in all service areas the Contractor serves (42 CFR 438.104(b)(1)(ii)).

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

5.1.5.1. Marketing materials in English must give directions in the Medicaid eligible population's primary languages for obtaining understandable materials.

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

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

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

5.1.8. The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment (42 CFR 438.104(b)(1)(v)).

5.1.9. The Contractor shall not make any assertion or statement, whether written or oral, in marketing materials that a Medicaid recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits (42 CFR 438.104(b)(2)(i)).

5.1.10. 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)).

5.2. **Information Requirements for Enrollees and Potential Enrollees:**

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

5.2.1.1. The Contractor shall provide sufficient, accurate oral and 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)).

5.2.1.2. The Contractor shall provide to potential enrollees upon request and to each enrollee, within fifteen (15) working days of enrollment, at any time upon request, and at least once a year, the information needed to understand benefit coverage and obtain care in accord with the provisions of this Section (42 CFR 438.10(b)(3) and 438.10(f)(3)).

5.2.1.3. At least thirty (30) calendar days prior to distribution, all enrollee information shall be submitted to DSHS for written approval. DSHS may waive the thirty day requirement if, in DSHS' sole judgment, it is in the best interest of DSHS and its clients.

5.2.1.4. Changes to State or Federal law shall be reflected in information to enrollees no more than ninety (90) calendar days after the effective date of the change and enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of DSHS, the change is significant in regard to the enrollees' quality of or access to care. DSHS shall notify the Contractor of any significant change in writing (42 CFR 438.6(i)(4) and 438.10(f)(4)).

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

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

5.2.1.5.2. Changing PCPs.

5.2.1.5.3. Accessing services outside the Contractor's service area.

5.2.1.5.4. Accessing Emergency Services.

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

5.2.1.5.6. Specialists available to enrollees and how to obtain specific information including a list of specialists that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

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

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

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

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

5.2.1.5.11. Informed consent guidelines.

5.2.1.5.12. Conversion rights under RCW 48.46.450 or RCW 48.44.370.

5.2.1.5.13. Requesting a termination of enrollment.

5.2.1.5.14. Information regarding advance directives to include (42 CFR 422.128 and 438.6(i)(1 and 3)):

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

5.2.1.5.14.2. 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.

5.2.1.5.14.3. An enrollee's rights under state law, including the right to file a grievance with the Contractor or DSHS regarding compliance with advance directive requirements in accord with the Advance Directive

provisions of the Enrollee Rights and Protections Section of this Contract .

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

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

5.2.1.5.17. 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):

5.2.1.5.17.1. 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).

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

5.2.1.5.17.3. 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.

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

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

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

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

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

5.2.1.5.18. The enrollee's rights and responsibilities with respect to receiving covered services.

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

5.2.1.5.20. Specific information regarding EPSDT and childhood immunizations as described in the Benefits Section of this Contract.

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

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

5.2.1.5.23. The enrollee's right to and procedure for obtaining a second opinion free of charge.

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

5.2.1.5.25. Information regarding the Contractors appointment wait time standards.

5.2.1.6. DSHS agrees to provide the Contractor with copies of written client information, which DSHS intends to distribute to enrollees.

5.3. **Equal Access for Enrollees & Potential Enrollees with Communication Barriers**: The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access for enrollees and potential enrollees with communication barriers (42 CFR 438.10).

5.3.1. The Contractor's policies and procedures related to Equal Access for Enrollees and Potential Enrollees with Communication Barriers shall ensure compliance with the requirements described in this section.

5.3.2. Oral Information:

5.3.2.1. 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:

5.3.2.1.1. Customer service

5.3.2.1.2. All appointments with any provider for any covered service

5.3.2.1.3. Emergency services

5.3.2.1.4. All steps necessary to file grievances and appeals.

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

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

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

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

5.3.2.6. 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)).

5.3.3. Written Information:

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

5.3.3.1.1. 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.

5.3.3.1.2. 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:

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

5.3.3.1.2.2. Providing the material on tape in the enrollee's or potential enrollee's primary language.

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

5.3.3.1.2.4. 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)).

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

5.3.3.2. 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 fulfils other requirements of the Contract as may be applicable to the materials (42 CFR 438.10(b)(1)).

5.3.3.3. DSHS may make exceptions to the sixth grade reading level when, in the sole judgment of DSHS, 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. DSHS approval of exceptions to the sixth grade reading level must be in writing.

5.3.3.4. 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.

5.3.3.5. All written materials must have the written approval of DSHS prior to use. For client-specific written materials, the Contractor may use templates that have been pre-approved in writing by DSHS.

The Contractor must provide DSHS with a copy of all approved materials in final form.

6. **PAYMENT AND SANCTIONS**

6.1. **Rates/Premiums:**

6.1.1. Subject to the Sanctions provisions of this Section, DSHS shall pay a monthly premium for each enrollee in full consideration of the work to be performed by the Contractor under this Contract. DSHS shall pay the Contractor, on or before the tenth (10th) working day of the month based on the DSHS 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 a claim to DSHS for any amount due the Contractor within three hundred sixty-five (365) calendar days of the month of service. Any claim submitted after the 365-day period will be denied. When DSHS' records confirm the Contractor's claim, DSHS shall remit payment within thirty (30) calendar days of the receipt of the claim.

6.1.3. The statewide Base Rate, Geographical Adjustment Factors, Risk Adjustment Factors and Age/Sex Factors are in Exhibit A, Premiums, Service Areas, and Capacity.

6.1.4. The monthly premium payment will be calculated as follows:

Premium Payment = Base Rate x Age/Sex Factor x Risk Adjustment Factor x Geographical Adjustment Factor as described herein.

6.1.5. Following the end of the annual legislative session, DSHS will provide to the Contractor the Base Rate, Age/Sex Factors, Risk Adjustment Factors, and Geographical Adjustment Factors for the following calendar year. DSHS will provide rates at least one hundred and twenty (120) calendar days prior to the first day of the following year. If the Contractor will not continue to provide HO/SCHIP services in the following calendar year, the Contractor shall notify DSHS 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 DSHS, this Contract shall terminate, without penalty to either party, effective midnight, December 31, of the current year. The termination will be considered a termination for convenience under the Termination for Convenience provisions of the General Terms and Conditions Section of

this Contract, but neither party shall have the right to assert a claim for costs.

6.1.6. The Geographical Adjustment Factors will be adjusted by DSHS for the period January 1, through December 31, of the following year for changes in utilization. In addition, the payment for Critical Access Hospitals (CAH) as required in the Payments to CAH provision in this Section may be prospectively updated by DSHS if, in DSHS' judgment, there are material changes in rates or utilization related to CAH.

6.1.7. The Risk Adjustment Factor will be recalculated by DSHS for the period January 1, through December 31, of the following year based on the most currently available enrollment and encounter data Risk Adjustment Factors may be recalculated by DSHS if, in DSHS' sole judgment, changes in contractor participation in HO/SCHIP require changes to the Risk Adjustment Factors.

6.1.8. Each year DSHS will develop a Quality Incentive based on HEDIS® measures for childhood immunizations and well child visits. The Quality Incentive information and amounts will be provided in writing to all HO/SCHIP contractors prior to generating payments for the Quality Incentive at the end of the first quarter of the year.

6.1.9. Notwithstanding an Amendment as defined in the General Terms and Conditions Section of this Contract, DSHS may modify Exhibit A, Premiums, Service Areas, and Capacity to add any changes in service areas, capacity, the Base Rate, Geographical Adjustment Factors, and Risk Adjustment Factors as needed. DSHS will provide such modifications to the Contractor in writing. If the Contractor does not disagree in writing with the modifications within fifteen (15) calendar days of the date the modifications are provided, the change will amend the Contract without any further action. If the Contractor does not accept the modifications, DSHS will terminate this Contract for convenience as provided herein, but neither party shall have a right to assert a claim for costs. If the modification changes the premium payments, the update is subject to CMS approval.

6.1.10. DSHS shall automatically generate newborn premiums whenever possible. For newborns whose premiums DSHS does not automatically generate, the Contractor shall submit a supplemental premium payment request to DSHS within 365 calendar days of the month of service. The Contractor shall be responsible for reviewing monthly data provided by DSHS of the newborn premiums to determine whether a supplemental premium request needs to be submitted. DSHS shall pay supplemental premiums through the end of the month in which the sixtieth (60th) day of life occurs.

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

6.1.12. The Contractor shall be responsible for covered medical services provided to the enrollee in any month for which DSHS paid the Contractor for the enrollee's care under the terms of this Contract.

6.2. **Delivery Case Rate Payment:** A one-time payment of $5,500.00 shall be made to the Contractor for labor and delivery expenses for enrollees enrolled with the Contractor during the month of delivery. The Delivery Case Rate shall only be paid to the Contractor if it has incurred expenses for and paid for labor and delivery. Delivery includes both live and stillbirths, but does not include miscarriage, induced abortion, or other fetal demise not requiring labor and delivery to terminate the pregnancy.

6.3. **Renegotiation of Rates:** The base rate set forth herein shall be subject to renegotiation during the Contract period only if DSHS, 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.

6.4. **Reinsurance/Risk Protection:** The Contractor may obtain reinsurance for coverage of enrollees only to the extent that it obtains such reinsurance for other groups enrolled by the Contractor, provided that the Contractor remains ultimately liable to DSHS for the services rendered.

6.5. **Recoupments:**

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

6.5.1.1. Covered by the Contractor with duplicate coverage.

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

6.5.1.3. Placed in the foster care medical program.

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

6.5.1.5. Newborns determined to have an SSI eligibility effective date within the first sixty (60) days of life in accord with the provisions in the Enrollees Eligible for Social Security Income (SSI) of the

Enrollment Section of this Contract. DSHS shall recoup all premiums paid for the enrollee, but not the birth mother or any other family member, back to the month of birth.

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

6.5.1.7. Incarcerated for any full month of enrollment.

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

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

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

6.7. **Payments to Critical Access Hospitals (CAH):** For services provided by CAH to enrollees, the Contractor shall pay the CAH the prospective Inpatient and Outpatient Departmental Weighted Cost-to-Charge rates published by DSHS for the fee-for-service program (see Attachment A for website link).

6.8. **Stop Loss for Hemophiliac Drugs:** DSHS will provide stop loss protection for the Contractor for paid claims for Factors VII, VIII and IX and the anti-inhibitor for enrollees with a diagnosis of hemophilia as identified by diagnosis codes 286.0-286.3, V83.01 and V83.02. DSHS will reimburse the Contractor seventy-five percent (75%) of all verifiable paid claims for the identified hemophiliac drugs in excess of $250,000 for any single enrollee enrolled with the Contractor during each contract year. The Contractor must submit documentation of paid claims as required by DSHS.

6.9. **Encounter Data:** The Contractor shall comply with the required format provided in the Encounter Data Transaction Guide published by DSHS (see Attachment A for website link). Encounter data includes claims paid by the Contractor for services delivered to enrollees through the Contractor during a

specified reporting period. DSHS collects and uses this data for many reasons such as: federal reporting (42 CFR 438.242(b)(1)); rate setting and risk adjustment; service verification, managed care quality improvement program, utilization patterns and access to care; DSHS hospital rate setting; and research studies.

DSHS may change the Encounter Data Transaction Guide with one hundred and fifty (150) calendar days' written notice to the Contractor. The Encounter Data Transaction Guide may be changed with less than one hundred and fifty (150) calendar days' notice by mutual agreement of the Contractor and DSHS. The Contractor shall, upon receipt of such notice from DSHS, provide notice of changes to subcontractors.

6.10. **Emergency Services by Non-Contracted Providers**: 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 DSHS' Medicaid FFS program (Deficit Reduction Act of 2005, Public Law No. 109-171, Section 6085).

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

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

6.11.1.1. The Contractor's Chief Executive Officer.

6.11.1.2. The Contractor's Chief Financial Officer.

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

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

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

6.11.4. DSHS 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, DSHS may impose sanctions by withholding up to five percent of its scheduled payments to

the Contractor.

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

6.12.1.2. DSHS 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 DSHS' position.

6.12.2. DSHS, 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, DSHS, 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 DSHS 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.

6.12.2.8. Intermediate sanctions may include:

6.12.2.8.1. Civil monetary penalties in the following amounts:

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

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

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

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

6.12.2.8.2. Appointment of temporary management for the Contractor as provided in 42 CFR 438.706. DSHS 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.

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

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

7. **ACCESS AND CAPACITY**

7.1. **Access and Capacity Policy and Procedure Requirements**: The Contractor's policies and procedures related to access and capacity shall ensure compliance with the requirements described in this section.

7.2. **Network Capacity**:

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

7.2.2. The Contractor shall provide covered services required by this Contract through non-participating providers, at a cost to the enrollee that is no greater than if the covered services were provided by participating providers, if its network of participating providers is insufficient to meet the medical 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.

7.2.3. 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 DSHS request or when there has been a change in the Contractor's network or operations that, in the sole judgment of DSHS, would adversely affect adequate capacity and/or the Contractor's ability to provide services (42 CFR 438.207(b & c)).

7.2.4. With the written approval of DSHS, the Contractor may increase capacity or set its capacity to unlimited at any time by giving written notice to DSHS. For unlimited capacity, DSHS will set capacity at the total number of eligibles in the service area. The Contractor shall provide evidence, as DSHS requires, demonstrating the Contractor's ability to support the capacity increase. DSHS may withhold approval of a requested capacity increase, if, in DSHS' sole judgment, the requested increase is not in the best interest of DSHS.

7.2.5. The Contractor may decrease capacity by giving DSHS sixty (60) calendar days' written notice. The decrease shall not be effective until the first day of the month which falls after the sixty (60) calendar days has elapsed. Exhibit A, Premiums, Service Areas, and Capacity will be updated by DSHS for increases and decreases in capacity.

7.3. **Service Delivery Network**: In the maintenance and monitoring of its network, the Contractor must consider the following (42 CFR 438.206(b)):

7.3.1. Expected enrollment.

7.3.2. The stated capacity in Exhibit A of this Contract.

7.3.3. Adequate access to all services covered under this Contract.

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

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

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

7.3.7. 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.

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

7.4. **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:

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

7.4.2. Mechanisms are established to ensure compliance by providers.

7.4.3. Providers are monitored regularly to determine compliance.

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

7.5. **Hours of Operation for Network Providers:** The Contractor must require that network providers offer hours of operation for enrollees that are no less than the hours of operation offered to any other patient (42 CFR 438.206(c)(1)(iii)).

7.6. **24/7 Availability:** The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week basis by telephone. These services

may be provided directly by the Contractor or may be delegated to subcontractors (42 CFR 438.206(c)(1)(iii)).

7.6.1. Medical advice for enrollees from licensed health care professionals.

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

7.6.3. Authorization of services.

7.6.4. Emergency drug supply, as described in the General Description of Covered Services provisions of the Benefits Section of this Contract.

7.7. **Appointment Standards:** The Contractor shall comply with appointment standards that are no longer than the following (42 CFR 438.206(c)(1)(i)):

7.7.1. 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.

7.7.2. 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.

7.7.3. 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.

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

7.8. **Integrated Provider Network Database (IPND):** The Contractor shall report its complete provider network, to include all current contracted providers, monthly to DSHS through the designated data management contact in accord with the Provider Network Reporting Requirements published by DSHS (see Attachment A for website link)(42 CFR 438.242(b)(1)).

7.9. **Provider Network — Distance Standards**:

7.9.1. The Contractor network of providers shall meet the distance standards below in every service area. The designation of a zip code in a service area as rural or urban is in Exhibit A, Premiums, Service Areas, and Capacity.

7.9.1.1. PCP

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

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

7.9.1.2. Obstetrics

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

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

7.9.1.3. Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

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

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

7.9.1.4. Hospital

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

7.9.1.5. Pharmacy

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

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

7.9.2. DSHS may, in its sole discretion, grant exceptions to the distance standards. DSHS' approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as DSHS may require to support 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 and meet measurable distance standards for high volume Specialty Care Providers to enrollees. The Contractor shall analyze performance against standards at minimum, annually.

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. **Access to Specialty Care**:

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

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

7.13. **Capacity Limits and Order of Acceptance:**

7.13.1. The Contractor shall provide care to all enrollees who voluntarily choose the Contractor. The Contractor shall accept assignments up to the capacity limits in Exhibit A, Premiums, Service Areas, and Capacity.

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

7.13.3. DSHS shall enroll all eligible clients with the contractor of their choice unless DSHS determines, in its sole judgment, that it is in DSHS' best interest to withhold or limit enrollment with the Contractor.

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

7.13.5. The Contractor shall accept clients who are assigned by DSHS in accord with this Contract, WAC 388-538, and WAC 388-542, except as specifically provided in the Enrollment Data and Requirements for Contractor's Response provisions in the Enrollment Section of this Contract.

7.13.6. No eligible client shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, the existence of a pre-existing physical or mental condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 CFR 438.6(d)(1 and 3)).

7.14. **Assignment of Enrollees:**

7.14.1. Potential enrollees who do not select a Healthy Options/SCHIP plan shall be assigned to a Healthy Options/SCHIP plan by DSHS as follows:

7.14.1.1. DSHS will identify the Contractor's capacity in each service area, as stated in Exhibit A, Premiums, Service Areas, and Capacity, modified by increases and decreases in capacity made in accord with this Contract.

7.14.1.2. DSHS will determine the total capacity of all contractors receiving assignment in each service area.

7.14.1.3. DSHS will determine the number of households in a service area.

7.14.1.4. Assignments will be calculated based on the Contractor's capacity divided by the total capacity of a service area and then multiplied by the total number of households in a service area. The result of this calculation will determine the number of households to be assigned to the Contractor in a specific service area. In any area where the Contractor's capacity is unlimited, DSHS will set the Contractor's capacity, for this calculation, at the total number of HO/SCHIP eligible's in the service area.

7.14.2. At DSHS' sole discretion, DSHS may not make assignments of enrollees to the Contractor in a service area if the Contractor's enrollment, when DSHS calculates assignments, is ninety percent (90%) or more of its capacity in that service area.

7.14.3. The Contractor may choose not to receive assignments or limit assignments in any service area by so notifying DSHS in writing at least sixty (60) calendar days before the first of the month it is requesting not to receive assignment of enrollees.

7.14.4. DSHS reserves the right to make no assignments, or to withhold or limit assignments to the Contractor, when, in its sole judgment, it is in the best interest of DSHS.

7.14.5. If either the Contractor or DSHS limits assignments as described herein, the Contractor's capacity shall be that limit.

7.15. **Provider Network Changes:**

7.15.1. The Contractor shall give DSHS 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/or the number of enrollees the Contractor has agreed to serve in a service area.

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 DSHS. 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.

8. **QUALITY OF CARE**

8.1. **Quality Assessment and Performance Improvement (QAPI) Program:**

8.1.1. The Contractor's policies and procedures related to quality assessment and performance improvement (QAPI) program shall ensure compliance with the requirements described in this section.

8.1.2. The Contractor shall have and maintain a quality assessment and performance improvement (QAPI) program for the services it furnishes to its enrollees that meets the provisions of 42 CFR 438.240.

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

8.1.2.2. The QAPI program structure shall include the following elements:

8.1.2.2.1. A written description of the QAPI program including identification of designated physician and behavioral health practitioners. The QAPI program description shall include:

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

8.1.2.2.1.2. Descriptions of committee responsibilities;

8.1.2.2.1.3. Contractor staff and practicing provider committee participant titles;

8.1.2.2.1.4. Meeting frequency; and

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

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

8.1.2.2.2.1. Recommend policy decisions;

8.1.2.2.2.2. Analyze and evaluate the results of QI activities;

8.1.2.2.2.3. Institute actions; and

8.1.2.2.2.4. Ensure appropriate follow-up.

8.1.2.2.3. An annual quality work plan.

8.1.2.2.4. An annual evaluation of the QAPI program to include an evaluation of performance improvement projects, trending of performance measures and evaluation of the overall effectiveness of the QI program (42 CFR 438.240(e)(2)).

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

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

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

8.1.4.2. Evaluation of the delegated organization prior to delegation;

8.1.4.3. An annual evaluation of the delegated entity;

8.1.4.4. Evaluation of regular delegated entity reports; and

8.1.4.5. Follow-up on issues out of compliance with delegated agreement or DSHS contract specifications.

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

8.2. **Performance Improvement Projects**:

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

8.2.2. The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas. The Contractor shall conduct at least two (2) Performance Improvement Projects (PIPs) of which at least one (1) is clinical and at least one (1) is non-clinical as described in 42 CFR 438.240 (b)(1) and as specified in the CMS protocol (see Attachment A for website link).

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

8.2.3.1. Measure performance using objective, quality indicators.

8.2.3.2. Implement system interventions to achieve improvement in quality.

8.2.3.3. Evaluate the effectiveness of the interventions.

8.2.3.4. Plan and initiate activities for increasing or sustaining improvement.

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

8.2.3.6. 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)).

8.2.4. Annually, the Contractor shall submit to DSHS one (1) clinical and one (1) non-clinical performance improvement project which, in the judgment of the Contractor, best meet the requirements of a performance improvement project. Each project will be documented on a performance improvement project worksheet found in the CMS protocol

entitled “Conducting Performance Improvement Projects” (see Attachment A for website link).

8.2.5. If any of the Contractor’s Health Plan Employer Data and Information Set (HEDIS®) rates on Well Child Visits in the first fifteen (15) months, six (6) or more well child visits measure), Well Child Visits in the third (3rd), fourth (4th), fifth (5th) and sixth (6th) years of life, or Adolescent Well Care Visits are below a sixty percent (60%) benchmark in 2008 or 2009, the Contractor shall implement a clinical PIP designed to increase the rates.

8.2.6. If any of the Contractor’s HEDIS® Combination 2, Childhood Immunization rates are below a seventy percent (70%) benchmark in 2008 or below a seventy-five percent (75%) benchmark in 2009 the Contractor shall implement a performance improvement project designed to increase the immunization rate.

8.2.7. If both the HEDIS® Well-Child Measure and Combination 2 Childhood Immunization measures do not meet contractually required benchmarks, the Contractor is required to conduct a second clinical PIP. The Contractor may count either the HEDIS® Well-Child or Combination 2 PIPs towards meeting the one (1) required clinical PIP. Both PIPs shall be submitted to DSHS.

8.2.8. The Contractor may be required to conduct a CAHPS® non-clinical performance improvement project(s) based on a correlation analysis of measures most likely to impact enrollee satisfaction. The Contractor will be notified of the PIP in January 2008 by DSHS. The Contractor may count the PIP towards meeting the one (1) required non-clinical PIP. The project must be initiated in 2008 and continue through the 2009 contract year.

8.2.9. In addition to the PIPs required under this Section the Contractor shall participate in a yearly statewide PIP.

8.2.9.1. The PIP will either be conducted by the Department of Health or by an organization selected by DSHS.

8.2.9.2. The PIP shall be designed to maximize resources and reduce cost to contractors.

8.2.9.3. The Contractor shall cooperate with DSHS’ designated External Quality Review Organization (EQRO) and the organization conducting the PIP.

8.2.9.4. The Contractor will receive copies of aggregate data and reports produced from these projects.

8.2.9.5. The Contractor shall provide financial support to the organization conducting the PIP in the following manner:

8.2.9.5.1. If the Contractors enrollment is less than 10,000 the Contractor shall provide $10,000 to support the PIP.

8.2.9.5.2. If the Contractors enrollment is more than 10,000 but less than 100,000 the Contractor shall provide $20,000 to support the PIP.

8.2.9.5.3. If the Contractors enrollment is more than 100,000 the Contractor shall provide $30,000 to support the PIP.

8.3. **Performance Measures using Health Employer Data & Information Set (HEDISâ):**

8.3.1. In accord with the Notices provisions of the General Terms and Conditions Section of this Contract, the Contractor shall report to DSHS HEDISâ measures using the current HEDISâ Technical Specifications and official corrections published by NCQA, unless directed otherwise in writing by DSHS. For the 2008 and 2009 HEDIS® measures listed below, the Contractor shall use the administrative or hybrid data collection methods, specified in the current HEDISâ Technical Specifications, unless directed otherwise by DSHS (42 CFR 438.240(b)(2)). The Contractor shall make its best effort to maximize data collection.

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

8.3.3. The following HEDIS® measures shall be submitted to DSHS in 2008 and 2009:

8.3.3.1. Childhood Immunization Status (Hybrid measure required);

8.3.3.2. Postpartum Care (Hybrid measure required);

8.3.3.3. Well Child Visits in the First 15 Months of Life (Hybrid measure required);

8.3.3.4. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (Hybrid measure required);

8.3.3.5. Adolescent Well Care Visits (Hybrid measure required);

8.3.3.6. Comprehensive Diabetes Care (Hybrid measure required)

8.3.3.7. Inpatient Utilization — Nonacute Care

8.3.3.8. Ambulatory Care

8.3.3.9. Frequency of Selected Procedures — a subset of measures to include: myringotomy, myringotomy with adenoidectomy, hysterectomy, mastectomy, lumpectomy

8.3.3.10. Race/Ethnicity diversity of membership

8.3.3.11. Language diversity of membership

8.3.4. The Contractor shall submit raw HEDIS® data to DSHS electronically for the Childhood Immunization Status measure, no later than June 30 of each year. The Contractor shall submit the raw HEDIS® data according to specifications provided by DSHS.

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

8.3.6. The Contractor shall cooperate with DSHS' designated EQRO to validate the Contractor's Health Employer Data and Information Set (HEDIS®) performance measures and CAHPS® sample frame.

8.3.6.1. If the Contractor does not have NCQA accreditation for Healthy Options managed care from the National Committee for Quality Assurance (NCQA), the Contractor shall receive a partial audit.

8.3.6.2. If the Contractor has NCQA accreditation for Healthy Options managed care or is seeking accreditation with a scheduled NCQA visit in 2008 or 2009, the Contractor shall receive a full audit.

8.3.6.3. 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 the DSHS designated EQRO.

8.3.7. 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.

8.3.8. The Contractor shall collect and maintain data on ethnicity, race and language markers as established by DSHS 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.

8.3.9. The Contractor shall rotate HEDIS® measures only with the advance written permission of DSHS. The Contractor may request permission to rotate measures by making a written request to the DSHS contact named in the Notices provisions of the General Terms and Conditions Section of this Contract. Childhood Immunization and well-child measures shall not be rotated.

8.4. **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**:

8.4.1. In 2008 a DSHS designated EQRO shall conduct the CAHPS® Children and Children with Chronic Conditions survey based upon 2007 HEDISâ Specifications for Survey Measures.

8.4.1.1. The Contractor shall create the sampling frame file.

8.4.1.1.1. The Contractor shall receive file specifications and instructions specifying the format and other required information for the sample files from DSHS, or the DSHS designated EQRO, by November 30, 2007.

8.4.1.1.2. The Contractor shall submit the eligible sample frames to the DSHS designated EQRO by January 18, 2008.

8.4.1.1.3. The Contractor shall receive written notice of the sample frame file(s) compliance audit certification from the DSHS designated EQRO by January 31, 2008.

8.4.1.2. The Contractor will be allowed up to eight (8) Contractor—determined supplemental questions. DSHS will notify the Contractor of DSHS-selected supplemental questions.

8.4.1.2.1. The Contractor shall submit the questions to DSHS for written approval for the amount, content, and survey placement prior to December 14, 2007.

8.4.1.2.2. The Contractor shall receive a copy of the approved DSHS questionnaire for informational purposes by January 31, 2008.

8.4.1.3. The Contractor shall provide National CAHPS® Benchmarking Database (NCBD) submission information as determined by DSHS.

8.4.1.3.1. The Contractor shall submit the information to the DSHS designated EQRO by April 14, 2008.

8.4.2. In 2009, the Contractor shall conduct the CAHPS® Adult survey to Medicaid members enrolled in Healthy Options.

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

8.4.2.1.1. Contractor CAHPS® survey staff member contact, CAHPS® vendor name and CAHPS® primary vendor contact by January 5, 2009.

8.4.2.1.2. Timeline for implementation of vendor tasks by February 16, 2009.

8.4.2.2. The Contractor shall ensure the survey sample frame consists of all non-Medicare and non-commercial adult plan members (not just subscribers) 18 (eighteen) years and older with Washington State addresses. The Contractor shall submit the survey sample frame to DSHS by January 11, 2009. In administering the CAHPS® the Contractor shall:

8.4.2.2.1. Be allowed up to eight (8) Contractor-determined supplemental questions.

8.4.2.2.2. Allow DSHS up to eight (8) supplemental questions.

8.4.2.2.3. Be notified of DSHS' selected eight (8) supplemental questions on or before November 3, 2008.

8.4.2.2.4. Submit their questions to DSHS for written approval prior to December 15, 2008.

8.4.2.2.5. Submit the eligible sample frame file(s) for certification by the DSHS designated EQRO, a Certified HEDISâ Auditor by January 11, 2009.

8.4.2.2.6. Receive written notice of the sample frame file(s) compliance audit certification from the DSHS designated EQRO by January 31, 2009.

8.4.2.2.7. Receive the approved DSHS questionnaire by January 31, 2009. DSHS EQRO shall determine the questionnaire format, questions and question placement, using the most recent HEDIS® version of the Medicaid adult questionnaire

(currently 3.0H), plus approved supplemental and/or custom questions as determined by DSHS.

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

8.4.2.2.9. Submit the final disposition report by June 10, 2009.

8.4.2.2.10. Submit a copy of the Washington State adult Medicaid response data set according to 2009 NCQA/CAHPS® standards to the DSHS designated EQRO by June 10, 2009.

8.4.2.3. The Contractor shall provide NCBD data submission information as determined by DSHS.

8.4.2.3.1. The Contractor shall submit the information to the DSHS designated EQRO by April 14, 2009.

8.4.2.3.2. The DSHS designated EQRO shall submit the data to the NCBD.

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

8.4.3. The Contractor shall provide the following:

8.4.3.1. The Contractor shall notify DSHS in writing if the Contractor cannot conduct the annual CAHPS® surveys (Children, Children with Chronic Conditions, or Adult) because of limited total enrollment and/or sample size. The written statement shall provide enrollment and/or sample size data to support the Contractor's inability to meet the requirement.

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

8.5. **External Quality Review**:

8.5.1. 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 DSHS, its agent, or an EQRO.

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

8.5.2.1. Performance improvement projects;

8.5.2.2. Performance measures; and

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

8.5.3. The following optional activity will be validated annually:

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

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

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

8.5.5.1. The Contractor shall, during an annual monitoring review of the Contractor's compliance with contract standards or upon request by DSHS 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® and CAHPS® results are used to identify and correct problems and to improve care and services to enrollees.

8.5.5.2. 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.

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

8.5.5.4. 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 DSHS. 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 DSHS, Department of Health (DOH), and Health Care Authority (HCA) as needed to reduce duplicated work for both the Contractor and the state.

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

8.7. **Practice Guidelines:** The Contractor's policies and procedures related to practice guidelines shall ensure compliance with the requirements described in this section.

8.7.1. The Contractor shall adopt practice guidelines. The Contractor may develop or adopt guidelines developed by organizations such as the American Diabetes Association or the American Lung Association. Practice guidelines shall meet the following requirements (42 CFR 438.236):

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

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

8.7.1.3. Are adopted in consultation with contracting health care professionals;

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

8.7.1.5. Are disseminated to all affected providers and, upon request, to DSHS, enrollees and potential enrollees (42 CFR 438.236(c)); and

8.7.1.6. 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)).

8.8. **Drug Formulary Review and Approval:** The Contractor shall submit its drug formulary, for use with enrollees covered under the terms of this Contract, to DSHS for review and approval by January 31 of each year of this Contract or upon DSHS' request. The formulary shall be submitted to:

Siri Childs, Pharm D, Pharmacy Policy Manager (or her successor)
Department of Social and Health Services
Division of Medical Management
P.O. Box 45506
Olympia, WA 98504-5506
E-mail: childsa@dshs.wa.gov

8.9. **Health Information Systems:** 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:

8.9.1. 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.

8.9.2. Ensure data received from providers is accurate and complete by:

8.9.2.1. Verifying the accuracy and timeliness of reported data;

8.9.2.2. Screening the data for completeness, logic, and consistency; and

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

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

8.10. **Technical Assistance**: The Contractor may request technical assistance for any matter pertaining to this Contract by contacting DSHS by e-mail at healthyoptions@dshs.wa.gov.

9. **POLICIES AND PROCEDURES**

9.1. The Contractor shall have and follow written policies and procedures related to the requirements found in the provisions and sections in this Contract.

9.1.1. The provisions and sections that require policy and procedure are as follows:

9.1.1.1. Access, to include:

9.1.1.1.1. Cultural Considerations

9.1.1.1.2. Direct access for enrollees with special health care needs

9.1.1.1.3. General requirements

9.1.1.1.4. Network Monitoring

9.1.1.2. Benefits, to include:

9.1.1.2.1. General requirements

9.1.1.2.2. Pharmacy Management

9.1.1.3. Claims Payment

9.1.1.4. Coordination and Continuity of Care

9.1.1.5. Coordination of Benefits

9.1.1.6. Coverage Authorization

9.1.1.7. Credentialing — Provider Selection

9.1.1.8. DCR Payment Process

9.1.1.9. Enrollee Rights, to include:

9.1.1.9.1. Advance Directives

9.1.1.9.2. Enrollee Choice of Primary Care Provider

9.1.1.9.3. General requirements

9.1.1.9.4. Informed Consent

9.1.1.9.5. Member Privacy

9.1.1.9.6. Provider — Enrollee Communication

9.1.1.9.7. Prohibition on Enrollee Charges for Covered Services

9.1.1.10. Enrollment and ended enrollment, to include:

9.1.1.10.1. Termination of Enrollment — this requirement does not apply to subcontractors or non-contracted providers.

9.1.1.10.2. Involuntary Termination of Enrollment

9.1.1.11. Fraud and Abuse

9.1.1.12. Grievance System to include:

9.1.1.12.1. Grievance Process

9.1.1.12.2. Appeal Process

9.1.1.12.3. Expedited Appeal Process

9.1.1.12.4. Independent Review

9.1.1.12.5. Continuation of Services

9.1.1.13. Health Information Systems

9.1.1.14. Marketing and Information Requirements to include:

9.1.1.14.1. Material Development Requirements

9.1.1.14.2. Equal Access Requirements

9.1.1.14.3. Material Distribution Requirements

9.1.1.15. Patient Review and Restriction (PRR)

9.1.1.16. Performance Improvement Programs

9.1.1.17. Pharmacy Management

9.1.1.18. Physician Incentive Plan

9.1.1.19. Practice Guidelines

9.1.1.20. Quality Improvement

9.1.1.21. Subcontracts and Delegation

9.1.1.22. Utilization Management

9.1.2. The Contractor's policies and procedures shall include the following:

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

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

9.1.2.3. Have 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.

9.1.2.4. Identify procedures for monitoring and auditing for compliance.

9.1.2.5. Have procedures identifying prompt response to detected non-compliance, and effective corrective action.

9.1.3. The Contractor shall submit a written copy of each policy and procedure related to this Contract to DSHS for review and approval by September 10th of each year or anytime there is a material change. In the event that a policy and procedure had been approved by DSHS the previous year, and remained unchanged, the Contractor shall not be required to resubmit the policy and procedure. The Contractor shall certify in writing to DSHS that the policy and procedure is unchanged, in accord with the Notices provision of the General Terms and Conditions Section of this Contract.

10. **SUBCONTRACTS**

10.1. **Subcontracts Policy and Procedure Requirements:** The Contractor's policies and procedures related to subcontracting and delegation shall ensure compliance with the requirements described in this section..

10.2. **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 DSHS for any work performed under this Contract (42 CFR 434.6 (c) & 438.230(a)).

10.3. **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.

10.4. **Provider Nondiscrimination**:

10.4.1. 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)).

10.4.2. 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)).

10.4.3. 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)).

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

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

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

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

10.5. **Required Provisions:** Subcontracts shall be in writing, consistent with the provisions of 42 CFR 434.6. All subcontracts shall contain the following provisions:

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

10.5.2. Procedures and specific criteria for terminating the subcontract.

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

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

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

10.5.6. Reasonable access to facilities and financial and medical records for duly authorized representatives of DSHS or DHHS for audit purposes, and immediate access for Medicaid fraud investigators (42 CFR 438.6(g)).

10.5.7. 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 DSHS required data to enable the Contractor to meet the reporting requirements in the Encounter Data Transaction Guide published by DSHS.

10.5.8. The requirement to comply with the Contractor's DSHS approved fraud and abuse policies and procedures.

10.5.9. No assignment of the subcontract shall take effect without the DSHS' written agreement.

10.5.10. 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).

10.5.11. 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)).

10.5.12. 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)):

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

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

10.5.12.3. 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.

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

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

10.6. **Health Care Provider Subcontracts**, including those for facilities and pharmacy benefit management, shall also contain the following provisions:

10.6.1. 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.

10.6.2. A statement that primary care and specialty care provider subcontractors shall cooperate with QI activities.

10.6.3. 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.

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

10.6.3.1.1. Assigned responsibilities;

10.6.3.1.2. Delegated activities;

10.6.3.1.3. A mechanism for evaluation; and

10.6.3.1.4. Corrective action policy and procedure.

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

10.6.5. The subcontractor accepts payment from the Contractor as payment in full and shall not request payment from DSHS or any enrollee for covered services performed under the subcontract.

10.6.6. The subcontractor agrees to hold harmless DSHS 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 DSHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DSHS 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)).

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

10.6.8. A ninety (90) day termination notice provision.

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

10.6.10. 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)).

10.6.11. 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)).

10.7. **Health Care Provider Subcontracts Delegating Administrative Functions:**

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

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

10.7.1.2. Clear descriptions of any administrative functions delegated by the Contractor in the subcontract, including but 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.

10.7.1.3. 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.

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

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

10.7.2. 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 DSHS for review by February 28th of each year.

10.8. **Excluded Providers:**

10.8.1. Pursuant to Section 1128 or Section 1128A of the Social Security Act, the Contractor may not employ or subcontract with an individual practitioner or provider, or an entity with an officer, director, agent, or manager, or an individual who owns or has a controlling interest in the entity, who has been (42 CFR 438.214(d)):

10.8.1.1. Convicted of crimes as specified in Section 1128 of the Social Security Act,

10.8.1.2. Excluded from participation in the Medicare and/or Medicaid program,

10.8.1.3. Assessed a civil penalty under the provisions of Section 1128

10.8.1.4. Has a contractual relationship with an entity convicted of a crime specified in Section 1128, or

10.8.1.5. Identified as a person described in the Debarment Certification provisions of the General Terms and Conditions Section of this Contract.

10.8.2. The Contractor shall terminate subcontracts of excluded providers immediately when the Contractor becomes aware of such exclusion or when the Contractor receives notice from DSHS, whichever is earlier.

10.8.3. In addition, if DSHS terminates a subcontractor from participation in any DSHS program, the Contractor shall exclude the subcontractor from participation in Healthy Options/SCHIP. The Contractor shall terminate subcontracts of excluded providers immediately when the Contractor becomes aware of such exclusion or when the Contractor receives notice from DSHS, whichever is earlier (WAC 388-502-0030).

10.8.4. If the Contractor terminates a subcontractor for cause, the Contractor shall notify DSHS, within ten (10) working days, in writing, after the Contractor's provider appeal process is concluded, as provided in the Notices provisions of the General Terms and Conditions Section of this Contract, including an explanation of the cause of the termination.

10.9. **Home Health Providers:** If the pending Medicaid home health agency surety bond requirement (Section 4708(d) of the Balanced Budget Act of 1997) becomes effective before or during the term of this Contract, beginning on the effective date of the requirement the Contractor may not subcontract

with a home health agency unless the state has obtained a surety bond from the home health agency in the amount required by federal law. DSHS will provide a current list of bonded home health agencies upon request to the Contractor.

10.10. **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). The Contractor's policies and procedures related to physician incentive plans shall ensure compliance with the following requirements described in this section:

10.10.1. 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.

10.10.2. Whether the incentive plan includes referral services.

10.10.3. If the incentive plan includes referral services:

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

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

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

10.10.3.4. The panel size and, if commercial members and enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or physician group's panel may be pooled provided the terms of risk for the pooled enrollees and commercial members are comparable, and the incentive payments are not calculated separately for pooled enrollees. Commercial members include military and Basic Health members.

10.10.4. 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.

10.10.4.1. If aggregate stop-loss protection is provided, it must cover ninety percent (90%) of the costs of referral services that exceed

twenty-five percent (25%) of maximum potential payments under the subcontract.

10.10.4.2. If stop-loss protection is based on a per-member limit, it must cover ninety percent (90%) of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.

10.10.4.2.1. 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional services, or $6,000 for combined services.

10.10.4.2.2. 1,001 — 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

10.10.4.2.3. 5,001 — 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

10.10.4.2.4. 8,001 — 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

10.10.4.2.5. 10,001 — 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

10.10.4.2.6. 25,001 members or more, there is no risk threshold.

10.10.4.3. For a physician or physician group at substantial financial risk, the Contractor shall periodically conduct surveys of enrollee satisfaction with the physician or physician group. DSHS shall require such surveys annually. DSHS may, at its sole option, conduct enrollee satisfaction surveys that satisfy this requirement. If the Contractors enrolled population is too small to allow a valid survey by DSHS, the Contractor shall conduct an enrollee satisfaction survey. . DSHS shall notify the Contractor in writing if DSHS will be conducting the survey that satisfies the requirement for the Contractor. If the Contractor conducts the survey it shall:

10.10.4.3.1. Include current enrollees, and enrollees who have terminated enrollment within 12 months of the survey for reasons other than loss of Medicaid eligibility or moving outside the Contractor’s service area.

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

10.10.4.3.3. Address enrollees satisfaction with the physician or physician groups:

10.10.4.3.3.1. Quality of services provided.

10.10.4.3.3.2. Degree of access to services.

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

10.12. **Provider Education:** The Contractor will maintain records of the number and type of providers and support staff participating in provider education, including evidence of assessment of participant satisfaction with the training process.

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

10.12.1.1. Covered services for enrollees served under this Contract;

10.12.1.2. Coordination of care requirements;

10.12.1.3. DSHS and the Contractor's policies and procedures as related to this Contract;

10.12.1.4. Interpretation of data from the quality improvement program; and

10.12.1.5. Practice guidelines as described in the provisions of the Quality of Care Section of this Contract.

10.13. **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 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.

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

10.13.2. 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.

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

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

10.14. **FQHC/RHC Report:** The Contractor shall provide DSHS with information related to subcontracted federally-qualified health centers (FQHC) and rural health clinics (RHC), as required by the DSHS Healthy Options Licensed Health Carrier Billing Instructions, published by DSHS and incorporated by reference (see Attachment A for website link).

10.15. **Provider Credentialing:** The Contractor shall follow the requirements related to the credentialing and recredentialing of providers who have signed contracts or participation agreements with the Contractor (42 CFR 438.12(a)(2) 438.206(a & b) and 438.214).

10.15.1. The Contractor's policies and procedures related to the credentialing and recredentialing of providers who have signed contracts or participation agreements with the Contractor shall ensure compliance with the following requirements described in this section:

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

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

10.15.1.3. The identification of the type of providers that are credentialed and recredentialed;

10.15.1.4. The verification sources used to make credentialing decisions, including any evidence of provider sanctions; and

10.15.1.5. Prohibition against employment or contracting with providers excluded from participation in Federal health care programs under federal law and as described in the Excluded Providers provisions of this Section.

10.15.2. The criteria used by the Contractor to credential and recredential providers shall include (42 CFR 438.230(b)(1)):

10.15.2.1. Evidence of a current valid license to practice;

10.15.2.2. A valid DEA or CDS certificate if applicable;

10.15.2.3. Evidence of appropriate education and training;

10.15.2.4. Board certification if applicable;

10.15.2.5. An Evaluation of work history; and

10.15.2.6. A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider.

10.15.3. The Contractor's process for making credentialing determinations, to include a signed, dated attestation statement from the provider that addresses:

10.15.3.1. The lack of present illegal drug use;

10.15.3.2. A history of loss of license and felony convictions;

10.15.3.3. A history of loss or limitation of privileges or disciplinary activity;

10.15.3.4. Current malpractice coverage; and

10.15.3.5. Accuracy and completeness of the application.

10.15.4. The Contractor's process for delegation of credentialing or recredentialing.

10.15.5. The Contractor's provider selection policies and procedures that are consistent with 42 CFR 438.12, and must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination.

10.15.6. The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials, including:

10.15.6.1. Communication of the provider's right to review materials;

10.15.6.2. Correct incorrect or erroneous information;

10.15.6.3. Be informed of their credentialing status; and

10.15.6.4. The ability to appeal an adverse determination by the Contractor.

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

10.15.8. The Contractor a process to ensure confidentiality.

10.15.9. 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.

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

10.15.11. The Contractor's process to ensure that offices of all primary care providers, obstetricians/gynecologists and high volume providers meet office site standards established by the Contractor.

10.15.12. A system for monitoring sanctions or 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.

11. **ENROLLEE RIGHTS AND PROTECTIONS:**

11.1. **General Requirements**: The written policies and procedures regarding enrollee rights shall ensure compliance with the following requirements described in this section:

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 participate in and cooperate with DSHS' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds (42 CFR 438.206(c)(2)).

11.3. **Advance Directives:**

11.3.1. The Contractor's policies and procedures for advance directives shall meet the requirements of WAC 388-501-0125, 42 CFR 438.6, 438.10, 422.128, 489.100 and 489 Subpart I as described in this section including the following:

11.3.2. The Contractor's advance directive policies and procedure shall be disseminated to all affected providers, enrollees, DSHS, 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 an 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 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's policies and procedures must require, and the Contractor must ensure, that the enrollee's medical record documents, in a prominent part, whether or not the individual has executed an 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 an 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 advance directives.

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

11.3.9. The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and Federal law concerning advance directives. The Contractor shall document its community education efforts (42 CFR 438.6(i)(3)).

11.3.10. The Contractor is not required to provide care that conflicts with an advance directive; and is not required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or any subcontractor providing services under this Contract to conscientiously object.

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 DSHS 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) working days after coverage begins.

11.4.5. The Contractor shall allow an enrollee to change PCP or clinic at anytime with the change becoming effective no later than the beginning of the month following the enrollees request for the change (WAC 388-538-060 and WAC 284-43-251(1)).

11.4.6. The Contractor may limit enrollees' ability to change PCP's in accord with the Patient Review and Restriction provisions of the Benefits Section of this Contract.

11.5. **Direct Access for Enrollees with Special Health Care Needs:** The Contractor shall allow enrollees with special health care needs who utilize a specialist frequently to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care. The Contractor shall also allow enrollees with special health care needs as defined in WAC 388-538-050 to retain a specialist as a PCP or be allowed direct access to a specialist if the assessment required under the provisions of this Contract demonstrates a need for a course of treatment or regular monitoring by such specialist (42 CFR 438.208(c)(4) and 438.6(m)).

11.6. **Prohibition on Enrollee Charges for Covered Services:**

11.6.1. Under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge enrollees for covered services (SSA 1932(b)(6), SSA 1128B(d)(1)), 42 CFR 438.106(c), 438.6(1), 438.230, and 438.204(a) and WAC 388-502-0160).

11.6.2. The Contractor shall have a separate and specific policy and procedure that fully articulates how the Contractor will protect enrollees from being billed for covered services.

11.7. **Provider/Enrollee Communication:** The Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope

of practice, from advising or advocating on behalf of an enrollee who is their patient, for the following (42 CFR 438.102(a)(1)(i)):

11.7.1. 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)).

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

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

11.7.4. The enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions (42 CFR 438.102(a)(1)(iv)).

11.8. **Enrollee Self-Determination:** The Contractor shall ensure that all providers: obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning advance directives (WAC 388-501-0125 and 42 CFR 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (RCW 68.50.540).

12. UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

12.1. **Utilization Management Program:** 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) for the services it furnishes its enrollees.

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 DSHS with 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 include the following content:

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.

12.1.6.2. Mechanisms for providers and enrollees on how they can obtain the UM decision-making criteria upon request, including UM action or denial determination letter template language reflecting same.

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

12.1.6.4. Written job descriptions with qualification for providers who review denials of care based on medical necessity that requires education, training or professional experience in medical or clinical practice and current non-restricted license.

12.1.6.5. Mechanisms to verify that claimed services were actually provided.

12.1.6.6. Mechanisms to detect both underutilization and over-utilization of services, including pharmacy underutilization and over-utilization, and produce a yearly report which identifies and reports findings on utilization measures and includes completed or planned interventions to address under or over-utilization patterns of care (42 CFR 438.240(b)(3)).

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

12.1.6.8. A physician or behavioral health practitioner or pharmacist as appropriate reviews any behavioral health denial of care based on medical necessity.

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

12.1.6.10. Appeals of adverse determinations evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease (PBOR, WAC 284-43-620(4)).

12.1.6.11. 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 (PBOR, WAC 284-43-210(6)).

12.2. **Authorization of Services:** The Contractor shall follow the authorization of services requirements described in this section.

12.2.1. The Contractor's policies and procedures related to authorization of services shall include the compliance with 42 CFR 438.210 and WAC 388-538, and require compliance of subcontractors with delegated authority for authorization of services with the requirements described in this section.

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

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

12.2.3.1. The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount,

duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease (42 CFR 438.210(b)(3)).

12.2.3.2. The Contractor shall notify the requesting provider, and give the enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the following requirements, except that the notice to the provider need not be in writing (42 CFR 438.210(c) and 438.404):

12.2.3.2.1. The notice to the enrollee shall be in writing and shall meet the requirements of the, Information Requirements for Enrollees and Potential Enrollees, provisions of the Marketing and Information Requirements Section, of this Contract to ensure ease of understanding.

12.2.3.2.2. The notice shall explain the following (42 CFR 438.404(b)(1-3)(5-7)):

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

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

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

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

12.2.3.2.2.5. The enrollee's right to file an appeal.

12.2.3.2.2.6. The procedures for exercising the enrollee's rights.

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

12.2.3.2.4. 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.

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

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

12.2.4.2. 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. The notice shall be mailed within this ten (10) calendar day period by a method that certifies receipt and assures delivery within three (3) calendar days.

12.2.4.2.1. For standard authorization, determinations are to be made within two (2) business 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)).

12.2.4.2.2. Beyond the fourteen (14) calendar day period, a possible extension of up to fourteen (14) additional calendar days (equal to a total of twenty-eight (28) calendar days) is allowed under the following circumstances (42 CFR 438.210(d)(1)(i-ii)):

12.2.4.2.2.1. The enrollee, or the provider, requests extension; or

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

12.2.4.2.2.3. If the Contractor extends that timeframe, it shall(438.408(c)(2):

12.2.4.2.2.3.1. 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

12.2.4.2.2.3.2. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

12.2.4.2.3. For standard authorization decisions, notification of the decision shall be made to the attending physician, ordering provider, facility and enrollee within two (2) business days (PBOR, WAC 284-43-410).

12.2.4.3. 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 and no later than three (3) working days after receipt of the request for service. The Contractor may extend the three (3) working days by up to fourteen (14) calendar days under the following circumstances (42 CFR 438.210(d)(2)):

12.2.4.3.1. The enrollee requests the extension; or

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

12.3. **Fraud and Abuse Requirements:** The Contractor shall have and follow the Fraud and Abuse requirements described in this section.

12.3.1. The Contractor's policies and procedures related to fraud and abuse shall include compliance with 42 CFR 438.608(a) and section 1902(a)(68) of the Social Security Act and include the requirement of compliance of staff and subcontractors with the requirements described in this section.

12.3.2. The Contractor shall have:

12.3.2.1. In effect a process to inform employees and subcontractors regarding the False Claims Act.

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

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

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

12.3.2.5. Effective training for the compliance officer and the Contractor's employees and subcontractors.

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

12.3.2.7. Enforcement of standards through well-publicized disciplinary guidelines.

12.3.2.8. Provision for internal monitoring and auditing.

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

12.3.2.10. Provision of detailed information to employees and subcontractors regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(68) of the Social Security Act.

12.3.3. The Contractor shall report in writing to DSHS all verified cases of fraud and abuse, including fraud and abuse by the Contractor's employees and subcontractors, within seven (7) calendar days according to the Notices provisions of the General Terms and Conditions Section of this Contract. The report shall include the following information:

12.3.3.1. Subject(s) of complaint by name and either provider/subcontractor type or employee position.

12.3.3.2. Source of complaint by name and provider/subcontractor type or employee position, if applicable.

12.3.3.3. Nature of complaint.

12.3.3.4. Estimate of the amount of funds involved.

12.3.3.5. Legal and administrative disposition of case.

13. **GRIEVANCE SYSTEM**

13.1. **General Requirements**: The Contractor shall have a grievance system which complies with the requirements of 42 CFR 438 Subpart F and WACs 388-538 and 284-43, insofar as those WACs are not in conflict with 42 CFR 438 Subpart F. The grievance system shall include a grievance process, an appeal process, and access to the hearing process. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

13.1.1. The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Contract. DSHS must approve, in writing, all grievance system policies and procedures and related notices to enrollees regarding the grievance system.

13.1.2. The Contractor shall give enrollees any assistance necessary in completing forms and other procedural steps for grievances and appeals (42 CFR 438.406(a)(1) and WAC 284-43-615(2)(e)).

13.1.3. The Contractor shall acknowledge receipt of each grievance, either orally or in writing, and appeal, in writing, within five (5) working days (42 CFR 438.406(a)(2) and (WAC 284-43-620).

13.1.4. The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making (42 CFR 438.406(a)(3)(i)).

13.1.5. Decisions regarding grievances and appeals shall be made by health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply (42 CFR 438.406(a)(3)(ii)):

13.1.5.1. If the enrollee is appealing an action concerning medical necessity.

13.1.5.2. If an enrollee grievance concerns a denial of expedited resolution of an appeal.

13.1.5.3. If the grievance or appeal involves any clinical issues.

13.2. **Grievance Process**: The following requirements are specific to the grievance process:

13.2.1. Only an enrollee may file a grievance with the Contractor; a provider may not file a grievance on behalf of an enrollee (42 CFR 438.402(b)(3)).

13.2.2. The Contractor shall accept grievances forwarded by DSHS.

13.2.3. The Contractor shall cooperate with any representative authorized in writing by the covered enrollee (WAC 284-43-615).

13.2.4. The Contractor shall consider all information submitted by the covered person or representative (WAC 284-43-615).

13.2.5. The Contractor shall investigate and resolve all grievances (WAC 284-43-615).

13.2.6. 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 ninety (90) calendar days from receipt of the grievance.

13.2.7. The Contractor may notify enrollees of the disposition of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

13.2.8. Enrollees do not have the right to a hearing in regard to the disposition of a grievance.

13.3. **Appeal Process**: The following requirements are specific to the appeal process:

13.3.1. An enrollee, or a provider acting on behalf of the enrollee and with the enrollee's written consent, may appeal a Contractor action (42 CFR 438.406(b)(1)).

13.3.2. If DSHS receives a request to appeal an action of the Contractor, DSHS will forward relevant information to the Contractor and the Contractor will contact the enrollee.

13.3.3. For appeals of standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety (90) calendar days of the date on the Contractor's notice of action. This also applies to an enrollee's request for an expedited appeal (42 CFR 438.406(b)(1)).

13.3.4. For appeals for termination, suspension, or reduction of previously authorized services when the enrollee requests continuation of such services, an enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the notice of action. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for appeals of standard resolution apply (42 CFR 438.408).

13.3.5. Oral inquiries seeking to appeal an action shall be treated as appeals and be confirmed in writing, unless the enrollee or provider requests an expedited resolution (42 CFR 438.406(b)(1)).

13.3.6. The appeal process shall provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the enrollee of the limited time available for this in the case of expedited resolution (42 CFR 438.406(b)(2)).

13.3.7. The appeal process shall provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process (42 CFR 438.406(b)(3)).

13.3.8. The appeal process shall include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate (42 CFR 438.406(b)(4)).

13.3.9. The Contractor shall resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following timeframes (42 CFR 438.408(b)(2-3):

13.3.9.1. For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within fourteen (14) 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) days of the request for appeal, without the informed written consent of the enrollee. In all circumstances the appeal determination must not be extended beyond forty-five (45) calendar days from the day the Contractor receives the appeal request.

13.3.9.2. For expedited resolution of appeals, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the appeal. This timeframe may not be extended.

13.3.10. The notice of the resolution of the appeal shall (42 CFR 438.408(d)):

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

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

13.3.10.3. A written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the Utilization Management clinical review or decision-making criteria.

13.3.10.4. For appeals not resolved wholly in favor of the enrollee (42 CFR 438.408(e)(2)):

13.3.10.4.1. Include information on the enrollee's right to request a hearing and how to do so.

13.3.10.4.2. Include information on the enrollee's right to receive services while the hearing is pending and how to make the request.

13.3.10.4.3. Inform the enrollee that the enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending, if the hearing decision upholds the Contractor's action.

13.4. **Expedited Appeal Process**:

13.4.1. The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines, for a request from the enrollee, or the provider indicates, in making the request on the enrollee's behalf or supporting the enrollee's request, that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function (42 CFR 438.410(a)).

13.4.2. 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.

13.4.3. The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal (42 CFR 438.410(b)).

13.4.4. If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice (42 CFR 438.410(c)).

13.4.5. 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.

13.5. **Hearings:**

13.5.1. A provider may not request a hearing on behalf of an enrollee.

13.5.2. If an enrollee does not agree with the Contractor's resolution of the appeal, the enrollee may file a request for a hearing within the following time frames (see WAC 388-538-112 for the hearing process for enrollees):

13.5.2.1. For hearings regarding a standard service, within ninety (90) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal 42 CFR 438.402 (b)(2)).

13.5.2.2. For hearings regarding termination, suspension, or reduction of a previously authorized service, if the enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the

appeal. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for a hearing regarding a standard service apply (42 CFR 438.420)

13.5.3. If the enrollee requests a hearing, the Contractor shall provide to DSHS upon request and within three (3) working days, all Contractor-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

13.5.4. The Contractor is an independent party and is responsible for its own representation in any hearing, independent review, Board of Appeals and subsequent judicial proceedings.

13.5.5. The Contractor's medical director or designee shall review all cases where a hearing is requested and any related appeals, when medical necessity is an issue.

13.5.6. The enrollee must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a hearing with DSHS (42 CFR 438.402(b)(2)(ii)).

13.5.7. DSHS will notify the Contractor of hearing determinations. The Contractor will be bound by the hearing determination, whether or not the hearing determination upholds the Contractor's decision. Implementation of such a hearing decision shall not be the basis for termination of enrollment by the Contractor.

13.5.8. If the hearing decision is not within the purview of this Contract, then DSHS will be responsible for the implementation of the hearing decision.

13.6. **Independent Review**: After exhausting both the Contractor's appeal process and the hearing process an enrollee has a right to independent review in accord with RCW 48.43.535 and WAC 284-43-630.

13.7. **Board of Appeals:** An enrollee who is aggrieved by the final decision of an independent review may appeal the decision to the DSHS Board of Appeals in accord with WAC ###-##-#### through ###-##-####. Notice of this right will be included in the written determination from the Contractor or Independent Review Organization.

13.8. **Continuation of Services**:

13.8.1. The Contractor shall continue the enrollee's services if all of the following apply (42 CFR 438.420):

13.8.1.1. An appeal, hearing or independent review is requested on or before the later of the following:

13.8.1.1.1. Within ten (10) calendar days of the Contractor mailing the notice of action, which for actions involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.

13.8.1.1.2. The intended effective date of the Contractor's proposed action.

13.8.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

13.8.1.3. The services were ordered by an authorized provider.

13.8.1.4. The original period covered by the original authorization has not expired.

13.8.1.5. The enrollee requests an extension of services.

13.8.2. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's services while the appeal, hearing, independent review or DSHS Board of Appeals is pending, the services shall be continued until one of the following occurs:

13.8.2.1. The enrollee withdraws the appeal, hearing or independent review request.

13.8.2.2. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the appeal and the enrollee has not requested a hearing (with continuation of services until the hearing decision is reached) within the ten (10) calendar days.

13.8.2.3. Ten (10) calendar days pass after DSHS mails the notice of resolution of the hearing and the enrollee has not requested an independent review (with continuation of services until the independent review decision is reached) within the ten (10) calendar days.

13.8.2.4. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the independent review and the enrollees has not requested a DSHS Board of Appeals (with continuation of services until the DSHS Board of Appeals decision is reached) within ten (10) calendar days.

13.8.2.5. The time period or service limits of a previously authorized service has been met.

13.8.3. If the final resolution of the appeal upholds the Contractor's action, the Contractor may recover from the enrollee the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

13.9. **Effect of Reversed Resolutions of Appeals and Hearings**:

13.9.1. If the Contractor, DSHS Office of Administrative Hearings (OAH), independent review organization (IRO) or DSHS Board of Appeals 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)).

13.9.2. If the Contractor, OAH, IRO or DSHS Board of Appeals 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.

13.10. **Actions, Grievances, Appeals and Independent Reviews**: The Contractor shall maintain records of all actions, grievances, appeals and independent reviews.

13.10.1. The records shall include actions, grievances and appeals handled by delegated entities.

13.10.2. The Contractor shall provide a report of complete actions, grievances, appeals and independent reviews to DSHS in accord with the Grievance System Reporting Requirements published by DSHS (see Attachment A for website link).

13.10.3. The Contractor is responsible for maintenance of records for and reporting of any grievance, actions and appeals handled by delegated entities.

13.10.4. Delegated actions, grievances and appeals are to be integrated into the Contractor's report.

13.10.5. Data shall be reported in the DSHS 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 DSHS within 30 calendar days.

13.10.6. The report medium shall be specified by DSHS and shall be in accord with the Grievance System Reporting Requirements published by DSHS (See Attachment A for website link).

13.10.7. Reporting of actions shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers unless the enrollee may be liable for payment in accord with WAC 388-502-0160 and the provisions of this Contract.

13.10.8. The Contractor shall provide information to DSHS regarding denial of payment to providers upon request.

13.10.9. Reporting of grievances shall include all expressions of enrollee dissatisfaction not related to an action. All grievances are to be recorded and counted whether the grievance is remedied by the Contractor immediately or through its grievance and quality of care service procedures.

14. **BENEFITS**

14.1. **Scope of Services:**

14.1.1. The Contractor is responsible for covering medically necessary services relating to (42 CFR 438.210(a)(4)):

14.1.1.1. The prevention, diagnosis, and treatment of health impairments.

14.1.1.2. The achievement of age-appropriate growth and development.

14.1.1.3. The attainment, maintenance, or regaining of functional capacity.

14.1.2. If a specific procedure or element of a covered service is covered by DSHS under its fee-for-service program, as described in DSHS' billing instructions, incorporated by reference (see Attachment A for website link), the Contractor shall cover the service subject to the specific exclusions and limitations as described in this Contract.

14.1.3. Except as otherwise specifically provided in this Contract, the Contractor shall provide covered services in the amount, duration and scope described in the Medicaid State Plan (42 CFR 438.210(a)(1 & 2)).

14.1.4. The amount and duration of covered services that are medically necessary depends on the enrollee's condition (42 CFR 438.210(a)(3)(i)).

14.1.5. 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).

14.1.6. 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 covered 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).

14.1.7. For specific covered services, the requirements of this Section shall also not be construed as requiring the Contractor to cover the specific items covered by DSHS under its fee-for-service program, but shall rather be construed to require the Contractor to cover the same scope of services.

14.1.8. 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)).

14.1.9. The Contractor may limit coverage of services to participating providers except as specifically provided in the Access and Capacity Section of this Contract; and the following provisions of this Section:

14.1.9.1. Emergency services;

14.1.9.2. Outside the Service Areas as necessary to provide medically necessary services; and

14.1.9.3. Coordination of Benefits, when an enrollee has other medical coverage as necessary to coordinate benefits.

14.1.10. 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.

14.1.11. 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:

14.1.11.1. Emergency and post-stabilization services.

14.1.11.2. 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.

14.1.11.3. 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.

14.1.11.4. The Contractor's obligation for services outside the service area is limited to ninety (90) calendar days beginning with the first of the month following the month in which the enrollee leaves the service area or changes residence, except when the enrollee is sent out of the service area by the Contractor to receive services.

14.1.11.5. The Contractor is not responsible for coverage of any services when an enrollee is outside the United States of America and its territories and possessions.

14.2. **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.

14.3. **Enrollee Self-Referral:**

14.3.1. 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.

14.3.2. The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

14.3.3. The enrollees also may choose to receive such services from the Contractor.

14.3.4. 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.

14.3.5. 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.

14.3.6. The services to which an enrollee may self-refer are:

14.3.6.1. Family planning services and sexually-transmitted disease screening and treatment services provided at family planning facilities, such as Planned Parenthood.

14.3.6.2. 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.

14.4. **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).

14.5. **Maternity Newborn Length of Stay:** The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

14.6. **Continuity of Care:** The Contract 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 (42 CFR 438.208).

14.6.1. 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.

14.6.2. If possible and reasonable, the Contractor shall preserve enrollee provider relationships through transitions.

14.6.3. Where preservation of provider relationships is not possible and reasonable, the Contractor shall provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the enrollee's medical condition requires.

14.6.4. The Contractor shall allow new enrollees with the Contractor to fill prescriptions written prior to enrollment until the first of the following occurs:

14.6.4.1. The enrollee's prescription expires.

14.6.4.2. A participating provider examines the enrollee to evaluate the continued need for the prescription. If the enrollee refuses an evaluation by a participating provider the Contractor may refuse to fill the prescription.

14.7. **Coordination of Care:** The Contractor shall ensure that health care services are coordinated for enrollees as follows (42 CFR 438.208):

14.7.1. The Contractor shall ensure that PCPs are responsible for the provision, coordination, and supervision of health care to meet the needs of each enrollee, including initiation and coordination of referrals for medically necessary specialty care.

14.7.2. 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)(4) and 45 CFR 160 and 164 subparts A and E).

14.7.3. The Contractor shall provide support services to assist PCPs in providing coordination if it is not provided directly by the Contractor.

14.7.4. The Contractor shall coordinate and ensure PCPs coordinate with community-based and DSHS services/programs including but not limited to services/programs described in this Section:

14.7.4.1. First Steps Maternity Services and Maternity Case Management;

14.7.4.2. Transportation services;

14.7.4.3. Regional Support Networks for mental health services;

14.7.4.4. Developmental Disability services;

14.7.4.5. Infant Toddler Early Intervention Program (ITEIP) for infants from the ages of birth to three;

14.7.4.6. Patient Review and Restriction (PRR) program, for enrollees who meet the criteria identified in WAC 388-501-0135;

14.7.4.7. Health Department services, including Title V services for children with special health care needs;

14.7.4.8. Home and Community Services for older and physically disabled individuals; and

14.7.4.9. Alcohol and Substance Abuse services.

14.7.5. The Contractor shall identify or shall ensure that providers identify enrollees with special health care needs as defined in WAC 388-538-050. The Contractor's obligation for identification of enrollees with special health care needs is limited to identification in the course of any contact or health care visit initiated by the enrollee and any information available to the Contractor regarding an enrollee's special health care needs. The Contractor shall maintain a record of all enrollee's identified as enrollee's with special health care needs.

14.7.6. The Contractor shall ensure that PCPs, in consultation with other appropriate health care professionals, assess and develop individualized treatment plans for children with special health care needs and enrollees with special health care needs as defined herein, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care (42 CFR 438.208(c)(2)).

14.7.6.1. Documentation regarding the assessment and treatment plan shall be in the enrollee's case file, including enrollee participation in the development of the treatment plan (42 CFR 438.208(c)(3)).

14.7.6.2. If the Contractor requires approval of the treatment plan, approval must be provided in a timely manner appropriate to the enrollee's health condition.

14.7.7. The Contractor must implement procedures to share with other MCOs and RSNs serving the enrollee the results of its identification and assessment of any children with special health care needs and enrollee with special health care needs so that those activities are not duplicated while protecting confidentiality and enrollee rights (42 CFR 438.208 (b)(3)).

14.8. **Second Opinions:**

14.8.1. 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, at no cost to the enrollee.

14.8.2. 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)).

14.9. **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 the DSHS Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is used.

14.10. **Experimental and Investigational Services:**

14.10.1. If the Contractor excludes or limits benefits for any services for one or more medical conditions or illnesses because such services are deemed experimental or investigational, the Contractor shall develop and follow policies and procedures for such exclusions and limitations. 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 DSHS upon request (WACs 284-44-043, 284-46-507 and 284-96-015).

14.10.2. In making the determination, whether to authorize a service the Contractor shall consider the following:

14.10.2.1. Evidence in peer-reviewed, medical literature, as defined herein, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications.

14.10.2.2. Whether evidence indicates the service or treatment is likely to be as beneficial as existing conventional treatment alternatives.

14.10.2.3. Any relevant, specific aspects of the condition.

14.10.2.4. Whether the service or treatment is generally used for the condition in the State of Washington.

14.10.2.5. Whether the service or treatment is under continuing scientific testing and research.

14.10.2.6. Whether the service or treatment shows a demonstrable benefit for the condition.

14.10.2.7. Whether the service or treatment is safe and efficacious.

14.10.2.8. Whether the service or treatment will result in greater benefits for the condition than another generally available service.

14.10.2.9. If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

14.10.3. Criteria to determine whether a service is experimental or investigational shall be no more stringent for Medicaid enrollees than that applied to any other members.

14.10.4. A service or treatment that is not experimental for one enrollee with a particular medical condition cannot be determined to be experimental for another enrollee with the same medical condition and similar health status.

14.10.5. A service or treatment may not be determined to be experimental and investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of significant benefit to enrollees.

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

14.11. **Enrollee Hospitalized at Enrollment:**

14.11.1. If an enrollee is in an acute care hospital at the time of enrollment and was not enrolled in Healthy Options/SCHIP on the day the enrollee is admitted to the hospital, DSHS 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.

14.11.2. If an enrollee is enrolled in Healthy Options/SCHIP 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.

14.11.3. For newborns, born while their mother is hospitalized, the party responsible for the payment of covered 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.

14.11.4. 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, DSHS 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.

14.11.5. If DSHS is responsible for payment of all covered inpatient facility and professional services provided to a mother, DSHS shall not pay the Contractor a Delivery Case Rate under the provisions of the Payment and Sanctions Section of this Contract.

14.12. **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;

14.12.1. The enrollee is no longer confined to an acute care hospital.

14.12.2. 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.

14.12.3. The enrollee's eligibility to receive Medicaid services ends. The Contractor's obligation for payment ends at the end of the month the enrollees Medicaid eligibility ends.

14.13. **General Description of Covered Services:** This Section is a general description of services covered under this Contract and is not intended to be exhaustive.

14.13.1. Medical services provided to enrollees who have a diagnosis of alcohol and/or chemical dependency or mental health diagnosis are covered when those services are otherwise covered services.

14.13.2. Inpatient Services: Provided by acute care hospitals (licensed under RCW 70.41), or nursing facilities (licensed under RCW 18.51) when nursing facility services are not covered by DSHS' Aging and Disability Services Administration and the Contractor determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included.

14.13.3. Outpatient Hospital Services: Provided by acute care hospitals (licensed under RCW 70.41).

14.13.4. Emergency Services and Post-stabilization Services:

14.13.4.1. Emergency Services: Emergency services are defined herein.

14.13.4.1.1. The Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 CFR 438.114.

14.13.4.1.2. 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)).

14.13.4.1.3. The Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, or the Contractor of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services (42 CFR 438.114 (c)(1)(ii)).

14.13.4.1.4. The only exclusions to the Contractor's coverage of emergency services are mental health services which are covered under separate contract, and dental services only if provided by a dentist or an oral surgeon to treat a dental diagnosis, covered under DSHS' fee-for-service program.

14.13.4.1.5. Emergency services shall be provided without requiring prior authorization.

14.13.4.1.6. 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)).

14.13.4.1.7. The Contractor shall cover treatment obtained under the following circumstances:

14.13.4.1.7.1. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition (42 CFR 438.114(c)(1)(ii)(A)).

14.13.4.1.7.2. A participating provider or other Contractor representative instructs the enrollee to seek emergency services (42 CFR 438.114(c)(1)(ii)(B)).

14.13.4.1.8. If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of

an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor (42 CFR 438.114 (d)(3)).

14.13.4.2. Post-stabilization Services: Post-stabilization services are defined herein.

14.13.4.2.1. 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).

14.13.4.2.2. The Contractor shall cover all post-stabilization 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.

14.13.4.2.3. The Contractor shall cover post-stabilization services under the following circumstances (42 CFR 438.114 (e) and 42 CFR 438.113(c)(2)(iii))):

14.13.4.2.3.1. The services are pre-approved by a participating provider or other Contractor representative.

14.13.4.2.3.2. 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.

14.13.4.2.3.3. 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:

14.13.4.2.3.3.1. The Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d));

14.13.4.2.3.3.2. The Contractor cannot be contacted; or

14.13.4.2.3.3.3. 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.

14.13.4.2.4. 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)):

14.13.4.2.4.1. A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

14.13.4.2.4.2. A participating provider assumes responsibility for the enrollee's care through transfer;

14.13.4.2.4.3. A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

14.13.4.2.4.4. The enrollee is discharged.

14.13.5. Ambulatory Surgery Center: Services provided at ambulatory surgery centers.

14.13.6. Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, and certified dietitians. Provider Services include, but are not limited to:

14.13.6.1. Medical examinations, including wellness exams for adults and EPSDT for children

14.13.6.2. Immunizations

14.13.6.3. Maternity care

14.13.6.4. Family planning services provided or referred by a participating provider or practitioner

14.13.6.5. Performing and/or reading diagnostic tests

14.13.6.6. Private duty nursing

14.13.6.7. Surgical services

14.13.6.8. Services to correct defects from birth, illness, or trauma, or for mastectomy reconstruction

14.13.6.9. Anesthesia

14.13.6.10. Administering pharmaceutical products

14.13.6.11. Fitting prosthetic and orthotic devices

14.13.6.12. Rehabilitation services

14.13.6.13. Enrollee health education

14.13.6.14. Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia

14.13.6.15. Bio-feedback training when determined medically necessary specifically for, perineal muscles, anorectral or urethral sphincter, including EMG and/or manometry for incontinence.

14.13.6.16. Genetic services when medically necessary for diagnosis of a medical condition.

14.13.7. Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel, and peripheral blood stem cell.

14.13.8. Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy.

14.13.9. Vision Care: Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The Contractor may restrict non-emergent care to participating providers. Enrollees may self-refer to participating providers for these services.

14.13.10. Outpatient Mental Health:

14.13.10.1. Psychiatric and psychological testing, evaluation and diagnosis:

14.13.10.1.1. Once every twelve (12) months for adults twenty-one (21) and over and children under age twenty-one when not ordered as a result of an EPSDT exam.

14.13.10.1.2. Unlimited for children under age twenty-one (21) when identified in an EPSDT exam.

14.13.10.2. Unlimited medication management:

14.13.10.2.1. Provided by the PCP or by PCP referral.

14.13.10.2.2. Provided in conjunction with mental health treatment covered by the Contractor.

14.13.10.3. Twelve hours per calendar year for treatment for enrollees who do not meet the RSNs access standards for receiving treatment.

14.13.10.4. Transition to the RSN, as appropriate to the enrollee's condition to assure continuity of care.

14.13.10.5. The Contractor may subcontract with RSNs to provide the outpatient mental health services that are the responsibility of the Contractor. Such contracts shall not be written or construed in a manner that provides less than the services otherwise described in this Section as the Contractor's responsibility for outpatient mental health services.

14.13.10.6. The DSHS Mental Health Division (MHD) and the Division of Healthcare Services (DHS) shall each appoint a Mental Health Care Coordinator (MHCC). The MHCCs shall be empowered to decide all Contractor and RSN issues regarding outpatient mental health coverage that cannot be otherwise resolved between the Contractor and the RSN. The MHCCs will also undertake training and technical assistance activities that further coordination of care between DPS, MHD, Healthy Options contractors, and RSNs. The Contractor shall cooperate with the activities of the MHCCs.

14.13.11. Neurodevelopmental Services, Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability when provided by a facility that is not a DSHS recognized neurodevelopmental center. The Contractor may refer children to a DSHS recognized neurodevelopmental center for the services as long as appointment wait time standards and access to care standards of this Contract are met (see Attachment A for website link).

14.13.12. Pharmaceutical Products:

14.13.12.1. 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 enrollees' medically necessary health care needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about

how to request non-formulary drugs.

14.13.12.2. The Contractor shall have in place a mechanism to deny prescriptions written by excluded providers.

14.13.12.3. The Contractor's policies and procedures for the administration of the pharmacy benefit shall ensure compliance with the following requirements described in this section:

14.13.12.3.1. Formulary exceptions: The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request.

14.13.12.3.2. Emergency drug supply: The Contractor shall have a process for providing an emergency drug supply to enrollees when a delay in authorization would interrupt a drug therapy that must be continuous or when the delay would pose a threat to the enrollees' health and safety. The drug supply provided must be sufficient to bridge the time until an authorization determination is made.

14.13.12.4. Covered drug products shall include:

14.13.12.4.1. Oral, enteral and parenteral nutritional supplements and supplies, including prescribed infant formulas;

14.13.12.4.2. All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies; including but not limited to Depo-Provera, Norplant, and OTC products;

14.13.12.4.3. Antigens and allergens; and

14.13.12.4.4. Therapeutic vitamins and iron prescribed for prenatal and postnatal care.

14.13.13. Home Health Services: Home health services through state-licensed agencies.

14.13.14. Durable Medical Equipment (DME) and Supplies: Including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the enrollee agrees.

14.13.15. Oxygen and Respiratory Services: Oxygen, and respiratory therapy equipment and supplies.

14.13.16. Hospice Services: When the enrollee elects hospice care. Includes facility services.

14.13.17. Blood, Blood Components and Human Blood Products: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products, the Contractor shall cover the cost of the blood or blood products.

14.13.18. Treatment for Renal Failure: Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

14.13.19. 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:

14.13.19.1. When it is necessary to transport an enrollee between facilities to receive a covered services; and,

14.13.19.2. When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

14.13.20. Smoking Cessation Services: For pregnant women through sixty (60) calendar days post pregnancy.

14.13.21. Newborn Screenings: The Contractor shall cover all newborn screenings required by the Department of Health.

14.13.22. EPSDT:

14.13.22.1. The Contractor shall meet all requirements under the DSHS EPSDT program policy and billing instructions, incorporated by reference (see Attachment A for website link).

14.13.22.2. The following services are covered when referred as a result of an EPSDT exam.

14.13.22.2.1. Chiropractic services;

14.13.22.2.2. Nutritional counseling; and

14.13.22.2.3. Unlimited psychiatric and psychological testing evaluation and diagnosis.

14.14. **Exclusions:** The following services and supplies are excluded from coverage under this Contract.

14.14.1. Unless otherwise required by this Contract, ancillary services resulting from excluded services are also excluded.

14.14.2. 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.

14.14.3. Services Covered By DSHS Fee-For-Service Or Through Other Contracts:

14.14.3.1. School Medical Services for Special Students as described in the DSHS billing instructions for School Medical Services.

14.14.3.2. Eyeglass Frames, Lenses, and Fabrication Services covered under DSHS' selective contract for these services, and associated fitting and dispensing services.

14.14.3.3. Voluntary Termination of Pregnancy.

14.14.3.4. Transportation Services other than Ambulance: including but not limited to Taxi, cabulance, voluntary transportation, public transportation and common carriers.

14.14.3.5. 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.

14.14.3.6. Hearing Aid Devices, including fitting, follow-up care and repair.

14.14.3.7. First Steps Child Care, Infant Case Management and Maternity Support Services as described in the DSHS program billing instructions (see Attachment A for website link).

14.14.3.8. Sterilizations for enrollees under age twenty-one (21), or those that do not meet other federal requirements (42 CFR 441 Subpart F) (see Attachment A for website link).

14.14.3.9. Health care services provided by a neurodevelopmental center recognized by DSHS.

14.14.3.10. Services provided by a health department or family planning clinic when a client self-refers for care.

14.14.3.11. Inpatient psychiatric professional services.

14.14.3.12. Emergency mental health services.

14.14.3.13. Pharmaceutical products prescribed by any provider related to services provided under a separate contract with DSHS.

14.14.3.14. Laboratory services required for medication management of drugs prescribed by community mental health providers whose services are purchased by the Mental Health Division.

14.14.3.15. Protease Inhibitors

14.14.3.16. Services ordered as a result of an EPSDT exam that are not otherwise covered services.

14.14.3.17. Surgical procedures for weight loss or reduction, when approved by DSHS in accord with WAC 388-531-0200. The Contractor has no obligation to cover surgical procedures for weight loss or reduction.

14.14.3.18. Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing.

14.14.4. Services Covered By Other Divisions In DSHS:

14.14.4.1. Substance abuse treatment services covered through the Division of Alcohol and Substance Abuse (DASA).

14.14.4.2. Community-based services (e.g., COPES and Personal Care Services) covered through the Aging and Disability Services Administration.

14.14.4.3. Nursing facilities covered through the Aging and Disability Services Administration.

14.14.4.4. Mental health services separately purchased for all Medicaid clients by the Mental Health Division, including 24-hour crisis intervention, outpatient mental health treatment services, Club House, respite care, Supported Employment and inpatient services.

14.14.4.5. Health care services covered through the Division of Developmental Disabilities for institutionalized clients.

14.14.4.6. Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health.

Medically necessary nutritional supplements for infants are covered under the pharmacy benefit.

14.14.5. Services Not Covered by Either DSHS or the Contractor in accord with WAC 388-501-070:

14.14.5.1. Any ancillary services provided in association with services not covered by either DSHS or the Contractor.

14.14.5.2. Medical examinations for Social Security Disability.

14.14.5.3. Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.

14.14.5.4. Physical examinations required for obtaining continuing employment, insurance or governmental licensing.

14.14.5.5. Sports physicals

14.14.5.6. Experimental and Investigational Treatment or Services, determined in accord with the Experimental and Investigational Services, provision of this Section and services associated with experimental or investigational treatment or services.

14.14.5.7. Reversal of voluntary induced sterilization.

14.14.5.8. Personal Comfort Items, including but not limited to guest trays, television and telephone charges.

14.14.5.9. Massage Therapy

14.14.5.10. Acupuncture

14.14.5.11. TMJ for Adults

14.14.5.12. Diagnosis and treatment of infertility, impotence, and sexual dysfunction.

14.14.5.13. Orthoptic (eye training) care for eye conditions

14.14.5.14. Naturopathy

14.14.5.15. Tissue or organ transplants that are not specifically listed as covered.

14.14.5.16. Immunizations required for international travel purposes only.

14.14.5.17. Court-ordered services

14.14.5.18. Gender dysphoria surgery and other services not covered by DSHS for gender dysphoria.

14.14.5.19. 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.

14.14.5.20. Pharmaceutical products prescribed by any provider related to a service not covered by either DSHS or the Contractor.

14.14.5.21. Any non covered product, service or supply under DSHS' fee-for-service program.

14.15. **Coordination of Benefits and Subrogation of Rights of Third Party Liability**:

14.15.1. Coordination of Benefits:

14.15.1.1. Until DSHS ends the enrollment of an enrollee who has comparable coverage as described in the Enrollment Section of this Contract, the services and benefits available under this Contract shall be secondary to any other medical coverage.

14.15.1.2. Nothing in this Section negates any of the Contractor's responsibilities under this Contract including, but not limited to, the requirement described in the Prohibition on Enrollee Charges for Covered Services provisions of the Enrollee Rights and Protections Section of this Contract. The Contractor shall:

14.15.1.2.1. Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in WAC 284-51.

14.15.1.2.2. Attempt to recover any third-party resources available to enrollees (42 CFR 433 Subpart D) and shall make all records pertaining to coordination of benefits collections for enrollees available for audit and review.

14.15.1.2.3. Pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties (42 CFR 433.139(b)(3)).

14.15.1.2.4. Pay claims for covered services when probable third party liability has not been established or the third party benefits

are not available to pay a claim at the time it is filed (42 CFR 433.139(c)).

14.15.1.2.5. Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

14.15.2. Subrogation Rights of Third-Party Liability:

14.15.2.1. Injured person means an enrollee covered by this Contract who sustains bodily injury.

14.15.2.2. Contractor's medical expense means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accord with the Contractor's fee-for-service schedule.

14.15.2.3. If an enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.

14.15.2.4. DSHS specifically assigns to the Contractor the DSHS' rights to such third party payments for medical care provided to an enrollee on behalf of DSHS, which the enrollee assigned to DSHS as provided in WAC 388-505-0540.

14.15.2.5. DSHS also assigns to the Contractor its statutory lien under RCW 43.20B.060. The Contractor shall be subrogated to the DSHS' rights and remedies under RCW 74.09.180 and RCW 43.20B.040 through RCW 43.20B.070 with respect to medical benefits provided to enrollees on behalf of DSHS under RCW 74.09.

14.15.2.6. The Contractor may obtain a signed agreement from the enrollee in which the enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.

14.15.2.7. The Contractor shall notify DSHS of the name, address, and other identifying information of any enrollee and the enrollee's attorney who settles a claim without protecting the Contractor's interest in contravention of RCW 43.20B.050.

14.16. **Patient Review and Restriction (PRR)**:

14.16.1. The Contractor's policies and procedures related to a Patient Review and Restriction (PRR) program, shall ensure compliance with the requirements described in this section

14.16.2. The Contractor shall have a PRR program that meets the requirements of WAC 388-501-0135. PRR is authorized by 42 USC 1396n (a)(2) and 42 CFR 431.54.

14.16.3. If either the Contractor or DSHS places an enrollee into the PRR program, both parties will honor that placement.

14.16.4. The Contractor's placement of an enrollee into the PRR program shall be considered an action, which shall be subject to appeal under the provisions of the Grievance System section of this Contract. If the enrollee appeals the PRR placement the Contractor will notify DSHS of the appeal and the outcome.

14.16.5. When an enrollee is placed in the Contractor's PRR program, the Contractor shall send the enrollee a written notice of the enrollee's PRR placement, or any change of status, in accord with the requirements of WAC 388-501-0135.

14.16.6. The Contractor shall send DSHS a written notice of the enrollee's PRR placement, or any change of status, in accord with the required format provided in the Patient Review and Restriction Program Guide published by DSHS (See Attachment A for website link.)

14.16.7. In accord with WAC 388-501-0135, DSHS will limit the ability of an enrollee placed in the PRR program to change their enrolled contractor for twelve months after the enrollee is in the PRR program by DSHS or the Contractor unless the PRR enrollee moves to a residence outside the Contractor's service areas.

14.16.8. If DSHS limits the ability of an enrollee to change their enrolled contractor family members may still change enrollment as provided in this Contract.

Adams		Benton		Chelan		Clallam		Clark		Columbia		Cowlitz		Douglas		Ferry		Franklin		Garfield	
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Benge (50)	99105	Benton City	99320	Ardenvoir	98811	Beaver	98305	Amboy	98601	Dayton	99328	Ariel (50)	98603	Bridgeport	98813	Boyd	99107	Connell	99326	Pomeroy	99347
Cunningham	99327	Kennewick (U)	99336	Cashmere	98815	Carlsborg	98324	Battle Ground	98604	Starbuck	99359	Carrolls	98609	East Wenatchee	98802	Curlew (50)	99118	Eltopia	99330		
Hatton	99332	Kennewick	99337	Chelan	98816	Clallam Bay	98326	Bush Prairie	98606			Castle Rock	98611	Mansfield	98830	Danville (50)	99121	Kahlotus	99335		
Lind	99341	Kennewick	99338	Chelan Falls	98817	Forks	98331	Camas	98607			Cougar (50)	98616	Orondo	98843	Inchelium (50)	99138	Mesa	99343		
Othello	99344	Paterson	99345	Dryden	98821	Joyce	98343	Heison	98622			Kalama	98625	Palisades	98845	Keller	99140	Pasco	99301		
Washtucna (50)	99371	Plymouth (50)	99346	Entiat	98822	La Push	98350	La Center	98629			Kelso	98626	Rock Island	98850	Laurier (50)	99146	Pasco	99302		
Ritzville	99169	Prosser	99350	Leavenworth	98826	Neah Bay (50)	98357	Ridgefield	98642			Longview	98632	Waterville	98858	Malo	99150				
		Richland	99352	Malaga	98828	Port Angeles	98362	Vancouver	98660			Ryderwood	98581			Orient	99160				
		West Richland	99353	Manson	98831	Port Angeles	98363	Vancouver (U)	98661			Silverlake	98645			Republic	99166				
		Richland	98354	Monitor	98836	Sekiu (50)	98381	Vancouver	98662			Toutle	98649								
				Peshastin	98847	Sequim	98382	Vancouver (U)	98663			Woodland	98674								
				Stehekin (CP 65)	98852			Vancouver (U)	98664												
				Wenatchee	98801			Vancouver	98665												
				Wenatchee	98807			Vancouver	98666												
								Vancouver	98667												
								Vancouver	98668												
								Vancouver	98682												
								Vancouver	98683												
								Vancouver (U)	98684												
								Vancouver	98685												
								Vancouver	98686												
								Vancouver	98687												
								Yacolt	98675												
								Washougal	98671												

Grant		Grays Harbor		Island		Jefferson		King								Kitsap		Kittitas		Klickitat	
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Beverly	99321	Aberdeen	98520	Clinton	98236	Brinnon	98320	Auburn	98001	Kent	98042	Seattle (U)	98111	Seattle	98166	Bainbridge Is.	98110	CleElum	98922	Appleton	98602
Coulee City	99115	Amanda Park	98526	Coupeville	98239	Chimacum	98325	Auburn (U)	98002	Kent	98064	Seattle (U)	98112	Seattle	98168	Bremerton (U)	98310	Easton	98925	Bickleton (50)	99322
Electric City	99123	Copalis Bch.	98535	Freeland	98249	Port Hadlock	98339	Auburn	98071	Kirkland (U)	98033	Seattle (U)	98114	Seattle (U)	98170	Bremerton	98311	Ellensburg	98926	Bingen	98605
Ephrata	98823	Copalis Cros	98536	Greenbank	98253	Nordland	98358	Auburn	98092	Kirkland (U)	98034	Seattle (U)	98115	Seattle (U)	98171	Bremerton	98312	Kittitas	98934	Centerville	98613
George	98824	Cosmopolis	98537	Langley	98260	Port Ludlow	98365	Baring (50)	98224	Kirkland	98083	Seattle (U)	98116	Seattle (U)	98174	Bremerton (U)	98314	Ronald	98940	Dallesport	98617
Grand Coulee	99133	Elma	98541	Oak Harbor	98277	Port Townsend	98368	Bellevue	98004	Maple Valley	98038	Seattle (U)	98117	Seattle (U)	98177	Bremerton	98337	Roslyn	98941	Glenwood (50)	98619
Hartline	99135	Grayland	98547	Oak Harbor	98278	Quilcene	98376	Bellevue (U)	98005	Medina	98039	Seattle (U)	98118	Seattle (U)	98178	Bremerton	98322	S. CleElum	98943	Goldendale	98620
Marlin	98832	Hoquiam	98550					Bellevue	98006	Mercer Is. (U)	98040	Seattle (U)	98119	Seattle (U)	98181	Hansville	98340	Thorp	98946	Husum	98623
Mattawa (50)	99349	Humptuliips	98552					Bellevue (U)	98007	North Bend	98045	Seattle (U)	98121	Seattle (U)	98184	Indianola	98342	Vantage	98950	Klickitat	98628
Moses Lake	98837	Malone	98559					Bellevue (U)	98008	Pacific (U)	98047	Seattle (U)	98122	Seattle (U)	98185	Keyport	98345			Lyle	98635
Quincy	98848	McCleary	98557					Bellevue	98009	Preston	98050	Seattle (U)	98124	Seattle	98188	Kingston	98346			Roosevelt (50)	99356
Royal City	99357	Moclips	98562					Bellevue	98015	Ravensdale	98051	Seattle (U)	98125	Seattle (U)	98190	Manchester	98353			Trout Lake	98650
Soap Lake	98851	Montesano	98563					Black Diamond	98010	Redmond	98052	Seattle (U)	98126	Seattle (U)	98191	Ollala	98359			Wahkiacus	98670
Stratford	98853	Neilton	98566					Bothell (U)	98011	Redmond	98053	Seattle (U)	98129	Seattle (U)	98195	Port Gamble	98364			White Salmon	98672
Warden	98857	Oakville	98568					Bothell	98041	Redmond	98073	Seattle (U)	98131	Seattle	98198	Port Orchard	98366			Wishram	98673
Wilson Creek	98860	Ocean Shores	98569					Burton	98013	Redmond	98074	Seattle (U)	98132	Seattle (U)	98199	Port Orchard	98367				
		Pacific Bch.	98571					Carnation	98014	Redondo	98054	Seattle (U)	98133	Skykomish (50)	98288	Poulsbo	98370				
		Quinault	98575					Duvall	98019	Renton	98055	Seattle (U)	98134	Snoqualmie	98065	Retsil	98378				
		Satsop	98583					Enumclaw (50)	98022	Renton (U)	98056	Seattle (U)	98136	Vashon	98070	Rollingbay	98061				
		Taholah	98587					Fall City	98024	Renton	98057	Seattle (U)	98138	Woodinville	98072	Seabeck	98380				
		Westport	98595					Federal Way (U)	98003	Renton	98058	Seattle (U)	98144	Snoqualmie Pass (50)	98068	Silverdale	98315				
								Federal Way (U)	98023	Renton	98059	Seattle (U)	98145			Silverdale	98383				
								Federal Way	98063	Seahurst	98062	Seattle (U)	98146			SouthColby	98384				
								Federal Way	98093	Seattle (U)	98101	Seattle	98148			Southworth	98386				
								Hobart	98025	Seattle (U)	98102	Seattle (U)	98151			Suquamish	98392				
								Issaquah	98027	Seattle (U)	98103	Seattle (U)	98154			Tracyton	98393				
								Issaquah	98029	Seattle (U)	98104	Seattle (U)	98155								
								Kent	98030	Seattle (U)	98105	SeaTac (U)	98158								
								Issaquah	98075	Seattle (U)	98106	Seattle (U)	98160								
								Kenmore	98028	Seattle (U)	98107	Seattle (U)	98161								
								Kent (U)	98031	Seattle (U)	98108	Seattle (U)	98164								
								Kent	98032	Seattle (U)	98109										
								Kent	98035												

Lewis		Lincoln		Mason		Okanogan		Pacific		Pend Oreille		Pierce				San Juan		Skagit	
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Adna	98522	Almira	99103	Allyn	98524	Brewster	98812	Bay Center	98527	Cusick (50)	99119	Anderson Is.	98303	South Prairie	98385	Tacoma (U)	98455	Deer Harbor	98243	Anacortes	98221
Centralia	98531	Creston	99117	Belfair	98528	Carlton	98814	Chinook	98614	Ione (50)	99139	Ashford (50)	98304	Spanaway	98387	Tacoma (U)	98460	Eastsound	98245	Bow	98232
Chehalis	98532	Davenport	99122	Grapeview	98546	Conconully	98819	Illwaco	98624	Metaline (50)	99152	Buckley	98321	Steilacoom	98388	University Place (U)	98464	Friday Harbor	98250	Bow	98246
Cinnabar	98533	Edwall	99008	Hoodsport	98548	Coulee Dam	99116	Lebam	98554	Metaline Falls (50)	99153	Camp Murray	98430	Sumner	98352	Tacoma (U)	98465	Lopez Is.	98261	Burlington	98233
Curtis	98538	Harrington	99134	Lilliwaup	98555	Elmer City	99124	Long Beach	98631	Newport	99156	Carbonado	98323	Sumner	98390	Tacoma (U)	98466	Olga	98279	Clear Lake	98235
Doty	98539	Odessa	99144	Matlock	98560	Loomis	98827	Menlo	98561	Usk	99180	Dupont	98327	Tacoma (U)	98401	Tacoma	98471	Orcas	98280	Concrete (50)	98237
Ethel	98542	Lincoln	99147	Shelton	98584	Malott	98829	Nahcotta	98637			Eatonville	98328	Tacoma (U)	98402	Tacoma	98477	Shaw Is.	98286	Conway	98238
Galvin	98544	Mohler	99154	Tahuya	98588	Mazama (50)	98833	Naselle	98638			Elbe	98330	Tacoma (U)	98403	Tacoma	98481	Waldron	98297	Hamilton	98255
Glennoma	98336	Odessa	99159	Union	98592	Methow	98834	Ocean Park	98640			Fox Island	98333	Tacoma (U)	98404	Tacoma	98493	Blakley Island	98222	La Conner	98257
Mineral	98355	Reardan	99029			Nespelem	99155	Oysterville	98641			Gig Harbor	98329	Tacoma (U)	98405	University Place	98467			Lyman	98263
Morton	98356	Sprague (50)	99032			Okanogan	98840	Raymond	98577			Gig Harbor	98332	Tacoma (U)	98406	Vaughn	98394			Marble Mount (50)	98267
Mossyrock	98564	Wilbur	99185			Omak	98841	Seaview	98644			Gig Harbor	98335	Tacoma (U)	98407	Wauna	98395			Mt. Vernon	98273
Napavine	98565					Oroville	98844	South Bend	98586			Graham	98338	Tacoma (U)	98408	Wilkeson	98396			Mt. Vernon	98274
Onalaska	98570					Pateros	98846	Tokeland	98590			Kapowsin	98344	Tacoma (U)	98409	Paradise Inn	98398			Rockport (50)	98283
Packwood (50)	98361					Riverside	98849					La Grande	98348	Tacoma (U)	98411					Sedro Wooley	98284
Pe Ell	98572					Tonasket	98855					Lake Bay	98349	Tacoma (U)	98412						
Randle (50)	98377					Twisp (50)	98856					Lakewood	98439	Tacoma (U)	98413						
Salkum	98582					Wauconda (50)	98859					Lakewood	98492	Tacoma (U)	98415						
Silver Creek	98585					Winthrop (50)	98862					Lakewood	98497	Tacoma (U)	98416						
Toledo	98591											Lakewood	98498	Tacoma (U)	98418						
Vader	98593											Lakewood	98499	Tacoma	98421						
Winlock	98596											Longbranch	98351	Tacoma	98422						
												Longmire	98397	Tacoma	98424						
												McChord AFB	98438	Tacoma	98431						
												McKenna	98558	Tacoma	98433						
												Milton	98354	Tacoma	98442						
												Orting	98360	Tacoma	98443						
												Puyallup	98371	Tacoma (U)	98444						
												Puyallup	98372	Tacoma (U)	98445						
												Puyallup (U)	98373	Tacoma	98446						
												Puyallup	98374	Tacoma (U)	98447						
												Puyallup	98375	Tacoma (U)	98450						
												Roy	98580								

Skamania		Snohomish		Spokane				Stevens		Thurston		Wahkiakum		Walla Walla		Whatcom		Whitman		Yakima	
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Carson	98610	Arlington	98223	Airway Hts.	99001	Spokane	99210	Addy	99101	Bucoda	98530	Cathlamet	98612	Burbank	99323	Acme	98220	Albion	99102	Brownstown	98920
N. Bonneville	98639	Bothell (U)	98021	Chattaroy	99003	Spokane	99211	Chewelah	99109	East Olympia	98540	Grays River	98621	College Place	99324	Bellingham (U)	98225	Belmont	99104	Buena	98921
Stevenson	98648	Bothell (U)	98012	Cheney	99004	Spokane	99212	Clayton	99110	Lacey	98503	Rosburg	98643	Dixie	99329	Bellingham	98226	Colfax	99111	Cowiche	98923
Underwood	98651	Bothell (U)	98082	Colbert	99005	Spokane	99213	Colville	99114	Lacey	98509	Skamokawa	98647	Prescott (50)	99348	Bellingham	98227	Colton	99113	Goose Prairie	98929
		Darrington (50)	98241	Deer Park	99006	Spokane	99214	Evans	99126	Littlerock	98556			Touchet	99360	Bellingham	98228	Endicott	99125	Grandview	98930
		Edmonds (U)	98020	Elk	99009	Spokane	99215	Ford	99013	Olympia	98501			Walla Walla	99362	Bellingham	98229	Farmington	99128	Granger	98932
		Edmonds (U)	98026	Fairchild AFB	99011	Spokane	99216	Fruitland	99129	Olympia	98502			Wallula	99363	Blaine	98230	Garfield	99130	Harrah	98933
		Everett	98201	Fairfield	99012	Spokane	99217	Gifford	99131	Olympia	98504			Waitsburg	99361	Blaine	98231	Hay	99136	Mabton	98935
		Everett	98203	Four Lakes	99014	Spokane (U)	99218	Hunters (50)	99137	Olympia	98505					Custer	98240	Hooper	99333	Moxee	98936
		Everett	98204	Freeman	99015	Spokane	99219	Kettle Falls (50)	99141	Olympia	98506					Deming	98244	LaCross	99143	Naches (50)	98937
		Everett	98205	Greenacres	99016	Spokane	99220	Loon Lake	99148	Olympia	98507					Everson	98247	Lamont	99017	Outlook	98938
		Everett	98206	Latah	99018	Spokane	99223	Marcus	99151	Olympia	98508					Ferndale	98248	Malden	99149	Parker	98939
		Everett	98207	Liberty Lake	99019	Spokane	99224	Northport (50)	99157	Olympia	98512					Lummi Is.	98262	Oakesdale	99158	Selah	98942
		Everett	98208	Marshall	99020	Spokane	99228	Rice	99167	Olympia	98513					Lynden	98264	Palouse	99161	Sunnyside	98944
		Gold Bar	98251	Mead	99021	Spokane	99251	Springdale	99173	Olympia	98516					Maple Falls	98266	Pullman	99163	Tieton	98947
		Granite Falls	98252	Medical Lake	99022	Spokane	99252	Tumtum	99034	Olympia	98599					Nooksack	98276	Pullman	99164	Toppenish	98948
		Index	98256	Mica	99023	Spokane	99256	Valley	99181	Rainier	98576					Pt. Roberts	98281	Pullman	99165	Wapato	98951
		Lake Stevens	98258	Newman Lake	99025	Spokane	99258	Wellpinit	99040	Rochester	98579					Sumas	98295	Rosalia	99170	White Swan	98952
		Lynnwood (U)	98036	Nine Miles Falls	99026	Spokane	99260			Tenino	98589							St John	99127	Yakima	98901
		Lynnwood (U)	98037	Otis Orchards	99027	Spokane	99299			Tumwater	98511							St. John	99171	Yakima (U)	98902
		Lynnwood (U)	98046	Rockford	99030	Valleyford	99036			Yelm	98597							Steptoe	99174	Yakima	98903
		Marysville	98270	Spangle	99031	Veradale	99037											Tekoa	99033	Yakima	98904
		Marysville	98271	Spokane (U)	99201	Waverly	99039											Thornton	99176	Yakima	98907
		Monroe	98272	Spokane (U)	99202													Uniontown	99179	Yakima	98908
		Mountlake Terrace (U)	98043	Spokane (U)	99203															Yakima	98909
		Mukilteo	98275	Spokane (U)	99204															Zillah	98953
		N. Lakewood	98259	Spokane (U)	99205																
		Silvana	98287	Spokane	99206																
		Snohomish	98290	Spokane (U)	99207																
		Snohomish	98291	Spokane	99208																
		Snohomish	98296	Spokane	99209																
		Stanwood	98282																		
		Stanwood	98292																		
		Startup	98293																		
		Sultan	98294																		

2006 — 2007 HO & SCHIP Contract
Exhibit A Premiums, Service Areas and Capacity
Exhibit A-1 Premiums
Contractor: Molina
Effective: January 1 — June 30, 2008

Contractor: Molina

MMIS Region	Reg	Service Area	Base Rate	Geo	Risk	Prem. before Age/Sex	Adjustment Factors: M&F <1	M&F 1-2	M&F 3-14	M 15-18	F 15-18	M 19-34	F 19-34	M 35-64	F 35-64	M&F 65+
							2.698	0.873	0.455	0.516	1.818	0.823	2.259	1.592	1.998	4.126
							Premiums with Age/Sex									
1	A	King	157.99	0.948	1.019	152.62	411.77	133.24	69.44	78.75	277.46	125.61	344.77	242.97	304.93	629.71
1	A	Walla Walla	157.99	0.948	1.019	152.62	411.77	133.24	69.44	78.75	277.46	125.61	344.77	242.97	304.93	629.71
1	A	Yakima	157.99	0.948	1.019	152.62	411.77	133.24	69.44	78.75	277.46	125.61	344.77	242.97	304.93	629.71
2	B	Asotin				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	Columbia	157.99	0.973	0.997	153.26	413.50	133.80	69.73	79.08	278.63	126.13	346.21	243.99	306.21	632.35
2	B	Garfield	157.99	0.973	0.997	153.26	413.50	133.80	69.73	79.08	278.63	126.13	346.21	243.99	306.21	632.35
2	B	Grays Harbor	157.99	0.973	0.997	153.26	413.50	133.80	69.73	79.08	278.63	126.13	346.21	243.99	306.21	632.35
2	B	Klickitat				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	San Juan	157.99	0.973	0.997	153.26	413.50	133.80	69.73	79.08	278.63	126.13	346.21	243.99	306.21	632.35
2	B	Skagit	157.99	0.973	0.997	153.26	413.50	133.80	69.73	79.08	278.63	126.13	346.21	243.99	306.21	632.35
2	B	Whatcom	157.99	0.973	0.997	153.26	413.50	133.80	69.73	79.08	278.63	126.13	346.21	243.99	306.21	632.35
2	B	Whitman	157.99	0.973	0.997	153.26	413.50	133.80	69.73	79.08	278.63	126.13	346.21	243.99	306.21	632.35
3	C	Adams	157.99	0.993	1.027	161.12	434.70	140.66	73.31	83.14	292.92	132.60	363.97	256.50	321.92	664.78
3	C	Benton	157.99	0.993	1.027	161.12	434.70	140.66	73.31	83.14	292.92	132.60	363.97	256.50	321.92	664.78
3	C	Clallam	157.99	0.993	1.027	161.12	434.70	140.66	73.31	83.14	292.92	132.60	363.97	256.50	321.92	664.78
3	C	Franklin	157.99	0.993	1.027	161.12	434.70	140.66	73.31	83.14	292.92	132.60	363.97	256.50	321.92	664.78
3	C	Pacific	157.99	0.993	1.027	161.12	434.70	140.66	73.31	83.14	292.92	132.60	363.97	256.50	321.92	664.78
3	C	Spokane	157.99	0.993	1.027	161.12	434.70	140.66	73.31	83.14	292.92	132.60	363.97	256.50	321.92	664.78
4	D	Ferry	157.99	1.023	1.030	166.47	449.14	145.33	75.74	85.90	302.64	137.00	376.06	265.02	332.61	686.86
4	D	Jefferson				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	D	Kittitas	157.99	1.023	1.030	166.47	449.14	145.33	75.74	85.90	302.64	137.00	376.06	265.02	332.61	686.86
4	D	Snohomish	157.99	1.023	1.030	166.47	449.14	145.33	75.74	85.90	302.64	137.00	376.06	265.02	332.61	686.86
4	D	Thurston	157.99	1.023	1.030	166.47	449.14	145.33	75.74	85.90	302.64	137.00	376.06	265.02	332.61	686.86
5	E	Chelan	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
5	E	Clark				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Cowlitz	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
5	E	Grant	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
5	E	Island				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Lewis	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
5	E	Lincoln	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
5	E	Mason	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
5	E	Okanogan	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
5	E	Pend Orielle	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
5	E	Pierce	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
5	E	Skamania				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Stevens	157.99	1.043	1.030	169.73	457.93	148.17	77.23	87.58	308.57	139.69	383.42	270.21	339.12	700.31
6	F	Douglas	157.99	1.063	1.026	172.31	464.89	150.43	78.40	88.91	313.26	141.81	389.25	274.32	344.28	710.95
6	F	Kitsap	157.99	1.063	1.026	172.31	464.89	150.43	78.40	88.91	313.26	141.81	389.25	274.32	344.28	710.95
6	F	Wahkiakum				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Note: Shaded areas are those not currently served.

2006 — 2007 HO & SCHIP Contract
Exhibit A Premiums, Service Areas and Capacity
Exhibit A-1 Premiums
Contractor: Molina
Effective: July 1 — December 31, 2008

Contractor: Molina

MMIS Region	Reg	Service Area	Base Rate	Geo	Risk		Adjustment Factors									
							M&F <1	M&F 1-2	M&F 3-14	M 15-18	F 15-18	M 19-34	F 19-34	M 35-64	F 35-64	M&F 65+
							2.698	0.873	0.455	0.516	1.818	0.823	2.259	1.592	1.998	4.126
						Prem. before Age/Sex	**Premiums with Age/Sex**									
1	A	King				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	A	Walla Walla				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	A	Yakima				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	Asotin				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	Columbia				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	Garfield				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	Grays Harbor				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	Klickitat				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	San Juan				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	Skagit				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	Whatcom				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2	B	Whitman				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	C	Adams				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	C	Benton				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	C	Clallam				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	C	Franklin				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	C	Pacific				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	C	Spokane				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	D	Ferry				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	D	Jefferson				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	D	Kittitas				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	D	Snohomish				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	D	Thurston				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Chelan				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Clark				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Cowlitz				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Grant				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Island				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Lewis				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Lincoln				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Mason				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Okanogan				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Pend Orielle				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Pierce				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Skamania				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
5	E	Stevens				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6	F	Douglas				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6	F	Kitsap				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6	F	Wahkiakum				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Note: Shaded areas are those not currently served.