| Washington State Health Care Authority | **AMENDED AND RESTATED STATE MEDICAID AGENCY CONTRACT** | HCA Contract Number: «Contract»<br>Amendment Number: «Amendment_»<br>MA Health Plan/Vendor Contract Number: |
|---|---|---|

**THIS AMENDED AND RESTATED STATE MEDICAID AGENCY CONTRACT (SMAC)** is made by and between Washington State Health Care Authority, (HCA) and «Organization_Name», (MA Health Plan).

| MA HEALTH PLAN NAME<br>«Organization_Name» | | MA HEALTH PLAN DOING BUSINESS AS (DBA) | | |
|---|---|---|---|---|
| MA HEALTH PLAN ADDRESS<br>«Mailing_AddressSt_Address» | Street | City<br>«City» | State<br>«State» | Zip Code<br>«Zip_Code» |
| MA HEALTH PLAN CONTACT<br>«Contact_Fname» «Contact_LName» | MA HEALTH PLAN TELEPHONE<br>«PhoneNo» | MA HEALTH PLAN E-MAIL ADDRESS<br>«EmailAddress» | | |
| Is MA Health Plan a Subrecipient under this Contract?<br>☐YES ☒NO | CFDA NUMBER(S): | FFATA Form Required<br>☐YES ☒NO | | |

| HCA PROGRAM<br>Managed Care Program | HCA DIVISION/SECTION<br>Medicaid Programs Division |
|---|---|
| HCA CONTACT NAME AND TITLE | HCA CONTACT ADDRESS<br>Health Care Authority<br>626 8th Avenue SE<br>PO Box «CM_Mailstop»<br>Olympia, WA 98504-____ |
| HCA CONTACT TELEPHONE<br>(360) 725-0480 | HCA CONTACT E-MAIL ADDRESS<br>johnny.shults@hca.wa.gov |

| CONTRACT START DATE | CONTRACT END DATE | TOTAL MAXIMUM CONTRACT AMOUNT |
|---|---|---|
| January 1, 2024 | December 31, 2024 | N/A |
| PURPOSE OF CONTRACT:<br>To provide, or arrange for the provision of, covered health care services to qualified Dual Eligible Beneficiaries | | |

The parties signing below warrant that they have read and understand this SMAC and have authority to execute this SMAC. This SMAC will be binding on HCA only upon signature by both parties.

| MA HEALTH PLAN SIGNATURE | PRINTED NAME AND TITLE | DATE SIGNED |
|---|---|---|
| HCA SIGNATURE | PRINTED NAME AND TITLE | DATE SIGNED |

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**Recitals. These Recitals are hereby incorporated by reference into this State Medicaid Agency Contract (SMAC).**

WHEREAS, MA Health Plan is a 501(c)(4) tax-exempt entity and a certified health care services Contractor organized and operating under the laws of the State of Washington, to provide or arrange for the provision of covered health care services to qualified Dual Eligible Beneficiaries enrolled in its benefit plans (Members);

*OR*

WHEREAS, MA Health Plan is an organization having a certificate of authority or certificate of registration from the Office of the Washington State Insurance Commissioner and operating under the laws of the State of Washington, to provide or arrange for the provision of covered health care services to qualified Dual Eligible Beneficiaries enrolled in its benefit plans (Members).

WHEREAS, MA Health Plan (or another organization under the same parent company) and HCA have a current Apple Health Medicaid Integrated Managed Care (IMC) Contract (HCA Contract Number «IMC_K»). Regions for which MA Health Plan has an IMC contract for Behavioral Health (BH) Services are referenced in Exhibit 2.

WHEREAS, MA Health Plan has entered into or has applied to enter into a Medicare Advantage Plan Agreement (MA Agreement) with the Centers for Medicare & Medicaid Services ("CMS") whereby MA Health Plan provides or desires to provide Medicare Covered health care benefits to qualified Dual Eligible Beneficiaries under a Dual Eligible SNP in the state of Washington.

WHEREAS, MA Health Plan holds an agreement with CMS to provide a Dual Special Needs Plan covered under this SMAC (or another organization under the same parent company) and receives direct capitation from HCA to provide coverage of the Medicaid benefits described in the Integrated Managed Care (IMC) Contract including BH Services listed in Exhibit 5.

WHEREAS, MA Health Plan will retain responsibility for providing, or arranging for Medicare-covered health care benefits to be provided to qualified Dual Eligible Beneficiaries under its Dual Eligible SNP.

WHEREAS, MA Health Plan will seek CMS designation as a Highly Integrated Dual Eligible Special Needs Plan as defined in this SMAC and 42 C.F.R. § 422.2.

WHEREAS, MA Health Plan will (i) ensure cost-sharing protections for all qualified Dual Eligible Beneficiaries in the event MA Health Plan offers Medicaid Covered Benefits under its Dual Eligible SNP; and (ii) ensure MA Health Plan can appropriately and accurately identify Medicare beneficiary qualification for HCA's Medicaid benefits and MA Health Plan's Dual Eligible SNP.

WHEREAS, MA Health Plan and HCA acknowledge the requirements of 42 C.F.R. § 422 whereby MA Health Plan must enter into an agreement with HCA to offer and provide a Dual Eligible SNP to qualified Dual Eligible Beneficiaries.

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

1. **Definitions**

1.1 American Indian/Alaska Native (AI/AN)

"American Indian/Alaska Native (AI/AN)" means any individual defined at 25 USC § 1603(13), § 1603(28), or § 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a Tribe or resides in an urban center and meets one or more of the following criteria:

1.1.1 Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is descendant, in the first or second degree of any such member;

1.1.2 Is an Eskimo or Aleut or other Alaska Native;

1.1.3 Is considered by the Secretary of the Interior to be an Indian for any purpose; or

1.1.4 Is determined to be an Indian under regulations issued by the Secretary.

The term AI/AN also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.1 Care Coordination

"Care Coordination" means a Member's healthcare needs are coordinated with the assistance of a Care Coordinator. The Care Coordinator provides information to the Member and the Member's caregivers and works with the Member to ensure that the Member receives the most appropriate treatment while ensuring that health care is not duplicated.

1.2 Care Management

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

1.3 Case Management

"Case Management" means Care Management services delivered to Members to obtain access to care and services and coordination of their care.

1.4 Communications

"Communications" means activities and use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. All activities and materials aimed at prospective and current enrollees, including their authorized representative, are "communications" within the scope of the regulations at 42 CFR Parts 417, 422, and 423.

1.5 Confidential Information

"Confidential Information" means information that may be exempt from disclosure to the public or other unauthorized persons under RCW 42.56, RCW 70.02, or other federal or state laws. Confidential Information includes but is not limited to, Personal Information and Protected Health Information.

1.6 Cost Sharing Obligations

"Cost Sharing Obligations" means those financial payment obligations incurred by HCA in satisfaction of the deductibles, coinsurance, and co-payments for the Medicare Part A and Part B programs with respect to Dual Eligible Members. For purposes of this SMAC, Cost Sharing Obligations do not include (1) Medicare premiums that HCA is required to pay under the Washington State Plan on behalf of qualified Dual Eligible Beneficiaries, or (2) wrap-around services that are covered by Medicaid.

1.7 Covered Services

"Covered Services" means those services and benefits that MA Health Plans are required to provide to Dual Eligible SNP Members under this SMAC and the contract with CMS. Coordination of Medicaid benefits is required per 42 C.F.R. § 422.107.

1.8 Data

"Data" means information produced, furnished, acquired, or used by MA Health Plan in meeting the requirements under this SMAC. For the purposes of this SMAC, "Data" is construed and treated the same as "Confidential Information."

1.9 Default Enrollment

"Default Enrollment" means a process approved by the State and CMS that allows the Contractor to offer enrollment to a Member of an affiliated Medicaid Managed Care

Organization (MCO) to its Medicare Dual Eligible Special Needs Plan (D-SNP) when that member becomes newly eligible for Medicare. (42 CFR 422.66)

1.10 Department of Social and Health Services (DSHS)

"Department of Social and Health Services (DSHS)" means the Washington State agency responsible for providing a broad array of health care and social services. DSHS administrations with which the MA Health Plan may interface include, but are not limited to:

Aging and Long-Term Support Administration (ALTSA) is responsible for providing a safe home, community, and nursing facility array of long-term support for Washington citizens.

Home and Community Services (HCS), a division of ALTSA, is responsible for promoting, planning, developing, and providing long-term care services for Washington citizens with disabilities and/or the elderly.

Development Disabilities Administration (DDA) is responsible for providing a safe, high-quality array of home, community, and facility-based residential services and employment support for Washington citizens with disabilities.

1.11 Dual Eligible Beneficiary

"Dual Eligible Beneficiary" means a Medicare managed care recipient who is also eligible for Medicaid, and for whom HCA has a responsibility for payment of Cost Sharing Obligations under the Washington State Plan. For purposes of this SMAC, Dual Eligibles are limited to the categories of recipients identified in Exhibit 1.

1.11.1 Qualified Medicare Beneficiary (QMB Only) and Qualified Medicare Beneficiary with Comprehensive Medical Benefits (QMB+). The QMB benefits covered by this SMAC are limited to the Cost Sharing Obligations as defined by the Washington State Plan.

1.11.2 Qualified Medicare Beneficiary without other Medicaid (QMB only): An individual entitled to Medicare Part A, with an income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplemental Social Security (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through HCA. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. Medicaid does not pay towards out-of-pocket (OOP) costs for deductibles, premiums, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.11.3 Qualified Medicare Beneficiary with Comprehensive Medical Benefits (QMB+): An individual entitled who meets the standards for QMB eligibility, and who also meets the criteria for Medicaid benefits covered under the program for which they become

eligible, e.g., the Medically Needy (MN) for those who meet spenddown requirements. These individuals often qualify for Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically Needy level. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. See also Full Benefit Dual Eligible #7. Medicaid does not pay towards the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.11.4 Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only): An individual entitled to Medicare Part A, with an income that exceeds 100% FPL but less than 120% FPL, with resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.11.5 Specified Low-Income Medicare Beneficiary with Comprehensive Medicaid Benefits (SLMB+): An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full HCA Medicaid benefits. The individuals are entitled to payment of the Medicare Part B premium, in addition to HCA Medicaid benefits covered under the program for which they become eligible, e.g., the Medically Needy (MN) for those who meet spenddown requirements. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level. See also Full Benefit Dual Eligible #7. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.11.6 Qualifying Individual (QI): An individual entitled to Medicare Part A, with an income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of the Medicare Part B premium only; they cannot also be eligible for other Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.11.7 Qualified Disabled and Working Individual (QDWI): An individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Part A premium only; they cannot also be eligible for other Medicaid benefits. Medicaid does not pay towards OOP

costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.11.8 Other Full Benefit Dual Eligible (FBDE): An individual who does not meet the income and/or resource criteria for QMB or SLMB but is eligible for Categorically Needy (CN) Medicaid or Medically Needy (MN) through coverage groups based on MN spend-down status, special income levels for institutionalized individuals, home and community-based waivers, or those with blindness or disability who are working and enrolled in Apple Health for Workers with Disabilities. HCA-funded buy-in pays for Part A, if not free to the individual, and Part B premiums. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.12 Dual Eligible Special Needs Plan (Dual Eligible SNP)

"Dual Eligible Special Needs Plan (Dual Eligible SNP)" means the Medicare Part C and other health plan services provided to MA Health Plan Members under a SNP as defined and pursuant to an MA Agreement, as defined in 42 C.F.R. § 422.2.

1.13 Highly Integrated Dual Eligible Special Needs Plan

"Highly Integrated Dual Eligible Special Needs Plan" means a Dual Eligible SNP offered by an MA Health Plan that provides coverage, consistent with HCA policy, of long-term services and supports, behavioral health services, or both, under a capitated agreement that meets one of the following arrangements:

1.13.1 The capitated agreement is between the MA Health Plan and HCA; or

1.13.2 The capitated agreement is between the MA Health Plan's parent organization or another entity that is owned and controlled by its parent organization, and HCA.

1.14 Home and Community Based Services

Home and Community Based Services means services approved by the Centers for Medicare and Medicaid Services (CMS) under section 1915(c) of the Social Security Act as an alternative to an intermediate care facility for individuals with intellectual disabilities (ICF/ID). (WAC 388-845-0005)

1.15 Indian Health Care Provider (IHCP)

"Indian Health Care Provider (IHCP)" means the Indian Health Service and/or any Tribe, Tribal organization, or Urban Indian Health Program (UIHP) that provides Medicare services.

1.16 MA Agreement

"MA Agreement" means the Medicare Advantage Plan Agreement between the MA Health Plan and CMS to provide MA benefit plans.

1.17 Marketing

"Marketing" means a subset of communications and must, unless otherwise noted, adhere to all communication requirements. To be considered marketing, communications materials must meet both intent and content standards. In evaluating the intent of an activity or material, HCA will consider objective information including, but not limited to, the audience, timing, and other context of the activity or material, as well as other information communicated by the activity or material. The organization's stated intent will be reviewed but not solely relied upon. These activities are directed from the Contractor or third-party sub-contractor to a Potential Enrollee or Enrollee who is enrolled with another HCA-Contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or either not enroll or to end their enrollment with another HCA-Contracted MCO. Marketing communications include written, oral, in-person (telephonic or face-to-face),) or electronic methods of communication, including email, text messaging, and social media (Facebook, Instagram and Twitter).

1.18 Medically Necessary Services

"Medically Necessary Services" means a requested service that is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the client that endanger life, cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (182-500-0070).

1.19 Member

"Member" means a full or partially dual eligible individual who has elected to enroll with the MA Health Plan.

1.20 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's license numbers, credit card numbers, any other identifying numbers, and any financial identifiers.

1.21 Potential Member

"Potential Member" means any individual who qualifies for enrollment in Medicare and Medicaid as a Dual Eligible Beneficiary and who is not enrolled with any Dual Special Needs Plan.

1.22 Service Area

"Service Area" means those counties or zip codes where MA Health Plan operates as approved by CMS and HCA and described in Exhibit 2, attached hereto.

1.23 Subcontractor

"Subcontractor" means an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the MA Health Plan's obligations under this SMAC.

1.24 Supplemental Benefits

"Supplemental Benefits" means services or benefits that are mandatory or optional health care services that are intended to maintain or improve the health status of members, for which the MA Health Plan incurs a cost or liability under an MA Health Plan (not solely an administrative processing cost) consistent with 42 CFR 422.102. See Exhibits 3 and 4 for Supplemental Benefits offered under this SMAC.

1.25 Trusted Systems

"Trusted Systems" include only the following methods of physical delivery: (1) hand delivery by a person authorized to have access to the Confidential Information with a written acknowledgment of receipt; (2) United States Postal Service ("USPS") first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail;(3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington Stale Governmental Network (SGN) is a Trusted System for communications within that Network.

1.26 Urban Indian Health Program (UIHP)

"Urban Indian Health Program (UIHP)" means a nonprofit corporate body situated in an urban center, governed by an urban Indian-controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, that is operating a facility delivering health care.

1.27 Value-Added Items and Services (VAIS)

"Value-Added Items and Services (VAIS)" are items and services that are not plan benefits, are not part of the MAO plan's benefit package, and may not be marketed to prospective members or used as an inducement or incentive for enrollment. VAIS are non-Medicare covered services

or items, typically discounts, offered by a VAIS provider to the members of an MA Health Plan. VAIS must be offered in accordance with Federal Guidance. See Exhibits 3 and 4 for VAIS offered under this SMAC.

1.28 Washington Apple Health – Integrated Managed Care (AH-IMC)

"Washington Apple Health – Integrated Managed Care (AH-IMC)" means the public health insurance programs, intended to meet the physical and behavioral health needs of eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the Children's Health Insurance Program (CHIP), and the state-only funded health care programs.

## 2. General Terms and Conditions

### 2.1 Amendments

No provision of this SMAC may be modified, amended, or waived except in writing and when signed by the parties to this SMAC. No course of dealing between the parties will modify, amend, or waive any provision of this SMAC or any rights or obligations of any party under or by reason of this SMAC.

### 2.2 Assignment

This SMAC and the rights and obligations of the parties under this SMAC will be assignedassigned, in whole or in part, by the MA Health Plan only with the prior written consent of the HCA point of contact identified in the Notices section.

This SMAC will be binding upon and inure to the benefit of the parties and their respective heirs, personal representatives, and, to the extent permitted by this section.

### 2.3 Compliance with Applicable Law

The MA Health Plan and its subcontractors will comply with all applicable federal, state, and local laws, regulations, and rules, as amended.

### 2.4 Contract Management

MA Health Plan's SMAC Manager, identified below, will be the principal point of contact for the HCA SMAC Manager for all business matters, performance matters, and administrative activities. HCA's SMAC Manager, identified below, is responsible for monitoring MA Health Plan's performance and will be the contact person for all communications regarding contract performance and deliverables. The contact information provided below may be changed by written notice of the change, or email acceptable, to the other party.

| **HCA SMAC Manager** | | **MA Health Plan SMAC Manager** | |
|---|---|---|---|
| Name: | Johnny Shults | Name: | «Contact_Fname» «Contact_LName» |
| Title: | Section Supervisor | Title: | «Working_Title» |
| Address: | 626 8th Avenue SE<br>P.O. Box 45530<br>Olympia, WA 98504 | Address: | «Mailing_AddressSt_Address»<br>«City», «State» «Zip_Code» |
| Phone: | (360) 725-0480 | Phone: | «PhoneNo» |
| Email: | johnny.shults@hca.wa.gov | Email: | «EmailAddress» |

### 2.5 Data Use, Confidentiality, and Security

#### 2.5.1 Covered Entities

MA Health Plan and HCA each acknowledge that it is a “Covered Entity," as defined in the standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164) pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing rules (the “Privacy Rule"). Each party will protect the confidentiality of Protected Health Information and will otherwise comply with the requirements of the Privacy Rule and with all other state and federal laws governing the confidentiality of PHI.

2.5.2 PRISM Access

2.5.2.1 Definitions.

2.5.2.1.1 “Medicare Data Use Requirements” refers to the documents attached and incorporated into this SMAC as Schedules 1, and 2, which set out the terms and conditions MA Health Plan must agree to for the access to and use of Medicare Data for the Members who are dually eligible in the Medicare and Medicaid programs.

2.5.2.1.2 “PRISM” means the DSHS secure, web-based clinical decision support tool that shows administrative data for each Medicaid Member and is organized to identify care coordination opportunities.

2.5.2.2 Purpose. To provide MA Health Plan, and subcontractors, with access to pertinent Member-level Medicaid and when appropriate Medicare Data via look-up access to the online PRISM application and to provide MA Health Plan staff and Subcontractor staff who have a need-to-know Member-level Data to coordinate care, improve quality, and manage services for their Members.

2.5.2.3 Justification. The Data being accessed is necessary for the MA Health Plan to provide care coordination, quality improvement, and case management services for Members.

2.5.2.4 PRISM Data Constraints.

2.5.2.4.1 The Data contained in PRISM is owned and belongs to DSHS and HCA. Access to PRISM Data is administered by DSHS.

2.5.2.5 System Access. MA Health Plan may request access for specific Authorized Users with a need-to-know to view Data in the PRISM System under this Contract.

2.5.2.5.1 MA Health Plan Contract Manager, or their designee, and the proposed Authorized User must complete and sign the PRISM Access Request Form, Schedule 2, for each proposed Authorized User. The completed form must be sent to prism.admin@dshs.wa.gov. HCA and DSHS will only accept requests from the MA Health Plan Contract Manager or their designee.

2.5.2.5.2 Authorized Users may view Medicare Data in PRISM once forms Schedule 1 and Schedule 2 are completed, submitted, and accepted as complete. No Medicare Data is released to MA Health Plan's Authorized User(s) until the two forms are completed and accepted by DSHS.

2.5.2.5.3 MA Health Plan must access these systems through SecureAccessWashington (SAW) or another method of secure access approved by the HCA and DSHS.

2.5.2.5.4 DSHS will grant the appropriate access permissions to MA Health Plan employees or Subcontractor employees.

2.5.2.5.5 HCA and DSHS **do not** allow shared User IDs and passwords for use with Confidential Information or to access systems that contain Confidential Information. MA Health Plan must ensure that only Authorized Users access and use the systems and do not allow employees, agents, or Subcontractors who are not authorized to borrow a User ID or password to access any systems.

2.5.2.5.6 MA Health Plan will notify prism.admin@dshs.wa.gov within five business days whenever an Authorized User who has access to the Data is no longer employed or contracted by the MA Health Plan, or whenever an Authorized User's duties change such that the user no longer requires access to the Data.

2.5.2.6 MA Health Plan's access to the systems may be continuously tracked and monitored. HCA and DSHS reserve the right at any time to terminate the Data access for an individual, conduct audits of systems access and use, and investigate possible violations of this Exhibit, federal, or state laws and regulations governing access to Protected Health Information.

2.5.3 Confidentiality

2.5.3.1 The MA Health Plan will not use, publish, transfer, sell, or otherwise disclose any Confidential Information gained by reason of this SMAC for any purpose that is not directly connected with MA Health Plan's operations as a Dual Eligible SNP under its MA Agreement with CMS and this SMAC, except:

2.5.3.1.1 As provided by law; or

2.5.3.1.2 In the case of Personal Information, with the prior written consent of the person or personal representative of the person who is the subject of the Personal Information.

2.5.3.2 Data Shared by the MA Health Plan

If Data access is to be provided to a Subcontractor under this SMAC, the MA Health Plan must include allthe Data security terms, conditions, and

requirements set forth in this SMAC in any such Subcontract or agreement. In no event will the existence of the Subcontract operate to release or reduce the liability of the MA Health Plan to HCA for any breach in the performance of the MA Health Plan's responsibilities.

2.5.4 Constraints

2.5.4.1 This SMAC does not constitute a release of the Data for the MA Health Plan's discretionary use. MA Health Plan must use the Data received or accessed under this SMAC only to carry out the purpose of this SMAC. Any ad hoc analysis or other use or reporting of the Data is not permitted without HCA's prior written consent. Any ad hoc analyses or other use or reporting of PRISM Data is not permitted without DSHS's and HCA's prior written consent.

2.5.4.2 Requirements for Access. Access to Data will be limited to the MA Health Plan's Designated Staff whom the MA Health Plan whose duties specifically require access to such Data in the performance of their assigned duties.

2.5.4.3 The MA Health Plan will not link the Data with Personal Information or individually identifiable data from any other source nor re-disclose or duplicate the Data unless specifically authorized to do so in this SMAC or by the prior written consent of HCA. Any disclosure of Data contrary to this SMAC is unauthorized and is subject to penalties identified in law.

2.5.4.4 Data shared under this SMAC includes data protected by 42 C.F.R. Part 2. In accordance with 42 C.F.R. § 2.32, this Data has been disclosed from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit the Receiving Party from making any further disclosure of the Data that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (42 C.F.R. § 2.31). The federal rules restrict any use of the SUD Data to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 C.F.R. §§ 2.12(c)(5) and 2.65.

2.5.5 Security

2.5.5.1 The MA Health Plan will protect and maintain all Confidential Information gained by reason of this SMAC against unauthorized use, access, disclosure, modification, or loss. This duty requires the MA Health Plan to employ reasonable security measures, which include restricting access to the Confidential Information by:

2.5.5.1.1 Allowing access only to staff that have an authorized business requirement to view the Confidential Information.

2.5.5.1.2 Physically Securing any computers, documents, or other media containing ConfidentialConfidential Information.

2.5.5.2 The MA Health Plan will exercise due care to protect Data from unauthorized physical and electronic access. Due care includes establishing and maintaining security policies, standards, and procedures that describe how the MA Health Plan will comply with the requirements set forth in Attachment 1 HCAHCA Requirements and OCIO Security Standard 141.10.

2.5.6 Data Disposition

2.5.6.1 The Data provided will remain the property of the HCA and will be promptly destroyed or returned to the HCA by the MA Health Plan when the work for which the Data was required, as fully described herein, is completed.

2.5.6.2 If the MA Health Plan and the HCA Contact agree that the Data will be destroyed by the MA Health Plan after the work for which the Data was required is completed; then the MA Health Plan will destroy the Data In accordance with the approved destruction methods described in Attachment 1, Data Security Requirements.

2.5.6.3 If applicable federal or state law or regulations prohibit the MA Health Plan from either returning or destroying the Data after the work for which the Data was required is completed; then the MA Health Plan will continue to protect Data from unauthorized physical and electronic access in accordance with this section and Attachment 1, Data Security Requirements, until such time as the applicable federal or state law or regulations would permit the Data's return or destruction.

2.5.7 Notification of Compromise or Potential Compromise

The compromise or potential compromise of Confidential Information must be reported to the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov within one business day of discovery. MA Health Plan must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or HCA.suu

2.5.8 Penalties for Unauthorized Disclosure of Data

State laws (including RCW 74.04.060 and RCW 70.02.020) and federal regulations (including HIPAA Privacy and Security Rules, 45 C.F.R. Part 160 and Part 164, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and Safeguarding Information on Applicants and Beneficiaries, 42 C.F.R. Part 431 Subpart F) prohibit unauthorized access, use, or disclosure of Confidential Information. Violation of these laws may result in criminal or civil penalties or fines. MA Health Plan accepts full responsibility and liability for any noncompliance by itself, its employees, and its Subcontractors with these laws and any violations of this SMAC.

## 2.6 Disputes

When a dispute arises between HCA and the MA Health Plan over an issue that pertains in any way to this SMAC, the parties agree to the following process to address the dispute:

2.6.1 The MA Health Plan shall request a dispute resolution conference with the Director. The request for a dispute resolution conference must be in writing and shall clearly state allthe following:

2.6.1.1 The disputed issue(s).

2.6.1.2 An explanation of the positions of the parties.

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

2.6.2 Requests for a dispute resolution conference must be mailed to the Director, Washington State HCA, P.O. Box 45502, Olympia, WA 98504-5502. Any such requests must be received by the Director within 15 calendar days after the MA Health Plan receives notice of the disputed issue(s).

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

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

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

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

2.6.6 Disputes regarding Overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Section. Disputes regarding other recoveries sought by the MFCD are governed by the authorities, laws, and regulations under which the MFCD operates.

2.7 Entire Agreement

This SMAC contains the entire understanding between the parties hereto with respect to the subject matter of this SMAC and supersedes any prior understandings, agreements, or representations, written or oral, relating to the subject matter of this SMAC.

2.8 Force Majeure

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

2.9 Governing Law and Venue

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

2.10 Headings

The headings and any table of contents contained in this SMAC are for reference purposes only and will not in any way affect the meaning or interpretation of this SMAC.

2.11 Incorporation of Documents and Order of Precedence

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

2.11.1 Applicable federal and state statutes and regulations;

2.11.2 Recitals;

2.11.3 SMAC Terms and Conditions;

2.11.4 Attachment 1, Data Security Requirements;

2.11.5 Exhibit 1, Covered Dual Eligible Recipient Aid Categories;

2.11.6 Exhibit 2, Service Area Washington;

2.11.7 Exhibit 3, Summary of Supplemental Benefits and Value-Added Items and Services (VAIS) for Full Dual Eligible Members;

2.11.8 Exhibit 4, Summary of Supplemental Benefits and Value-Added Items and Services (VAIS) for Partial Dual Eligible Members;

2.11.9 Exhibit 5, Summary of Behavioral Health Benefits Covered Under IMC Contract;

2.11.10 Exhibit 6, MA Health Plan Health Home; and

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

2.12 Indemnification and Hold Harmless

Each party will be responsible for its acts and omissions and the acts and omissions of its agents and employees. Each party to this SMAC will defend, protect, and hold harmless the other party 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 acts and omissions of the first party, or agents of the first party, while performing under the terms of this SMAC 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. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim. The MA Health Plan 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.

2.13 Inspection

HCA, HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, and records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under MA Health Plan's CMS contract, or as the Secretary *may* deem necessary to enforce MA Health Plan's CMS contract. MA Health Plan agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities, and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the end of the final contract period or completion of the audit, whichever is later. (42 C.F.R. § 422.504(d), 42 C.F.R. §§ 422.504(e)(2), 422.504(e)(3), 422.504(e)(4), and 422.504(i)(2)(ii)).

2.14 Legal Notices

All notices, consents, requests, instructions, approvals, or other communications provided for herein will be in writing and delivered by personal delivery, overnight courier, mail, or electronic facsimile addressed to the receiving party at the address set forth herein. All such communications will be effective when received.

HCA:
Attn: HCA Contracts Administrator
Health Care Authority
Division of Legal Services

MA Health Plan:

P.O. Box 42702
Olympia, Washington 98504-2702

A party may change the contact information set forth above by giving written notice to the other party.

2.15 Maintenance of Records

MA Health Plan agrees to maintain for 10 years from the expiration or termination of the SMAC: books, records, documents, and other evidence of accounting procedures and practices that:

2.15.1 Are sufficient to the following:

2.15.1.1 Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the bid) of the MA Health Plan.

2.15.1.2 Enable CMS to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the MA Health Plan's CMS contract, and the facilities of the MA Health Plan.

2.15.1.3 Enable CMS to audit and inspect any books and records of the MA Health Plan that pertain to the ability of the organization to bear the risk of potential financial losses, or for services performed or determinations of amounts payable under MA Health Plan's CMS contract.

2.15.1.4 Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the bid proposal.

2.15.1.5 Establish component rates of the bid for determining additional and supplementary benefits.

2.15.1.6 Determine the rates utilized in setting premiums for State insurance agency purposes and other government and private purchasers.

2.15.2 Include at least records of the following:

2.15.2.1 Ownership and operation of the MA Health Plan's financial, medical, and other record-keeping systems.

2.15.2.2 Financial statements for the current contract period and 10 prior periods.

2.15.2.3 Federal income tax or informational returns for the current contract period and 10 prior periods.

2.15.2.4 Asset acquisition, lease, sale, or other action.

2.15.2.5 Agreements, contracts, and subcontracts.

2.15.2.6 Franchise, marketing, and management agreements.

2.15.2.7 Schedules of charges for the MA Health Plan's fee-for-service patients.

2.15.2.8 Matters pertaining to costs of operations.

2.15.2.9 Amounts of income received by source and payment.

2.15.2.10 Cash flow statements.

2.15.2.11 Any financial reports filed with other federal programs or State authorities.

2.16 No Endorsement

Nothing in this SMAC will be construed as an endorsement by HCA of the products, services, or personnel of MA Health Plan.

2.17 No Third-Party Beneficiaries

Nothing in this SMAC, express or implied, is intended to confer upon any other person any rights, remedies, obligations, or liabilities of any nature whatsoever.

2.18 Public Disclosure

2.18.1 MA Health Plan acknowledges that this SMAC is a public record pursuant to chapter 42.56 of the Revised Code of Washington. Any documents submitted to HCA by the MA Health Plan may be construed as “public records” and therefore subject to public disclosure, except as otherwise provided in 42.56 RCW or other applicable law. HCA may post a “model” contract of this SMAC on the HCA website.

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

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

2.18.4 Nothing in this Section will prevent HCA from filing its own lawsuit or joining any other lawsuit in an attempt to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will promptly notify the MA Health Plan of the filing of any such lawsuit.

2.18.5 Notwithstanding other requirements in this Section, nothing in this SMAC prohibits HCA from making the following types of disclosures:

2.18.5.1 Disclosures required by law, including disclosures in the course of:

2.18.5.1.1 Litigation, with an appropriate court order;

2.18.5.1.1.1 HCA will provide the MA Health Plan with notice and opportunity to file legal proceedings in accordance with subsection 2.18.3.

2.18.5.1.2 Oversight review or audits, including reviews by the State Auditor's Office (SAO), the Office of the Inspector General (OIG), or CMS; or

2.18.5.1.3 Medicaid Fraud Control Division (MFCD) review or investigation.

2.18.5.2 Disclosures of information that is not directly identifiable by MA Health Plan, including disclosures;

2.18.5.3 Disclosures to Contractors working on behalf of HCA, to the minimum extent necessary for the performance of services. HCA will use best efforts to ensure continued confidential treatment of MA Health Plan's disclosed proprietary information or trade secrets;

2.18.5.4 Disclosures of aggregated information; and

2.18.5.5 Any other disclosure of paid amount information with the prior written consent of MA Health Plan.

2.19 Reservation of Rights and Remedies

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

2.20 Severability

Whenever possible, each provision of this SMAC will be interpreted in such a manner as to be effective and valid under applicable law. If any provision of this SMAC is held to be invalid, illegal, or unenforceable under any applicable law or rule, the validity, legality, and enforceability of the other provisions of this SMAC will not be affected or impaired thereby.

2.21 Term and Termination

2.21.1 Term

The term of this SMAC will begin on January 1, 20244 (the "Effective Date") and end on December 31, 20244. The term of this SMAC may be extended by mutual agreement of the parties, in writing.

2.21.2 Termination. This SMAC may be terminated under the following conditions:

2.21.2.1 The SMAC will automatically terminate the day the MA Agreement expires or is terminated.

2.21.2.2 This SMAC may be terminated by mutual agreement of the parties. Such anan agreement must be in writing.

2.21.2.3 HCA may terminate the SMAC in whole or in part and at any time when, in its sole discretion, it determines that termination is in the best interests of HCA. The termination will be effective on the date specified in HCA's notice of termination. HCA will provide the MA Health Plan with written notice of such termination at least 30 calendar days prior to the effective date of termination unless HCA determines that circumstances warrant a shorter notice period.

2.21.2.4 In addition to the reasons set forth above, HCA reserves the right to terminate this SMAC, in whole or in part, upon the following conditions:

2.21.2.4.1 HCA may terminate this SMAC at any time if a court of competent jurisdiction finds MA Health Plan failed to adhere to any laws, ordinances, rules, regulations, or orders of any public authority having jurisdiction and such violation prevents or substantially impairs the performance of MA Health Plan's duties under this SMAC.

2.21.2.4.2 HCA may terminate the SMAC at any time if the MA Health Plan: files for bankruptcy; becomes or is declared insolvent; or is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar Officer for it; makes an assignment for the benefit of all or substantially all of its creditors; or enters into an agreement for the composition, extension, or readjustment of substantially all of its obligations.

2.21.2.4.3 HCA will have the right to terminate the SMAC at any time and in whole or in part if it determines, at its sole discretion, that the MA Health Plan has materially breached the SMAC.

2.21.2.5 The MA Health Plan may terminate this SMAC by providing HCA written notice at least 30 calendar days prior to termination. The termination will be effective on the date specified in the MA Health Plan's notice of termination.

2.22 Corrective Action Plan (CAP)

If HCA determines, in HCA's sole discretion, MA Health Plan is out of compliance with one or more terms or conditions of this SMAC, HCA may require the MA Health Plan to adhere to a Corrective Action Plan (CAP). HCA will specify the requirements of any such CAP in a written communication to the MA Health Plan.

2.23 Sanctions and Liquidated Damages

The Contractor's failure to comply with the terms of any corrective action plan may result in the imposition of sanctions under the Sanctions section of this Contract. Additionally, HCA may also impose liquidated damages under the Liquidated Damages section of this Contract.

2.24 Waiver

No delay on the part of either party in exercising any right under this SMAC will operate as a waiver of such right. No waiver, express or implied, by either party of any right or any breach by the other party, will constitute a waiver of any other right or breach by the other party.

3. **Marketing**

3.1 Marketing

3.1.1 HCA must review and provide written approval for allall marketing materials in which HCA's name or Medicaid is mentioned, language is used, or Internet links are provided from which the connection of HCA's name with MA Health Plan's Services may, in HCA's judgment, be inferred or implied, prior to distribution. Marketing materials must be developed and submitted in accordance with the Medicare Marketing Guidelines and any guidance developed and distributed by HCA. Marketing materials include any items developed by the Contractor for distribution to Members or potential Members that are intended to provide information about the Contractor's benefits administration, including:

3.1.1.1 Print media;

3.1.1.2 Websites; and

3.1.1.3 Electronic Media (Television/Radio/Internet/Social Media).

3.1.2 Marketing materials shall not contain misrepresentations, or false, inaccurate, or misleading information (42 C.F.R. § 422.2262).

3.1.3 Marketing materials must be distributed only in service areas the Contractor is approved to serve. Default Enrollment materials may only be utilized in counties where the Contractor has received written HCA approval in advance to conduct Default Enrollment outreach.

3.1.3.1 In areas where MA Health Plan service areasareas align with the MA Health Plan's Medicaid IMC contract, HCA may collaborate on marketing materials to support aligned enrollment and care coordination.

3.1.3.2 In areas where the MA plan does not have an aligned service area and/or offers a Coordination Only Special Need Plan,Plans the Contractor may only market their DSNP in accordance with HCA guidelines for these types of plans

3.1.3.2.1 Coordination only plan where they achieve a Star Rating of four (4) stars or more, they may market their plan under the following conditions:

3.1.3.2.1.1 To support Care Coordination.

3.1.3.2.1.2 Communicate clearly outlined policies for referral and coordination.

3.1.3.2.1.3 Support transition from One MA Plan to the Contractor or from Medicaid to the MA Plan.

3.1.3.2.1.4 Provide standard marketing materials approved by CMS.

3.1.3.2.2 Coordination only plan where they achieve a Star Rating of Three (3) stars or more, they may share information for their plan under the following conditions:

3.1.3.2.2.1 To support Care Coordination.

3.1.3.2.2.2 Communicate clearly outlined policies for referral and coordination.

3.1.3.2.2.3 Support transition from One MA Plan to the Contractor or from Medicaid to the MA Plan.

3.1.4 Marketing material distributed by the Contractor or Third-Party Marketing Organization must not contain an invitation, implied or implicit, for a Member to change from one AH-IMC BHSO (or Fee-to-Service Medicaid Program for AI/AN Members) to the Contractor's corresponding BHSO or imply that the Contractor's benefits are substantially different from any other AH-IMC BHSO. This does not preclude the Contractor from distributing state-approved communications to Members regarding the scope of their own benefits.

3.1.5 Marketing materials must be in compliance with federal rules regarding translation and Interpreter services (42 ).§ 422.2267). Marketing materials distributed in English must give directions for obtaining understandable materials in the population's primary languages.

3.1.6 The Contractor must comply with all relevant Federal and state laws, including, when applicable, the anti-kickback statute and the civil monetary penalty prohibiting inducements to beneficiaries.

3.1.7 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 a similar entity (42 C.F.R. § 422.226(a)(1)(xi))

3.2 Information Requirements for Members and Potential Members

3.2.1 The Contractor shall provide to Potential Members and New Members the information needed to understand benefit coverage and obtain care in accordance with the Medicare Marketing guidelines and the Equal Access for Members and Potential Members with Communication Barrier section of this contract.

3.2.2 The Contractor shall notify Members of their ability to request the information in their chosen language.

3.2.3 The Contractor shall include with all written materials a tagline and information on how the Member can request Auxiliary Aids and Services including the provision of information in an alternative language and format that is understandable to the Member. If the Member requests the tagline in 12-point font, the Contractor shall provide it to the Member in either paper form or electronically within five (5) Business Days.

3.2.4 The Contractor shall submit branding materials developed by the Contractor that specifically mention Medicaid, AH–FIMC, or HCA for review and approval. No such materials shall be disseminated to Members, Potential Members, providers, or other members of the public without HCA's approval.

3.2.5 The Contractor shall submit for approval Member information developed by the Contractor that specifically mentions HCA, AH-IMC, or the specific benefits provided under Medicaid at least thirty (30) calendar days prior to distribution for review and approval.

3.2.6 The Contractor will have a written process for development, review, and approval of all marketing and Member information including those provided by a third party. This process shall be provided to HCA upon request. It must include the names of the approving source for all internal and third-party documents. All documents must be approved by the Contractor as meeting all contract terms, and federal, state, and local laws prior to submission to HCA.

3.3 Equal Access for Members and Potential Members with Communication Barriers

The Contractor shall assure equal access for all Members and Potential Members when oral or written language communications create a barrier to such access. (42 C.F.R. § 422.2267).

3.3.1 Oral Information

3.3.1.1 The Contractor shall ensure interpreter services are provided free of charge for Members and Potential Members with a primary language other than English or those who are Deaf, Deaf/Blind, or Hard of Hearing. This includes oral interpretation, Sign Language (SL), and the use of Auxiliary Aids and Services as defined in this Contract (42 C.F.R. § 422.2267) Interpreter services shall be provided for all interactions between such Members or Potential Members and the Contractor (42 C.F.R. § 422.111 and 42 C.F.R. § 422.128) or any of its providers including, but not limited to:

3.3.1.1.1 Customer service,

3.3.1.1.2 All interactions with any provider for any covered service,

3.3.1.1.3 Emergency Services, and

3.3.1.1.4 All steps necessary to file Grievances and Appeals including requests for Independent Review of Contractor decisions.

3.3.2 Written Information

3.3.2.1 The Contractor shall provide all generally available and Member-specific written materials through Auxiliary Aids and Services in a manner that takes into consideration the special needs of Members and Potential Members (42 C.F.R. § 422.2264 (c)) and 423.2267). For the purposes of this subsection, the Member's preferred language may not be the same as their primary language. The Contractor must translate materials into the Member's preferred language.

3.3.2.1.1 The Contractor shall include with all written material a conspicuously visible font size tagline, information on how the Member or Potential Member can request Auxiliary Aids and Services, including the provision of information in an alternative language and format that is understandable to the Member or Potential Member.

3.3.2.1.2 If 5 percent or 1,000, whichever is less, of the Contractor's Member speak a language other than English, standardized materials, must be translated into that language.

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

3.3.2.1.3.1 Translating the material into the Member's or Potential Member's preferred language.

3.3.2.1.3.2 Providing the material in an audio format in the Member's or Potential Member's preferred language.

3.3.2.1.3.3 Having an interpreter read the material to the Member or Potential Member in the Member's preferred language.

3.3.2.1.3.4 Making the materials available via Auxiliary Aids and Services, or a format acceptable to the Member or Potential Member. The Contractor shall document the Member's or Potential Member's acceptance of the material in an alternative medium or format (42 C.F.R. § 438.10(d)(1)(ii)).

3.3.2.1.3.5 Providing the material in English, if the Contractor documents the Member's or Potential Member's preference for receiving material in English.

Summary

3.3.2.2 The Contractor shall ensure that all written information provided to Members or Potential Members is accurate, not misleading, comprehensible to its intended audience, designed to provide the greatest degree of understanding, written at the sixth-grade reading level, provided in no smaller than 12 point font, Times New Roman or equivalent, and fulfills other requirements of the Contract as may be applicable to the materials (42 C.F.R. § 438.10(d)(6), 42 CFR § 422.2267).

3.3.3 If the Contractor provides ~~this information~~ required materials electronically, it must meet the following requirements:

3.3.3.1 Ensure the process is voluntary and the member's approval is documented.

3.3.3.2 Have safeguards to ensure a Member'sMembers contact information is correct and current, ensure materials are sent and received timely, and important materials are identified in a way members understand the importance.

3.3.3.3 The format is readily accessible and takes into consideration the special needs of Member and Potential Members with disabilities or limited English proficiency;

3.3.3.4 The information is placed in a location on the Contractor's website that is prominent and readily accessible;

3.3.3.5 The information is provided in an electronic form which can be electronically retained and printed;

3.3.3.6 The Member must be informed that the information is available in paper form without charge within five (5) Business Days of the Member request.

3.4 Member Communication

3.4.1 MA Health Plan will ensure all Member communications are in accordance with 42 C.F.R. Subpart V and the Medicare Communications and Marketing Guidelines (MCMG).

3.4.2 MA Health Plan will publish, on MA Health Plan's website, a contact phone number that will be available for Members' Washington-specific questions around care coordination, provider access, billing questions, and for providers to inquire about Washington-specific Medicaid or Medicare benefit coordination or billing.

3.4.2.1 MA Health Plan will begin developing a Washington-specific information webpage to support members and members accessing services in Washington State. Webpage will be developed and posted to the MA Health Plan's website by 10/1/2023.

## 4. **MA Health Plan Obligations**

4.1 Eligibility and Enrollment

4.1.1 Service Area

MA Health Plan may offer a Dual Eligible SNP to eligible beneficiaries who reside in those counties where the MA Health Plan offers such benefit plan under its MA Agreement as described in this SMAC. Specific counties or zip codes covered by this SMAC are described in Exhibit 2.

4.1.2 Eligibility Verification

HCA will provide MA Health Plan a method of verifying Medicaid eligibility which may include, but is not limited to, verification through a systems query to a State eligibility data system.

4.1.3 HCA will provide the Contractor with a weekly list of IMCenrolled individuals in their corresponding Plan who are eligible or will be eligible for Medicare so the Contractor may conduct outreach and Default Enrollment in approved areas. The file will be named DSNP_Default Enrollment _[Plan Name]_Date Generated. The file will be posted weekly to the Contractor MFT site.

4.1.4 Enrollment

4.1.4.1 Unless a Dual Eligible is otherwise excluded under federal Medicare Advantage plan rules, the MA Health Plan will accept all Full and Partial Dual Eligibles who: (i) are eligible for enrollment per SMAC, Exhibit 2; and (ii) select the MA Health Plan's SNP, without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, national origin, race, color, or religion, and will not use any policy or practice that has the effect of such discrimination.

4.1.4.1.1 MA Health Plan to verify Dual Eligible Member eligibility and plan enrollment as needed using the verification process identified in the Eligibility and Enrollment Section of this SMAC.

4.1.4.1.2 MA Health Plan to report to HCA any changes in Dual Eligible Member eligibility. Changes include but are not limited toto moving out of state, deaths, or loss of eligibility.

4.1.4.2 Upon receiving written approval from HCA, the MA Health Plan may operate separate Plan Benefit Packages (PBP) for full dual eligible Members and partial dual eligible Members. The MA Health Plan's PBPs and eligible Member categories are detailed in Exhibit 2. Each PBP must meet requirements under this SMAC. To receive approval, the request must:

4.1.4.2.1 Be submitted in writing via email to HCA MC Programs hcamcprograms@hca.wa.gov;

4.1.4.2.2 Clearly delineate any differences, including cost sharing between the PBPs; and

4.1.4.2.3 Meet all Medicare requirements.

4.1.5 Default Enrollment Process

4.1.5.1 MA Health Plan shall conduct Default Enrollment in HCA approved counties as provided by 42 CFR 422.66 and 422.68.

4.1.5.2 Default Enrollment

4.1.5.2.1 The Contractor will complete the Default Enrollment process for currently enrolled and eligible members who receive medical assistance benefits, and who become newly Medicare eligible either by age or disability for the first time.. The ContractorContractor shall perform the Default Enrollment process as provided by 42 CFR 422.66 and 422.68.

4.1.5.2.2 The Contractor will be required to meet all network alignment requirements and receive approval from CMS and the HCA prior to initiating any Default Enrollment activities.

4.1.5.2.3 The Contractor will be required to use the approved Default Enrollment notice. No changes shall be made without prior written approval from the HCA.

4.1.5.3 Through this Agreement, in conformance with 42 CFR 422.66(c)(2)(i)(B) and 42 CFR 422.107, HCA approves the Contractor's implementation of the Default Enrollment process subject to CMS' prior approval as per the requirements of 42 CFR 422.66(c)(2)(i)(E), (F), and (G) inclusive; 422.66(c)(2)(ii); and other CMS-published regulatory guidance as applicable. The contractor shall be responsible for obtaining initial Default Enrollment process approval from HCA and CMS no later than 120 calendar days prior to the Effective Date of this Agreement. The Contractor will coordinate with HCA regarding those activities necessary to obtain prior approval. The Contractor shall forward to HCA a copy of CMS' Default Enrollment process prior approval notification or correspondence to the Contractor within 10 calendar days of receipt.

4.1.5.4 TheThe Contractor shall also be responsible for coordinating those necessary activities to renew any existing Default Enrollment process approval(s) with HCA and CMS, as per the requirements of 42 CFR 422.66(c)(2)(ii), so that any such subsequent CMS approval(s)/renewal(s) of an existing approved Default Enrollment process shall be effective no later than 120 calendar days prior to the expiration of the existing CMS approval requested to be renewed. The Contractor shall coordinate with HCA regarding those activities necessary to obtain such CMS renewal approval(s) of an existing Default Enrollment process. The Contractor shall forward to HCA copies of its Default Enrollment process renewal notification and materials to CMS, and CMS' renewal approval(s) notification or correspondence to the ContractorContractor, within 10 calendar days of receipt.

4.1.5.5 The Contractor shall achieve and maintain a minimum 3.0 overall plan Star rating as assigned by CMS on the Medicare Advantage and Part D Star Ratings report to implement the Default Enrollment process. The Contractor's implementation of the Default Enrollment process shall be revoked by HCA and CMS if a minimum 3.0 overall plan Star rating is not maintained, and Default Enrollment cannot be re-applied for with CMS until the ContractorContractor has subsequently achieved this minimum Star rating and notified in writing to HCA.

4.1.5.6 The Contractor shall achieve and maintain a 95% alignment of their Medicare network to their Medicaid Network to implement the Default Enrollment process. The Contractor's implementation of the Default Enrollment process shall be revoked by HCA ~~and CMS~~ if a minimum of 95% is not achieved and maintained. Default Enrollment approval cannot be re-applied for with HCA until the Contractor has achieved 95% alignment or higher as allowed by HCA.

4.1.5.7 Through the implementation of the Default Enrollment process, HCA shall provide the Contractor with information necessary to prospectively identify those HCA categorically eligible members who are or will be in their Medicare Initial Coverage Election Period.

4.1.5.8 The Contractor shall report quarterly, by month, to HCA its Default Enrollment activities on an HCA approved template.

4.1.6 Behavioral Health Services

4.1.6.1 When a Member is enrolled with MA Health Plan with respect to both D-SNP and Integrated Managed Care, where applicable, MA Health Plan will coordinate BH services and provide the BH services under the Integrated Managed Care contract when medically necessary as defined in the IMC and Behavioral Health Wraparound contracts. Benefits may be found in Exhibit 5.

4.1.6.1.1 Services not covered by this SMAC. Medicaid-Medicaid covered services are in the capitated rate paid to the Behavioral Health Services Only Managed Care Organization by HCA for behavioral health under the IMC contract for Behavioral Health Services. The MA Health Plan is not required to provide these services unless covered by Medicare but is responsible for ensuring coordination of these services, in accordance with 42 C.F.R. § 422.107(c)(1).

4.1.6.1.2 Where services are covered by Medicare or other Third Party, the Contractor shall ensure the provider is paid accordingly and then coordinate any remaining payment or balance with the BHSO as appropriate. The Contractor will develop a process to assist and refer eligible claims to the BHSO to ensure prompt payment when requested by the Provider.

4.1.6.2 MA Health plan will develop the necessary agreements to coordinate with HCA Behavioral Health Administrative Services Organizations (BH-ASO) to support crisis and ombuds services. Final contracts will be made available to HCA upon request.

4.1.6.3 MA Health plan will provide all necessary coordination of services for Members receiving Medicare covered BH services regardless of who is responsible for payment. MA Health plan will work with the Member's BHSO to coordinate care in instances where the provider is not a provider type eligible to provide services under Medicare but is eligible to provide services under Medicaid for dual eligible members. Nothing within this SMAC is intended to require MA Health plan to provide or pay for services that are not covered under Medicare or to pay providers ineligible to receive Medicare payment. MA Health plan will ensure coordination with BHSO for Medicaid covered BH services when not covered by Medicare.

4.2 Cost Sharing

4.2.1 Beneficiary Enrollment and Financial Protection

MA Health Plan must provide each prospective Dual Eligible SNP Member, prior to enrollment, with a comprehensive written statement of benefits and cost sharing protections under MA Health Plan's SNP as compared to protections under the

relevant State Medicaid plan. MA Health Plan is prohibited from imposing cost-sharing requirements on Members that would exceed the amounts permitted under the State Medicaid plan if the Member were not enrolled in the MA Health Plan's Dual Eligible SNP. This requirement is to assist a prospective dual-eligible Member to determine if they will receive any value from enrolling in the Dual Eligible SNP that is not already available under the State Medicaid program.

4.2.2 MA Health Plan Member Financial Protections

MA Health Plan assures that its contracts with MA Health Plan participating providers contain provisions that require such participating providers to accept Medicare fee schedules plus Member cost sharing as payment in full. Under MA Health Plan's Dual Eligible SNP, the participating providers may only collect such Member cost sharing as specified by MA Health Plan and pursuant to the limitations of Beneficiary Enrollment and Financial Protection section of this SMAC.

4.3 Network and Access to Care

4.3.1 MA Health Plan Participating Providers

4.3.1.1 MA Health Plan maintains contracts with participating providers whereby MA Health Plan assures adequate access and availability to Members for all medically necessary Covered Services, following CMS access standards and guidelines. MA Health Plan maintains policies and procedures to regularly monitor the access and availability of such participating providers to ensure MA Health Plan consistently meets such access standards and guidelines. MA Health Plan agrees to maintain a contracted participating provider network which is qualified to serve the Members enrolled in MA Health Plan under the SNP, including any specific special medical care needs of such membership which are covered benefits under the SNP.

4.3.2 Contractors will align their Medicare with their Medicaid networks. By November 1 of each calendar year, MA Health Plan will provide a list of all counties and relative percentages for the next upcoming contract year showing the alignment percentage. In Counties where less than 95% percent of their Medicaid providers also accept Medicare members for the current plan year, the Contractor will develop an action plan to reach 95% alignment by January 1, 2024. This will be provided to HCA via email to HCAMCPrograms@hca.wa.gov, utilizing the Network Alignment Template.

4.3.3 The MA Health Plan will have Ninety-five percent (95%) of their Medicare network aligned with their Medicaid network in each county it offers a DSNP by January 1, 2024. If the MCO does not offer a Medicaid option, they will still need to complete all required reports.

4.3.3.1 If the Contractor is not at 95% in a county, they may not market their DSNP to Dual eligible Members or utilize any information provided by the HCA for outreach purposes.

4.3.3.1.1 The Contractor will be required to submit a corrective action plan for how they will increase the alignment to 95% by June 1, 2024.

4.3.3.2 If the Contractor fails to reach 95% by June 1, 2024, the Contractor may not represent their Contract as a Highly Integrated Dual Eligible Plan and may be subject to contract termination effective January 1 of the following year.

4.3.3.2.1 All Marketing of DSNP across the state will be prohibited. HCA will no longer provide access to Medicare eligible member information, and the contract will be reported to CMS as in violation.

4.3.4 MA Health Plans with greater than 95% alignment in a county may work with HCA, their Medicaid 834 file, and Medicare Eligibility Report to conduct outreach to potential members who are becoming eligible for Medicare due to age or disability in that county based on their annual Network Alignment report.

4.3.4.1 The network alignment report must include access to Indian Health Care Services

4.3.4.2 An assessment of health equity, including identification of health disparities and access to care

4.3.4.3 Plans to expand their MA Health plan to completely overlap the service area of the affiliated Medicaid managed care plan.

4.3.4.4 The Contractor may resubmit their report by June 1, 2024, for HCA approval to conduct Default Enrollment in new areas.

4.3.4.5 The Contractor will be required to include in their NovemberNovember 1, 2024, report how they will reach 95% alignment in all areas they operate a DSNP.

4.3.5 MA Health Plan will notify HCA of any changes in contract that may result in less than 95% percent alignment within 30 days of determination.

4.4 Model of Care

4.4.1 MA Health Plan will include in its Model of Care (MOC):

4.4.1.1 A health home program, in alignment with the Medicaid Health Homes program, for at least those individuals engaged in Medicaid Health Homes program at the time of enrollment in the MA Health Plan.

4.4.1.2 A method for identification of members currently receiving Home and Community Based Services and how the Contractor will address the unique challenges of this population in the State of Washington

4.4.1.3 A method for identification of members with significant behavioral health conditions and how the Contractor will address the unique challenges of this population in the State of Washington.

4.4.2 CMS Model of Care Approval (MOC)

MA Health Plan will submit to HCA via email - HCAMCPrograms@hca.wa.gov:

4.4.2.1 The approved Model of Care; and

4.4.2.2 One of the following:

4.4.2.2.1 Written approval from CMS of the Model of Care, or

4.4.2.2.2 The full NCQA accreditation report and accreditation status results within 30 days of each accreditation visit for any accreditation applicable to this SMAC (42 CFRCFR 422.152(g)); or

4.4.2.2.3 NCQA Medicare Advantage Deeming status (42 CFRCFR 422.158); and

4.4.2.3 If the MA Health Plan makes any changes to their MOC, the MA Health Plan will resubmit their MOC to HCA within thirty (30) days of submission to CMS.

4.4.3 The MA Health Plan will include as part of their training for staff and providers the following Washington-specificspecific topics:

4.4.3.1 The MA Health Plan's responsibility for coordination of Medicare and Medicaid benefits and grievances for Dual Eligible SNP Members;

4.4.3.2 Health Homes;

4.4.3.3 The MA Health Plan's policies and processes for coordination of Medicare and Medicaid benefits for Washington DSNP Members, including services provided by the Behavioral Health Administrative Services Organizations, Behavioral Health Services Only, prescription drug benefits, and other services paid for by the state of Washington; and

4.4.3.4 Programs to address health disparities, especially where evidence of inequity of health outcomes is measured.

4.4.3.5 How Long-Term Services and Supports are provided in the State of Washington and the role of the DSNP Care Coordinators in collaborating with the Area Agency on Aging (AAA) in serving Dual Eligible populations. The DSNP will collaborate with the AAA on development of the training materials.

4.5 Health Homes Program

4.5.1 MA Health Plan must:

4.5.1.1 Contract with all HCA contracted community-based Health Home (HH) Lead Entities in the service areas their DSNP covers.

4.5.1.2 Use template health home contract provided by HCA to contract with the community-based organizations to provide Health Home Services. Any changes to the template will require advance written approval from HCA.

4.5.1.3 Pay at least the Medicaid rates for HH services according to the definition of said services.

4.5.2 Health Home program shall be community-based, integrated and coordinated across medical, behavioral health, and long-term services and supports to members based on the services described in Section 1945(h)(4) of the Social Security Act. See exhibit 6 for program specific requirements.

4.6 Contractor Quality Assurance

4.6.1 Quality Measures:

4.6.1.1 MA Health Plan will submit via email to HCAMCPrograms@hca.wa.gov annual HEDIS® reports, CAHPS® if participating, and *any* other quality strategies and evaluations. HEDIS® and CAHPS® reports must be submitted within 30 calendar days of report completion.

4.6.1.2 Additionally, annually by January 31, MA Health Plan will submit a notification via email to HCAMCPrograms@hca.wa.gov which CAHPS® survey(s) they intend to conduct for that calendar year.

4.6.1.3 MA Health Plan will submit the CMS Medicare Advantage (Medicare Part C) and Medicare Part D Star Ratings report to HCA within 30 days of receipt of final draft.

4.6.1.3.1 If Star report is less than 44 stars, the MA Health Plan will consult with HCA and provide an action plan on steps the MA Health Plan is taking to raise score in the State of Washington within 90 days of the final draft.

4.7 Policies and Procedures

MA Health Plan will submit to HCA a list of internal policies and procedures and, make available for viewing any policy and procedure pertaining to this SMAC upon request from HCA.

4.8 Member Rights and Protections

MA Health Plan will comply with state and federal laws pertaining to Member rights under the Washington State Patient Bill of Rights and ensure its staff and affiliated providers or subcontractors protect and promote those rights when furnishing services to Members.

4.8.1 General Member Rights. Member will:

4.8.1.1 Be treated with dignity and respect at all times;

4.8.1.2 Be protected from discrimination;

4.8.1.3 Have personal and health information kept private;

4.8.1.4 Receive information in a way they can easily understand, including information to help Members make health care decisions;

4.8.1.5 Have adequate access to doctors, specialists, and hospitals according to CMS network adequacy standards;

4.8.1.6 Learn about treatment choices in clear language that Member can understand, and participate in treatment decisions;

4.8.1.7 Get health care services in a language Member understands and in a culturally sensitive way;

4.8.1.8 Get Medicare-covered services in an emergency;

4.8.1.9 Get a decision about health care payment, coverage of services, or prescription drug coverage, including the ability to file an appeal if Member disagrees with the decision of the claim;

4.8.1.10 Request an appeal of decisions about health care payment, coverage of services, or prescription drug coverage; and

4.8.1.11 File grievances, including complaints about quality of care, and other concerns with MA Health Plan

4.8.2 Member Provider Choice. Member has the right to:

4.8.2.1 Choose health care providers within the plan;

4.8.2.2 Receive treatment from their provider:

4.8.2.2.1 For complex or serious medical condition(s), a treatment plan allows Member to see a specialist within the plan as many times as needed, as determined by Member and their provider;

4.8.2.2.2 Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.

4.8.2.3 Know how their doctors are paid.

4.9 Grievance and Appeals

4.9.1 MA Health Plan will assist Members in accessing the Medicaid and/or Medicare Grievance and Appeals System(s).

4.9.2 The ContractorContractor will develop policies and procedures around assisting members in accessing Grievance and Appeal systems for both Medicare and Medicaid. These shall be provided to HCA upon request.

4.9.2.1 Trainings should clearly outline how to assist Members with accessing grievance Systems.

4.9.2.2 MA Health Plan will also have policies on how to work with BH Ombuds in the state of Washington.

4.9.3 The Contractor will coordinate with all contracted DSNPs and BHSOs in the state of Washington to develop Contact Names and a referral process to be used by their Grievance and Appeals teams for directing members and providers for grievances referring behavioral health to the appropriate resources. The referral must include steps for a warm handoff as necessary to ensure prompt review. The Contractor shall prepare and provide a report upon request of all grievances that were received and referred to the BHSO.

4.9.4 The Contractor process must include how to access State and Federal ombuds services.

4.9.5 Where the Member is aligned for Behavioral and Physical Health services the Contractor shall track and report all grievances for dual eligible members. This report shall be made available upon request.

4.10 Care Coordination

4.10.1 Coordination of Health Care Services

MA Health Plan will provide the Dual Eligible SNP benefits to all Dual Eligible MA Health Plan Members who are qualified to receive such services under the terms of the MA Agreement.

4.10.1.1 MA Health Plan responsibility to coordinate services:

4.10.1.1.1 The MA Health Plan is responsible for the coordination of both Medicare and Medicaid integrated health care benefits,

regardless of whether a Dual Eligible Member is enrolled with the MA Health Plan's Behavioral Health Services Only (BHSO) health plan for Medicaid benefits.

4.10.1.1.2 If a Dual Eligible Member is enrolled with the MA health Plan for both Medicare and Medicaid benefits, the MA Health Plan is responsible for coordinating all benefits covered by both Medicare and Medicaid.

4.10.1.1.2.1 The Contractor will coordinate with all contracted DSNPs and BHSOs in the state of Washington to develop Contact Names and a referral process to be used by their care coordination teams for coordinating across BHSO and MA plan.

4.10.1.1.3

4.10.1.1.4 If a Dual Eligible Member is enrolled with the MA Health Plan for both Medicare and Medicaid benefits, the MA Health Plan will utilize Medicare Parts A, B, and D data, and Medicaid health care and other data received from HCA, to coordinate all aspects of the Dual Eligible Member's integrated health care benefits, including, but not limited to transition planning, disease management, and care management.

4.10.1.1.5 If a Dual Eligible Member is not enrolled with the MA Health Plan companion Medicaid MCO for Medicaid benefits, the MA Health Plan shall coordinate Medicaid-only benefits with the Dual Eligible Member's assigned MCO for BH services. Coordination of Medicaid benefits is not the Dual Eligible Member's responsibility.

4.10.1.2 Care Coordination General Requirements. MA Health Plan will:

Have access to and ensure utilization of the Predictive Risk Intelligence System (PRISM) to obtain a more comprehensive overview of a member's health and patterns of service use, and to identify gaps in needed care. Utilize Benefit Enrollment information to identify and develop a standard for when to coordinate care for members receiving HCBS and BHSO benefits.

4.10.1.2.1 Participate in care coordination efforts facilitated by the state and utilize any tools and processes developed through these efforts.

4.10.1.2.2 Provide or oversee interventions that address the physical health, social, economic, behavioral health, functional

impairment, cultural, and environmental factors affecting health and health care choices;

4.10.1.2.3 Deliver services in a culturally competent manner that addresses health disparities by, for example, interacting directly and in person with the Member and their family in the Member's primary language, with appropriate consideration of literacy and cultural preference; and

4.10.1.2.4 Use and promote recovery and resiliency principles to mitigate future risk of the development of physical or behavioral health care conditions.

4.10.1.2.5 The Contractor shall ensure Continuity of Care for Members with chronic or acute physical or behavioral health conditions. The Contractor shall ensure continued access to services during a transition between FFS and the Contractor's MA Plan, or from one Integrated Managed Care or BHSO to another MA plan, consistent with the Contractor's Model of Care (42 C.F.R. § 422.101). The Contractor shall ensure medically necessary care for Members is not interrupted during transitions from one setting or level of care to another or transitioning from Behavioral Health or Correctional Facilities.Facilities. (42 CFRCFR § 422.112)

4.10.1.2.5.1 The Contractor shall coordinate with its Integrated Managed Care Plan to identify and utilize the same or comparable questions required by Medicaid for the Health Risk Assessment to assess Social Determinants of Health. Questions at a minimum will address housing stability, food security, and access to transportation. These questions will be provided to the Contractor as developed. If questions are not identical, the Contractor will submit to HCA their selected questions for approval.

4.10.1.2.5.2 The aggregated responses will be provided annually to HCA by December 30th of the contract year in the HRA Social Determinants report. The report will cover 12/1 of the previous contract year through 11/30 of the current contract year. A template will be provided to the Contractor by HCA no later than October 1 of the contract year.

4.10.1.2.5.3 The Contractor will coordinate with HCA, DSHS, and the other MA health plans to discuss and develop proposed benefits for the next SMAC development.

4.10.1.3 Information Sharing to Improve Care Coordination and Care Outcomes

MA Health Plan will establish and maintain health services programs and resources to ensure appropriate and adequate coordination and integration of Medicare and Medicaid benefits available to Dual Eligible Members under this SMAC. Such health services programs and resources include but are not limited to dedicated programs and staff to support care management and case management services. MA Health Plan will establish care management programs for Dual Eligible SNP Members to assist in accessing services offered by the MA Health Plan, or the State's Medicaid program where benefits and services may be available. MA Health Plan will offer care coordination to Members accessing any services through the State's Medicaid Program.

4.10.1.3.1 MA Health Plan will have policies and implement mechanisms to provide care management and care coordination to Members in consultation with any providers caring for the Member, including for Members currently receiving Medicaid-funded long-term care or long-term services and supports from DSHS, to meet CMS goals for reducing duplication of assessment and care planning activities for improved coordination and Member outcomes.

4.10.1.3.2 MA Health Plan will have policies and protocols to coordinate services between settings of care and include all relevant parties involved in discharge or transition planning, including HCS if the member receives HCBS services. This coordination will include appropriate discharge planning for short-term and long-term hospital and institutional stays:

4.10.1.3.2.1 With the services the Member receives from any other Medicaid MCO;

4.10.1.3.2.2 With the services the Member receives in fee-for-service (FFS) Medicaid, including long-term care and long-term services and supports; and

4.10.1.3.2.3 With the services the Member receives from community and social support providers.

4.10.1.3.3 MA Health Plan will have policies and protocols for sharing information with system partners such as; the Department of

Social and Health Services (DSHS) Aging and Long-Term Support Administration (ALTSA), Home Community Services (HCS), and Developmental Disabilities Administration (DDA), and other MCOs or DSNPs serving the Member to reduce duplication of assessment and care planning activities.

4.10.1.3.4 MA Health Plan will have mechanisms to receive referrals for health care screening or assessment for Members receiving long-term care of long-term services and supports, work closely with HCA or MCO intensive care management for coordination around health risk screenings and assessment requirements within 30 calendar days for referrals and 90 calendar days for new Members, or as quickly as the Member's health condition requires.

4.10.1.3.5 For Members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, MA Health Plan will have a mechanism in place to allow Members to directly access a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the Member's condition and identified needs. MA Health Plan will work to ensure the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the Member's ongoing need for such services and supportsupport.

4.10.1.4 For all Dual Eligible Members receiving Medicaid-covered Long-Term Care (LTC) and Long-Term Services and Supports (LTSS) through State programs, MA Health Plan will make reasonable efforts to coordinate benefits and services, which include:

4.10.1.4.1 Outreach, coordination, and making a direct connection with Medicaid LTC and LTSS programs for services and care coordination; and

4.10.1.4.2 Provide HCA with a contact, including email address, for HCS staff to coordinate care for discharges or contact the MA Health Plan regarding care coordination needs of shared Members.

4.10.1.5 MA Health Plan will ensure any MCOhas information to access care coordination services as needed by connecting with MCO care coordination leads for integration of care. This includes provision of phone number(s), email address(es), and name(s) of key care coordination staff assigned to support Members in care navigation or care coordination activities. MA Health Plan will notify MCO care coordination leads of any changes within 30 calendar days.

## 4.11 Benefits

### 4.11.1 Benefits Comparison Charts Information Sharing

4.11.1.1 On an annual basis, MA Health Plan will determine its benefits, including Value-Added Items and Services (VAIS), and supplemental benefits for the chronically ill for the calendar year that will be provided to Dual Eligible Members under the Dual Eligible SNP. Such benefits will be approved by CMS prior to January 1 of each successive calendar year. This will include listing their maximum-out-of-pocket (MOOP) limit (42 C.F.R § 422.100 (4))

4.11.1.2 MA Health Plan will develop comparison charts (“Comparison Charts") summarizing the products and services offered under the various MA Health Plan's Dual Eligible SNP plans for each service area in the state. To be included on the comparison chart are:

4.11.1.2.1 A list of benefits offered by the MA Health Plan;

4.11.1.2.2 A list of Medicaid benefits offered by HCA to qualified Dual Eligible beneficiaries;

4.11.1.2.3 MA Health Plan's defined cost sharing for each benefit;

4.11.1.2.4 HCA's Medicaid Cost Sharing Obligations for each benefit; and

4.11.1.2.5 Identification of overlap between MA Health Plan's benefits, services, and cost sharing with HCA's Medicaid Cost Sharing Obligations for each benefit and each qualified beneficiary.

4.11.1.3 MA Health Plan will submit to HCA, with their SMAC or Amendment to SMAC, in an agreed upon format and HCA will review and approve the draft comparison charts regardingregarding appropriate documentation of Medicaid benefits and cost sharing offered by HCA. The MA Health Plan will provide the final version via email to HCAMCPrograms@hca.wa.gov by August 1 with CMS approval.

4.11.1.3.1 MA Health Plan will distribute such Comparison Charts to appropriate MA Health Plan departments and personnel for the express purpose of providing education and resources to MA Health Plan staff to enable efficient and appropriate coordination of benefits that may be available to Dual Eligible Members under their State Medicaid program.

4.11.1.3.2 MA Health Plan will distribute such Comparison Charts to MA Health Plan participating providers for the express purpose of providing education and resources to MA Health Plan participating providers to enable efficient and appropriate collection of applicable cost sharing under MA Health Plan's Dual Eligible SNP plan benefits and as required by the Beneficiary Enrollment and Financial Protection section of this SMAC.

4.11.1.3.3 MA Health Plan will distribute such Comparison Charts to Dual Eligible Members under the Dual Eligible SNP and make

available to staff for Member questions regarding benefits and the Comparison Chart.

4.11.1.3.4 Comparison Charts must be distributed by December 1, or upon enrollment. MA Health Plan may meet the requirements of distribution to participating providers and Members by posting the Comparison Charts on their website and providing information on accessing services.

4.11.2 Medicaid Benefit Information

HCA will provide MA Health Plan with information summarizing the products and services offered under the various State Medicaid benefit plans to support MA Health Plan's production of the Comparison Charts, via Medicaid Program or billing instructions on the HCA website.

4.11.3 Telehealth

MA Health Plan will provide and encourage the use of telehealth solutions to allow long-distance patient and clinician contact to include but is not limited to care, advice, reminders, education, intervention, and monitoring. “Telehealth” includes the distribution of health-related services and information via electronic information and telecommunication technologies.

4.12 Reporting Requirements

4.12.1 MA Health Plan shall provide all SMAC Reporting Deliverables timely, as directed by the HCA. All emails submissions must include HCA MC Programs hcamcprograms@hca.wa.gov in addition to any identified contacts.

4.12.2 MA Health Plan shall provide timely notification of all admissions to a hospital or skilled nursing facility (SNF) for a subpopulation of Members receiving Medicaid Long Term Services and Supports with RAC and Group Codes, in Exhibit 1.

4.12.2.1 MA Health Plan will provide a report via SFT in the established HCA template on a weekly basis due close of business Monday for the previous week, Sunday through Saturday. The report will contain all full dual Members who are currently receiving HCBS services and are currently admitted to a hospital or SNF for any reason. This report shall only include those Members who are currently admitted, all members who transition from an inpatient setting will be removed prior to the next submission. An email will be sent to HCA at HCAMCPrograms@hca.wa.gov and DSHS ALTSA at DSNPLTSSreporting@dshs.wa.gov with a notification the report is available. Reports will include:

4.12.2.1.1 Name of Member;

4.12.2.1.2 ProviderOne ID;

4.12.2.1.3 Hospital or Skilled Nursing Facility (SNF);

4.12.2.1.4 Date of Admission;

4.12.2.1.5 Admitting Diagnosis;

4.12.2.1.6 Diagnosis Code;

4.12.2.1.7 Point of Contact;

4.12.2.1.8 County the Member resides in; and

4.12.2.1.9 MemberMember-enrolled BHSO.

4.12.3 MA Health Plan will provide a summary report in HCA's established template via SFT to HCA and DSHS ALTSA on semi-annual basis due July 31st and January 31st for the previous six-month period to HCA and DSHS ALTSA for Members hospitalized or in a skilled nursing facility for behavioral health needs. If the date falls on a weekend, the report will be due by close of business on the next business day. This report will be broken into a report on full-dual-eligible and a report for partial-dual-eligible Members. An email will be sent to HCA at HCAMCPrograms@hca.wa.gov and DSHS ALTSA at DSNPLTSSreporting@dshs.wa.gov with a notification the report is available. Report will include:

4.12.3.1 Number and Percentage of population hospitalized;

4.12.3.2 Percentage of population having care coordination prior to hospitalization;

4.12.3.3 Number and percentage of populations offered care coordination following hospitalization;

4.12.3.4 Number and percentage of population accepting care coordination;

4.12.3.5 Number and percentage of populations readmitted from the prior year;

4.12.3.6 Average length of stay;

4.12.3.7 Number and percentage of Member's that remain hospitalized when not medically necessary; and

4.12.3.8 A summary of steps MA Health plan will or are taking to address re-admittance and stays exceeding medically necessary guidelines.

4.12.4 MA Health Plan will provide a Membership Churn report via SFT to HCA and DSHS ALTSA on an annual basis due July 31st for the prior contract year. If the date falls on a weekend, the report will be due by close of business on the next business day. An email will be sent to HCA at HCAMCPrograms@hca.wa.gov and DSHS ALTSA at

DSNPLTSSreporting@dshs.wa.gov with a notification that the report is available. Report will include:

4.12.4.1 Annual state level reporting;

4.12.4.2 Disenrollment for cause vs. loss of eligibility as a percentage;

4.12.4.3 Narrative analysis of areas of the state based on their percentage of loss or gain;

4.12.4.4 Root cause analysis and connection to quality strategy.

4.12.5 MA Health Plan will provide their Medicare Advantage (Medicare Part C) and Medicare Part D Star Ratings via SFT to HCA within 30 calendar days of theof the Contractor receiving their official report by email to HCAMCPrograms@hca.wa.gov.

4.12.6 MA Health Plan will submit a semi-annual Health Home Services report, due August 15 for January through June, and February 15 for July through December, on an HCA-provided template by email to HCAMCPrograms@hca.wa.gov. HCA may request off-cycle updates to this report.

4.13 Encounter Submission

4.13.1 The MA Health Plan shall submit and maintain accurate, timely, and complete encounter data. The MA Health Plan shall comply with allthe following:

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

4.13.1.2 Submit to HCA complete, accurate, and timely data for all services for which the MA Health Plan provided services under this SMAC as reported to CMS.

4.13.1.3 Encounter data must be submitted to HCA via SFT upload monthly, at a minimum, and no later than 30 calendar days from the end of the month in which the MA Health Plan submitted encounter data to CMS.

4.13.1.4 Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter.

4.13.1.5 The MA Health Plan shall submit to HCA, without alteration, omission, or splitting, all available claim data in its entirety from the MA Health Plan's submission to CMS with the exception of adding the Medicaid enrolled ProviderOne ID.

4.13.1.5.1 Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA.

4.13.2 MA Health Plan will develop and provide a Washington specific summary of provider networks, drug coverages, plan benefits, care coordination, supplemental benefits, and VAIS to assist with helping potential Members make plan choices to the Statewide Health Insurance Benefits Advisors (SHIBA). This information will be developed in a format decided by HCA and SHIBA to best support outreach efforts. This will be provided to HCAMCPrograms@hca.wa.gov via email annually in advance of open enrollment no later than October 5th of each calendar year. This report will be shared by DSHS and HCA with the Area Agencies on Aging and posted to the HCA website.

4.13.2.1.1

4.14 Transaction Standards.

4.14.1 The data quality standards listed within this SMACare incorporated by reference into this SMAC. The MA Health Plan shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with HCA's data quality standards as defined and subsequently amended.

4.14.2 Additional detailsdetails can be found in the Encounter Data Reporting Guide published by HCA. The Encounter Data Reporting Guide, as currently existing and hereafter amended, is hereby incorporated by reference into this SMAC.

4.14.2.1 HCA may change the Encounter Data Reporting Guide with 90 calendar days written notice to the MA Health Plan.

4.14.2.2 The Encounter Date Reporting Guide may be changed with less than 90 calendar days' notice by mutual agreement of the MA Health Plan and HCA.

4.14.2.3 The MA Health Plan shall, upon receipt of such notice from HCA, provide notice of changes to subcontractors.

## 5. Enrollee Advisory Committee

5.1 Enrollee Advisory Committee Guidelines

5.1.1 Consistent with 42 CFR 422.107(f), the Contractor will develop an Enrollee Advisory Committee..

5.1.1.1 The enrollee advisory committee must include at least a reasonably representative sample of the population enrolled in the dual eligible special needs plan or plans, or other individuals representing those enrollees, and solicit input on, among other topics, ways to improve access to covered services, coordination of services, and health equity for underserved populations.

5.1.1.2 Rules for participation and thethe member selection process will be posted on the Contractor Website.

5.1.1.3 Agendas and Meeting notes shall be provided to HCA upon request.

1.1.1.1 At least one member from the Statewide Health Benefits Advisors, The Department of Social and Health Services, and the Health Care Authority shall be invited to attend the meetings. These will be non-voting members,

5.1.2 By December 1 of each year, the Contractor will provide an annual report summarizing;

5.1.2.1 All high-level topics discussed,

5.1.2.2 All Action items taken to address plan performance in the current year,

5.1.2.3 All Action items that will address plan performance in the coming year.

5.2 Community Stakeholder Group

5.2.1 The Contractor may also develop a second community Stakeholder group that includes community organizations but must also include at least two Enrollees. All requirements for the Enrollee Advisory Committee must apply to this group as well.

6. **Contracting with Washington Tribes**

6.1.1 The Contractor shall coordinate with and pay all IHCPs who provide a service to AI/AN Beneficiaries under this Contract regardless of the IHCP's decision whether to subcontract.

6.1.2 The Contractor will pay IHS facilities and Tribal 638 Facilities, including Tribal FQHCs, the full IHS encounter rate for each qualifying outpatient service furnished to an AI/AN Enrollee by an IHS or Tribal 638 Facility, including Tribal FQHC.

6.1.3 In the case of AI/AN Enrollees, the Enrollee may choose any IHCP enrolled with the HCA for primary care, behavioral health care, or other services covered under this Contract (42 C.F.R. § 438.14(b)). If the Enrollee chooses an IHCP as PCP, the Contractor shall treat the IHCP as PCP for all purposes under this Contract.

7. **Sanction and Liquidated Damages**

7.1.1 In the event the Contractor fails to meet one or more of its obligations under this Contract HCA, in its sole discretion may require the Contractor to devise a CAP for HCA approval or implement a CAP developed by HCA:

7.1.1.1 Until the default is cured or any resulting dispute is resolved in the Contractor's favor, HCA may: (i) impose sanctions or liquidated damages, (ii) limit the ability of Contractor to conduct outreach or marketing activities within specific counties or across the state including any national marketing campaigns and/or (iii) suspend or terminate Default Enrollment activities.

7.1.1.2 HCA must aprovide a reasonable cure period and impose a CAP on the Contractor prior to imposing sanctions.

7.1.2 HCA may impose sanctions if the Contractor fails to meet one or more of its obligations under this Contract, a CAP, or applicable law, including but not limited to submitting reports, documents, data, or any other information that is inaccurate, incomplete, untruthful, or untimely. HCA will consider the Contractor's failure in this regard as default. The Contractor will be in default, and HCA may impose reasonable sanctions.

7.1.2.1 Sanctions are distinct from liquidated damages and are not mutually exclusive.

7.1.2.2 Sanctions are intended as a penalty for default, whereas liquidated damages are intended as a remedy for noncompliance where the non-compliance resulted in cost to the HCA or DSHS to correct.

7.1.3 HCA, CMS, or the Office of the Inspector General (OIG) may impose intermediate sanctions in accordance with applicable law including 42 CFRCFR 42.422 subpart 0 against the Contractor, without a cure period, for:

7.1.3.1 Failing to provide Medically Necessary Services that the Contractor is required to provide, under law or under this Contract, to aa Member covered under this Contract.

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

7.1.3.3 Misrepresenting or falsifying information that it furnishes to CMS or HCA.

7.1.3.4 Misrepresenting or falsifying information that it furnishes to Member, Potential Member, or any of its Subcontractors.

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

7.1.3.6 Violating any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, and any implemented regulations

7.1.3.7 HCA shall notify the Contractor in writing of any default by the Contractor. The notice will advise the Contractor of the basis of the determination of a default if a cure period is being allowed if a CAP will be required, if any sanctions are being imposed, and of the dispute resolution process.

8. **HCA Obligations**

8.1 HCA's Financial Responsibility

HCA will retain financial responsibility for applicable Medicaid Cost Sharing Obligations, including coordination of benefits, coinsurance, and/or copayments to healthcare providers as detailed in the State Plan. Providers will submit claims eligible for coordination of cost sharing directly to HCA for payment of any applicable payments as determined by HCA.

8.2 Medicaid Provider Participation

HCA will provide MA Health Plan with access to available information to enable MA Health Plan to verify provider participation in the State's Medicaid programs.

8.3 SMAC Monitoring

HCA reserves the ability to schedule Washington specific Readiness Reviews and On-Site Reviews as needed to ensure Network Adequacy in alignment with federal guidance and this contract. HCA's monitoring will not duplicate monitoring efforts completed by CMS.

9. **Federal Audits**

9.1 Within 90 days of the receipt of the audit findings, the Contractor shall provide HCA with a summary of any audit findings identified by CMS for its contract.

9.1.1 The Contractor will conduct an analysis of any activities that directly or indirectly impacted the State of Washington and how it will be addressed.

9.1.2 The Contractor will provide a report to HCA of their analysis and any Corrective Action plans developed.

9.2 HCA reserves the right to audit the Contractor including but not limited to claims paid, referrals, and utilization management to support Program Integrity and Contract monitoring activities.

## Exhibit 1, RAC Codes

**Apple Health Fully Integrated Managed Care (AH-FIMC)**
**Medical and Behavioral Health (BH)**

Exhibit J: RAC Codes — Medicare status code 02,04,06,08

| Category | Description | BSP | Medicaid Service Level | Current RACs (*Disabled RACs are in **bold**) |
|---|---|---|---|---|
| **(a)** Apple Health Family = Healthy Options (HO) **CNP** | Washington Apple Health managed care for families (parents, children, and pregnant women) | CN | QMB QMB + | **1018**, **1023**, 1026, 1197, 1198, 1199, 1200, 1202, 1203, 1204, 1205, 1274 |
| **(b)** Apple Health Blind Disabled = Healthy Options Blind/Disabled (HOBD) **CNP** | Washington Apple Health managed care for blind/disabled clients. Supplemental Security Income (SSI) and SSI related. Categorically Needy Program and may receive home and community-based waiver/hospice services | CN | QMB QMB + | **1047**, **1105**, **1107**, **1110**, **1111**, **1121**, **1134**, **1147**, **1150**, **1151**, **1153**, **1175**, **1219**, **1221**, **1224**, **1225**, **1237**, **1239**, **1245**, **1247**, **1252**, **1253**, **1254**, **1255**, **1258**, **1259**, **1261**, **1263**, **1267**, **1268**, **1269, 1271** |
| | Categorically Needy Program, Long-Term Care child <19, pregnant age 19> in hospital or facility over 30 days; or 19-22 in a mental institution since before 21st birthday | CN | QMB QMB + | 1052, 1053, 1055 *living arrangement/institutional status code is "not IM |
| | Categorically Needy Program, Long-Term Care 65+<br><br>*Added to HOBD program effective 04/01/2016 | CN | QMB QMB + | 1065, 1068, 1071, 1073 *living arrangement/ institutional status "not IM" |
| | Categorically Needy Program, Long-Term Care, Blind/Disabled<br><br>*Added to HOBD program effective 04/01/2016 | CN | QMB QMB + | 1067, 1070, 1162, 1163 *living arrangement/ institutional status "not IM" |
| | Categorically Needy Program, 65+<br><br>*Added to HOBD program effective 04/01/2016 | CN | QMB QMB + | 1046, 1104, 1106, 1108, 1109, 1146, 1148, 1149, 1152, 1174, 1218, 1220, 1222, 1223, 1236, 1238, 1244, 1246, 1248, 1249, 1250, 1251, 1256, 1257, 1260, 1262, 1264, 1265, 1266 |
| **(c)** Apple Health Adult Coverage (AHAC) **ABP** | Washington Apple Health managed care for single adults (expansion population). Categorically Needy Program plus habilitative services | ABP | QMB QMB + | 1201, 1217, 1275 |

| | | | | |
|---|---|---|---|---|
| **(d)** State Children's Health Insurance Program (SCHIP) **CNP** | Children with incomes above Medicaid limit. Are enrolled in Apple Family Health = Healthy Options but pay a small premium. Categorically needy program benefits. | CNP | QMB QMB + | 1140, 1206, 1207 |

*Medicaid clients who are exempt from AH-FIMC will be enrolled into a BHSO plan to access their behavioral health services.

Behavioral Health Services Only (BHSO)
Mental Health and Substance Use Disorder Services
Fee for Service Medical

## Medicaid Dual Eligible Population (a)

Medicare Savings Program (MSP) RACs by themselves pay Medicare premiums only; when used in combination with a Medicaid RAC with CNP or MNP benefits and Medicare Status code 2, 2H, 4, 4H the client becomes a Dual and Behavioral Health Services Only (BHSO) premiums are paid.

The H Modifier will indicate eligibility for Health Homes Program. This will not indicate if the individual is engaged or enrolled.

Medicare Status Code 8 or 8H in combination with any Medicaid RAC CNP or MNP the client becomes a Dual and would receive BHSO in the Early Adopter program.

| **Category** | **Description** | **BSP** | **Medicaid Service Level** | **Current RACS** (*Disabled RACs are in **bold**) |
|---|---|---|---|---|
| **MSP** Medicare Savings Program | Medicare Savings Program: state only pays deductible, coinsurance, or premiums | Partial | Partial | 1112, 1113, 1114, 1115, 1116, 1117, 1118 |

**Comparable Coverage (Third Party Insurance/Liability) (c)**
A Medicaid client who also has other insurance that HCA has determined provides a full scope of health care benefits.

## Behavioral Health Services Only (BHSO)
## Mental Health and Substance Use Disorder Services
## Fee for Service Medical

### Spend-down (d)

| Category | Description | BSP | Medicaid Service Level | Current RACS (*Disabled RACs are in **bold**) |
|---|---|---|---|---|
| **LCP-MNP** Spenddown child under 19 | Limited Casualty- Medically Needy Program, spenddown child under 19 | MN | Partial dual until they meet spenddown then are MN | 1039 |
| **LCP-MNP**, Duals, 65+, Spenddown | Limited Casualty-Medically Needy Program, dual coverage on spenddown | MN | Partial dual until they meet spenddown then are MN | 1124 |
| **LCP-MNP**, Spenddown, Blind/Disabled | Limited Casualty-Medically needy Program on spenddown, blind/disabled | MN | Partial dual until they meet spenddown then are MN | **1126** |
| **LCP-MNP**, Pregnancy, Spenddown | Limited Casualty-Medically Needy Program, pregnancy on spenddown | MN | Partial dual until they meet spenddown | 1101, 1102 |

| | | | | |
|---|---|---|---|---|
| | | | then are MN | |
| **LCP-MNP**, ALF, 65+, | Limited Casualty - Medically Needy Program, living in Alternate Living Facility (adult family home, boarding home, or other DDD group home). 65+ and may have spenddown | MN | Partial dual until they meet spenddown then are MN | 1048 |
| **LCP-MNP**, ALF, Blind/Disabled | Limited Casualty - Medically Needy Program, living in Alternate Living Facility (adult family home, boarding home, or other DDD group home). Blind/disabled and may have spenddown | MN | Partial dual until they meet spenddown then are MN | **1049** |
| **LCP-MNP**, LTC, Spenddown, Blind/Disabled | Limited Casualty-Medically Needy Program on spenddown, blind/disabled | | Partial dual until they meet spenddown then are MN | **1086**, **1091** |
| **LCP-MNP**, Dual, 65+, LTC, Spenddown | Limited Casualty-Medically Needy Program, long term care with dual coverage, 65+, spenddown | MN | Partial dual until they meet spenddown then are MN | 1083, 1088 |

## Behavioral Health Services Only (BHSO)
## Mental Health and Substance Use Disorder Services
## Fee for Service Medical
## Institution for Mental Disease (e)

| Category | Description | BSP | Medicaid Service Level | Current RACS (*Disabled RACs are in **bold**) |
|---|---|---|---|---|
| **CNP**, Institutional SSI, and Institutional SSI Related in IMD (child under 22), Blind/Disabled | Categorically Needy Program, blind/disabled in Institution for Mental Disease Long Term Care (child under 22) | .CN | | **1164**, **1165**, **1168**, **1169** |
| **CNP**, Institutional SSI, and Institutional SSI Related in IMD 65+ | Categorically Needy Program, SSI eligible, , in Institution for Mental Disease (65+) | CN | | 1066, 1069, 1072, 1074 |
| **MNP**, Institutional SSI, and Institutional SSI Related in IMD, Blind/Disabled | Medically Needy Program, blind/disabled, in Institution for Mental Disease, age <=22 may have spenddown | MN | Partial dual until they meet spenddown then are MN | **1166**, **1167** |
| LCP-**MNP**, Institutional SSI, and Institutional SSI Related in IMD, Spenddown | Limited Casualty -Medically Needy Program, in Institution for Mental Disease, (65+) may have spenddown | MN | Partial dual until they meet spenddown then are MN | 1084, 1089 |
| **CNP**, LTC | Categorically Needy Program, Long-Term Care child <19, pregnant woman age 19> in hospital or facility over 30 days; or 19-22 in a mental institution since before 21st birthday; or 65> in mental institution | CN | X | 1052, 1053, 1055<br>If living arrangement or institutional status code is "IM" |
| LCP-**MNP**, LTC | Limited Casualty - Medically Needy Program, Long Term Care, in institution for Mental Disease, may have spenddown. | MN | Partial dual until they meet spenddown then are MN | 1059, 1061 |
| **Pregnant Women non-citizens (undocumented) (f)** | | | | |

| | | | | |
|---|---|---|---|---|
| CNP, MAGI, Federally funded pregnancy for non-citizens (**undocumented**) | Categorically Needy Program, Modified Adjusted Gross Income, Federally funded pregnancy for non-citizens (**undocumented**) | CN | X | 1096, 1209 |
| CNP, BCCTP | Categorically Needy Program, Breast and Cervical Cancer Treatment Program for women (BCCTP) | CN | X | 11231122 |

## Behavioral Health Services Only (BHSO)
## Mental Health and Substance Use Disorder Services
## Fee for Service Medical

### Foster Care (g)

| Category | Description | FIMC | BHSO | Current RACS (*Disabled RACs are in **bold**) |
|---|---|---|---|---|
| Healthy Options Foster Care | Apple Health Managed Care Program for Foster Care Children | CN | | **1014**, **1015**, **1016**, **1017**, **1019**, **1020**, **1021**, **1022** |
| CNP, Foster Care Alumni | Categorically Needy, Foster Care under 26 (if in Foster Care at age 18) | CN | | 1196 |
| **Hospice (h)** | | | | |
| CNP, Hospice, SSI, CNIL, SIL, 65+ | Hospice Categorically Needy Income level, Special Income Level to determine eligibility, 65+ | CN | X | 1240, 1241 |
| CNP, Hospice, SSI, CNIL, SIL, Blind/Disabled | Hospice Categorically Needy Income level, Special Income Level to determine eligibility, blind /disabled | CN | X | **1242**, **1243** |
| **Long Term Care Institutional (i)** | | | | |
| **CNP,** LTC,65+ | Categorically Needy Program, Long- Term Care 65+ | CN | X | 1065, 1068, 1071, 1073 |

| | | | | |
|---|---|---|---|---|
| | | | | living arrangement /institutional status “IM” |
| **CNP,** SSI or SSI related institutional, Blind/Disabled | Categorically Needy Program, Long-Term Care, blind/disabled | CN | X | **1067**, **1070**, **1162**, **1163** living arrangement /institutional status “IM” |

| Refugees (j) | | | | |
|---|---|---|---|---|
| **CNP,** Family LTC, Adults | Categorically Needy Family Long Term Care; adult Refugee with date of entry <= 7 months; in hospital or LTC facility over 30 days | CN | X | 1054 |
| **CNP,** Refugee adult or child | Refugee Medical Assistance | CN | X | 1103 |

| Breast and Cervical Cancer (k) | | | | |
|---|---|---|---|---|
| CNP, BCCTP | Categorically Needy Program, Breast and Cervical Cancer Treatment Program (BCCTP) for women | CN | X | 1122 |

| Pregnant Women (not federally qualified) (l) | | | | |
|---|---|---|---|---|
| CNP | Categorically Needy Magi Pregnancy Medicaid; for pregnant women who are not federally qualified due to citizenship/alien status. | Not Eligible | Not Eligible | 1209 |

- 00-Not Dual, Not a Medicare Beneficiary
  - Client will have a Medical RAC identified.
  - No Medicare entitlement segment (A or B)
- 02-Full Benefit Dual with QMB
  - Beneficiary is an S03
  - May also have a medical RAC
- 04-Full Benefit Dual with SLMB
  - Beneficiary is an S05
  - May also have a medical RAC
- 08-Other Dual Eligible with Medicaid coverage no MSP

- Beneficiary will have Medical RAC 1000 thru 1999

## Exhibit 2

## Service Area Washington

The following counties define the Service Area covered under this SMAC:

**Exhibit 3**

**Summary of Supplemental Benefits and Value-Added Items and Services (VAIS) for Full Dual Eligible Members**

To be finalized between HCA and MA Health Plan by December 31 each year for the following year. Thereafter MA Health Plan will notify HCA upon any changes to the Supplemental Benefits and VAIS. Services will be listed in the following format.

| Supplemental Benefit/VAIS Name | Description | Service Limits | Copay/Co-Insurance |
|---|---|---|---|
| *Example:* Transportation | One-way non-emergency trips to plan services | 100 one-way trips do not exceed 100 miles. Member must contact MA Health plan to arrange. | $0 |
| | | | |

**Exhibit 4**

**Summary of Supplemental Benefits and Value-Added Items and Services (VAIS) for Partial Dual Eligible Members**

To be finalized between HCA and MA Health Plan by December 31 each year for the following year. Thereafter MA Health Plan will notify HCA upon any changes to the Supplemental Benefits and VAIS. Services will be listed in the following format.

| Supplemental Benefit/VAIS Name | Description | Service Limits | Copay/Co-Insurance |
|---|---|---|---|
| *Example:* Transportation | One-way non-emergency trips to plan services | 100 one-way trips do not exceed 100 miles. Member must contact MA Health plan to arrange. | $0 |
| | | | |

**Exhibit 5**

**Summary of Behavioral Health Benefits Covered Under IMC Contract**

The following services are required by the Integrated Managed Care (IMC) contract with the HCA. The IMC Contractor is required to coordinate Members access to these services with the members identified Behavioral Health Services Organization (BHSO). Services may be found in the Integrated Managed Care found at https://www.hca.wa.gov/billers-providers-partners/programs-and-services/model-managed-care-contracts. Services include but are not limited to:

1. Behavioral health services as described in Section 13d, Rehabilitative Services, of the Medicaid State Plan
2. Inpatient Behavioral Health Services as defined by the Medicaid State Plan:
    a. Consultations with specialty providers, including psychiatric or psychology consultations, are covered during hospital stays.
    b. Inpatient professional mental health services associated with an AH-IMC behavioral health approved ITA or voluntary inpatient psychiatric admission.
    c. Inpatient psychiatric mental health services except when the Member is approved for placement in a state hospital.
    d. Covered services provided during an inpatient admission for medical detoxification services.
    e. Inpatient Withdrawal Management (substance acute withdrawal management) Services required for the care and/or treatment of individuals intoxicated or incapacitated by substances while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from substances. Services are provided in facilities with sixteen (16) beds or less and exclude room and board. Services include:
        i. Screening and acute withdrawal management; and
        ii. Counseling of persons admitted to a program within a certified Facility, regarding their illness in order to stimulate motivation to obtain further treatment and referral of detoxified persons with SUD to other appropriate substance use disorder treatment service providers.
    f. Inpatient/Residential Substance Abuse Treatment Services: Rehabilitative services including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward Members who are harmfully affected by the use of mood-altering substances or have been diagnosed with a SUD. Techniques have a goal of recovery for individuals with SUDs. Provided in certified residential treatment facilities with sixteen (16) beds or less. Excludes room and board.
    g. Court-ordered behavioral health Involuntary Treatment Act (ITA) commitment inpatient admission, except those identified as exclusions to the BHSO.
    a. IMD Services. Covered Services provided to Members who are primarily receiving short-term treatment and withdrawal management services for SUD in facilities that meet the definition of an IMD which are not otherwise matchable expenditures under Section 1903 of the Social Security Act. Excludes room and board.
3. Medication Assisted Treatment, including assessment, counseling, medical management, and prescribing to assist clients in treatment for SUD in a medical office setting.
4. MAT including medications prescribed or administered as part of a MAT protocol, except for methadone, when treatment is provided in.
    a. a SUD clinic setting.

5. Outpatient Behavioral Health Services as defined in the Medicaid State Plan:
    a. Brief Intervention Treatment.
    b. Day Support, including in a club house setting.
    c. Family Treatment.
    d. Freestanding Evaluation and Treatment.
    e. Mental Health Group Treatment Services.
    f. High Intensity Treatment.
    g. Individual Treatment Services.
    h. Intake Evaluation.
    i. Medication Management.
    j. Medication Monitoring.
    k. Mental Health Peer Support Services.
    l. Psychological Assessment.
    m. Rehabilitation Case Management.
    n. Residential Mental Health Services.
    o. Stabilization Services.
    p. Special Population Evaluation.
    q. Therapeutic Psychoeducation.
    r. Substance Use Disorder Case Management.
    s. Substance Use Disorder Outpatient Services.
    t. Opiate Substitution Treatment;
    u. Medication Assisted Treatment;
    v. Collaborative Care Services;
    w. The IMC Contractor shall ensure Medication Management is:
        i. Provided by the PCP; or
        ii. Provided in conjunction with a Mental Health
        iii. Professional or SUDP contracted with the IMC Contractor; or
        iv. Provided by an appropriate behavioral health specialist; and
        **v.** In accord with the requirements of pharmacists under RCW 69.41.190(3).
    **x.** Substance Use Disorder Peer Support Services.
6. Wraparound with Intensive Services (WISe) provides a combination of the services identified in the current Mental Health State Plan including evaluation and Provision of WISe services.

**Exhibit 6**

**Health Homes Program**

## 1. Health Home Definitions

1.1. "Area Agency on Aging (AAA)" means a network of state and local programs that help older people to plan and care for their lifelong needs.

1.2. "Behavioral Health Services" means services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.

1.3. "Care Coordinator (CC)" means an individual employed by the Lead organization or a CCO who provides Health Home Services.

1.4. "Care Coordination Organization (CCO)" means an organization within the Qualified Health Home network that is responsible for delivering Health Home services.

1.5. "Caregiver Activation Measure® (CAM®)" means an assessment that gauges the knowledge, skills, and confidence essential to a caregiver providing care for a person with chronic conditions.

1.6. "Comprehensive Assessment Report and Evaluation (CARE)" means a person- centered tool used by case managers to document a beneficiary's functional ability, determine eligibility for long-term care services, evaluate what and how much assistance a beneficiary will receive, and develop a plan of care, as defined in chapter 388-106 WAC.

1.7. "Department of Social and Health Services (DSHS)" means the Washington State Department of Social and Health Services.

1.8. "Eligibility" Means aa member who was engaged in the HCA HH program at the time HCA notifies the HH Lead the member enrolled in a DSNP and had an encounter within the 3 months prior to HCA notification of enrollment in the DSNP.

1.9. "Engagement" means the member's agreement to participate in Health Homes as demonstrated by the completion of the member's Health Action Plan and that the beneficiary had an encounter in the last 3 months.

1.10. "Hallmark Events" means elevated episodes of care that have potential to seriously affect the member's health or health outcomes.

1.11. "Health Action Plan (HAP)" means aa member-prioritized plan identifying what the member plans to do to improve his or her health and well-being.

1.12. "Health Home Care Coordinator" means an individual employed by a lead organization or a CCO who provides Health Home Services.

1.13. "Health Home Participation Authorization and Information Sharing Consent Form" means a release form signed by the member to confirm the Member's consent to participate in the Health Home program and to authorize the release of information to facilitate the sharing of the member's health

information.

1.14. "Health Home Services" means a group of six services defined under Section 2703 of the Affordable Care Act. The six Health Home Services are:

1.14.1. Comprehensive Care Management

1.14.2. Care Coordination and Health Promotion

1.14.3. Comprehensive transitional care from inpatient to other settings including appropriate follow-up.

1.14.4. Individual and Family Support

1.14.5. Referral to Community and Social Support Services

1.14.6. The use of Health Information Technology to link services, as appropriate.

1.15. "Katz Index of Independence in Activities of Daily Living (Katz ADL)" means a screening instrument used to assess basic activities of daily living in older adults in a variety of care settings.

1.16. "Long Term Services and Supports (LTSS)" means the variety of services and supports that help people with functional impairments meet their daily needs for assistance in community-based settings and improve the quality of their lives.

1.17. "Parent Patient Activation Measure® (PPAM®)" means an assessment that gauges the knowledge, skills, and confidence of the parent's management of their child's health.

1.18. "Patient Activation Measure® (PAM®)" means an assessment that gauges the knowledge, skills, and confidence essential to managing one's own health and health care.

1.19. "Patient Protection and Affordable Care Act" or "ACA" means Public Laws 111-148 and 111-152 (both enacted in March 2010).

1.20. "Qualified Health Home" means an entity qualified by the state to administer the Health Home program to eligible beneficiaries.

**2. Health Home Program for DSNP MA Health Members**

2.1. Health Home Services shall be community-based, integrated, and coordinated across medical, behavioral health, and long-term services and supports to members based on the services described in Section 1945(h)(4) of the Social Security Act.

2.2. The MA Health Plan shall ensure that the following are operational:

2.2.1. A system to track and share member information and care needs among providers, to monitor processes of care and outcomes, and to initiate recommended changes in care as necessary to support health action goals, including the member's preferences and identified needs;

2.2.2. A system to track Health Home Services through claims paid or services rendered and report the utilization data;

**3. Health Homes Eligibility and Enrollment**

3.1. HCA shall communicate a care coordination file and identify members who are potentially eligible for the MA Health Plan's DSNP Health Home program.

3.1.1. HCA identifies Health Home (HH) beneficiaries that have enrolled in DSNP and notifies HH Lead and MA Health Plan which MA Health Plan the beneficiary enrolled with. MA Health Plan receives list of beneficiaries who have enrolled in DSNP and which HH lead the beneficiary is assigned to.

3.1.1.1. FilesFiles will be sent monthly in a non-standard file format and will be delivered via Secure File Transfer (SFT).

3.1.1.2. MA Health Plan and leads will establish a communication process to determine which beneficiaries are engaged in HH services at the time of enrollment in the MA Health Plan.

3.2. MA Health Plan 834 file will include a HH "Y" indicator.

3.2.1. The MA Health Plan will use the 270/271 to identify which Lead members who are eligible for HHs are active with (HH Y indicator and Lead is included in the response file).

3.2.2. The MA Health Plan will contact the Lead to determine which members are engaged.

3.3. The MA Health Plan shall ensure Health Home members continue to be assigned a Health Home Care Coordinator through a Qualified Health Home.

3.4. Members who have agreed to participate may disenroll from the Health Home program at any time. The MA Health Plan shall maintain a record of all members who choose to disenroll from the Health Home program and the reason why.

3.5. The MA plan may re-enroll the beneficiary in services if the member requests it, and the plan determines it is the most appropriate service. The MA Health Plan shall provide HH services to engaged members but may choose to provide Health Homes program to individuals that do not meet the required criteria of engagement prior to enrollment in the MA Health Plan.

**4. Assignment**

4.1. The MA Health Plan shall ensure the Health Home eligible member is assigned to the same Health Home Lead (including community-based lead) and CCO as they were prior to enrollment within thirty (30) calendar days of initial date of Health Home identification and enrollment. If the CCO is not contracted with the community-based lead, then the lead may reassign the beneficiary/member to another CCO within their network.

4.1.1. Lead assignment should ensure continuity of the Care Coordinator for the member and reduce administrative burden.

4.1.2. MA Health Plan shall assign to a community-based lead:

4.1.2.1. If the member was served by a community-based lead in the Medicaid program,

4.1.2.2. If the member is transitioning from a non-aligned Medicaid plan and assignment to a community-based lead will create continuity for the beneficiary and Care Coordinator.

4.2. MA Health Plan shall assign to an internal lead:

4.2.1. If the member was served by a managed care lead in the Medicaid program.

4.2.2. If the member is transitioning from a non-aligned Medicaid plan and assignment to an internal lead will create continuity for the beneficiary and Care Coordinator

4.2.3. If at any time the Health Homes engaged MA Health Plan member changes MA Health Plan enrollment to another plan, the beneficiary's Health Home services will continue with the assigned lead and CCO.

**5. Health Action Plan (HAP)**

5.1. The MA Health Plan shall ensure the Health Home Lead follows Medicaid policy to develop member HAPs:

5.2. The Health Home Care Coordinator shall meet with the member in person to complete the HAP including the following:

5.2.1. The Health Home Care Coordinator meets in-person with each member at the member's choice of location;

5.2.2. The Health Home Participation Authorization and Information Sharing Consent form is reviewed and completed;

5.2.3. The Care Coordinator evaluates the member's support system;

5.2.4. The Care Coordinator explains, develops, and completes the HAP with input from the member and/or the member's caregiver(s);

5.2.5. The HAP documents the member's diagnosis, long-term goals, short-term goals, and related action steps to achieve those goals identifying the individual responsible to complete the action steps;

5.2.6. The HAP includes the required BMI, Katz ADL, PSC-17, and PHQ-9 screening scores;

5.2.7. The HAP includes the required Patient Activation Measure (PAM®), or Patient Parent Activation Measure (PPAM®), or Caregiver Activation Measure (CAM®) activation level and screening score;

5.2.8. The Health Home Care Coordinator also documents in the HAP all other screenings administered when medically indicated; and

5.2.9. The HAP includes the reason the member declined assessment or screening tools.

5.2.10. HAPs must be reviewed and updated by the Health Home Care Coordinator at a minimum:

5.2.10.1. After every four (4) month activity period to update the PAM®, PPAM®, or CAM®;

BMI; Katz ADL; PSC-17 and PHQ-9 screening scores and reassess the member's progress towards meeting self-identified health action goals, add new goals or change in current goals; and

5.2.10.2. Whenever there is a change in the member's health status or a change in the member's needs or preferences.

5.2.11. A completed and updated HAP with the member's goals and action steps must be provided to the member and with the member's consent shared with the member's caregiver and family in a format that is easily understood. Any additional information shall be included as an addendum to the HAP.

5.2.12. Additional information not included in the State-developed HAP form must be included as an addendum.

5.2.13. Written information in the HAP must use language that is understandable to the member and/or the member's caregiver(s).

5.2.14. With Member's consent, completed and updated HAPs must be shared with other individuals identified and authorized by the member on the signed Health Home Participation Authorization and Information Sharing Consent form.

5.2.15. The Health Home Care Coordinator shall meet with the member in-person to complete the HAP, including the following:

5.2.15.1. Explain the HAP and the development process to the member;

5.2.15.2. Complete a Health Home Participation Authorization and Information Sharing Consent form;

5.2.15.3. Evaluate the member's support system; and

5.2.15.4. Administer and score either the PAM®, PPAM® or CAM®.

5.2.16. The Health Home Care Coordinator uses the PAM®; PPAM®; or CAM® to:

5.2.16.1. Measure activation and behaviors that underlie activation including ability to self-manage, collaborate with providers, maintain function, prevent declines, and access appropriate and high-quality health care;

5.2.16.2. Target tools and resources commensurate with the member's level of activation;

5.2.16.3. Provide insight into how to reduce unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health;

5.2.16.4. Document health care problems through the combined review of medical records, PRISM, and face-to-face visits with the member; and

5.2.16.5. As indicated by clinical judgment, complete HCA-approved screening tools for behavioral health conditions, if not already obtained from other sources.

**6. Health Home Key Services**

6.1. The following services are delivered by the HH Lead to HH enrolled beneficiaries based on needs and preferences identified in the HAP.

**6.2. Comprehensive Care Management Services**

6.2.1. Health Home Care Coordinators deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include state approved screens and development of a person-centered Health Action Plan (HAP). Care Coordinators provide continuity and coordination of care through face-to-face visits and telephonic support, assess beneficiary readiness for self-management, and promote self-management skills so the beneficiary is better able to engage with health and service providers. By working with beneficiaries, Care Coordinators support the achievement of self-directed, person-centered health goals designed to attain recovery, improve functional or health status, or prevent or slow declines in functioning.

**6.3. Care coordination**

6.3.1. The Care Coordinator plays a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. Care Coordinators have the ability to accompany beneficiaries to health care appointments as needed. The Care Coordinator fosters communication between care providers including primary care providers, medical specialists, and entities authorizing behavioral health and Long-Term Services and Supports (LTSS). Care coordination bridges all the beneficiary's systems of care, including non-clinical support.

6.3.2. Care coordination shall provide informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors that impact a beneficiary's health and health care choices. Joint office visits by the beneficiary and the Care Coordinator with health care providers offer opportunities for mentoring and modeling communication with providers. Care Coordinators may establish multidisciplinary care teams or participate on an existing team. Their participation aids to better coordinate services, identify and address gaps in care, and ensure cross-systems coordination to ensure continuity of care.

**6.4. Health Promotion**

6.4.1. Health promotion includes education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes. The Care Coordinator uses the beneficiary's activation score and level to determine the coaching methodology for each beneficiary to develop a teaching and support plan. Educational materials are customized and introduced according to the beneficiary's readiness for change and progress with a beneficiary's level of confidence and self-management abilities. The Health Home will provide wellness and prevention education specific to the beneficiary's chronic conditions and HAP. Health promotion and education includes assessment of need, facilitation of routine and preventive care, support for improving social connections to community networks, and linking beneficiaries with resources that support a health promoting lifestyle. Health promotion and education may also occur with parents, family members, caregivers, legal representatives, and other collaterals to support the beneficiary in achieving improved health outcomes.

**6.5. Transitional Care**

**6.5.1.** Comprehensive transitional care is provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment, or residential habilitation setting) and to ensure proper and timely follow-up care.

**6.5.2.** Transitional care planning includes:

**6.5.2.1.** A notification system with managed care plans, hospitals, nursing facilities, and residential/rehabilitation facilities to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient facility, skilled nursing or residential/rehabilitation facility, and with proper, permissions, a substance use disorder treatment setting. Progress notes or a case file will document the notification. The HAP is updated as a part of transition planning.

**6.5.2.2.** Active participation of the Care Coordinator in appropriate phases of care transition including discharge planning visits during hospitalizations or nursing facility stays, post discharge face-to-face visits, medication reconciliation, and telephone calls.

**6.5.2.3.** Beneficiary education to support discharge care needs including medication management, follow-up care, and self-management of chronic or acute conditions. Information on when to seek medical care and emergency care is also provided. Involvement of formal or informal caregivers is facilitated when requested by the beneficiary.

**6.5.2.4.** A systematic follow-up protocol to assure timely access to follow-up care post discharge.

### 6.6. Individual and family support

6.6.1. The Care Coordinator recognizes the unique role the beneficiary may give family members, identified decision makers, and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

6.6.2. The Care Coordinator will:

6.6.3. Identify the role that parents, family members, informal supports, and paid caregivers provide to the beneficiary to achieve self-management and optimal levels of physical and cognitive function;

6.6.4. educate and support self-management, self-help, and recovery by accessing other resources necessary for the beneficiary, their family, and their caregivers;

6.6.5. discuss advance care planning with beneficiaries and their families within the first year of participation;

6.6.6. communicate and share information with beneficiaries, their families, and their caregivers with appropriate consideration of language, activation level, literacy, and cultural preferences.

### 6.7. Referral to community and social support services

6.7.1. The Care Coordinator identifies available community-based resources and actively manages referrals. They assist the beneficiary in advocating for access to care and promote engagement with community and social support related to goal achievement documented in the HAP. When needed and not provided through other case management systems, the Care Coordinator provides assistance to obtain and maintain eligibility for health care services, Medicaid, disability benefits, housing, personal needs, and legal services. These services are coordinated with appropriate departments of local, state, and federal governments, and community-based organizations. Referral to community and social support services includes LTSS, mental health, substance use disorder, and other community and social service support providers needed to support the beneficiary in achieving health action goals.

**7. Compensation and Payment**

7.1. Payments to the contracted lead organizations are made in three Rate Tiers as follows:

7.1.1. Tier 1: Outreach, Engagement, and HAP Development includes:

7.1.1.1. Outreach by mail; phone; or other methods, continues until the eligible Beneficiary agrees to participate or declines participation in the Health Home program. Lead must document all attempts to contact Beneficiary.

7.1.1.2. Engagement occurs when the Beneficiary agrees to a face-to-face visit between the Beneficiary and the Health Home Care Coordinator in a location of the Beneficiary's choosing, such as their home or provider's office.

7.1.1.3. HAP Development includes face-to-face visits to complete the initial HAP, the Health Home Participation Authorization, and Information Sharing Consent form, and coaching to assist the Beneficiary in identifying short and long-term goals and associated action steps.

7.1.1.4. The MA Health Plan will pay $884.8989 for Outreach, Engagement, and HAP Development once in a lifetime per Beneficiary.

7.1.2. Tier 2: Intensive Health Home Care Coordination: This is the highest level of Health Home Care Coordination services using one (1) or more elements of the six defined Health Home Services.

7.1.3. Intensive Health Home Care Coordination includes evidence that the Care Coordinator, the Beneficiary, and the Beneficiary's caregivers are:

7.1.3.1. Actively engaged in achieving health action goals,

7.1.3.2. Participating in activities that support improved health and well-being; and

7.1.3.3. Have value for the Beneficiary and caregivers, supporting an active level of care coordination through the delivery of the Health Home Services.

7.1.4. Typically, intensive Health Home Care Coordination includes a face-to-face visit with the Beneficiary every month in which a Qualified Health Home Service is provided. Exceptions to the monthly face-to-face visit may be approved by the MA Health Plan as long the Health Home Services provided during the month achieve one or more of the following:

7.1.4.1. Clinical, functional, and resource use screens, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual;

7.1.4.2. Continuity and coordination of care through in-person visits, and the ability to accompany Beneficiaries to health care provider appointments, as needed; 4.4.5.4.3 Beneficiary assessments to determine readiness for self-management and to promote self-management skills to improve functional or health status, or prevent or slow declines in functioning;

7.1.4.3. Fostering communication between the providers of care, including the treating primary care provider, medical specialists, personal care providers, and others; and entities authorizing behavioral health and long-term services and supports;

7.1.4.4. Promoting optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the HAP;

7.1.4.5. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes;

7.1.4.6. Use of peer supports, support groups, and self-care programs to increase the Beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment; and

7.1.4.7. The MA Health Plan will pay $248.68 per Beneficiary per month for intensive Health Home Care Coordination.

7.1.4.8. By March 1, 2024, The Contractor will evaluate 2023 Tier 2 billing data to determine impacts on administrative costs with a focus on increasing the rates to pay FFS rates effective 7/1/2024. The Contractor will provide the results of their evaluation to HCA by May 1, 2024, with a statement of their implementation activities.

7.1.5. Tier 3: Low-Level Health Home Care Coordination: Low-level Health Home Care Coordination occurs when the Beneficiary and Health Home Care Coordinator identify that the Beneficiary has achieved a sustainable level of progress toward meeting self-directed goals or upon the Beneficiary's request.

7.1.5.1. Low-Level Health Home Care Coordination includes monitoring the Beneficiary's health care needs and progress toward meeting self-directed goals using one (1) or more of the six defined Health Home Services.

7.1.5.2. At least one (1) Qualified Health Home Service must be delivered during the month through face-to-face visits or telephone calls prior to submitting a claim for low-level Health Home Care Coordination.

7.1.5.3. The MA Health Plan will pay $204.29 per Beneficiary per month for Low-level Health Home Care Coordination.

7.1.6. The Contractor shall pay the Indian Health Services Tribal Encounter Rate for each qualifying event. The Encounter Rate is determined annually by the Indian Health Services. Paid encounters will be adjusted to reflect the IHS rate for the beginning of the calendar year.

7.1.7. Payment to Subcontracted Care Coordination Organizations (CCOs): The Lead may retain up to a maximum of 10% from each rate tier listed above for administrative costs.

**Attachment 1**

**Data Security Requirements**

## 1. Definitions

In addition to the definitions set out in section 1, *Definitions*, of the SMAC, the definitions below apply to this Attachment.

a. "Hardened Password" means a string of characters containing at least three of the following character classes: upper case letters; lower case letters; numerals; and special characters, such as an asterisk, ampersand, or exclamation point.

   i. Passwords for external authentication must be a minimum of 10 characters long.

   ii. Passwords for internal authentication must be a minimum of 8 characters long.

   iii. Passwords used for system service or service accounts must be a minimum of 20 characters long.

b. "Portable/Removable Media" means any data storage device that can be detached or removed from a computer and transported, including but not limited to optical media (e.g. CDs, DVDs); USB drives; or flash media (e.g. CompactFlash, SD, MMC).

c. "Portable/Removable Devices" means any small computing device that can be transported, including but not limited to: handhelds/PDAs/Smartphones; Ultramobile PCs, flash memory devices (e.g. USB flash drives, personal media players); and laptop/notebook/tablet computers. If used to store Confidential Information, devices should be Federal Information Processing Standards (FIPS) Level 2 compliant (FIPS 140-2).

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

e. "Transmitting" means the transferring of data electronically, such as via email, SFTP, web services, AWS Snowball, etc.

f. "Trusted System(s)" means the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with a written acknowledgment of receipt; (2) United States Postal Service ("USPS") first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail, or Registered Mail; (3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.

g. "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.

## 2. Data Transmission

a. When transmitting HCA's Confidential Information electronically, including via email, the Data must be encrypted using NIST 800-series approved algorithms (http://csrc.nist.gov/publications/PubsSPs.html). This includes transmission over the public internet.

b. When transmitting HCA's Confidential Information via paper documents, the Receiving Party must use a Trusted System.

**3. Protection of Data**

The Receiving Party agrees to store and protect Confidential Information as described:

a. Data at Rest:

i. Data will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data. Access to the Data will be restricted to Authorized Users through the use of access control lists, a Unique User ID, and a Hardened Password, or other authentication mechanisms that provide equal or greater security, such as biometrics or smart cards. Systems that contain or provide access to Confidential Information must be located in an area that is accessible only to authorized personnel, with access controlled through the use of a key, card key, combination lock, or comparable mechanism.

ii. Data stored on Portable/Removable Media or Devices:

A. Confidential Information provided by HCA on Removable Media will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the Data.

B. HCA's data must not be stored by the Receiving Party on Portable Devices or Media unless specifically authorized within the SMAC. If so authorized, the Receiving Party must protect the Data by:

1. Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;
2. Control access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics; 1010
3. Keeping devices in locked storage when not in use;
4. Using check-in/check-out procedures when devices are shared;
5. Maintain an inventory of devices; and
6. Ensure that when being transported outside of a Secured Area, all devices with Data are under the physical control of an Authorized User.

b. **Paper documents.** Any paper records containing Confidential Information must be protected by storing the records in a Secured Area that is accessible only to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

**4. Data Segregation**

HCA's Data received under this SMAC must be segregated or otherwise distinguishable from non-HCA Data. This is to ensure that when no longer needed by the Receiving Party, all of HCA's Data can be identified for return or destruction. It also aids in determining whether HCA's Data has or may have been compromised in the event of a security breach.

a. HCA's Data must be kept in one of the following ways:

i. on media (e.g., hard disk, optical disc, tape, etc.) which will contain only HCA Data; or

ii. In a logical container on electronic media, such as a partition or folder dedicated to HCA's Data; or

iii. In a database that will contain only HCA Data; or

iv. within a database and will be distinguishable from non-HCA Data by the value of a specific field or fields within database records; or

v. When stored as physical paper documents, physically segregated from non-HCA Data in a drawer, folder, or other container.

b. When it is not feasible or practical to segregate HCA's Data from non-HCA data, then both HCA's Data and the non-HCA data with which it is commingled must be protected as described in this Attachment.

**5. Data Disposition**

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

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