

HCA Contract #K-1807

ADMINISTRATIVE & HEALTH TRANSFORMATION SERVICES CONTRACT

between

REGENCE BLUESHIELD

and

THE STATE OF WASHINGTON HEALTH CARE AUTHORITY

The terms and conditions of this Contract, including all exhibits, attachments, and schedules incorporated herein, are an integration and representation of the final, entire, and exclusive understanding between the parties, superseding and merging all previous agreements, writings, and communications, oral or otherwise, regarding the subject matter of this Contract. HCA's RFP No. 1807, including any and all amendments, and Contractor's Proposal to RFP No. 1807 are an integral part of this contract and are considered to be part of this final Contract. By signing this Contract, the parties warrant they have read and understand this Contract, and have the authority to execute this Contract on behalf of Contractor or HCA, respectively. This Contract shall be binding on HCA only upon signature by an authorized HCA representative.

Table of Contents

SECTION 1.	OVERVIEW.....	9
SECTION 2.	HCA RESPONSIBILITIES	9
2.1	Responsibility	9
2.2	Information.....	10
2.3	Eligibility Information.....	10
2.4	Procedures for Applying for UMP Plan Benefits.....	10
2.5	Member Communications.....	10
2.6	Value Based Payment Initiatives.....	10
2.7	Payment of Administrative & Implementation Charges.....	10
2.8	Funding Claims.....	11
2.9	HCA Senior Account Sponsor for UMP	11
2.10	Operations Manual	11
SECTION 3.	ADMINISTRATIVE SERVICES FOR UMP PLANS.....	11
3.1.	In General.....	11
3.1.1.	Services and Payment	11
3.1.2.	Representations	12
3.1.3.	Customer Satisfaction	12
3.1.4.	Washington Health Alliance and HCA Data Partners	12
3.1.5.	Health Technology Clinical Committee	12
3.1.6.	Notice of Change in Control	14
3.1.7.	Subcontracting	14
3.1.8.	Operations Manual	15
3.1.9.	Reporting Manual	15
3.1.10.	Deliverable Review & Acceptance	15
3.1.11.	Changes in UMP Benefits	15
3.1.12.	Changes in Laws, Rules, or Regulations	16
3.2.	Claims Services	16
3.2.1.	General.....	16
3.2.2.	Coordination of Benefits	19
3.2.3.	Claims Payments for Washington and Out-of-State Networks	20
3.2.4.	Erroneous Payments & Misquotes.....	20
3.2.5.	Fraud, Waste, and Abuse Detection & Prevention.....	21
3.2.6.	Provider & Claims Information Resource	22
3.2.7.	Subrogation	22
3.3.	Clinical Management	22
3.3.1.	Scope	23
3.3.2.	Administration of Clinical Management.....	24
3.3.3.	Clinical Programs	24
3.4.	Utilization Management	25
3.4.1.	Functions.....	26
3.4.2.	Administration.....	26
3.5.	Quality Management and Improvement	27
3.5.1.	Functions	27
3.5.2.	Administration.....	27
3.6.	Complex Case Management.....	28
3.6.1.	Functions	28
3.6.2.	Administration.....	29
3.7.	Chronic Condition Management.....	30
3.7.1.	Functions	30
3.7.2.	Administration.....	31
3.8.	HCA Clinical and Medical Policies	31
3.9.	Innovations in Clinical Management.....	33
3.9.1.	Contractor Requirements	33
3.10.	Medical Benefit Drug Management Program	33

3.10.1.	Functions.....	33
3.10.2.	Coordination with UMP Pharmacy Benefit Manager.....	35
3.10.3.	Preferred Drug List.....	35
3.10.4.	Plan Design.....	36
3.10.5.	Medical Drug Rebates.....	36
3.10.6.	Audit.....	36
3.11.	Disabled Dependent Certification.....	36
3.12.	Appeals and Complaints.....	39
3.12.1.	Requirements: All Level Appeals.....	39
3.12.2.	Requirements: Second Level Appeals, and Requests for Independent Review.....	39
3.12.3.	Expedited Appeals and IROs.....	40
3.12.4.	Member Materials.....	40
3.12.5.	Complaint Response.....	40
3.13.	Account Management.....	41
3.13.1.	General.....	41
3.13.2.	Account Management Functions.....	41
3.13.3.	Account Management Staffing Levels.....	43
3.13.4.	Strategic Account Managers.....	44
3.13.5.	Daily Operations Managers.....	45
3.13.6.	ACN Account Manager.....	45
3.13.7.	Clinical Programs Managers.....	45
3.13.8.	Medical Director (MD or DO).....	46
3.13.9.	Data Analyst.....	46
3.13.10.	ACN Data Reporting Product Manager.....	47
3.13.11.	Communications Specialist.....	47
3.13.12.	Implementation Management.....	48
3.13.13.	Clinical Analyst.....	49
3.13.14.	Pharmacist (as needed).....	49
3.13.15.	Account Contact (as needed).....	49
3.13.16.	Legal Contact (as needed).....	49
3.13.17.	Legislative Support Services.....	50
3.13.18.	Account Management for Public Relations.....	50
3.13.19.	Emergency Response Account Management.....	50
3.14.	Member and Customer Services.....	50
3.14.1.	General.....	50
3.14.2.	Services.....	51
3.15.	Enrollee Communications.....	52
3.15.1.	General.....	52
3.15.2.	Services.....	52
3.15.3.	Administration.....	54
3.16.	Online Services.....	54
3.16.1.	General Requirements.....	54
3.16.2.	Standards.....	54
3.16.3.	Non-Secure Access.....	55
3.16.4.	Secure Access.....	56
3.17.	Data, Systems, and Reporting.....	57
3.17.1.	General.....	57
3.17.2.	File Transfer and Access Requirements.....	57
3.17.3.	Contractor Generated Identification Numbers.....	58
3.17.4.	HCA Generated Identification Numbers.....	59
3.17.5.	Eligibility Files.....	59
3.17.6.	Eligibility Files and Matches.....	59
3.17.7.	Reports.....	60
3.18.	Conversion Offering.....	64
3.19.	Implementation.....	65
3.19.1.	Implementation in General.....	65
3.19.2.	Eligibility Files.....	65

3.19.3.	Implementation Plan.....	65
3.19.4.	Additional Implementation Costs.....	65
SECTION 4.	UMP CDHP WITH HSA	65
4.1.	Responsibilities of Contractor	65
4.2.	Responsibilities of Contractor for Services Performed by HSA Trustee	66
4.2.1.	Account Administration.....	66
4.2.2.	Fulfillment	67
4.2.3.	Customer Service.....	67
4.2.4.	Employer & HCA Support.....	67
4.2.5.	Custom Website/Online account.....	68
4.3.	Responsibilities of HCA	68
SECTION 5.	UMP PLUS ADMINISTRATIVE SERVICES.....	69
5.1.	Benefits Administration	69
5.2.	Communications	69
5.3.	Network Administration	71
5.4.	Data and Reporting.....	71
5.5.	Operational Requirements.....	73
SECTION 6.	PERFORMANCE STANDARDS AND GUARANTEES.....	74
6.1.	General.....	74
6.1.1.	Definitions.....	75
6.2.	Guarantees.....	75
6.2.1.	Implementation Services Performance Guarantees (One time)	76
6.2.2.	Ongoing Core Measure Performance Guarantees	77
6.2.3.	Appeals & Complaints Performance Guarantees	80
6.2.4.	Reporting Performance Guarantees	81
6.2.5.	Overall Trend Performance Guarantees	82
6.2.6.	Account Management Satisfaction Performance Guarantees.....	83
6.2.7.	Value-Based Performance Guarantee	84
6.2.8.	Clinical Outcomes Measures Performance Guarantee.....	86
6.3.	Measurement of Performance Standards.....	89
6.3.1.	Timeliness	89
6.3.2.	Audit of Performance Guarantees.....	89
6.4.	Mechanism of Adjustment.....	90
6.5.	Failures Caused by HCA	90
6.6.	Waiver	90
6.7.	Transition of Performance Measures	90
SECTION 7.	PROVIDER NETWORK.....	90
7.1.	Contractor Functions	91
7.2.	General Network Requirements.....	92
7.2.1.	Washington State Network Adequacy.....	92
7.2.2.	Contractor Network Adequacy Standards.....	94
7.2.3.	Additional Contractor Network Responsibilities	94
7.3.	Washington State Provider Network	95
7.4.	Out-of-State Provider Network	95
7.5.	BlueCard.....	95
7.5.1.	BlueCard Disclosure.....	96
7.5.2.	Definitions.....	96
7.5.3.	BlueCard® Program	97
7.5.4.	Value-Based Programs	98
7.5.5.	Return of Overpayments.....	100
SECTION 8.	STRATEGIC PARTNERING ON HEALTH TRANSFORMATION.....	101
8.1.	Innovative Leadership & Administrative Support.....	101

8.2.	Paying for Value through Value Based Payments and Alternative Payment Models	102
8.3.	Contractor ACO	103
8.4.	Member Engagement & Experience	104
8.4.1.	Shared Decision Making	104
8.4.2.	Member Website	104
8.4.3.	Multichannel Communications, Tool, & Resources	105
8.4.4.	Tools and Resources for Self-Management & Health Literacy	106
8.5.	Customized Reports & Data Analytics	106
8.6.	Multi-Stakeholder Quality Improvement & Transparency Initiatives	107
8.6.1.	Washington Health Alliance (WHA)	107
8.6.2.	Bree Collaborative	107
8.6.3.	Accountable Communities of Health (ACHs)	107
8.6.4.	Hutchinson Institute for Cancer Outcomes Research (HICOR)	108
8.6.5.	National Business on Health e-Value8™ Initiative	108
8.6.6.	Practice Transformation Support Hub	108
8.6.7.	Improving Prior Authorization	108
8.6.8.	Transparency Initiative Participation	108
SECTION 9.	WORK ORDERS	109
9.1.	Work Order Process	109
9.1.1.	UMP Contract Manager	109
9.1.2.	Contents of Work Order	109
9.1.3.	Contractor's Response	110
9.1.4.	HCA's Response	110
9.1.5.	Monitoring of Work Orders	110
9.1.6.	Completion	110
9.1.7.	Implement Health Technology Clinical Committee (HTCC) Determinations	110
9.1.8.	Other Legal Mandates	111
9.2.	Charges for Work Orders	111
9.2.1.	General Billing	111
9.2.2.	Work with No Extra Charge	111
SECTION 10.	REQUESTS FOR RENEWAL	112
SECTION 11.	BUSINESS ASSOCIATE	112
SECTION 12.	GENERAL TERMS AND CONDITIONS	112
12.1.	Indemnification and Hold Harmless	112
12.1.1.	General	112
12.1.2.	Industrial Insurance Waiver	112
12.1.3.	HCA Indemnity	112
12.2.	Assistance in Legal Actions	113
12.3.	Attorneys' Fees	113
12.4.	Audits	113
12.5.	Assignment	113
12.6.	Relationship to Blue Cross and Blue Shield Association	114
12.7.	Taxes	114
12.8.	Independent Contractor	114
12.9.	Modification of Contract	114
12.9.1.	General	114
12.9.2.	Notice of Plan Changes	114
12.9.3.	Changes in Plans	114
12.10.	Termination	115
12.10.1.	Termination by HCA	115
12.10.2.	Termination by Contractor	116
12.10.3.	Termination Procedure	116
12.10.4.	Termination of UMP CDHP with a Health Savings Account	116

12.10.5. Termination of UMP Plus or an ACN	116
12.11. Services after Termination	117
12.11.1. General.....	117
12.11.2. Ad Hoc Reporting	117
12.11.3. Secondary Medicare	117
12.11.4. Claims Adjudication.....	117
12.11.5. Transition of Services.....	117
12.11.6. Eligibility Updates	118
12.11.7. Appeals & IROs.....	118
12.11.8. Online Accounts	118
12.11.9. Case Management Enrollees.....	118
12.11.10. Customer Service	118
12.11.11. Provider Search Tool.....	118
12.11.12. Hearing & Vision Hardware	118
12.11.13. Subrogation	119
12.11.14. OneHealthPort Access	119
12.11.15. Form 1099s.....	119
12.11.16. Data & Reports	119
12.12. Severability	119
12.13. Data of UMP	119
12.14. Offshoring.....	120
12.15. Advance Payments Prohibited.....	120
12.16. Communication with UMP Enrollees	121
12.17. Disputes	121
12.17.1. Timing.....	121
12.17.2. Dispute Conference Request	121
12.17.3. Response	121
12.17.4. Action.....	121
12.17.5. Prerequisite	122
12.17.6. Continuation	122
12.18. Right of Inspection	122
12.19. Confidentiality	122
12.19.1. Confidentiality Standards	122
12.19.2. Uses of Personal Information.....	122
12.19.3. Permitted Disclosures	123
12.19.4. Responsibility for Violations	123
12.19.5. Procedures	123
12.19.6. Security Breach	123
12.19.7. "Personal Information".....	124
12.19.8. Confidentiality Audit.....	124
12.20. Funding or Legal Authority Limitations	124
12.21. Licensing, Accreditation, and Registration	125
12.22. Insurance Coverage	125
12.22.1. Liability Insurance.....	125
12.22.2. Employers Liability ("Stop Gap") Insurance	125
12.22.3. Additional Provisions	126
12.22.4. Worker's Compensation Coverage	126
12.23. Covenant Against Contingent Fees.....	127
12.24. Compliance with Applicable Law.....	127
12.25. Nondiscrimination	127
12.26. Pay Equity	128
12.27. Force Majeure	128
12.28. Waiver	129
12.29. No Third-Party Beneficiaries	129
12.30. Governing Law; Venue	129

12.31.	Survival.....	129
12.32.	Antitrust Assignment.....	129
12.33.	Intellectual Property Ownership	129
	12.33.1. Customized Material Ownership	129
	12.33.2. Non-Customized Material Ownership	130
	12.33.3. Deliverables Ownership	130
	12.33.4. License	130
	12.33.5. Notice to HCA.....	130
12.34.	Public Records Act	130
12.35.	Contingencies.....	131
	12.35.1. Legal Actions and Procedural Challenges	131
	12.35.2. Assignable Contracts	131
12.36.	Debarment and Suspension.....	131
12.37.	Construction	131
12.38.	Order of Precedence	132
SECTION 13.	DEFINITIONS	133
Exhibit A	Administrative Fees	144
Exhibit B	ERB HIPAA 834 Eligibility File Format.....	151
Exhibit C-1	Enrollment Full File Layout Required Match.....	152
Exhibit C-2	Completion Dates for Quarterly Eligibility Reconciliation.....	153
Exhibit D	Washington Provider Network Adequacy Standards	154
Exhibit E-1	Unit Cost Margin Guarantee and Utilization Trend Margin Guarantee Rates –	156
PEBB		
Exhibit E-2	Unit Cost Margin and Utilization Trend Margin Performance Guarantee	160
Exhibit E-3	Medicare Lite	165
Exhibit F-1	Operations Manual.....	166
Exhibit F-2	Reporting Manual.....	167
Exhibit G-1	Business Associate Agreement.....	168
Exhibit G-2	Data Share Agreement.....	176
Exhibit H	Business Interruption and Disaster Management Plan	191
Exhibit I	HCA Request for Proposals No. K1807	192
Exhibit J	Contractor Response to RFP No. K1807	193
Exhibit K	OCIO Policies	194
Exhibit L	Implementation Plan	195
Exhibit M	Paying for Value Survey	196
Exhibit N	Adding & Removing ACN Providers	197
Exhibit O	Out-of-Network Provider Consent Process.....	198
Exhibit P	Provider Search Project Plan	199
Exhibit Q	Application of Pooled Hour Examples.....	201
Exhibit R	ACN Reports.....	203
Exhibit S	Standard Programs.....	206

ADMINISTRATIVE & HEALTH TRANSFORMATION SERVICES AGREEMENT

This Administrative & Health Transformation Services Contract (the Contract) is made and entered into by and between the Washington State Health Care Authority (HCA), an agency of the state of Washington, and Regence BlueShield (Contractor), a [state] [corporation/limited liability company/partnership/etc.] with its principal place of business located at [address]. Together, HCA and Contractor are referred to as “the parties.”

WHEREAS, on November 21, 2016, HCA issued Request for Proposals #K1807 (the RFP) for the purposes of obtaining services for the administration of health plans offered to certain employees of state and local government entities, and to assist HCA in its efforts to transform the delivery of health care in the state of Washington.

WHEREAS, on or around April 20, 2017, Contractor submitted to HCA its written response to the RFP, as subsequently supplemented (the Proposal), and represented to HCA that it had the services, skills and personnel required to meet the requirements of, and perform the services identified in, the RFP, all upon the terms and conditions set forth herein.

WHEREAS, in reliance on the representations made by Contractor in the Proposal and subsequent discussions, presentations, and commitments and assurances made by Contractor, and in compliance with Washington state laws and regulations, HCA selected Contractor over other prospective service providers to perform the services described in the RFP.

WHEREAS, HCA and Contractor want to specify the terms and conditions under which Contractor will provide services to HCA.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree to the foregoing and as follows:

SECTION 1. OVERVIEW

1.1 Purpose & Scope

The purpose of this Contract is to establish Contractor as the Third Party Administrator for HCA's Uniform Medical Plans (UMP) to include UMP Classic, UMP CDHP and UMP Plus. The following categories of services that Contractor will provide to HCA are:

- A. Administrative Services, including Clinical Management Services. Services will include implementation of HCA clinical and coverage policies, adjudication of worldwide Claims, Quality Management and Quality Improvement, Clinical Management, Member services, development and maintenance of a statewide and national provider network, account management, and online tools and services. All Standard Programs will be provided to the UMP Plans within the then current Administrative Fee. HCA will specify risk pools within the UMP Plans.
- B. Health Transformation strategy services. Services will include assistance with development of health transformation strategies related to UMP Plans in alignment with Healthier Washington initiatives, including offering an Accountable Care Organization (ACO) commercial product within individual markets and Contractor's Book-of-Business that includes key components of HCA's Accountable Care Networks (ACNs). Contractor will support HCA with the development and implementation of health transformation strategies related to UMP Plans, as well as enhance and/or change its own business practices and payment strategies to accelerate health transformation.

1.2 Term

This Contract is effective on the last date both parties have signed it (Effective Date) and will remain in effect through December 31, 2029 (Initial Term), unless terminated earlier or extended as provided below. Except as noted below, Contractor will begin providing administrative services under this Contract on January 1, 2020. After the Initial Term, this Contract may be extended, by mutual agreement of both parties, in increments of not less than one (1) year, for a maximum period not exceeding seven (7) additional years (each such extension a Renewal Term), unless either party terminates this Contract earlier. The Initial Term together with any and all Renewal Terms is referred to herein as the Term. Any increase in Administrative Fees prior to the start of a Renewal Term may not exceed maximum annual increases set forth in Exhibit A.

SECTION 2. HCA RESPONSIBILITIES

2.1 Responsibility

HCA, as the State's sponsor of the Public Employees Benefits Board (PEBB) program and the School Employees Benefits Board (SEBB) program, retains final authority and responsibility for the UMP Plans and their management. HCA is responsible for defining eligibility and coverage requirements, and will fund all benefits for Claims incurred during the Term of this Contract.

2.2 Information

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

2.3 Eligibility Information

HCA will give Contractor daily electronic eligibility information. Contractor may rely upon the latest information received as correct without further verification unless there is an obvious error. When necessary, HCA may provide eligibility updates by telephone or email or other transmission, followed by confirmation via the American National Standards Institute (ANSI) 834. Eligibility information will be in a format compliant with HIPAA.

2.4 Procedures for Applying for UMP Plan Benefits

HCA will require all persons applying for UMP Plan benefits to follow consistent procedures.

2.5 Member Communications

HCA will define eligibility and coverage requirements that are to be used by Contractor in Member communications. HCA will establish and comply with document control policies and procedures and will set timelines in the Operations Manual each year. A single point of contact will be provided to Contractor at the beginning of each year.

2.6 Value Based Payment Initiatives

HCA will inform Contractor a minimum of sixty (60) days prior to implementation of (a) any new Value Based Payment initiative or program, and (b) any significant changes to existing Value Based Payment initiatives or programs. For the purposes of this section, HCA's Accountable Care Networks are included within the scope of "Value Based Payment initiatives or programs." Notwithstanding anything herein, if such Value Based Payment initiative or program requires Contractor to implement complex system changes or to recontract with providers, HCA will inform Contractor with a minimum of one-hundred eighty (180) days notice, when possible.

2.7 Payment of Administrative & Implementation Charges

HCA will pay Contractor the Administrative Fees based on HCA's enrollment information as of the last day of the previous month, by the fifth Business Day of each month. HCA will pay the charges described in Exhibit A for services performed as described in this Contract. These payments are subject to the provisions of Section 6, *Performance Standards and Guarantees*. The first monthly Administrative Fee shall be payable in February 2020 for services received in January 2020 based on enrollment in UMP Plans on January 31, 2020. Adjustments to the Administrative Fees will be made quarterly and annually on PSPM payments for Performance Credits. After the Initial Term, any increase in the PSPM for any Renewal Term may not exceed the "Maximum Annual PSPM Increase for Contract Years 2030 and thereafter" percentage set forth in Exhibit A.

Compensation for implementation and services performed prior to January 1, 2020 is included in the Administrative Fees. HCA will not pay any amounts to Contractor except as specifically provided in this Contract.

HCA will reimburse Contractor for the actual Independent Review Organization (IRO) fees incurred by Contractor as a result of using an IRO for purposes of meeting the requirements of

Section 3.12.2, *Requirements: Second Level Appeals, and Requests for Independent Review*. Contractor will submit those charges to HCA on a monthly basis as IRO appeals are completed.

2.8 Funding Claims

On a weekly basis, Contractor will report via e-mail to HCA the total dollar amount of Claims paid during that week. HCA will reimburse Claims by wire transfer to a bank account designated by Contractor. HCA will wire the funds within three (3) Business Days after receiving the Contractor's report.

If HCA fails to timely respond to Contractor's initial request to provide funds for the payment of Claims, Contractor will follow up with HCA to confirm whether HCA received and does not contest the funding request. If HCA does not pay uncontested amounts within two (2) Business Days after Contractor confirms the request was received and is not contested, Contractor may cease the processing of Claims until the requested funds have been provided.

2.9 HCA Senior Account Sponsor for UMP

HCA will designate one (1) or more Senior Account Sponsors for the UMP Plans. HCA reserves the right to designate different Senior Account Sponsors at any time by providing written notice to Contractor.

An HCA Senior Account Sponsor may delegate responsibilities assigned by this Contract to other HCA employees.

The initial HCA Senior Account Sponsor shall be:

Name: David Iseminger
Address: 626 8th Avenue SE
Olympia, WA 98504
Phone: (360) 725-1108
Email: David.Iseminger@hca.wa.gov

2.10 Operations Manual

HCA will follow the procedures and requirements written in the most recently signed Operations Manual, which is hereby incorporated by reference. The initial Operations Manual is attached as Exhibit F-1. The Operations Manual will be updated twice per year on January 1 and July 1 of every year throughout the Term of this Contract.

SECTION 3. ADMINISTRATIVE SERVICES FOR UMP PLANS

3.1. In General

3.1.1. Services and Payment

Except as otherwise indicated in this Contract, Contractor will provide services for HCA as described in this Contract for both the PEBB and SEBB populations. Contractor will not charge or be entitled to receive any payment from HCA except the charges described in Exhibit A, *Administrative Fees*, or through specific Work Orders issued by

HCA in accordance with Section 9, *Work Orders*. Pooled Hours must be used completely before payment is made based upon the Pooled Rate in Exhibit A.

The parties understand and agree that SEBB UMP Plans that are not Substantially Similar to the PEBB UMP Plans will require an amendment to this Contract to be included within the scope of this Contract. If the parties fail to reach agreement on whether a SEBB UMP Plan is substantially similar to a PEBB UMP Plan, then the parties shall follow the dispute resolution process outlined in Section 12.17.

3.1.2. Representations

Contractor represents that it meets the minimum qualifications stated in the RFP. Contractor represents that the answers it gave in the written portion of its Proposal and in oral presentations are still true as of the Effective Date. If any of those representations were not true when made, were not true when Contractor submitted its bid, or are not true at any time during the Term of this Contract, HCA may terminate this Contract upon twenty (20) Days' notice. The Proposal is incorporated by reference to this Contract in Exhibit J.

3.1.3. Customer Satisfaction

At no additional charge to HCA, Contractor will subcontract with an HCA approved third-party vendor to administer the annual Consumer Assessment of Health Plans Survey (CAHPS) to a random sample of all non-Medicare Members in UMP Plans.

3.1.4. Washington Health Alliance and HCA Data Partners

Contractor will deliver data requested by HCA to the Washington Health Alliance (WHA) for both the UMP Plans and for Contractor's individual and non-ERISA Book-of-Business in the State of Washington, and Contractor will participate in the WHA consumer experience survey. Contractor will also submit UMP Plans and individual and non-ERISA data to the All-Payer Claims Database, the Fred Hutchinson Institute for Cancer Outcomes Research (HICOR) and any other HCA data partner as requested by HCA at no additional cost, except data that Contractor is specifically prohibited from providing by law. Any data partner not listed in this Section 3.1.4, unless the HCA is required by law to produce information, must meet the security protections and requirements of the Business Associate Agreement attached to this Contract as Exhibit G-1.

3.1.5. Health Technology Clinical Committee

- a. As directed by HCA, Contractor must at all times implement and follow coverage determinations made by the Health Technology Clinical Committee (HTCC). Contractor cannot implement any medical policy that results in either more permissive or more restrictive coverage or different medical necessity criteria than HTCC's determination for UMP Plan benefits and Claims.
- b. Contractor will maintain an HTCC coverage determination documentation spreadsheet (Master Grid) as part of the Operations Manual, and will update it as new information is received. Contractor will send this spreadsheet to HCA on a monthly basis on the last Business Day of each month for HCA approval. Some examples of what this Master Grid must include are:

- i. Topic Name
 - ii. Target Date for implementation
 - iii. Implementation Date
 - iv. Affected Codes
 - v. Non-Covered Codes
 - vi. Covered Codes
 - vii. Procedure and Diagnosis Codes Requiring Prior Authorization
 - viii. Hyperlinks to criteria for respective services
 - ix. Portion of the COC (i.e., the Exclusion # or page #) in which the HTCC determination is addressed
- c. Newly added or changed HTCC coverage determination procedures will be documented and incorporated in the Master Grid by HCA no later than September 30 of each year. The procedures include, but are not limited to, updated timelines, work-flows, and documentation.
- d. Contractor will develop and maintain an implementation plan, which will include provider and/or Member notice, for each HTCC determination, and store those plans within the Master Grid. The Master Grid with final approved HTCC determinations must be updated by Contractor and sent to HCA no later than September 30 of each year.
- e. HCA must approve, in writing, all documents and templates related to implementation of HTCC determinations. All denials based on HTCC determinations must include the HTCC determination as the denial reason.
- f. Contractor will attend meetings as required by HCA. HCA will inform Contractor of the dates, times and locations of each required meeting, including those listed below:
- i. HCA Clinical Meeting
 - 1. Occurs every week
 - 2. Meeting agenda is led by Contractor's Clinical Programs Managers
 - 3. Clinical issues are discussed and tracked by Contractor in a "clinical action log"
 - ii. HTCC Medical Director Meetings between Contractor and HCA
 - 1. Occurs once per month
 - 2. Meeting agenda is led by Contractor's Clinical Programs Managers
 - 3. Discussion topics are: HTCC determinations, pending decisions, reviews, and implementation plan and/or concerns.
 - 4. Final approval for HTCC implementation in the UMP Plans is done at this meeting with written documentation sent via email to the HCA Medical Director and Contractor's Medical Director for signature
 - iii. Clinical Strategy Workgroup Meeting
 - 1. Occurs one week prior to the Clinical Strategy Leadership meeting

2. Medical Directors need not attend
 3. Meeting agenda will be led by Contractor's Clinical Programs Managers
 4. The purpose of the meeting is for the HCA/Contractor team to weigh in on issues to be discussed in the Clinical Strategy Leadership meeting
- iv. Clinical Strategy Leadership Meeting
1. Occurs once per month
 2. Meeting agenda is led by Contractor's Clinical Programs Managers
 3. Standing agenda items: Bree Collaborative implementation and general updates, monthly Book-of-Business medical policy updates, program updates, HTCC initiatives.
 4. Issues discussed such as: program updates or concerns, clinical programs, any specific Member question or complaint, HTCC determinations that are active and pending.

3.1.6. Notice of Change in Control

Contractor will notify the HCA Senior Account Sponsor within thirty (30) Days of any of the following (each a "Change in Control"):

- a. Changes in the ownership or partners or control affecting 10% or greater interest in Contractor,
- b. Any acquisition by Contractor of 10% or greater interest in any subsidiary that affects services under this Contract,
- c. Any change in the direct effective control of the Contractor, and
- d. Any new agreement with, by, or between any affiliates of Contractor that directly impacts Contractor's performance under this Contract.

Contractor will also notify the HCA Senior Account Sponsor within thirty (30) Days of any Change in Control of any Subcontractor performing a major portion (as that term is defined in Section 3.1.7) of the work under this Contract.

3.1.7. Subcontracting

- a. Contractor shall not enter into any subcontract under this Contract without the prior written approval of HCA, other than with Contractor's Affiliated Entities, for any major portion of the work under this Contract, or if such subcontract involves Subcontractors providing services directly to UMP Plans, Members, or providers, unless terms of this Contract are incorporated into the agreement as requested for such subcontract at HCA's sole discretion. Contractor will inform HCA of such agreements at least ninety (90) Days in advance of any service being rendered. For the purposes of this Section 3.1.7, "major portion" means any subcontract involving the direct provision of services to UMP Plans, Members, or providers, or requiring Protected Health Information (PHI) access or use by the Subcontractor, and having a cost of \$50,000 in a twelve (12) month period.
- b. Contractor will not disclose any PHI about Members to any Subcontractor without first entering into a privacy, security, and confidentiality agreement with that Subcontractor. The privacy, confidentiality, and security agreement between

Contractor and its Subcontractors must be legally enforceable in Washington State and satisfy all applicable requirements of State and federal laws governing privacy and security of PHI. At a minimum, these agreements will legally bind the Subcontractor and its agents and employees to safeguard PHI to the extent required of Contractor in this Contract.

- c. Regardless of any partnering or subcontracting, Contractor is responsible for all work performed by Affiliated Entities and Subcontractors, and Contractor is responsible for all payments to the Affiliated Entities and Subcontractors. The rejection or approval by HCA of any Subcontractor or the termination of a Subcontractor shall not relieve Contractor of any of its responsibilities under this Contract, or be the basis for additional charges to HCA.
- d. The terms of any subcontract must include a provision such that Subcontractor agrees and consents to granting HCA the unilateral right to terminate such subcontract.
- e. HCA reserves the right to review and approve all Subcontractors and Subcontracts under this Contract.

3.1.8. Operations Manual

Contractor will follow the written procedures and requirements in the most recently signed Operations Manual, which is hereby incorporated by reference. The Operations Manual is attached as Exhibit F-1. This will be updated twice per year on January 1 and July 1 of every year of the Term of this Contract.

3.1.9. Reporting Manual

Contractor will follow the written procedures and requirements in the most recently signed Reporting Manual, which is hereby incorporated by reference. The Reporting Manual is attached as Exhibit F-2. This will be updated periodically by mutual agreement throughout the Term of this Contract. The Reporting Manual will provide additional details about how reports described in Section 3.17.7 and Exhibit R are provided, such as identifying persons in each party to whom such reports are to be provided, and describing the form and format of such report.

3.1.10. Deliverable Review & Acceptance

Each report, document, data delivery, or other deliverable provided by Contractor, whether pursuant to this Contract, any Exhibit, or a Work Order, shall be in a form, format, and in such detail as is necessary to: (a) cause it to conform to any specifications described herein or therein; (b) considering the purpose of the deliverable, cause it to be acceptable to HCA; and (c) be of fit quality as determined solely by HCA. HCA shall review the deliverable and notify Contractor of any deficiencies. Contractor will modify any non-conforming deliverable within fourteen (14) Days and resubmit it to HCA for its review.

3.1.11. Changes in UMP Benefits

If during the term of this Contract, HCA chooses to change vendors or remove or add a benefit, such as a vision benefit, from the UMP Plans and have a stand-alone benefit, the Contractor will subcontract with such entities, or collaborate with such entities, necessary for the implementation of such services. HCA and Contractor will complete a

Work Order for each subcontract or collaboration under this Section 3.1.11. Details will be established through the Work Order process. The only permissible charges for any such Work Order will be limited to (a) charges made by such Subcontractor to Contractor specifically for the provision of such benefit, and (b) one-time costs necessary to implement such benefit as further described in the Work Order; provided, however, that any available Pooled Hours will be applied prior to any such charges. Any agreement entered in to by Contractor and any such entity(-ies) shall be provided to HCA for its review and inspection within thirty (30) Days of the entities signing such agreement.

3.1.12. Changes in Laws, Rules, or Regulations

Contractor will notify the HCA Senior Account Sponsor within thirty (30) Days of any changes in laws, rules or regulations that may impact Contractor's administration of the UMP Plans or performance of other services described in this Contract.

3.2. Claims Services

3.2.1. General

Contractor is responsible for Claims adjudication, Appeals/Complaints management, reports, and customer service for all Claims for dates-of-services within the Contract, to include all run-out Claims with dates-of-services within the Contract timeframe at the end of the Term, for sixty (60) months after termination, at no Administrative Fee or additional payment (see, Section 12.11). Claims processing must be located and performed within the United States.

Contractor will:

- a. Administer the Plan benefits as outlined in the most current Certificates of Coverage (COCs), as described in this Contract. HCA will approve all COCs for all UMP Plans every calendar year.
- b. Adjudicate all U.S. and Foreign Claims and Washington Tribal Clinic Claims that cover all active, COBRA, and retiree Members in accordance with UMP Plan benefits in the applicable COC. For all Members, this excludes retail, mail-order, and specialty pharmacy Claims. Administer covered Foreign Claims at the in-network level of reimbursement and in accordance with the applicable COC and medical policies.
- c. Support and implement HCA strategic initiatives and demonstration projects, such as Accountable Care Networks (ACNs), Centers of Excellence (COE) contracting, bundled payment, and tiered hospital networks identified by HCA for Members. HCA and Contractor will complete a Work Order for each initiative or project under this section. Implementation details will be established through the Work Order process.

For such Work Orders, up to the first 4,500 Contractor hours needed to support and implement such initiative or project will be applied against Pooled Hours. The next 1,500 Contractor hours will be performed for no additional charge and without any reduction in Pooled Hours. HCA will decide how any remaining Contractor hours will (i) be applied against any remaining Pooled Hours, or ii) charged to HCA. Examples of how these hours will be applied are provided in Exhibit Q. For purposes of clarification, prior to January 1, 2020, Implementation Hours, as defined in Section 9, will be utilized for these initiatives and projects.

- d. Support and implement any Healthier Washington initiatives and other Value Based Payment or alternative payment initiatives not described in Subsection c. identified by HCA for Members. HCA and Contractor will complete a Work Order for each initiative or project under this section. Implementation details will be established through the Work Order process. The only permissible charges for any such Work Order will be limited to (i) charges made by a Subcontractor to Contractor specifically for the provision of such initiative, and (ii) one-time costs necessary to implement such initiative as further described in the Work Order; provided, however, that any available Pooled Hours will be applied prior to any charges.
- e. Support and implement HCA strategic initiatives and demonstration projects, such as Accountable Care Networks (ACNs), Centers of Excellence (COE) contracting, Healthier Washington initiatives, bundled payment, tiered hospital networks, and other Value Based Payment or alternative payment initiatives identified by HCA within Contractor's Book-of-Business that aligns to overall goals to drive Healthier Washington and supports transformation of the market in a manner that does not negatively impact Contractor's Book-of-Business.
- f. Subcontract for services with specific vendors identified by HCA for Diabetes Control and Prevention Programs, Tobacco Cessation program, and a specific HSA Trustee. HCA and Contractor will complete a Work Order for each initiative or project under this section. Implementation details will be established through the Work Order process. All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours. If there is a change in the selected vendor, the parties will complete a Work Order with the details for making such change. If the newly identified vendor does not accept eligibility files in the standard format, then such Work Order will include charges for customizing eligibility files to meet the vendor's requirements; provided, however, that any available Pooled Hours will be applied prior to any charges.
- g. Subject to the completion of a Work Order as outlined in this Contract, subcontract for some services with specific vendors as identified and requested by HCA for other services. Implementation details will be established through the Work Order process. The only permissible charges for any such Work Order will be limited to (i) charges made by such Subcontractor to Contractor specifically for the provision of such benefit, and (ii) one-time costs necessary to implement such benefit as further described in the Work Order; provided, however, that any available Pooled Hours will be applied prior to any charges.
- h. Provide fraud, waste, and abuse (collectively called program integrity) awareness, detection, and recovery services, and provide HCA at least monthly reports thereof.
- i. Provide a structured, dedicated, and adequately staffed United States-based Claims office that delivers a consistently high degree of Claims payment accuracy and timeliness as measured by the Performance Guarantees.
- j. Provide services for Claim adjudication, Appeals/Complaints management, reports and customer service for all Claims for dates-of-service during the Term and for all run-out Claims for sixty (60) months after termination, at no additional Administrative Fee or payment.
- k. Resolve issues with Claims requiring additional information for proper adjudication, including:

- i. Member eligibility
 - ii. Referral
 - iii. Authorization
 - iv. Coordination of Benefits
 - v. Third-party liability
 - vi. Workers' Compensation information.
- l. Include all Claims and provider networks in one resource enabling Members to receive EOBs, access Claims information (electronic and paper based), and search for providers. As set forth in Exhibit L, *Implementation Plan*, the EOB will be customized to HCA's specifications at no additional cost. Any subsequent HCA customizations will be established through the Work Order process. The only permissible charges for any such Work Order will be limited to one-time costs necessary to implement such customization as further described in the Work Order; provided, however, that any available Pooled Hours will be applied prior to any charges.
 - m. For any new ACN, or change to an existing ACN, of which Contractor was informed pursuant to Section 2.6, co-develop, implement, and administer the ACN, and manage payments to providers for ACNs.
 - n. For any new Value Based Payment arrangement, new alternative payment model, or change to an existing arrangement or model, of which Contractor was informed pursuant to Section 2.6, co-develop, implement, and administer such arrangements or models as requested by HCA.
 - o. Perform other Claims-related functions necessary to provide a complete administration of Claims service.
 - p. Provide internal audit, training, and performance management programs to ensure consistency and accuracy of Claims processing, coverage decisions, customer service, and administrative performance.
 - q. Provide a credit balance recovery service and provide HCA quarterly reports thereof.
 - r. Make benefit revisions, and update the Claims system to pay accordingly, on sixty (60) Days' advance notice from HCA. HCA has final authority for benefits administration and Claims payments.
 - s. Collect information from Members via mail, or other methods approved by HCA, at least annually (at the same time after Open Enrollment that "Welcome Packets" are mailed by Contractor) about other health insurance coverage the Member has for administration of Coordination of Benefits.
 - t. Administer Member incentives identified by HCA for Member completion, or participation in HCA-sponsored wellness or disease management activities, such as SmartHealth. HCA will inform Contractor via the eligibility file which Subscribers receive a reward as an incentive as a result of such programs. This will include Subscribers who earned their wellness incentive for the year in which they enroll in Medicare mid-year (February 2 – December 31). Contractor will participate in HCA-requested data exchanges with the wellness vendor(s) through the Work Order process as requested by HCA.

- u. Track and resolve incomplete or pending Claims using an automated process and within designated timeframes.
- v. Provide a fully operational Claims payment service by January 1, 2020 that includes the ability to accurately auto-adjudicate 85% of all non-Medicare Claims.
- w. Provide corrective action plan(s) for resolution of Claims adjudication issues, including administration in accordance with UMP Plan benefits, Member eligibility, referral, authorization, Coordination of Benefits, third-party liability, subrogation, fraud, overpayments, or workers' compensation information, within fifteen (15) Days of being notified of any such issue.
- x. Provide a controlled process to print and electronically produce checks and Explanations of Benefits, send the payment data to the provider within ten (10) Business Days of the check printing, handle check reconciliation and correction accounting, and offer electronic funds transfer to providers.
- y. Before Claims payment is made, perform all authorization processes or edits to Claims administration, such as prior authorization, based on Book-of-Business medical policies, HCA custom medical policies, HTCC determinations, and UMP Plan coverage limitations or exclusions.
- z. For any new Value Based Payment arrangement, new alternative payment model, or change to an existing arrangement or model, of which Contractor was informed pursuant to Section 2.6, utilize such arrangement or model to pay the Contractor's contracted network of hospitals, professional providers and other non-hospital providers,
 - aa. Upon HCA request, apply non-duplication of benefits approach for all Medicare retirees upon sixty (60) Days' notice from HCA.
 - bb. Coordinate benefits with other group health insurance entities using a non-duplication of benefits method of coordination for active Members and non-Medicare retiree Members.
 - cc. Accept ERB Division eligibility data in the format provided by HCA.
 - dd. Use only Washington licensed clinicians when the need for consultation arises during any part of the Claims administration process. While these licensed clinicians may be geographically located throughout the United States, each must be licensed in Washington.

3.2.2. *Coordination of Benefits*

Apply standard Coordination of Benefits rules for all Medicare retiree and other Medicare-primary Members' Claims (ESRD, etc.), consistent with State insurance regulations in chapter 284-51 WAC.

In addition to those rules set forth in WAC 284-51, Contractor must use Medicare crossover Claims for all available facility (Part A) and non-facility (Part B) Claims, including paid in full crossover Claims. COB savings accrued will be applied to each Claim as it is processed by Contractor, rather than delayed and batched after a period of time (for example, weekly or monthly). Contractor shall include an explanation of savings achieved by Member as a result of the COB process.

The following Table 3.2.2 presents an example of the expected Claim-by-Claim COB transactions:

Medicare COB Example											
Claim #	Charge	Medicare allows	Medicare deductible	Medicare Pays	UMP deductible	UMP Benefit	UMP 2nd Payment	UMP COB Savings	Cumulative Allowed	Cumulative Paid	Member OOP Balance
1	100.00	80.00	80.00	-	80.00	-	-	-	0.00	-	80.00
2	300.00	300.00	60.00	192.00	170.00	108.00	108 + 2.50 COB savings to mbr = 110.50	2.50	400.00	305.00	77.50
3	200.00	180.00	0.00	144.00	0.00	153.00	36 + 77.50 COB savings to mbr = 113.50	39.50	560.00	560.00	0.00
Totals		560.00		336.00		261.00					

3.2.3. Claims Payments for Washington and Out-of-State Networks

Effective January 1, 2020, Contractor will pay Claims in U.S. currency as follows:

- a. Pay providers in Contractor’s Washington State provider network (hospitals, professional providers, ambulatory surgical centers, and ancillary providers) based on the terms of Contractor’s contracts with those providers, and in a manner that is aligned with UMP Plan administration.
- b. Pay Claims arising outside Contractor’s Washington service area through Contractor’s Book-of-Business contracts, and in a manner that is aligned with UMP Plan administration.
- c. Process Foreign Claims at network rates using currency conversion rates in effect on the date of service, and provide translation services for those Claims at no additional charge to the Member.
- d. Process out-of-network Claims at lower non-network reimbursement rate based on the UMP Plan design.
- e. Process payments for COE bundled payments only upon HCA’s request.
- f. If Contractor utilizes Subcontractors to process any Claims, Contractor must provide a list of Subcontractors to HCA and details of the subcontractor Claims processes for primary and secondary Claims adjudication.
- g. Contractor will add ACN Providers into Contractor's network as requested by HCA.
- h. Ensure access to providers to provide all covered services for all UMP Plans.

3.2.4. Erroneous Payments & Misquotes

- a. If HCA or Contractor determines that Contractor made a payment to a provider that was an Erroneous Payment, Contractor will diligently attempt to recover that payment. As set forth in the Operations Manual, Contractor will (i) review its payments to discover any Erroneous Payments at least monthly, and (ii) use only lawful means to seek to collect those payments. Contractor will report to HCA in writing on a quarterly basis any Erroneous Payments that have not been recovered, including the amount paid and the amount that Contractor believes should have been paid.

- b. Contractor will keep HCA informed as to the methods being used to attempt to recover Erroneous Payments and the status of such efforts in the monthly operations meetings. Contractor must submit a written request to HCA and obtain HCA's written approval before (i) referring or transferring its recovery rights to any third party or (ii) pursuing any legal action in any attempt to recover Erroneous Payments. If HCA determines in its sole discretion that legal action should be taken, HCA may request Contractor bring the action in the name of HCA, and in such event, Contractor will comply.
- c. Contractor must report and fund all Misquotes. Members will not be financially responsible for Misquotes for services by network providers. For non-network providers, Contractor will complete an Administrative Corrective Action form (included in the Operations Manual) and submit it to HCA for review.
- d. When Contractor identifies a Misquote before a service is rendered, Contractor will contact the Member by telephone within seventy-two (72) hours to explain the error and help find alternative care options.
- e. Contractor will follow the Administrative Corrective Action plan and process as described in the Operations Manual.
- f. Contractor must provide a detailed report of Erroneous Payments on a quarterly basis in a format approved by HCA to include Misquotes.
- g. HCA will not reimburse Contractor as Claims costs for (i) Misquotes or (ii) Erroneous Payments that result from fraud or gross negligence by Contractor or any employee, agent, or subcontractor of Contractor. Other Erroneous Payments that are not recovered will be reimbursed as Claims costs.
- h. Any money recovered by Contractor will be credited to the HCA at the time of such recovery.
- i. Contractor will correct Underpayments within ten (10) Business Days of becoming aware of them.

3.2.5. *Fraud, Waste, and Abuse Detection & Prevention*

Contractor must administer a comprehensive fraud, waste, and abuse prevention and detection program and cooperate with Washington State's efforts to eliminate and prosecute health care fraud. Contractor must have procedures in place to identify providers and/or Members who appear to be committing fraud and work with HCA and appropriate law enforcement agencies to pursue prosecution; and when a Member or provider is being prosecuted, provide all Claim information and participate as a fact witness or an expert witness as necessary, for no additional charge. Contractor will provide a description of fraud and abuse programs and policies to HCA annually and upon HCA's request.

As part of these services, Contractor will cooperate and collaborate with HCA and state health plan administrators, external investigators, law enforcement, prosecutors, and others involved in fraud and abuse detection, prevention, and prosecution as required by HCA.

HCA will require specific reports, on quarterly bases, on ongoing processes, prevention methods and recovery services and dollar amounts outstanding and recovered as set forth in Section 3.17.

3.2.6. Provider & Claims Information Resource

Contractor will provide one (1) online resource by which Members can access Claims information, such as EOBs, maximum out-of-pocket status, deductible status; search for providers; estimate costs; provider quality tool; become engaged and educated in their care; and other features as requested by HCA.

3.2.7. Subrogation

- a. Contractor will identify and pursue opportunities in which a party other than HCA might have primary financial obligations with regard to Claims submitted during the Term of the Contract. HCA will notify Contractor of post-pay recovery opportunities of which it has actual knowledge. Contractor will not be required to pursue or recover any specific opportunity, nor will HCA be required to conduct any inquiry or investigation to determine if any opportunity exists. HCA does not pay for third party liability Claims covered by workers' compensation. Work related illness and injury Claims are excluded services under all UMP Plans.
- b. Contractor will investigate whether any third-party recoveries are possible from all Claims from the following sources:
 - i. Motor vehicle accidents.
 - ii. Property Casualty/Homeowner liability insurance.
 - iii. Subrogation settlements.
 - iv. Other situations where a party other than HCA might be liable.
- c. Contractor shall remit or issue a credit to HCA for all amount(s) recovered, less the fee for subrogation activities as stated in Exhibit A, *Administrative Fees*.
- d. Contractor shall pursue subrogation opportunities existing as of the effective date of termination of this Contract, both before and after the end of any run-out period. Contractor shall pursue such recoveries only as long as it determines such recoveries are viable. Contractor shall continue to provide HCA with quarterly reporting during the run-out period. Any additional reporting provided to HCA after the end of the run-out period is subject to mutual agreement.
- e. Contractor may offset payments due from Members and/or recipients against unpaid Claims, if permissible under HCA policies communicated to Contractor in advance, and under applicable law and regulations.
- f. Contractor shall remit recoveries and report to HCA accounting any withheld fees for subrogation or settlement on at least a monthly basis.
- g. Contractor will provide HCA a quarterly report of post-pay recovery activities. Reports will be delivered to the HCA Contract Manager forty-five (45) Days after the end of each quarter.

3.3. Clinical Management

Contractor will collaborate with HCA's clinical team; proactively identify and manage Members who are at risk for excessive health service utilization; provide Patient Decision Aids to support appropriate patient self-management; collaborate and integrate with providers and delivery systems on clinical matters; reduce unnecessary variation in clinical practice; and lower healthcare costs.

3.3.1. Scope

Contractor's Clinical Management will include the following:

- a. Use of evidence-based medicine and Bree Collaborative best practice recommendations, including integrated physical and Behavioral Health services.
- b. Alignment with NCQA or URAC standards, and compliance with the UMP Plan coverage, reimbursement, and benefit provisions defined in the applicable COC.
- c. All Standard Programs and services offered and provided to Contractor's fully insured book-of-business within the Administrative Fee, unless otherwise notified by HCA, for the Term of this Contract. Contractor will provide HCA a full list of Standard Programs each year and update anytime there is another Standard Program or service added.
- d. Participation in Accountable Communities of Health to address Social Determinants of Health, as it relates to HCA's and Contractor's joint interests, or if requested by HCA.
- e. Incorporation of condition-specific Clinical Management Services and programs, including, but not limited to, maternity and high-risk pregnancies, radiology, medical infusion, Autism, transgender, and other programs offered in the Book-of-Business (all programs will be included within the Administrative Fee).
- f. Utilization review processes, including prior authorization and concurrent review.
- g. Contractor shall not contract out a major portion of integrated Behavioral Health clinical management services without HCA approval. If Contractor carves out Behavioral Health services, such services must be (i) approved in writing by HCA, and (ii) fully integrated to appear to any member as if the services were performed directly by Contractor. For the purposes of this subsection, "major portion" shall have the same meaning as set forth in Section 3.1.7.
- h. Medical expertise provided through at least one (1) Contractor Medical Director to support the Washington State Health Technology Assessment program, the Washington State Prescription Drug Program, and other HCA-identified performance improvement efforts as they relate to the UMP Plans and HCA delivery system purchasing strategies.
- i. Medical imaging management programs for the UMP Plans that comply with HTCC determinations. This program will include prior authorizations and clinical edits within the Claims systems. Full prior authorization on all radiological services is required, and if such prior authorization services are subcontracted to an imaging management vendor, such subcontract will include any radiological services covered by HTCC decisions.
- j. HCA approved application and implementation of HTCC determinations as set forth in the applicable implementation plan in the Operations Manual.
- k. Adherence to a documented process, subject to HCA's review and approval, that uses HCA-determined clinical criteria, guidelines, protocols, and/or other tools (e.g., HCA medical policy, Bree Collaborative, HTCC, Contractor's medical policy) to accurately determine the medical necessity of health care services, equipment, and supplies.
- l. Collaboration with local medical and health care communities, associations, and societies during the development and implementation of medical policies, for both Book-of-Business medical policies and HCA custom policies.
- m. Active promotion for network providers to participate in relevant quality improvement programs of the Foundation for Health Care Quality.

3.3.2. Administration of Clinical Management

Contractor will do all the following:

- a. Provide HCA with an annual written description of its Clinical Management programs that have been approved by Contractor's Medical Director for its Book-of-Business by May 1 of each Plan Year. HCA will inform Contractor which programs will go into effect by Work Order, ninety (90) Days before implementation.
- b. Notify HCA of changes in medical policy that materially affect UMP Plan payments at least thirty (30) Days before making the change.
- c. Notify providers of changes in medical policy that materially affect UMP Plan payments at least ninety (90) Days before making the change.
- d. Through the completion of a Work Order, accept and follow all of HCA's coverage and medical policies, including policies based on the determinations of the HTCC. Implementation details will be established through the Work Order process. All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours.
- e. Administer a benefit exception process as defined in the operations manual and approved by HCA.

3.3.3. Clinical Programs

As of the Effective Date of this Contract, Contractor shall provide all of the Clinical Programs listed in Exhibit S, *Standard Programs*, and all of the programs listed in this Section 3.3.3 and are hereby made available to HCA, Members, and the Members' providers, as appropriate. Such programs will be reviewed by the parties and updated on an annual basis.

- a. Complex Case Management: Direct referrals, top ten high claimants monthly, inpatient stays over 5 days, and emergency room overuse and avoidable use.
- b. Specialized Case Management: Predictive modeling that uses advanced analytics to identify high-risk and high opportunity members.
- c. Palliative Care: Case management support for members and their families facing advanced illness or life-limiting conditions.
- d. Preauthorization: For HTCC determinations, HCA's customized medical policies, and for Contractor's preauthorization list.
- e. Tertiary CM/UM: Skilled nursing facility, long term acute care, inpatient rehabilitation, and residential treatment center that is managed by one clinician for the CM and UM work.
- f. Clinical Review and Reimbursement: Contractor reviews all inpatient Claims through data base review. High risk Claims are pulled out and reviewed through a 14-point audit for medical necessity review and appropriateness of billing.
- g. High Tech Imaging Management: Order number required (otherwise Claim denies to provider liability), including the following:
 - i. Computed Tomography (CT)
 - ii. Computed Tomographic Angiography (CTA)
 - iii. Nuclear Cardiology

- iv. Magnetic Resonance Imaging (MRI)
 - v. Magnetic Resonance Angiography (MRA)
 - vi. Positron Emission Tomography (PET)
 - vii. Stress echocardiography (SE) / Resting transthoracic echocardiography (TTE) / Transesophageal echocardiography (TEE).
- h. Advice24: Contractor's 24 Hour Nurse-Line.
 - i. BabyWise: Maternity management with varying degrees of outreach dependent on risk-level of pregnant members, ranging from newsletters for low risk members to nurse outreach and Care Management options for high risk members. Also includes DueDate Plus maternity application.
 - j. Condition Manager - Disease Management: Low risk educational and high risk educational plus nurse engagement option for common diseases including diabetes, CAD, CHF, COPD and Asthma. A single case manager for Members with multiple conditions will be provided by Contractor.
 - k. Sleep Medicine: Designed to manage testing and therapy services for sleep disorders. This is an extension to Contractor's existing Utilization Management (UM) program.
 - l. Physical Medicine: Providers are required to receive preauthorization for a full suite of physical medicine therapy, procedures and other services, including but not limited to:
 - i. Complementary Alternative Medicine (acupuncture/massage/chiropractic)
 - ii. Joint management
 - iii. Pain
 - iv. PT/OT/ST
 - v. Spinal Fusion
 - m. Site of Care: Pharmacy program for infused medications that ensures members are receiving medications at the most cost effective and convenient locations.
 - n. Preventative Member Engagement: Outreach by phone and mail to members on open preventative service gaps such as colonoscopy, mammogram, blood glucose testing, and immunizations. This program is currently implemented for fully-insured and MedAdvantage lines of business.

Additional Standard Programs may be added by HCA at any time through a Work Order. All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours.

3.4. Utilization Management

Contractor shall provide a Utilization Management (UM) program that incorporates at least the elements listed below. If HCA does not have an applicable custom clinical policy or procedure, Contractor shall use its own clinical policies and procedures. Contractor's UM program staff will include members that are Board Certified by either the American Board of Medical Specialties or the American Osteopathic Association, and located in Washington state.

All of Contractor's Standard Programs for UM shall be available to HCA at no additional cost, but must first be approved by HCA before being implemented. The Contractor will provide HCA a full list of Standard Programs for UM each year and update anytime there is another Standard

Program for UM or UM service added. Implementation details will be established through the Work Order process. All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours. All HTCC determinations must be implemented through medical policies (e.g., pre-authorization and hard-coded edits) or COC exclusions.

At each Strategic Account Meeting described in Section 3.13.2, Contractor will inform HCA of all Pilot Programs for UM that Contractor develops or implements. HCA and Contractor will collaborate in HCA's participation in such Pilot Programs.

3.4.1. *Functions*

Contractor will provide a Utilization Management business function that:

- a. Utilizes Contractor's fully-insured book-of-business evidence-based medical policies, unless the HCA requires use of customized medical policies (such as gender dysphoria or HTCC), as well as available Bree Collaborative recommendations.
- b. Possesses Quality Management and Quality Assurance methods and programs to promote adherence to and incorporate the UM processes listed below across its Book-of-Business, including clinical performance and consumer experience measurement, predictive modeling and Expert Medical Opinion (EMO), also called "second opinion."
- c. Meets or exceeds NCQA or URAC standards, throughout the term of this Contract.
- d. Monitors for medically necessary services by providing pre-service (also called preauthorization and prior authorization), and retrospective reviews for medical necessity. Contractor will continue to advance efforts to work more holistically with providers on care coordination.
- e. Develops and implements care management strategies and incents care delivery systems to improve member outcomes, considering both presenting medical condition(s) and social determinants.
- f. Complies with Washington State Office of the Insurance Commissioner (OIC) applicable timeframes for utilization management decision-making and processes for reviews of Appeals and IROs.
- g. Includes UMP Plans coverage as provided in the COCs, custom policies, benefits provisions, and mandates.
- h. Includes UM for (i) physical health and Behavioral Health, and (ii) patients receiving inpatient and outpatient/ambulatory healthcare services.
- i. Supports timely and appropriate care, Member safety, quality of care, and Shared Decision Making.
- j. Uses HCA-certified Shared Decision Making tools when available to support patient centered care.
- k. Facilitates appropriate and timely referrals to other benefit programs (e.g., Complex Case Management).
- l. Allows for a HCA observer for NCQA accreditation review at HCA's request.

3.4.2. *Administration*

Contractor will provide the following:

- a. Accreditation for full health plan and medical management with either URAC or NCQA. If accreditation is not maintained, Contractor will take necessary steps in order to regain the accreditation within twelve (12) months of losing accreditation.
- b. Annual documentation of continued accreditation while this Contract is in effect to the HCA Contract Manager.
- c. A documented process that uses HCA-determined clinical criteria (e.g., HCA medical policy, HTCC, Bree Collaborative, Contractor's medical policy) to accurately determine the medical necessity of health care.
- d. Effective use of multiple channels of communication with Members and providers, including, as appropriate, telephone, fax, email, texting, Web-based, etc.
- e. Web-based approach for submitting reviews and receiving UM review decisions, including Auto Adjudicated review processes for HTCC Claims designated by HCA for web-based submission, review, and determination.
- f. As requested by HCA, reporting of detailed program statistics to HCA.

3.5. Quality Management and Improvement

3.5.1. Functions

All of Contractor's Standard Programs for Quality Management and Improvement (QMI) shall be available to HCA at no additional cost, but must first be approved by HCA before being implemented. The Contractor will provide HCA a full list of Standard Programs for QMI each year and update anytime there is another Standard Program for QMI or QMI service added. Implementation details will be established through the Work Order process. All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours.

At each Strategic Account Meeting described in Section 3.13.2, Contractor will inform HCA of all Pilot Programs for QMI that Contractor develops or implements. HCA and contractor will collaborate in HCA's participation in such Pilot Programs.

3.5.2. Administration

Contractor will provide the following:

- a. A QMI program to include governance, scope, measurable goals and objectives, staffing structure and staff responsibilities.
- b. QMI efforts related to the calculation and reporting of clinical performance measures, defined by the HCA, produced by the Contractor annually at no additional charge regardless as to the form of data collection, i.e., administrative, medical record or hybrid methods.
- c. Participation in collaborative quality improvement efforts with the HCA targeting one or two performance measures for improvement across the HCA's book of business, i.e., Medicaid and ERB populations.
- d. Assurance that the Contractor shall align clinical performance measures that the Contractor links to payment through its Accountable Care initiatives with the measures that HCA links to payment through the ACNs.

- e. QMI efforts related to non-clinical administrative services, such as Claims administration, provider contracting, and customer service.
- f. Key performance indicators for non-clinical administrative services.
- g. Information on suppliers and Subcontractors involved in the QMI program for non-clinical administrative services.
- h. QMI tools and/or methodologies.
- i. Processes that address Complaints from initiation through resolution, and incorporated into overall QMI program.

3.6. Complex Case Management

Contractor must use HCA's evidence-based medical policies and guidelines when available, as well as applicable Bree Collaborative recommendations in the Case Management care planning and decision-making processes. Contractor must use its own criteria for complex Case Management when there are no HCA criteria. HCA requires Contractor to conduct complex Case Management (also called catastrophic Case Management) for individuals with physical health and Behavioral Health conditions.

All of Contractor's Standard Programs for complex Case Management shall be available to HCA at no additional cost, but must be approved by HCA before being implemented. The Contractor will give HCA a full list of Standard Programs and services for complex Case Management each year and update anytime there is another Standard Program for complex Case Management or complex Case Management service added. Implementation details will be established through the Work Order process. All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours.

At each Strategic Account Meeting described in Section 3.13.2, Contractor will inform HCA of all Pilot Programs for complex Case Management that Contractor develops or implements. HCA and contractor will collaborate in HCA's participation in such Pilot Programs.

3.6.1. Functions

Contractor will provide a complex Case Management business function that identifies Members with complex, serious, or difficult healthcare needs to ensure:

- a. Utilization of Contractor's Book-of-Business evidence-based medical policies, unless HCA has instructed Contractor to use customized medical policies (such as gender dysphoria, and HTCC determinations), as well as available Bree Collaborative best practice recommendations, in the complex Case Management decision-making processes.
- b. Development and implementation of Care Coordination strategies to incent care delivery systems to improve member outcomes, considering both presenting health conditions and social determinants.
- c. Inclusion of UMP Plan coverage and benefit provisions in such complex Case Management.
- d. Contractor's program meets or exceeds NCQA or URAC standards.
- e. Members receive needed inpatient and outpatient/ambulatory healthcare services.

- f. Support of optimal patient self-management and Shared Decision Making coordination as requested by HCA.
- g. Appropriate and timely access to medically necessary healthcare services, equipment, and supplies.
- h. Proactive identification of patients at risk for health service utilization in order to implement interventions as the earliest possible time.
- i. Cost containment to the extent consistent with the above.
- j. Incorporation of Social Determinants of Health, Member self-management, and Shared Decision Making as part of the care planning process are addressed.
- k. Incorporation of physical health and Behavioral Health in the care planning process.
- l. Facilitation of appropriate and timely referrals to healthcare and other benefit programs (e.g., wellness programs), and community-based resources that can help the patient and/or family better manage complex illness.
- m. Support of Member safety and quality of care.

3.6.2. Administration

Contractor will provide the following:

- a. Accreditation with either URAC or NCQA and will maintain accreditation for full health plan and medical management with either URAC or NCQA. If accreditation is not maintained, Contractor will take necessary steps in order to regain the accreditation within twelve (12) months of losing accreditation.
- b. Annual documentation of continued accreditation while this Contract is in effect or upon HCA request.
- c. A documented process that accurately identifies the Member population eligible for, and most likely to benefit from complex Case Management.
- d. HCA prefers delivery of services to be provided at the clinic or facility or in person; or aligned with Primary Care practices, whenever possible.
- e. A process for designing and implementing individualized treatment plans and distributing those plans within thirty (30) Days of initial contact with the Member.
- f. Coordination with other UMP Plan vendors to achieve integrated care.
- g. As requested by HCA, report detailed program statistics to HCA, including common health conditions managed, the work the case managers are performing, utilization, cost, member experience, and quality outcomes, and other information to be determined by HCA.
- h. Ability to manage specific health conditions under the complex Case Management program, including services provided to individuals with the diagnosis of substance use disorder and severe and persistent mental health conditions or individuals with both severe mental health conditions and substance use disorder.
- i. Application of the COC provisions that require Members served by complex Case Management before the plan covers certain services or conditions.

3.7. Chronic Condition Management

Contractor shall provide a Chronic Condition Management program that meets the elements listed below. Contractor must use HCA evidence-based medical policies and guidelines, when available, as well as available Bree Collaborative best practice recommendations in the Chronic Condition Management care planning and decision-making processes. Contractor must use its own criteria for Chronic Condition Management when there are no such criteria or recommendations.

All of Contractor's Standard Programs for Chronic Condition Management shall be available to HCA at no additional cost, but must be approved by HCA before being implemented. Contractor will give HCA a full list of Standard Programs for Chronic Condition Management or Chronic Condition Management services each year and update anytime there is another Standard Program or service for Chronic Condition Management added. Implementation details will be established through the Work Order process. All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours.

At each Strategic Account Meeting described in Section 3.13.2, Contractor will inform HCA of all Pilot Programs for Chronic Condition Management that Contractor develops or implements. HCA and contractor will collaborate in HCA's participation in such Pilot Programs.

Contractor must provide Chronic Condition Management programs grounded in the tenets of the Chronic Care Model, evidence-based practice, patient self-management and shared decision making, facilitate timely and appropriate referrals for physical health and Behavioral Health services, coordinates care across the healthcare delivery system, and positive patient and provider experiences.

3.7.1. Functions

Contractor will provide a Chronic Condition Management business function that identifies Members with multiple, persistent, severe healthcare needs to ensure:

- a. Appropriate use and incorporation of Bree Collaborative best practice recommendations, evidence-based clinical guidelines, UMP Plan coverage and benefit provisions, Social Determinants of Health, patient self-management, Shared Decision Making tools, and NCQA or URAC standards in Chronic Condition Management.
- b. Incorporation of the tenets of the Chronic Care Model and Patient Centered Medical Home (PCMH).
- c. Delivery of services is embedded on-site or in person, or aligned with Primary Care practices, whenever possible.
- d. Incorporation of Social Determinants of Health, patient self-management, and Shared Decision Making into the care planning processes.
- e. Improved care coordination across healthcare delivery system and positive patient and provider experiences, this includes integration between Contractor, the complex Case Management team, and the Member's Primary Care team to facilitate a comprehensive Member care plan.
- f. Development, implementation, and revision of a Contractor clinical team care plan.
- g. Inclusion of UMP Plans coverage and benefit provisions.

- h. Timely and appropriate referrals for physical health, Behavioral Health services and other benefit programs, including community-based resources that can help the patient and/or family better manage chronic illness.
- i. Support of Member safety and quality of care, and improvement of Member and provider satisfaction.
- j. Compliance with OIC rules and timeframes for reviews and Appeals.
- k. Proactive identification of patients at risk for health service utilization in order to implement interventions as the earliest possible time to enhance outcomes and effectiveness.
- l. Cost containment to the extent consistent with the above.

3.7.2. Administration

Contractor will provide the following:

- a. Accreditation with either URAC or NCQA and will maintain accreditation for full health plan and medical management with either URAC or NCQA. If accreditation is not maintained, Contractor will take necessary steps in order to regain the accreditation within twelve (12) months of losing accreditation.
- b. Annual documentation of continued accreditation while this Contract is in effect. Contractor shall provide its NCQA or similar reporting in a mutually agreed upon format and on a mutually agreed upon timeframe(s).
- c. A documented process that accurately identifies the Member population eligible and most likely to benefit from Chronic Condition Management.
- d. A process for designing and implementing individualized Contractor clinical care plans and distributing those plans within thirty (30) Days of initial contact with the Member.
- e. Coordination with other UMP Plan vendors to achieve integrated care.
- f. As requested by HCA, report detailed program statistics to HCA, including common health conditions managed, the work the chronic care managers are performing, utilization, cost, member experience, and quality outcomes, and other information to be determined by HCA.
- g. Ability to manage specific service types under the Chronic Condition Management program, including inpatient chemical dependency and mental health care.
- h. Application of the COC provisions that require Members to be in Chronic Condition Management before the plan covers certain services or conditions.

3.8. HCA Clinical and Medical Policies

Through the completion of a Work Order, Contractor shall develop, implement, and manage customized HCA medical policies or exclusions, as well as determinations made by the HTCC in a way that is not more restrictive or more liberal than the HTCC determinations allows (see, RCW 70.14.120(1)). Implementation details will be established through the Work Order process.

All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours.

Contractor will:

- a. Assist in developing customized medical policies, including drafting policies according to high level direction and timelines provided by HCA.
- b. Develop pathways for implementing each policy, including, but not limited to, the development of:
 - i. Implement coverage or benefit updates;
 - ii. Meet target dates for implementation of new policies;
 - iii. Develop and maintain Care Coordination, clinical guidelines and/or criteria, including procedure and diagnostic codes requiring prior authorization;
 - iv. Implement Claim system modifications, including UMP Plan-specific covered and non-covered procedure codes;
 - v. Provide Utilization Management staff training to ensure consistent application of HCA clinical policies;
 - vi. Provide ongoing call center staff training and development of call center staff reference materials that assure consistent, accurate communication regarding the clinical and medical policies and guidelines; and
 - vii. Through the completion of a Work Order, implement a web-based approach for submitting reviews and receiving UM review decisions, including Auto Adjudicated review processes for HTCC Claims designated by HCA for web-based submission, review, and determination. Implementation details will be established through the Work Order process. All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours.
- c. Implement medical necessity criteria, technology coverage and reimbursement in accordance with the implementation strategies and time frames established by the Clinical Quality and Care Transformation Division of HCA.
- d. Create detailed implementation plans (including procedure and diagnosis codes) for each determination that must meet the approval of HCA's medical director.
- e. Implement and administer all HTCC determinations through medical policies (e.g., pre-authorization and hard-coded edits) as required under Section 3.1.5., including all BlueCard non-Medicare Claims. In order to ensure compliance with HTCC decisions, Contractor shall:
 - i. Train and assign dedicated Contractor staff to develop and execute any work plans created for HTCC decision implementation,
 - ii. Conduct quarterly quality assurance reviews of a sample of HTCC decisions, including denial and preauthorization letters, to ensure accurate and complete implementation of HTCC decisions, and
 - iii. Report findings of the quarterly quality assurance review and any corrective action required to assure staff accuracy in HTCC implementation.
- f. Evaluate all HCA medical policies (Medicaid, UMP, and HTCC) when modified to assess the impact and differences between such policies and Contractor's medical policies for

its Book-of-Business. The results of such assessment shall be provided to HCA within ten (10) Business Days of completion.

- g. Participate in HCA activities to affirm the Contractor's conformance to policies, including audits.

3.9. Innovations in Clinical Management

Contractor will have a systematic approach for identifying and implementing innovations in the delivery, management, and payment of health care services. There will be changes in Clinical Management due to a variety of factors, such as:

- a. Changes in financial reimbursement, including adoption of the HCP-LAN models.
- b. Adaptation and use of technology.
- c. Implementation of new evidence-based clinical practices.

3.9.1. Contractor Requirements

Contractor will:

- a. Provide health innovation programs and processes created and dedicated to health innovation, including staff and other resources.
- b. Involve HCA, providers, plan sponsors, Members and other patients, and other stakeholders in its development of health innovation initiatives.
- c. At each Strategic Account Meeting described in Section 3.13.2, Contractor will inform HCA of all other Pilot Programs for Clinical Management that Contractor develops or implements. HCA and contractor will collaborate in HCA's participation in such Pilot Programs.
- d. Submit an innovation plan for each year, including specific involvement and impact on clinical management programs, during all terms of this Contract.

3.10. Medical Benefit Drug Management Program

Contractor shall have a robust Medical Benefit Drug Management Program (MBDMP) that is strategically aligned with the outpatient pharmacy benefit administered by the UMP Pharmacy Benefit Manager (UMP PBM). Contractor will provide written notice of any change in its MBDMP Subcontractor no later than 180 Calendar Days prior to the effective date of such change.

3.10.1. Functions

Contractor will provide a MBDMP business function that includes:

- a. Utilization and Preferred Drug Management
 - i. Policies
 - 1. Policies that ensure drugs are used for the appropriate FDA approved diagnosis(-es) at the appropriate dose, frequency, and duration of therapy.
 - 2. Policies that ensure the most cost-effective drug is prescribed and administered, and how multiple drugs within a therapeutic class are selected as the preferred drug for its class.

3. Communication to Members and the medical community on changes to the HCA preferred drug list.
4. Make specific coverage criteria available for prescribers and Members as set forth in RCW 41.05.074.
5. Recommendations on clinical pathways to be implemented that involve pharmaceuticals.
6. Update coverage criteria and benefits in accordance with HTCC release and target dates for implementation of the criteria established for agreed upon implementation dates.
7. Ensure appropriate configuration of codes to match HCA medical policies and guidelines within the web-based provider tool used for submitting reviews, prior approvals, and obtaining review decisions, as well as auto authorizations when appropriate.

ii. Prior Authorization Process

1. A prior authorization process, including approvals, denials and appeals.
2. Collaborate with the UMP PBM to enforce step-therapy protocols and other Utilization Management that require a self-administered or other drugs, covered under the pharmacy benefit, be used prior to an infused or other drug covered under the medical benefit.
3. Monitor ongoing Clinical Pharmacy Management performance.
4. Provide an electronic platform that prescribers can access to obtain a coverage decision for medications that require pre-authorizations.

iii. New Prescription Drug Market

Inform HCA about new drugs coming into the market by providing industry benchmarks and advanced information on new drugs to include cost projections and coverage recommendations, including a plan specific economic analysis of coverage options for expensive new therapies.

iv. Fee Schedule Management and Payment Integrity

1. Verify Claims are paid at the contracted rate and improve opportunities to achieve Rebates.
2. Includes a reimbursement process for Medical Drugs (e.g. Average Wholesale Price, Average Sales Price, Wholesale Acquisition Cost, etc.).
3. A pre-payment Claim edit in place to ensure that drugs are used for the appropriate FDA-approved diagnosis(-es) at the appropriate dose, frequency, and duration.

4. Adjudicate all medical drug Claims using NDC codes and basing reimbursement and Member cost share on the NDC codes rather than J-codes.
- v. Utilize a Site of Care Coordination system to manage where drugs are given for infusions and re-direct Members to the lowest-cost and most appropriate medication(s) channel.
- vi. Rebate Management
 1. A Rebate management program that is transparent, auditable, and includes the following elements:
 - a) Rebates with third parties that are specific to HCA Preferred Drug List and are not dependent on the Contractor's Book-of-Business market share or preferred drug list.
 - b) Rebate terms prospectively to enable HCA to make informed benefit design decisions.
 - c) Negotiate Rebates and discount units with pharmaceutical manufacturers for drugs covered under the medical benefit based on the Contractor's wrap around medical preferred drug list.
 - d) Pass 100% of Rebates on Medical Drugs back to HCA on a quarterly basis, less any compensation, commission, or fee owed by Contractor to a third-party for services provided directly to obtain such Rebate and not to exceed 10% of the total invoice value of such Rebate. Any compensation, commission, or fee owed by Contractor to a third-party for services provided directly to obtain such Rebate must be provided to HCA as part of the invoice process.

3.10.2. Coordination with UMP Pharmacy Benefit Manager

Contractor shall routinely coordinate with the UMP PBM. This will include regular joint monthly participation in clinical strategy meetings, sharing of patient and Claim information by both parties to coordinate care of Members as needed, and support of data analysis of both the Contractor and the UMP PBM as directed by HCA. Monthly, Contractor shall receive a data file from the UMP PBM and complete data analysis such as UMP-specific, HEDIS-like reporting for HCA. Any such data provided to Contractor by the UMP PBM shall be firewalled from the rest of Contractor's Book-of-Business data. A Business Associate Agreement and/or Data Sharing Agreements will be executed by the Contractor and the UMP PBM for this purpose.

3.10.3. Preferred Drug List

Contractor shall, through coordination with and approval from HCA, administer a clinically appropriate, safe, and cost-effective "medical preferred drug list" that is consistent with (i)(1) the Washington Preferred Drug List and (2) the Plan wrap-around

preferred drug list maintained by the UMP PBM, or (ii) the medical preferred drug list provided by HCA.

3.10.4. Plan Design

Through the completion of a Work Order, Contractor shall administer the UMP Plan design for Medical Drugs to be aligned with the UMP outpatient pharmacy benefit, specifically to allow for step-therapy protocols and other Utilization Management that require a self-administered or other drugs, covered in the pharmacy benefit, be used prior to a Medical Drug and the administration of different cost-sharing for drugs based on their "preferred" status to align with the outpatient pharmacy benefit. This may also include a closed formulary as determined and approved by HCA. Implementation details will be established through the Work Order process. All such Work Orders will be for no additional cost, and hours will not be deducted from the Pooled Hours.

3.10.5. Medical Drug Rebates

Contractor shall (i) at the request of HCA, negotiate Rebates with third parties that are specific to the HCA Preferred Drug List and coordinate with the UMP PBM and HCA to align HCA's medical and pharmacy benefits; (ii) prospectively provide HCA with a summary of all rebate terms and conditions for Medical Drug Rebates and any subsequent changes to medical policies prior to agreement of Rebates with third parties to enable HCA to make informed decisions for the management of the Medical Preferred Drug List; (iii) inform HCA of any material changes to all Rebate terms at least sixty (60) days prior to the Effective Date; (iv) on a monthly basis, pay or pass through to HCA (pay back to HCA) all Rebates, discounts, incentives, or other credits, however characterized, for Medical Drugs utilized by Members on which such Rebates, discounts, incentives, or other credits apply, less any compensation, commission, or fee owed by Contractor to a third-party for services provided directly to obtain such Rebate and not to exceed 10% of the total invoice value of such Rebate. Any compensation, commission, or fee owed by Contractor to a third-party for services provided directly to obtain such Rebate must be provided to HCA as part of the invoice process; and (v) provide HCA with quarterly reports detailing the Rebate submission by pharmaceutical company, drug product by NDC, and Claim count.

3.10.6. Audit

Contractor shall allow HCA or its delegates to review (i) contracts with manufacturers and, (ii) data specific to the administration of the MBDMP, in order to audit such records and contracts for compliance with the terms of this Contract. The rights of HCA in this subsection are conditioned on (iii) HCA providing a written request for such review and audit at least ten (10) Business Days in advance, and (iv) HCA signing a mutually agreeable confidentiality agreement. Such review will be, at HCA's sole discretion, either of original documents at Contractor's facilities, or of copies of such documents.

3.11. Disabled Dependent Certification

Contractor will process disabled Dependent certifications and meet notification requirements set forth in the table below. While these processes and requirements are current as of the Effective Date, they may change over time and will be included in the Operations Manual. Contractor will follow processes and requirements as outlined in the most current Operations Manual.

Table 3.11.

Event		Time Allowed for Member to Return Forms	Description of Timeline
Initial Certification	New employee enrolling a Disabled Dependent age 26 or older	31 Days	The form must be received by his or her employer no later than thirty-one Days after the employee becomes eligible for PEBB or SEBB benefits.
	New retiree enrolling a Disabled Dependent age 26 or older	60 Days	The form must be received by the PEBB Program no later than sixty Days after the employee's employer paid or COBRA coverage ends.
	New COBRA, Leave Without Pay, or Continuation Coverage Subscribers enrolling a Disabled Dependent age 26 or older	60 Days	The form must be received by the PEBB or SEBB Program no later than 60 Days after the employee's employer paid coverage ends.
	Current employee enrolling a Disabled Dependent following the Dependent's 26th birthday	60 Days	The form must be received by his or her employer no later than sixty Days after the last Day of the month in which the child reaches age 26.
	Current retiree enrolling a Disabled Dependent following	60 Days	The form must be received by the PEBB or SEBB Program no later than sixty Days after the

Table 3.11.		
Event	Time Allowed for Member to Return Forms	Description of Timeline
	the Dependent's 26 th birthday	last Day of three month in which the child reaches age 26.
	Current COBRA, Leave Without Pay, or Continuation Coverage Subscriber enrolling a Disabled Dependent following the Dependent's 26 th birthday	60 Days The form must be received by the PEBB or SEBB Program no later than 60 Days after the last Days of the month in which the child reaches age 26.
Re-certification	Child currently enrolled as a Dependent with a disability that needs to recertify	60 Days The re-certification form must be sent by Contractor no later than 90 Days prior to termination date, allowing Member 30 Days to return. If not received in 30 Days, Contractor shall send a reminder notice 60 Days before termination.
Open Enrollment	Current employee enrolling a Disabled Dependent age 26 or older during Open Enrollment	Last Day of the annual Open Enrollment period. Forms must be received by his or her employer no later than the last Day of the annual Open Enrollment.
Special Open Enrollment	Current employee enrolling a Disabled Dependent over age 26 due to a qualifying event under special open enrollment rules	60 Days The forms must be received by his or her employer no later than sixty Days after the event that creates the special open enrollment.

3.12. Appeals and Complaints

The HCA requires an Appeals and Complaints administrative service to administer, document, and track first-level and second level Appeals, Independent Review Organization (IRO) requests, pre-authorizations, Complaints, and related issues, and to process associated correspondence in compliance with all applicable laws. The UMP Plans are not ERISA plans, but state-sponsored health plans subject to applicable provisions of Washington law, including RCW 41.05.017, which includes part of the Washington State Health Care Patient Bill of Rights.

HCA reserves the right to customize all Appeals and Complaints communications and processes. Unless otherwise required by HCA, the Contractor shall administer an Appeals and Complaint process consistent with the remainder of this Section.

3.12.1. Requirements: All Level Appeals

For all levels of Appeals or Complaints, Contractor shall:

- a. Provide Appeals administration for medical necessity as well as other contractual issues.
- b. Administer, document, and track first-level Member Appeals, Complaints, and related issues.
- c. Notify the Member in writing within seventy-two (72) hours of receipt of an oral or written request for Appeal of an adverse benefit determination as defined in RCW 48.43.005.
- d. Resolve first-level and Second level Appeals and Complaints within thirty (30) days of receipt, unless an extension is granted by the Member or is otherwise permissible under Washington state regulations.
- e. Process associated correspondence in compliance with all applicable laws for patient privacy and promptness.
- f. Comply with the Appeals processes and coverage provisions of the COC and Washington State Health Care Patient Bill of Rights, as described in RCW 41.05.017, as well as other applicable law.
- g. Customize standard Appeals, pre-authorizations, and other related materials as directed by HCA. All denials of coverage will contain a description of the Appeal process within the document. This includes excluded or limited services, pre-authorizations, denials, denials based on HTCC determinations, medical necessity denials, and others, as directed by HCA.
- h. Administer, document, and track Expedited Appeals, IROs, and Expedited IROs, as described in the COC, as well as any other Appeals that are required by law to be resolved within a shorter time.
- i. Notify Members of Appeal rights for all denials, including denials of reimbursement or prior authorization, or exclusions, including when a Member requests preauthorization for a service that is not on the preauthorization list.

3.12.2. Requirements: Second Level Appeals, and Requests for Independent Review

For second level Appeals and for Member requests for a review by an IRO, Contractor shall:

- a. Administer, document, and track second level Member Appeals.

- b. Notify the Member in writing that the second level Appeal was received within seventy-two (72) hours of receipt.
- c. Answer second level Appeals within thirty (30) Days of receipt unless an extension is granted by the Member or otherwise permissible under Washington State law or regulations and as required under the COC.
- d. Administer, document, and track Independent Review Requests (as defined in the COC).
- e. Follow the IRO process required by Washington State law utilizing Washington certified IROs sequentially.
- f. Clearly and accurately note whether the IRO request is for a review of medical necessity or contract review of an excluded service. This requirement applies to denials based on an HTCC determination, which could be either a specific contract exclusion denial or a medical necessity denial depending on the technology at issue
- g. Complete and send to the IRO all independent review requests within three (3) Business Days of receipt of the Member's request. Contractor will provide a cover letter to the IRO that includes at a minimum (i) whether Contractor needs a clinical or legal review, (ii) for HTCC decisions, a citation to RCW 70.14.120 requiring HCA to follow HTCC decisions, and (iii) for HTCC decisions, attach HTCC decision or medical policy that was used to deny the Claim.
- h. Give HCA copies of each IRO decision within seven (7) Days of the final IRO decision.
- i. Notify Members of Appeal rights for all denials, including denials of reimbursement or prior authorization.

3.12.3. *Expedited Appeals and IROs*

There are two parts to the Expedited Appeals process: (1) Appeal on an expedited basis, and (2) an expedited Independent Review. If the UMP Plan denies coverage for services and the provider determines that taking the usual time allowed could seriously affect a Member's life, health or ability to regain maximum function, or would subject the Member to severe pain that cannot be adequately managed without the disputed care or treatment, the Member's provider can initiate an Expedited Appeal. Contractor will decide the Expedited Appeal within seventy-two (72) hours of the request. Contractor will report to HCA the number of Expedited Appeals requested each quarter (or monthly, if requested by HCA), including information about requests determined not to be urgent, requests denied, and requests approved.

3.12.4. *Member Materials*

- a. Contractor will customize standard Appeals-related materials as directed by HCA.
- b. Contractor will document, track, and respond to Member Complaints within thirty (30) Days.

3.12.5. *Complaint Response*

If a Member has a written Complaint, the Member will receive a written response by Contractor; or if a Member requests, a verbal response by telephone. Contractor may respond to verbal Complaints verbally or in writing and if requested by Member to respond in writing, Contractor will comply. Contractor shall also document, track, and respond to Member Complaints within thirty (30) Days of receipt of the Complaint.

3.13. Account Management

3.13.1. General

All FTEs required below will be included in the Administrative Fees. Account management staff solely dedicated to the HCA account are indicated.

Contractor will provide an account management administrative service team that is proficient in coordinating resources and services to meet all Contract requirements and Performance Guarantees and is responsive to HCA requests for support and coordination. The resources listed in Sections 3.13.3 through 3.13.16 (Account Team) will be dedicated to the UMP Plans account and responsive to all requests from HCA.

Contractor shall: (a) respond to resolve problems regardless of the cause (acknowledge receipt of email and have an estimated resolution time within 24 hours and provide HCA 24 hour phone access for urgent issues), (b) minimize negative direct impacts to Members and providers, and (c) be sensitive to the economic and political environment associated with UMP Plans as public health plans serving Members of state and local legislative, executive, and judicial branches of government and faculty and staff of institutions of higher education. The Account Team may be required to travel to in-person meetings as required by HCA. No new employees will be assigned to the Account Team without HCA's written approval. HCA has the authority to require replacement of Account Team members. Contractor shall not replace Account Team members without the express written consent of HCA, and HCA will also be part of the interview process for Account Team members when replaced and final approval of replacements.

In addition, the following members of Contractor's executive leadership will attend the following meetings described further below:

Title	Meeting
President of Washington Plan	Operations Account Meetings
Cambia – COO or CRO	Strategic Account Meetings (minimum 2 x per year)
Cambia – Chief Medical Officer	Strategic Account Meetings (minimum 2 x per year)
Cambia – VP, Network Management	Strategic Account Meetings (minimum 2x per year)/ Clinical Strategies meetings as required

3.13.2. Account Management Functions

Contractor will do all the following:

- a. General
 - i. Designate solely dedicated, experienced account management staff and other experienced subject matter experts for each contracted administrative service in sufficient numbers for the size and complexity of the UMP Plans.
 - ii. Be responsive to HCA inquiries, acknowledge receipt of each request within 24 hours and answer each request within three (3) Business Days; provided,

however, requests designated by HCA as urgent or a legislative request must be answered within 24 hours.

- iii. Keep HCA informed of new and outstanding issues related to UMP Plan administration.
- iv. Have a dedicated escalation process and point of contact for Member inquiries that come directly to HCA.
- v. Report quarterly on performance, including key features of UMP Plan operations and presentation of analyses and recommendations in response to reported performance outcomes.
- vi. Contractor's personnel that provide account management are located in Washington State.
- vii. Attend all Clinical Management meetings and follow through with clinical programs manager as needed.
- viii. Attend all meetings of the PEBB and SEBB.
- ix. Collaborate and coordinate with the Office of the Attorney General (OAG) and any Special Assistant Attorney General, when requested by the OAG, on any actual or potential legal action litigation against HCA related in any way to the UMP Plans. This includes the gathering by Contractor of information, data, and documents used internally at Contractor or any Subcontractor, and providing witnesses as requested by HCA or required as part of the litigation process. No additional fees will be paid for such services.
- x. Manage the contract with the HSA Trustee for UMP CDHP.
- xi. Include HCA in Contractor's hiring and replacement processes for the roles described in this Section 3.13, including participating in reviewing qualifications of candidates, participation in in-person or telephone interviews]. No person shall be provided by Contractor for any role set forth in this Section 3.13 without the approval of HCA.

b. Operations Account Meetings

- i. Hold monthly operations account management meetings and present the monthly operations reports to HCA at HCA offices in person. All members of the Account Team will participate.
- ii. Hold weekly core team meetings with HCA wherein Contractor will keep and maintain a log of all current and past issues and Work Orders and the team will discuss and log progress on issues each week.
- iii. Hold additional telephone or in-person meetings as requested by HCA.
- iv. The Account Team will build the Operations Manual and update twice a year.

c. Strategic Account Meetings

Senior management representatives of HCA and Contractor will meet on a regularly scheduled basis to discuss performance and to develop strategic priorities and action plans to advance the UMP Plans value proposition. Such meetings shall also include the disclosure and discussion of the features, scope, results, and appropriateness of any new or existing Pilot Programs. At HCA's discretion, these meetings will be held either

quarterly or twice per year. Contractor shall produce and provide quarterly utilization reports.

d. UMP PBM Meetings

Representatives of HCA and Contractor will meet on a regularly scheduled basis to discuss issues related to Contractor's MDBMP, to the relationship between Contractor and the UMP PBM, and to Contractor's services described in Section 3.10. At HCA's discretion, these meetings will be held either quarterly or twice per year

e. ACN Meetings

Representatives of HCA and Contractor, to include at least the ACN Account Manager, will meet on a regularly scheduled basis to discuss performance of the ACNs and to develop strategic priorities and action plans to advance the objectives of UMP Plus, such as reporting, ACN management, provider search, case/care management, and Member experience. At HCA's discretion, these meetings will be held either annually, quarterly, or twice per year. Also, upon HCA's request, leadership from ACN provider systems will attend relevant meetings.

f. Other Meetings

In addition to the meetings specifically set forth in this Section, upon written notice and request from HCA, appropriate representatives from Contractor shall meet telephonically or in-person at a location designated by HCA to discuss the overall relationship of the parties, the status of services, and the status of and any risks or issues.

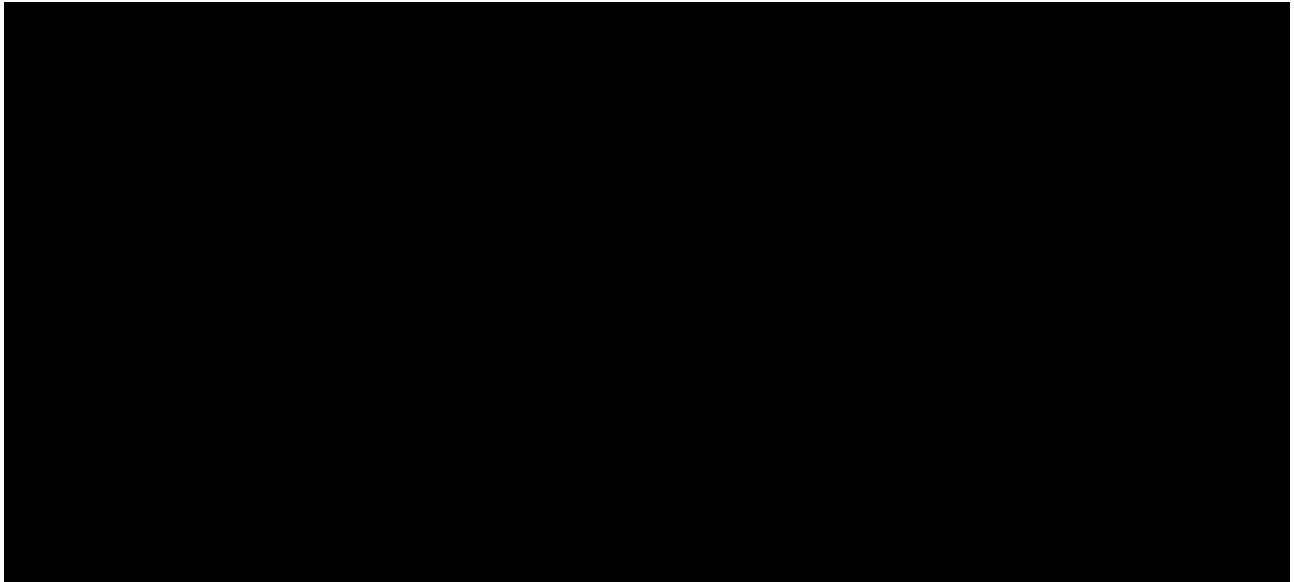
g. Banking

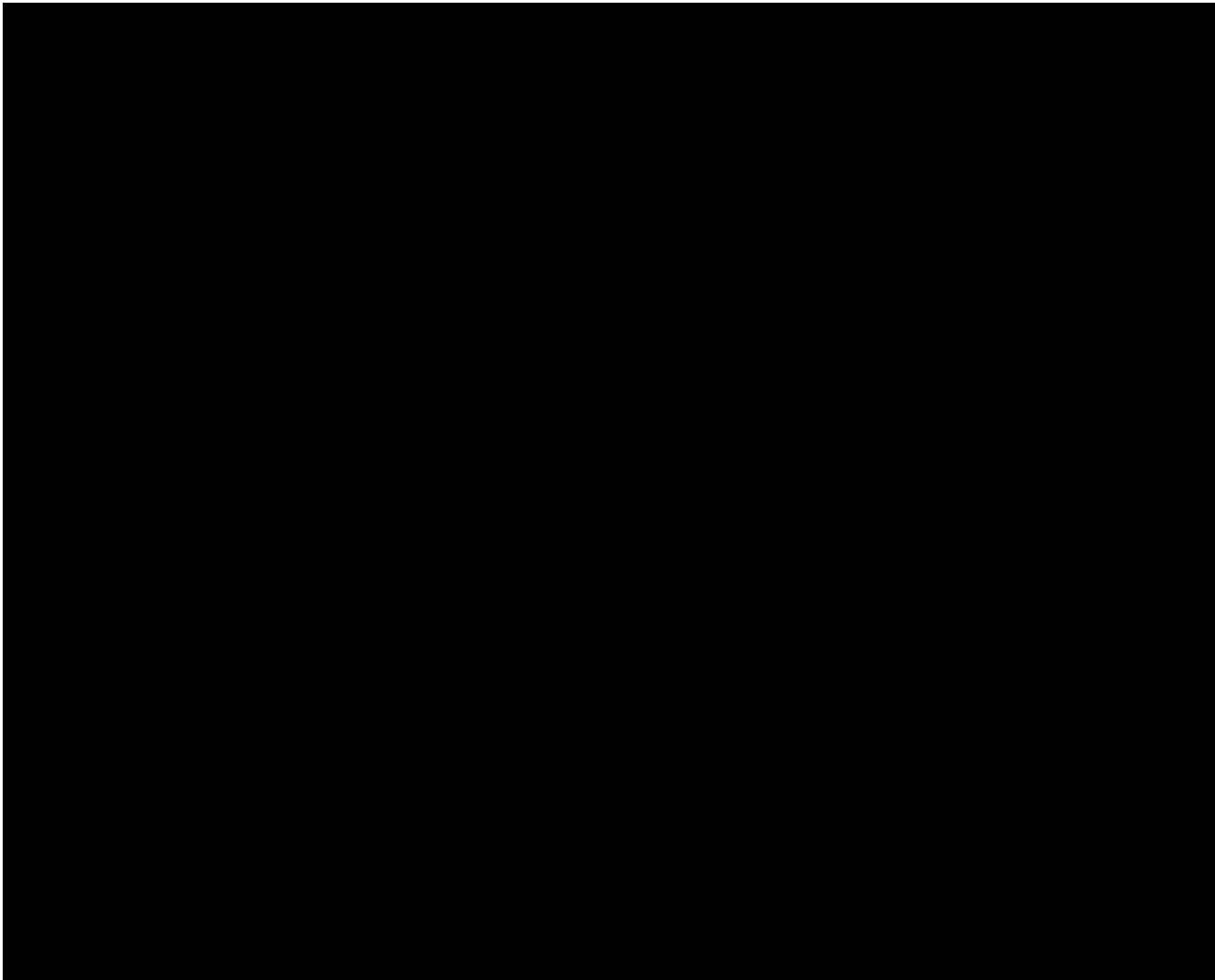
Contractor shall notify HCA via email on a weekly basis of Claim payments issued.

h. Escheat

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

3.13.3. *Account Management Staffing Levels*





3.13.4. *Strategic Account Managers*

Contractor's Strategic Account Manager(s) will be set forth in the Operations Manual. The Strategic Account Manager will:

- a. Be the points of contact for the HCA Senior Account Sponsor(s) and for the escalation of issues between Contractor and HCA.
- b. Coordinate and recommend strategies to the PEBB and SEBB with HCA, including lowering or maintaining cost trend, improving Utilization Management, and changing the health care market to achieve Healthier Washington goals.
- c. Respond to HCA account team within 24 hours of initial request, and with an answer or solution within three (3) Business Days of request.
- d. Respond when called for urgent issues within four (4) hours.
- e. Respond to proposed Work Orders within the contracted timelines.
- f. Attend weekly account management meetings, and be onsite at the HCA's headquarters as requested.

3.13.5. *Daily Operations Managers*

Daily Operations Managers will:

- a. Be the points of contact for the HCA account team.
- b. Maintain the action log and track escalated and legislative requests, reporting, Performance Guarantee reports, Work Orders, and other daily operations tasks.
- c. Respond to HCA account team within 24 hours of initial request and with answer or solution within three (3) business days of HCA request or an estimated time for resolution of the request.

3.13.6. *ACN Account Manager*

ACN Account Managers will:

- a. Be responsible for all ACN operations, including network set up and processes, data and reporting to HCA and its data intermediary, and benefits programming and operations.
- b. Respond to HCA account team within 24 hours of initial request and with an answer or solution within three (3) Business Days of HCA request or an estimated time for resolution of the request.
- c. Attend all regularly scheduled meetings of HCA, Contractor, and the ACNs, and attend any special meetings between HCA and one or more ACNs at the request of HCA.

3.13.7. *Clinical Programs Managers*

Within fifteen (15) Days of the Effective Date, Contractor will identify two (2) Clinical Program Managers (CPMs) who will be responsible for the actions listed below. Each CPM will be a licensed practical nurse or a registered nurse with current, active, and unrestricted licenses in Washington State. The CPMs will:

- a. Serve as the points of contact for the HCA clinical programs manager.
- b. Attend weekly meetings with HCA regarding clinical programs for UMP Plans, and other meetings as deemed appropriate by HCA.
- c. Participate and facilitate the bi-monthly Clinical Strategies Team and Clinical Strategies Workgroup meetings, will attend the weekly Core Team Meetings, and will provide monthly updated medical polices in operations and clinical strategies meetings.
- d. Coordinate all HTCC related activities by attending weekly HTA meetings, providing feedback and input to HTA processes and programs on behalf of Contractor, and coordinating HTA activities with Contractor's Medical Directors, Implementation Teams, and Clinical Teams.
- e. Provide oversight and management for all Clinical Management programs.
- f. Provide leadership and oversight for the Quality Management and Quality Improvement for all Clinical Management programs.
- g. Serve as clinical representatives when required for clinical topics when communicating and coordinating with other relevant programs, such as the ACNs and other benefit programs.

- h. Attend all HTCC meetings (approximately six (6) times a year).
- i. Attend Bree Collaborative meetings as requested by HCA.
- j. Maintain a Master Grid for all HTCC determinations and implementation plans.
- k. Coordinate all of the ABA program related activities, including attending all ABA program meetings; providing feedback and input related to ABA processes and programs to HCA on behalf of Contractor; and coordinating ABA activities with Contractor Medical Directors, implementation, operations, and analytics teams. Additionally, the CPMs will provide Member advocacy services to ABA program participants, including review of denials, Appeals, and escalated issues.
- l. Establish and maintain a “clinical action log” to document, prioritize, and track clinical issues that are raised as a part of the meetings and activities described above. The form and content of such log will be subject to HCA’s approval.
- m. Review medical policies and do research as requested by HCA to inform HCA customized medical policies, and legislative research as needed.
- n. Provide detailed quarterly and annual Clinical Management reporting, including activities, processes, and outcomes reporting.
- o. Provide detailed annual Appeals and IRO reporting at Member level detail.
- p. Coordinate with Contractor and HCA communications specialists on updates to medical policies to be posted on the HCA website monthly.
- q. Support all UMP Plans, including Care Transformation of the UMP Plus and other ACN programs.
- r. Brief HCA on Book-of-Business Clinical Management programs and implementation thereof. Implementation plans and progress of Bree and other customized HCA medical policies. This also includes clinical requests for information from HCA account team or solutions/recommendations to issues with Members and clinical situations and issues.

3.13.8. *Medical Director (MD or DO)*

The Medical Director will:

- a. Be an employed physician who holds a current, active, and unrestricted license to practice medicine in Washington State who is associated with Contractor to provide medical expertise and support HCA’s Health Technology Assessment program, the Prescription Drug Program, the Bree Collaborative, and other the HCA-identified performance improvement efforts as they relate to the UMP Plans and the State’s health care purchasing system. This will include HCA customized medical policies and other requests from HCA.
- b. Approve the annually written description of Contractor’s Clinical Management program.

3.13.9. *Data Analyst*

Contractor will provide certain analytic support services on Claims and utilization data within the UMP Plans. These services are included in the Administrative Fees. The Data Analysts will:

- a. Provide a UMP Plan specific database, and Book-of-Business comparisons, analytics and decision support.
- b. Facilitate enhanced access to Contractor's data analytics team, with priority handling and rapid turnaround time facilitated of HCA requests. HCA requests will be maintained separately from other Contractor clients and may require turnaround times as short as twelve (12) hours due to legislative or other HCA requirements. These requests will be tracked via a log sheet, and Contractor will communicate prioritization to HCA through weekly triage calls. Weekly triage calls will also be used to assess the content and intent of prioritized requests to ensure that meaningful data is provided in a timely and reliable manner. The parties may hold additional ad hoc meetings as necessary.
- c. Provide monthly dashboard reports and in-depth analysis of cost and utilization patterns in an attempt to proactively identify cost drivers and trends. Additionally, one (1) or two (2) members of the consulting team will be available to attend up to six (6) in-person meetings with HCA per year.
- d. Provide monthly PDF files of any prior authorization standards, criteria or information the UMP Plans use for medical necessity decisions in compliance with chapter 41.05 RCW.
- e. Provide priority handling and rapid turnaround of data reports and analytics.
- f. Provide analytic support and services on Claims and utilization data with the UMP Plans.
- g. Use the Contractor Account Manager and the HCA Portfolio Management and Monitoring team member who submitted the data request as points of contact.
- h. Accept data/report requests for HCA only from an HCA Portfolio Management and Monitoring team member. All data/report requests will be specific and include detailed requirements necessary for Contractor to prepare the report. HCA will also work with Contractor to create a prioritization of all data/report requests.
- i. Provide HCA employees twenty-four (24) hour a Day, seven (7) Days a week access to a UMP Plans Claims database for ad hoc reporting.
- j. Provide leadership and support on all UMP Plus data layouts, reports, transfers and data dictionary or data integration.

3.13.10. ACN Data Reporting Product Manager

The ACN Data Reporting Product Manager is responsible for managing the daily and strategic delivery of the technical solutions for HCA throughout Contractor and its affiliates. This person has oversight of the validation and mitigation processes for accuracy compliance, as well as constant oversight of delivery timelines and parameters. This individual must have demonstrated ability to discover and describe the current state situation, understand strategic business goals, design and articulate future state, perform gap analysis and make recommendations to business leadership that meet goals and requirements. This individual must have demonstrated ability to understand, translate and communicate technical and complex ideas and situations to a wide variety of audiences including clients, coworkers and management.

3.13.11. Communications Specialist

The Communications Specialist will:

- a. Be the point of contact for all communications documents and website language, to include printed materials, Certificates of Coverage, updates to HCA websites, updates to medical policies, provider termination communications to Members, and anything that will be viewed by Enrollees.
- b. Have oversight for website and electronic communications for Members and will collaborate with HCA Communications on all Member correspondence.
- c. Subject to HCA review and approval, develop UMP member and stakeholder communications.
 - i. Write (edit or revise), coordinate reviews of, and finalize UMP communications. This may be print, electronic (such as web or email), or verbal (such as FAQs or talking points) communications. Coordinate with HCA to schedule and/or coordinate reviews, design, data pulls, posting, and distribution. Notify appropriate staff of changes to UMP timelines, new material updates, and other plan news.
 - ii. Co-lead the UMP Production Timelines, and share with appropriate HCA staff to ensure expectations and timelines are met.
 - iii. Co-lead the writing, review, and updates to the UMP website. Provide content, design, and usability recommendations for UMP's website to the Web Team and/or PEBB lead web writer to ensure that UMP and members' needs are met. Coordinate with the ERB Lead Web Writer for content and linkage, to provide useful information to UMP members in a timely manner.
- d. Support the development of PEBB and SEBB Program communications by, as needed, writing (or revising), coordinating reviews of, and finalizing PEBB and SEBB Program communications. This may be print, electronic (such as emails or web), or verbal (such as FAQs or talking points) communications. Contractor will coordinate with HCA to schedule design, data pulls, posting, and distribution, and notify appropriate staff of changes to PEBB and SEBB timelines, new material updates, and other program news.
- e. Lead or participate in HCA projects or teams that affect ERB communications. Review team or project recommendations about communications affecting UMP, or PEBB and SEBB Programs, and provide input. Develop materials or messaging to implement project or team goals. Communicate changes to appropriate staff.
- f. Provide ERB intranet support.
 - i. Provide timely notice of updates to HCA account team and ERB communications and mailings to ERB intranet staff to post, to ensure that ERB staff has information on upcoming communications and changes. This includes provider terminations.
 - ii. Provide timely notice of updates to HCA account team and ERB communications and mailings to ERB intranet staff to post, to ensure that ERB staff has information on upcoming communications and changes.
 - iii. As needed, provide advice on usability of site to ensure that ERB staff needs are met.

3.13.12. *Implementation Management*

The Implementation Management team will consist of:

- a. Implementation Manager

- i. Serve as the single point of contact for HCA Account Manager and HCA Project Manager on implementation activities.
 - ii. Coordinate and ensure performance of the implementation Services; will work full-time in support of Contractor's implementation services.
 - iii. Provide services from the Effective Date through June 2020 for initial phase and if any new plans are added, Contractor will supply an implementation manager for such projects.
- b. Project Managers
 - i. Contractor will provide at least two (2) solely dedicated FTEs to service as Project Managers reporting to the Implementation Manager.
 - ii. Project Managers will support implementation activities as directed by the Implementation Manager, coordinate and ensure performance of the implementation services, and provide services from the Effective Date through June 2020 for initial phase and, if any new projects are added, Contractor will supply an implementation manager for such projects.

3.13.13. *Clinical Analyst*

The Clinical Analyst supports the UMP Clinical Programs Manager and the Account Team by researching and analyzing clinical data, compiling reports, coordinating special programs, such as ABA and Transgender, and maintaining and ensuring clinical documentation is current. The Clinical Analyst collaborates with the Communications Manager on clinical documentation, correspondence, and webpage resources.

3.13.14. *Pharmacist (as needed)*

The Pharmacist will be employed by Contractor to provide medical pharmaceutical expertise in collaborating with the HCA and its designated PBM to ensure alignment in the execution of drug formulary, utilization management policies and other clinical initiatives as needed. This position will also assist in developing, executing and maintaining strategies to support cost containment, benefit design and clinical quality improvements related to medical drug management; and it will support executive updates on plan performance and presenting best practice opportunities to HCA. The Pharmacist must have a current, active, and unrestricted license to practice in Washington State.

3.13.15. *Account Contact (as needed)*

The Account Contact will serve as the primary point of contact for all Contracts and amendments and will represent Contractor on accounting and finance questions as HCA requires; available as needed.

3.13.16. *Legal Contact (as needed)*

The Legal Contact will be an attorney for Contractor who will be the point of contact for all Contracts and Amendments for Contractor and will represent Contractor on legal questions as HCA requires. Contractor will have no more than five (5) Business Days to turn around HCA requested timelines and all legal documents, to include Contract amendments, BAAs,

and Data Share Agreements. The Legal Contact will also be the point person to coordinate with the OAG on litigation against HCA or the UMP Plans, as required by HCA or the OAG.

3.13.17. Legislative Support Services

Contractor will support HCA in completing its analyses of pertinent bills under consideration by the Washington State Legislature. Contractor will provide documents or information in satisfaction of HCA's requests in connection with such bill analyses within twenty-four (24) hours of HCA's request. If Contractor reasonably believes it would be unable to implement a new mandate or process under consideration by the Legislature, then it will notify HCA immediately, and provide its rationale, so this information can be considered as part of the legislative process.

3.13.18. Account Management for Public Relations

As a state-wide public sector health plan, HCA operates within a complex public environment and the Account Team needs to be sensitive and responsive to public relations issues and inquiries.

3.13.19. Emergency Response Account Management

The Contractor must be able to maintain critical functions during an extended closure or emergency or severe weather event.

Contractor will:

- a. Provide Contractor's Business Continuity & Disaster Recovery plan that maintains uninterrupted core business operations during natural disasters, Contractor system or power outages, or other abnormal events (Event), on an annual basis and upon HCA's request.
- b. Maintain core business operations during an Event and provide HCA specific information that clearly relates the emergency response to the UMP Plans during an Event no less frequent than once per 24-hours.
- c. Contractor will maintain in an uninterrupted manner those business functions and services listed in Section 3.1.11 (Claims Services), Section 3.3 (Clinical Management), Section 3.4 (Utilization Management), Section 3.6 (Complex Case Management), Section 3.7 (Chronic Condition Management), Section 3.10 (Medical Benefit Drug Management), Section 3.13 (Account Management), and Section 3.14 (Member and Customer Service), during an Event. Within five (5) Days of a request from HCA, and annually on July 1, Contractor will provide its current Business Interruption and Disaster Management Plan specific to UMP Plan operations. An initial UMP disaster plan is included as Exhibit H.

3.14. Member and Customer Services

3.14.1. General

Contractor's Member and customer services will provide knowledgeable, responsive, high quality customer service to all Enrollees, regardless of their location. Contractor's center providing such services will be structured to provide a consistently high degree of customer services and timeliness as measured through the applicable performance standards defined in Section 6, *Performance Standards & Guarantees*. A minimum of 70% of the customer or Member Services team must be physically located in the State, and all must be within the

United States. Claims processing must be located and performed within the United States. Contractor's customer or Member service center must be well-versed in the geographic, cultural, and social aspects of Washington State. Customer service and Member services team will be a dedicated resource to HCA.

3.14.2. Services

Contractor will:

- a. Beginning on November 1, 2019, and each year thereafter, provide at least two (2) trained staff for every Open Enrollment benefits fair (which could be held multiple times in different locations in Washington over the Open Enrollment period) who can knowledgeably discuss topics including benefits and cost-sharing, network providers, Claim procedures, Member services, and plan informational tools and resources. These trained staff will not be Contractor's account managers or members of the Account Team.
- b. Provide dedicated customer service staff who are fully trained on specialty UMP Plans, such as UMP Plus.
- c. Provide interactive voice response (IVR) for providers to access eligibility and Claims information, and for Members to access self-service customer service options.
- d. Provide a secure on-line portal to allow providers access to eligibility and Claims information.
- e. Provide language translation services and TTY/TDD services, or other available modes of communication, to accommodate visually and hearing impaired Members in accordance with Washington State and federal law.
- f. Provide for a backup customer service when local customer service is disrupted.
- g. Provide customer service coordination with UMP Plan eligibility and enrollment, with the UMP PBM and other HCA vendors as directed by HCA.
- h. Collect Member feedback and respond appropriately.
- i. Establish and maintain a process and system for monitoring call quality.
- j. Support Members working on assignment in other countries for extended periods by providing assistance and information with evidence or verification of benefits for Foreign governments and with filing and tracking status of Claims.
- k. Provide a clinical case manager or reviewer as the first point of contact for clinical programs.
- l. Provide one trained staff member to manage the disabled Dependent certification process.
- m. Provide a UMP dedicated customer service escalation team for Members and the HCA account team for Complaints. This team should be able to resolve Complaints within two (2) Business Days and investigate the reasons and outcomes for Claims, payment and medical policy issues.
- n. Provide customer service via telephone (Monday through Friday, 8 a.m. to 8 p.m. Pacific Time and Saturday 8 a.m. to 4:30 p.m. Pacific Time), live online chats, email, and mail.

3.15. Enrollee Communications

3.15.1. General

Contractor will work in collaboration with HCA communications staff. Contractor will comply with the document control policies and procedures that are established by HCA. At the beginning of each Plan Year, Contractor will provide HCA a single point of contact regarding these services. All communications will be readable and clear, ADA-compliant, and in full compliance of Section 1557 of the Affordable Care Act (including the availability of language translation services, and translated materials to be provided upon member request within seven (7) Days).

3.15.2. Services

Contractor will:

- a. Assume responsibility to write, design, print, and distribute the COCs for the UMP Plans annually, ensuring their compatibility with Contractor's administration of the UMP Plans and HCA's responsibility for defining eligibility and benefits. Contractor will develop the review schedule subject to HCA's approval. HCA has final approval of COC benefits, content, and design, which must be finalized in PDF format at least one (1) Business Day before November 1 of each year.
- b. Write, design, print, and distribute the Open Enrollment materials (both physical and electronic copies) listed below. All Open Enrollment and new plan year communications must be approved by HCA before October 15.
 - i. Summary of Benefits and Coverage documents,
 - ii. Benefits summary comparison documents,
 - iii. CDHP materials,
 - iv. Provider directories (print copies to be available for reference at annual benefit fairs and to Members upon request only),
 - v. Informational materials, including the "What's Changing for UMP" document
 - vi. Web services promotional page,
 - vii. Postcard to request a hard copy of the COC, and
 - viii. Disclosure items required by the Washington State Health Care Patient Bill of Rights described in RCW 41.05.017.
- c. Design and issue identification cards that display an HCA-approved logo in the upper left corner of the card, Contractor logo of equal size in the upper right corner of the card, the UMP PBM logo, RxBin number, RxPCN, Group number, ACN logo and information and other information as requested by HCA.

- d. Issue replacements for lost identification cards at no charge to the Member or HCA. Members can also print a replacement ID card from Contractor's website or download a digital copy from Contractor's smartphone app.
- e. At any point after January 1, 2020, reissue identification cards to all Members when directed by HCA through a chargeable Work Order; provided, however, that any available Pooled Hours (but not any Implementation Hours) will be applied prior to any charges.
- f. For each Plan, write, design, print, and distribute a hard copy welcome packet for new and renewing Members no later than (1) December 20 of each year if Contractor receives the full membership eligibility file by December 10, and (2) within thirty (30) days for enrollment by a new Member if Contractor receives the updated membership eligibility file within five (5) Business Days of the Member's start date. If Contractor does not receive the full membership eligibility file by December 10 of each year, then Contractor is obligated to mail the welcome packet within seven (7) Days of receiving such file. The contents will include but are not limited to:
 - i. Cover letter,
 - ii. Wellness promotional piece (one page),
 - iii. Notice of Privacy Practices (print and distribute only),
 - iv. Web services promotional piece,
 - v. A postcard to request a hard copy of the COC,
 - vi. Pharmacy Benefits Manager quick tips,
 - vii. Other materials, including other vendor materials, as requested by the HCA, and
 - viii. PEBB and SEBB Wellness Program materials.
- g. For each UMP Plan, Contractor must provide the Explanation of Benefits both (i) in writing and (ii) in a single online portal. Members may opt out of paper copies, but Contractor cannot force Members to opt out.
- h. For each UMP Plan, Contractor must update, print, provide an internet-ready and ADA accessible PDF, and distribute the federal Summary of Benefits and Coverage, for all Members. Contractor will follow federal formatting standards and guidelines, including providing the documents in ADA alternate formats and required languages. The Summary of Benefits and Coverage must be provided as a PDF in compliance with HCA's timelines. Printed versions must be mailed to Members upon request from either HCA or the Member.
- i. Provide special announcements to the ERB Division staff and HCA Senior Account Sponsor(s) and HCA Communications at least five (5) Business Days in advance of notifying Members and/or providers.
- j. Contractor shall provide HCA Communications with a PDF file each month with the coverage criteria for the UMP Plans that meets the requirements of RCW 41.05.074(3), which requires HCA to "post on its web site and provide upon the request of a covered

person or contracting provider any prior authorization standards, criteria, or information the health plan uses for medical necessity decisions.”

3.15.3. Administration

Contractor will do all the following:

- a. Submit Member identification card design for approval, in advance, to HCA, and not print or distribute the identification card until HCA approves it.
- b. Ensure appropriate communications to be sent to Subscribers, Members, or Enrollees. Contractor must (i) receive advanced written approval from the HCA Portfolio Management or the HCA Communications staff per WAC 182-08-220, and (ii) ensure that such communications are in compliance with the ADA and Section 1557 of the Affordable Care Act (including the availability of language translation services). This includes UMP-specific content from the Contractor’s website, smartphone app (if applicable), emails, print materials, social media, and any other electronic messaging.
- c. Ensure that all communications relate directly to only the UMP Plans. Contractor will not send, help, or allow any other person or entity to send, communications to Subscribers, Members, or Enrollees except those relating directly to the UMP Plans, unless authorized in writing in advance by HCA.
- d. Dual brand, between HCA and Contractor, all communications as UMP, with the UMP or HCA logo and name the same size as Contractor’s name and logo, unless HCA requests single branding. No communications will be branded as being solely from the Contractor except with advance written approval of HCA.

3.16. Online Services

3.16.1. General Requirements

Contractor will do the following:

- a. Provide ongoing maintenance of the online service portal to the UMP Plan websites as part of the Administrative Fee. Website maintenance will include updates to content both (i) as benefits and UMP Plans are updated and (ii) upon HCA request.
- b. Provide Member access to the UMP Plan websites and Contractor's smartphone app, twenty-four (24) hours a Day, seven (7) Days a week, except for scheduled downtime.
- c. Ensure that information on the website is up-to-date, accurate, and complies with the ADA and other regulations, such as HIPAA.
- d. Respond to all Member emails by the end of the next Business Day.
- e. Capture and maintain all Member communications within a searchable data warehouse.

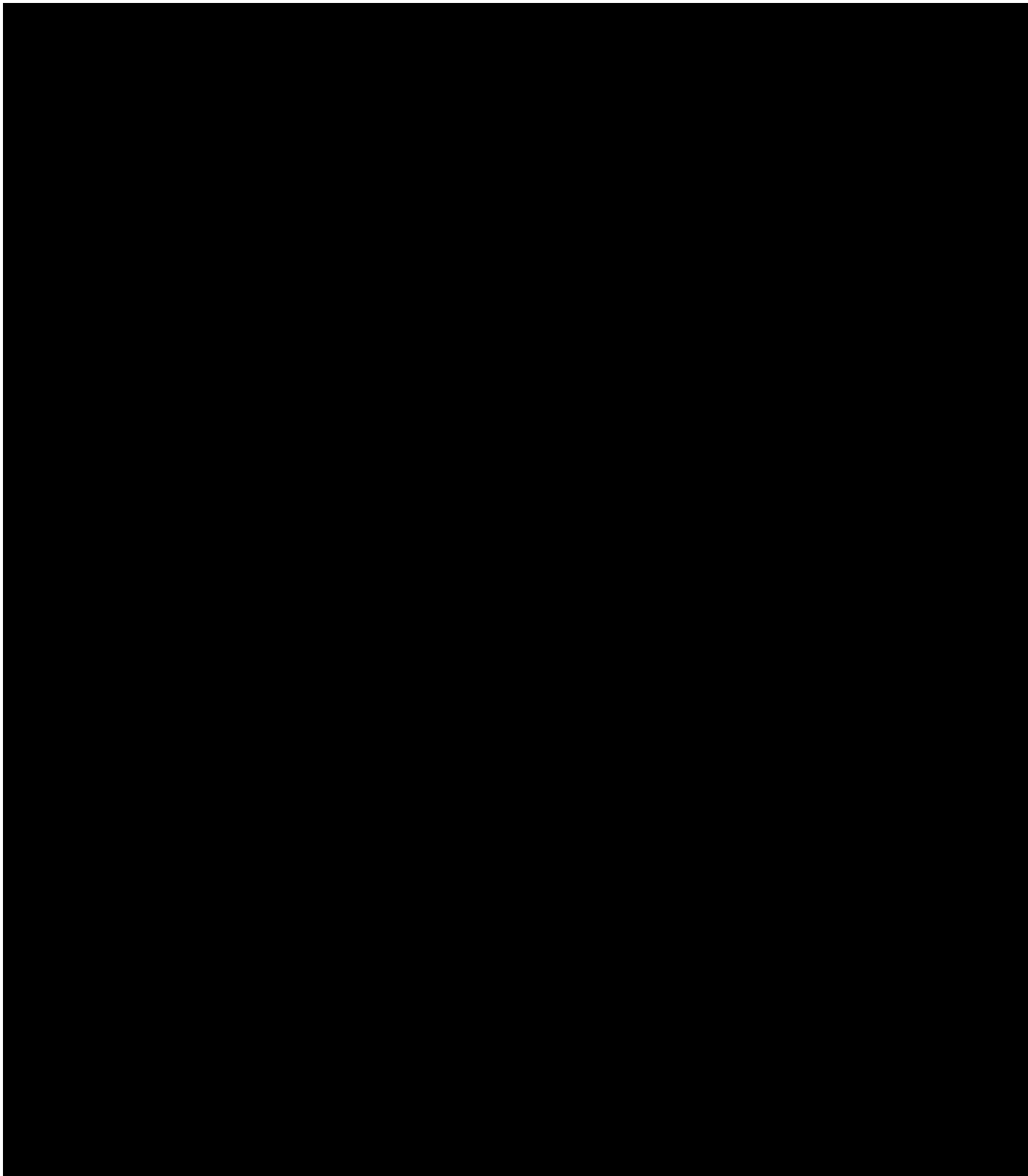
3.16.2. Standards

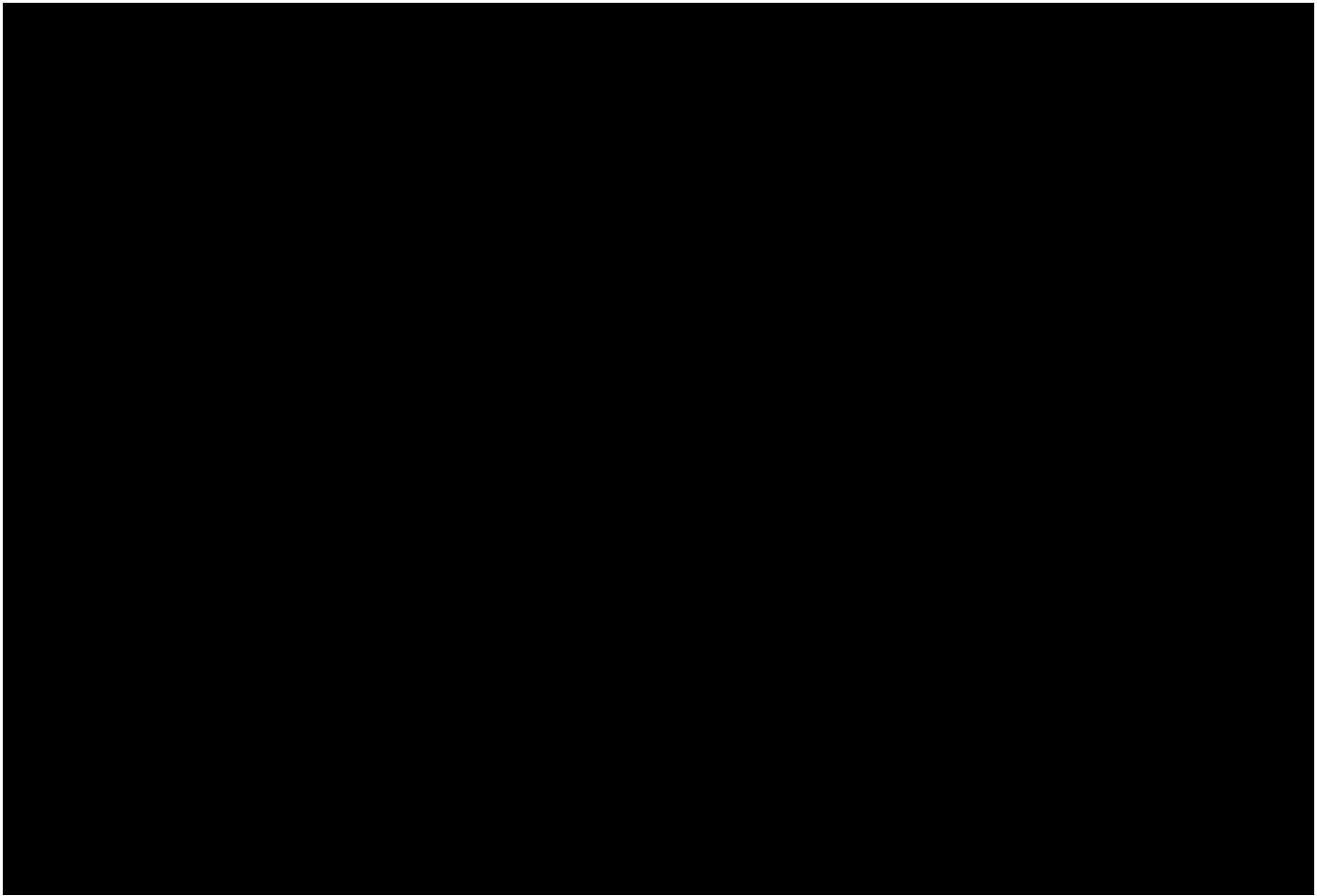
The Online Services must at all times meet or exceed the following State of Washington Information Technology Standards attached as Exhibit K, or their replacements or successors:

- a. [Security](#)

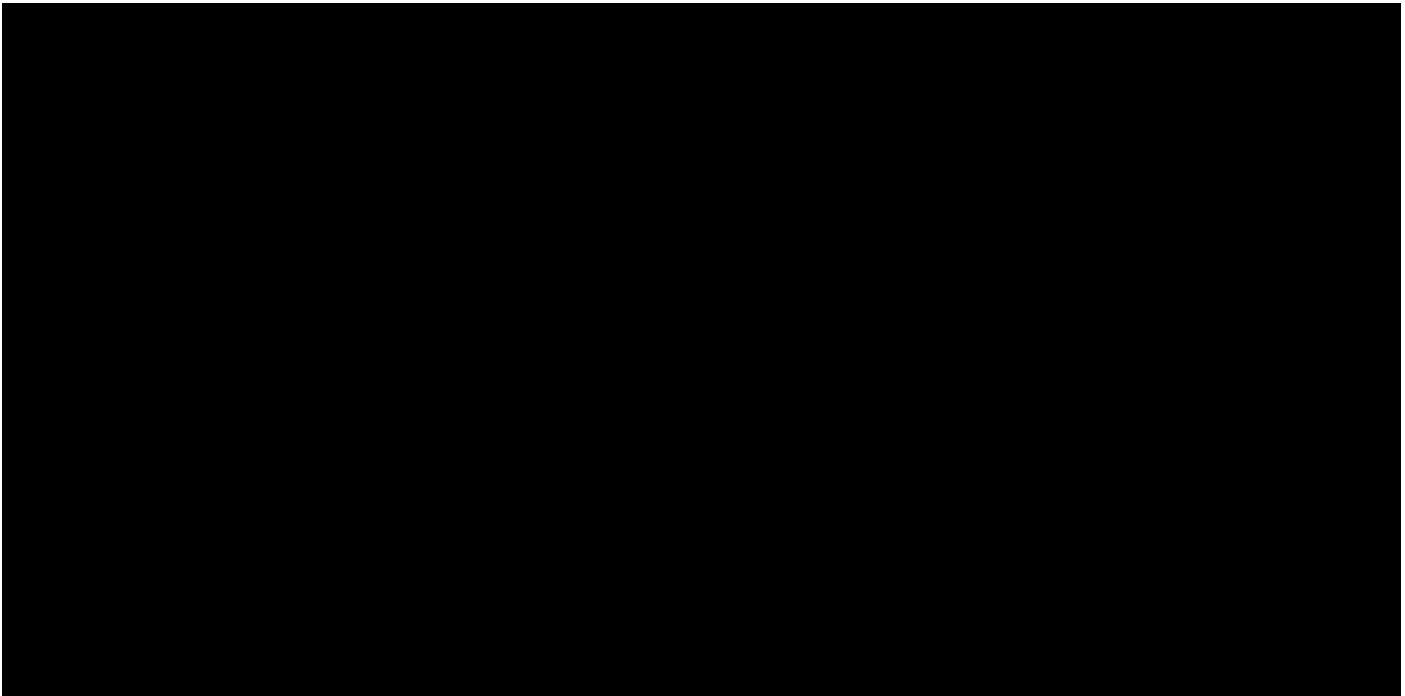
- b. [Accessibility Guidelines](#)
- c. [Public Records Privacy Protection Policy](#)

3.16.3. *Non-Secure Access*





3.16.4. Secure Access



3.17. Data, Systems, and Reporting

3.17.1. General

- a. Contractor must successfully complete a security design review to be conducted by the HCA Office of Security Services and the WaTech Office of Cyber Security. This review shall use as its basis the Washington OCIO security standards referenced within Exhibit K. Such review may be re-conducted in the event of a significant system change.
- b. Contractor will participate and provide data in compliance with HIPAA within the Administrative Fee with various current and future HCA programs (including new initiatives and ongoing operations) that require data on Members. These efforts will require various levels of data to be submitted on Members. Contractor will work with HCA staff to determine the data flows and processes that will be needed, and to ensure safeguarding of the data. Examples of HCA initiatives include but are not limited to Healthier Washington's Analytics, Interoperability, and Measurement (AIM) function including program evaluation, Healthier Washington Test Models 3 (Accountable Care Program) and 4 (Multi-Payer), and Link4Health (Clinical Data Repository). HCA will work with Contractor regarding each initiative to determine the specific parameters and needs as they develop.
- c. Contractor will provide the requested data on a timely basis as described in this section, and all data provided will come with recommendations for action.
- d. Contractor will ensure all data is reviewed for accuracy and applicability.
- e. Contractor will share data with third parties, including HCA partners, only as requested by HCA and in accordance with the terms of this Contract and all applicable privacy and security requirements. Data will be shared with other external vendors only after fully executed and compliant BAAs are in place between Contractor and HCA, and between HCA and such vendors.
- f. On an annual basis, restructuring of group structure as requested by HCA, at no additional cost.
- g. Contractor will comply with requests from HCA for any internal or external audits.

3.17.2. File Transfer and Access Requirements

Contractor will do all of the following:

- a. Pick up and process electronic data files from Washington State's secure file transfer service.
- b. Accept and execute electronic data file transfers on behalf of the HCA only to business associates of HCA when requested.
- c. Refuse to accept or transfer data with any other vendor unless that vendor has an executed BAA in place with the HCA.
- d. Require no other HCA contractors to execute separate data sharing, confidentiality, business associate or other contracts with Contractor for purposes of sharing HCA data, and will accept any such contract that has been executed by HCA and such contractor, provided that language regarding Contractor's ability to pursue wrongful use of the data is included in any HCA data sharing agreement. The HCA data sharing agreement will have terms substantively similar to the document attached as Exhibit G-2.

- e. Administer Member information in compliance with HIPAA and OCIO standards for privacy, security, and electronic data interchange.
- f. Comply with HCA data requests for any internal or external audits. In compliance with OCIO IT standards 141.10.1.6(1), Contractor consents to an independent audit on behalf of HCA once every three (3) years.
- g. Give network and non-network providers access to eligibility and Claims look-up through OneHealthPort.
- h. Transmit and/or retrieve PEBB and SEBB data directly to/from external contracted vendors and other HCA business associates as determined by the HCA.
- i. Provide Claims, eligibility, and ACN data extracts as directed by HCA, including but not limited to allowed, paid, and billed costs at a Claim line level, to HCA, and to HCA business associates as directed by HCA, at no additional cost. HCA business associates include but are not limited to: HCA's actuarial consultants, polypharmacy vendor and data warehouse vendor. Such data transfers may occur on a weekly or monthly basis, as specified by HCA.
- j. Build data files and transfer separately-defined eligibility and Claims files to the data warehouse vendor on a monthly basis in the format it requests. This process must be established by June 1, 2019. The HCA data warehouse vendor's file specifications will be provided to Contractor under a non-disclosure agreement, or if the vendor changes, will be supplied within four (4) weeks of the transfer of vendor, with the full understanding that HCA may be the vendor of choice for that data warehouse.
- k. Develop and maintain data transfers for all current and future HCA vendors (including Limeade, SmartHealth, and Diabetes Prevention and Control Alliance), as well as future HCA programs and/or partnerships as required by HCA.
- l. Use current UMP ID numbers to maintain clear relations between associated vendors (see also, Section 3.17.3).

3.17.3. Contractor Generated Identification Numbers

Contractor will generate a unique, permanently assigned, HIPAA compliant non-Social Security Number (SSN) based ID number for each Subscriber. If Contractor uses its own algorithm to assign ID numbers, that algorithm must be approved in advance by HCA. It must guarantee a random number, from which the SSN and other PHI cannot be determined or approximated; it must be nine (9) or ten (10) characters; it cannot duplicate other IDs used by Contractor; and it must include a check digit.

Contractor shall use the existing ID numbers assigned to current Members, as well as the same algorithm now in use to create the non-SSN ID numbers for new Members. The ID must be in the form below:

W7CXXXXXXX

Where: W7 = constant

C = calculated check digit

XXXXXXX = ascending 7 digit sequential number beginning with zero

3.17.4. HCA Generated Identification Numbers

If in the future HCA begins generating its own Member identification numbers, Contractor will be advised of the selected algorithm to be used by contracted vendors.

3.17.5. Eligibility Files

Contractor shall:

- a. Create a current version HIPAA 834 standard transaction to send to the UMP PBM and HCA's business partners, including any optional fields requested by HCA, at no additional cost.
- b. Conduct a quarterly full eligibility file match with HCA and the UMP PBM, promptly reconcile any differences and report any reconciled differences and any other discrepancies to HCA.
- c. Accept and process ERB Division eligibility files daily in two formats and two systems designated by HCA. A sample is outlined in the ERB Eligibility File Format found in Exhibit B, but is subject to change as determined by HCA in its sole discretion.
- d. Store Member data, including SSNs, along with non-SSN and other non-PHI algorithm-generated Member IDs, in order to communicate with ERB eligibility staff and perform quarterly eligibility audits.
- e. Transmit eligibility and 'Other Coverage' data in a HIPAA-compliant format to the UMP PBM at least weekly in a format acceptable to the UMP PBM. Transmit similar files to other ERB business associates as directed by HCA.
- f. Transfer SSNs of Employees and their Dependents to other HCA vendors and Subcontractors.
- g. Provide Member SSNs for transfer from Contractor to other HCA vendors, as requested by HCA.
- h. Create and transmit eligibility data in a format defined by the HCA study partner, as requested by HCA.

3.17.6. Eligibility Files and Matches

Contractor shall:

- a. Conduct a reconciliation of the full eligibility file with HCA each calendar quarter. Within seven (7) Business Days of the start of each calendar quarter, Contractor will request a full enrollment file via email to HCA (send to an email address specified by HCA, and forward a copy to HCA Senior Account Sponsor(s)). Contractor will conduct the full file audit by comparing Contractor enrollment records with enrollment records supplied in the full file from HCA. Contractor will then complete and submit the full eligibility file audit within twenty (20) Business Days from receipt of the file.
- b. Reconcile any differences within ten (10) Business Days of the completion of the quarterly file audit.
- c. Include matching each Member-level data element of the ERB HIPAA 834 Eligibility File Format, found in Exhibit B, and must reconcile all data fields that do not match. Contractor will report all unreconciled differences and any other discrepancies to HCA Senior Account Sponsor(s) and UMP PBM contract managers within seven (7) Business Days of completion of the quarterly full file match. Upon completion of the full file match

and reconciliation, Contractor will prepare the full file and submit it to the UMP PBM within seven (7) Business Days of completion.

- d. Conduct a quarterly full eligibility file match with the UMP PBM after completion of the match and reconciliation process under (a), (b), and (c) above. The UMP PBM is required to reconcile any file differences with Contractor within ten (10) Business Days of completion of the UMP PBM's full file match.

3.17.7. Reports

In addition to any other reporting requirement in this Agreement, Contractor will provide the periodic reports listed in the following table during the Term of this Contract. The table includes the frequency and a general description of the content of each report.

	Report Name	Report Frequency	Due Date to the HCA	Content
1	Medical Management OPS Report	Monthly	30 th of the following month	Information about all Clinical Management services and activities, including Case Management count of open bariatric and transgender cases, medical policy updates, and ABA Participation Spreadsheet; updates on implementation of Bree Collaborative best practice recommendation.
2	OPS Report	Monthly	30 th of the following month	PowerPoint deck to include: Claims inventory; customer service call volumes and top 5 reasons for calling; escalations report and Appeals/Complaints reports; pre-authorization reasons; ABA summary; detailed summary of annual service hours used to date; include an explanation of any significant changes in the reported data
3	Paid Claims	Weekly		Email to HCA Contract Manager of Claims paid
4	Erroneous Payments	Quarterly	15 Days following end of quarter	Overpayments that have not been recovered; any money recovered will be credited to the HCA at the time of recovery.
5	Description of Clinical Management Program	Annually	May 1	Written description of Clinical Management program, which has been approved by the Contractor's Medical Director
6	Changes in Medical Policy	Variable	30 Days prior to change	Notice of changes in medical policy that materially affect Plan payments

Table 3.17.7

	Report Name	Report Frequency	Due Date to the HCA	Content
7	Clinical Management Program Statistics	By request	By request	Detailed program statistics, including disease type, Case Manager work, outcomes, and other information as determined by the HCA
8	IRO Decisions	Variable	7 Days after final decision	Copies of each IRO decision
9	Account Management Team Notification	Annually; and upon request	January 1	Memo identifying the Account Management Team
10	Performance Outcomes	Quarterly	April 30 July 31 October 31 January 31	Performance; key features of Plan operations; presentation of analyses and recommendations in response to reported performance outcomes
11	Executive Report	Quarterly	April 30 July 31 October 31 January 31	Utilization and cost by overall payments; Administrative Fee payments; discount rates; payments by type of service (inpatient, outpatient, ambulatory surgical center, or professional); second-level Appeals summaries; credit balance recovery report, including total dollars recovered that will be credited to the HCA
12	Eligibility and Claims Report	By Request	By Request	Separate and combined reports for Non-Medicare and Medicare risk groups; Correct reporting of Medicare risk group Members including those who have Medicare as their primary coverage, and all other Members included in the Non-Medicare risk group
13	Standard Key and Ad Hoc Reports	By request	By request	Standard key reports and ad hoc reports; accurate and adhering to mutually-established dates and response times
14	SOC1 and SOC 2 Audit Results	By request	By request	SOC1 Type II and SOC2 Type II audit results, upon request within 3 days
15	Service Hours/Project Report	Monthly	30 th of each month	Requested project details; number of hours remaining in the Pooled Hours for Work Orders
16	WHA Claims Data Report, APCD, and HICOR	By request	By request	Claims data to Washington Health Alliance (WHA) for UMP Plans and Contractor's fully-insured business in Washington State, and to the APCD and HICOR in standard formats as requested by HCA, the WHA, APCD, or HICOR

Table 3.17.7

	Report Name	Report Frequency	Due Date to the HCA	Content
17	HEDIS and the Common Measure Set	By request	By request	Healthcare Effectiveness Data and Information Set (HEDIS) and Common Measure Set data specified by the HCA
18	Data & Analytics Dashboard	Monthly		Dashboard reports; in-depth analysis of cost and utilization patterns
19	Yearly Performance Guarantee Report	Yearly	March 31	Performance Guarantee results; delivered to the HCA Senior Account Sponsor(s); include any Performance Credits
20	Quarterly Performance Guarantee Report	Quarterly	45 Days following end of quarter	Performance Guarantee results; delivered to the HCA Senior Account Sponsor(s); include any Performance Credits
21	Network Discounts	Variable	Variable	Modifications to network contracted discount arrangements may result in an increase of 0.2% or more in monthly Claims costs
22	Overall Trend	Yearly	October 31	Overall Trend Guarantee measured annually for Claims paid through June 30 of the current Plan Year; draft report of initial measurements; final settlement report
23	Subrogation Report	Quarterly	45 Days following end of quarter	Third party liability activities; delivered to the HCA Contract Manager
24	Disabled Dependent Determinations and Terminations	Monthly	Last Business Day of each month	Routine monitoring/reporting; maintain accurate and timely eligibility files
25	Smart Health Data	Monthly	By the 22 nd of the following month	
26	Transgender Surgery	Monthly	30 Days following the end of quarter	Number of intake cases each quarter to match the invoice
27	Appeals and IRO report overturned	Annually	30 Day following the end of the year	All cases that were overturned at any level of Appeal or IRO; include case number, Claim number (or indication that it was a preauthorization request), diagnosis codes and descriptions, procedure codes and descriptions, indicator of HTA decision or

Table 3.17.7

	Report Name	Report Frequency	Due Date to the HCA	Content
				not, reason for initial denial, reason for overturn, case description
28	Network Access Report	Semi-Annual	March 1 and October 1	Network access maps and access statistical tables by UMP Plan; remediation plan and timeline if any provider type or geography does not meet contractual standards
29	Paying for Value Survey	Annually	Within 30 Days of HCA request	All portions of survey results from Contractor and all network providers
30	Business Continuity & Disaster Recovery	Annually; and upon request	January 1	Business continuity/disaster recovery plan designed to maintain uninterrupted business operations necessary to meet obligations during natural disasters or other abnormal events
31	Expedited Appeals	Quarterly		Number of expedited Appeal requests determined to be not urgent, denied or approved
32	Core Team & Clinical Action Log	Weekly		See Section 3.13 above.
33	Overpayments, Fraud and Erroneous payments reports	Quarterly	15 Days after the quarter ends	Information about program integrity services, including cases involving potential or actual fraud, waste, and abuse. Processes and service descriptions of each; dollars identified as each for UMP; dollars collected for each; running annual totals
34	Primary Care Expenditures	Annually	Within 30 Days of HCA request	Summary of the total expenditures allocated for Primary Care under both the UMP Plans and the entire Book-of-Business using HCA directed definitions and an HCA provided form.
35	Disabled Dependent Audit Report	Quarterly	5 days after the quarter ends	Full audit of all enrolled disabled Dependents, including certifications, end dates, and all appeals.
36	Quarterly medical pharmacy rebate report	Quarterly	15 Days after the quarter ends	HCA to approve format and content.

Table 3.17.7

	Report Name	Report Frequency	Due Date to the HCA	Content
37	Inpatient Concurrent Review Report	Monthly	15 Days after the month ends	Contractor will report on appeals and denials for inpatient Claims in place of concurrent review.

Contractor shall also:

- a. Compile a quarterly executive report that includes utilization and cost reports by overall payments, PMPM payments, discount rates, and by payments by type of service (inpatient, outpatient, ambulatory surgical center, or professional) and second level Appeals summary information. This report will also include a credit balance recovery report describing the total dollars recovered that will be credited to the HCA. Contractor will deliver this report within thirty (30) Days of the end of the quarter reported.
- b. Provide standard eligibility and Claims reports separately for Non-Medicare and Medicare risk groups by UMP Plan and network, as well as combined, within five (5) Business Days of HCA's request.
- c. Provide designated HCA personnel access to the Contractor's web-enabled online reporting tools at no additional cost.
- d. Provide monthly and quarterly reports detailing Utilization Management reviews, including process and outcomes metrics as directed by HCA.
- e. Provide monthly and quarterly reports detailing Appeals and Complaints, including process and outcomes metrics.
- f. Provide monthly and quarterly reports detailing Case Management, including process and outcomes metrics as directed by HCA.
- g. Provide monthly and quarterly reports detailing other innovative Clinical Management programs and consumer support services, including process and outcomes metrics.
- h. Provide monthly and quarterly reports detailing Quality Management and Quality Improvement activities, including process and outcomes metrics to be defined by HCA.
- i. Accept and process encounter data and electronic health records (EHR) data for the ability to monitor and report on ACNs.
- j. Provide Contractor's net promoter score on a quarterly basis.
- k. Participate in an annual customer satisfaction survey at HCA's request. The survey will be the current version of the NCQA Consumer Assessment of Health Plan Survey (CAHPS) or a similar survey tool identified by HCA. A third party will be used to conduct any such survey.

3.18. Conversion Offering

Contractor shall offer a standard Conversion policy that provides benefits for hospital or medical care (Conversion Plan) to Members terminating PEBB or SEBB coverage that are not entitled to Medicare or other group coverage if the Subscriber resides in a state that mandates a Conversion Plan offering.

If the terminating Member does not reside in a state with a mandated Conversion Plan offering, Contractor must offer an individual health policy without any waiting period or proof of insurability.

The one-time conversion fee to transition terminating Members is listed in Exhibit A. All other costs and premiums to continue individual coverage will be billed to the Member.

3.19. Implementation

3.19.1. Implementation in General

Contractor will fully implement a written implementation plan approved by HCA to assure a timely and accurate transition from the incumbent administrative services vendor to Contractor to achieve full operations of contracted services on January 1, 2020.

3.19.2. Eligibility Files

Section 3.17.6 describes the required file matching. Contractor must also complete that entire process no later than September 1, 2019. If there are more than 0.5% of the records not reconciled, Contractor will repeat the process, and continue repeating it until all records reconcile within 0.5%. Contractor will ensure that no more than 0.5% of records fail to reconcile before the go-live date.

3.19.3. Implementation Plan

The plan to implement the services described in this Contract existing as of the Effective Date is set forth in Exhibit L, *Implementation Plan*. The Implementation Plan may be revised from time-to-time by mutual agreement of the parties, and once revised shall become incorporated into and a part of this Contract.

In the event HCA makes changes to its eligibility system(s), any work necessary for Contractor to support or implement such changes will be established through the Work Order process and will be chargeable to HCA; provided, however, that Pooled Hours may be applied prior to any charges.

3.19.4. Additional Implementation Costs

No additional payments will be made by HCA to Contractor for implementation services. Contractor shall bear all risk for any increases or additional costs not accounted for by Contractor in the PSPM.

SECTION 4. UMP CDHP WITH HSA

4.1. Responsibilities of Contractor

Contractor shall:

- a. Fulfill all obligations and duties for UMP CDHP as are required for the administration of UMP Classic, as well as the additional obligations and duties described herein.
- b. Enter into a subcontract with HCA's choice of an HSA trustee for the duration of this Contract including any extensions. Administer an integrated IRS-qualified CDHP/HSA. Contractor will remain responsible for the administration and assumes full responsibility for HSA Trustee performance. Contractor shall be responsible for implementation,

including all processes, procedures, and systems necessary for an effective date for UMP CDHP of January 1, 2020. Contractor will engage proactively with all stakeholder groups, including but not limited to the PEBB, the SEBB, the UMP PBM, and the HSA Trustee.

- c. Send representatives to all Open Enrollment benefit fairs. Benefit fair representatives will be trained in the details of UMP CDHP benefits, HSA accounts, and salient issues that affect Members.
- d. Upon HCA approval, pass all UMP CDHP/HSA Member eligibility information to the HSA Trustee, complying with federal and state privacy laws and eligibility audit standards. Contractor will collect and retain authorization from Members to transfer Claims information to the HSA Trustee.
- e. Collaborate with the UMP PBM to pass shared accumulator information for Member deductible and out-of-pocket maximum at least once per Day.
- f. Develop, design, print, and distribute the documents listed below, in coordination with the HSA Trustee and HCA. All communications must be approved by HCA prior to being sent to Members.
 - i. UMP CDHP/HSA education materials for use at benefit fairs (such as UMP CDHP summaries, descriptions, and summaries of benefits and coverage) and in welcome packets (such as ID Cards, quick tips on how to use the UMP CDHP, and information on how to access COCs).
 - ii. Customized online information about the UMP CDHP, including COCs, in a format that complies with the ADA, how to reach Contractor's and the HSA Trustee's customer service, as well as access to consumer education tools that help Members estimate their costs for services and choose between the UMP CDHP or UMP Classic.
 - iii. If requested by a Member, UMP CDHP Certificate of Coverage.
- g. Provide parallel reports that mirror all standard and custom reports required, including monthly and quarterly status reports and reporting on performance metrics.
- h. Partner with the HSA trustee to implement Member single sign on (SSO), in a safe and secure manner using Security Assertion Markup Language 2.0 or greater.

4.2. Responsibilities of Contractor for Services Performed by HSA Trustee

4.2.1. Account Administration

Contractor will require the HSA Trustee to:

- a. Accept enrollment files via FTP and/or online submission process. New Member accounts will be set up within two (2) Business Days of receipt of file.
- b. Accept employer contributions from the HCA via secure protocols. Deposits will be available to Members within one (1) Business Day.
- c. Accept Member discretionary contributions via payroll deduction in the form of data files from employing agencies using accepted secure protocols. Member contributions must be accessible in their account within one (1) Business Day.
- d. Accept Member contributions via Member's online accounts or paper check. Funds must be available to Member within one (1) Business Day of transaction of receipt.

- e. Notify Members if annual contributions are anticipated to exceed IRS maximum contribution amounts, based on the combination of employer contribution, SmartHealth Financial wellness incentives, and Members voluntary contributions.
- f. Provide employer with notification of completed files within one (1) Business Day of receipt.
- g. Provide paper and electronic statements to Members.
- h. Provide paper tax reporting to Members for IRS form 1099.
- i. Provide mutual funds for Members with a minimum balance of \$2,000.
- j. Follow eligibility audit procedures with Contractor as specified and approved by the HCA.
- k. Escalate to Contractor any concerns about the benefit coverage design of the UMP CDHP and/or qualified expenses eligible for HSA reimbursement.

4.2.2. *Fulfillment*

Contractor will require the HSA Trustee to:

- a. Send 95% of debit cards/welcome kits within five (5) Business Days of account activation, completing 100% sent within seven (7) Business Days.
- b. Send 95% of replacement debit cards within five (5) Business Days of request, completing 100% sent within seven (7) Business Days.
- c. Provide customizable welcome packet materials to be reviewed and approved by HCA no later than (i) December 20 of each year for re-enrolled Members, and (ii) within thirty (30) days of enrollment by a new Member.

4.2.3. *Customer Service*

Contractor will require the HSA Trustee to:

- a. Provide twenty-four (24) hour per Day, seven (7) Days per week live customer support for every day of the year.
- b. Provide 98% call resolution within two (2) Business Days measured on a monthly basis.
- c. Answer 80% of calls within thirty (30) seconds or less measured on a monthly basis.
- d. Offer an average call abandonment rate of less than five percent (5%) measured on a monthly basis.
- e. Provide a process for reimbursement of paper/electronic submissions within three (3) Business Days.
- f. Assist Contractor in providing quarterly reporting on all metrics above, to be completed within forty-five (45) Days after the quarter ends.

4.2.4. *Employer & HCA Support*

Contractor will require the HSA Trustee to:

- a. Provide live employer support to HCA and all UMP Plan eligible employers and agencies from at least 7:00 a.m. through 6:00 p.m. Pacific Time, Monday through Friday.
- b. Electronic access to view and download reporting to manage the employee card program.

- c. Manage an employer portal that provides access to reporting on employee activity, and offers the ability to make adjustments to individual accounts.
- d. Make an Account Manager available to the HCA for escalated issues.
- e. Coordinate between HCA and Contractor customer service including warm transfers and escalation processes.
- f. Collaborate with HCA to develop and revise enrollment and contribution processes as needed, including processes for payroll deductions and employer contributions.

4.2.5. *Custom Website/Online account*

Contractor will require the HSA Trustee to:

- a. Provide Members with twenty-four (24) hours per Day, seven (7) Days per week access to online accounts that provide the Member's HSA balance, access to Member's medical Claim information and the ability to pay Claims using HSA funds online. All Members must complete an authorization in order for the Subscriber to view their Claims data. Members will have bi-directional single sign-on from both the Contractor's and the HSA Trustee's websites and mobile apps, and will be able to view the HSA account balance on the Contractor's website.
- b. Maintain a customized website that is mobile-optimized, includes employer co-branding, and provides tools and consumer education materials that help Members get the most utility from their HSA.

4.3. Responsibilities of HCA

- a. HCA will pay the Administrative Fee for work performed by Contractor for each Subscriber enrolled in UMP CDHP.
- b. HCA will pay an additional administrative fee outlined in Exhibit A for work performed by HSA Trustee for each Subscriber enrolled in UMP CDHP. HCA will pay this fee directly to the HSA Trustee on Contractor's behalf.
- c. HCA may retroactively terminate a Member's enrollment in UMP CDHP. HCA agrees to remit a twenty dollar (\$20.00) administrative fee to the HSA Trustee for each disenrollment that results in the recovery of the terminated Member's HSA employer contribution deposited after the effective date of termination.
- d. HCA will provide eligibility files as stated in the Contract and will assign an eligibility data expert to work with Contractor and the HSA Trustee.
- e. HCA will send employer contribution data files to HSA Trustee for deposit into Member HSA accounts on a monthly basis according to procedures established jointly between HCA and the HSA Trustee.
- f. Upon fifteen (15) Days' written notice, at any time during the term of this Contract, HCA reserves the right to require Contractor to (i) terminate the HSA Trustees services, (ii) coordinate with an HSA Trustee that HCA directly contracts with for services, and (iii) reduce the Administrative Fee fee by the amount shown in Exhibit A to assume the duties of Contractor's HSA Trustee.

SECTION 5. UMP PLUS ADMINISTRATIVE SERVICES

HCA has contracted directly with two (2) ACNs to offer UMP Plus to non-Medicare Members. The HCA reserves the right to add future ACNs at its sole discretion. In addition to the obligations and duties described in this Section 5, the Contractor will fulfill all obligations and duties as are set forth in Section 3 for UMP Plus and will consistently administer requirements across all UMP Plans for the two (2) types of UMP Plus members:

- a. Designated Members: Those who select and enroll in a UMP Plus Network. They live or work in a Washington state county served by a UMP Plus Network.
- b. Attributed Members: Members in UMP Classic or UMP CDHP that attribute to one of the ACNs. The Contractor provides the algorithm for attributing a UMP Classic or UMP CDHP Member to one of the ACNs based upon commonly received services in that network. Attributed Members need not live or work in a county served by a UMP Plus network.

5.1. Benefits Administration

Contractor will:

- a. Conduct ongoing sharing, testing, maintenance, enhancements, and auditing, in accordance with the schedule of eligibility reporting requirements included in this Contract.
- b. Coordinate with HCA to develop additional ACN contracts or amend current ACN contracts in a way that is consistent with Contractor's role as TPA of all UMP Plans.
- c. Work in good faith with HCA and the ACNs to resolve any issues that arise in a timely manner.
- d. Administer UMP Plus provider network and Claims payment for each ACN as well as a wrap-around ACN Ancillary Provider network that may differ for each ACN, but in both cases must be present in all 39 Washington State counties, and may be updated during the plan year, and at a minimum, annually.
- e. Contract with all ACN Partner Providers and ACN Affiliate Providers.

5.2. Communications

Contractor will:

- a. Write, design, print, and distribute the documents and tools listed below, in coordination with the HCA:
 - i. UMP Plus education materials for use at benefit fairs
 - ii. For each Plan, write, design, print, and distribute a hard copy welcome packet for new and renewing Members no later than (1) December 20 of each year if Contractor receives the full membership eligibility file by December 10, and (2) within thirty (30) days for enrollment by a new Member if Contractor receives the updated membership eligibility file within five (5) business days of the Member's start date.
 - iii. Customized UMP Plus ID Cards for each ACN with HCA approved logos and contact information for each ACN. HCA will provide Contractor with a UMP logo to be placed in the upper left corner of the card, while a Contractor logo of equal size may be included only in the upper right corner of the card.

- iv. If requested by a Member, annual COCs for each ACN.
- b. For each ACN, build and maintain a search tool that lists all in-network provider functions in the manner listed below:
 - i. Content must be updated to stay consistent with provider credentialing and new files from all the ACNs.
 - ii. Provide separate search functionality for the current plan year and the upcoming plan year in support of Open Enrollment. It must also clearly identify the availability of both functions to Members.
 - iii. Integrate all search tools together for a seamless user experience when the ACNs expand geographic areas.
 - iv. Provide HCA with custom links for provider search tools for the UMP Plus website, as well as HCA maintained websites such as for the UMP Plans, the PEBB, and the SEBB.
- c. Send specialized representatives (excluding Account Team members) to all Open Enrollment benefit fairs. Benefit fair representatives will be trained by Contractor in the details of UMP Plus benefits as well as any benefit design differences from other Health Plans. Contractor representatives will collaborate with the PEBB, the SEBB, and HCA staff when necessary to provide service at benefit fairs.
- d. Provide Health Literacy information, which may be supplied by Contractor to HCA, and a cost-calculator, supplied to Contractor by HCA in a coordinated fashion with the provider search tool.
- e. Provide HCA with custom links for provider search tools for ACN websites.
- f. Provide customized web site(s) upon HCA request with HCA requested branding that provides customer education tools for consumer education materials to help Members get the most utility from the site, subject to HCA review and approval.
- g. Annually review, report, and recommend enhancements to search technology, processes, provider content, organization and display of the content, and implement those recommendations and enhancements adopted by HCA.
- h. Coordinate with HCA on a due date for submitting draft communications for the next plan year that provides HCA with reasonable time to review and provide reasonable comments. All communications must be approved by HCA before October 15 of the preceding plan year. Contractor will collaborate with HCA on communications.
- i. Provide a customer call center specializing in benefit design questions regarding UMP Plus.
 - i. Answer 80% of calls within thirty (30) seconds or less measured on a monthly basis.
 - ii. Maintain an average call abandonment rate of less than 5% measured on a monthly basis.
- j. Provide quarterly reporting on all metrics above to be completed by forty-five (45) calendar Days after the quarter ends.
- k. Collaborate with HCA on other communications.

5.3. Network Administration

Contractor will:

- a. Add or remove providers to a clinically integrated network and/or add or remove or update information on an ACN Partner Provider or ACN Affiliate Provider Tax Identification Number (TIN).
- b. Not unreasonably withhold inclusion of an ACN provider from being a Contractor in-network provider. Providers must go through a regular credentialing process.
- c. Administer the ACN out of network consent process as documented within the ACN operations manual. This process may be different for each ACN. HCA will accept a monthly provider TIN Roster from each ACN that adds or removes provider TINs from UMP Plus.
- d. Update the UMP Plus website and network status for payment within thirty (30) Days of receipt if providers are already credentialed with Contractor.
- e. Follow Contractor's credentialing process for providers not credentialed. Once credentialed, provider is approved, and will be added to the website and monthly provider TIN Roster and have an updated network status. HCA will approve providers before each monthly roster and the UMP Plus account manager will be responsible for those approvals.
- f. Contractor will expand its network geography to add providers as HCA and any ACNs expand into new geographic locations, including those outside of the geographic areas Contractor serves within Washington.
- g. At HCA's sole discretion, Contractor will add UMP Classic and UMP CDHP Members to Contractor's Total Cost of Care contracts.

5.4. Data and Reporting

Contractor will:

- a. Provide reporting and/or systems that enable ACNs to manage the covered population in most comprehensive way possible. Contractor will facilitate a meeting to review the reports and systems at least two (2) times per year to determine enhancements or modifications that further support clinical care coordination with the ACNs (see also, Section 3.13.2.e). Data provided shall support the goal of continuous improvement to support the goals of Healthier Washington. At a minimum, the following will be included in such report or system, with frequency and content defined and updated in the Report Manual:
 - i. High Cost/High Risk patients for outreach
 - ii. Hospital Discharge and/or admissions as available
 - iii. Care Management / Care Coordination reports
- b. Develop reporting and/or systems that enable ongoing improvements in clinical care coordination for ACNs and rural providers. Contractor will include items such as Electronic Health Record (EHR) data, patient status changes, key utilization measures, etc., as they are available to support Clinical Management. The mode of communication will leverage systems whenever possible to increase accuracy and speed up the access for network providers.

- c. All data provided under this Section 5.4 shall fall under the Performance Guarantees set forth in Section 6.2.4, unless agreed to be excluded by Contractor and HCA. All reporting, measurement and issue mitigation shall be included and updated in the Report Manual.
- d. In collaboration with HCA and the ACNs, Contractor will develop an annual work plan describing additional or replacement reporting and/or systems, data integration, risk score methodologies, EHR reporting, the Bree Collaborative and other health care quality initiatives, and others as further detailed in the Report Manual.
- e. Transmit all UMP Plus Member eligibility information, Utilization Management reviews, other applicable Clinical Management services information, and Claims information to each ACN or data intermediaries, complying with federal and state privacy laws, confidentiality agreements and HCA audit standards to enable the ACNs to send out ACN Welcome Packets to new UMP Plus Members. Data files shall include all information needed for mailings and to be sent monthly or weekly, with dates to be specified by HCA and documented in the Report Manual.
- f. Maintain an updated UMP Plus data inventory with added reports, updated changes, data fields, layouts, date and whom the data is delivered and any other changes directed by HCA and detailed in the Operations Manual. Costs of this requirement are included within the Administrative Fee.
- g. Maintain compliance with any data extract and confidentiality agreement between the ACN data intermediary, the ACN provider, and Contractor, and provide HCA with amended and updated versions of any such agreement.
- h. Maintain a Secure File Transfer Protocol (SFTP) site with ACNs and any data intermediaries.
- i. Process files within agreed to timelines of data specifications. All monthly reports will be transmitted accurately by the 25th of the following month.
- j. Complete eligibility and Claims implementation and testing as specified and approved by HCA on mutually agreed upon dates but not more frequently than once per year. After testing is complete, for the next year, eligibility and Claims data will be delivered to HCA or third party on mutually agreed upon dates and frequencies.
- k. Provide vendor data integration and reporting, risk score methodology, Primary Care provider election (if HCA requires it), and EHR records provided to Contractor.
- l. Troubleshoot data reporting issues to resolution with ACNs, data intermediaries, consulting actuaries for HCA, and HCA. Contractor will provide a corrective action plan to HCA within three (3) Business Days of discovering or being informed of any data reporting issues.
- m. Create a process where Contractor informs a ACN with key patient clinical information as defined in the Operations Manual on the same day Contractor becomes aware of such information.
- n. Weekly case management reports valuable to a primary care provider on patients assigned to an ACN, the contents of which will be detailed in the Report Manual.
- o. HCA and Contractor will build a mutually agreed upon process that informs a Member of clinical and benefit design, such as the network status of the providers.
- p. The following items are examples of processes that will be set forth in the Report Manual and Operations Manual:

- i. Accurate data to the specifications of a file or report.
- ii. System for documenting data fields and methodology that created the data.
 - a) Updates of the documentation and methodology reported monthly in an agreed-upon format and media to HCA and ACP Networks.
 - b) Documentation and methodology will focus upon supporting analysis, reporting, and manipulation of the data.
- iii. Validation of all data files and reports using peer review to assure accurate delivery of each file and report.
- iv. Storage and availability of data to support the quality improvement system metrics of UMP Plus.
- v. Deliver in, an agreed-upon format and media, daily Claim feeds as set forth in the Operations Manual and Report Manual.

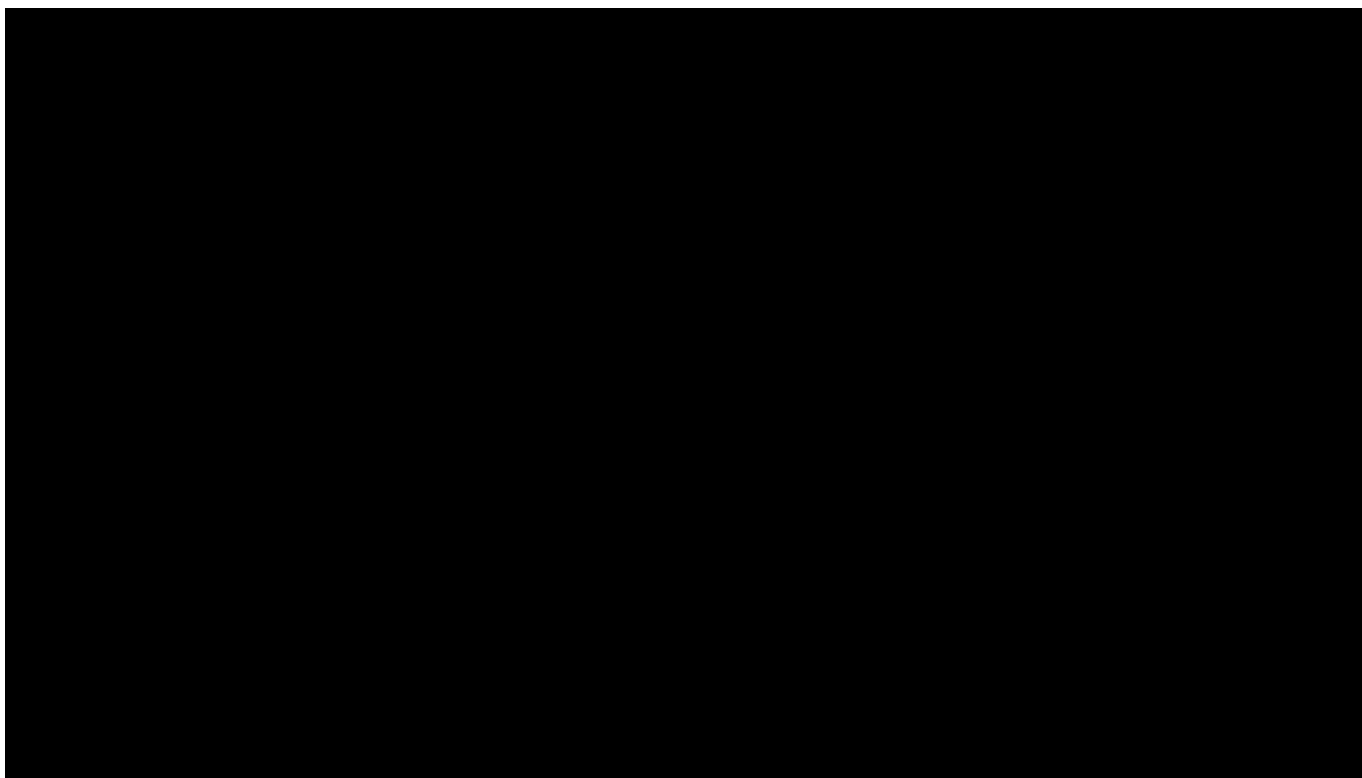
5.5. Operational Requirements

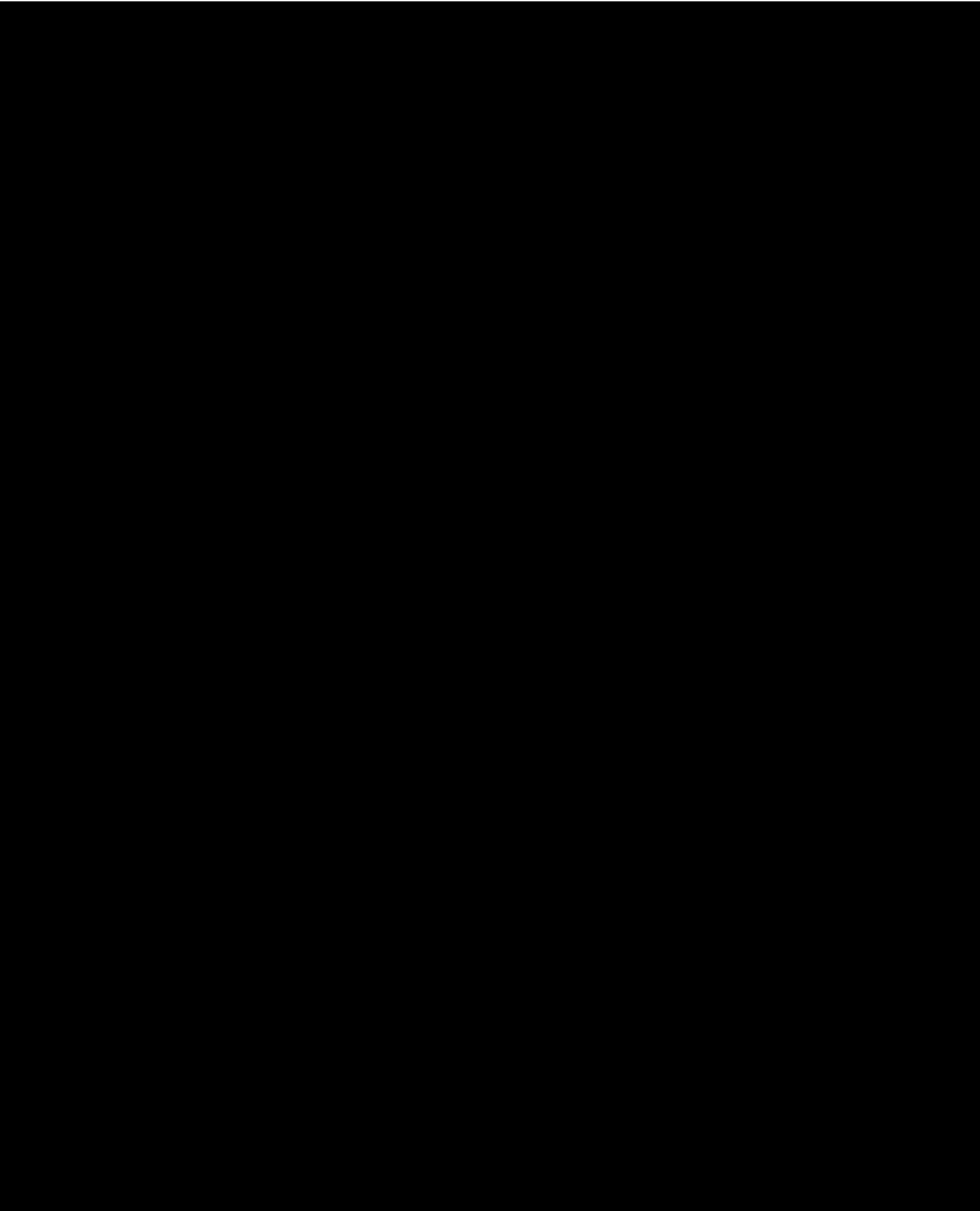
Contractor will:

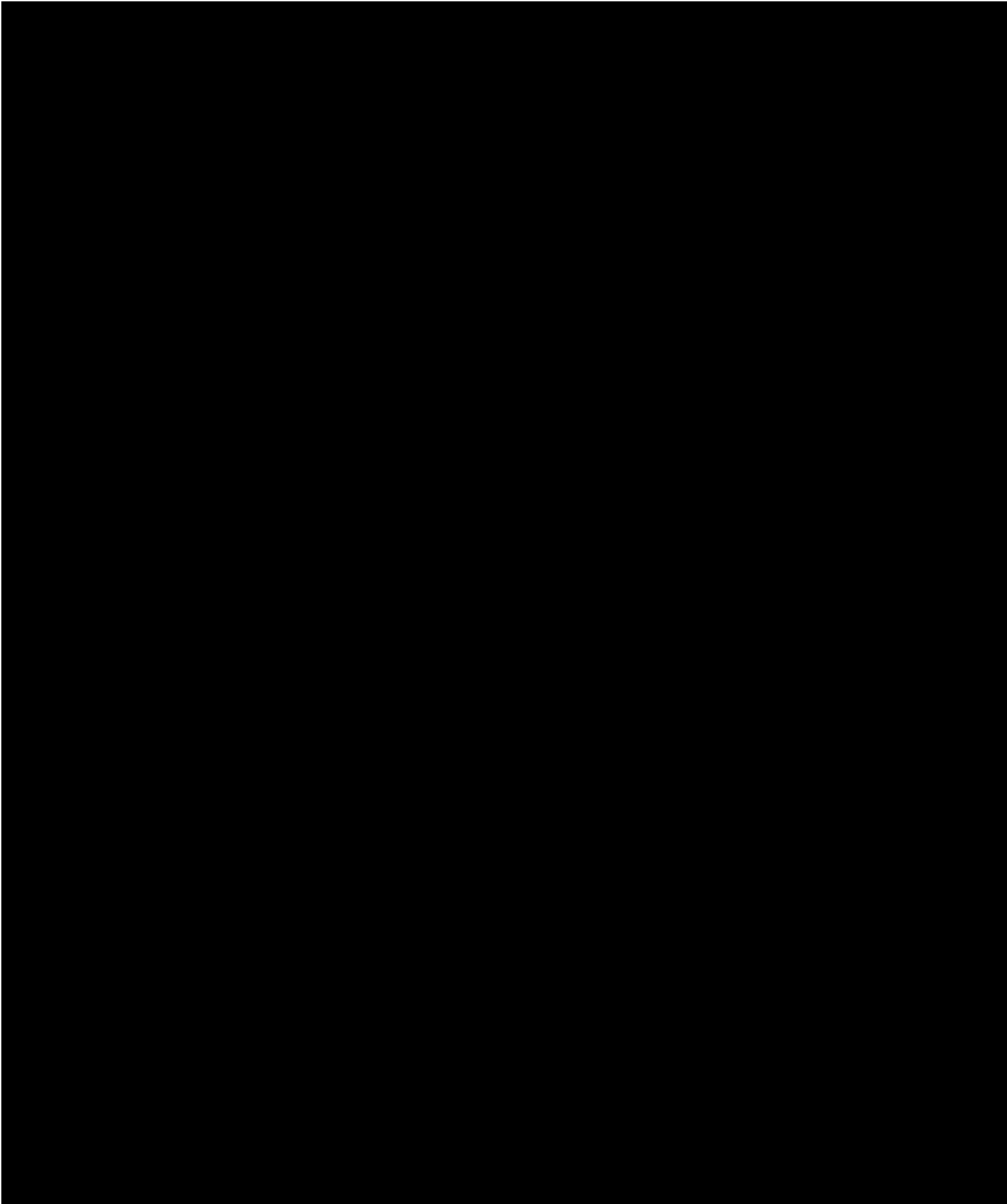
- a. Provide a UMP Plus account program manager to support new implementation of additional networks or geographic or population-based expansions of current ACNs. This program manager will attend as-needed and on-going HCA/ACN meetings as requested by HCA.
- b. Perform all administrative activities necessary to launch an ACN, collaborate on drafting and reviewing any ACN procurement by HCA, and review procurement documents to safeguard against operational gaps or inconsistencies in such administrative services.
- c. Perform all administrative activities necessary to remove an ACN.
- d. Participate in the development and review of operational processes to perform the necessary functions of the ACN program. Contractor shall:
 - i. Support the development and implementation of processes that specify the responsibilities and actions of a UMP Plus Plan, HCA, and Contractor.
 - ii. Support the development and implementation of the UMP Plus financial reconciliation process to include developing and supplying data reports.
 - iii. Support HCA's monitoring of ACN financial and care transformation performance as specified in contracts with each ACN by providing relevant and timely reporting on the ACNs.
 - iv. Coordinate the implementation and performance of Care Management and/or Care Coordination programs so the programs align with similar programs performed by the ACN for the Attributed and Designated Member populations. If requested by HCA, Contractor shall discontinue Case Management and Utilization Management programs for ACNs and the PSPM for such services would then be deducted from the Administrative Fees.
 - v. Provide the same standard and custom reports noted in Section 3.17, including monthly and quarterly status reports and reporting on performance metrics.

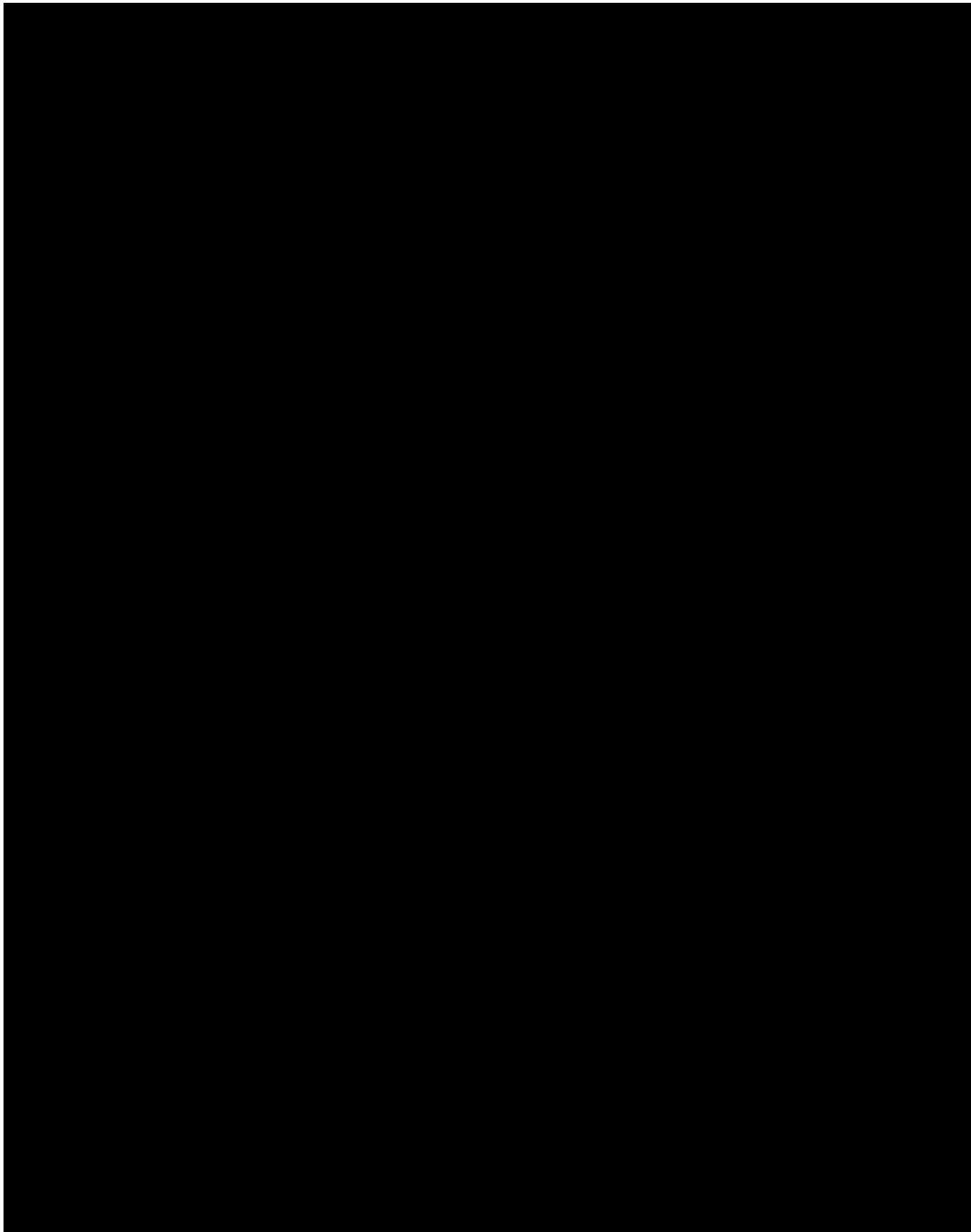
- vi. Maintain all data reporting in Section 3.17, and transmit the HCA UMP Plus Data and Reporting Inventory to the ACNs and the data intermediaries or the HCA directly, as indicated.
- vii. Add and remove providers from the UMP Plus networks on a monthly basis as outlined in Exhibit N.
- viii. Add ACN data to monthly data files to HCA's consulting actuary or a third party as requested by HCA.
- ix. Administer the provider consent process for non-network and out-of-network providers as described in Exhibit O.
- x. Execute a three-party data sharing and confidentiality agreement with each of the ACNs and data intermediaries within three (3) months of the Effective Date and update as necessary.
- xi. Administer or modify benefits, services or networks as directed by HCA within thirty (30) Days of written request.
- xii. Add ACN Ancillary Providers from a list of provider types that will be provided by HCA annually and the geographic region of an ACN Ancillary Provider network may change. Contractor will include those provider types within the ancillary in-network providers for the ACNs. These ACN Ancillary Provider networks may be different for each ACN and different for each county served by an ACN. Contractor will include all ACN Ancillary Providers within provider search tools and ACNs, and HCA will have authority to approve or delete such inclusions.

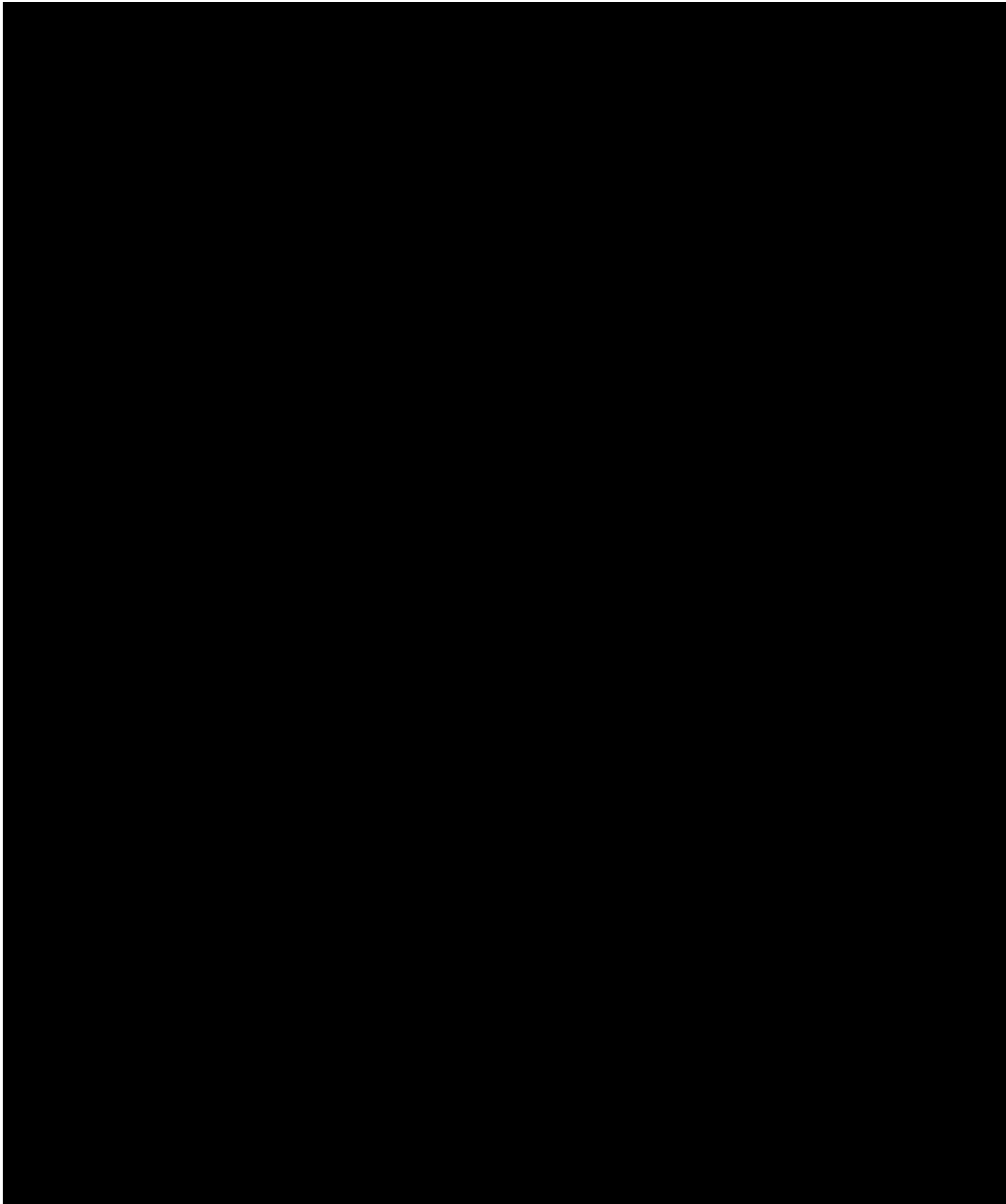
SECTION 6. PERFORMANCE STANDARDS AND GUARANTEES

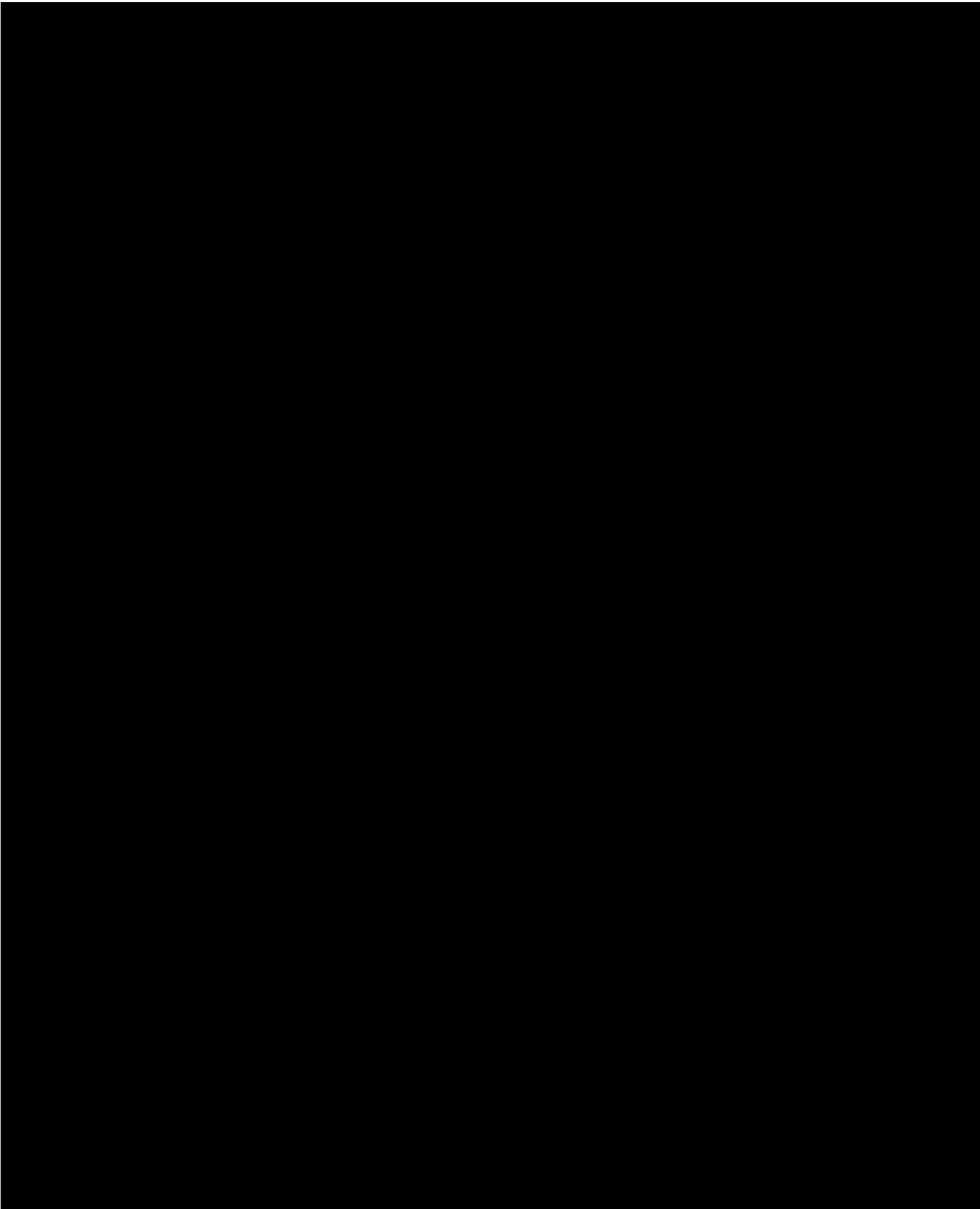


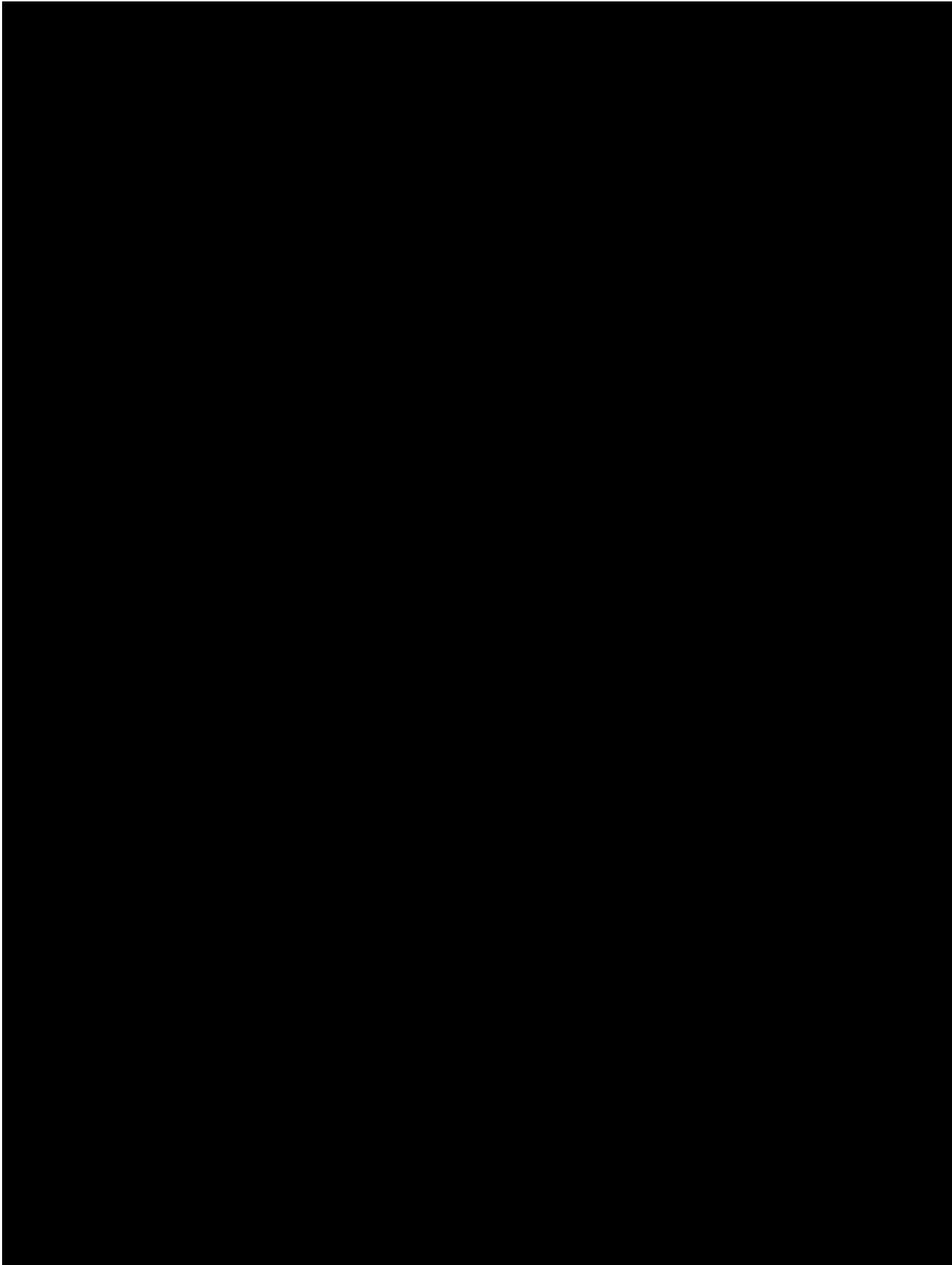


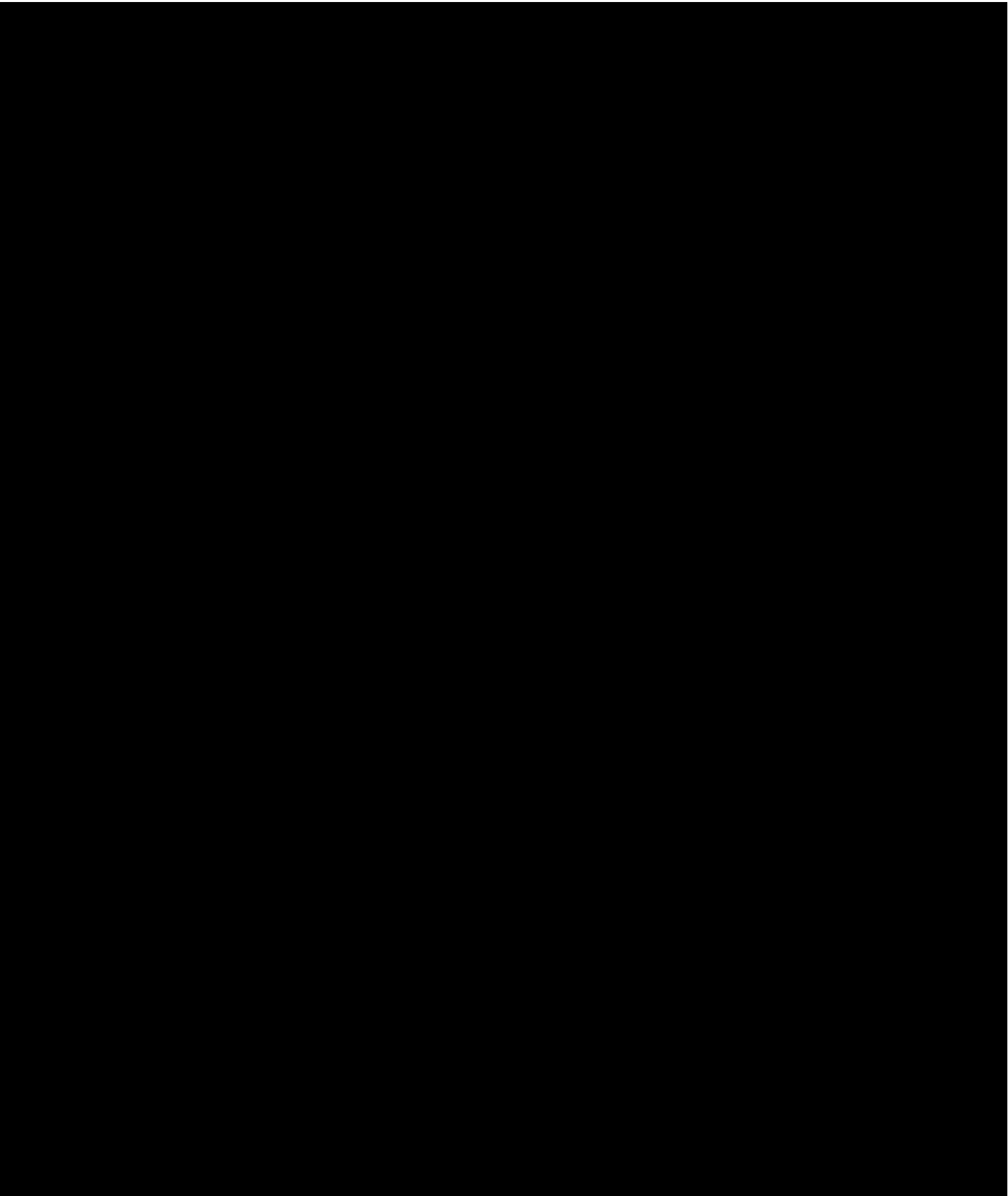


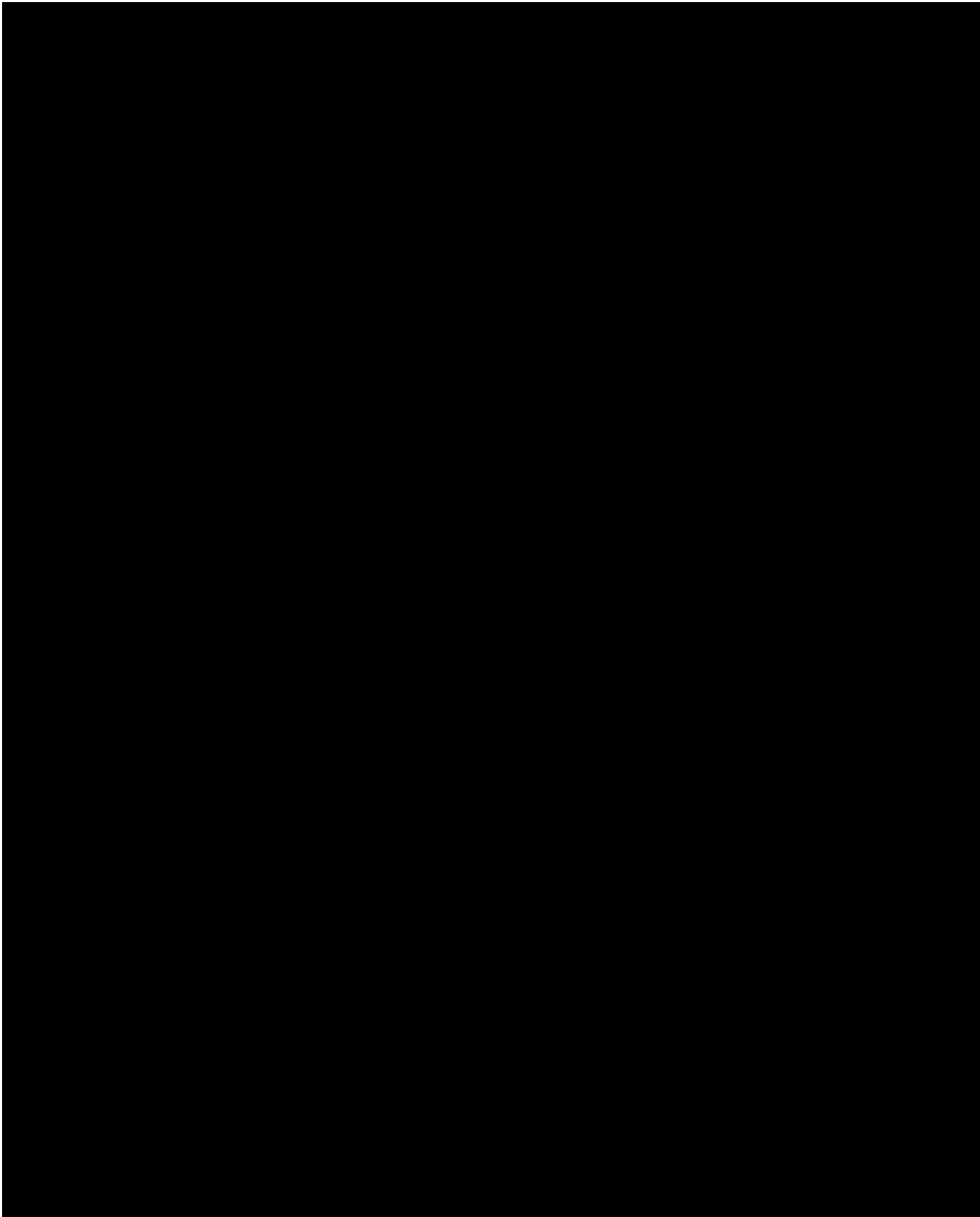


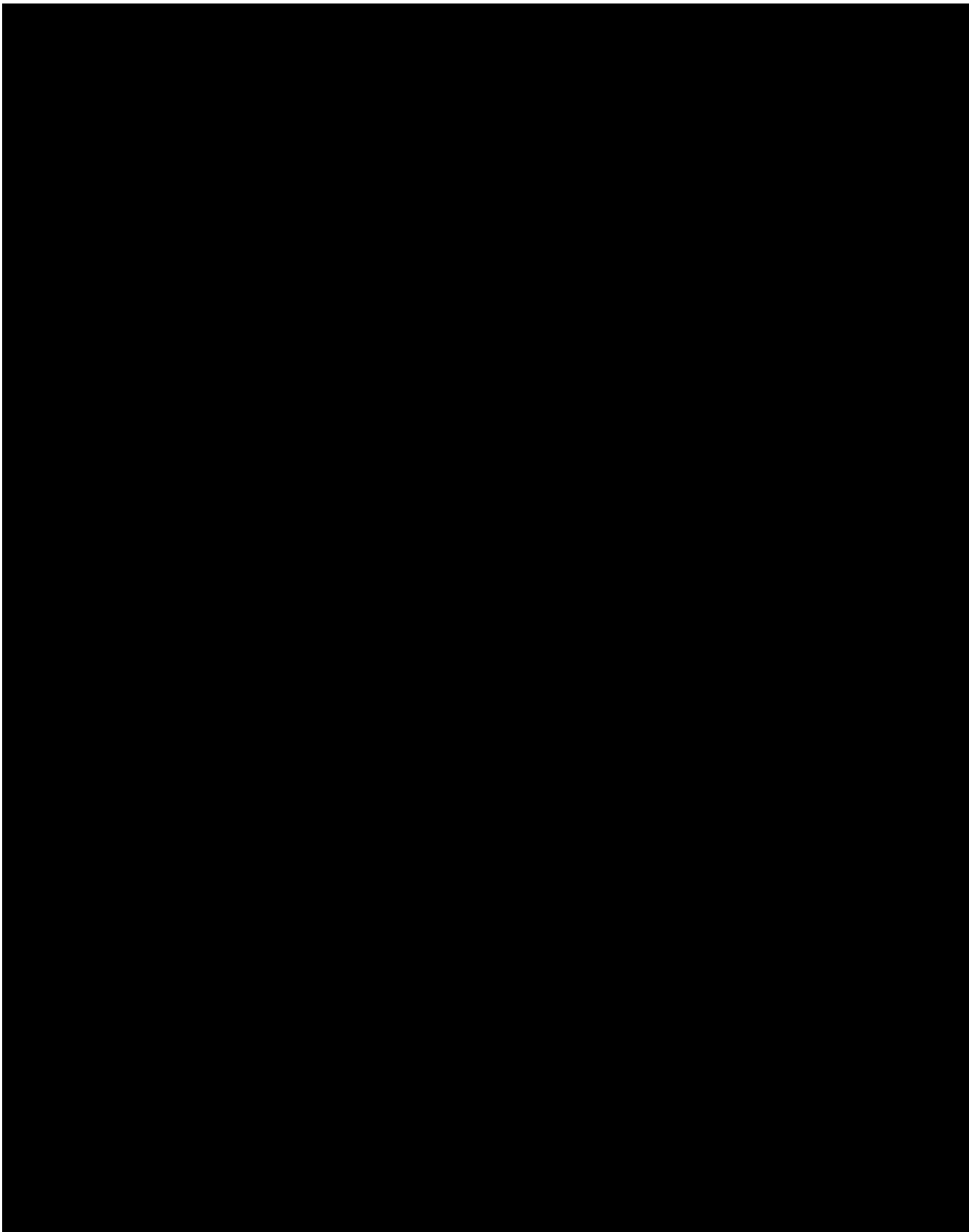


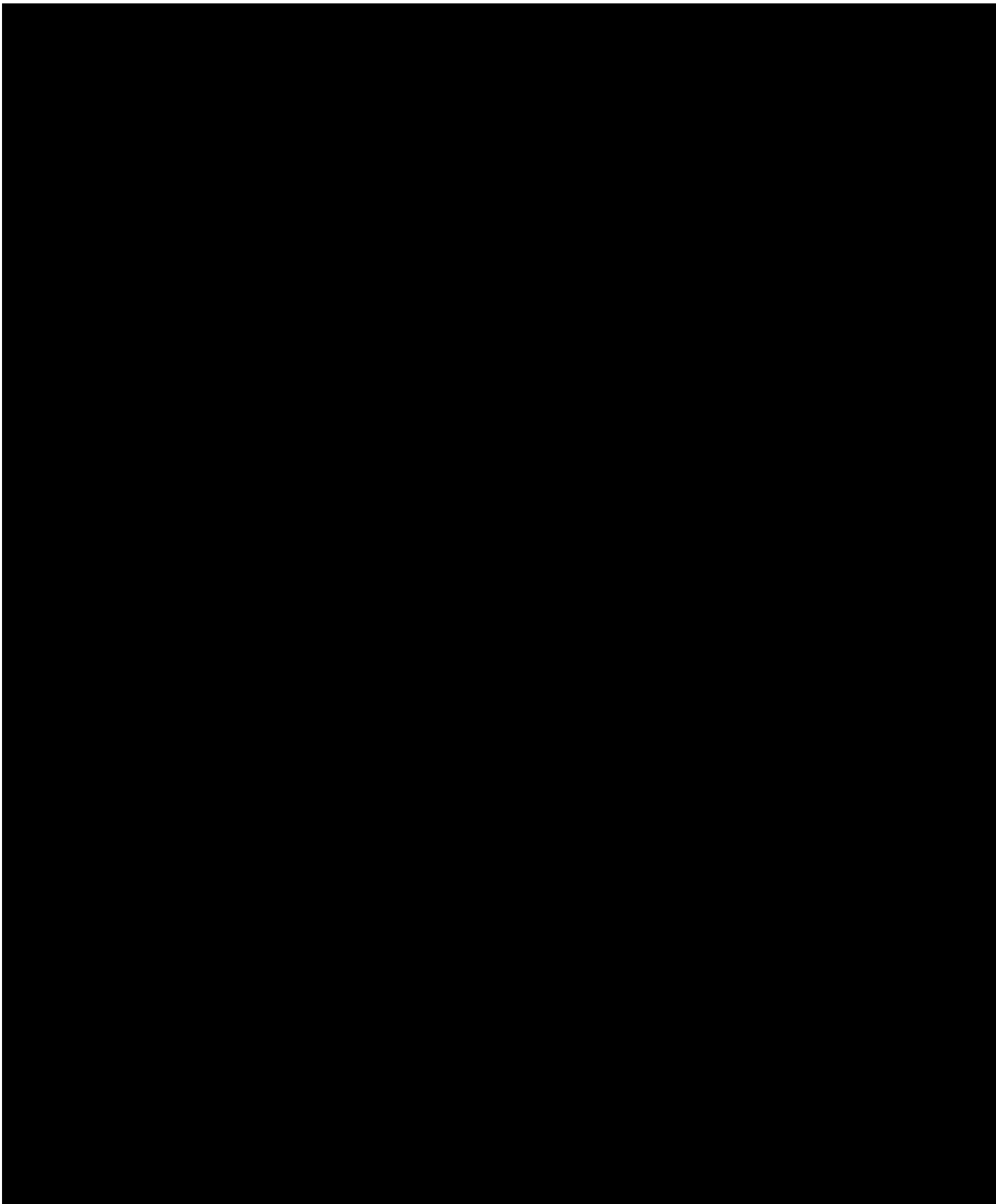


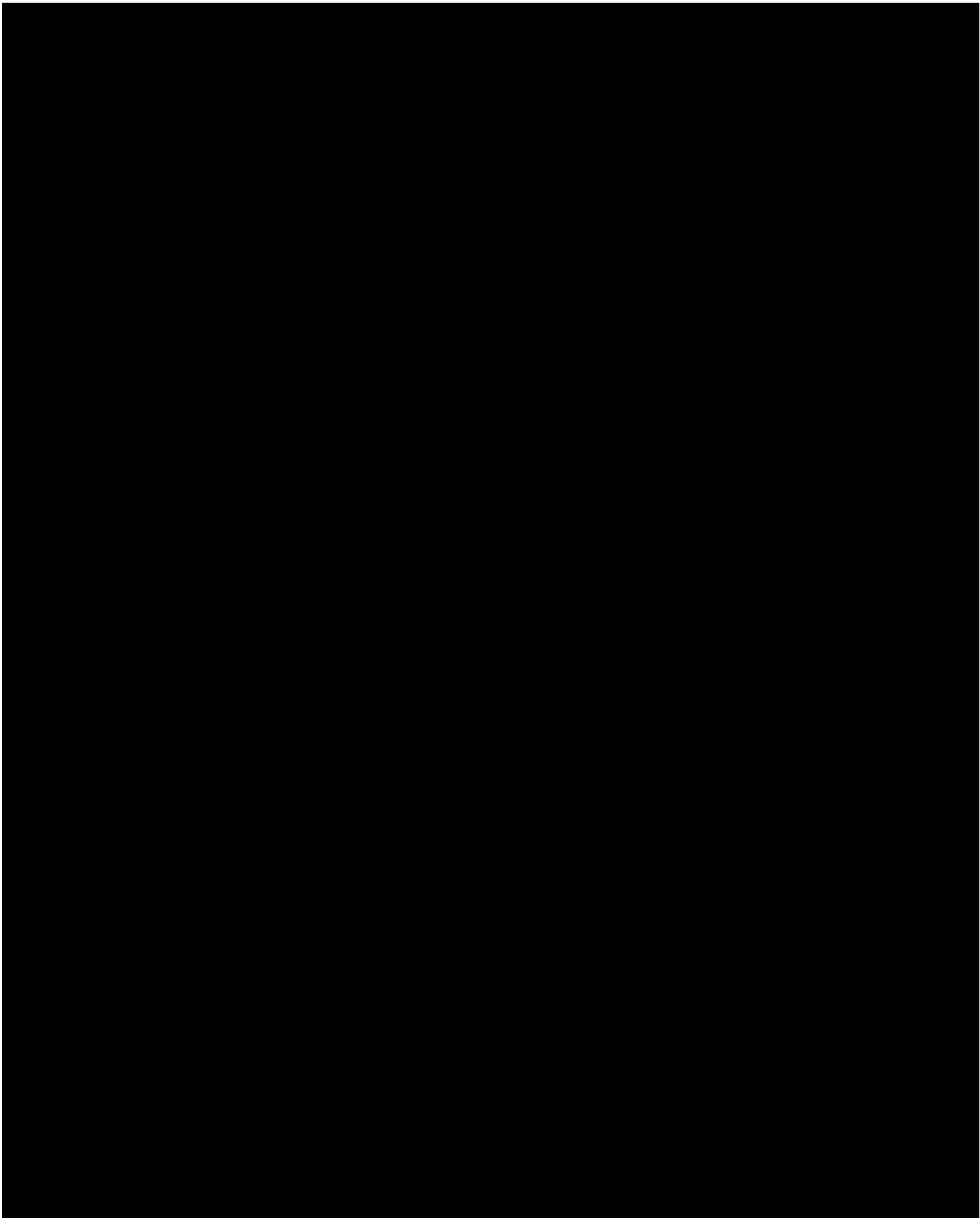


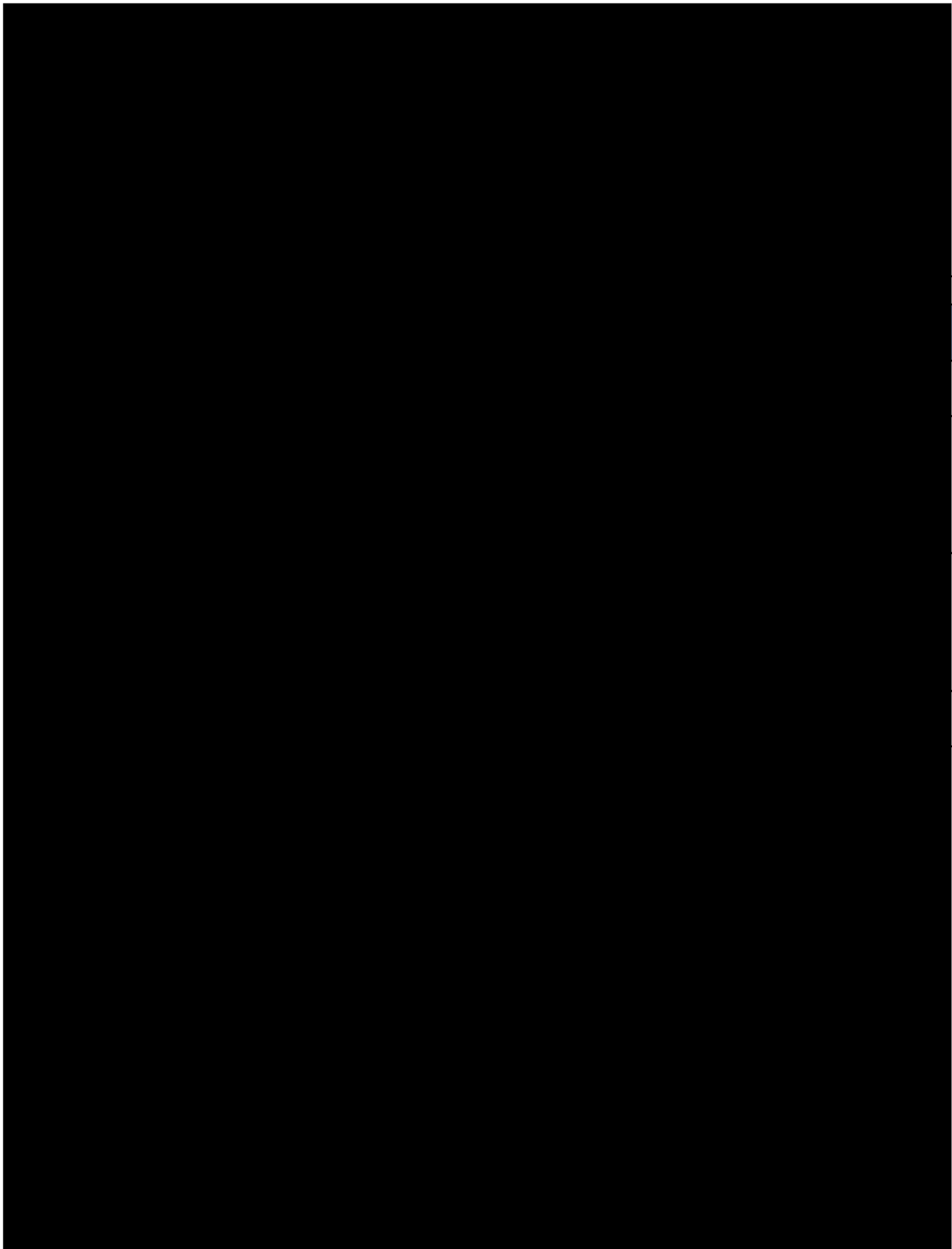














SECTION 7. PROVIDER NETWORK

Contractor shall:

- a. Provide a network contracting and credentialing program consistent with NCQA or URAC accreditation standards that applies to all providers in all networks available to Members, including ACNs, and provide such program in writing annually to HCA.
- b. Maintain a contracted provider network that meets or exceeds nationally accepted access standards for all applicable HCA-approved provider categories, adjusted for geographical factors. In the case where national standards are not available, the

standards in Table 7.2.1, Washington Provider Network Coverage Access Standards, will apply for the UMP Plans.

- c. Notify HCA sixty (60) Days prior to any provider group or facility becoming out-of-network.
- d. Perform the network analysis set forth in Table 7.2.1 on an annual basis, and provide results to HCA by January 31 of each year.
- e. Respond to network adequacy issues, taking all necessary action to ensure Members have access to a preferred provider for all covered services. This includes recruiting new providers into the professional provider network and following HCA-led recruitment priorities.
- f. Provide a network that meets both OIC network adequacy requirements in WAC 284-170 and HCA standards for every county in Washington State for UMP Classic and UMP CDHP.
- g. Incorporate language requiring adherence to Bree Collaborative recommendations in network agreements as those agreements are renegotiated; provided, however, that HCA may waive this requirement upon Contractor's request if it is unable to make such a change to the provider contract.

7.1. Contractor Functions

a. Behavioral Health Diagnoses

Contractor must offer a provider network that contains an adequate number of Behavioral Health subspecialty providers to diagnose and treat Members for all covered services for conditions used in the current version of the ICD 10-CM and DSM 5 Diagnostic Guides. Contractor must promote the use of Behavioral Health evidence-based, research-based or promising Behavioral Health practices recognized by the Washington State Institute for Public Policy (See <http://wsipp.wa.gov/Reports>) or the federal Substance Abuse and Mental Health Services Administration (SAMSHA).

b. Applied Behavioral Analysis

Contractor must have or agree to contract with Applied Behavioral Analysis (ABA) providers within its local and national network.

c. Gender Dysphoria

Contractor must have contracts with or agree to contract with providers for the UMP Plans transgender and gender dysphoria benefit within its local and national network.

d. Future Plan Growth

Contractor must agree to expand its network as needed to maintain Network Adequacy for all plans administered by HCA.

e. Contracting with Accountable Care Network Providers

Contractor will contract with all current ACN Providers, as well as new providers who enter into an ACN(s) during the Contract term, to ensure that such ACN Providers are within Contractor's network for Members. As requested by HCA, Contractor will provide HCA with copies of some or all of such contracts as set forth in Section 6.2.4.

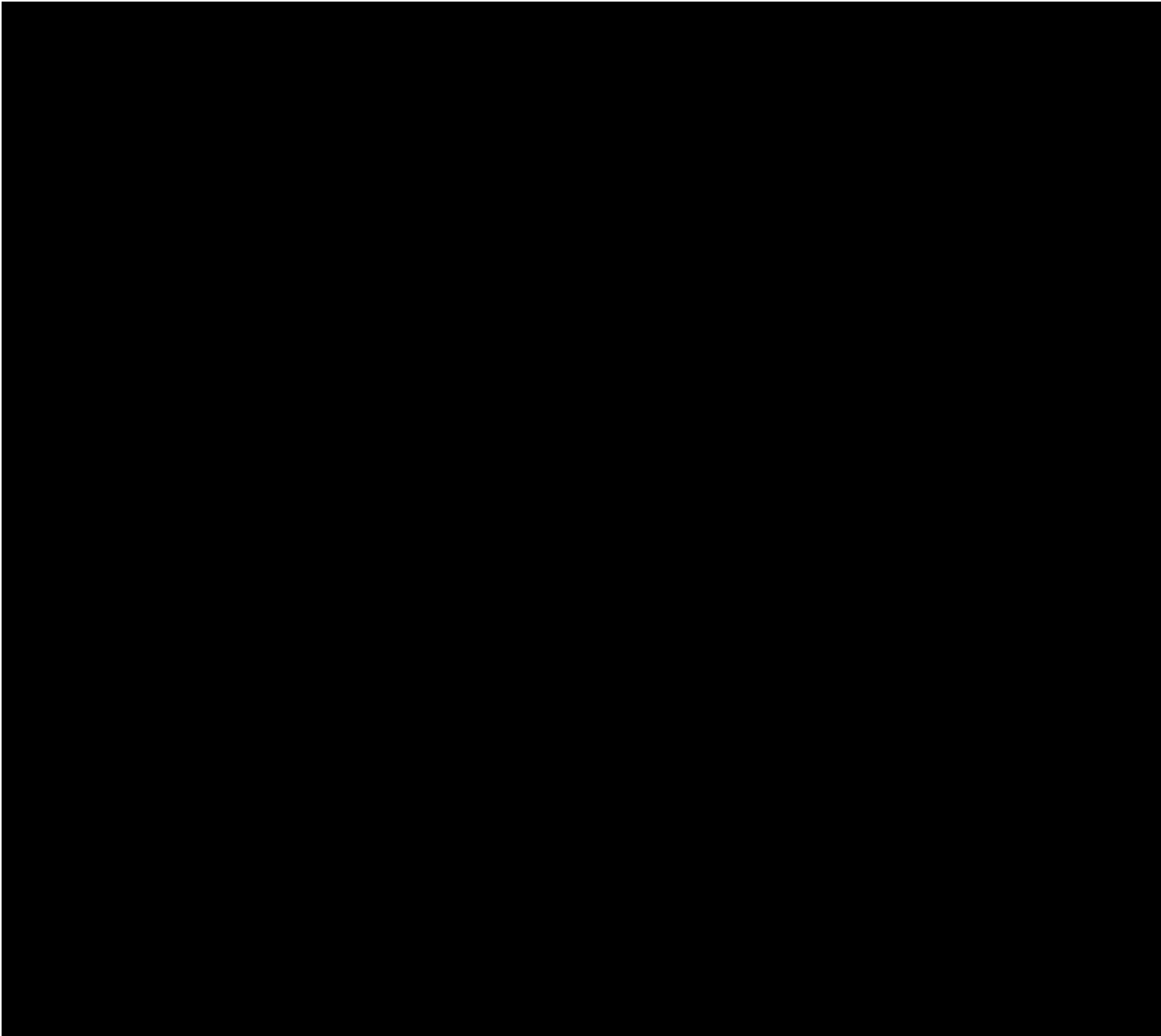
f. Adherence to New Clinical Policies and Required Provider Types

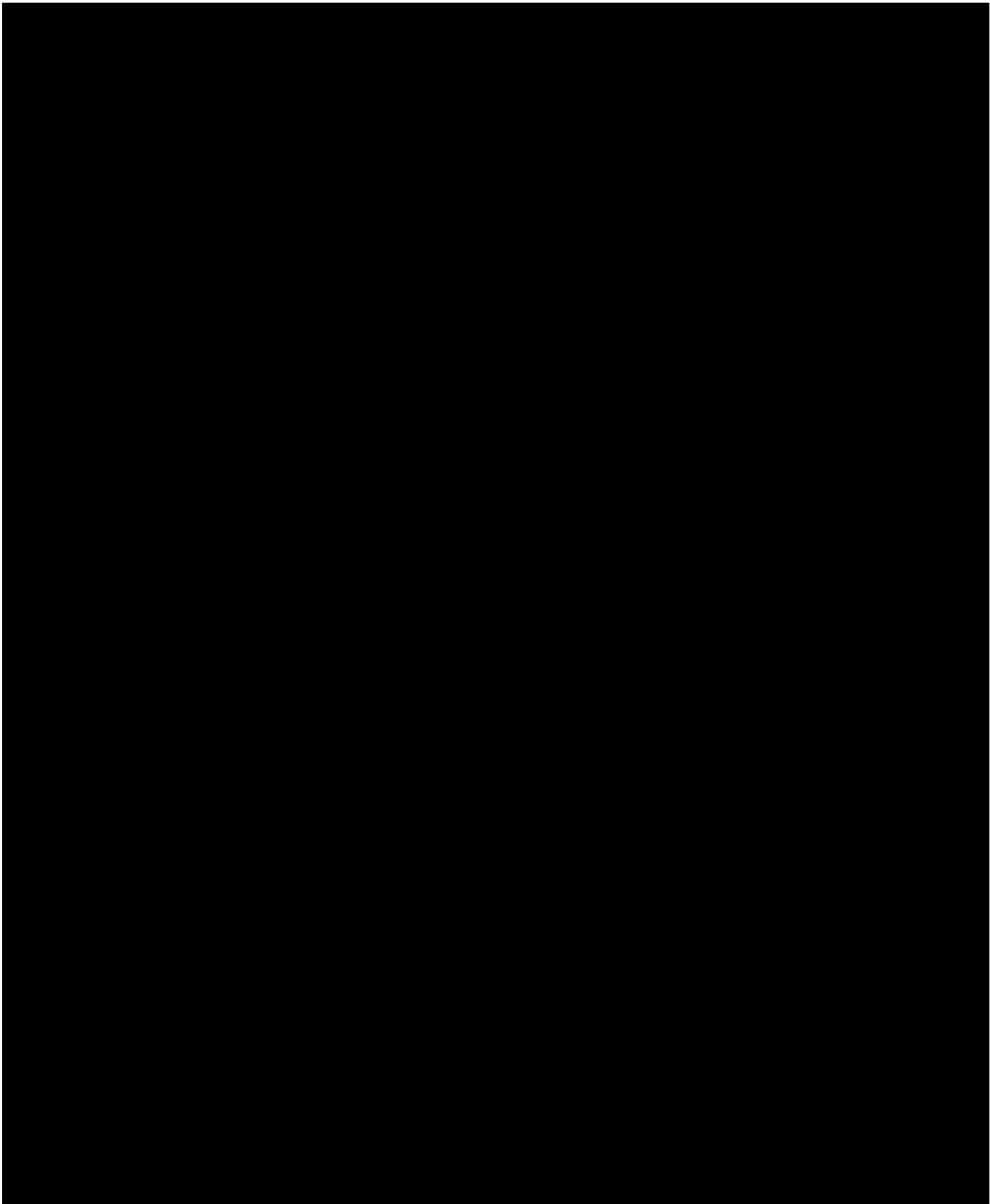
As HCA creates new clinical policies, Contractor will adhere to the new policies and contract with new provider types as required by such policies for the UMP Plans.


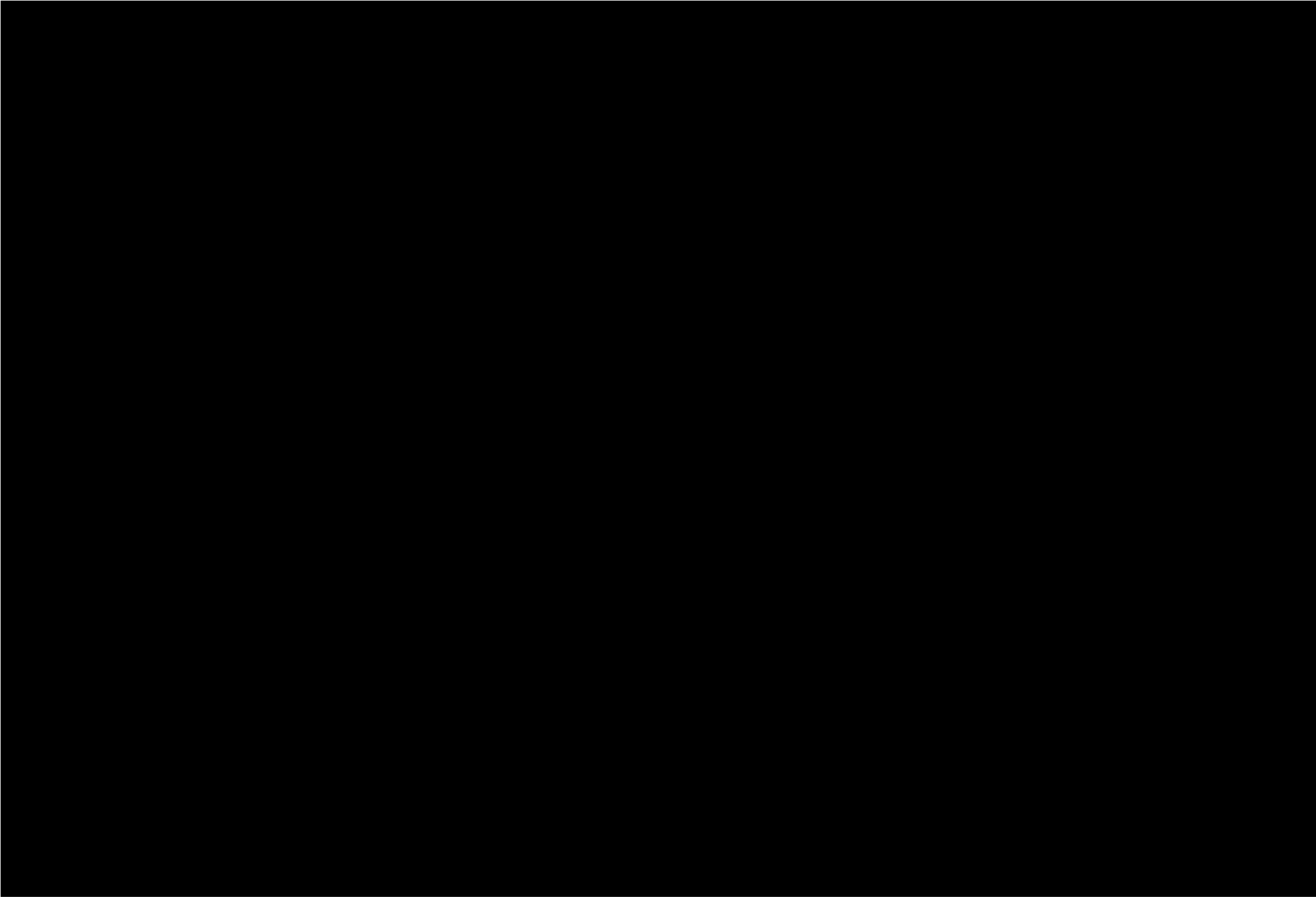
g. Never Events Policy

Contractor shall have a policy that places provider reimbursement at risk upon the occurrence of a Never Event. This policy must also be reflected in the terms and conditions of the Contractor's contracts with the providers in its network.

7.2. General Network Requirements







7.2.3. *Additional Contractor Network Responsibilities*

Contractor will do the following:

- a. Provide a network contracting and credentialing program consistent with NCQA or URAC accreditation standards. Submit written confirmation annually to HCA that contracting and credentialing processes meet URAC or NCQA standards.
- b. This credentialing program applies to all providers in all Contractor networks available under this Contract, including the Contractor's ACO.
- c. Prioritize UMP Plus credentialing by provider or provider type and provide progress reports every two (2) weeks.
- d. Have a contracted provider network that meets or exceeds HCA Washington standards for all applicable HCA approved provider categories, adjusted for geographical factors. In the case where national standards are not available, the standards in Exhibit D, *Washington Provider Network Adequacy Standards*, will apply for the State.
- e. Maintain discount differential in aggregate of UMP-specific rates for provider contracts.
- f. Expand use of contracts between Contractor and providers that contain reimbursement rates or discount amounts for Members and/or the UMP Plans in collaboration with HCA.
- g. Notify HCA when modifications to Contractor's network contracted discount arrangements may result in an increase of 2% or more in monthly Claims costs.

- h. Perform the network analysis set forth in Table 6.2.1 on an annual basis. Results of this analysis must be provided to HCA by January 31 of each year.
- i. Respond to network adequacy issues, including recruiting new providers into the professional provider network. HCA may set priorities for Contractor on recruiting providers. Contractor should provide a network that meets all the qualifications for OIC network adequacy standards and HCA standards for every county in the State, and will take all necessary action to ensure that Members have access to a preferred provider for all covered services. Contractor will provide annual reports on network adequacy as set forth in the table in Section 3.17.7.

7.3. Washington State Provider Network

Contractor will do all the following:

- a. Meet all OIC standards for Washington State related to provider network adequacy for UMP Classic and CDHP Plans as set forth in Table 7.2.1.
- b. Provide documentation that the Washington State provider network is in place annually or as requested by the HCA, including detailed information about whether there are recognized provider types consistent with RCW 48.43.045(1) and at least 10,000 physicians (M.D. or D.O.) in the network.
- c. Provide a written explanation at HCA's request regarding any Washington hospitals or large provider groups not in the network.
- d. Ensure its provider network complies with the requirements of WAC 284-170-200.
- e. Ensure accurate network information is provided for Members, including online provider information, paper directories available upon request, and information provided verbally to Members.
- f. As mutually agreed, customize provider contracts.

7.4. Out-of-State Provider Network

Contractor will provide an adequate out-of-state provider network, from January 1, 2020 through the Term of the Contract, which will provide coverage to meet comparable standards to the Washington State provider network and provide all covered UMP Plans services. Such network must be available in the other 49 States, District of Columbia and all U.S. territories. Contractor shall provide documentation that the out-of-state provider network is in place annually or as requested by the HCA.

7.5. BlueCard

Contractor is required to include the disclosure contained in subsection 7.5.1 under rules adopted by the Blue Cross Blue Shield Association ("BCBSA"), of which Contractor is a member. Nothing in subsection 7.5.1 requires HCA to make any additional payments for BlueCard services, all of the costs of which are included in the base administrative fee HCA is paying Contractor under subsection 2.7, *Payment of Administrative and Implementation Charges*, and set forth in Exhibit A, *Base Administrative Fees*.

7.5.1. BlueCard Disclosure

- a. Contractor has a variety of relationships with other Blue Licensees referred to generally as “Inter-Plan Programs.” Whenever Members access healthcare services outside Contractor’s Service Area, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to Contractor for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The BlueCard Programs available to Members under this Contract are described generally below.
- b. Typically, Members, when accessing care outside Contractor’s Service Area, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Licensee in that other geographic area (“Host Blue”). In some instances, Members may obtain care from non-participating healthcare providers. Contractor’s payment practices in both instances are described below.

7.5.2. Definitions

For purposes of this section 7.5, the following terms shall have these meanings:

“Accountable Care Organization (ACO)” means a group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

“Blue Licensee” means health plans and other licensed affiliates, and any other entities licensed to use the proprietary brands or marks of the BCBSA.

“Blue Members” means persons enrolled in or covered under Blue Products.

“Care Coordination” means an organized information-driven patient care activities intended to facilitate the appropriate responses to a Participant’s healthcare needs across the continuum of care.

“Care Coordinator Fee” means a fixed amount paid by a Blue Licensee to providers periodically for Care Coordination under a Value-Based Program.

“Global Payment/Total Cost of Care” means a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

“Patient-Centered Medical Home” means a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

“Provider Incentive” means an additional amount of compensation paid to a healthcare provider by a Blue Licensee, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

“Service Area” means the geographic area that a Blue Licensee may serve.

“Shared Savings” means a payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

“Value-Based Programs (VBP)” means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment

7.5.3. *BlueCard® Program*

Under the BlueCard® Program, when Members access covered healthcare services within the Service Area served by a Host Blue, Contractor will remain responsible to HCA for fulfilling Contractor’s contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, Contractor’s action will be consistent with the spirit of this description.

a. Liability Calculation Method Per Claim

The calculation of Member liability on Claims for covered services processed through the BlueCard Program will be based on the lower of the provider’s billed charges or the negotiated price made available to Contractor by the Host Blue.

The calculation of HCA liability on Claims for covered services processed through BlueCard will be based on the negotiated price made available to Contractor by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services.

b. Claims Pricing

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s healthcare provider contracts. The negotiated price made available to Contractor by the Host Blue will represent a payment negotiated by a Host Blue with a healthcare provider that is the actual price. The actual price is a negotiated payment without any other increases or decreases.

A small number of states require Host Blues either (i) to use a basis for determining Memberliability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Contractor would then calculate Memberliability and HCA liability in accordance with applicable law.

c. Inter-Plan Program Fees and Compensation

HCA understands and agrees to reimburse Contractor for certain fees and compensation which Contractor is obligated under the BlueCard Program to pay to the Host Blues, to the BCBSA, and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the BlueCard Program’s standard procedures for revising such fees and compensation, which do not provide for prior approval by any HCA. Such revisions typically are made annually as a result of BlueCard Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given

calendar year, and they do not necessarily coincide with HCA's benefit period under this Contract.

Contractor will charge these fees as follows:

- i. Fees associated with claims processing:
 - Access Fees
 - Administrative Expense Allowance (AEA) fees
 - Per Contract Per Month (PCPM) fees
 - Non-Standard AEA fees
 - Central Financial Agency (CFA) fees
 - ITS transaction fees
 - Other possible BlueCard Program-related fees:
 - Toll-free (e.g., 800 number) number fees
 - PPO Provider directory fees
- ii. Some of these fees and compensation are charged each time a Claim is processed through the BlueCard Program and include, but are not limited to, access fees, administrative expense allowance fees, central financial agency fees, and ITS transaction fees. An access fee may be passed on to HCA as an additional Claim liability. If one is charged, it will be a percentage of the discount/differential Contractor receives from the Host Blue, based on the current rate in accordance with the BlueCard Program's standard procedures for establishing the access fee rate. The access fee will not exceed \$2,000 for any claim. Other BlueCard Program-related fees that Contractor may charge include, but are not limited to, a toll-free number fee, and a fee for providing PPO healthcare provider directories.
- iii. A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its healthcare provider prohibits billing Members for amounts in excess of the negotiated payment. However, a healthcare provider may bill for non-covered healthcare services and for Member cost sharing (for example, deductibles, copayments, and/or coinsurance) related to a particular Claim.
- iv. When Contractor is charged a BlueCard Program access fee, Contractor may pass the charge along to HCA as a Claim expense or as a separate amount. The access fee will not exceed \$2,000 for any Claim. If Contractor receives an access fee credit, Contractor will give HCA a Claim expense credit or a separate credit. Instances may occur in which the Claim payment is zero or Contractor pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Contractor will pay the Host Blue's access fee and pass it along to HCA as stated above even though HCA paid little or had no Claim liability.

7.5.4. Value-Based Programs.

- a. Members may access covered services from providers that participate in a Host Blue's and/or Contractor's Value-Based Programs. A Host Blue's Value-Based Program may

be delivered through the BlueCard Program. Contractor's Value-Based Program applies for services rendered locally. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient-Centered Medical Homes and Shared Savings arrangements.

- b. Under Value-Based Programs, a Host Blue and/or Contractor may pay providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, provider incentives, share of target savings, Care Coordination fees, and/or other allowed amounts.
- c. Contractor will pass these provider payments (either from the Host Blue or from Contractor when services rendered locally) on to GHP and HCA as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.
- d. When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue and/or Contractor:
 - i. Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to GHP and HCA via an enhanced provider fee schedule.
 - ii. Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the increase in the Claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the Claim, they may be billed as follows:

- Annual Lump Sum Billings: Lump Sum billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the Claim system. Contractor will pass these charges directly through to GHP and HCA as a separately identified amount on the group billings annually. Contractor will bill annual lump sum billings no more than 24 months after the end of Term or termination; or
 - Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the Claim system. Contractor will pass these charges directly through to GHP and HCA as a separately identified amount on the group billings.
- e. The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

- f. At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Contractor and/or Host Blues will take one of the following actions:
 - i. Use any surplus in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period; or
 - ii. Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.
- g. The Host Blue and/or Contractor will not receive compensation resulting from how estimated, average, or PMPM price methods, described above, are calculated. If GHP and HCA terminate, GHP and HCA will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Contract.
- h. Variance account balances are small amounts relative to the overall paid Claims amounts and will be drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds. Host Blues may retain interest earned on funds held in variance accounts.
- i. Members will not bear any portion of the cost of Value-Based Programs except when a Host Blue and/or Contractor uses either average pricing or actual pricing to pay providers under Value-Based Programs.
- j. Host Blues may also bill Contractor for and/or Contractor may also pay Care Coordination fees for provider services which Contractor will pass on to GHP and HCA as follows:
 - i. PMPM billings; or
 - ii. Individual claim billings.

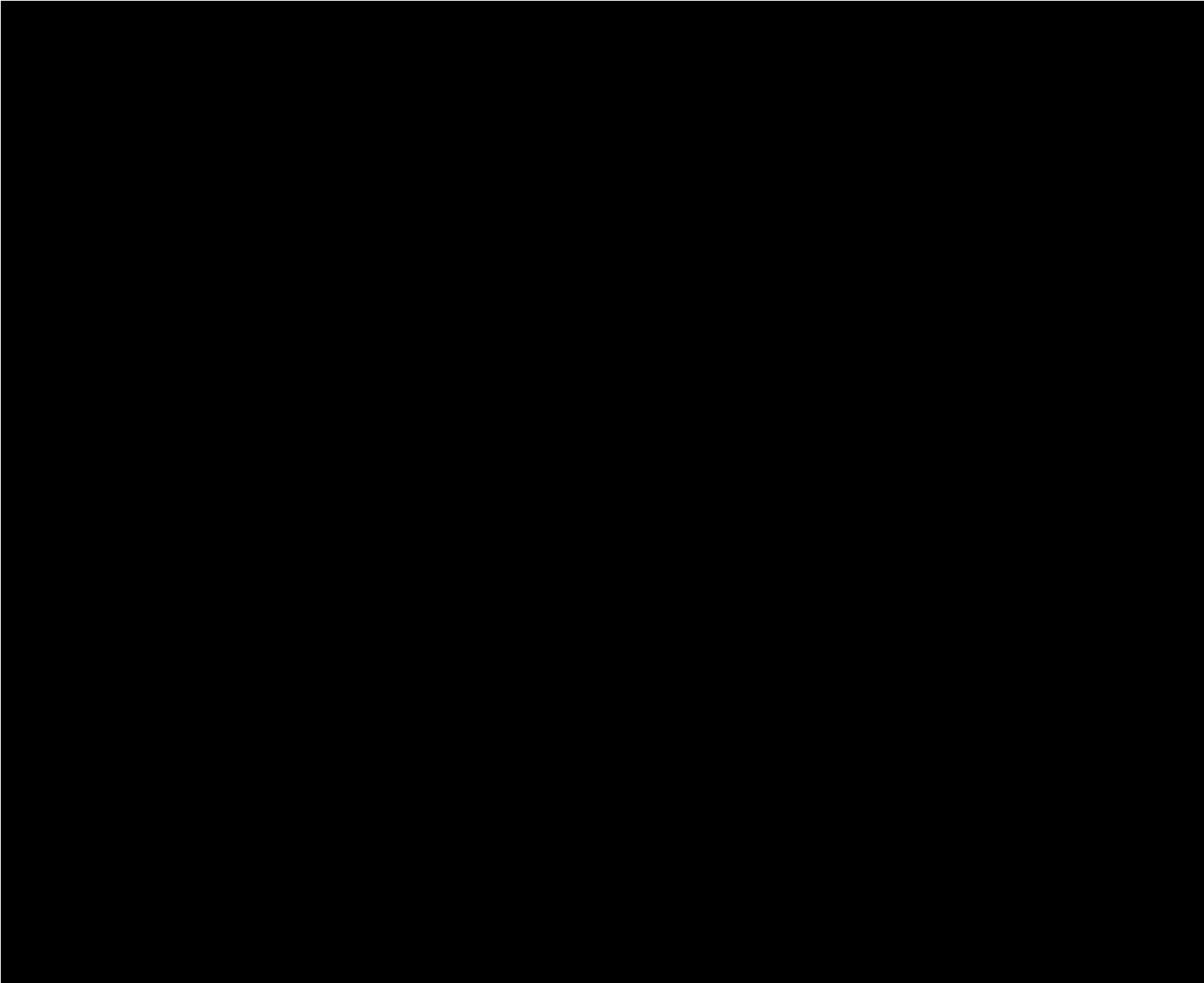
Contractor and the GHP/HCA will not impose Member cost-sharing for Care Coordination Fees.

7.5.5. Return of Overpayments.

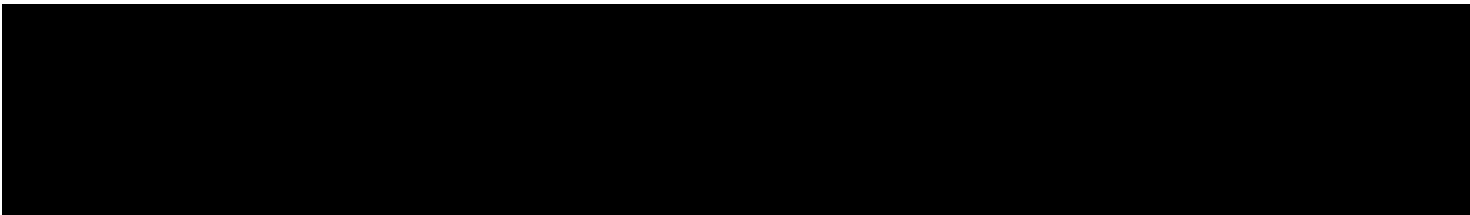
Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including but not limited to anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to HCA as a percentage of the recovery. Recovery amounts determined in this way will be applied in accordance with applicable BlueCard policies, which generally require correction on a Claim-by-Claim or prospective basis. Unless otherwise agreed to by the Host Blue, Contractor may request adjustments from the Host Blue for full refunds from healthcare providers due to the retroactive cancellation of membership but only for one year after the date of the BlueCard financial settlement process for the original claim. In some

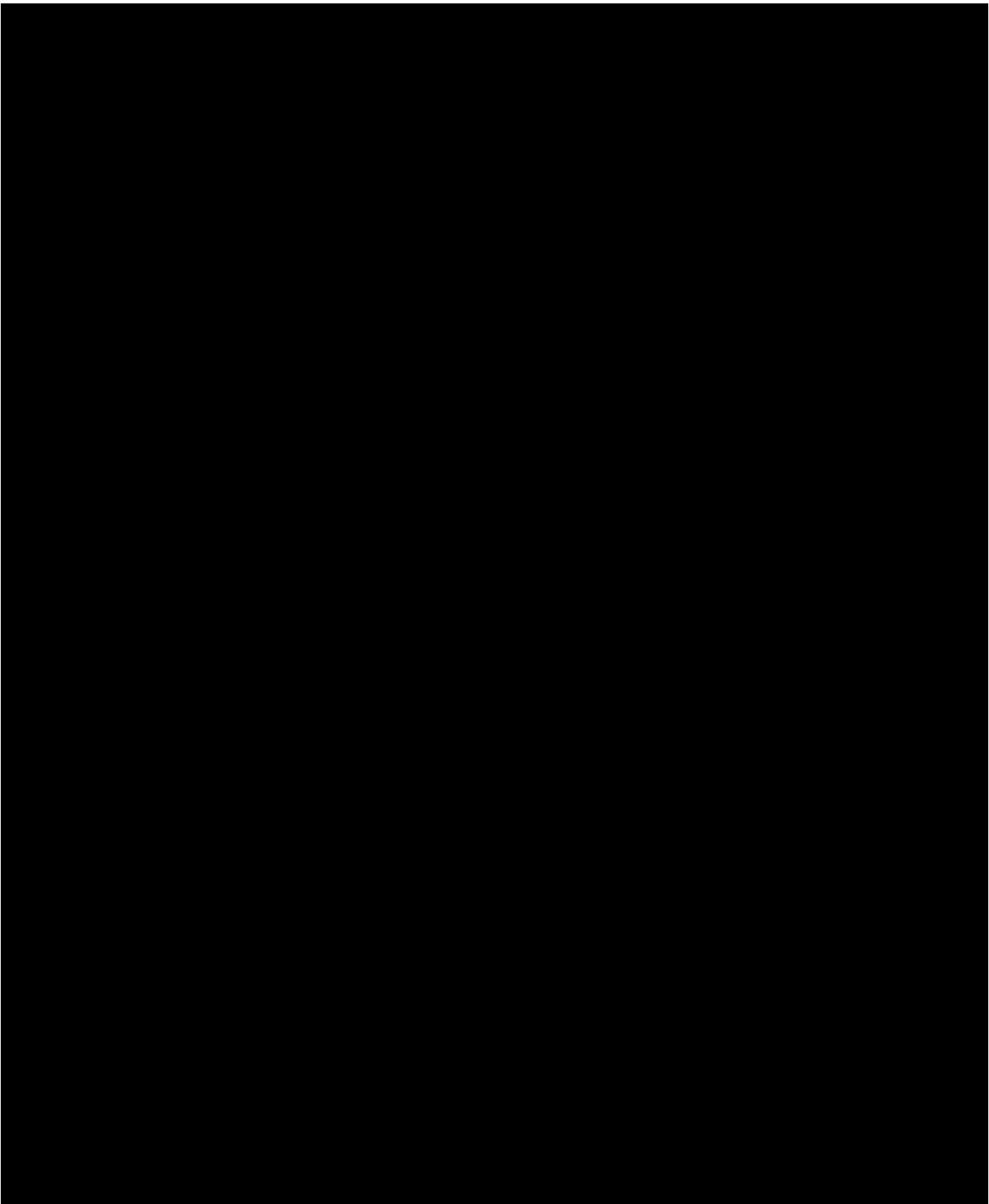
cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or healthcare provider contracts or jeopardizes its relationship with its healthcare providers.

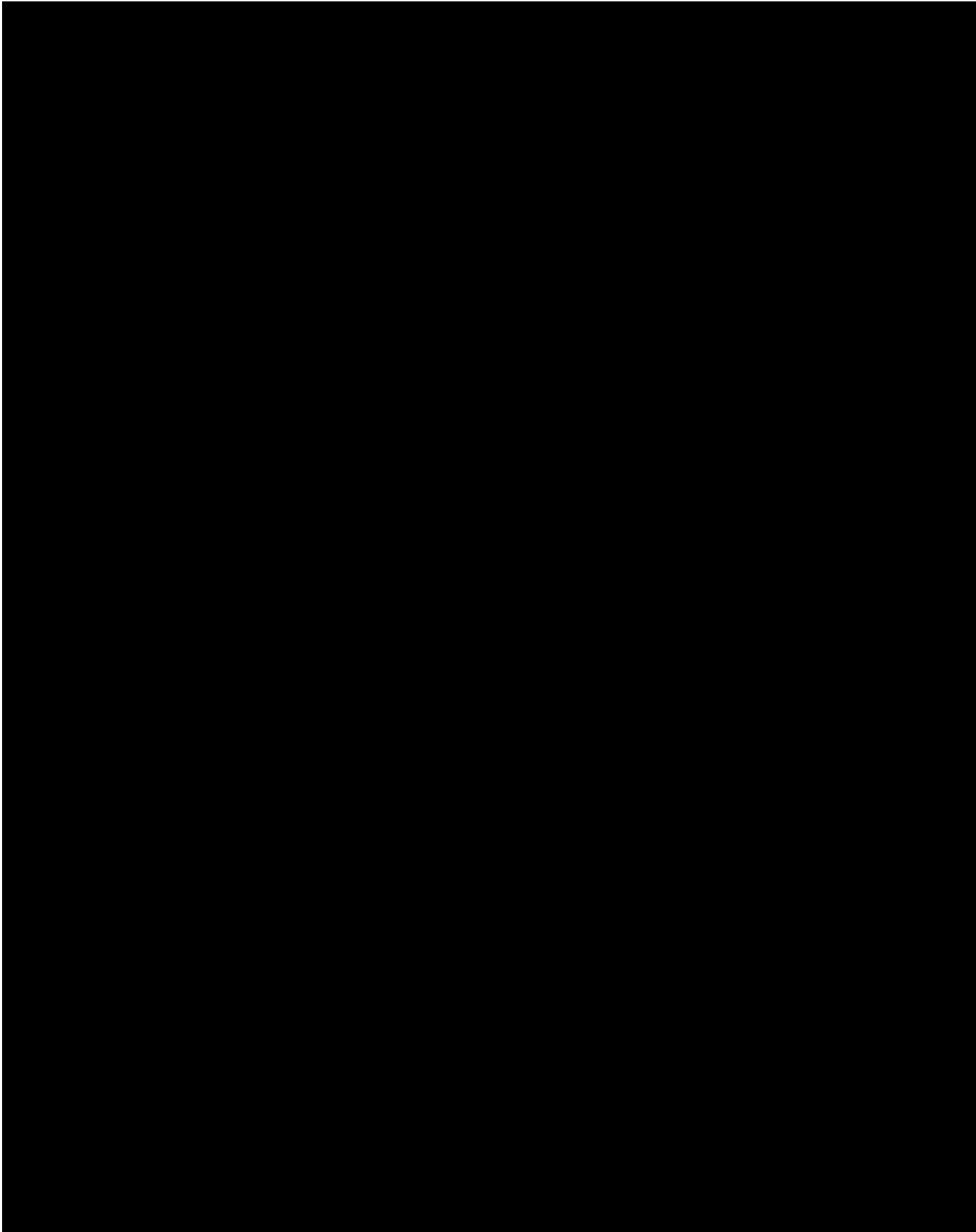
SECTION 8. STRATEGIC PARTNERING ON HEALTH TRANSFORMATION

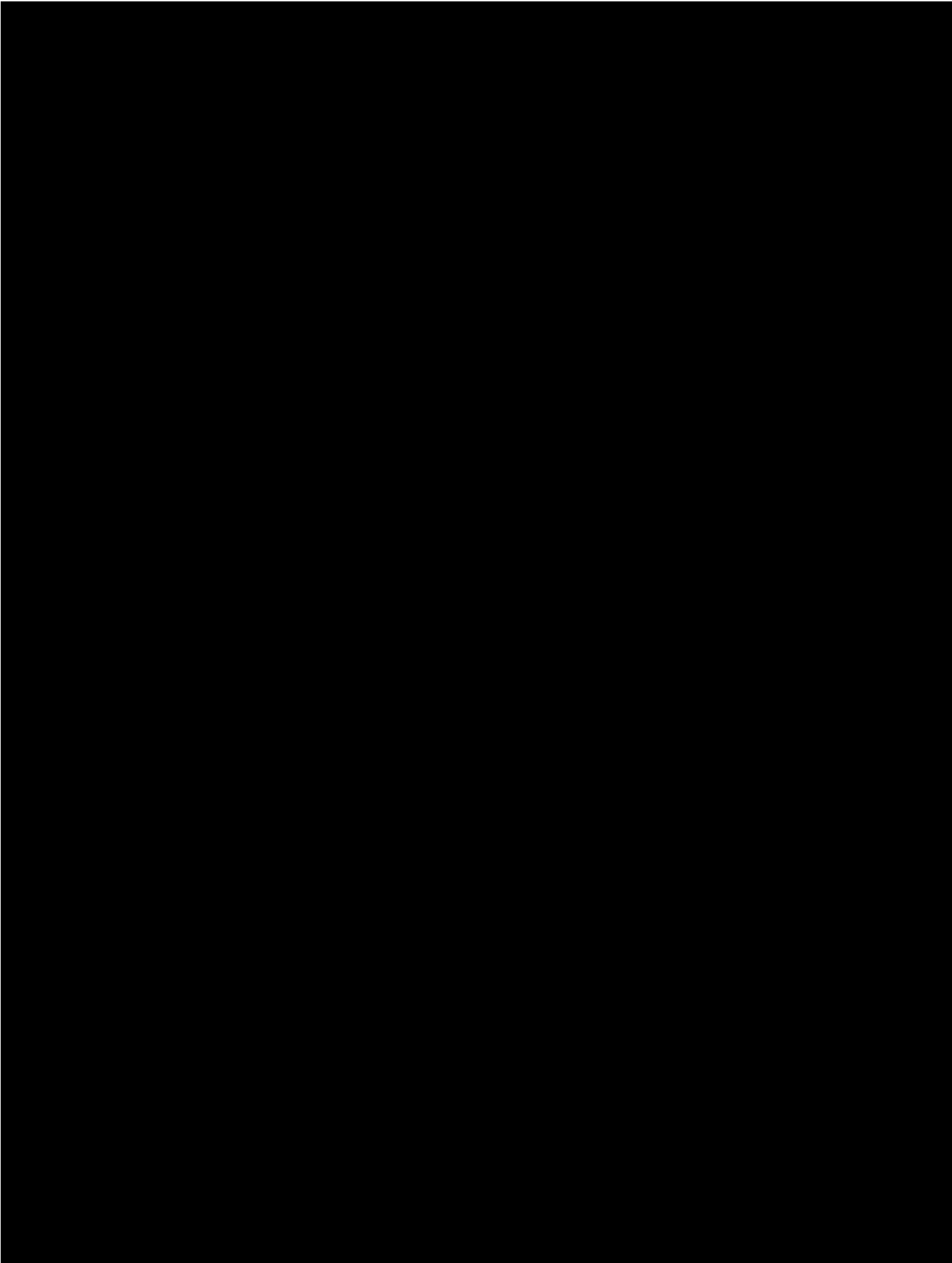


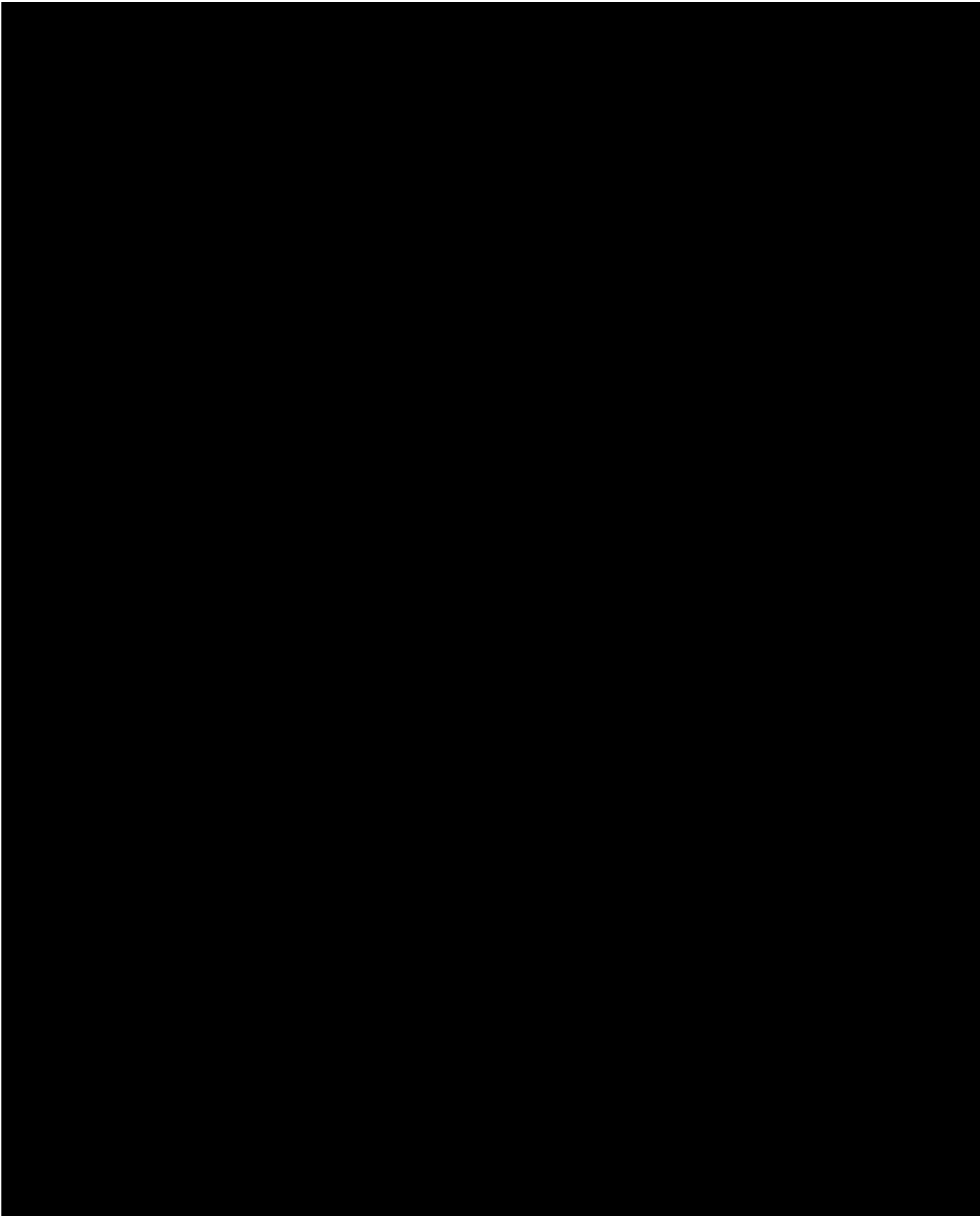
8.1. Innovative Leadership & Administrative Support

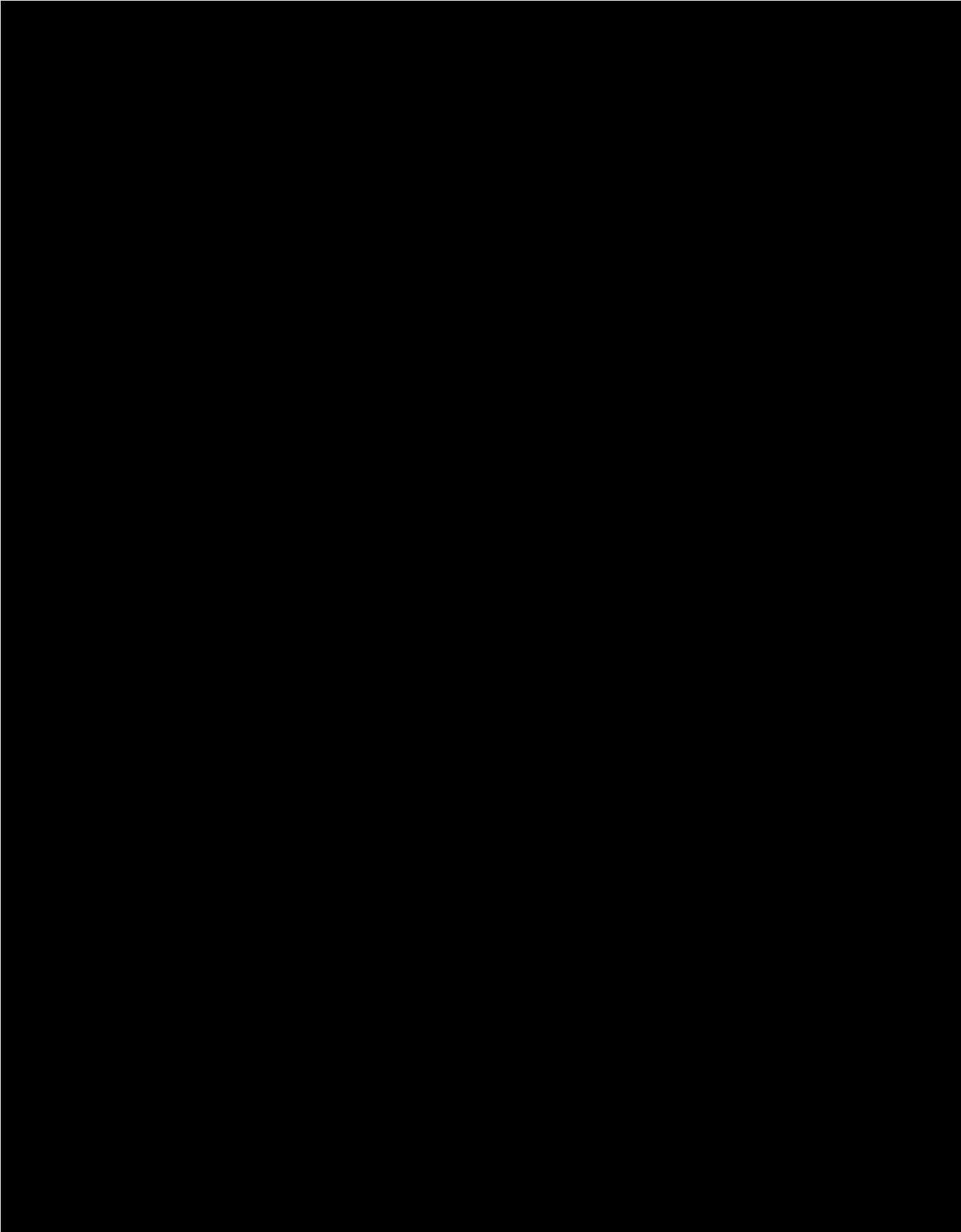


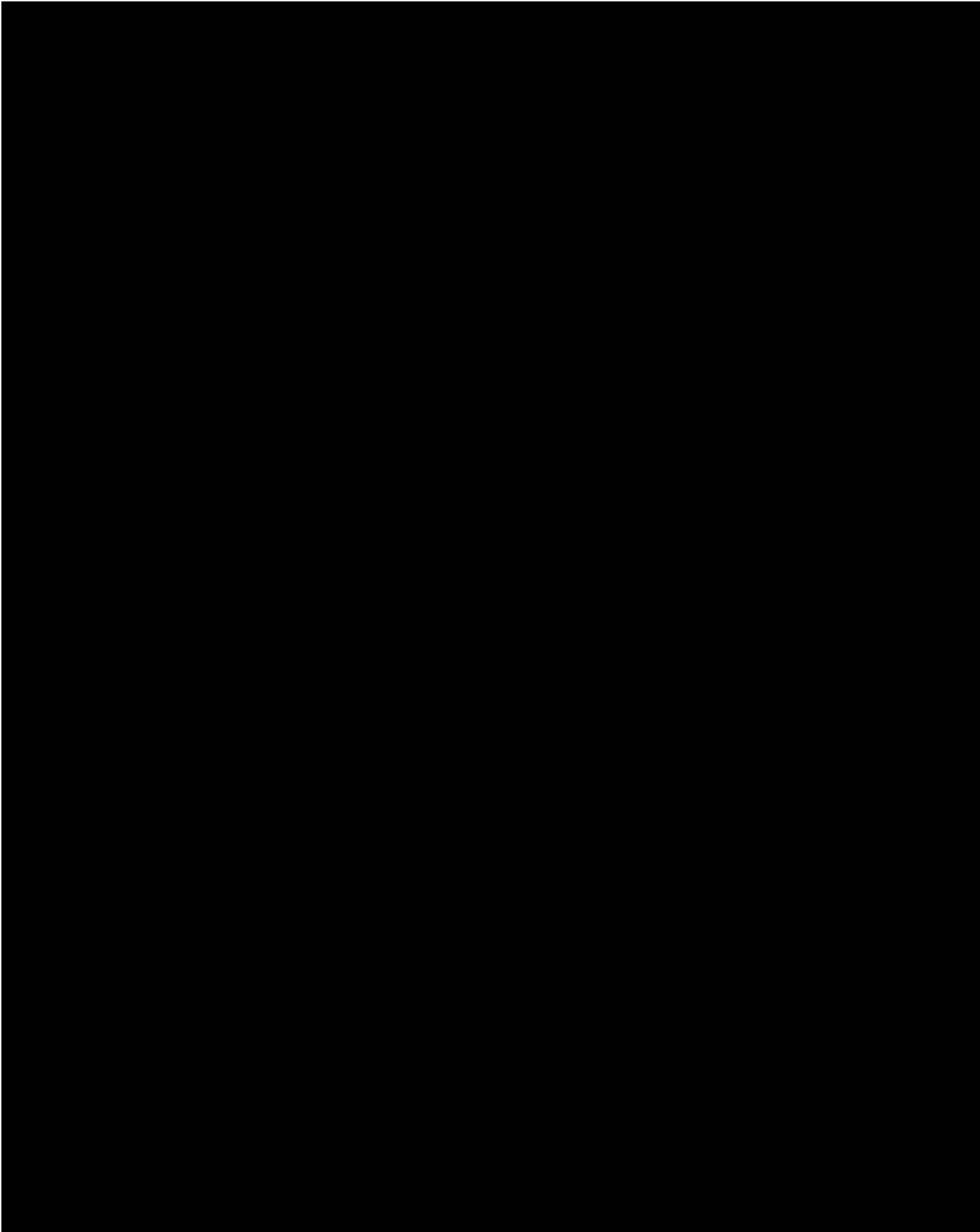


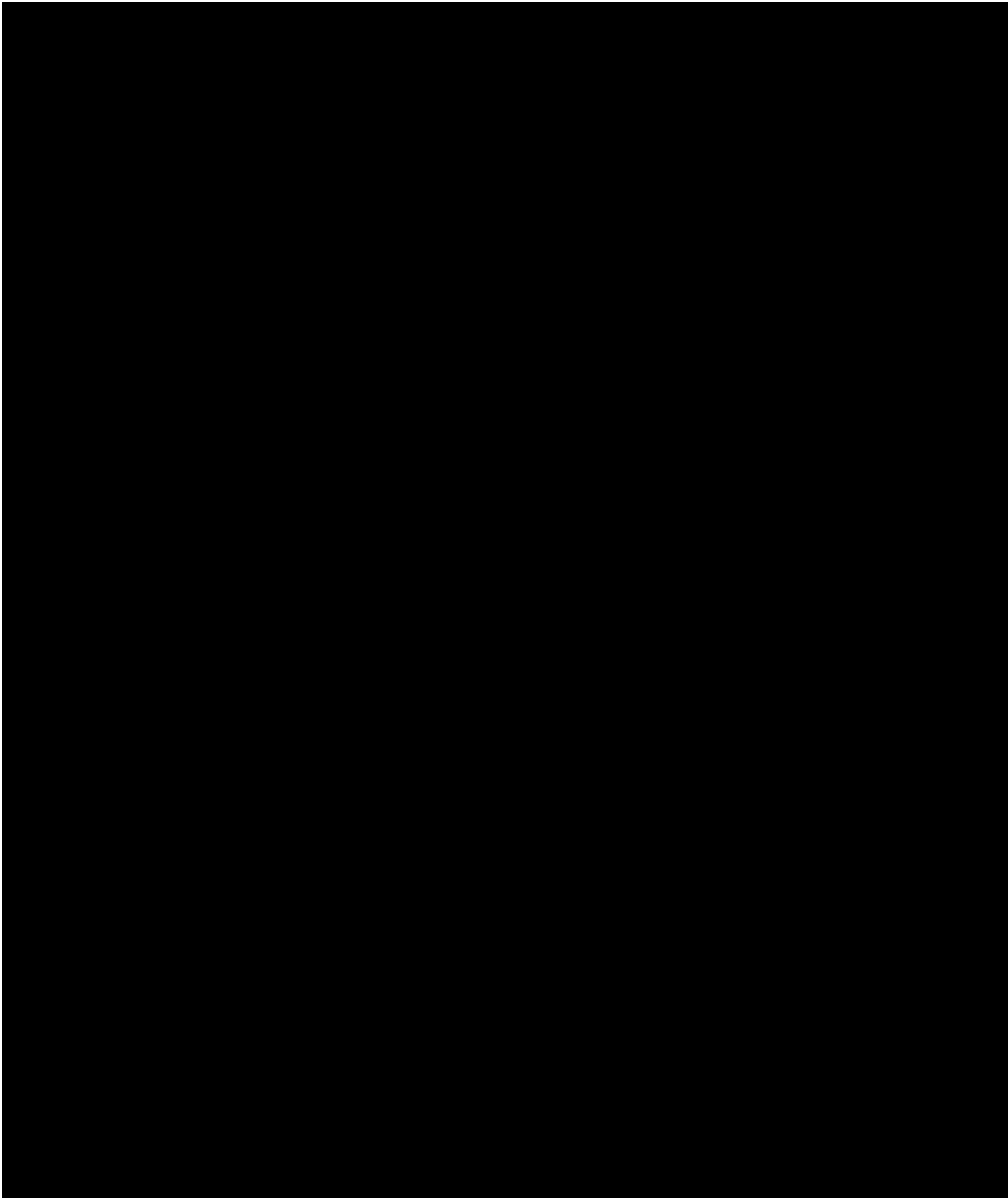












SECTION 9. WORK ORDERS

This Section sets forth the process to be used for (a) special tasks outside of, but related to, the scope of the contracted services; and (b) services described in this Contract that call for a Work Order to be used to document the details of such services. Beginning on January 1, 2020, HCA will be entitled to 5,000 annual service hours at no additional charge (Pooled Hours). All Pooled Hours must be used before HCA will pay any charges or costs related to any such additional services. Unused Pooled Hours will accumulate and carry over into the following year and will not expire throughout the term of the Contract such that a maximum number of Pooled Hours available in any year will be 10,000 Pooled Hours. When applicable, a detailed itemized list of services completed is required on the invoice from Contractor to receive payment and approved by HCA.

In addition to, and separate from, the Pooled Hours described above, HCA will be entitled to up to a total of 2,500 implementation service hours at no additional charge ("Implementation Hours") during 2018 and 2019. These hours are solely available for services necessary to complete the implementation process. Unused Implementation Hours will not accumulate and/or carry over past December 31, 2019, and any unused hours will be forfeited on January 1, 2020. These Implementation Hours will be limited for the use toward the development or creation of ACNs, COE contracting, bundled payment, and tiered hospital networks that are not Substantially Similar to PEBB UMP Plans.

Pooled Hours will not be used for any work within the scope of this Contract, such as data reporting, Contractor's Book-of-Business Programs, or other items as described in this Contract. Other than the compensation identified in Exhibit A, and any agreed upon on fees paid under this process, there will be no other payments to Contractor. Specified additional work, or a change in existing services or procedures, expected completion date and criteria, including system acceptance testing procedures, and any compensation, will be set forth in a Work Order form attached to the Contract (Work Order). Each Work Order will be issued and approved by the HCA Contract Manager. The expected completion date will be the date by which the parties intend the work or change to be operational. Contractor will not charge or accept any compensation from any Member for any purpose.

9.1. Work Order Process

9.1.1. UMP Contract Manager

An HCA Contract Manager or delegate will be responsible for issuing all Work Orders under this Contract. HCA will send Work Orders to Contractor's designated Work Order coordinator.

9.1.2. Contents of Work Order

HCA will notify Contractor of new or additional work to be performed under this Contract, and of changes to any work already described in this Contract, by issuing a written Work Order. Work Orders may be transmitted electronically. The Work Order will specify the work or the change in services or procedures, state the expected completion date; define completion criteria, including system acceptance testing procedures; and set an estimated cost. The Work Order will be issued and approved by the HCA Contract Manager. The expected completion date will be the date by which HCA intends the work or change to be operational. HCA will use its best efforts to tell Contractor of anticipated changes as soon as possible. HCA will give Contractor ninety (90) Days' notice of changes in the benefit design intended for each new year.

9.1.3. *Contractor's Response*

Contractor will respond to a Work Order in writing. Contractor's response must be from a member of Contractor's account management team. Contractor's response must be in an agreed upon standard format. The response must be received by HCA within five (5) Business Days after Contractor received the Work Order. The response must indicate the following:

- a. Contractor to perform the work or change within the expected completion date, an accurate estimate and itemized breakdown of the required goods and services and the costs associated with such goods and services, and the sample outcome for HCA to review for expectations.
- b. The terms, costs, and completion dates are at least as favorable as the terms granted by Contractor for similar work provided to other plans; or
- c. Acknowledgment of receipt of the Work Order and statement of the need for further information and specification of the information needed, or
- d. Acknowledgment of receipt of the Work Order and statement of the reasons why the work cannot be performed by the expected completion date, specification of an alternative completion date within which the work will be performed, and an estimate of the cost, or
- e. Acknowledgment of receipt of the Work Order and statement of reasons why the work cannot be performed.

9.1.4. *HCA's Response*

HCA will review Contractor's response, determine whether the terms are acceptable, and make such modifications as may be necessary for HCA to agree to the proposed Work Order.

9.1.5. *Monitoring of Work Orders*

Contractor must maintain an up-to-date working log of active Work Orders. It will be reviewed at weekly core account sponsor meetings.

9.1.6. *Completion*

Contractor will notify the HCA Contract Manager in writing as each Work Order is completed and becomes operational. A Work Order has not been completed until Contractor has updated all administrative procedures and supporting documents affected by the Work Order, and HCA has certified the Work Order is complete.

9.1.7. *Implement Health Technology Clinical Committee (HTCC) Determinations*

HCA will send Contractor a no charge Work Order in September of each year that details the HTCC's final determinations for that year. Contractor's response to such Work Order will include all the requirements, detailed procedure codes, and International Classification of Diseases (ICD) codes, in order for Contractor to implement the changes by the effective date provided. Services necessary to complete this Work Order will be completed by September 30 annually, for determinations made in that same year, unless otherwise specified by HCA in the Work Order. Contractor will have specific ICD (9 or 10) version by

2019 and maintain version updates. Section 3.1.5 includes additional details about the implementation of HTCC determinations.

9.1.8 Other Legal Mandates

Mandates include all legal obligations the HCA has under any governing statute, regulation, case law, or court order. Contractor is solely responsible for adhering to all such legal mandates. Contractor will make all changes or modifications to its programs and services for HCA and the UMP Plans to be compliant with such mandates. HCA and Contractor will complete a Work Order for each mandate. For mandates that apply to Contractor's fully-insured Book-of-Business, there will be no additional charges for implementing such mandates in UMP Plans. For mandates that apply only to the UMP Plans, the only permissible charges will be limited to (a) charges made by any Subcontractor to Contractor specifically for such mandate, and (b) one-time costs necessary to implement such mandate as further described in the Work Order. If ongoing costs to administer a mandate that applies only to UMP Plans are required, the Parties will negotiate an amendment to this Contract to account for such costs.

9.2. Charges for Work Orders

9.2.1. General Billing

When applicable, time may be billed to HCA at the Pooled Rate after all Pooled Hours have been used. Contractor shall not bill HCA, nor will HCA pay, for services necessary to implement annual changes in benefits or other scope of work covered in the Contract. Contractor shall not deduct from the Pooled Hours for services included in the Contract.

Contractor must provide a cost estimate in the Work Order when applicable using an hourly rate less than or equal to the Pooled Rate. Contractor will not charge HCA more than the charges agreed to in the Work Order unless HCA agrees in writing. Contractor shall bill HCA for applicable costs via invoice once the services described in the Work Order have been completed.

Work Orders may only identify charges for goods or materials obtained by Contractor for which HCA has agreed to reimbursement. Any such costs for such goods may not exceed the actual cost paid by Contractor.

9.2.2. Work with No Extra Charge

Work Orders may be completed to document work as part of the Contract without any additional charges (No Charge Work Orders). Some examples of this are implementation of HTCC determinations, HCA customized medical policies, annual benefit changes, or services performed using Pooled Hours.

All other requests, except for data requests, must be presented through the Work Order process outlined in Section 9.1, but may not always have an associated charge. Pooled Hours not used in one (1) calendar year will be carried forward to the next calendar year such that a maximum number of Pooled Hours available in any year will be 10,000 Pooled Hours. Within five (5) Business Days of the end of each month, Contractor will provide HCA a report detailing (a) the number of Pooled Hours used in that month, (b) total Pooled Hours expended in that calendar year, and (c) total remaining Pooled Hours. If the Pooled Hours

balance falls to zero, Contractor will perform additional services at the Pooled Rate set forth in Exhibit A. This will be part of the monthly operations reports.

SECTION 10. REQUESTS FOR RENEWAL

On an annual basis, HCA conducts a Request for Renewal (RFR) process for both fully-insured health plans and self-insured third-party administrators. The annual RFR process enables the PEBB and/or the SEBB to adjust employee benefits.

In the first quarter of each year, HCA will gather a list of approved changes for the following year's benefits. Contractor will respond with a detailed proposal regarding how it intends to implement the changes, and inform the HCA of possible changes to timelines and resources as a result. If the annual RFR requests are legislative mandates, or are in the course of normal operations, or are included in the scope of this Contract, no new funding will be given by HCA following implementation of the benefit changes. All costs incurred by Contractor in responding to an RFR shall be borne solely by Contractor and not charged to HCA.

Contractor shall:

- a. Carefully read and analyze the RFR.
- b. Provide a clear and comprehensive evaluation and implementation plan for each benefit change in the time period allotted for proposals.
- c. Respond to any No Charge Work Order request for detailed work issued by HCA.

SECTION 11. BUSINESS ASSOCIATE

Contractor is a "Business Associate" as defined in the privacy and security rules of HIPAA. Accordingly, Contractor shall sign the Business Associate Agreement attached as Exhibit G-1 prior to beginning any services under this Contract.

SECTION 12. GENERAL TERMS AND CONDITIONS

12.1. Indemnification and Hold Harmless

12.1.1. General

Contractor will defend, indemnify, and hold HCA and its officers, employees, representatives, agents, successors and assigns (the "Indemnified Parties") harmless from and against all claims, demands, or suits, including reasonable attorneys' fees, for any or all injuries to persons or damage to property arising from willful or negligent acts or omissions of Contractor, its officers, employees, agents, or subcontractors and their officers, employees, or agents, in the performance of this Contract.

12.1.2. Industrial Insurance Waiver

Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the Indemnified Parties.

12.1.3. HCA Indemnity

To the fullest extent permitted by law, HCA shall indemnify and hold harmless Contractor from all claims, costs, damages, or expenses arising out of HCA's negligence. HCA shall

indemnify and hold harmless Contractor from all claims, costs, damages, or expenses arising out of the adherence by Contractor to (i) final rules from HCA published in the Washington State Register pertaining directly to the UMP Plans; (ii) written policies from HCA that have agreed implementation processes pertaining directly to the UMP Plans and have been conveyed to Contractor by HCA's Senior Account Sponsor(s); (iii) written directives from HCA (other than for Contractor to follow its standard procedures, policies, and protocols) pertaining to specific Member appeal determinations that have been conveyed to Contractor by HCA's Senior Account Sponsor(s); and (iv) fully-executed Work Orders. This subsection shall not apply to any oral communications between HCA and Contractor. Furthermore, Contractor acknowledges and agrees that any written policies that have agreed implementation processes that it may receive from anyone other than the Senior Account Sponsor(s) shall not be subject to the provisions of this subsection. In the event of negligence of both Contractor and HCA, any damages allowed shall be levied in proportion to the percentage of negligence attributable to each party.

12.2. Assistance in Legal Actions

In addition to any other similar requirement, right, or obligations of the parties set forth in this Contract, each party will advise each other as to matters that come to its attention with respect to actual or potential substantial legal actions related in any way to the UMP Plans. Contractor and its Subcontractors, if any, will fully cooperate with HCA to assist in litigating or otherwise pursuing any action on behalf of HCA or the State of Washington, by providing, without additional fee, all information relating to such causes of action and providing necessary testimony.

12.3. Attorneys' Fees

In the event of litigation or other action brought to enforce the terms of this Contract, each party agrees to bear its own attorneys' fees and costs.

12.4. Audits

HCA will require an annual Claims audit and may require other audits of Contractor's performance under this Contract. Contractor will be given a complete and accurate listing of transactions to be pulled for such audit not less than thirty (30) Business Days before the date the audit is to begin, unless mutually determined otherwise. The annual Claims audit will be performed by a third-party selected by HCA in its sole discretion. Annual Claims audits will be paid for by Contractor.

Other audit(s) may be performed by HCA staff, by another state agency, or by another party designated by HCA. The scope of the audit(s) will be communicated to Contractor before commencement of the audit(s).

Contractor will have the right to examine and comment on the draft of any audit report before it is made final. HCA will provide a deadline by which such review and comment must be completed at the time the report is provided. The fee of any professional audit firm(s) will be borne by HCA for any other audits commissioned by HCA.

12.5. Assignment

No assignment by Contractor of any of its obligations pertaining to this Contract will be valid without the prior written consent of HCA, which HCA can grant or deny in its sole discretion.

12.6. Relationship to Blue Cross and Blue Shield Association

HCA on behalf of itself and its Members hereby expressly acknowledges that this Contract constitutes an agreement solely between HCA and Contractor, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Contractor to use the Washington license, for those counties designated in Contractor's Service Area, and that Contractor is not contracting as the agent of the Association. HCA on behalf of itself and its Members further acknowledges and agrees that it has not entered into this Contract based upon representations by any person or entity other than Contractor and that no person or entity other than Contractor will be held accountable or liable to HCA or the Members for any of Contractor's obligations to HCA created under this Contract, except as expressly specified herein. This paragraph will not create any additional obligations whatsoever on the part of Contractor other than those obligations created under other provisions of this Contract.

12.7. Taxes

Contractor is solely responsible for all payroll taxes, unemployment contributions, and any other taxes, insurance or other expenses related to the receipt of payments received from HCA under this Contract.

12.8. Independent Contractor

Contractor and its employees or agents performing under this Contract are not employees or agents of HCA. Contractor and its employees and agents will not hold themselves out as, nor claim to be, officers, employees, or agents of HCA or of the State of Washington, nor will Contractor or its employees or agents make any claim of right, privilege, or benefit which would accrue to an employee of the State.

12.9. Modification of Contract

12.9.1. General

Unless otherwise provided, no modification or amendment of the terms of this Contract will be valid unless in writing and signed by an authorized agent of HCA and of Contractor. Notwithstanding the foregoing, any provisions of this Contract which, on or after its Effective Date, are in conflict with applicable state or federal laws or regulations, are hereby amended to conform to the minimum requirements of such laws or regulations.

12.9.2. Notice of Plan Changes

HCA will give Contractor at least sixty (60) Days' notice of Plan benefit changes, which usually are intended to be implemented for the next plan year. HCA will furnish Contractor with a copy of each modification or amendment of the Plan benefits as soon as is practicable.

12.9.3. Changes in Plans

a. Plan Addition

HCA reserves the right to add, at any time, Health Plans to the scope of this Contract (each an "Additional Plan"), either in place of or in addition to UMP Classic, UMP Plus, and UMP CDHP. In the event HCA exercises this right, it shall provide Contractor sixty (60) Days' notice of such change. If HCA requests only the administrative services listed

in Section 2 for the Additional Plan(s), then the only charge to be made to HCA shall be for the additional Subscribers to the Additional Plan to be included in calculating PSPM for UMP Classic as listed in Exhibit A, *Administrative Fees*. If additional services are required, the parties will negotiate in good faith to determine the costs of those services, and amend Exhibit A to add a new fee table similar to those for UMP Plus and UMP CDHP.

b. Plan Reduction

HCA reserves the right to remove any Plan(s) within the scope of this Contract at any time. In the event HCA exercises this right, it shall provide Contractor sixty (60) Days' notice of such change. As of the effective date of the removal of a Plan, Contractor shall no longer charge, and HCA shall not be obligated to pay, any Administrative Fee for such plan listed in Exhibit A, *Administrative Fees*.

12.10. Termination

12.10.1. Termination by HCA

- a. Termination for Cause - In the event Contractor violates any material term or condition of this Contract, or fails to fulfill in a timely and proper manner its material obligations under this Contract, then HCA has the right to suspend or terminate this Contract. Before invoking this remedy, HCA shall notify Contractor, in writing, of the Contractor's need to take corrective action. If corrective action is not taken within sixty (60) Days, or other time period agreed to in writing, the Contract may be terminated. The Dispute Section in 12.17 applies to "Termination for Cause."

In the event of termination, the Contractor shall be liable for damages as authorized by law as a result of such violation or failure, including costs to replace Contractor's services.

- b. Termination for Convenience – HCA may terminate this Contract, at HCA's sole discretion, by giving seventy-five (75) calendar days' written notice. If this Contract is so terminated, HCA shall be liable only for properly authorized services rendered and accepted by HCA before the effective date of Contract termination, and for reimbursement of all Claims adjudicated before that date, in accordance with Section 2.7, Payment of Administrative and Implementation Charges. Termination for convenience may be invoked by the HCA when HCA determines in its sole discretion it is in the best interest of the State. HCA shall consult with Contractor in good faith during such notice period and cooperate with Contractor to seek to arrive at an accommodation that may meet the State's needs without termination; provided, however, that the final decision regarding termination remains in HCA's sole discretion.
- c. Termination for Performance Guarantees - HCA may terminate this Contract by giving Contractor sixty (60) Days' written notice, upon (i) Contractor's failure to comply with one or more Performance Standards as stated in Section 6 in two (2) consecutive measurement periods, and (ii) failure to take effective and prompt steps to correct the alleged failures or unsatisfactory performance or to demonstrate that the concerns of HCA are not justified.
- d. Termination for Conflict of Interest - For purposes of this Contract, Contractor agrees that the Ethics in Public Service Act, Chapter 42.52 RCW applies to Contractor's

employees as if they were employees of the state of Washington. If HCA determines that a violation has occurred of the Ethics in Public Service Act, or any other laws regarding ethics in public acquisitions and procurement and performance of contracts, then HCA will provide written notice of the violation to Contractor. Contractor will have fifteen (15) Business Days to rectify the violation, which may include precluding the violator from further performance of work under this Contract or participating in Contractor's future procurements with HCA and the state of Washington. If Contractor fails to rectify the violation, then HCA may terminate this Contract for cause by written notice to Contractor.

- e. Termination for Funding or Legislative Authority – HCA may terminate this contract as set forth in Section 12.20.
- f. Except for subsections b. and e., if this Contract is terminated as provided above, HCA will be entitled to pursue the same remedies against Contractor as it could pursue in the event of a breach of the Contract by Contractor. The rights and remedies of HCA provided for in this provision are not exclusive and are in addition to any other rights and remedies provided by law. The existence of facts upon which the Director of HCA makes any determination under this clause may be reviewed as provided in the "Disputes" clause of this Contract.

12.10.2. Termination by Contractor

This Contract may be terminated at any time by Contractor, by giving advance written notice received by HCA not less than six (6) months prior to termination, for failure of HCA to pay undisputed monthly fees in the amounts and manner specified in this Contract; provided, however, that HCA shall have thirty (30) Days following receipt of written notice of such failure to make such payment.

12.10.3. Termination Procedure

- a. Any notice of termination required under this Contract will explain the reason for termination, if any is required, and will include an explanation of any alleged breach, if applicable. Notwithstanding anything herein provided to the contrary, the breaching party will have the right to cure the breach during the notice period, if the termination pertains to an alleged breach.
- b. Termination will be in addition to any other remedies that may be available by law or under this Contract. Termination of this Contract will not terminate the rights or liabilities of either party arising out of performance for any period prior to such termination.

12.10.4. Termination of UMP CDHP with a Health Savings Account

Upon thirty (30) Days' notice, HCA may terminate the UMP CDHP at any time with or without cause. Termination of UMP CDHP does not, in itself, terminate this Contract. Termination of this Contract will automatically terminate the UMP CDHP administration services.

12.10.5. Termination of UMP Plus or an ACN

Upon thirty (30) Days' notice, HCA may terminate UMP Plus at any time with or without cause. Termination of UMP Plus does not, in itself, terminate the Contract. Termination of this Agreement will automatically terminate UMP Plus administration services. The

termination procedures in Section 12.10.1.a. and Section 12.10.3 will apply except that the written notice requirement will be ten (10) Business Days.

12.11. Services after Termination

12.11.1. General

Upon termination or expiration of this Contract under any of its provisions, Contractor will complete processing all Claims for benefits under UMP Plans for services with dates of service during the Term of the Contract, applying and according to the terms and conditions that would have been applicable if this Contract remained in effect, including the Administrative Fee described in Exhibit A for that period, for 60 months after termination date. Services include Claims processing, appeals and IRO interface, customer service, Clinical and Utilization Management, quality control, administrative support, subrogation, escheatment, case management, fraud, overpayment, erroneous payments, correspondence, data extracts (ViPS, Washington Health Alliance, and HCA's consulting actuarial firm), Account Management, One Health Port/Office Ally access, UMP provider search tools, and EOBs. Weekly Claims billing will continue through the first 36 months; thereafter for months 37-60, monthly Claims billing or as deemed appropriate. HCA will require Contractor to provide the services above at no additional cost to HCA, meaning the last Administrative Fee will be paid on the fifth Business Day following the termination date based on HCA's enrollment information as of the termination date and no more Administrative Fee will be charged thereafter.

12.11.2. Ad Hoc Reporting

Contractor shall continue to provide ad hoc reporting services as described in this Contract.

12.11.3. Secondary Medicare

For Medicare Secondary-Payer Claims, Contractor shall follow the proper Claim rules to process such Claims until Claim is complete at no additional cost and provide reporting to Medicare for at least 60 months. Contractor will handle and report Medicare Secondary Payer Recovery Program (MSPRC) Claims for 60 months after termination, consistent (a) with its practice at the time of termination and (b) with the Contract.

12.11.4. Claims Adjudication

Contractor will continue to provide Claims adjudication services within the 60 month period for Claims incurred prior to the termination or expiration of this Contract in accordance with the refund and adjustment timelines outlined in Contractor's provider contract arrangements and in accordance with the Appeal/IRO process outlined in the Certificate of Coverage.

12.11.5. Transition of Services

Contractor, HCA, and HCA's designee will work collaboratively to ensure a smooth and professional transition of services from Contractor to any vendor designated by HCA. Contractor will transfer all Member records to the new vendor within fifteen (15) Days of HCA's request. Contractor will work collaboratively with HCA and the new vendor to prepare a specific transition plan. This plan will include providing sufficient dedicated staff to the transition as well as processes for ensuring transfer of materials. Nothing in the transition plan to be developed is intended to divulge trade secrets.

12.11.6. Eligibility Updates

- a. Contractor will accept and process daily eligibility updates from HCA, consistent with its current practice at the time of termination of this Contract, for three (3) years after termination.
- b. Contractor will send daily eligibility updates to the UMP PBM in the HIPAA 834 format for three (3) years after termination, for purposes of the Retiree Drug Subsidy (RDS). Contractor will send those updates by a means agreed upon with the UMP PBM.

12.11.7. Appeals & IROs

Contractor will handle appeals and requests for review by IROs relating to services incurred during the term of this Contract. It will handle them under procedures consistent (a) with its current practices for Appeals and (b) with this Contract. Contractor will assume these practices for 60 months after termination.

12.11.8. Online Accounts

Contractor will maintain the Enrollee online accounts for three (3) years after termination or expiration, in a manner consistent with the Contract.

12.11.9. Case Management Enrollees

- a. By the first Business Day of the last month before termination is effective, Contractor will give HCA all information in the Case Management system on Members who are in Case Management.
- b. By the fifteenth Day of the first month after termination is effective, Contractor will update such report to include all information from the Case Management system on Members who went into Case Management after such report was prepared, but before the effective date of the termination.

12.11.10. Customer Service

Contractor will maintain a customer service program to handle Enrollee and provider inquiries and Complaints for sixty (60) months after termination. This program will be consistent (a) with such services being offered at the time of termination and (b) with the requirements in the Contract, including customer service Performance Guarantees.

12.11.11. Provider Search Tool

Contractor will maintain the provider search tool at least one (1) year after the effective date of termination.

12.11.12. Hearing & Vision Hardware

For the first year after termination, Contractor will report to HCA the amounts paid on behalf of each Member for hearing aids or vision hardware benefits by the first Business Day of the third month after termination, with data as current as possible. If, during the term of the Contract, vision hardware benefits are no longer included in the UMP Plans, than Contractor will report on hearing aids only.

If during the term of this Contract, HCA chooses to remove or add a vision contractor and have a stand-alone benefit, the Contractor will continue to subcontract with such entities as

requested by HCA, or collaborate with such entities, necessary for the implementation of such services.

12.11.13. Subrogation

Contractor will open and administer subrogation, third party liability, and right of reimbursement claims that arise during the first twenty-four (24) months after termination in a manner consistent (a) with its practice at the time of termination and (b) with the Contract. Contractor will retain 30% of amounts collected on such claims.

12.11.14. OneHealthPort Access

For the first year after termination, Contractor will provide OneHealthPort and Office Ally access for providers on Claims for services rendered while this Contract was in effect, in a manner consistent (a) with its practice at the time of termination and (b) with the Contract.

12.11.15. Form 1099s

Contractor will produce IRS Form 1099s for Claims processed while this Contract is in effect, or processed in accordance with Section 12.11.1 or 12.11.5 above, consistent with the Contract, for sixty (60) months.

12.11.16. Data & Reports

- a. Contractor will provide data extracts consistent with the requirements of this Contract:
 - i. Full data to HCA database contractor for the database monthly, and with same format and information as in the last data sent before termination, 60 months after termination.
 - ii. Extract to Washington Health Alliance for the last year this Contract is in effect, in the same format and information as previous extracts to the Alliance, as requested by WHA up to sixty (60) months.
 - iii. Full data to HCA's designated actuarial consultant, in the same format and information as previous Claims data and risk adjustment data sent to such consultant, for the last year this Contract is in effect, for sixty (60) months following termination.
- b. Contractor will provide all reports, consistent with the requirements of this Contract, to HCA that are required to be provided within three (3) months after the termination or expiration is effective.

12.12. Severability

If any provision of this Contract, or the application thereof to any person(s) or circumstances, is held invalid by a court of competent jurisdiction, such invalidity shall not affect the other provisions or applications of this Contract that can be given effect without the invalid provision, and to this end the provisions or application of this Contract are declared severable.

12.13. Data of UMP

- a. As set forth in RCW 41.05.075, all Enrollee Claims data shall be the property of HCA and not of Contractor. Claims data includes, but is not limited to, Claim line level detail for each Claim, to include Allowed, Paid and Submitted Amounts. Contractor agrees all

data accumulated by Contractor from Claims on Enrollees will be given to HCA upon request with three (3) Days' notice.

- b. Other than as necessary to calculate Medicare Lite and Contractor's compliance with the Performance Guarantees set forth in Section 6.2.5 and Exhibits E-1 through E-3, HCA shall not reverse compile or reverse engineer such Claims data for the purposes of determining any discount rate included in any contract between Contractor and any provider, provider group, clinic, hospital, or other facility providing health care services related to this Contract.
- c. Except as is necessary for the fulfillment of its obligations under this Contract, Contractor will not disclose other confidential information pertaining to any UMP Plan without the prior written permission of HCA unless required by statute, regulation, or an order from a regulatory authority or court of competent jurisdiction.
- d. Unless otherwise prohibited by law, subject to its obligations under this Contract, Contractor is granted an irrevocable, nonexclusive, worldwide and fully paid license, with the right to sublicense others, to pool such Claims data anonymously with other Claim data Contractor collects for the purpose of trend and statistical analysis. Notwithstanding the foregoing, HCA may revoke the license (i) in the event a law, regulation or other order is issued by an executive, legislative or judicial authority prohibit the sharing of this data, or (ii) upon termination or expiration (and the associated period of run out) of this Contract.

12.14. Offshoring

Contractor represents, warrants and covenants to HCA that Contractor shall not, except as may otherwise be approved in advance by HCA in writing: (a) perform any of its obligations under the Contract from locations, or using employees, Subcontractors and/or agents, situated outside the United States; or (b) directly or indirectly (including through the use of Subcontractors) transmit any HCA data outside the United States; or (c) allow any HCA data to be accessed by employees, Subcontractors, and/or agents from locations outside the United States. If HCA permits certain services may be provided offshore, Contractor acknowledges and agrees that it shall change the delivery of any offshore services in a manner requested or approved by HCA. Further, in any case where access to HCA data is permitted outside the United States, System Integrator shall: (d) comply with the security policies and procedures relating to network and security; (e) implement software controls to permit "view only" access to HCA data, which controls shall prohibit downloading, printing, copying and/or further transmitting or transferring such data; (f) inform any personnel with access to HCA data of the restrictions contained herein; (g) implement a program to monitor compliance with the terms contained herein; and (h) immediately notify HCA of any violations of these terms and conditions. To the extent that a Member is physically located outside of the United States and requests access to such Member's data, provision of such data to such Member shall not constitute a breach of this Section provided that Contractor otherwise complies with the terms of this Section.

12.15. Advance Payments Prohibited

No payment in advance or in anticipation of services or supplies to be provided under this Contract will be made by HCA. HCA has no obligation to pay Contractor for activities or services performed by Contractor before the effective date of the Contract.

12.16. Communication with UMP Enrollees

Contractor may communicate directly with Enrollees and prospective Members and their Dependents individually or personally, but only as is necessary to carry out Contractor's obligations to HCA.

12.17. Disputes

Except as otherwise provided in this Contract, when a dispute arises between HCA and Contractor and it cannot be resolved, either party may request a dispute conference with the Director of HCA (who may name a designee).

The dispute conference shall not be considered an adjudicative proceeding within the meaning of Washington's Administrative Procedure Act, chapter 34.05 RCW.

12.17.1. Timing

- a. If the parties agree that they cannot resolve a dispute then within three (3) Business Days of such agreement either party can request a dispute conference.
- b. If the parties do not agree whether resolution to a dispute is possible, either party may give the other written notice that there appears to be an impasse, identifying the issue(s), and if the matter is not resolved within seven (7) Business Days, either party may request a dispute conference.

12.17.2. Dispute Conference Request

The request for a dispute conference must:

- be in writing;
- state the disputed issue(s);
- state the relative positions of the parties;
- state the requestor's name, address, and Contract number;
- include information that is materially relevant and provides context to the issues(s) and may impact or limit possible resolution(s);
- be provided to the Director of HCA; and
- be provided to the other party. For Contractor requests, the request shall be sent to the HCA Contract Manager. For HCA requests, the request shall be mailed to the Legal Contact listed in Section 3.13.16

12.17.3. Response

A written response by the non-requesting party to the conference request will be sent to both the Director of HCA and the requester within five (5) Business Days of receipt of the request. The response will include whether the responder agrees with the description of the disputed issue(s) and the parties' relative positions, a counter statement of the issues(s) and position(s) if necessary, and information that is relevant and provides context to the issue(s) and may impact or limit possible resolution(s).

12.17.4. Action

The Director of HCA, or the Director's designee, will review the written statements and reply in writing to both parties within ten (10) Business Days after receiving the response. At all times, the Director of HCA retains the right to make the final decision on the dispute. The

Director of HCA, or the Director's designee, may extend the 10-day period referenced above by notifying the parties in writing. The HCA Director, or the Director's designee, may request additional information or documents from either party at any time during this process.

12.17.5. Prerequisite

The parties agree that this dispute process will precede any action in a judicial or quasi-judicial tribunal.

12.17.6. Continuation

Regardless of the dispute, HCA and Contractor will continue without delay to carry out all their respective responsibilities under this Contract which are not affected by the dispute. Both parties agree to exercise good faith in the dispute resolution and to attempt in good faith to settle disputes before commencing any judicial action.

12.18. Right of Inspection

Contractor will provide right of access to its facilities to HCA, or any of its officers, or to any other authorized agent or official of the State of Washington at all times, with advance notice, in order to monitor and evaluate performance, compliance, and quality assurance under this Contract. Those persons also will be given access to Contractor documentation such as policies, procedures, and internal reports, but only those that relate to the services provided by Contractor under this Contract.

12.19. Confidentiality

12.19.1. Confidentiality Standards

Contractor and its officers, directors, and employees performing under this Contract will comply with chapter 70.02 RCW regarding health care information use, access, and disclosure, and any other applicable state or federal statutes or rules pertaining to privacy protection, including but not limited to HIPAA. Besides HIPAA and chapter 70.02 RCW, these include but are not limited to the Governor's Executive Order on the Protection of Personal Information (EO 00-03) and the Washington Health Care Patient Bill of Rights. Contractor will assure that any Subcontractor agrees to protect confidentiality as provided in this Section. If there is a conflict between the provisions in this Section and those in Exhibit G-1, *Business Associate Agreement*, or if the confidential information is PHI, then Exhibit G-1 controls.

HCA will also maintain the confidentiality of any Enrollee identifiable information provided to it by Contractor in accordance with the confidentiality requirements set forth in this Section. In addition, HCA is responsible for assuring that any other vendors of HCA who receive such information protect its confidentiality as provided in this Section.

12.19.2. Uses of Personal Information

Personal information collected, used, or acquired in connection with this Contract will be used solely for the purposes of this Contract. Contractor and its Subcontractors agree not to release, divulge, publish, transfer, sell or otherwise make known to unauthorized persons personal information without the express written consent of HCA or as required by law. Contractor agrees to implement physical, electronic, and managerial safeguards to prevent unauthorized access to personal information.

12.19.3. Permitted Disclosures

Under certain limited circumstances Contractor may disclose such information to other parties without prior authorization. Such circumstances may include disclosure:

- a. complying with a court-issued subpoena or judicial order;
- b. to a medical provider or institution for the purpose of verifying coverage or benefits or conducting an audit; or
- c. to administer Coordination of Benefits provisions.

12.19.4. Responsibility for Violations

HCA will not be in any way responsible for violations of privacy laws, statutes, or regulations when such violations arise from the unauthorized acts or omissions of Contractor or its officers, directors, employees, or Subcontractors. Contractor agrees to indemnify and hold harmless HCA for any damages related to such unauthorized use or disclosure of personal information.

12.19.5. Procedures

Contractor agrees to implement and maintain procedures that are designed to prevent the inappropriate disclosure of confidential "personal information" to third parties.

12.19.6. Security Breach

If Contractor discovers or is notified of the destruction, loss and/or unauthorized access, disclosure, use and/or alteration of confidential information or any attempt to access confidential information that is reasonably likely to result in the destruction, loss and/or unauthorized access, disclosure, use and/or alteration of confidential information (each such event, a "Security Event"), Contractor shall without undue delay and unless prohibited by Law: (a) promptly notify HCA of the Security Event; (b) investigate the Security Event and provide reasonable cooperation with HCA's investigation of the Security Event, including periodic updates with respect to Contractor's investigation of the Security Event; (c) if the source of the Security Event is not within the control of Contractor, provide reasonable cooperation with HCA's development of a risk assessment, root cause analysis, and corrective action plan, including HCA's mitigation and remediation activities; and (d) comply to the extent applicable to Contractor's personnel, and provide reasonable cooperation with HCA in complying with, the requirements of all applicable laws, rules, and regulations. If the source of the Security Event is within the control of Contractor's personnel, Contractor shall: (e) promptly provide a written report to HCA that sets forth Contractor's risk assessment, root cause analysis and corrective action plan; (f) implement the corrective action plan and mitigate the effects of the Security Event as soon as practicable; (g) provide any notice required by any law, rule, or regulation to individuals affected by the Security Event; (h) provide a minimum of one (1) year credit monitoring for any Member affected by the Security Event at no cost to Member or HCA; and (i) provide HCA periodic updates with respect to Contractor's mitigation and corrective action efforts.

12.19.7. "Personal Information"

For purposes of this provision, personal information includes, but is not limited to, information identifiable to an individual that relates to a natural person's health, finances, education, business, use or receipt of governmental services, or other activities, names, addresses, phone numbers, social security numbers, driver license numbers, financial profiles, credit card numbers, financial identifiers, and other identifying numbers.

12.19.8. Confidentiality Audit

At any time, upon ten (10) Business Days' notice, HCA has the right to inspect Contractor's confidentiality policies and procedures. HCA also has the right to audit Contractor's compliance with its confidentiality policies and procedures, including Contractor's oversight of agents' and Subcontractors' compliance with Contractor's confidentiality policies and procedures. If the HCA has reason to believe that Contractor or its agents or Subcontractors are in material breach of the confidentiality provisions of this Contract, HCA will share the supporting information with Contractor and will allow Contractor 30 Days to rebut or refute the claim that Contractor is in material breach with such provisions. Any audit or inspection conducted pursuant to this section shall be subject to the following:

- a. Contractor and HCA shall mutually agree in advance upon the timing and location of such an inspection; the scope of the audit or inspection is limited to information, policies, and procedures of Contractor, its agents, or Subcontractors, that appear pertinent to Enrollees and Contractor's performance under the Contract and the potential breach.
- b. HCA shall protect the confidentiality of all confidential and proprietary information of Contractor to which HCA or any of its agents, Subcontractors or employees has access during the course of such inspection to the extent permitted by law; and
- c. HCA shall, and shall cause its agents, Subcontractors or employees participating in such audit to, execute a nondisclosure agreement, upon terms permitted by law and mutually agreed upon by the parties, if requested by Contractor.

12.20. Funding or Legal Authority Limitations

Notwithstanding any other provision in this Contract, if HCA's authority to perform any of its duties related to this Contract is withdrawn, reduced, or limited, or if funding from state, federal, or other sources is withdrawn, reduced, or limited in any way, HCA may terminate the Contract immediately, subject to renegotiation at HCA's discretion under those new authority or funding limitations and conditions. If this Contract is so terminated, HCA will be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination and Section 12.11, *Services After Termination*, will apply.

In addition, if funding from any state, federal, or other source is withdrawn, reduced, or limited in any way, on a temporary basis (e.g., a full or partial state or federal government shutdown), HCA may suspend the Contract upon written notice to Contractor, effective as of the date set forth in such notice. Within twenty-four (24) hours of receipt of such notice, Contractor shall provide HCA with an invoice for all Claims paid and in process at the time of the notice, but not yet invoiced to HCA. HCA shall use its best efforts to pay Contractor the full amount of such invoice prior to the withdrawal, reduction, or limitation of funding. During the suspension, Contractor shall (1) continue to pay all Claims for a period of up to, but not exceeding, thirty (30) days, Claims paid by Contractor during this period shall continue to be owed to Contractor and HCA shall pay interest on all outstanding balances as set forth in Chapter 39.76 RCW, and (2)

refrain from submitting, charging, or attempting to collect any Administrative Fees, after which period Contractor shall be paid in full for all Administrative Fees and other applicable service fees owed for this period plus interest at the statutory rate.

If this Contract is not terminated or suspended as set forth in this Section, then Contractor shall continue to provide all services described in this Contract, but HCA shall be relieved from all of duties and obligations whatsoever until such time as funding has been restored.

12.21. Licensing, Accreditation, and Registration

Contractor will comply with all applicable local, state, and federal licensing, accreditation, and registration requirements necessary for the performance of this Contract.

12.22. Insurance Coverage

Contractor shall, at its own expense, obtain and maintain in full force and effect the insurance coverages listed below during the term of the Contract. Upon request from HCA, Contractor shall provide Certificates of Insurance executed by a duly authorized representative of each insurer, showing compliance with the insurance requirements set forth below.

Additionally, Contractor is responsible for ensuring that any partnering organization(s) and subcontractors provide adequate insurance coverage for the activities arising out of subcontracts.

12.22.1. Liability Insurance

- a. Commercial General Liability Insurance: Contractor shall maintain commercial general liability (CGL) insurance and, if necessary, commercial umbrella insurance, with a limit of not less than \$5,000,000 per each occurrence. If CGL insurance contains aggregate limits, the General Aggregate limit shall be at least twice the “each occurrence” limit. CGL insurance shall have products-completed operations aggregate limit of at least two times the “each occurrence” limit. CGL insurance shall be written on ISO occurrence from CG 00 01 (or a substitute form providing equivalent coverage). All insurance shall cover liability assumed under an insured contract (including the tort liability of another assumed in a business contract), and contain separation of insured’s (cross liability) condition.
- b. Professional Liability: Errors and Omissions coverage with a limit of not less than \$1,000,000 per occurrence and \$2,000,000, aggregate.
- c. Crime Coverage: Including fraud, forgery, money and securities and employee dishonesty coverage with a per occurrence limit equal to the maximum amount of money and/or securities any employee might have access to at any one time.
- d. Cyberliability & Data Breach Policy: Liability coverage with a limit of not less than \$10,000,000 per occurrence and \$20,000,000 in the aggregate.
- e. Business Auto Policy: As applicable, Contractor shall maintain business auto liability and, if necessary, commercial umbrella liability insurance with a limit not less than \$1,000,000 per accident. Such insurance shall cover liability arising out of “Any Auto.” Business auto coverage shall be written on ISO form CA 00 01, 1990 or later edition, or substitute liability form providing equivalent coverage.

12.22.2. Employers Liability (“Stop Gap”) Insurance

In addition, Contractor shall buy employers liability insurance and, if necessary, commercial

umbrella liability insurance with limits not less than \$1,000,000 each accident for bodily injury by accident or \$1,000,000 each employee for bodily injury by disease.

12.22.3. Additional Provisions

The above insurance policies shall include the following provisions:

- a. **Additional Insured.** The State of Washington, HCA, its elected and appointed officials, agents, and employees shall be named as an additional insured. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State, but only as respects the acts or omissions of Contractor, its employees, agents, or Subcontractors.
- b. **Cancellation.** HCA shall be provided written notice before cancellation or non-renewal in accord with the following specifications. Insurers subject to 48.18 RCW (Admitted and Regulation by the Insurance Commissioner): The insurer shall give HCA 45 Days advance notice of cancellation or non-renewal. If cancellation is due to non-payment of premium, HCA shall be given ten (10) Days advance notice of cancellation. Insurers subject to 48.15 RCW (Surplus lines): HCA shall be given twenty (20) Days advance notice of cancellation. If cancellation is due to non-payment of premium, HCA shall be given ten (10) Days advance notice of cancellation.
- c. **Identification.** Certificates must reference HCA's Contract number and the agency name.
- d. **Insurance Carrier Rating.** All insurance and bonds must be issued by companies admitted to do business within the State of Washington and have a rating of A-, Class VII or better in the most recently published edition of Best's Reports. Any exception shall be reviewed and approved by HCA Risk Manager, or the Risk Manager for the State of Washington, before the Contract is accepted or work may begin. If an insurer is not admitted, all insurance policies and procedures for issuing the insurance policies must comply with chapter 48.15 RCW and 284-15 WAC.
- e. **Excess Coverage.** By requiring insurance herein, HCA does not represent that coverage and limits will be adequate to protect Contractor and such coverage and limits shall not limit Contractor's liability under the indemnities and reimbursements granted to HCA in this Contract.

12.22.4. Worker's Compensation Coverage

- a. Contractor will comply with the provisions of Title 51 RCW, Industrial Insurance. Prior to performing work under this Contract, Contractor will provide or purchase Industrial Insurance coverage for Contractor employees, as may be required of an "employer" as defined in Title 51 RCW, and will maintain full compliance with Title 51 RCW during the course of this Contract. If Contractor fails to provide industrial insurance coverage or fails to pay premiums or penalties on behalf of its employees as may be required by law, HCA may collect from Contractor the full amount payable to the Industrial Insurance accident fund. HCA may deduct the amount owed by Contractor to the accident fund from the amount payable to Contractor by HCA under this Contract, and transmit the deducted amount to the Department of Labor and Industries (L&I), Division of Insurance Services. This provision does not waive any of L&I's rights to collect from Contractor.
- b. Neither HCA nor the State will be held responsible for workers' compensation claims filed by Contractor or its employees for services performed under the terms of this Contract.

- c. Industrial Insurance coverage through the Department of Labor & Industries is optional for sole proprietors, partners, corporate officers and others, in accordance with RCW 51.12.020.

12.23. Covenant Against Contingent Fees

Contractor warrants that no person or selling agent has been employed or retained to solicit or secure this Contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established agents maintained by Contractor for the purpose of securing business. Contractor also warrants that it will not include brokers' fees in the Administrative Fees set forth in Exhibit A. HCA will have the right, in the event of breach of this clause by Contractor, to terminate this Contract or, in its discretion, to deduct from amounts due Contractor under the Contract or recover by other means the full amount of such commission, percentage, brokerage or contingent fee.

12.24. Compliance with Applicable Law

Contractor shall at all times comply with all applicable laws, including HIPAA, applicable provisions of the Washington State Health Care Patient Bill of Rights, Chapter 70.02 RCW, Chapter 41.05 RCW, Chapter 182-08 WAC, Chapter 182-12 WAC, and Chapter 182-16 WAC, and all other rules, regulations and policies promulgated thereunder, including the commitment to negotiate in good faith any sub-agreements that may be required to be entered into by the parties pursuant to such laws, and any and all obligations to obtain similar protections in or institute safeguards with respect to any third party agreements and/or arrangements. Contractor shall obtain and maintain all necessary licenses, permits, accreditations, and governmental authorizations and approvals necessary to the performance of this Contract. Contractor's non-compliance, or refusal to comply, with any applicable law shall constitute a material breach of this Contract.

12.25. Nondiscrimination

During the performance of this Contract, Contractor will comply with all applicable federal and state nondiscrimination laws, regulations, and policies. This includes but is not limited to:

- Providing full and equal access to people with disabilities (28 CFR § 35.130).
- Providing effective communication to all clients, including people who have limited English proficiency or disabilities (28 CFR § 35.160).

This means:

- Removal of physical barriers to ensure facilities are accessible.
- Providing auxiliary aids or services.
- Modifying policies, procedures, or processes to ensure participation.

When dealing with people with disabilities, Contractor shall give primary consideration to the choice of accommodations expressed by the individual. Primary consideration means that Contractor must honor the choice, unless:

- it can be demonstrated that another equally effective method of communication is available, or
- the use of the method chosen would result in a fundamental alteration to the service, program or activity or in undue financial or administrative burden.

Contractor cannot charge clients a fee to cover any costs for providing accommodations or modifications of policies and procedures.

Contractor must also ensure web accessibility of IT systems in accordance with Section 508 of the Rehabilitation Act of 1973, as amended, and Web Content Accessibility Guidelines (WCAG) 2.0

Contractor agrees to promptly respond to any complaint regarding accessibility to its services or systems.

In the event of Contractor's noncompliance or refusal to comply with any nondiscrimination law, regulation, or policy, HCA may terminate this Contract, in whole or in part, and may declare Contractor ineligible for further contracts with HCA.

12.26. Pay Equity

- a. Contractor represents and warrants that, as required by Washington state law (Laws of 2017 (3rd Special Session), Chap. 1, § 213(1)(pp)), during the term of this Contract, it agrees to equality among its workers by ensuring similarly employed individuals are compensated as equals. For purposes of this provision, employees are similarly employed if (i) the individuals work for Contractor, (ii) the performance of the job requires comparable skill, effort, and responsibility, and (iii) the jobs are performed under similar working conditions. Job titles alone are not determinative of whether employees are similarly employed.
- b. Contractor may allow differentials in compensation for its workers based in good faith on any of the following: (i) a seniority system; (ii) a merit system; (iii) a system that measures earnings by quantity or quality of production; (iv) bona fide job-related factor(s); or (v) a bona fide regional difference in compensation levels.
- c. "Bona fide job-related factor(s)" may include, but not be limited to, education, training, or experience, that is: (i) consistent with business necessity; (ii) not based on or derived from a gender-based differential; and (iii) accounts for the entire differential.
- d. A "bona fide regional difference in compensation level" must be (i) consistent with business necessity; (ii) not based on or derived from a gender-based differential; and (iii) account for the entire differential.
- e. Notwithstanding any provision to the contrary, upon breach of warranty and Contractor's failure to provide satisfactory evidence of compliance within thirty (30) Days of HCA's request for such evidence, HCA may suspend or terminate this Contract.

12.27. Force Majeure

Neither HCA nor Contractor will be liable for any failure of or delay in the performance of this Contract for the period that such failure or delay is due to causes beyond its reasonable control, including but not limited to: fires, floods, earthquakes, landslides, riots, strikes or labor disputes, major epidemics, acts of God, war, terrorist acts, embargoes, or any other similar force majeure event. Nonperformance under this Contract related to force majeure events will not be a ground for termination by default. Contractor is required to take all commercially reasonable actions to prevent the impact of a foreseeable force majeure event. Immediately upon the occurrence of any such event, Contractor shall commence to use its best efforts to provide, directly or indirectly, alternative and, to the extent practicable, comparable performance. Nothing in this Section shall be construed to prevent HCA from terminating this Contract for reasons other than

for default during the period of the events set forth above, or for default, if such default occurred prior to such event.

12.28. Waiver

In order to be effective, any waiver of any right or benefit to either party must be made in writing by a person authorized to bind such party and provided to the other party. Waiver of any default or breach is not a waiver of any subsequent default or breach relating to that or any other provision. Any waiver is not a modification of the terms of the Contract unless stated to be such in writing signed by both parties.

12.29. No Third-Party Beneficiaries

HCA and Contractor are the only parties to this Contract and are the only persons or entities entitled to enforce its terms. Nothing in this Contract gives, is intended to give, or will be construed to give or provide any benefit or right not made generally available to the public to any third party unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Contract.

12.30. Governing Law; Venue

This Contract will be construed and interpreted in accordance with the laws of the State of Washington without regard for any choice-of-law rules that might direct the application of the laws of any other jurisdiction. The only permissible venue of any action brought under or relating to this Contract will be in the Superior Court of Thurston County, Washington. Contractor agrees to jurisdiction and venue in that court. Nothing in this Contract is intended to waive the State's protections granted by the 11^h Amendment to the U.S. Constitution.

12.31. Survival

Any terms of this Contract that would, by their nature or through their express terms, survive the expiration or termination of this Contract shall so survive, including, but not limited to, the terms relating to payment, billing, reports, confidentiality, business associate, data access, termination, services after termination, and termination procedure.

12.32. Antitrust Assignment

Contractor hereby assigns to the State of Washington any and all of its claims for price fixing or overcharges which arise under the antitrust laws of the United States, or the antitrust laws of the State of Washington, relating to the goods, products, or services purchased under this Contract.

12.33. Intellectual Property Ownership

12.33.1. Customized Material Ownership

Unless otherwise provided, all Customized Materials shall be owned by HCA. HCA shall be considered the author of such Customized Materials. Contractor hereby irrevocably assigns all rights, title, and interest in Customized Materials, including all intellectual property rights, to HCA effective from the moment of creation of, or full performance of any Work Order requiring creation of, such Customized Materials. HCA expressly agrees that its rights and ownership will not extend to, or encompass any software programs made available as part of the services, unless developed solely for HCA use and paid for by HCA. Rights and ownership by HCA of Customized Materials does not extend to or include any Non-Customized Materials.

12.33.2. *Non-Customized Material Ownership*

Contractor retains all rights, title and interest in and to all Non-Customized Materials, unless it contains any confidential information or proprietary data of HCA or of the State of Washington. Rights and ownership by Contractor of Non-Customized Materials does not extend to or include any of HCA's proprietary data or confidential information, including Claims data described in Section 12.13.

12.33.3. *Deliverables Ownership*

HCA shall be considered the author or owner of all Deliverables provided to HCA during the term of this Contract. Contractor shall deliver all such Deliverables to HCA promptly upon request. Notwithstanding the foregoing, HCA shall have no ownership interest in Non-Customized Materials, identified by Contractor as such prior to delivery and included in such Deliverable(s).

12.33.4. *License*

For Customized Materials and Deliverables that incorporate Non-Customized Materials, Contractor hereby grants to HCA a nonexclusive, royalty-free, irrevocable license (with rights to sublicense others) to use, translate, reproduce, distribute, prepare derivative works, publicly perform, and publicly display such Non-Customized Materials. Contractor warrants and represents that Contractor has all rights and permissions, including intellectual property rights, moral rights, and rights of publicity, necessary to grant such a license to HCA.

For Customized Materials, HCA hereby grants to Contractor a nonexclusive, royalty-free, irrevocable license (with rights to sublicense others) to use, translate, reproduce, distribute, prepare derivative works, publicly perform, and publicly display such Customized Materials for the purpose of enhancing services provided to members across its lines of business.

12.33.5. *Notice to HCA*

- a. Contractor will exert all efforts to advise HCA, at the time of delivery of Deliverables, of all known or potential intellectual property infringement or invasions of privacy contained in any portion of the Deliverable.
- b. Contractor will give HCA prompt written notice of each notice or claim of copyright infringement received by Contractor with respect to any Deliverable. HCA may not modify or remove any restrictive markings placed upon the Deliverable by Contractor. The preceding sentence shall not apply to Customized Materials.

12.34. Public Records Act

Contractor acknowledges HCA is subject to chapter 42.56 RCW and that this Contract, including all items incorporated by reference and all work products, are public records as defined in chapter 42.56 RCW. Any specific information that is claimed by Contractor to be Proprietary or Confidential must be clearly identified as such by Contractor. To the extent consistent with chapter 42.56 RCW, HCA shall maintain the confidentiality of all such information marked proprietary information in its possession. If a public disclosure request is made to view the information identified as confidential, HCA will notify Contractor of the request and of the date that such records will be released to the requester unless Contractor obtains a court order from a court of competent jurisdiction enjoining that disclosure. If Contractor fails to obtain the court order enjoining disclosure by the date specified in HCA's notice to the Contractor, HCA will release the requested information.

12.35. Contingencies

12.35.1. Legal Actions and Procedural Challenges

The parties recognize that legal or procedural actions may result in delayed or canceled implementation of all or a portion of the activities detailed in this Contract. The parties further recognize that such a delay or cancellation may result in uncompensated obligations for activities occurring before January 1, 2020. Nonetheless, the parties agree to execute this Contract and proceed in good faith. Further, the parties agree as follows:

- a. If legal action or a procedural challenge is filed or threatened, HCA may, at its sole discretion and at any time before January 1, 2020, terminate this Contract with no notice and without penalty, and extend its existing administrative services contract or take such other action as HCA chooses. This remedy is in addition to HCA's termination rights in subsection 12.10.1. In the event of a termination under this subsection, Section 12.11, *Services After Termination*, shall apply.
- b. In the case of termination on or after January 1, 2020, HCA's only obligation will be to pay to Contractor Administrative Fees for the time before termination, and will reimburse Contractor for Claim payments made before the notice of termination.
- c. If there is a legal action or a procedural challenge, HCA may settle the matter on such terms as it chooses. If there is more than one legal action or procedural challenge, HCA may settle any one or more of them on such terms as it decides are appropriate, and whether or not the settlements are consistent with each other. HCA does not need to give Contractor notice of any settlement being considered and Contractor's consent is not required. Contractor has no right to any payment or other consideration from HCA as a result of any such settlement.
- d. At its sole discretion, HCA may continue any or all UMP Plans in force after January 1, 2020, for as long as it deems appropriate.

12.35.2. Assignable Contracts

The parties recognize that if this Contract does not take effect for any reason, or takes effect and then is terminated, HCA will need a provider network. Therefore, Contractor agrees that all of its contracts with any professional provider, hospital, or other provider to specifically serve Enrollees as part of a network will include a provision permitting the assignment of that UMP-specific contract to HCA without the consent of the provider. At the option of Contractor, this right to assign may be limited to services for Enrollees. These Plan providers will be paid at the rates listed in the assigned contract. This applies to agreements Contractor enters with providers specifically to serve Enrollees, and not to contracts to serve Contractor's Book-of-Business generally.

12.36. Debarment and Suspension

Contractor certifies that it is not debarred, suspended, or otherwise excluded from, or ineligible for, participation in federal or state government contracts in any state. Contractor must not contract with a Subcontractor that is so debarred or suspended.

12.37. Construction

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

- b. In this Contract, where applicable, references to the singular shall include the plural and references to the plural shall include the singular.
- c. Regardless of capitalization, “including” means, unless the context requires otherwise, “including but not limited to.”
- d. If any deadline for performance of an obligation in this Contract does not fall on a Business Day, the deadline for performance will be the next Business Day.

12.38. Order of Precedence

Each of the Exhibits listed below is by this reference hereby incorporated into this Contract. In the event of an inconsistency in this Contract, and unless otherwise specifically provided elsewhere in this Contract, the inconsistency shall be resolved by giving precedence in the order below, with documents within, but not between, any Exhibit last in time given precedence over conflicting terms in documents earlier in time:

- a. Applicable Federal and State of Washington statutes and regulations
- b. General Terms and Conditions of the Agreement
- c. Any other term and condition of this Agreement and the following Exhibits
 - i. Exhibit A: Administrative Fees
 - ii. Exhibit B: ERB HIPAA 834 Eligibility File Format
 - iii. Exhibit C-1: Enrollment Full File Layout Required Match
 - iv. Exhibit C-2: Completion Dates for Quarterly Eligibility Reconciliation
 - v. Exhibit D: Washington Provider Network Adequacy Standards
 - vi. Exhibit E-1: Unit Cost Margin Guarantee and Utilization Trend Margin Guarantee Rates – PEBB
 - vii. Exhibit E-2: Unit Cost Margin and Utilization Trend Margin Performance Guarantee
 - viii. Exhibit E-3: Medicare Lite
 - ix. Exhibit F-1: Operations Manual
 - x. Exhibit F-2: Reporting Manual
 - xi. Exhibit G-1: Business Associate Agreement
 - xii. Exhibit G-2: Data Share Agreement
 - xiii. Exhibit H: Business Interruption & Disaster Management Plan
- d. Exhibit I: HCA Request for Proposals No. K1807
- e. Exhibit J: Contractor’s Response to RFP No. 1807
- f. Any other provision, term or material incorporated herein by reference or otherwise incorporated.

SECTION 13. DEFINITIONS

Whenever used in this Contract, the capitalized terms listed below have the following meanings.

“Accountable Care Network” or “ACN” is a clinically integrated health organization with a formal network of providers and health systems that collaborates to deliver integrated care and assumes financial risk and clinical accountability for a defined population. As of the Effective Date, HCA’s ACNs are a part of UMP Plus.

“Accountable Care Organization” or “ACO” is a clinically integrated health organization with a formal network of providers and health systems that collaborates to deliver integrated care and assumes financial risk and clinical accountability for a defined population. Contractor will be required to offer an ACO product to its fully-insured book-of-business.

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

“ACN Affiliate Providers” means hospitals, facilities, clinics, and physicians, including radiology, that are individually contracted with one or more ACN(s) to ensure access to providers.

“ACN Ancillary Providers” means a non-hospital provider that does not have any provider agreement with an ACN and have been designated by the HCA as an Ancillary Provider.

“ACN Partner Providers” means the core hospitals, facilities, clinics, and physicians, including radiology, with partner provider agreements, with one or more ACN(s).

“ACN Providers” means ACN Affiliate Providers, ACN Ancillary Providers, and ACN Partner Providers.

“ACN Welcome Packet” means materials that inform Members of the provider network and value-added services provided by the applicable ACN.

“ADA” means Americans with Disabilities Act, 42 U.S.C. §12101, and its corresponding federal regulations.

“Administrative Fee” means the monthly administrative fee for each UMP Plan set forth in Exhibit A, *Administrative Fees*.

“Affiliated Entities” means any person, firm, corporation, partnership, limited liability company, joint venture, association, business trust or other similar entity that, now or in the future, directly or indirectly, controls, is controlled with or by, or is under common control with, Contractor. For purposes of the foregoing, “control” shall mean the direct or indirect control of fifty percent (50%) or more of the voting power to elect directors thereof, or any other entity, the power to direct the management of such entity.

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

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

“Auto Adjudicate” or **“Auto Adjudication”** means Claims received that were adjudicated without human intervention.

“BAA” means a Business Associate Agreement between HCA and Contractor regarding the protection of Personal Health Information as required by HIPAA.

“Behavioral Health” is a term used to refer to both mental health and substance use disorder treatment.

“Book-of-Business” means all commercial health insurance business of Contractor including fully-insured and self-insured products within the Contractor’s accounts, including individual products and networks. “Book-of-Business” does not include Medicare, Medicaid, Employer Group Waiver Plan, or other similar programs.

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

“Business Day” means Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Time, except for holidays observed by the state of Washington, unless otherwise specified within this Contract.

“Care Coordination” is the coordination of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

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

“Certificate of Coverage” or **“COC”** is a summary of the essential features of the group coverage contract produced and made available to each covered person. “COC” is the UMP Certificate of Coverage, and, as the context requires, the plan year version in effect on the date of service.

“Certified Health Information Technology” means electronic health record systems that have been certified by the Office of the National Coordinator for Health Information Technology. More information about certification can be found at <https://www.healthit.gov/policy-researchers-implementers/about-onc-health-it-certification-program>.

“Chronic Care Model” means a multifaceted, evidence-based framework for enhancing care delivery by identifying essential components of the health care system that can be modified to support high-quality, patient-centered chronic disease management.

“Claim” is the written notice on a form acceptable to the Contractor for reimbursement for any health care service or supply pursuant to the terms of the applicable Certificate of Coverage.

“Clinical Management” means the programs that apply systems, science, incentives, and information to improve medical practice and assist both consumers and their support system to

become engaged in a collaborative process designed to manage medical/social/Behavioral Health conditions more effectively. The goal of Clinical Management is to achieve an optimal level of wellness and improve Care Coordination while providing cost effective, non-duplicative services.

“Clinical Management Services” means the use of best practice recommendations (such as the Bree Collaborative recommendations) in the provision of Clinical Management to support optimal health outcomes, in collaboration with the HCA’s clinical team; proactive identification and management of Members who are at risk for health service utilization; provision of Patient Decision Aids to support appropriate patient self-management; collaboration and integration with providers and delivery systems; reduction of unnecessary variation in clinical practice; and lower healthcare costs.

“Clinical Programs” means all programs for Utilization Management, Quality Management, Quality Improvement, Case Management, Chronic Condition Management, and any other Clinical Management programs.

“CMS” means the Centers for Medicare and Medicaid Services, an agency of the federal government.

“COBRA” means Consolidated Omnibus Budget Reconciliation Act. COBRA requires employers to offer continuation of group health and/or dental benefits for a specified time to individuals who would otherwise lose coverage due to certain qualifying events.

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

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

“Complaint” means an oral or written expression of dissatisfaction submitted by or on behalf of a Member regarding:

- a. The denial of health care services or payment for health care services;
- b. Issues other than denial of or payment for health care services, including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers; or
- c. Dissatisfaction with UMP Plan practices or action unrelated to health care services.

For the purpose of this document, grievances are considered to be the same.

“Contract” means this written agreement between Contractor and the HCA, including all exhibits, schedules, attachments, and other terms or documents referred to, incorporated by reference or attached hereto.

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

“Covered Lives” means the number of people enrolled in a particular health insurance plan.

“Customized Materials” means work product, designs, programs, tools, formulas, methods, or other ideas or materials developed by Contractor, alone or jointly with HCA, produced pursuant to this Contract, the Operations Manual, or Work Order, that are not Non-Customized Materials.

“Customized Materials” includes any Pilot Program developed exclusively for HCA; provided, however, that if such Pilot Program becomes a Standard Program or adopted by any self-insured client, it would be Non-Customized Materials.

“**Day**” is calendar Day, including weekends and holidays. All statements referring to a number of Days mean calendar days, regardless of the number of Days, unless something different is explicitly specified. If the time when something must be performed falls on a weekend, a day observed as a holiday by the State of Washington as an employer, or a day when HCA is officially closed for other reasons, then that action is due on the next Business Day. Day one is the Day after receipt, unless something different is explicitly specified.

“**Deliverables**” means all tangible objects, reports, work product, program or tool documentation, designs, formulas, methods, or other documents and materials provided or delivered by Contractor to HCA pursuant to the terms of this Contract. “Deliverables” will consist of Customized Materials and/or Non-Customized Materials.

“**Dependent**” means an eligible spouse, Washington State registered domestic partner, and/or dependent child of a Subscriber, who meets the eligibility requirements of Chapter 182-12 WAC.

“**Employee**” shall have the meaning set forth in Chapter 182-12 WAC.

“**Enrollee**” means a person who meets all eligibility requirements defined in Chapter 182-12 WAC, and either (1) is enrolled in PEBB or SEBB benefits for whom all applicable premium payments and any applicable premium surcharges have been paid, or (2) waived medical coverage available as a PEBB or SEBB benefit.

“**ERB Division**” means the Employees & Retirees Benefits Division of the HCA, which manages the operations that provide insurance coverage for Members of Washington State agencies, higher education institutions, school and other educational districts and entities, and certain other employer groups.

“**Erroneous Payments**” means any Claims payment made by Contractor under this Contract that (i) either HCA or Contractor determines should not have been paid; (ii) was an Overpayment; (iii) was paid to or on behalf of a non-Member; (iv) was a Misquote; or (v) was otherwise in error.

“**e-Value8**” is a program of the National Business Group on Health which measures and evaluates health plan performance. The Washington Health Alliance deploys e-Value8 in Washington State every other year.

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

“**Fee-for-Service**” or “**FFS**” means payment to health care providers on the basis of each service performed, such as an office visit, test, or procedure; currently, the predominant reimbursement methodology in the United States and in Washington.

“**Foreign**” means not within United States, and outside the United States.

“**Foundation for Healthcare Quality**” means a non-profit organization based in Seattle that coordinates hospital Quality Improvement programs in the state of Washington. Among the projects are the: Surgical Care and Outcomes Assessment Program (SCOAP) and Cardiac Care and Outcomes Assessment Program (COAP).

“**HCA Senior Account Sponsor**” means one or more employee of the HCA designated to represent HCA in matters relating to the Contract.

“HCA Value-based Roadmap” is the HCA’s plan to guide achievement of the HCA’s Value Based Payment goals. Created in June 2016 and updated periodically, this document braids together various initiatives, including four payment models, a Medicaid transformation demonstration project, and engagement activities within the broader health care marketplace.

“HDHP” means an IRS-qualified high-deductible health plan that allows for tax-deferred contributions to a health savings account.

“Health Benefit Exchange” is responsible for the operation of Washington Healthplanfinder, an easily accessible, online marketplace for individuals, families, and small businesses to find, compare, and enroll in qualified health plans and Washington Apple Health (Medicaid).

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

“Health Literacy” means the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

“Health Plan” means one of the fully-insured or self-insured medical plans offered by the HCA. Each “Health Plan” includes a Certificate of Coverage for services relating to medical, Behavioral Health, and pharmacy Claims.

“Healthier Washington” is the state initiative aimed at health transformation so Washington State residents experience better health and receive better, more affordable care.

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

“HMO” means Health Maintenance Organization.

“HSA” means Health Savings Account, a tax-advantaged medical savings account linked to the UMP CDHP in which Members, the employer, and others may deposit funds.

“HSA Trustee” means the subcontracted IRS-qualified trustee responsible for managing HSAs for all UMP CDHP Members.

“HTCC” means Health Technology Clinical Committee as established under statute RCW 70.14.080.

“Independent Review Organization” or **“IRO”** shall have the meaning set forth in WAC 246-305-010(14).

“Key Subcontractor” means an entity that Contractor plans to utilize for the purposes of services described in this Contract that will be involved in any activities involving account management, network management, direct Member contact, access to Personal Health Information, access to other information controlled by HIPAA or data security provisions, or sensitive financial information.

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

“Medical Drugs” means oral or infused drugs covered under the medical benefit of the UMP Plans.

“Medical Management” means a program component of Health Plan coverage that may contain multiple systems to manage and ensure all care is appropriate, within the HCA established benefit design, and is medically necessary, effective, and cost-efficient across all medical services, procedures and facilities.

“Member” means Subscribers and their Dependents who are enrolled in a UMP Plan, and for whom applicable premium contributions and any applicable premium surcharges have been made.

“Misquotes” occur when Contractor provides erroneous information to a Member regarding the UMP Plans and a negative financial impact to a Member or provider is a direct result. Misquotes can concern any aspect of the UMP Plans, including coverage, pre-authorization, eligibility, provider network status, deductible or co-pay status, etc.

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

“Never Events” are adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

“Non-Customized Materials” means work product, designs, programs, tools, formulas, methods, or other ideas or materials developed solely by Contractor that are delivered under this Contract, but that do not originate therefrom. “Non-Customized Materials” includes Standard Programs and any Pilot Program not developed exclusively for HCA.

“Open Enrollment” means the annual period during which a Subscriber can change Health Plans, add or remove Dependents, and take certain other actions regarding benefits offered through the Health Plans and other plans offered by HCA.

“Operations Manual” means the document that includes additional details and specifications regarding the performance of the rights and obligations of each party to the Contract, and attached as Appendix 6, Attachment 8.

“Overpayments” means any payment, in any amount, in excess of that to which is entitled by law, rule, or contract, including amounts in dispute.

“Patient Centered Medical Home” or “PCMH” means a team based primary care model that provides comprehensive and continuous care to consumers over time with the goal of improving health and health care, and lowering costs.

“Patient Decision Aids” means tools that are certified by HCA to help people engage in shared health decisions with their health care provider. A list of Patient Decision Aids that have been certified can be found at <http://www.hca.wa.gov/about-hca/healthier-washington/patient-decision-aids-pdas>.

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

“Paying for Value Survey” means the questionnaire administered by the HCA to measure payer and provider progress towards Value-Based Payment adoption. The qualitative section of the survey is included with the RFP as Appendix 6, Attachment 24.

“PEBB” means the Public Employees Benefits Board, which is authorized to design benefits and determine the terms and conditions for participation in health insurance benefits for eligible public employees and retirees under RCW 41.05.065.

“PEBB UMP Plan” means a UMP Plan that is administered by HCA on behalf of PEBB.

“Performance Credit” is the financial consequence associated with failure to meet the applicable performance standards or guarantees.

“Performance Guarantee” a list of expectations that the HCA views as critical to the success of the UMP Plans. Failure to achieve a Performance Guarantee will result in the issuance of Performance Credits.

“PHI” means Protected Health Information, as defined in 45 C.F.R. §160.103.

“Pilot Program” means any program offered to improve a person’s health, the provision of health care, improve member experience, improve provider experience, or lower costs, including any Clinical Program, that is not a Standard Program. The term “Pilot Program” shall include such programs owned by Contractor, and such programs owned, performed, or provided by or through any Subcontractor.

“PMM” means Portfolio Management and Monitoring, the ERB Division section that manages all contracts for Members benefits, including the Contract for administration services for the UMP Plans.

“PMPM” means per Member per month.

“Pooled Hours” means the service hours accumulated by HCA for the performance of services in connection with the Contract, for services not within the Contract and documented through Work Orders. The term “Pooled Hours” includes both the annual number of hours for these services earned by HCA as well as the accumulated, unused hours from prior years.

“Pooled Rate” means the blended hourly rate for the performance of services under the Work Order process described in the Contract for service hours incurred after all Pooled Hours have been used.

“PPO” means Preferred Provider Organization. All UMP Plans are currently supported by a PPO network.

“Preferred Provider” means any provider that has contracted with the TPA to be a part of the TPA’s preferred provider organization network.

“Primary Care” means any one and all of the following specialties: general practice, family practice, internal medicine, obstetrics/gynecology, pediatric medicine, geriatric medicine, nurse practitioner, preventative medicine, certified clinical nurse specialist, physician assistant, and/or nurse (non-practitioner).

“Prime Contractor” means in the case of two (2) or more entities submitting a joint Proposal, the entity identified as the HCA’s primary point of contact that bears sole responsibility for performance under a contract resulting from this procurement.

“PSPM” means per Subscriber per month.

“Quality Assurance” is a retrospective review process, typically focusing on individuals, that measures compliance against necessary standards.

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

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

“RCW” means Revised Code of Washington. Any references to specific titles, chapters, or sections of the RCW include any substitute, successor, or replacement title, chapter, or section.

“Rebates” means retrospective payments or discounts, including promotional or volume-related refunds, incentives or other credits, however characterized, pre-arranged with pharmaceutical companies on certain prescription drugs, which are paid to or on behalf of a TPA, and are directly attributable to the utilization of certain drugs by Members, including Administrative Fees and software or data fees paid by pharmaceutical companies. “Rebate” includes all rebates, discounts, payments or benefits, however characterized, generated by Medical Drug Claims, or derived from any other payment or benefit for the dispensing or administration of prescription drugs or classes or brands of drugs within the HCA’s programs or arising out of any relationships the TPA has with pharmaceutical companies, including but not limited to Rebate sharing, market share allowances, educational allowances, gifts, promotions, or any other form of revenue whatsoever.

“Run-Out Period” means the sixty (60) months following termination of the Contract during which Contractor will provide certain administrative services as set forth in the Contract for no additional charge.

“RxBin” means an assigned data element used by a pharmacy to identify the UMP PBM.

“RxPCN” means the Processor Control Number issued by the UMP PBM to identify the HCA, Member, and the pharmacy benefit plan.

“SEBB” means the School Employees Benefits Board, which is authorized to design benefits and determine the terms and conditions for participation in health insurance benefits for eligible school employees under Chapter 41.05 RCW.

“SEBB UMP Plan” means a UMP Plan that is administered by HCA on behalf of SEBB.

“Senior Account Sponsor(s)” means the HCA employee(s) that is/are appointed by the HCA to work to coordinate resources and services to meet all Contract requirements. The Senior Account Sponsor may also be referred to as the “HCA Contract Manager.”

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

“SmartHealth” is the ERB Division’s wellness incentive program initiated by Governor’s Executive Order 13-06.

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

“Standard Programs” means any current or future program offered to improve a person’s health, the provision of health care, or lower costs provided as a Clinical Program, that is either (a) listed as a Standard Program in Exhibit S to this Contract, or (b) offered to all clients of Contractor’s fully insured Book-of-Business. The term “Standard Program” shall include such programs owned, performed, or provided by or through Contractor; and such programs owned, performed, or provided by or through any Subcontractor.

“Subcontractor” means person, partnership, or entity not in the employ of or owned by Contractor, who is performing all or part of those services under a separate contract with or on behalf of Contractor. The terms “Subcontractor” mean Subcontractors in any tier.

“Subscriber” means the employee, former employee, or retiree who has signed up to participate in a UMP Plan and, as a result of his or her current or former employment, is the main account holder (i.e., not a Dependent).

“Substantially Similar” means a plan that is not:

- a. materially different in plan structure from the PEBB UMP Plans. Plan structure excludes points of service cost sharing, such as out-of-pocket maximums, deductibles, and mutually agreed covered or excluded services;
- b. materially different mechanisms for provider payment from those included in the PEBB UMP Plans;
- c. materially different reporting requirements set forth in Section 3.17.7 and Exhibit R;
- d. materially different utilization of custom vendors or administrative services; or
- e. material differences in medical policies or network design.

“Top Box Score” means the percent of survey respondents who chose the most positive score for a given item response scale.

“Third Party Administrator” or **“TPA”** means an organization that processes Claims and performs other administrative services on behalf of the UMP Plans. The TPA will handle the administration of the plans including: processing and adjudication of Claims, provider network, Claims database, services described in any Work Orders, and all other functions and services described in this Contract.

“Triple Aim” means a framework for optimizing health system performance to improve the health of populations, improve customer experience of care (quality and patient experience), and reduce cost.

“UMP CDHP” means UMP Consumer Directed Health Plan, plan type HDHP. Subscribers enrolled in the UMP CDHP have access to a HSA and the same PPO network as UMP Classic. IRS rules control dollar limits to annual contributions, use of HSA funds, and may allow Subscribers to pay less federal taxes. The deductible and out-of-pocket limits are significantly higher, and are “combined” (include both medical expenses and prescription drug costs). HDHPs are subject to IRS rules regarding who is eligible to enroll and use HSA funds. UMP CDHP also covers the same services and is designed to be an IRS qualified high deductible health plan.

“UMP Classic” is the state of Washington’s self-insured PPO medical plan. Medicare-primary Members enrolled in UMP Classic have the same covered services as all UMP Classic Members, including some services not covered by Medicare, or for which UMP Classic covers more than Medicare.

“UMP PBM” means the HCA-contracted pharmacy benefits manager for the UMP Plans, currently Moda Health and known as Washington State Prescription Services.

“UMP Plan(s)” is the collective term referring to the self-insured medical plans UMP Classic, UMP CDHP, and UMP Plus. UMP Plans also includes any future self-insured medical plans or benefits offered to Members.

“UMP Plus” means the UMP plan that includes an affiliation with an Accountable Care Network. It is a clinically integrated health organization with a formal network of providers and health systems that collaborates to deliver integrated care and assumes financial risk and clinical accountability for a defined population. UMP Plus currently includes two distinct ACNs (the University of Washington, the ACN of Puget Sound High Value Network), and the term will also include any future ACNs added by the HCA.

“Use” means with respect to individually identifiable health information, as defined in 45 CFR § 160.103, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

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

“Value Based Payment” is a form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness. The HCA defines Value Based Payments as payment arrangements in the CMS Health Care Learning & Action Network Categories 2c – 4b (see, Table 8).

“WAC” means the Washington Administrative Code. Any references to specific titles, chapters, or sections of the WAC includes any substitute, successor, or replacement title, chapter, or section.

“Washington Health Alliance” or **“WHA”** is a multi-stakeholder group of employers, providers, medical and dental plans and networks, pharmaceutical companies, consultants, and community partners serving to build a strong alliance among patients, doctors, hospitals, purchasers, health plans and others to promote health and improve quality and affordability by reducing overuse, underuse and misuse of health care services.

“Writing” includes, in addition to the usual meaning, communication by electronic mail.

In Witness whereof, Contractor and the HCA have caused this Contract to be signed as of the date below by their respective officers who are duly authorized.

[CONTRACTOR]

**WASHINGTON STATE
HEALTH CARE AUTHORITY**

Signature _____ Date _____

Print Name and Title _____

Email Address: _____

Telephone No: _____

Signature _____ Date _____

Print Name and Title _____

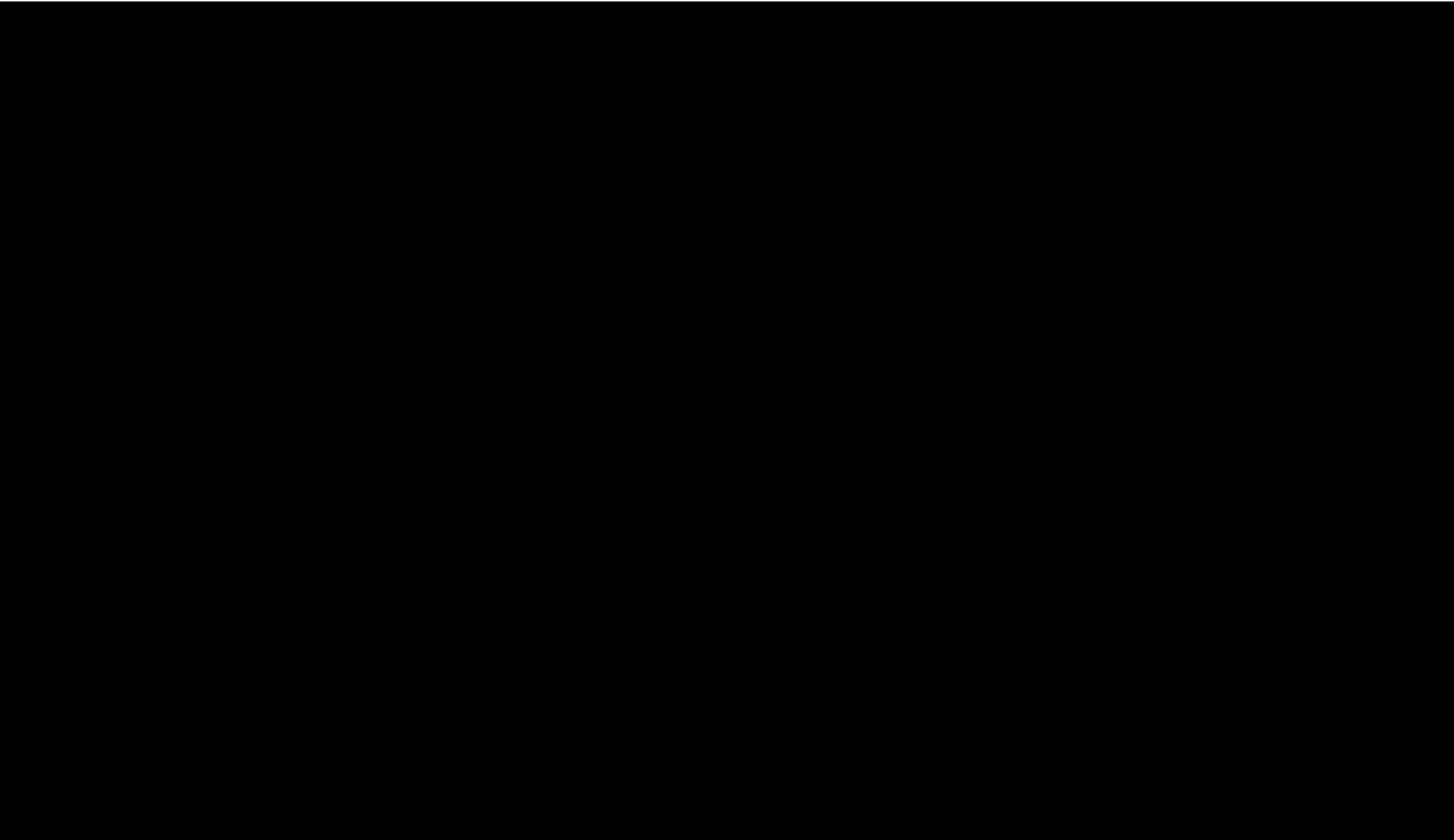
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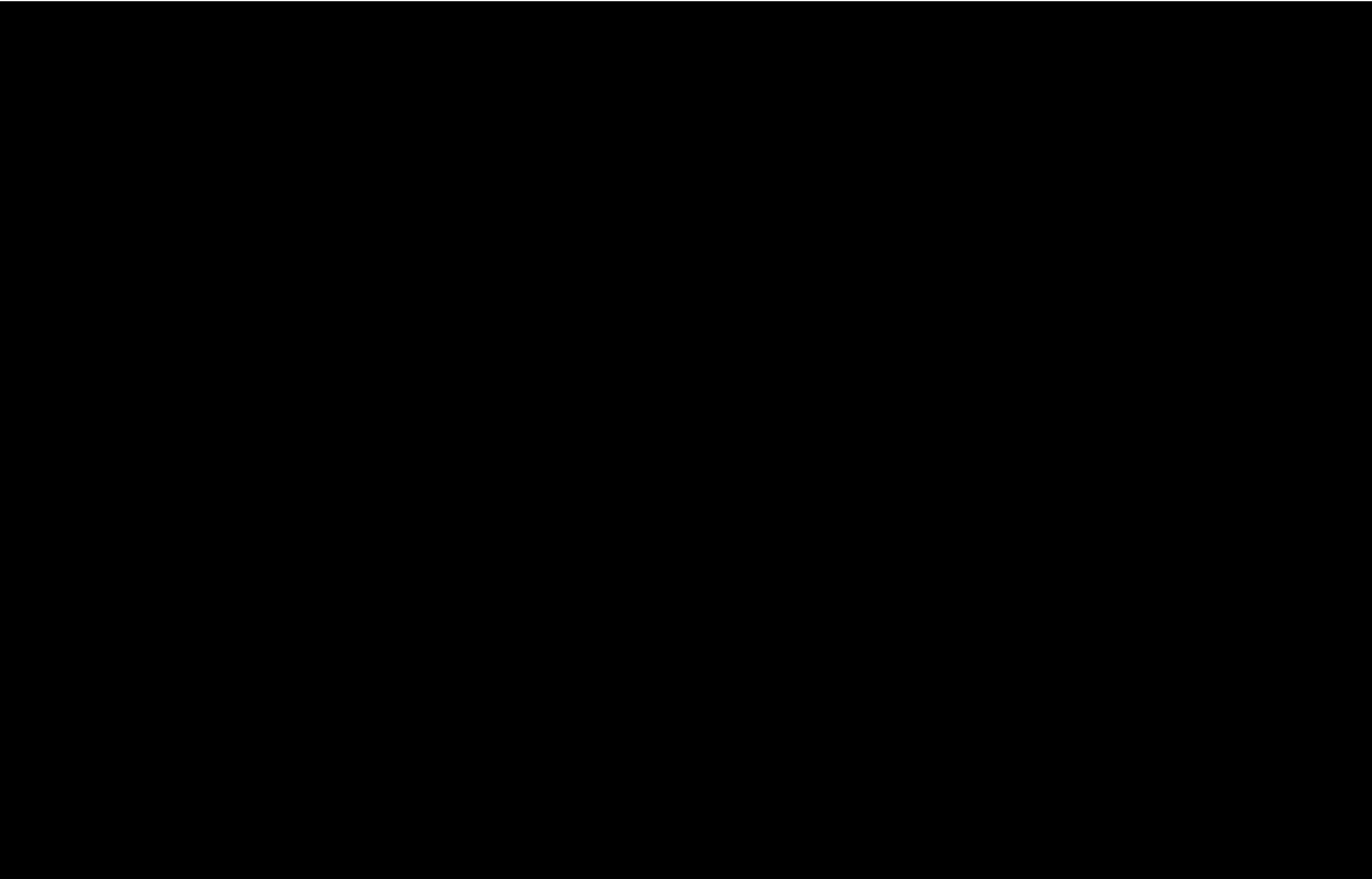
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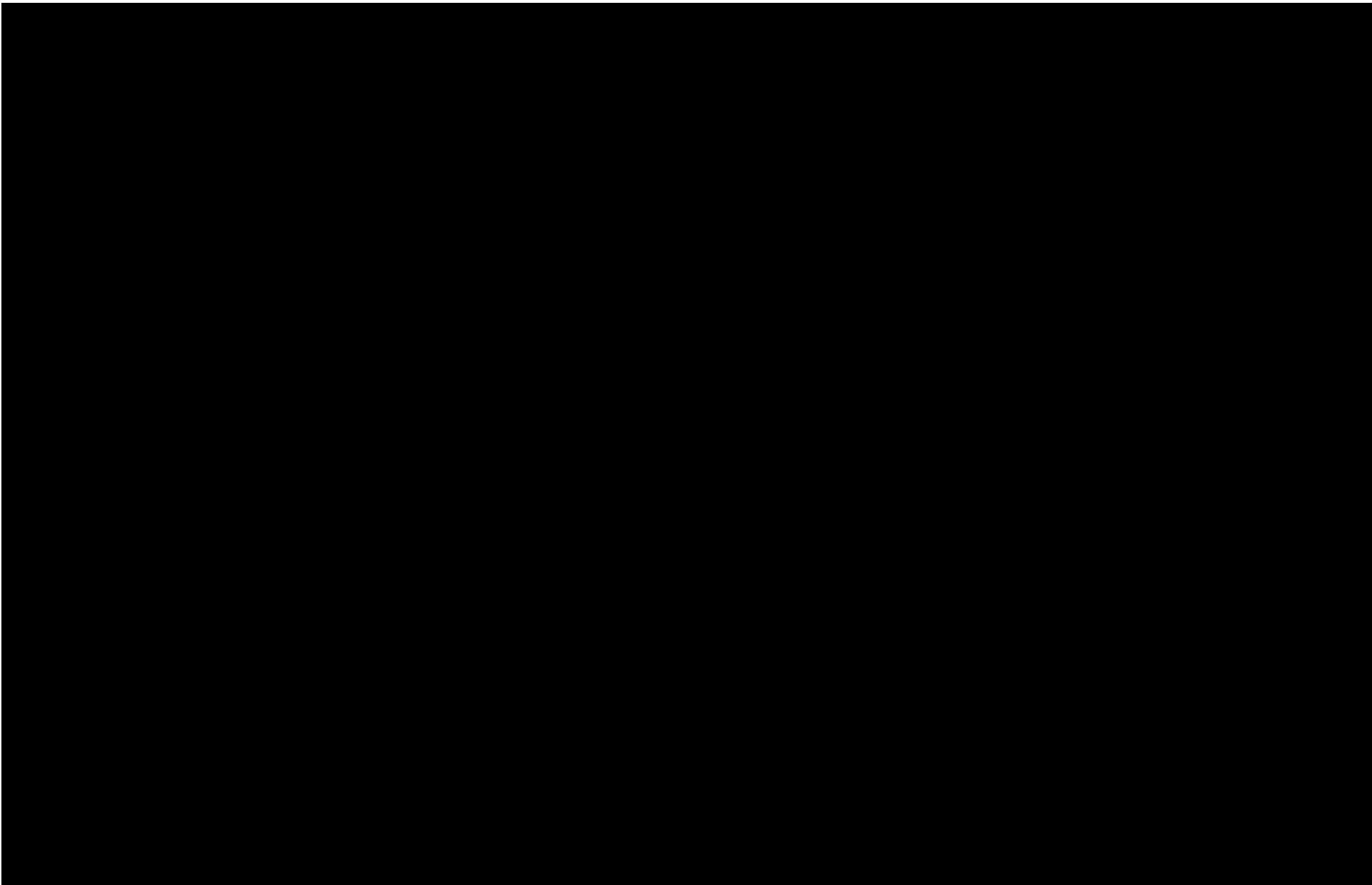
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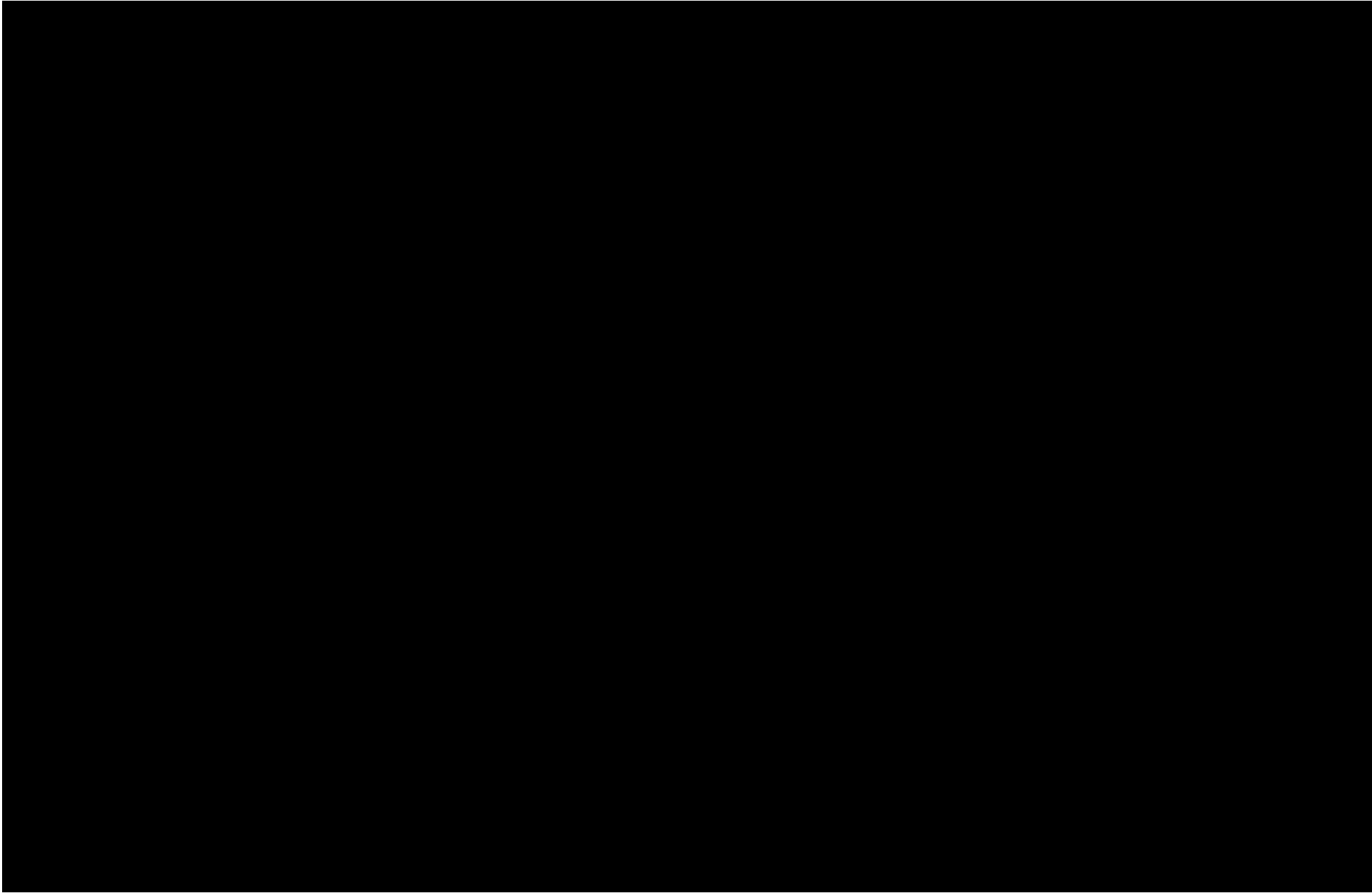
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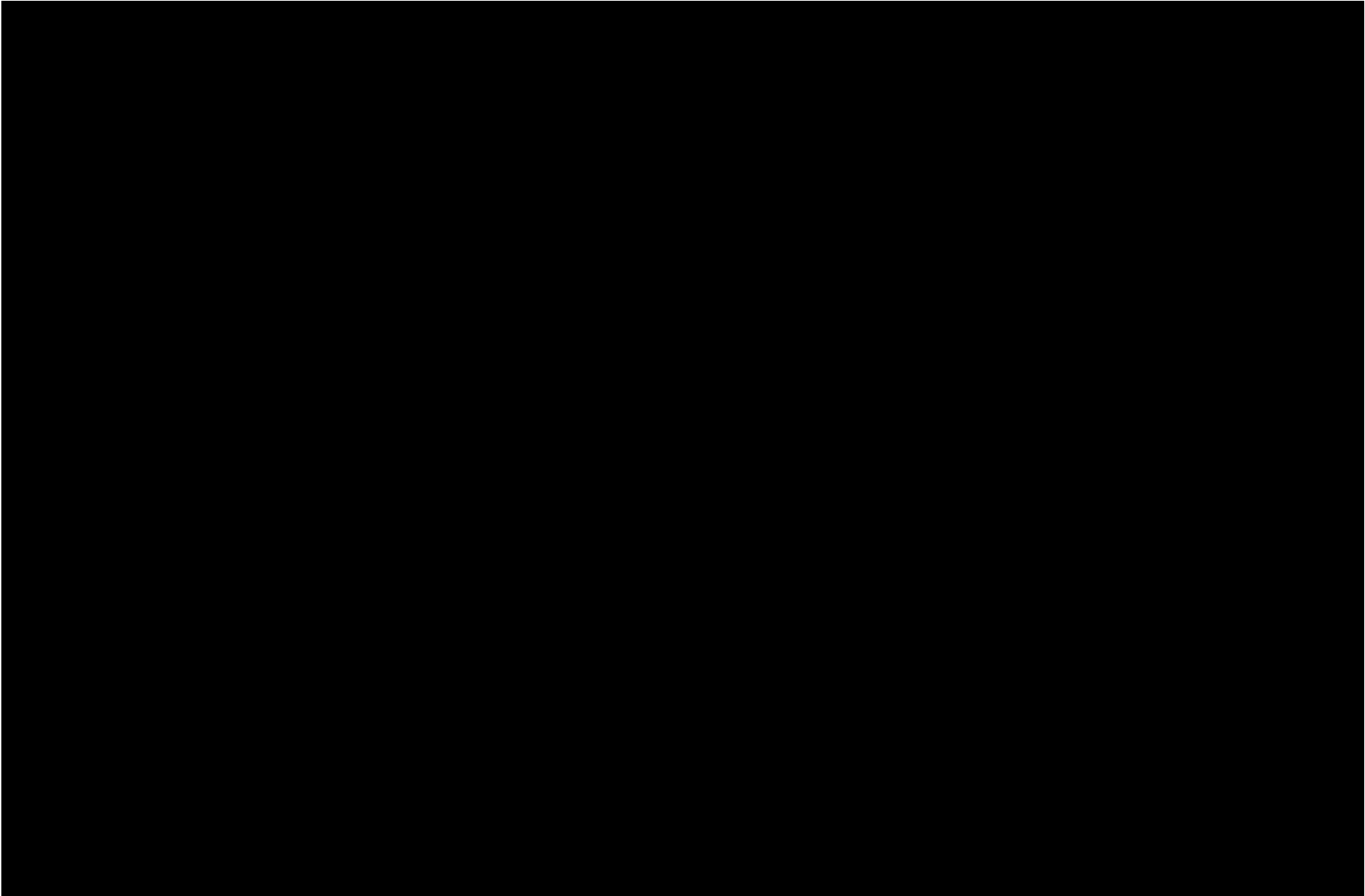
_____, Assistant Attorney General
Print Name and Title

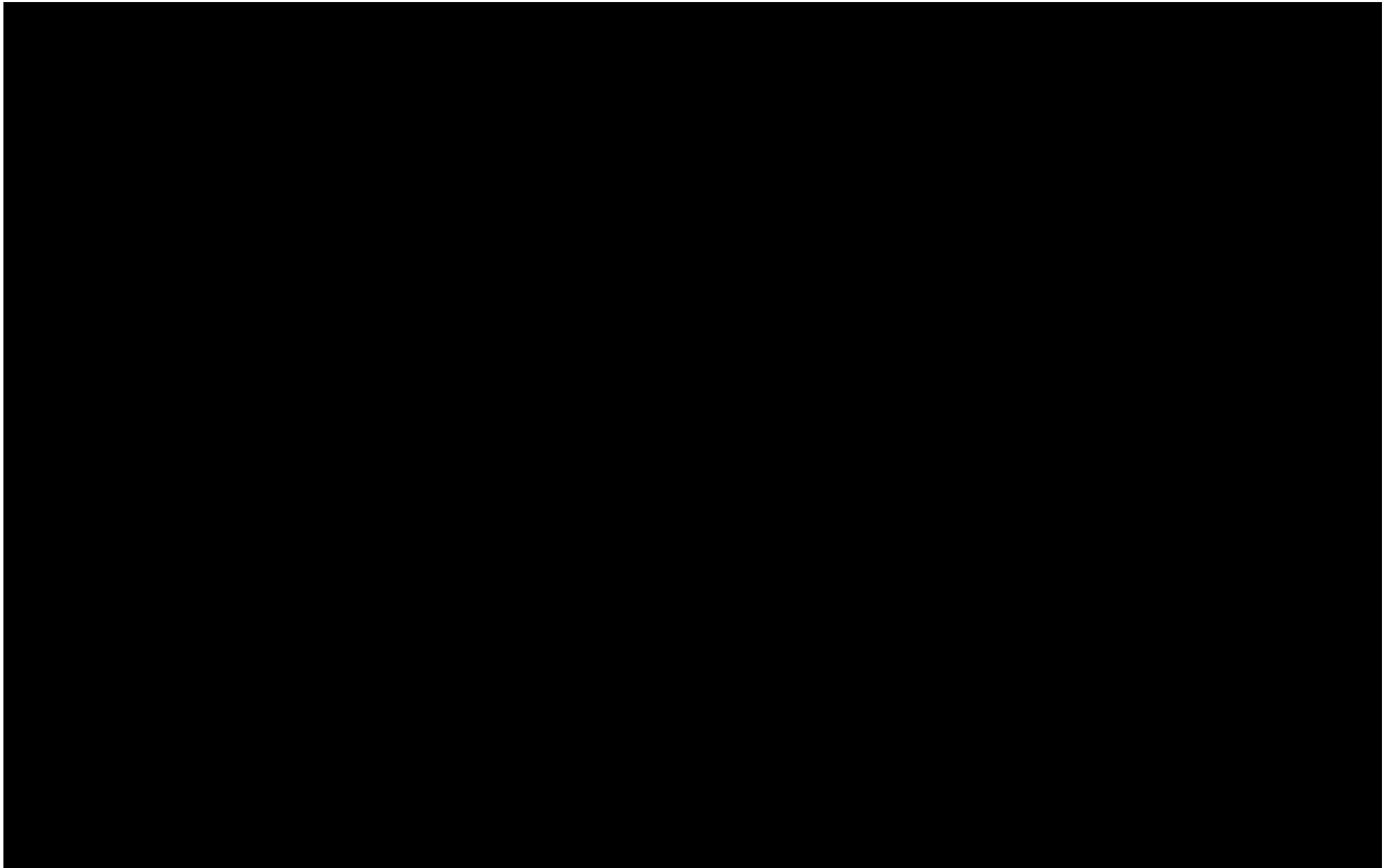












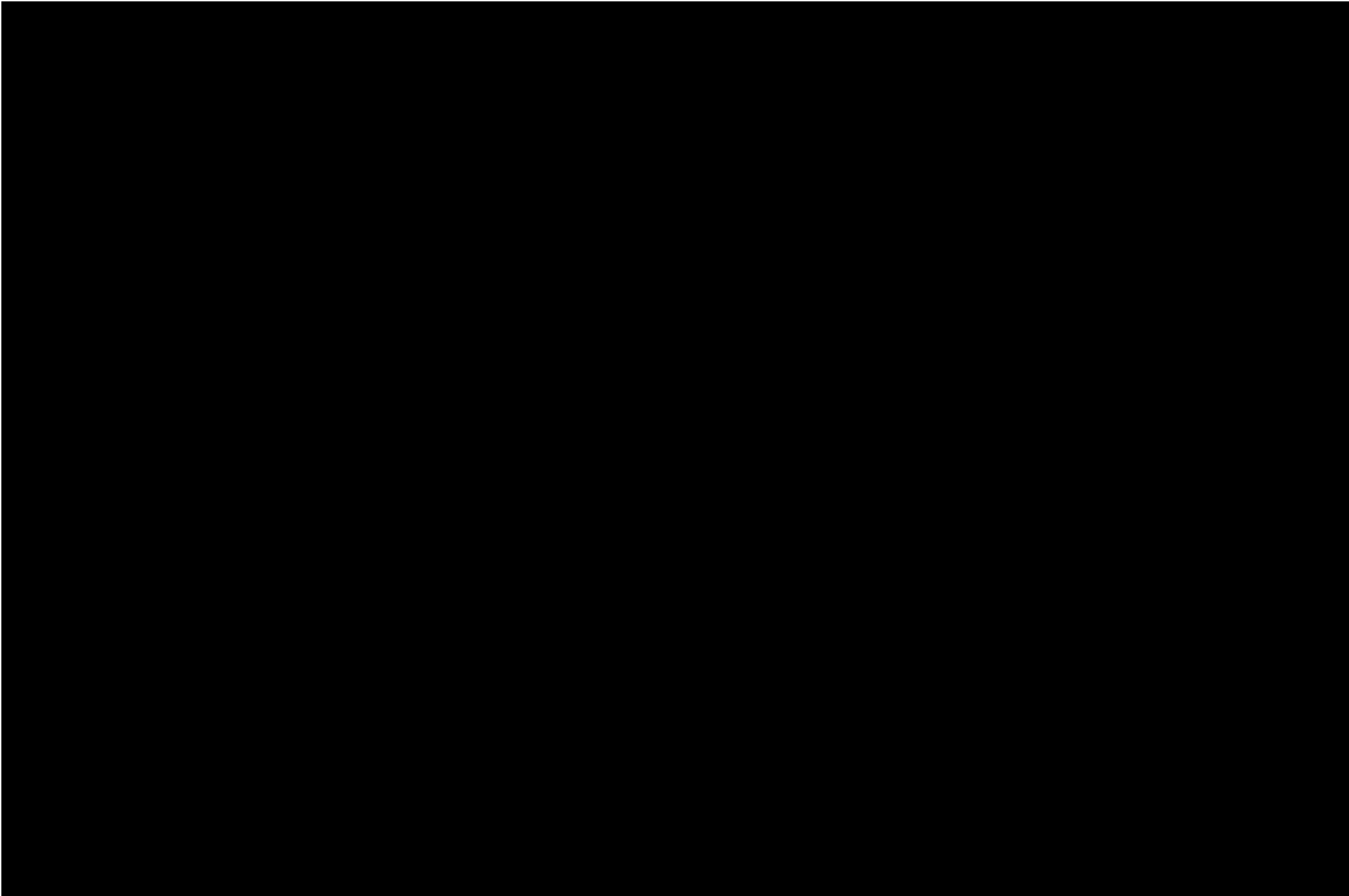


Exhibit B

ERB HIPAA 834 Eligibility File Format



K1807-ExB-PEBB
834 Companion Gui

Exhibit C-1 Enrollment Full File Layout Required Match



K1807-ExC-1-Carrier
Interface Record Lay

Exhibit C-2 Completion Dates for Quarterly Eligibility Reconciliation

Milestone / Deliverable	Responsible Party	Due Date
Request the full eligibility file from HCA Help Desk.	Contractor	Five (5) Business Days after each quarter end
Place the full eligibility file on HCA FTP site and notify Contractor (provide file name and password).	HCA	Ten (10) Business Days after each quarter end
Run the full eligibility file. If there are errors, place a “no record listed report” or an “error report” in a customer folder on the secure web site for HCA to review and advise on discrepancies. The report will be in an Excel spreadsheet.		
Complete the full eligibility file audit.	Contractor	Twenty (20) Business Days after each quarter end
Reconcile any discrepancies with HCA.	Contractor	Thirty (30) Business Days after each quarter end
Submit the quarterly full file to PBM.	Contractor	Forty (40) Business Days after each quarter end
Submit final audit report summary to HCA Senior Account Sponsor(s).		
Reconcile any file differences with Contractor	HCA	Twenty (20) Business Days of receiving file.

Exhibit D Washington Provider Network Adequacy Standards

During the term of this Contract, Contractor shall offer and maintain a provider network meeting or exceeding the minimum standards for provider network access in table provided below. For the purposes of this Exhibit D, the HCA defines Urban and Rural service areas as follows:

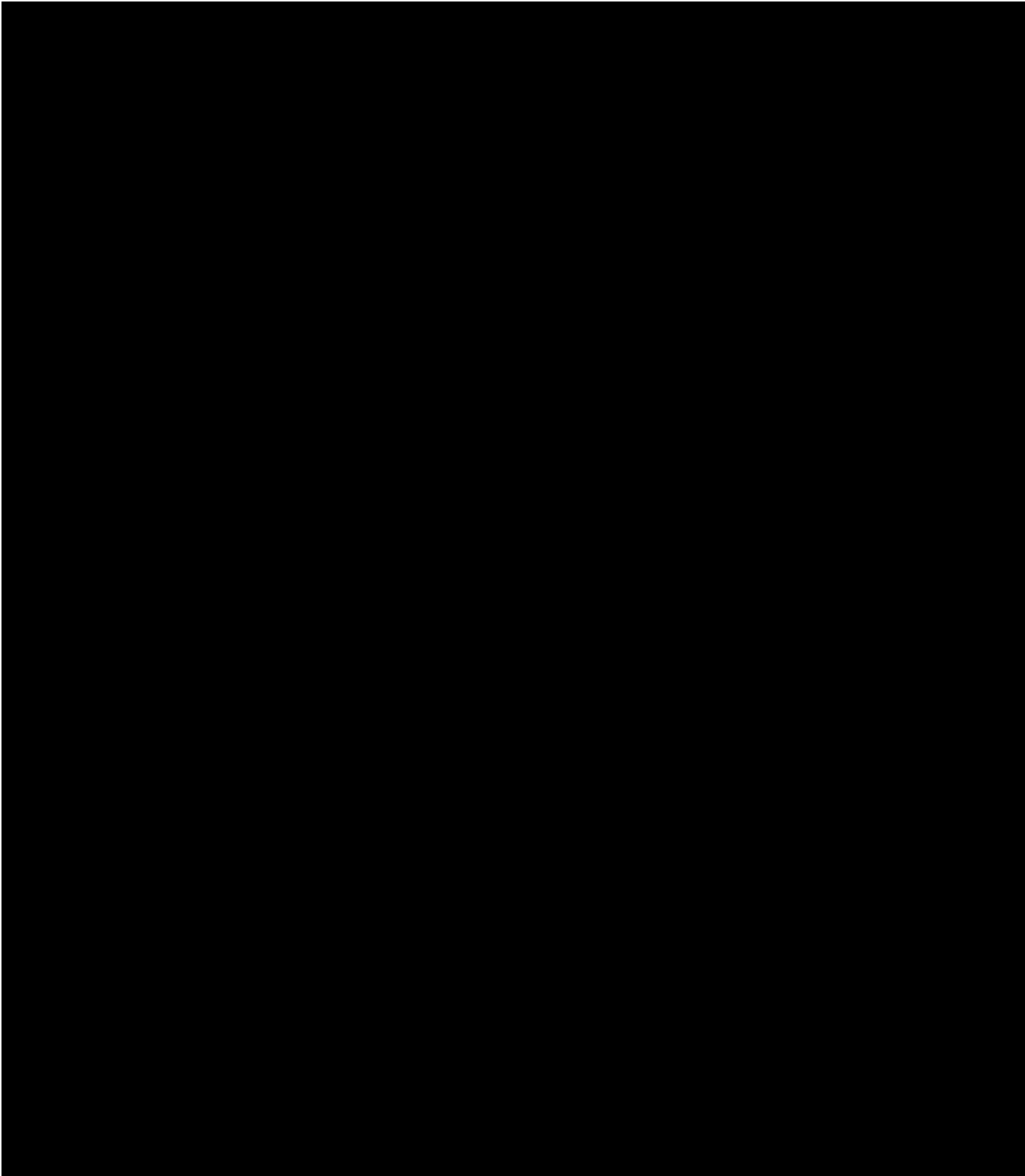
1. Urban – a county with a density of 90 or more persons per square mile.
2. Rural – a county with a density of 89 or fewer persons per square mile.

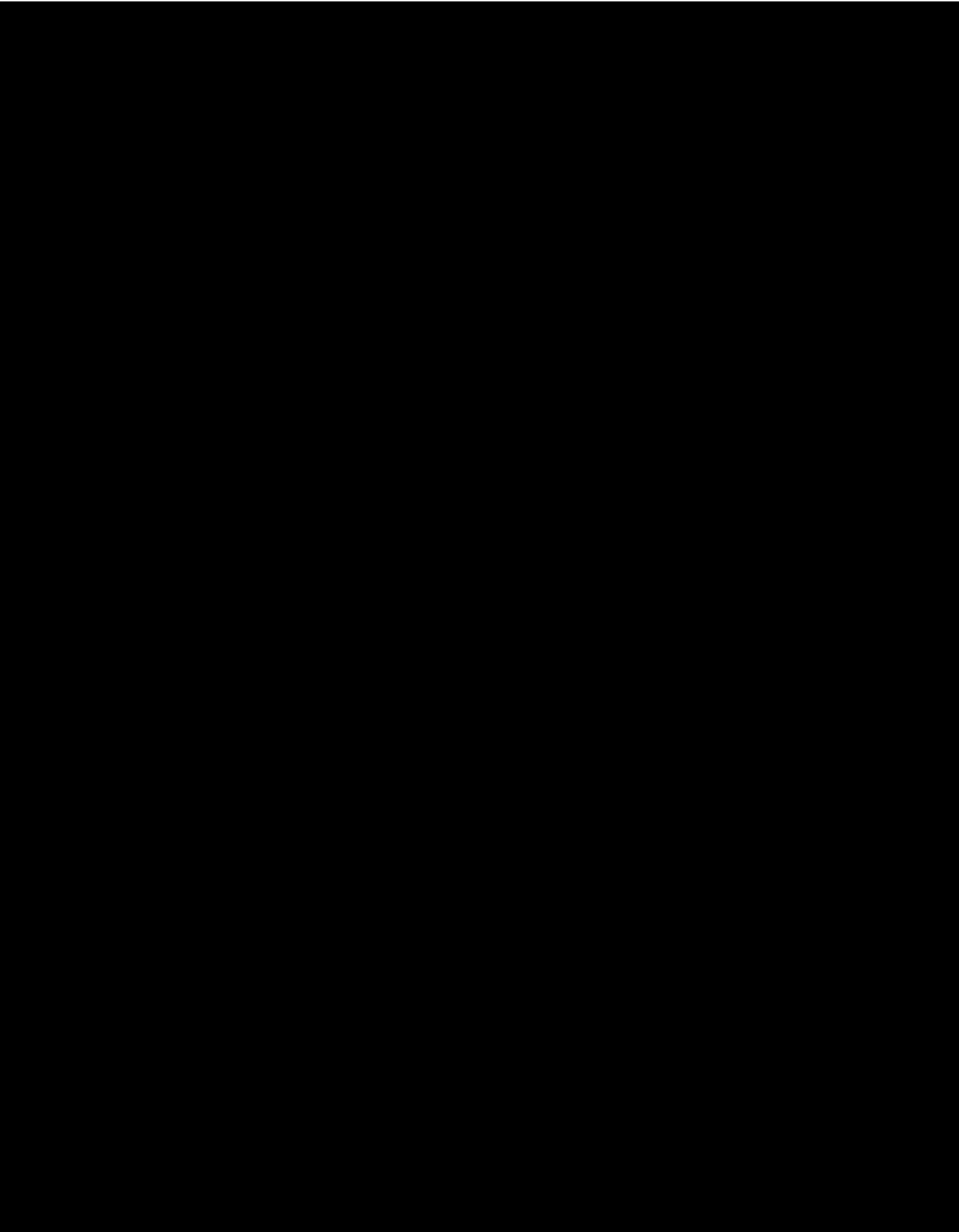
Contractor shall provide HCA data validating compliance with the minimum standards listed in the table below by county or ZIP Code on an annual basis, or as requested by HCA.

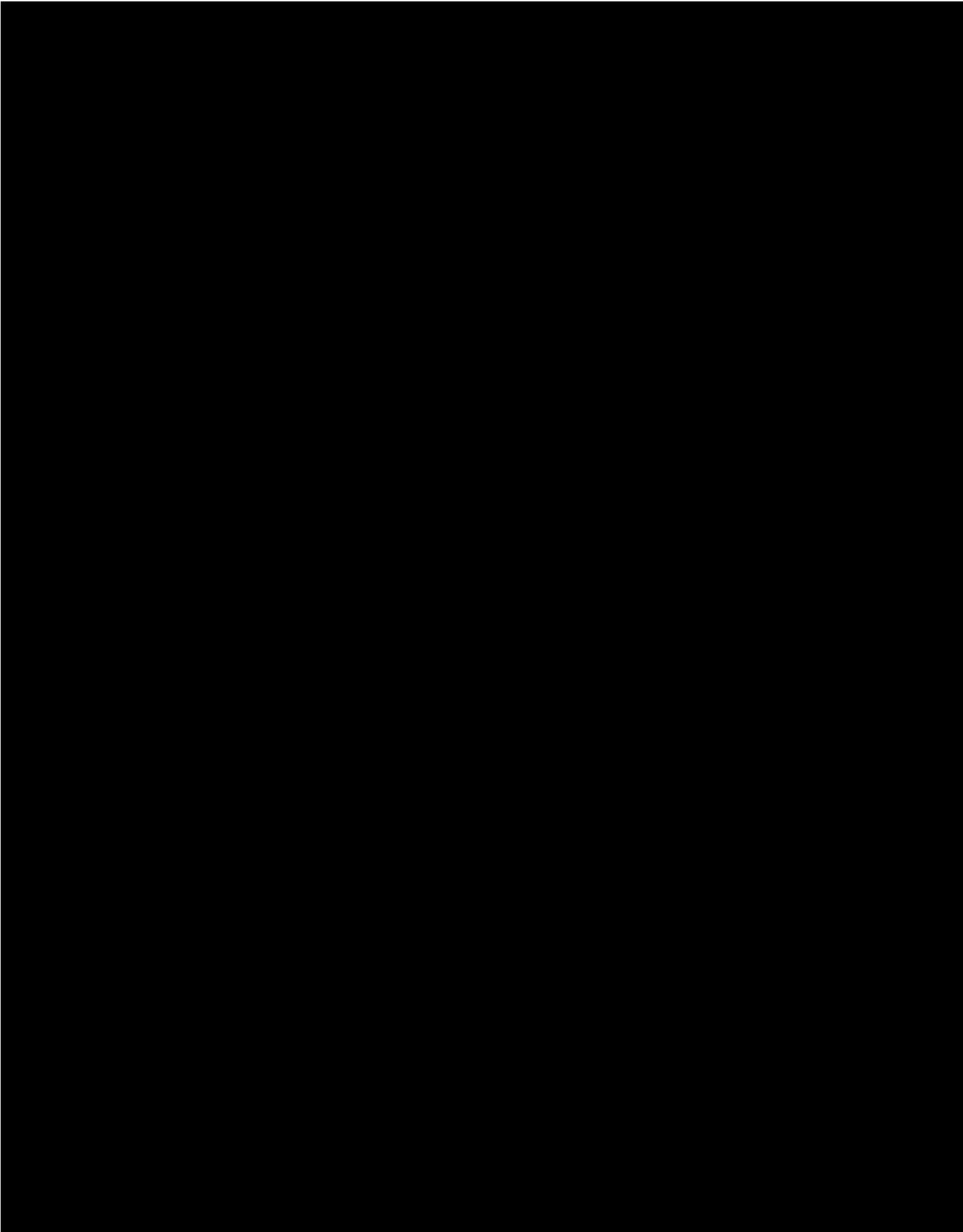
Additional Provider Network Adequacy Standards
Acupuncturist (L.Ac/EAMP) Urban 1:10 miles and 1:4000 members
Acupuncturist (L.Ac/EAMP) Rural 1:25 miles and 1:4000 members
Massage Therapist (LMP) Urban 1:10 miles and 1:1000 members
Massage Therapist (LMP) Rural 1:25 miles and 1:1000 members
Chiropractor (DC) Urban 1:10 miles and 1:1000 members
Chiropractor (DC) Rural 1:25 miles and 1:1000 members
Naturopath (ND) Urban 1:10 miles and 1:4000 members
Naturopath (ND) Rural 1:25 miles and 1:4000 members
Behavioral Health - Psychiatrists and Mental Health Counselors
1:30,000*
Urban - 2 providers within 15 miles
Rural - 1 provider within 75 miles
Behavioral Health - Psychologists
1:15,000*
Urban - 2 providers within 15 miles
Rural - 1 provider within 75 miles

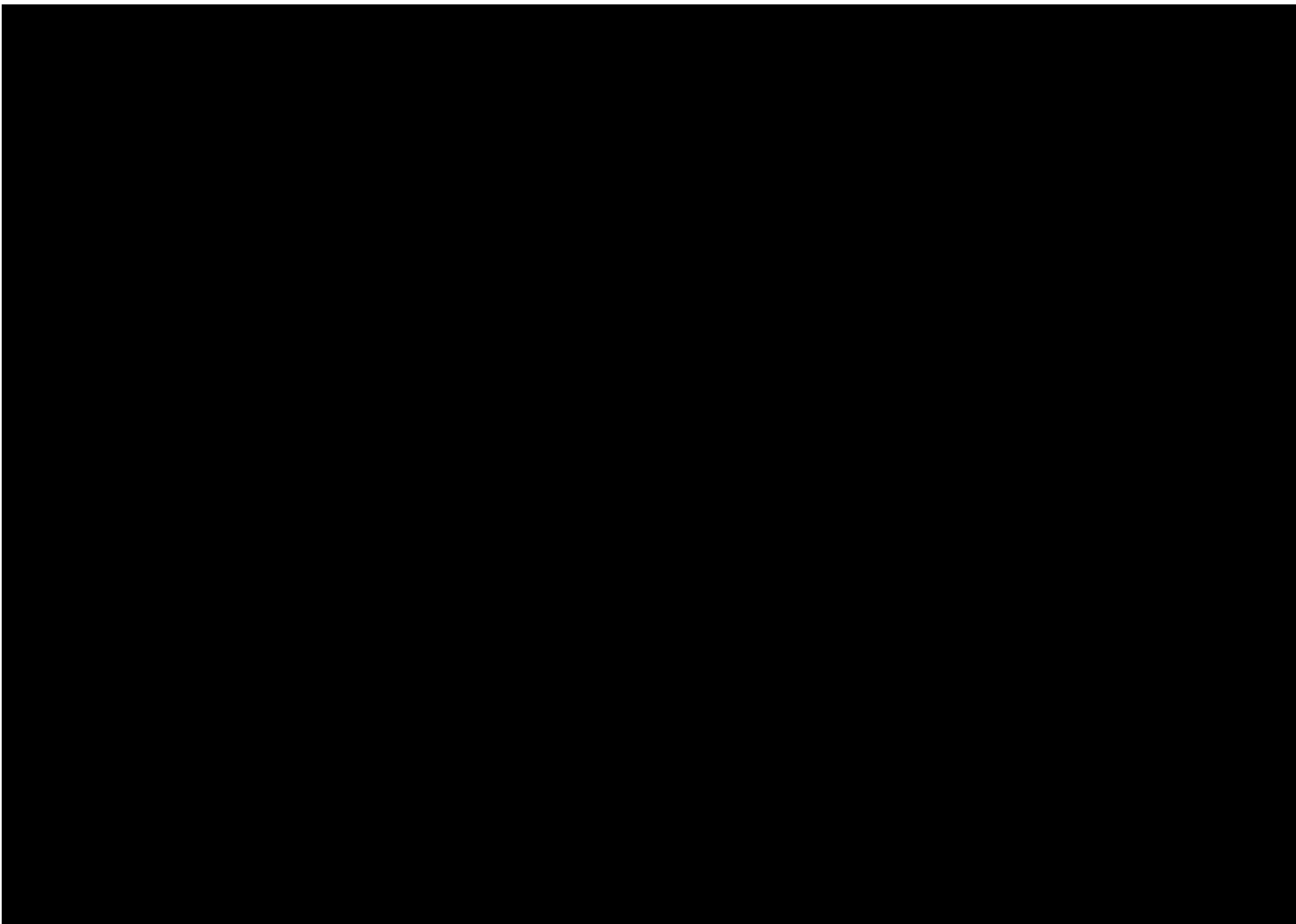
*Based on federal access requirements for TRICARE

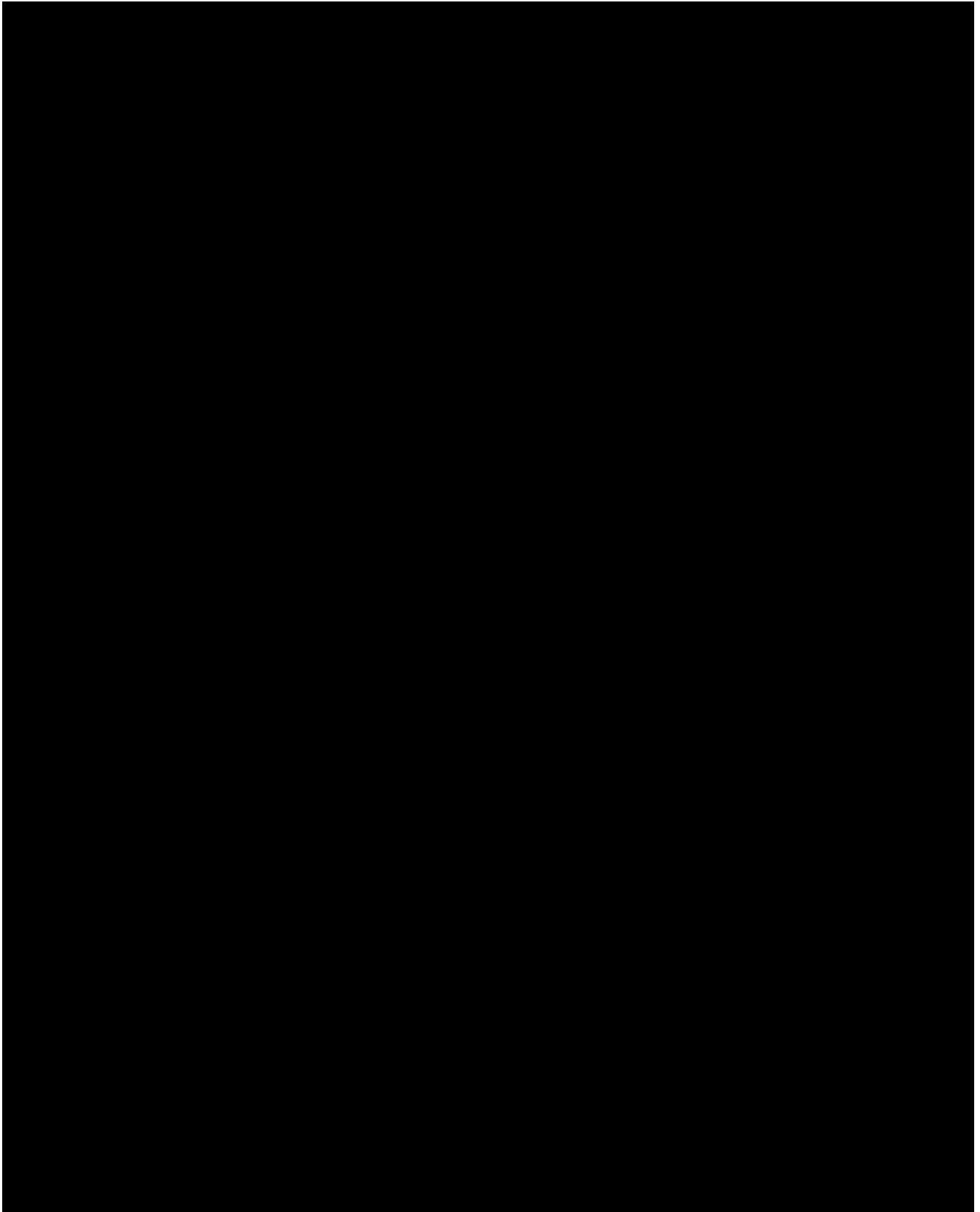
**Exhibit E-1 Unit Cost Margin Guarantee and Utilization Trend Margin Guarantee
Rates – PEBB**

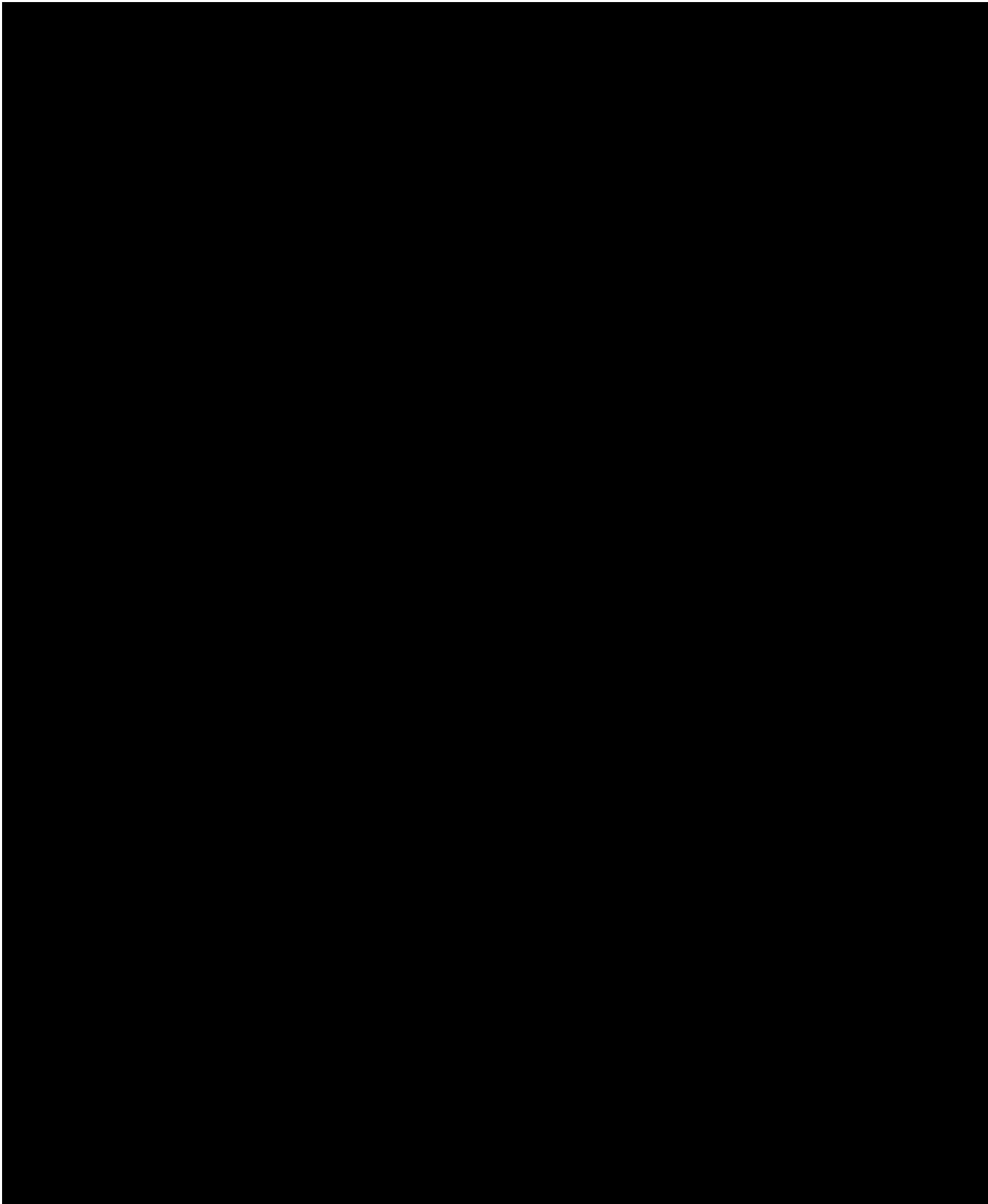


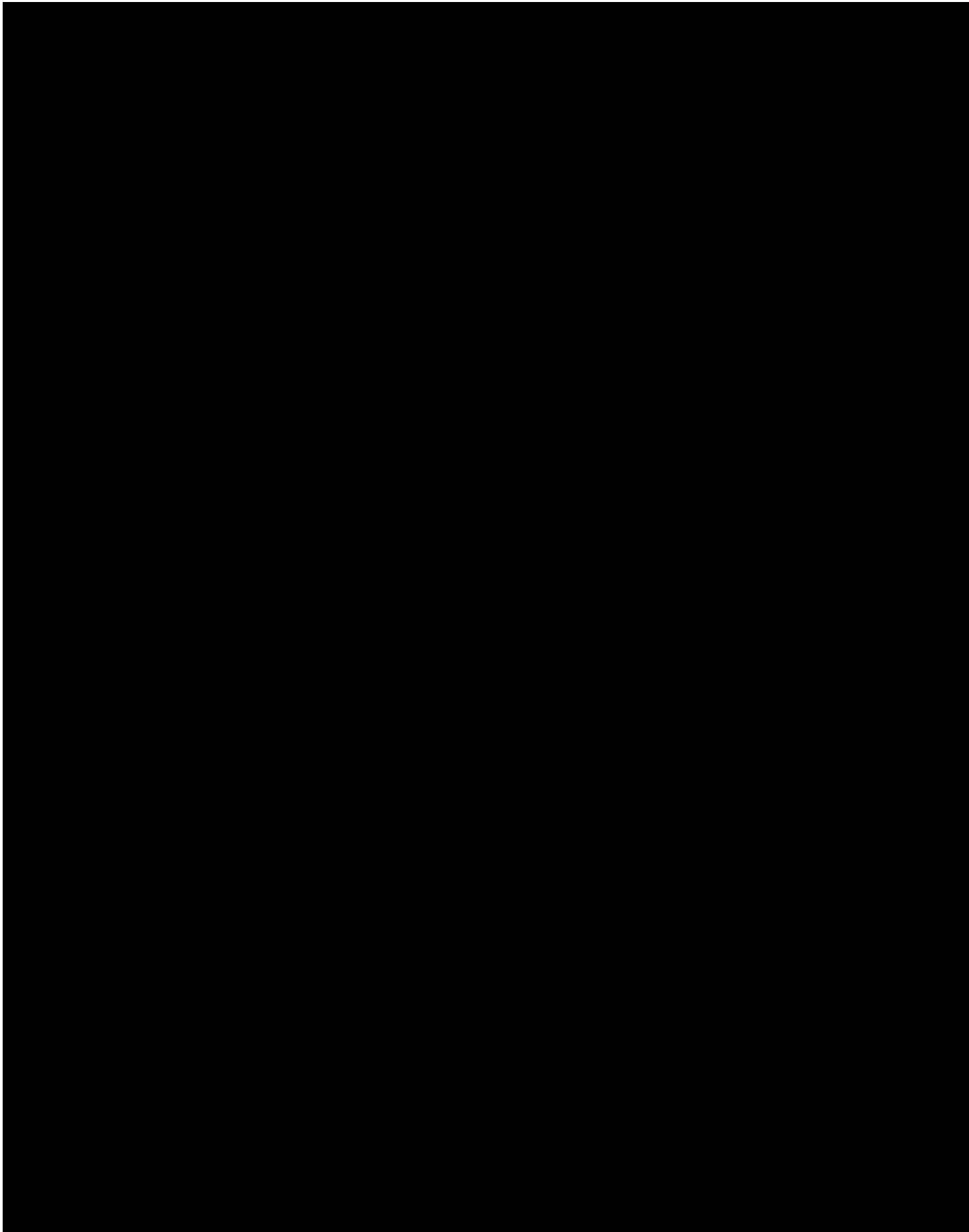












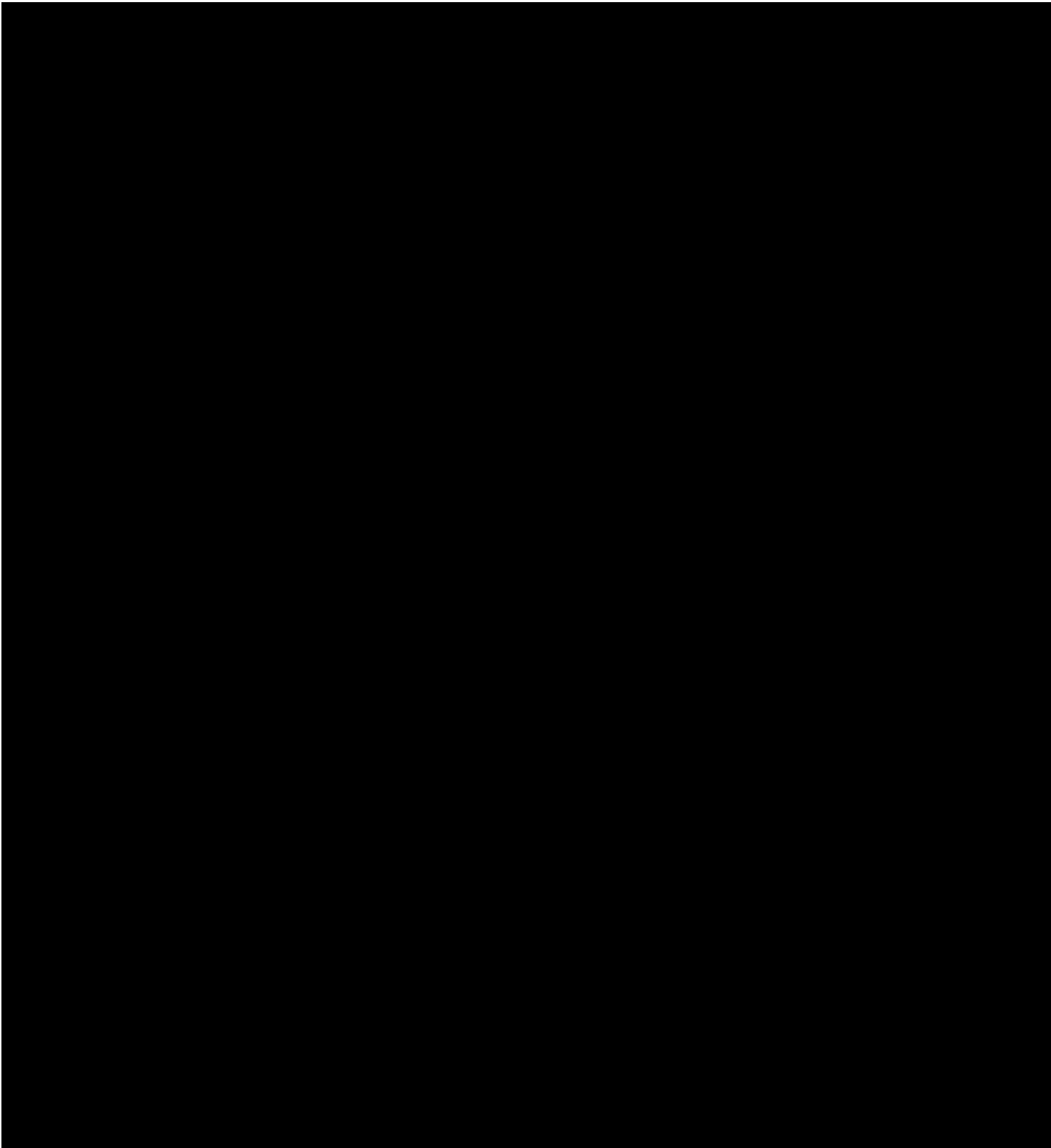


Exhibit E-3

Medicare Lite



K1807-ExE-3-201802
15 Medicare Methoc



Exhibit F-2 Reporting Manual

TBD

Exhibit G-1 Business Associate Agreement

This BUSINESS ASSOCIATE AGREEMENT is made between **[ENTER BUSINESS ASSOCIATE NAME]** (Business Associate) and the Washington State Health Care Authority (HCA). This agreement does not expire or automatically terminate except as stated in Section 5.

This Agreement relates to all business relationships between the Business Associate and HCA unless otherwise agreed. Business Associate is or may be a “Business Associate” of HCA as defined in the HIPAA Rules. If there is a conflict between the provisions of this Agreement and provisions of other contracts, this Agreement controls; otherwise, the provisions in this Agreement do not replace any provisions of any other contracts. If the other Contract is terminated, this Agreement nonetheless continues in effect.

This Business Associate Agreement supersedes any existing Business Associate Agreement the Business Associate may have with HCA. It also supersedes any “business associate” section in an underlying Contract.

Article I. Definitions

Access attempts

Information systems are the frequent target of probes, scans, “pings,” and other activities that may or may not indicate threats, whose sources may be difficult or impossible to identify, and whose motives are unknown, and which do not result in access or risk to any information system or PHI. Those activities are “access attempts.”

Day

“Day” means business days observed by Washington State government.

Catch-all definitions

The following terms used in this Agreement have the same meaning as those terms in the HIPAA Rules: Breach, Business Associate, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information (PHI), and Use.

Clients or Individuals

“Clients” or “individuals” are people who have health or other coverage or benefits from or through HCA. They include Medicaid clients, Public Employees Benefits Board subscribers and enrollees, and others.

Contract or Underlying Contract

“Contract” or “underlying contract” means all agreements between Business Associate and HCA under which Business Associate is a “business associate” as defined in the Security or Privacy Rules. The terms apply whether there is one such agreement or more than one, and if there is more than one the terms include them all even though a singular form is used except as otherwise specified. The terms include agreements now in effect and agreements that become effective after the effective date of this Agreement.

Effective Date

“Effective Date” means the date of the signature with the latest date affixed to the Agreement.

HIPAA Rules; Security, Breach Notification, and Privacy Rules

“HIPAA Rules” means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164, as now in effect and as modified from time to time. In part 164 of title 45 CFR, the “Security Rule” is subpart C (beginning with §164.302), the “Breach Notification Rule” is subpart D (beginning with § 164.400), and the “Privacy Rule” is subpart E (beginning with § 164.500).

Protected Health Information or PHI

"Protected Health Information" has the same meaning as in the HIPAA Rules except that in this Agreement the term includes only information created by Business Associate or any of its contractors, or received from or on behalf of HCA, and relating to Clients. “PHI” means Protected Health Information.

Article II. Obligations and Activities of Business Associate

Section 2.01 Limits

Business Associate will not use or disclose PHI other than as permitted or required by the Contract or this Agreement or as required by law. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI on behalf of, or as necessary for purposes of the underlying contract, if such use or disclosure of PHI would not violate the Privacy Rule if done by a Covered Entity and is the minimum necessary.

Section 2.02 Safeguards

Business Associate will use appropriate safeguards, and will comply with the Security Rule with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Contract or this Agreement. Business Associate will store and transfer PHI in encrypted form.

Section 2.03 Reporting Security Incidents

- A. Business Associate will report security incidents that materially interfere with an information system used in connection with PHI. Business Associate will report those security incidents to HCA within five days of their discovery by Business Associate. If such an incident is also a Breach or may be a Breach, subsection 2.4 applies instead of this provision.
- B. Access Attempts shall be recorded in Business Associate’s system logs. Access Attempts are not categorically considered unauthorized Use or Disclosure, but Access Attempts do fall under the definition of Security Incident and Business Associate is required to report them to HCA.
- C. Since Business Associate’s reporting and HCA’s review of all records of Access Attempts would be materially burdensome to both parties without necessarily reducing risks to information systems or PHI, the parties agree that Business Associate will review logs and other records of Access Attempts, will investigate events where it is not clear whether or not an apparent Access Attempt was successful, and determine whether an Access Attempt:
 - 1) Was in fact a “successful” unauthorized Access to, or unauthorized Use, Disclosure, modification, or destruction of PHI subject to this Agreement, or

- 2) Resulted in material interference with Business Associate's information system used with respect to PHI subject to this Agreement, or
 - 3) Caused an unauthorized Use or Disclosure.
- D. Subject to Business Associate's performance as described in 2.3.2., this provision shall serve as Business Associate's notice to HCA that Access Attempts will occur and are anticipated to continue occurring with respect to Business Associate's information systems. HCA acknowledges this notification, and Business Associate is not required to provide further notification of Access Attempts unless they are successful as described in Section 2.3.2. above, in which case Business Associate will report them in accordance with Section 2.3.1 or Section 2.4.

Section 2.04 Breach notification

- A. "Breach" is defined in the Breach Notification Rule. The time when a Breach is considered to have been discovered is explained in that Rule. HCA, or its designee, is responsible for determining whether an unauthorized Use or Disclosure constitutes a Breach under the Breach Notification Rule, RCW 42.56.590 or RCW 19.255.010, or other law or rule, and for any notification under the Breach Notification Rule, RCW 42.56.590 or RCW 19.255.010, or other law or rule.
- B. Business Associate will notify HCA of any unauthorized use or disclosure and any other possible Breach within five days of discovery. If Business Associate does not have full details at that time, it will report what information it has, and provide full details within 15 days after discovery. The initial report may be oral. Business Associate will give a written report to HCA, however, as soon as possible. To the extent possible, these reports must include the following:
- 1) The identification of each individual whose PHI has been or may have been accessed, acquired, or disclosed;
 - 2) The nature of the unauthorized Use or Disclosure, including a brief description of what happened, the date of the event(s), and the date of discovery;
 - 3) A description of the types of PHI involved;
 - 4) The investigative and remedial actions the Business Associate or its subcontractor took or will take to prevent and mitigate harmful effects, and protect against recurrence;
 - 5) Any details necessary for a determination of the potential harm to Individuals whose PHI is believed to have been Used or Disclosed and the steps such Individuals should take to protect themselves; and
 - 6) Such other information as HCA may request.
- C. If Business Associate determines that it has or may have an independent notification obligation under any state breach notification laws, Business Associate will promptly notify HCA. In any event, Business Associate will notify HCA of its intent to give any notification under a state breach notification law no fewer than ten business days before giving such notification.
- D. If Business Associate or any subcontractor or agent of Business Associate actually makes or causes, or fails to prevent, a use or disclosure constituting a Breach within the meaning of

the Breach Notification Rule, and if notification of that use or disclosure must (in the judgment of HCA) be made under the Breach Notification Rule, or RCW 42.56.590 or RCW 19.255.010, or other law or rule, then:

- 1) HCA may choose to make any notifications to the individuals, to the Secretary, and to the media, or direct Business Associate to make them or any of them.
- 2) In any case, Business Associate will pay the costs of notification to individuals, media, and governmental agencies and of other actions HCA considers appropriate to protect clients (such as paying for regular credit watches in some cases), and
- 3) Business Associate will compensate HCA clients for harms caused to them by the Breach or possible Breach described above.

E. Business Associate's obligations regarding breach notification survive the termination of this Agreement and continue for as long as Business Associate maintains the PHI and for any breach or possible breach at any time.

Section 2.05 Subcontractors

Business Associate will ensure that any subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to protective restrictions, conditions, and requirements at least as strict as those that apply to the Business Associate with respect to that information. Upon request by HCA, Business Associate will identify to HCA all its subcontractors and provide copies of its agreements (including business associate agreements or contracts) with them. The fact that Business Associate subcontracted or otherwise delegated any responsibility to a subcontractor or anyone else does not relieve Business Associate of its responsibilities.

Section 2.06 Access

Business Associate will make available PHI in a designated record set to the HCA as necessary to satisfy HCA's obligations under 45 CFR § 164.524. Business Associate will give the information to HCA within five days of the request from the individual or HCA, whichever is earlier. If HCA requests, Business Associate will make that information available directly to the individual. If Business Associate receives a request for access directly from the individual, Business Associate will inform HCA of the request within three days, and if requested by HCA it will provide the access in accordance with the HIPAA Rules.

Section 2.07 Amending PHI

Business Associate will make any amendments to PHI in a designated record set as directed or agreed to by the HCA pursuant to 45 CFR § 164.526, or take other measures requested by HCA to satisfy HCA's obligations under that provision. If Business Associate receives a request for amendment directly from an individual, Business Associate will both acknowledge it and inform HCA within three days, and if HCA so requests act on it within ten days and inform HCA of its actions.

Section 2.08 Accounting

Business Associate will maintain and make available to HCA the information required to provide an accounting of disclosures as necessary to satisfy HCA's obligations under 45 CFR § 164.528. If Business Associate receives an individual's request for an accounting, it will either

provide the accounting as required by the Privacy Rule or, at its option, pass the request on to HCA within ten days after receiving it.

Section 2.09 Obligations

To the extent the Business Associate is to carry out one or more of HCA's obligations under the Privacy Rule, it will comply with the requirements of that rule that apply to HCA in the performance of such obligations.

Section 2.10 Books, etc.

Business Associate will make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

Section 2.11 Mitigation

Business Associate will mitigate, to the extent practicable, any harmful effect of a use or disclosure of PHI by Business Associate or any of its agents or subcontractors in violation of the requirements of any of the HIPAA Rules, this Agreement, or the Contract.

Section 2.12 Indemnification

To the fullest extent permitted by law, Business Associate will indemnify, defend, and hold harmless the State of Washington, HCA, and all officials, agents and employees of the State from and against all claims of any kind arising out of or resulting from the performance of this Agreement, including Breach or violation of HIPAA Rules.

Article III. Permitted Uses and Disclosures by Business Associate

Section 3.01 Limited use and disclosure

Except as provided in this Section 3, Business Associate may use or disclose PHI only as necessary to perform the services set forth in the Contract.

Section 3.02 General limitation

Business Associate will not use or disclose PHI in a manner that would violate the Privacy Rule if done by HCA.

Section 3.03 Required by law

Business Associate may use or disclose PHI as Required by Law.

Section 3.04 De-identifying

Business Associate may de-identified PHI in accordance with 45 CFR § 164.514(a)-(c).

Section 3.05 Minimum necessary

Business Associate will make uses and disclosures of only the minimum necessary PHI, and will request only the minimum necessary PHI.

Section 3.06 Disclosure for management and administration of Business Associate

A. Subject to subsection 3.6.2, Business Associate may disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate.

- B. The disclosures mentioned in subsection 3.6.1 above are permitted only if either:
- 1) The disclosures are required by law, or
 - 2) Business Associate obtains assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and that the person will notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

Section 3.07 Aggregation

Business Associate may use PHI to provide data aggregation services relating to the health care operations of the HCA, if those services are part of the Contract.

Article IV. Activities of HCA

Section 4.01 Notice of privacy practices

HCA will provide a copy of its current notice of privacy practices under the Privacy Rule to Business Associate on request. HCA will also provide any revised versions of that notice by posting on its website, and will send it on request.

Section 4.02 Changes in permissions

HCA will notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

Section 4.03 Restrictions

HCA will notify Business Associate of any restriction on the use or disclosure of PHI that HCA has agreed to or is required to abide by under 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI. Business Associate will comply with any such restriction.

Article V. Term and Termination

Section 5.01 Term

- A. This Agreement is effective as of the earliest of:
- 1) The first date on which Business Associate receives or creates PHI subject to this Agreement, or
 - 2) The effective date of the Contract, or if there is more than one Contract then the effective date of the first one to be signed by both parties.
- B. This Agreement continues in effect until the earlier of:
- 1) Termination of the provision of Services under the Contract or, if there is more than one Contract, under the last of the Contracts under which services are terminated,
 - 2) The termination of this Agreement as provided below, or
 - 3) The written agreement of the parties.

Section 5.02 Termination for Cause

HCA may terminate this Agreement and the Contract (or either of them), if HCA determines Business Associate has violated a material term of the Agreement. The termination will be effective as of the date stated in the notice of termination.

Section 5.03 Obligations of Business Associate upon termination

The obligations of the Business Associate under this subsection 5.3 survive the termination of the Agreement. Upon termination of this Agreement for any reason, Business Associate will:

- A. Retain only that PHI that is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
- B. Return to HCA or, if agreed to by HCA, destroy the PHI that the Business Associate and any subcontractor of Business Associate still has in any form (for purposes of this subsection 5.3, to destroy PHI is to render it unusable, unreadable, or indecipherable to the extent necessary to establish it is not Unsecured PHI, and Business Associate will provide HCA with appropriate evidence of destruction within ten days of the destruction);
- C. Continue to use appropriate safeguards and comply with the Security Rule with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Agreement, for as long as Business Associate retains any of the PHI (for purposes of this subsection 5.03, If the PHI is destroyed it shall be rendered unusable, unreadable or indecipherable to the extent necessary to establish it is not Unsecured PHI. Business Associate will provide HCA with appropriate evidence of destruction);
- D. Not use or disclose any PHI retained by Business Associate other than for the purposes for which the PHI was retained and subject to the same conditions that applied before termination;
- E. Return to HCA, or, if agreed to by HCA, destroy, the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities; and
- F. Business Associate's obligations relating to providing information to the Secretary and other government survive the termination of this Agreement for any reason.

Section 5.04 Successor

Nothing in this Agreement limits the obligations of Business Associate under the Contract regarding giving data to HCA or to a successor Business Associate after termination of the Contract.

Article VI. Miscellaneous

Section 6.01 Amendment

The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

Section 6.02 Interpretation

Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

Section 6.03 HCA Contact for Reporting and Notification Requirements

Business Associate will address all reporting and notification communications required in this Agreement to:

HCA Privacy Officer
Washington State Health Care Authority
626 8th Avenue SE
PO Box 42700
Olympia, WA 98504-2700
Telephone: 360-725-1116
E-mail: PrivacyOfficer@hca.wa.gov

Exhibit G-2 Data Share Agreement

Purpose of the DSA

The purpose of this Data Share Agreement (DSA) is to identify, describe and protect the Data being provided by HCA from the Receiving Party. The purpose for sharing the Data is for the Receiving Party to

Justification and Authority for Data Sharing

The Data to be shared under this DSA are necessary to comply with

[Explain the justification for the data sharing and provide the statutory or rule authority for the data to be shared.]

Definitions

“**Agreement**” means this Data Share Agreement.

“**Authorized User**” means an individual or individuals with an authorized business need to access HCA’s Confidential Information under this Agreement.

“**Breach**” means the unauthorized acquisition, access, use, or disclosure of Data shared under this Agreement that compromises the security, confidentiality or integrity of the Data.

“**CFR**” means the Code of Federal Regulations. All references in this Data Share Agreement to CFR chapters or sections will include any successor, amended, or replacement regulation. The CFR may be accessed at <http://www.ecfr.gov/cgi-bin/ECFR?page=browse>

“**Client**” means an individual who is eligible for or receiving Medicaid services.

“**Confidential Information**” means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential Information comprises both Category 3 and Category 4 Data as described in Section 0, *Data Classification*, which includes, but is not limited to, Personal Information and Protected Health Information. For purposes of this DSA, Confidential Information means the same as “Data.”

“**Contract Administrator**” means the individual designated to receive legal notices and to administer, amend, or terminate this Agreement.

“**Contract Manager**” means the individual identified on the cover page of this DSA who will provide oversight of the activities conducted under this DSA.

“**Data**” means the information that is disclosed or exchanged as described by this Data Share Agreement. For purposes of this DSA, Data means the same as “Confidential Information.”

“**Disclosure**” means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

“**DSA**” means this Data Share Agreement.

“**HCA**” means the state of Washington Health Care Authority, any section, unit or other entity of HCA, or any of the officers or other officials lawfully representing HCA.

“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.

“Protected Health Information” or **“PHI”** means information that relates to the provision of health care to an individual; the past, present, or future physical or mental health or condition of an individual; or past, present or future payment for provision of health care to an individual. 45 CFR 160 and 164. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe, can be used to identify the individual. 45 CFR 160.103. PHI is information transmitted, maintained, or stored in any form or medium. 45 CFR 164.501. PHI does not include education records covered by the Family Educational Right and Privacy Act, as amended, 20 USC 1232g(a)(4)(b)(iv).

“ProviderOne” means the Medicaid Management Information System, which is the State’s Medicaid payment system managed by HCA.

“RCW” means the Revised Code of Washington. All references in this Agreement to RCW chapters or sections will include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at: <http://apps.leg.wa.gov/rcw/>.

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

“Receiving Party” means the entity that is identified on the cover page of this DSA and is a party to this Agreement, and includes the entity’s owners, members, officers, directors, partners, trustees, employees, and Subcontractors and their owners, members, officers, directors, partners, trustees, and employees.

“Subcontract” means any separate agreement or contract between the Receiving Party and an individual or entity (“Subcontractor”) to perform any duties that give rise to a business requirement to access the Data that is the subject of this DSA.

“Subcontractor” means a person or entity that is not in the employment of the Receiving Party, who is performing services or any duties that give rise to a business requirement to access the Data that is the subject of this DSA.

“USC” means the United States Code. All references in this Data Share Agreement to USC chapters or sections will include any successor, amended, or replacement statute. The USC may be accessed at <http://uscode.house.gov/>

“Use” includes the sharing, employment, application, utilization, examination, or analysis, of Data.

“WAC” means the Washington Administrative Code. All references in this Agreement to WAC chapters or sections will include any successor, amended, or replacement regulation. Pertinent WAC chapters or sections can be accessed at: <http://apps.leg.wa.gov/wac/>.

Description of Data to be Shared

The Data to be shared is set out in attached Schedule 1: *Description of Shared Data*.

The Data will be provided *[how often and how shared – example: one time via an HCA Secure FTP site. HCA will provide access to the Receiving Party.]*

Data Classification

The State classifies data into categories based on the sensitivity of the data pursuant to the Security policy and standards promulgated by the Office of the state of Washington Chief Information Officer. (See Section 4, *Data Security*, of *Securing IT Assets Standards* No. 141.10 in the *State Technology Manual* at <https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets>. Section 4 is hereby incorporated by reference into this Agreement.)

The Data that is the subject of this DSA is classified as indicated below:

Category 1 – Public Information

Public information is information that can be or currently is released to the public. It does not need protection from unauthorized disclosure, but does need integrity and availability protection controls.

Category 2 – Sensitive Information

Sensitive information may not be specifically protected from disclosure by law and is for official use only. Sensitive information is generally not released to the public unless specifically requested.

Category 3 – Confidential Information

Confidential information is information that is specifically protected from disclosure by law. It may include but is not limited to:

- Personal Information about individuals, regardless of how that information is obtained;
- Information concerning employee personnel records;
- Information regarding IT infrastructure and security of computer and telecommunications systems;

Category 4 – Confidential Information Requiring Special Handling

Confidential information requiring special handling is information that is specifically protected from disclosure by law and for which:

- Especially strict handling requirements are dictated, such as by statutes, regulations, or agreements;
- Serious consequences could arise from unauthorized disclosure, such as threats to health and safety, or legal sanctions.

Constraints on Use of Data

The Data being shared/accessed is owned and belongs to HCA.

This Agreement does not constitute a release of the Data for the Receiving Party's discretionary use. Receiving Party must use the Data received or accessed under this DSA only to carry out the purpose and justification of this agreement as set out in sections 2, *Purpose of the Data Sharing*, and 3, *Justification and Authority for Data Sharing*. Any analysis, use, or reporting that is not within the Purpose of this DSA is not permitted without HCA's prior written consent.

Any disclosure of Data contrary to this Agreement is unauthorized and is subject to penalties identified in law.

Security of Data

Data Protection

The Receiving Party must protect and maintain all Confidential Information gained by reason of this Agreement against unauthorized use, access, disclosure, modification or loss. This duty requires the Receiving Party to employ reasonable security measures, which include restricting access to the Confidential Information by:

- Allowing access only to staff that have an authorized business requirement to view the Confidential Information.
- Physically securing any computers, documents, or other media containing the Confidential Information.

Data Security Standards

Receiving Party must comply with the Data Security Requirements set out in Exhibit A and the Washington OCIO Security Standard, 141.10 (<https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets>.) The Security Standard 141.10 is hereby incorporated by reference into this Agreement.

Data Disposition

Upon request by HCA, or at the end of the DSA term, or when no longer needed, Confidential Information/Data must be disposed of as set out in Exhibit A, Section 5 *Data Disposition*, except as required to be maintained for compliance or accounting purposes. Receiving Party will provide written certification of disposition at HCA's request.

Data Confidentiality and Non-Disclosure

Data Confidentiality.

The Receiving Party will not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Agreement for any purpose that is not directly connected with the purpose and justification of this DSA, as set out in Sections 0 and 0 above, except: (a) as provided by law; or (b) with the prior written consent of the person or personal representative of the person who is the subject of the Confidential Information.

Non-Disclosure of Data

The Receiving Party must ensure that all employees or Subcontractors who will have access to the Data described in this Agreement (including both employees who will use the Data and IT support staff) are instructed and made aware of the use restrictions and protection requirements of this DSA before gaining access to the Data identified herein. The Receiving Party will also instruct and make any new employee aware of the use restrictions and protection requirements of this DSA before they gain access to the Data.

The Receiving Party will ensure that each employee or Subcontractor who will access the Data signs the *User Agreement on Non-Disclosure of Confidential Information*, Exhibit B hereto. The Receiving Party will retain the signed copy of the *User Agreement on Non-Disclosure of Confidential Information* in each employee's personnel file for a minimum of six years from the date the employee's access to the data ends. The documentation must be available to HCA upon request.

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 CFR Part 160 and Part 164; Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2; and Safeguarding Information on Applicants and Beneficiaries, 42 CFR

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.

The Receiving Party accepts full responsibility and liability for any noncompliance by itself, its employees, and its Subcontractors with these laws and any violations of the Agreement.

Public Disclosure (*Public Agency*)

If the Receiving Party receives a public records request under Chapter 42.56 RCW for any records containing Data subject to this DSA, Receiving Party agrees to notify the HCA Public Disclosure Officer within five (5) business days and to follow the procedure set out in this section before disclosing any records. The HCA Public Disclosure Officer can be contacted at PublicDisclosure@hca.wa.gov.

The Receiving Party must provide a copy of the records with proposed redactions to HCA when they are available and ready. HCA will respond within ten (10) business days of receipt of the redacted records to identify concerns with disclosure of the records, propose any changes to the Receiving Party redactions, or request more time if needed. If Receiving Party disagrees with any of HCA's concerns or proposed changes, Receiving Party must notify HCA of that disagreement and provide HCA with a minimum of fifteen (15) business days to obtain a restraining order or injunction under RCW 42.56.540 before disclosing any records.

Public Disclosure (*non-Public Agency*)

Receiving Party acknowledges that HCA is subject to the Public Records Act (Chapter 42.56 RCW). This Agreement will be a "public record" as defined in Chapter 42.56 RCW. Any documents submitted to HCA by Receiving Party may also be construed as "public records" and therefore subject to public disclosure.

Data Shared with Subcontractors

The Receiving Party will not enter into any Subcontract without the express, written permission of HCA, which will approve or deny the proposed contract in its sole discretion. If Data access is to be provided to a Subcontractor under this DSA, the Receiving Party must include all of the Data security terms, conditions and requirements set forth in this Agreement in any such Subcontract. In no event will the existence of the Subcontract operate to release or reduce the liability of the Receiving Party to HCA for any breach in the performance of the Receiving Party's responsibilities.

HIPAA Compliance

The parties to this DSA have entered into a Business Associate Agreement dated [DATE] (HCA Contract Number K) that sets out Receiving Party's obligations for compliance with HIPAA, the HIPAA Rules, and all attendant regulations as promulgated by the U.S. Department of Health and Human Services, Office for Civil Rights, as applicable.

Non PHI Data Breach Notification

The Breach of non-PHI Data shared under this Agreement must be reported to the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov within five (5) business days of discovery. The Receiving Party must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by applicable law or reasonably requested by HCA in order to meet its regulatory obligations.

Amendments and Alterations

This Agreement, or any term or condition, may be modified only by a written amendment signed by all parties. Only personnel authorized to bind each of the parties will sign an amendment.

Assignment

The Receiving Party will not assign rights or obligations derived from this Agreement to a third party without the prior, written consent of HCA and the written assumption of the Receiving Party's obligations by the third party.

Dispute Resolution *(Option 1: non-Public Agency)*

The parties will use their best, good faith efforts to cooperatively resolve disputes and problems that arise in connection with this Agreement. Both parties will continue without delay to carry out their respective responsibilities under this Agreement while attempting to resolve any dispute. When a genuine dispute arises between HCA and the Receiving Party regarding the terms of this Agreement or the responsibilities imposed herein and it cannot be resolved between the parties' Contract Managers, either party may initiate the following dispute resolution process.

The initiating party will reduce its description of the dispute to writing and deliver it to the responding party (email acceptable). The responding party will respond in writing within five (5) Business Days (email acceptable). If after five (5) additional Business Days the parties have not resolved the Dispute, it will be submitted to the HCA Director, who may employ whatever dispute resolution methods the Director deems appropriate to resolve the dispute.

A party's request for a dispute resolution must:

- Be in writing;
- Include a written description of the dispute;
- State the relative positions of the parties and the remedy sought;
- State the Contract Number and the names and contact information for the parties;

This dispute resolution process constitutes the sole administrative remedy available under this Agreement. There is no right under this Agreement to an adjudicative proceeding under the Administrative Procedure Act.

Dispute Resolution *(Option 2: Agencies)*

The parties agree to work in good faith to resolve all conflicts at the lowest level possible. However, if the parties are not able to promptly and efficiently resolve, through direct informal contact, any dispute concerning the interpretation, application, or implementation of any section of this Agreement, either party may reduce its description of the dispute in writing, and deliver it to the other party for consideration. Once received, the assigned managers or designees of each party will work to informally and amicably resolve the issue within five (5) business days. If managers or designees are unable to come to a mutually acceptable decision within five (5) business days, they may agree to issue an extension to allow for more time.

If the dispute cannot be resolved by the managers or designees, the issue will be referred through each Agency's respective operational protocols, to the Director of HCA ("Director") and the Receiving Party's Agency Head ("Agency Head") or their deputies or designated delegates. Both parties will be responsible for submitting all relevant documentation, along with a short statement as to how they believe the dispute should be settled, to the Director and Agency Head.

Upon receipt of the referral and relevant documentation, the Director and Agency Head will confer to consider the potential options of resolution, and to arrive at a decision within fifteen (15) business days. The Director and Agency Head may appoint a review team, a facilitator, or both, to assist in the resolution

of the dispute. If the Director and Agency Head are unable to come to a mutually acceptable decision within fifteen (15) business days, they may agree to issue an extension to allow for more time.

The final decision will be put in writing, and will be signed by both the Director and Agency Head. If the agreement is active at the time of resolution, the parties will execute an amendment or change order to incorporate the final decision into the agreement. The decision will be final and binding as to the matter reviewed and the dispute will be settled in accordance with the terms of the decision.

If the Director and Agency Head are unable to come to a mutually acceptable decision, the parties will request intervention by the Governor, per RCW 43.17.330, in which case the governor may employ whatever dispute resolution methods that the governor deems appropriate in resolving the dispute.

Both parties agree that, the existence of a dispute notwithstanding, the parties will continue without delay to carry out all respective responsibilities under this agreement that are not affected by the dispute.

Entire Agreement

This Agreement, including all documents attached to or incorporated by reference, contains all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Agreement, will be deemed to exist or bind the parties.

Governing Law and Venue

This Agreement is governed by, and will be construed and enforced in accordance with, the laws of the State of Washington. In the event of a lawsuit involving this Agreement, jurisdiction is proper only in the Superior Court of Washington, and venue is proper only in Thurston County, Washington.

Incorporated Documents and Order of Precedence

Each of the documents listed below is, by this reference, incorporated into this Agreement as though fully set forth herein.

- Schedule 1 – Description of Shared Data
- Exhibit A – Data Security Requirements
- Exhibit B – User Agreement on Non-Disclosure of Confidential Information
- Section 4 of OCIO 141.10, *Securing Information Technology Assets Standards: Data Security* (<https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets.>)

In the event of any inconsistency in this Agreement, the inconsistency will be resolved in the following order of precedence:

- Applicable federal and state statutes, laws, and regulations;
- Sections of this Data Share Agreement;
- Attachments, Exhibits and Schedules to this Data Share Agreement.

Inspection

No more than once per quarter during the term of this Agreement and for six (6) years following termination or expiration of this Agreement, HCA will have the right at reasonable times and upon no less than five (5) business days prior written notice to access the Receiving Party's records and place of business for the purpose of auditing, and evaluating the Receiving Party's compliance with this Agreement and applicable laws and regulations.

Insurance

HCA certifies that it is self-insured under the State's self-insurance liability program, as provided by RCW 4.92.130, and will pay for losses for which HCA is found liable.

The Receiving Party certifies that it is self-insured, is a member of a risk pool, or maintains the types and amounts of insurance identified below and will provide certificates of insurance to that effect to HCA upon request.

Required Insurance or Self-Insured Equivalent

- Commercial General Liability Insurance (CGL) covering the risks of bodily injury (including death), property damage, and contractual liability, with a limit of not less than \$1 million per occurrence, \$2 million aggregate.
- Cyber Liability/Privacy Breach Response Coverage. For the term of this Agreement and 3 years following its termination or expiration, Receiving Party must maintain insurance to cover costs incurred in connection with a security incident, privacy Breach, or potential compromise of Data including:
 - Computer forensics assistance to assess the impact of a Data Breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach notification laws;
 - Notification and call center services for individuals affected by a security incident, or privacy Breach;
 - Breach resolution and mitigation services for individuals affected by a security incident or privacy Breach, including fraud prevention, credit monitoring, and identity theft assistance; and
 - Regulatory defense, fines, and penalties from any claim in the form of a regulatory proceeding resulting from a violation of any applicable privacy or security law(s) or regulation(s).
- If any of the required policies provide coverage on a claims-made basis:
 - The retroactive date must be shown and must be before the date of the Agreement or of the beginning of Agreement work.
 - If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date prior to the Agreement effective date, the Receiving Party must purchase "extended reporting" coverage for a minimum of 3 years after completion of Agreement work.

The State of Washington, including but not limited to HCA, must be named as additional insureds.

In the event of cancellation, non-renewal, revocation or other termination of any insurance coverage required by this Agreement, Receiving Party must provide written notice of such to HCA within one (1) Business Day of Receiving Party's receipt of such notice.

By requiring insurance herein, HCA does not represent that coverage and limits will be adequate to protect Receiving Party. Such coverage and limits will not limit Receiving Party's liability under the indemnities and reimbursements granted to HCA in this Agreement.

Legal Notices

Any other notice or demand or other communication required or permitted to be given under this DSA or applicable law will be effective only if it is in writing and signed by the applicable party, properly addressed, and either delivered in person, or by a recognized courier service, or deposited with the

United States Postal Service as first-class mail, postage prepaid certified mail, return receipt requested, to the parties at the addresses provided in this section.

To Receiving Party at:

[Address of Receiving Party]

To HCA at:

Contract Administrator

Division of Legal Services

Health Care Authority

P. O. Box 42702

Olympia, Washington 98504-2702

Notices will be effective upon receipt or four (4) Business Days after mailing, whichever is earlier. The notice address and information provided above may be changed by written notice given as provided above.

Maintenance of Records

The Receiving Party must maintain records related to compliance with this Agreement for six (6) years after expiration or termination of this Agreement. HCA or its designee will have the right to access those records during that six-year period for purposes of auditing.

Responsibility

HCA and the Receiving Party will each be responsible for their own acts and omissions and for the acts and omissions of their agents and employees. Each party to this Agreement must defend, protect, and hold harmless the other party, or any of the other party's agents, from and against any loss and all claims, settlements, judgments, costs, penalties, and expenses, including reasonable attorney fees, arising from any willful misconduct or dishonest, fraudulent, reckless, unlawful, or negligent act or omission of the first party, or agents of the first party, while performing under the terms of this Agreement, except to the extent that such losses result from the willful misconduct, or dishonest, fraudulent, reckless, unlawful, or negligent act or omission on the part of the second party. 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.

Severability

The provisions of this Agreement are severable. If any provision of this Agreement is held invalid by any court of competent jurisdiction, that invalidity will not affect the other provisions of this Agreement and the invalid provision will be considered modified to conform to the existing law.

Survival Clauses

The terms and conditions contained in this Agreement that by their sense and context are intended to survive the expiration or other termination of this Agreement must survive. Surviving terms include, but

are not limited to: *Constraints on Use of Data, Security of Data, Data Confidentiality and Non-Disclosure of Data, Data Breach Notification and Obligations, Dispute Resolution, Inspection, Insurance, Maintenance of Records, and Responsibility.*

Term and Termination

Term. This Agreement will begin on [BEGINNING DATE] or date of execution, whichever is later, and continue through [ENDING DATE], unless terminated sooner as provided in this Section.

Termination for Convenience. Either HCA or the Receiving Party may terminate this Agreement for convenience with thirty (30) calendar days' written notice to the other. However, once Data is accessed by the Receiving Party, this Agreement is binding as to the confidentiality, use and disposition of all Data received as a result of access, unless otherwise agreed in writing.

Termination for Cause. HCA may terminate this Agreement for default, in whole or in part, by written notice to the Receiving Party, if HCA has a reasonable basis to believe that the Receiving Party has: (1) failed to perform under any provision of this Agreement; (2) violated any law, regulation, rule, or ordinance applicable to this Agreement; and/or (3) otherwise breached any provision or condition of this Agreement.

Before HCA terminates this Agreement for default, HCA will provide the Receiving Party with written notice of its noncompliance with the Agreement and provide the Receiving Party a reasonable opportunity to correct its noncompliance. If the Receiving Party does not correct the noncompliance within the period of time specified in the written notice of noncompliance, HCA may then terminate the Agreement. HCA may terminate the Agreement for default without such written notice and without opportunity for correction if HCA has a reasonable basis to believe that a Client's health or safety is in jeopardy. The determination of whether or not the Receiving Party corrected the noncompliance will be made by HCA, in its sole discretion.

Waiver

Waiver of any breach or default on any occasion will not be deemed to be a waiver of any subsequent breach or default. Any waiver will not be construed to be a modification of the terms and conditions of this Agreement.

Signatures and Counterparts

The signatures on the cover page indicate agreement between the parties. The parties may execute this Agreement in multiple counterparts, each of which is deemed an original and all of which constitute only one agreement.

Schedule 1: Description of Shared Data

Exhibit A – Data Security Requirements

1. Definitions

In addition to the definitions set out in section 0, *Definitions*, of the Data Share Agreement, the definitions below apply to this Exhibit.

“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.

- Passwords for external authentication must be a minimum of 10 characters long.
- Passwords for internal authentication must be a minimum of 8 characters long.
- Passwords used for system service or service accounts must be a minimum of 20 characters long.

“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).

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

“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.

“Transmitting” means the transferring of data electronically, such as via email, SFTP, webservices, AWS Snowball, etc.

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

“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

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.

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:

3.1. Data at Rest:

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

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

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

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

3.3. 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 DSA 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.

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

- on media (e.g. hard disk, optical disc, tape, etc.) which will contain only HCA Data; or
- in a logical container on electronic media, such as a partition or folder dedicated to HCA's Data; or
- in a database that will contain only HCA Data; or
- within a database and will be distinguishable from non-HCA Data by the value of a specific field or fields within database records; or
- when stored as physical paper documents, physically segregated from non-HCA Data in a drawer, folder, or other container.

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 Exhibit.

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>).

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 Exhibit may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

User Agreement on Non-Disclosure of Confidential Information

Your organization has entered into a Data Share Agreement with the state of Washington Health Care Authority (HCA) that will allow you access to data and records that are deemed Confidential Information as defined below. Prior to accessing this Confidential Information you must sign this *User Agreement on Non-Disclosure of Confidential Information*.

Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Protected Health Information and Personal Information. For purposes of the pertinent Data Share Agreement, Confidential Information means the same as "Data."

"Protected Health Information" means information that relates to: the provision of health care to an individual; the past, present, or future physical or mental health or condition of an individual; or the past, present or future payment for provision of health care to an individual and includes demographic information that identifies the individual or can be used to identify the individual.

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

Regulatory Requirements and Penalties

State laws (including, but not limited to, RCW 74.04.060, RCW 74.34.095, and RCW 70.02.020) and federal regulations (including, but not limited to, HIPAA Privacy and Security Rules, 45 CFR Part 160 and Part 164; Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2; and Safeguarding Information on Applicants and Beneficiaries, 42 CFR 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.

User Assurance of Confidentiality

In consideration for HCA granting me access to the Confidential Information that is the subject of this Agreement, I agree that I:

Will access, use, and disclose Confidential Information only in accordance with the terms of this Agreement and consistent with applicable statutes, regulations, and policies.

Have an authorized business requirement to access and use the Confidential Information.

Will not use or disclose any Confidential Information gained by reason of this Agreement for any commercial or personal purpose, or any other purpose that is not directly connected with this Agreement.

Will not use my access to look up or view information about family members, friends, the relatives or friends of other employees, or any persons who are not directly related to my assigned job duties.

Will not discuss Confidential Information in public spaces in a manner in which unauthorized individuals could overhear and will not discuss Confidential Information with unauthorized individuals, including spouses, domestic partners, family members, or friends.

Will protect all Confidential Information against unauthorized use, access, disclosure, or loss by employing reasonable security measures, including physically securing any computers, documents, or other media containing Confidential Information and viewing Confidential Information only on secure workstations in non-public areas.

Will not make copies of Confidential Information, or print system screens unless necessary to perform my assigned job duties and will not transfer any Confidential Information to a portable electronic device or medium, or remove Confidential Information on a portable device or medium from facility premises, unless the information is encrypted and I have obtained prior permission from my supervisor.

Will access, use or disclose only the "minimum necessary" Confidential Information required to perform my assigned job duties.

Will not distribute, transfer, or otherwise share any software with anyone.

Will forward any requests that I may receive to disclose Confidential Information to my supervisor for resolution and will immediately inform my supervisor of any actual or potential security breaches involving Confidential Information, or of any access to or use of Confidential Information by unauthorized users.

Understand at any time, HCA may audit, investigate, monitor, access, and disclose information about my use of the Confidential Information and that my intentional or unintentional violation of the terms of this Agreement may result in revocation of privileges to access the Confidential Information, disciplinary actions against me, or possible civil or criminal penalties or fines.

Understand that my assurance of confidentiality and these requirements will continue and do not cease at the time I terminate my relationship with my employer.

Signature

Print User's Name	User Signature	Date

Exhibit H

Business Interruption and Disaster Management Plan

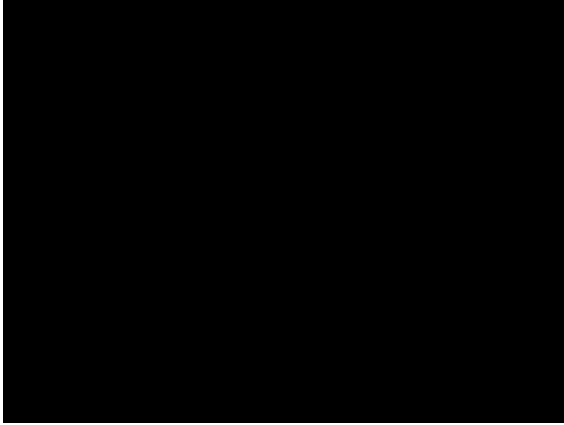


Exhibit I HCA Request for Proposals No. K1807

HCA's RFP K1807 consists of the following, all of which are a part of this Exhibit I:

1. RFP K1807, including Appendices 1-7
2. RFP Amendments 1-10
3. The Written Questions and Agenda for Oral Presentations, provided on or about July 19, 2017
4. HCA's BAFO Request, provided on or about August 25, 2017

Exhibit J Contractor Response to RFP No. K1807

Contractor's Response to the RFP shall consist of the following, all of which are a part of this Exhibit J:

1. Contractor's written Proposal submitted on or about April 21, 2016, along with materials submitted in clarification of such Proposal
2. Contractor's written responses provided during the Oral Presentation phase of the RFP, submitted on or about August 2, 2017
3. Contractor's BAFO Response, submitted on or about September 11, 2017.

Exhibit K

OCIO Policies



K1807-ExK-OCS
Design Review Chec



K1807-ExK-OCIO
141.10.pdf

Exhibit L

Implementation Plan



K1807-ExL-Implementation Project Plan.



K1807-ExL-UMP Implementation Res

Exhibit M

Paying for Value Survey



K1807-Ex_M-Paying
_for_Value_Survey.xl

Exhibit N

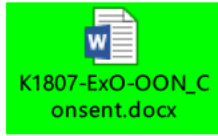
Adding & Removing ACN Providers

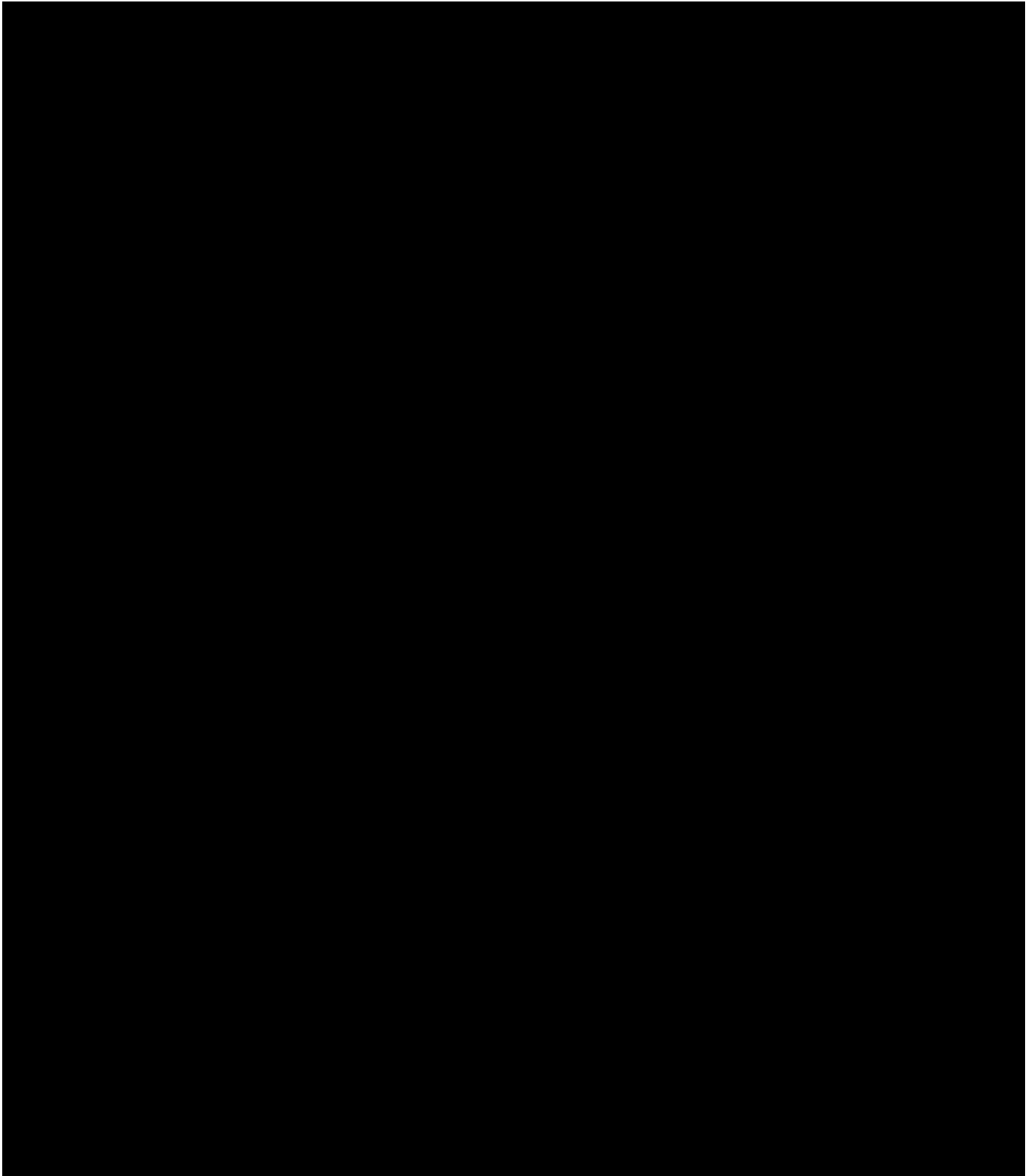


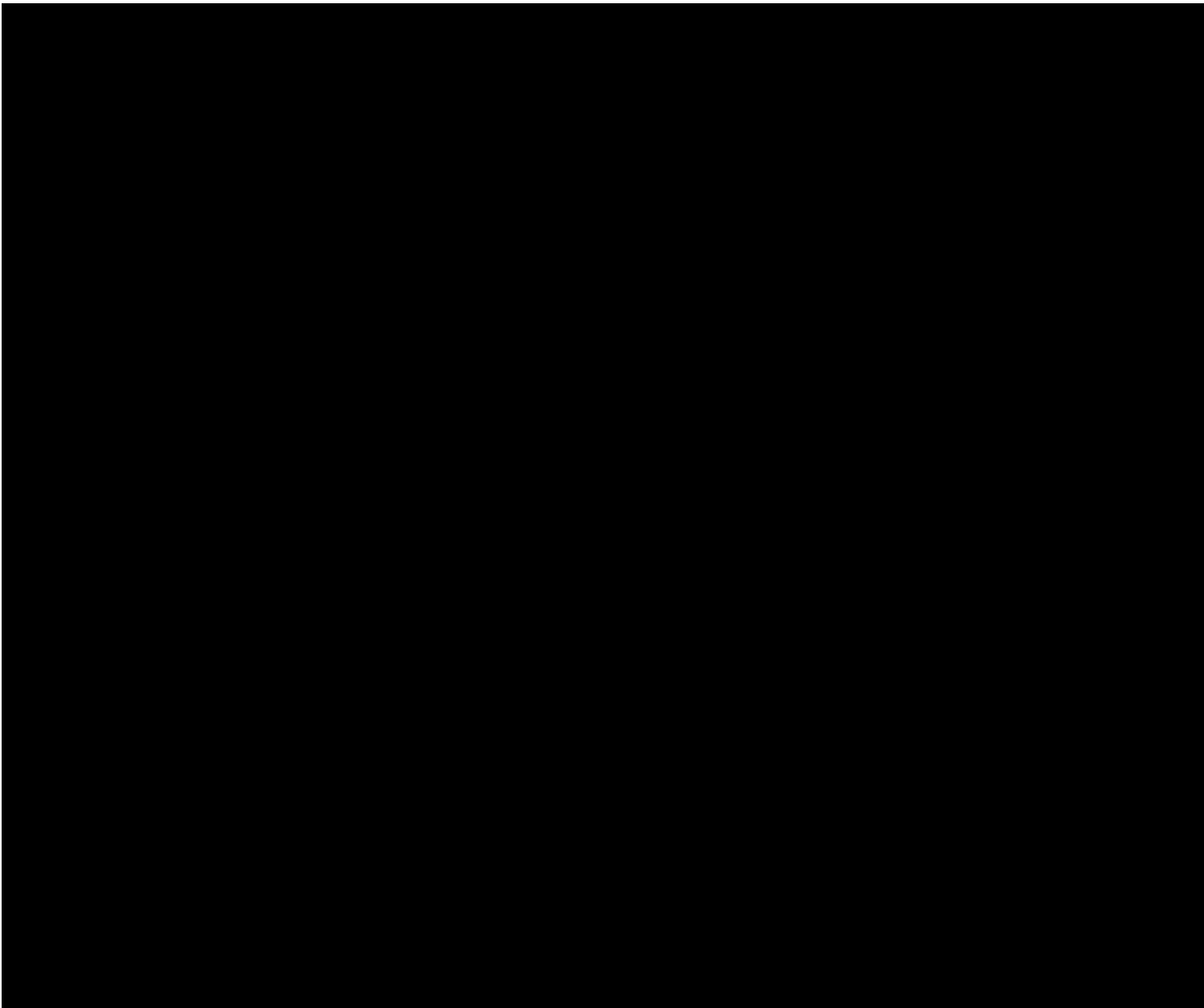
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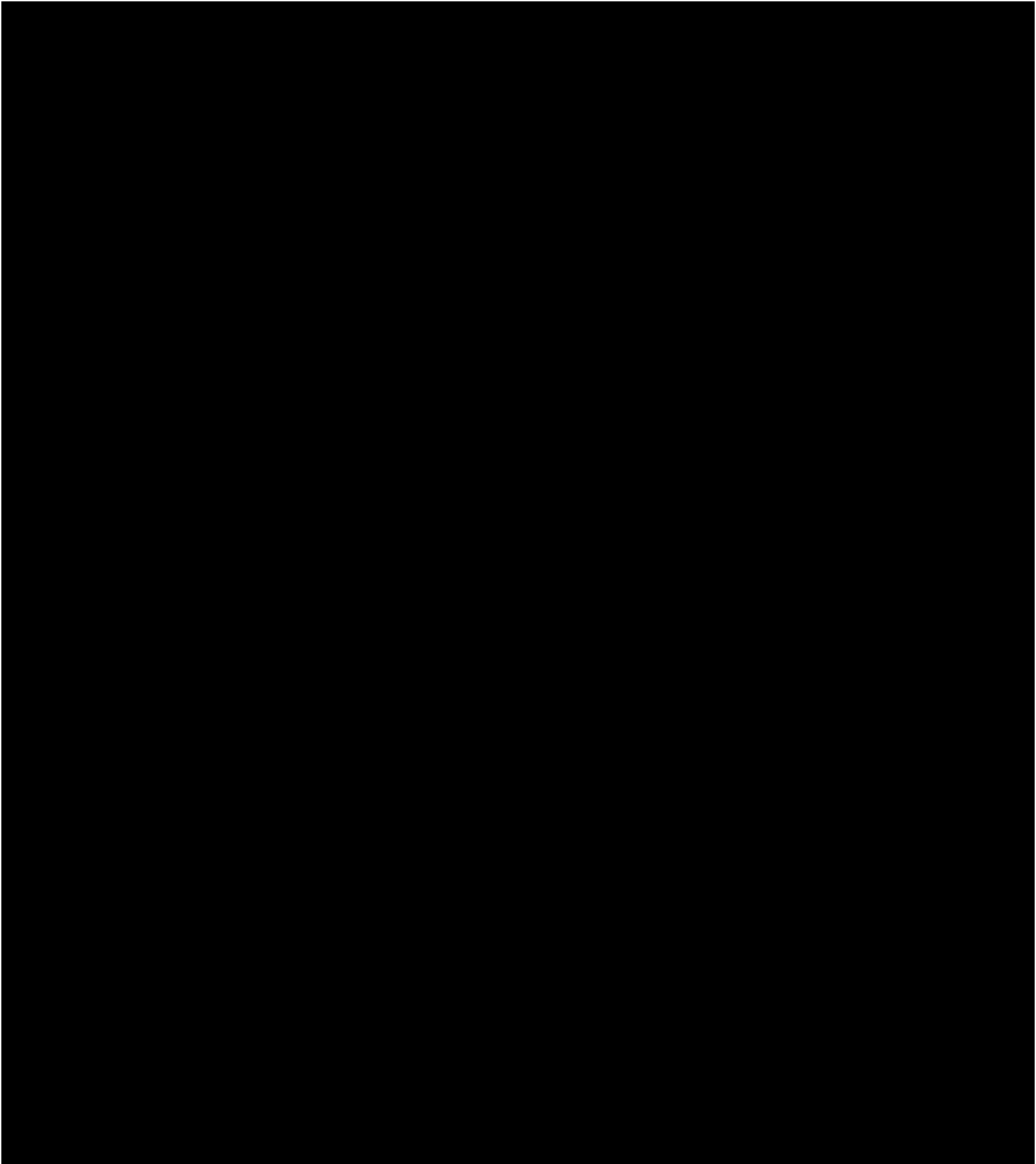
Exhibit O

Out-of-Network Provider Consent Process









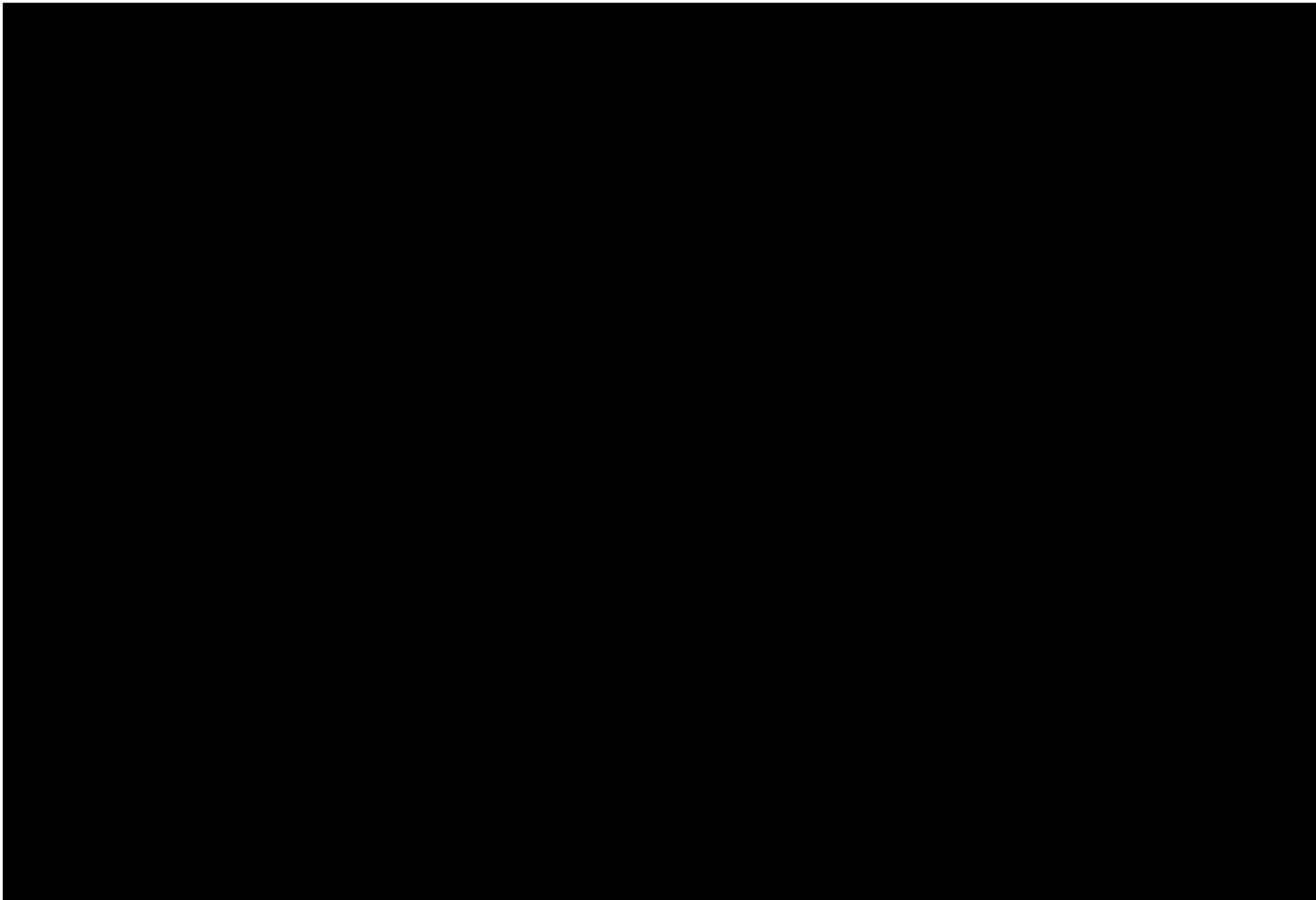


Exhibit R ACN Reports

The following table shows the list of reports Contractor is required to provide to HCA over the term of this Contract to be used in measuring Contractor’s performance in regard to the “ACN Reporting” Performance Guarantee described in Section 6.2.2.

Deliverable	Description	Frequency	Number of Unique Reports	Total Reports*
Claims data extract - Medical and Behavior Health	Claims data on utilization of medical and behavioral health services.	Monthly	2	24
Enrollment Eligibility File	File on the designated or tentatively-attributed members of an ACP Network.	Monthly	2	24
Member Demographics	Demographics data on designated or tentatively-attributed members of an ACP Network.	Monthly	2	24
In-patient Admission Report	File of daily inpatient hospital admissions, current stays, and discharges of designated or tentatively-attributed members for an ACP Network.	Each business day	2	520
Tentative Attribution & Designated Roster	Current month designated or tentatively-attributed members of an ACP Network.	Monthly	2	24
Definitive Attribution	Final attributed members assigned to each Network from the previous performance year.	Annual	2	2

High cost claimant reports - supplemental	Report of designated and attributed members at risk to become high-cost users of health care services.	Monthly	2	24
Annual Eligibility (4 files Jan, Feb March, April)	File of annual designated and attributed members from the previous performance year.	4 Times per Year	2	8
Annual Claims - Medical and Behavior Health (4 files Jan, Feb March, April)	File of claims from designated and attributed members from the previous performance year.	4 Times per Year	2	8
Historical Claims - Medical and Behavior Health	One-time file of historical claims of UMP Classic and CDHP members who attributed to providers in either ACP Network. Produced before 2016 to assist both Networks in launching ACP.	One-time	1	1
Control Totals Claims - Med & BH	Number of medical and behavioral health records.	Monthly	2	24
Control Totals Eligibility/Enrollment	Number of enrollment records.	Monthly	2	24
Control Totals Member Demographics	Number of member demographic records.	Monthly	2	24

Control Totals Tentative Attribution & Designated Roster	Number of records for designated and tentatively-attributed records.	Monthly	2	24
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*The "Total Reports" figure is the number of unique reports for a single year.

