



WASHINGTON STATE HEALTH CARE AUTHORITY  
OLYMPIA, WASHINGTON

QUALIFIED HEALTH HOMES

Request for Applications for Designation (RFA) Number 12-005 RELEASE C for Coverage  
Areas #s1, 2, and #6

PROJECT TITLE: Qualified Health Homes

APPLICATION DUE DATE FOR RELEASE C: July 12, 2013, 3:00pm Pacific Time

Coverage Area -- 1: Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and  
Thurston Counties

Coverage Area -- 2: Island, San Juan, Skagit, and Whatcom Counties

Coverage Area -- 6: Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille,  
Spokane, Stevens, and Whitman

**NOTE: Release C includes revisions from Release A and B, including changes in the Exhibits.**

EXPECTED TIME PERIOD FOR CONTRACT: Each Awarded Contract shall have an initial Period of Performance of two (2) years. The start and end date of the two (2) year period of performance is based upon the start date for each release. HCA shall have the option at its sole discretion to extend any contract for an additional one to two years.

PROVIDER ELIGIBILITY: This solicitation is open to those providers that satisfy the minimum qualifications stated herein and that are available for work in Washington State.

**Communications:**

Upon each release of this Request for Applications, all communications in regard to this opportunity shall be directed in writing to the RFA Coordinator named below.

RFA # 12-005C  
Contract Services  
Washington State Health Care Authority  
PO Box 42702  
Olympia, Washington 98504-2702  
Email: [contracts@hca.wa.gov](mailto:contracts@hca.wa.gov)  
Attn: Charles Pugh

Communications regarding this Request for Applications with any HCA staff other than the RFA Coordinator named above may result in disqualification.

The primary method of communication regarding this application will be email. Additional information, including responses to RFA questions or amendments will be posted at the following HCA website: [www.hca.wa.gov/rfp.html](http://www.hca.wa.gov/rfp.html).

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## 1. INTRODUCTION

The Washington State Health Care Authority (HCA), in conjunction with the Washington State Department of Social and Health Services, invite interested applicants to submit applications for designation as a *Health Home* in the jointly administered *Health Home* Program.

### 1.1 BACKGROUND AND PURPOSE

#### 1.1.1 Background

Under Washington State's approach, *Health Homes* are the bridge to integrate care within existing health delivery systems. *Health Home* implementation is authorized by Section 2703 of the federal Patient Protection and Affordable Care Acts, the Managed Fee-for-Service Demonstration model, and Substitute Senate Bill 5394 from the 2011 legislative session.

A designated *Health Home* provider (aka Lead Entity) is the central point for directing patient-centered care for high risk, high cost beneficiaries in a specified geographic coverage area. Each designated *Health Home* provider is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. Each designated *Health Home* provider will provide timely post discharge follow-up, and improve patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports.

The hallmark of *Health Homes* is a care coordinator, assigned to a Medicaid or Medicare/Medicaid beneficiary embedded in community based settings to effectively manage the full-breadth of beneficiary needs.

*Health Homes* must be qualified by the state of Washington Medicaid program, and agree to comply with all Medicaid program requirements. Refer to Exhibit B, Definitions.

Implementation of Washington State's *Health Home* program is contingent upon Federal approval of Washington's State Plan Amendment (SPA). Any changes to the SPA required by the Centers for Medicare and Medicaid Services (CMS) may require revisions to the RFA and/or any *Health Home* contracts resulting from this application process, which HCA may change at any time, in its sole discretion.

#### Qualification

There is only one (1) qualification process that encompasses all the providers in the *Health Home* network. Only Lead Entities must apply to become a Qualified *Health Homes*. Care Coordination Organizations qualify under a Lead Entity's application by virtue of their subcontracts with the Lead Entity.

### **1.1.2 Purpose**

The purpose of this solicitation is to provide HCA with a limited number of geographically based qualified *Health Home* providers, who through their respective networks, provide intensive *Health Home* care coordination services to high-cost, high-need Medicaid and Medicaid/Medicare beneficiaries to ensure that services are integrated and coordinated across medical, mental health, chemical dependency and long term services and supports. Beneficiaries who are eligible for *Health Homes* receive direct services from HCA and DSHS but the *Health Home* contracts are based in HCA.

## **1.2 SCOPE**

*Health Home* implementation will be statewide, using a “phase in” approach, by coverage areas with dual goals to improve the delivery of both health care and social services. *Health Home* services will be available to both managed care and Fee-for-Service beneficiaries. *Health Homes* provide an opportunity to build a person-centered system that achieves improved outcomes for beneficiaries and increases the quality and efficiency of the State’s Medicaid program. *Health Homes* provide targeted and intensive interventions that improve health outcomes, beneficiary’s experience in accessing and navigating the care system and reduce preventable hospitalizations, emergency room visits and unnecessary institutionalizations.

*Health Homes* are defined by a set of six (6) specific care coordination services:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services, if relevant; and
6. The use of health information technology to link services, as feasible and appropriate.

For a detailed description of the six (6) care coordination services, please see Exhibit D, *Health Home’s* PROVIDER QUALIFICATIONS AND STANDARDS.

## COVERAGE AREAS & COUNTY

COVERAGE AREA	COUNTY
1	Kitsap, Clallam, Grays Harbor, Jefferson, Lewis, Mason, Pacific, and Thurston
2	Island, San Juan, Skagit, and Whatcom
4	Pierce
5	Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum
6	Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens and Whitman
7	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, and Yakima

Only HCA will qualify Lead Entities in Release C who will be responsible for delivery of *Health Home* services in Coverage Areas 1, 2, or 6. Applicants may apply to become Lead Entities in anyone or any combination of the three (3) coverage areas. Managed Care Organizations (MCOs) applying to become Lead Entities or subcontracting their *Health Home* services to another Lead Entity in Coverage Areas 1, 2, and/or 6 must provide *Health Home* services in the counties where the MCO has a Healthy Options contract. Organizations applying to become Lead Entities for Fee-for-Service (FFS) beneficiaries must serve all counties in the coverage area.

***Please take note that King County and Snohomish County are not included in Release C.***

HCA will enroll FFS eligible beneficiaries into Qualified *Health Homes* that are serving FFS beneficiaries. The five (5) managed care plans will enroll their *Health Home* eligible managed care beneficiaries into Qualified *Health Homes* that are serving managed care enrollees. Managed care plans operate in Washington State under their Medicaid contract.

*Health Home* enrollees must have at least one (1) chronic condition and be at risk of a second with a minimum predictive risk score of 1.5. The chronic conditions covered are mental health conditions, substance use disorders, asthma, diabetes, heart disease, cancer, cerebrovascular disease, coronary artery disease, dementia or Alzheimer's disease, intellectual disability or disease, HIV/AIDS, renal failure, chronic respiratory conditions, neurological disease, gastrointestinal, hematological, and musculoskeletal conditions.

The predictive risk score of 1.5 means a beneficiary's expected future medical expenditures are projected to be 50% greater than the base reference group, the WA Supplemental Security Income (SSI) disabled population. The WA risk score is based on the Chronic Illness & Disability Payment System and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California, San Diego, with risk weights normalized for the WA Medicaid population. Diagnoses, prescriptions, age and gender from the beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) are analyzed, a risk score is calculated and chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies; N=does not qualify) is loaded into the WA Medicaid Management Information System (MMIS). For those beneficiaries with an electronic claims history of less than 15 months or referred from a provider, a tool will be available to manually calculate clinical qualification. The clinical indicator in the MMIS can then be set to Y in cases where a previously non-qualified beneficiary requests or is referred for Health Home Assignment and eligibility criteria is met.

HCA intends to award a limited number of contracts per coverage area based on the results from this RFA process and the projected number of eligible *Health Home* beneficiaries within each coverage area.

**1.3. HEALTH HOME PROVIDER COMPENSATION**

Consideration paid to successful applicants for *Health Home* services provided under a resultant contract shall be paid at a monthly encounter rate for Fee-for-Service participating beneficiaries. Payment for eligible managed care beneficiaries is built into the Healthy Options capitation rate and no additional payment will be made for their contractually required *Health Homes* services.

Per Participant Per Month FFS Program Payment Rates					
Stage of Care Coordination	Total Rate	Rate Net of Withhold	Total Admin.	Withhold Portion of Admin	Admin. Net Withhold
<u>Outreach, Engagement, and Health Action Plan</u>	\$252.93	\$252.93	\$25.29	N/A	\$25.29
<u>Intensive Health Home Care Coordination</u>	\$172.61	\$169.16	\$17.26	\$3.45	\$13.81
<u>Low-Level Health Home Care Coordination</u> (Payable only with an Encounter)	\$67.50	\$66.15	\$6.75	\$1.35	\$5.40

Any contracts awarded as a result of this solicitation are contingent upon the availability of funding. The rates are subject to change based on legislative direction or appropriation.

#### **1.4. PERIOD OF PERFORMANCE**

The period of performance of any contract(s) resulting from this RFA shall have an initial Period of Performance of two (2) years. The start and end date of the two (2) year period of performance is based upon the start date for each awarded contract. HCA reserves the right to terminate the contract at any time. HCA shall have the option at its sole discretion to extend any contract for an additional one (1) to two (2) years.

#### **1.5 RELEASE SCHEDULE**

<b>Release # C Coverage Areas 1, 2, and 6</b>	
<b>Activity</b>	<b>Date/Time**</b>
<b>RFA Release Date</b>	<b>5/10/2013</b>
<b>Questions Due from Applicants</b>	<b>5/17/2013</b>
<b>HCA Response to Applicant Questions</b>	<b>6/27/2013</b>
<b>Complaints Deadline</b>	<b>7/3/2013</b>
<b>RFA Proposal Due Date</b>	<b>7/12/2013</b>
<b>Projected Announcement of Apparently Successful Applicants</b>	<b>8/9/2013</b>
<b>Projected request debriefing conferences</b>	<b>8/12 – 8/16/2013</b>
<b>Projected protest period</b>	<b>8/19 – 8/23/2013</b>
<b>Readiness Reviews</b>	<b>8/26 – 8/30/2013</b>
<b>Contracts Signed</b>	<b>9/2013</b>
<b>Projected Start Date of contracts</b>	<b>10/2013</b>

Coverage Area One (1) – Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston

Coverage Area Two (2) – Island, San Juan, Skagit, and Whatcom.

Coverage Area Six (6) – Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman

#### **1.6 ADA**

HCA complies with the Americans with Disabilities Act (ADA). Applicants may contact the RFA Coordinator to receive this Request for Applications in Braille or on tape.

## 2. GENERAL INFORMATION FOR APPLICANTS

### 2.1 RFA COORDINATOR

The RFA Coordinator is the sole point of contact within HCA for this solicitation. All communication between the Applicant and HCA upon receipt of this RFA shall be with the RFA Coordinator, as follows:

<b>Name</b>	Charles Pugh
<b>Mailing Address</b>	PO Box # 42702, Olympia, Washington 98504-2702
	OR
<b>Street Address</b>	Cherry Street Plaza, Fifth Floor, 626 Eighth Avenue SE, Olympia, Washington 98501
<b>Phone Number</b>	(360) 725-1843
<b>E-Mail Address</b>	<a href="mailto:contracts@hca.wa.gov">contracts@hca.wa.gov</a>

**Note: Submission of all applications in response to this RFA is different from the above address. See Section 2.3 SUBMISSION OF PROPOSALS below.**

**Any other communication will be considered unofficial and non-binding on HCA. Applicants are to rely on written statements issued by the RFA Coordinator. Communication directed to parties other than the RFA Coordinator may result in disqualification of the Applicant's Application(s).**

### 2.2 QUESTION AND ANSWER PERIOD

Specific questions concerning the RFA must be submitted by email to the RFA coordinator during the question and answer period.

The answer to any question which is given orally is to be considered tentative. Questions will be researched and the official answer published in writing on the HCA website by the date specified in the schedule. This will assure accurate, consistent responses to all vendors. Only the written responses will be considered official.

### 2.3 COMPLAINT PROCESS

A potential Applicant may submit a complaint regarding this RFA. Grounds for the complaint must be based on at least one (1) of the following:

- The solicitation unnecessarily restricts competition.
- The solicitation evaluation or scoring process is unfair or flawed.
- The solicitation requirements are inadequate or insufficient to prepare a response.

The complaint must be submitted in writing to the RFA Coordinator by the Complaints Deadline. The complaint may not be raised again during the Protest Period.

The complaint must contain ALL of the following:

- The complainant's name, name of primary point of contact, mailing address, telephone number, and e-mail address (if any)
- A clear and specific statement articulating the basis for the complaint
- A proposed remedy

HCA will send a written response to the complainant before the deadline for Application submissions. The response will explain HCA's decision and steps it will take in response to the complaint (if any). The complaint and the response, including any changes to the solicitation that may result, will be posted on the same HCA web page as the original RFA. HCA's decision is final; no further appeal will be available.

#### **2.4 SUBMISSION OF PROPOSALS**

The submission of Release C includes revisions to the application from Releases A and B. If an applicant submitted a proposal for Release A and/or B, make sure your proposal(s) address the requirements specified in this Release. Revisions to the wording and numbering of some of the questions have been made to this Release. Reliance by the Applicant on a previous Release may result in disqualification of the Application as non-responsive or lower scores during the evaluation process.

Applicants are required to submit one (1) original and six (6) copies of each proposal for each coverage area. The original must have original signature in blue ink and the remaining copies can have photocopied signatures. With each original submit two (2) disks. One (1) disk should contain the Applicant's proposal without the network adequacy spreadsheet and the second disk should contain the Applicant's Network Adequacy Excel spreadsheets. With each copy of each application submit one (1) disk containing the Applicants' Network Adequacy Excel spreadsheet for the Coverage Area for which the Applicant is applying.

Each proposal, whether mailed or hand delivered, must be received by HCA no later than 3:00 p.m., Pacific time, on July 12, 2013 for Coverage Area One (1), Coverage Area Two (2), and Coverage Area Six (6) for which the Applicant is applying, as stated in Section 1.5, Release Schedule. Applicants may submit proposals for Coverage Area One (1), Coverage Two (2), or Coverage Area Six (6) or any combination of Coverage Areas. When applying for more than one Coverage Areas in Release C, Applicants must submit a distinct proposal for each Coverage Area and include all binders and disks for each proposal.

RFA # 12-005C  
Contract Services  
Legal and Administrative Services Division  
Health Care Authority  
3819 Pacific Avenue SE, Suite # A  
Lacey, WA 98503

Applicants mailing proposals should allow normal mail delivery time to ensure timely receipt of their proposals by the RFA Coordinator. Applicants assume the risk for the

method of delivery chosen. HCA assumes no responsibility for delays caused by any delivery service. Proposals may not be transmitted using facsimile transmission or electronic mail transmission.

Late proposals will not be accepted and will be automatically disqualified from further consideration. All proposals and any accompanying documentation become the property of HCA and will not be returned.

## **2.5 PROPRIETARY INFORMATION/PUBLIC DISCLOSURE**

To the extent allowed by law, HCA will consider all proposals received as confidential until contract(s) for a particular geographic coverage area, if any, resulting from this RFA is/are signed by the Director of HCA, or her Designee, and the apparently successful applicant(s). Thereafter, the proposals shall be deemed public records as defined in Chapter 42.56 of the Revised Code of Washington (RCW).

Any information in the proposal that the Applicant desires to claim as proprietary and exempt from disclosure under the provisions of Chapter 42.56 RCW, or other state or federal law that provides for the nondisclosure of your document, must be clearly designated. The information must be clearly identified and the particular exemption from disclosure upon which the Applicant is making the claim must be cited in the Letter of Submittal. Each page containing the information claimed to be exempt from disclosure must be clearly identified by the words "Proprietary Information" printed on the lower right hand corner of the page. Marking the entire proposal exempt from disclosure or as "Proprietary Information" will not be honored. HCA makes no guarantees that any information that the Applicant considers confidential or proprietary will be considered as such by HCA or by any court.

If a public records request is made for the information that the Applicant has marked as "Proprietary Information" HCA will notify the Applicant of the request and of the date that the records will be released to the requester unless the Applicant obtains a court order enjoining that disclosure. If the Applicant fails to obtain the court order enjoining disclosure, HCA will release the requested information on the date specified. If an Applicant obtains a court order from a court of competent jurisdiction enjoining disclosure pursuant to Chapter 42.56 RCW, or other state or federal law that provides for nondisclosure, HCA shall maintain the confidentiality of the Applicant's information per the court order.

A charge will be made for copying and shipping, as outlined in Chapter 42.56 RCW. No fee shall be charged for inspection of contract files, but twenty-four (24) hours' notice to the RFA Coordinator is required. All requests for information should be directed to the RFA Coordinator.

## **2.6 REVISIONS TO THE RFA**

In the event that HCA determines, at its sole discretion, to revise any part of this RFA, addenda will be posted on the same HCA web page as the original RFA.

HCA also reserves the right to cancel or to reissue the RFA in whole or in part, prior to execution of any contract.

## **2.7 MINORITY & WOMEN-OWNED BUSINESS PARTICIPATION**

In accordance with the legislative findings and policies set forth in Chapter 39.19 RCW, the state of Washington encourages participation in all of its contracts by firms certified by the Office of Minority and Women's Business Enterprises (OMWBE). Participation may be either on a direct basis in response to this solicitation or on a subcontractor basis. However, no preference will be included in the evaluation of proposals, no minimum level of Minority and Women's Business Enterprise participation shall be required as a condition for receiving an award, and proposals will not be rejected or considered non-responsive on that basis.

The established annual procurement participation goals for Minority Business Enterprises is 10% and for Women's Business Enterprise, 4%, for this type of project. These goals are voluntary. Bidders may contact OMWBE at 360/753-9693 to obtain information on certified firms.

## **2.8 ACCEPTANCE PERIOD**

Proposals must provide one hundred eighty (180) days for acceptance by HCA from the due date for receipt of proposals.

## **2.9 RESPONSIVENESS**

All proposals will be reviewed by the RFA Coordinator, or other Contract Services staff, to determine compliance with administrative requirements and instructions specified in this RFA Release. The Applicant is specifically notified that failure to comply with any part of the RFA may result in rejection of the proposal as non-responsive.

HCA also reserves the right, however, at its sole discretion to waive minor administrative irregularities.

## **2.10 MOST FAVORABLE TERMS**

HCA reserves the right to make an award without further discussion of the proposal submitted. Therefore, the proposal should be submitted initially on the most favorable terms which the Applicant can propose. HCA does reserve the right to contact an Applicant for clarification of its proposal.

The Applicant should be prepared to accept this RFA for incorporation into any contract resulting from this RFA. Contract negotiations may incorporate some or all of the Applicant's proposal. It is understood that each proposal will become a part of the official solicitation file on this matter without obligation to HCA.

## **2.11 CONTRACT AND GENERAL TERMS & CONDITIONS**

Each apparently successful applicant will be expected to enter into a contract which is substantially the same as the sample contract with regard to its general terms and conditions attached as Exhibit I. In no event is an Applicant to submit its own standard contract terms and conditions in response to this solicitation, which HCA can make in its sole discretion.

## **2.12 COSTS TO PROPOSE**

HCA will not be liable for any costs incurred by the Applicant in preparation of any proposal submitted in response to this RFA, or any other activity related to responding to this RFA.

## **2.13 NO OBLIGATION TO CONTRACT**

This RFA does not obligate the state of Washington or HCA to contract for services specified herein.

## **2.14 REJECTION OF PROPOSALS**

HCA reserves the right at its sole discretion to reject any and all proposals received without penalty and not to issue a contract as a result of this RFA.

## **2.15 COMMITMENT OF FUNDS**

The director of HCA or the director's delegate is the only individual who may legally commit HCA to the expenditures of funds for a contract resulting from this RFA. No cost chargeable to the proposed contract may be incurred before receipt of a fully executed contract.

## **2.16 INSURANCE COVERAGE**

The Contractor shall, at Contractor's own expense, obtain and keep in force insurance coverage in the types and amounts described below, during the term of the contract. The Contractor, upon request after contract execution by HCA staff, shall submit a copy of the Certificate of Insurance, policy, and additional insured endorsement for each coverage required by the contract.

### Liability Insurance

*Commercial General Liability Insurance (CGL):* Contractor shall maintain general liability insurance and, if necessary, commercial umbrella insurance, with a limit of not less than \$1,000,000 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 insureds (cross liability) condition.

Additionally, the Contractor is responsible for ensuring that any subcontractors provide adequate insurance coverage for the activities arising out of subcontracts.

*Business Auto Policy:* As applicable, the Contractor shall maintain business auto liability and, if necessary, commercial umbrella liability insurance with a limit not less than \$1,000,000 per accident combined single limit. 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.

*Professional Liability Policy:* As applicable, the Contractor shall maintain professional liability or Errors & Omissions insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - \$1,000,000; Aggregate - \$2,000,000,

#### *Employers Liability ("Stop Gap") Insurance*

In addition, the 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.

#### *Additional Provisions*

Above insurance policy shall include the following provisions:

1. **Additional Insured.** HCA, its elected and appointed officials, agents and employees shall be named as additional insureds on all general liability, excess, umbrella and property insurance policies. All insurance provided in compliance with this solicitation document shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the state.
2. **Cancellation.** HCA shall be provided written notice before cancellation or non-renewal of any insurance referred to therein, in accord with the following specifications. Insurers subject to Chapter 48.18 RCW (Admitted and Regulation by the Insurance Commissioner): The insurer shall give the state 45 days advance notice of cancellation or non-renewal. If cancellation is due to non-payment of premium, the state shall be given 10 days advance notice of cancellation. Insurers subject to Chapter 48.15 RCW (Surplus lines): The state shall be given 20 days advance notice of cancellation. If cancellation is due to non-payment of premium, the state shall be given 10 days advance notice of cancellation.
3. **Identification.** Policy must reference the state's contract number and HCA name.
4. **Insurance Carrier Rating.** All insurance and bonds should 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, 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 Chapter 284-15 WAC.
5. **Excess Coverage.** By requiring insurance herein, the state does not represent that coverage and limits will be adequate to protect the Contractor and such coverage and limits shall not limit Contractor's liability under the indemnities and reimbursements granted to the state in a resulting contract.
6. **Workers' Compensation Coverage.** The Contractor will at all times comply with all applicable workers' compensation, occupational disease, and occupational health and safety laws, statutes, and regulations to the full extent applicable. The state will not be held responsible in any way for claims filed by the Contractor or their employees for services performed under the terms of any resulting contract.

### 3. PROPOSAL CONTENTS

Proposals must be submitted on eight and one-half inch by eleven inch (8 ½" x 11") paper, single-spaced, with standard margins – top margin is one (1) inch, bottom margin is one (1) inch, left margin is one (1) inch and right margin is one (1) inch. Tabs must separate the major sections of the proposal. Each proposal and each copy of each proposal must clearly indicate in the upper right corner of the first page the *Health Home* coverage area the Applicant is proposing to serve. The six (6) major divided narrative sections of the proposal are to be submitted in the order noted below:

1. Letter of Submittal
2. Minimum Qualifications
3. Exhibit E, Provider Network Excel Template
4. Organizational Infrastructure and Provider Network
5. Core Health Home Requirements
6. CMS Health Home Provider Functional Requirements

State your organization's name on the first page of all of the major sections of each original proposal and copy of each proposal. Proposals must provide information in the same order as presented in this document with the same headings. Title and number each item the same way it appears in the appropriate sections. **Do not use an alternate numbering scheme. Answer each question separately. Do not combine answers to items requesting information.** This will not only be helpful to the evaluators of the proposal, but should assist the Applicant in preparing a thorough response.

Items in this section marked "mandatory" must be included as part of the proposal for the proposal to be considered responsive, however, these items are not scored. All items in the "Minimum Requirements" Section are pass/fail. Items marked "scored" are those that are awarded points as part of the evaluation conducted by the evaluation team. The responses for each major section should stand on their own and not refer to the response in another section, unless noted in the RFA.

#### **3.1 LETTER OF SUBMITTAL (MANDATORY)**

The purpose of the Letter of Submittal is to transmit the proposal, provide bidder-specific information, and acknowledge the receipt of any addenda. The Letter of Submittal must be prepared on bidder letterhead and signed by an individual who is authorized to commit the bidder to the services and requirements as stated in this RFA. The Letter of Submittal must include, in the order given:

- A. Identifying information about the Prime Applicant to include the following:
  1. The Applicant's business name, address, County, telephone number, and email.
  2. The Applicant's NPI, if they have one.

3. The Applicant's Federal Taxpayer Identification number, the Applicant's Washington Uniform Business Identification (UBI) number issued by the State of Washington Department of Revenue and the Statewide Vendor (SWV) number issued by the state of Washington Office of Financial Management. If the Applicant does not have a UBI number and/or a SWV number, the Applicant must state that it will become licensed in Washington, and registered as a state of Washington payee within thirty (30) days of being selected as an apparently successful applicant.
4. Type of lead entity (for example, Managed Care Organization, Regional Support Network, Community Mental Health Agency, Chemical Dependency Treatment Agency, Area Agency on Aging, Federally Qualified Health Center, Rural Health Clinic, Accountable Care Organization, Regional Health Alliance, Hospital, Primary Care Case Management entity, Tribal Clinic, Primary Care Medical Home). A lead entity may be more than one type. If so, list all that apply, including any that may not be one of the above examples. For example a Federally Qualified Health Center may provide medical, mental health and chemical dependency treatment.
5. The legal status of the applying entity (sole proprietorship, partnership, corporation, etc.) and the year the entity was organized as it now substantially exists.
6. The name, address, email address and telephone number of the applying entity, and of the partners or principal officers as appropriate.
7. The name of the person who will have primary contact with the Health Care Authority in carrying out the responsibilities of a resultant contract.
8. The name(s) and titles of all persons authorized to speak on behalf of the Applicant on matters related to this solicitation.
9. The name and address of the entity that receives legal notices for the Applicant.
10. If the Applicant or any major Subcontractor contracted with the State of Washington during the past twenty-four (24) months, indicate the name of the agency, the contract number and brief description of the purpose of the contract
11. Provide a statement affirming that by submitting a response to this solicitation, the Applicant and its key subcontractors represent that they are not in arrears in the payment of any obligations due and owing the State of Washington, including the payment of taxes and employee benefits, and that it shall not become in arrears during the term of a resultant contract if the Applicant is selected for contract award.

Failure to adequately satisfy all of the Minimum Qualifications will result in disqualification and the proposal will not be evaluated.

**B. Conflict of Interest Information:**

1. If any employees or officers of the Applicant or key subcontractors' employees or officers who shall provide services under this contract are or were employed by the State of Washington during the last two (2) years, state their positions within the Applicant, their proposed duties under any resulting contract, their duties and position during their employment with the State and the date of their separation from State employment. If a decision regarding potential conflict of interest has been obtained from the State Ethics Board, submit the decision.
2. If any owner, key officer or key employee of the Applicant is related by blood or marriage to any employee of HCA or has a close personal relationship to same, identify all the parties, identify their current or proposed positions and describe the nature of the relationship.
3. If the Applicant is aware of any other real or potential conflict of interest, the Applicant must fully disclose the nature and circumstances of such potential conflict of interest.

If, after review of the information provided and the situation, Agency determines that a potential conflict of interest exists, Agency may, at its sole option, request a change in personnel assigned to the account or disqualify the Applicant from participating in this solicitation.

4. If the applicant is both a Lead entity and a Care Coordination Organization, the applicant must describe their methods to ensure there is no conflict of interest when assigning Health Home beneficiaries to the other Care Coordination Organizations in their network in this portion of the Letter of Submittal.

Failure to fully disclose any real or potential conflict of interest may result in the disqualification of the Applicant or the termination for default of any contract with the Contractor resulting from a proposal submitted by the Applicant.

**C. References**

List names, titles, addresses, telephone numbers, and e-mail addresses of three (3) business references for which contract work similar to the care coordination services proposed in this Solicitation has been accomplished and briefly describe the type of service provided. The Applicant must grant permission to the Agency to contact the references. Do not include current Agency staff as references. References will be contacted for the regionally top-scoring proposal(s) only.

**D. Debarment**

The Applicant must certify that the Applicant, and all subcontractors proposed to perform work under a resultant contract are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency from participating in transactions (Debarred). The Applicant also agrees to include this requirement in any and all subcontracts into which it enters to perform work

under a resultant contract. The Applicant agrees to immediately notify the Agency if, during the term of any resultant contract, the Contractor becomes debarred. The names of providers who have been debarred can be found at [www.epa.gov/ogd/sdd/espl.htm](http://www.epa.gov/ogd/sdd/espl.htm).

#### E. Compliance with Provider Disclosure Requirements

The applicant may be required to comply with subcontractor ownership disclosure requirements of 42 CFR §455.106 so state your willingness to comply if required.

#### F. Prior Terminations for Default

1. Applicants must indicate whether they have had a contract terminated for default in the last five (5) years. Termination for default is defined as a notice to stop work due to the Applicant's nonperformance or poor performance, where the issue of performance was either, litigated or not litigated due to inaction on the part of the Applicant, or litigated and determined that the Applicant was in default.
2. If the Applicant has had a contract terminated for default in the last five (5) years, the Applicant must submit full details including the other party's name, address and telephone number. The bidder must specifically grant HCA permission to contact any and all involved parties and access any and all information HCA determines is necessary to satisfy its investigation of the termination. HCA will evaluate the circumstances of the termination and may at its sole discretion, bar the participation of the Applicant in this solicitation.

#### G. Declaration of Parts of Proposal Marked as Proprietary or Confidential

The applicant must list the page numbers and names of any proposal elements being claimed as "Proprietary" or "Confidential" (see Section 2.4.). Include an explanation for each claim of confidentiality.

#### H. List of RFP Amendments Received

The Applicant shall list of all RFA Release C amendments read or downloaded from the HCA Contracts and Grants web page by issue date. If no RFA amendments were read or downloaded, write a statement to that effect. Applicant questions/HCA responses are considered an amendment to the RFA.

#### I. Attachments

The Applicant must include a detailed list of all materials and enclosures being sent in the proposal.

#### J. Certifications and Assurances

The Applicant must attach a copy of the Certifications and Assurances (Exhibit H) signed by a person authorized to bind the Applicant to a contract.

### **3.2 MINIMUM QUALIFICATIONS SECTION (MANDATORY)**

This application is open to those public or private organizations that satisfy the minimum qualification requirements contained in this Section. The applicant must provide evidence of community based partners that can deliver the care coordination function and the six (6) Health Home services, as described under Exhibit C, ESSENTIAL REQUIREMENTS and Exhibit D, PROVIDER QUALIFICATIONS AND STANDARDS.

Assurances. The applicant must attest that the requirements specified below are met.

1. The applicant is currently licensed as a business in the state of Washington.  
Yes  No
2. Only answer this question if your answer to number one (1) is no. If the applicant is not currently licensed in the state of Washington, will the applicant get a Washington State business license in the next thirty (30) days? Yes  No
3. The applicant is a Medicaid provider in good standing. Yes  No
4. The applicant will serve as the lead entity as part of the *Health Home* provider network. Yes  No
5. The applicant has completed and returned the Exhibit E, Excel Provider Network Template in an electronic format (CD) on one (1) original CD and one (1) copy CD with each of the six copies of each of their proposal(s). Yes  No
6. The applicant assures when providing *Health Homes* for Fee-for-Service beneficiaries, all counties in the coverage area(s) are served. Yes  No  OR  
  
The applicant is not providing *Health Home* services to Fee-for-Service beneficiaries.
7. The applicant assures when providing *Health Homes* for managed care beneficiaries, all counties in the coverage area(s) are served, as specified by their State Medicaid managed care contract. Yes  No  OR  
  
The applicant is not providing *Health Home* services to managed care beneficiaries.
8. The applicant assures local community organizations that authorize Medicaid, state or federal funded mental health, long-term services and supports (including the direct care workforce), chemical dependency and medical services are part of their *Health Home* provider network. For example, Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, and Substance Use Disorder providers and DSHS staff that authorize services, such as long-term services and supports. Yes  No
9. The applicant has experience operating broad-based regional provider networks.  
Yes  No
10. The applicant has capacity to provide the six (6) *Health Home* services for 1,000 to 2,000 beneficiaries within their *Health Home* provider network for the Coverage Area the applicant proposes to serve. Yes  No

11. The applicant assures that twenty-four (24) hours/seven (7) days a week information and referral; and emergency consultation services will be available to *Health Home* beneficiaries.  
Yes  No
12. The applicant and their subcontracted Care Coordination Organizations will document beneficiary consent for *Health Home* participation and will share beneficiary and treatment information in manners that conform to HIPAA requirements. Yes  No
13. The applicant's sub-contracts will be in place with *Health Home* Care Coordination Organizations prior to enrollment of eligible beneficiaries. Yes  No
14. The applicant assures their *Health Home* provider network can provide the following services:
- a. Coordination of care and services after critical events, such as emergency department use and hospital inpatient admission and discharge. Yes  No
  - b. Language access/translation capability; Yes  No
  - c. Links to acute and outpatient medical, mental health and substance abuse services; Yes  No
  - d. Links to community-based social support services - including housing.  
Yes  No

Applicants who do not meet the above minimum qualifications will be rejected as non-responsive and will not receive further consideration. Any proposal that is rejected as non-responsive will not be evaluated or scored.

**3.3 EXCEL PROVIDER NETWORK WORKSHEET (SCORED)**  
**Maximum Points: 210**

The intent of this section is to assess the applicant's provider network. Provider networks will be scored based on the data contained in the Excel Provider Network Worksheet. Networks must be submitted in an electronic format on CD in accordance with the instructions in Section 2.3 SUBMISSION OF PROPOSALS. The Applicant may submit a hard copy of their network as well as the electronic copy if they so choose. Submittal or non-submittal of a hard copy of the Provider Network Worksheet does not count against the applicant nor does it increase their score.

The spreadsheet has six (6) sections – Instructions, Lead Entity, Care Coordination Organizations, Authorizing Entities, Hospitals and Supporting Providers. Data must be entered in the correct section and clearly labeled or it will not be included in the score. More detailed instructions are in the Provider Network excel spreadsheet.

**3.4 ORGANIZATIONAL INFRASTRUCTURE and PROVIDER NETWORK (SCORED)**  
**Maximum Points: 178**

The intent of this section is to provide the applicant with the opportunity to describe their organizational infrastructure and *Health Home* provider network, including subcontracted Care Coordination Organizations and other provider network partners. In order to be

approved as a qualified *Health Home*, the applicant must demonstrate the necessary infrastructure to administer the program and an adequate network to provide *Health Home* services. For additional information on organizational infrastructure and provider networks, review Exhibit C, Essential Requirements and Exhibit D, Provider Qualifications and Standards. **(Limit of twelve (12) pages total, excluding organizational chart listing/description of management staff).**

### ***Items and Questions for Response***

1. Which population(s) is the applicant proposing to cover:
  - a. Medicaid managed care beneficiaries
  - b. Medicare/Medicaid (Dual Eligible) Fee-for-Service beneficiaries
  - c. Medicaid Fee-for-Service beneficiaries
  - d. American Indians/Alaska Natives enrolled in a PCCM
2. Is the applicant proposing to be a Care Coordination Organization as well as a Lead Entity? Yes  No
3. Provide a complete description of your organization, including a listing and description of management staff responsible for Health Home services and organizational structure. Include an organizational chart as an attachment. The listing and description of management staff and the chart will not count against the required amount of pages.
4. Describe how the administrative functions will be operationalized within the applicant's organization and the Care Coordination Organizations.
5. Describe your experience operating broad-based regional provider networks, such as Regional Support Networks, Area Agencies on Aging, Managed Care Organizations, Hospitals, Rural Health Clinics, Federally Qualified Health Centers, Chemical Dependency Treatment Agencies, etc.
6. Does the applicant have toll-free phone lines and customer service staff to respond to Health Home beneficiary calls and complaints? Yes  No 
  - a. If yes, describe their functions and hours of operation.
  - b. How many toll-free line staff and customer service representatives are currently employed?
  - c. If the applicant does not have toll-free phone lines and customer service representatives, please describe how the applicant will ensure that *Health Home* beneficiaries have the ability to ask for and receive help after normal business hours.
7. Describe the process and timeline for bringing additional Care Coordination Organizations (CCO) and Health Home Care Coordinators into the Health Home provider network to ensure the integrity of face-to-face Health Home care coordination activities.
  - a. What event would trigger the addition of Care Coordination Organizations?
  - b. What event would trigger the addition of Health Home Care Coordinators?
  - c. Include any detail on who would be providing support services to the Care

Coordinators.

8. Describe the process to assign and track Health Home beneficiaries to Care Coordination Organizations.
9. Describe how the Health Home provider network will ensure that hospitals have procedures in place for referring Health Home-eligible beneficiaries who seek or need treatment in a hospital emergency department for Health Home enrollment?
10. Describe the applicant's experience in performing administrative functions for:
  - a. Collecting and submitting claims or encounters,
  - b. Payment disbursement, taking into account intensity levels and/or movement between CCOs,
  - c. Quality monitoring,
  - d. Sub-contracting,
  - e. Collecting, analyzing and reporting financial, health status and performance and outcome measures to objectively determine progress towards meeting *Health Home* goals.
11. Describe how the Health Home provider network will refer and assure access for beneficiaries who seek or need treatment/services to a Medicaid provider?
12. Describe the process to include beneficiary participation on governing and advisory boards to ensure input and involvement in planning and process improvements.
13. How will the Health Home ensure that roles and responsibilities for Health Home beneficiaries are not duplicated when providing comprehensive or intensive care management?
14. Describe how the applicant would partner with "Project Echo," an intensive care coordination model and use the Intensivist Team in Washington's Health Home model if available in the coverage area.
15. Describe the process used when a Health Home beneficiary is moved to another Health Home or Care Coordination Organization?
  - a. How will the applicant ensure continuity of the Care Coordinator-Health Home beneficiary relationship?
  - b. How will the Lead entity and Care Coordination Organization ensure a seamless transition when a beneficiary moves or requests a transfer to an alternate Lead entity and Care Coordination Organization?

**3.5 CORE HEALTH HOME REQUIREMENTS (SCORED) Maximum Points: 336**

The six (6) services provided under the *Health Home* program are non-duplicated care coordination functions provided through person-centered medical, behavioral health and long-term care services and supports, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services to Medicaid and Medicaid/Medicare eligible beneficiaries residing within specified geographic coverage areas.

### ***Items and Questions for Response***

In this section of the proposal, the applicant should describe your organization's capability and capacity to meet each core requirement included in Washington's PROVIDER QUALIFICATIONS AND STANDARDS (Exhibit D). **(Limit 20 pages)**

#### **1. Comprehensive Care Management**

- a. How will the *Health Home* engage beneficiaries in establishing health action goals, defining interventions, making behavior changes and increasing confidence and skills in managing chronic conditions when creating the Health Action Plan?
  - i. How will the Health Home demonstrate a strong integrated network that is capable of providing face-to-face support that is necessary to be effective with beneficiaries with complex, chronic conditions?
  - ii. What kind of preparation will take place before the Care Coordinator visits the beneficiary?
  - iii. What methods will be used to guarantee cultural competency?
  - iv. Describe how the Care Coordinator will use the Patient Activation Measure and coaching tools when establishing a Health Action Plan.
  - v. What staff and support staff will be used to support the beneficiary?
- b. Describe the process used to identify the Health Home beneficiary's use of services, including gaps in meeting beneficiary needs. For example, describe how standardized screening takes place and will inform the development of the Health Action Plan.
- c. How will the *Health Home* ensure the use of evidence-based/informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting the beneficiary's health and health care choices?

#### **2. Care Coordination and Health Promotion**

- a. Describe the process that will be used to talk to the beneficiary's treating/authorizing entities when changes to beneficiary's circumstances, condition or Health Action Plan necessitate timely changes in treatment or services.
- b. Provide an example of when the *Health Home* would need to pull together a cross-system team or meeting to ensure coordination of care and achievement of beneficiary Health Action Plan goals.
- c. Describe how the *Health Home* network providers ensure 24/7 availability of information and emergency consultation services to the beneficiary.
- d. How will the *Health Home* arrange for priority appointments for the beneficiary for medical, behavioral health, and long-term services and supports?

- e. Describe the *Health Home* processes to link beneficiaries to resources that will promote a healthy lifestyle.
3. Comprehensive Transitional Care
- a. What kind of notification system will be in place with hospitals, nursing homes and residential/rehabilitation facilities to provide prompt communication of a beneficiary's admission and/or discharge from an emergency room, inpatient, nursing home or residential/rehabilitation setting or a substance use disorder treatment setting?
  - b. Describe your *Health Home's* approach to providing transitions in care? Include a description of activities from pre-institutional admission to discharge to home or lower-intensity setting.
  - c. Describe a successful transitional process and the type and form of education you will provide to beneficiaries to promote successful transitions.
  - d. Describe the process that will be used to assure beneficiaries have prescribed medication upon discharge and follow-up with pharmacy to get scripts filled.
  - e. Describe the process that will be used to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.
  - f. Describe the process the *Health Home* would use to refer the beneficiary for additional services such as mental health, chemical dependency or long-term services and supports and ensure follow-up on those referrals.
4. Individual and Family Support Services (including authorized representatives and identified decision makers).
- a. How will the *Health Home* use peer supports, support groups, and self-management programs to increase the beneficiary and caregiver knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities and help the beneficiary improve adherence to their prescribed treatment?
  - b. How will the *Health Home* engage direct care providers of long-term services and supports to assist the beneficiary in achieving health action goals?
  - c. How will the *Health Home* incorporate beneficiary preferences, education and support for self-management; self-help recovery and identify other resources necessary for the beneficiary, their family and their caregiver to support the beneficiary's individualized health action goals?
  - d. How will the *Health Home* engage families, informal supports and caregivers to support the beneficiary in achieving self-management and optimal levels of physical and cognitive function?
5. Referral to Community and Social Support Services

- a. Describe the process for identifying community-based resources for beneficiaries with chronic, complex health care needs.
  - b. How will the Health Home actively manage referrals, advocate for access to care and services, and provide coaching to beneficiaries to engage in self-care?
  - c. Describe the process for assisting the beneficiary to obtain and maintain health care services, disability benefits, housing, personal needs, and legal services.
6. Use of Health Information Technology (HIT) to Link Services
- a. How will the *Health Home* use health information technology to identify and support management of high risk participants in Health Homes?
  - b. How will the *Health Home* use conferencing tools to support case conferences/team-based care including audio, video and/or web deployed solutions with security protocols and precautions to protect Protected Health Information (PHI)?
  - c. Describe the process/system that will be used to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate changes in care, as necessary, to address beneficiary need and preferences.
  - d. How will the *Health Home* use health information technology registries and referral tracking systems?
  - e. How will the *Health Home* track service utilization and quality indicators?
  - f. How will the Health Home provide timely and actionable information to the Care Coordinator regarding under, or over utilization patterns?
  - g. How will the Health Home develop methods to communicate real time use of emergency room, inpatient hospitalizations, discharge from a nursing facility, missed prescription refills, and the need for evidence-based preventive care to the care coordinator?
7. Quality Measure Reporting to HCA.
- a. Describe the applicant's experience in providing project management and oversight. What data, data sources, and management systems will be used to monitor the *Health Home*?
  - b. Describe the care coordination function for collecting, reporting, and sharing data with *Health Home* network providers, and HCA and DSHS for quality reporting purposes.
  - c. Describe your process for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits.
  - d. Describe how you would increase the amount of *Health Home* beneficiaries who

agree to participate in a *Health Home*.

**3.6 CMS HEALTH HOME PROVIDER FUNCTIONAL REQUIREMENTS**  
**Maximum Points: 33**

The intent of this section is for the applicant to describe how the applicant and the Care Coordination Organizations will meet each functional component as required by CMS. Health home providers must demonstrate their ability to perform each of the following federally-required functions, including documentation of the processes used to perform these functions and the processes and timeframes used to assure service delivery takes place in the described manner. Documentation should also include a description of the proposed multifaceted Health Home service interventions that will be provided to promote beneficiary engagement, participation in their Health Action Plan and assurance that beneficiaries will have access to the continuum of physical and behavioral health care and social services appropriate to their needs. If the applicant feels prior responses in this application are appropriate for these questions, they may use those responses. **(Limit five pages)**

1. How will the Health Home provide quality-driven, cost-effective, culturally appropriate, and person and family centered Health Home services?
2. How will the Health Home coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines?
3. How will the Health Home coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders?
4. How will the Health Home coordinate and provide access to mental health and substance abuse services?
5. How will the Health Home coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings? Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
6. How will the Health Home coordinate and provide access to chronic disease management, including self-management support to individuals and their families?
7. How will the Health Home coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services?
8. How will the Health Home coordinate and provide access to long-term care supports and services?
9. How will the Health Home develop a person-centered Health Action Plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services?

10. How will the Health Home demonstrate the capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate?
11. How will the Health Home establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level?

**3.7 OMWBE CERTIFICATION (OPTIONAL AND NOT SCORED)**

Include proof of certification issued by the Washington State Office of Minority and Women's Business Enterprises if certified minority-owned firm and/or women-owned firm(s) will be participating on this project.

**4. EVALUATION AND CONTRACT AWARD**

**4.1 EVALUATION PROCEDURE**

Responsive applications will be evaluated strictly in accordance with the requirements stated in this solicitation and any addenda issued. The evaluation of applications shall be accomplished by an evaluation team to be designated by HCA, which will determine the ranking of the applications submitted for the same covered service area.

**4.2 CLARIFICATION OF PROPOSAL**

The RFA Coordinator may contact the Applicant for clarification of any portion of the Applicant's proposal.

**4.3 EVALUATION SCORING**

The following points will be assigned to the proposal for evaluation purposes:

<i>EXCEL PROVIDER NETWORK SPREADSHEET -</i>	<b><u>210 points</u></b>
<i>ORGANIZATIONAL INFRASTRUCTURE and PROVIDER NETWORK -</i>	<b><u>178 points</u></b>
<i>CORE HEALTH HOME REQUIREMENTS -</i>	<b><u>336 points</u></b>
<i>CMS HEALTH HOME PROVIDER FUNCTIONAL REQUIREMENTS -</i>	<b><u>33 points</u></b>
<i>TOTAL -</i>	<b><u>757 points</u></b>
<i>REFERENCES -</i>	<b><u>90 points</u></b>
<i>GRAND TOTAL -</i>	<b><u>847 Points</u></b>

**4.4 DEBRIEFING OF UNSUCCESSFUL APPLICANTS**

Upon request, a debriefing conference will be scheduled with an unsuccessful applicant. The request for a debriefing conference must be received by the RFA Coordinator within three (3) business days after a Notification of Unsuccessful Applicant is e-mailed to the Applicant. The debriefing must be held within three (3) business days of the request.

Discussion will be limited to a critique of the requesting Applicant's proposal. Comparisons between proposals or evaluations of the other proposals will not be allowed. Debriefing conferences will be conducted on the telephone and will be scheduled for a maximum of one hour.

#### **4.5 PROTEST PROCEDURE**

This procedure is available to Applicants who submitted an unsuccessful response to this solicitation document and who have participated in a debriefing conference. Upon completing the debriefing conference, the Applicant is allowed five (5) business days to file a protest of the acquisition with the RFA Coordinator. Protests may be submitted by email, but should be followed by regular mail or courier delivery of the original document.

Applicants protesting this solicitation shall follow the procedures described below. Protests that do not follow these procedures shall not be considered. This protest procedure constitutes the sole administrative remedy available to Applicants under this solicitation.

All protests must be in writing and signed by the protesting party or an authorized Agent. The protest must state the grounds for the protest with specific facts and complete statements of the action(s) being protested. A description of the relief or corrective action being requested should also be included. All protests shall be addressed to the RFA Coordinator.

Only protests stipulating an issue of fact concerning the following subjects shall be considered:

1. A matter of bias, discrimination or conflict of interest on the part of the evaluator
2. Errors in computing the score
3. Non-compliance with procedures described in the solicitation document or HCA policy

Protests not based on procedural matters will not be considered. Protests will be rejected as without merit if they address issues such as: 1) An evaluator's professional judgment on the quality of a proposal, or 2) HCA's assessment of its own and/or other agencies' needs or requirements.

Upon receipt of a protest, a protest review will be held by HCA. HCA director or an employee delegated by the director who was not involved in the solicitation, will consider the record and all available facts and issue a decision within five business days of receipt of the protest. If additional time is required, the protesting party will be notified of the delay.

In the event a protest may affect the interest of another Applicant that submitted a proposal, such Applicant will be given an opportunity to submit its views and any relevant information on the protest to the RFA Coordinator.

The final determination of the protest shall:

1. Find the protest lacking in merit and uphold HCA's action.
2. Find only technical or harmless errors in HCA's acquisition process and determine HCA to be in substantial compliance and reject the protest.

3. Find merit in the protest and provide HCA options which may include:
  - a. Correct the errors and re-evaluate all proposals
  - b. Reissue the solicitation document and begin a new process
  - c. Make other findings and determine other courses of action as appropriate

If HCA determines that the protest is without merit, HCA will enter into a contract with apparently successful applicant(s) for the covered service area that is the subject of the protest. If the protest is determined to have merit, one of the alternatives noted in the preceding paragraph will be taken.

## **RFA EXHIBITS**

- A. Estimated Schedule of Release Activities
- B. Definitions
- C. Essential Requirements
- D. Provider Qualifications and Standards
- E. Excel Provider Network Worksheet
- F. List of Primary Care Case Management Tribal Clinics
- G. Proposal Submittal Checklist
- H. Certifications and Assurances
- I. Sample Client Services Contract with General Terms and Conditions

**Exhibit A – ESTIMATED SCHEDULE OF RELEASE ACTIVITIES**

**Schedule\***

<b>Release #</b>	<b>C</b>
<b>Coverage Area</b>	<b>Coverage Areas 1, 2, 3, &amp; 6</b>
<b>Activity</b>	<b>Anticipated Date/Time**</b>
<b>RFA Release Date</b>	<b>5/10/2013</b>
<b>Questions Due from Applicants</b>	<b>5/17/2013</b>
<b>HCA Response to Applicant Questions</b>	<b>6/27/2013</b>
<b>Complaints Deadline</b>	<b>7/3/2013</b>
<b>RFA Proposal Due Date</b>	<b>7/12/2013</b>
<b>Projected Announcement of Apparently Successful Applicants</b>	<b>8/9/2013</b>
<b>Projected request debriefing conferences</b>	<b>8/12 – 8/16/2013</b>
<b>Projected protest period</b>	<b>8/19 – 8/23/2013</b>
<b>Readiness Reviews</b>	<b>8/26 – 8/30/2013</b>
<b>Contracts Signed</b>	<b>9/2013</b>
<b>Projected Start Date of contracts</b>	<b>10/2013</b>

\* This schedule is subject to change at the discretion of Health Care Authority.

\*\* All Due Dates/Times are dates/times by which HCA must be in receipt of the Activity related documents.

## Exhibit B - DEFINITIONS

Definitions for the purposes of this RFA include:

**Affordable Care Act.** Public Laws 111-148 and 111-152 (both enacted in March 2010). The law includes multiple provisions that are scheduled to take effect over a matter of years, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions.

**Agency or HCA.** The Washington State Health Care Authority.

**AOD.** Alcohol and Other Drugs.

**Assignment.** The process used to determine which *Health Home* Care Coordination Organization is responsible for delivering the six Health Home care coordination services to the beneficiary.

**Applicant.** Individual, company, or firm submitting a proposal in order to attain a contract as a Health Home Lead Entity with HCA.

**Area Agency on Agency.** Area Agency(s) on Aging are a network of State and local programs that help older people to plan and care for their life long needs. They were created under Federal law, Older Americans Act.

**Authorizing Entity.** Organizations contracted by the state to approve or disapprove covered benefits for Medicaid beneficiaries following utilization guidelines. Examples include Managed Care Organizations, Regional Support Networks, Home and Community Based Services Providers.

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

**Beneficiary or Participant.** In the context of this RFA, a person who is eligible for Health Home services based upon at least one chronic condition and being at risk of a second, determined by a minimum predictive risk score of 1.5.

**Broad-based Regional Provider Networks.** Community entities composed of a broad array of service providers that are responsible to serve all beneficiaries in a defined geographical area.

**Care Coordination Organization.** The organization, within the qualified *Health Home* network, responsible for delivering the six *Health Home* care coordination services to the participating beneficiary.

**Chronic Conditions.** means a physical or behavioral health condition that is persistent or otherwise long lasting in its effects.

**CMS.** Centers for Medicare & Medicaid Services is the Federal Agency that regulates Medicare and Medicaid.

**Contractor.** Individual or company whose proposal has been accepted by HCA and is awarded a fully executed, written contract.

**Coverage Area(s).** Pre-determined geographical areas composed of specific counties in order to manage a phased-in implementation of *Health Homes*.

**Covered Services.** The set of services across Medicare and Medicaid to be coordinated as part of this Demonstration, including Medicaid *Health Home* services.

**DSHS.** The Department of Social and Health Services.

**Dual Eligible.** For the purposes of this RFA, individuals who are enrolled in Medicare Part A and B and eligible for and receiving Medicaid and no other comprehensive private or public health coverage.

**Enrollment.** A process used to place *Health Home* eligible beneficiaries into a qualified *Health Home*.

**Federally Qualified Health Center.** Community based organizations that provide comprehensive primary care and preventive care, including health, oral and mental health/substance abuse services to people of all ages, regardless of their ability to pay or health insurance status. Examples are Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs and Public Housing.

**Fee-For-Service.** A Medicaid delivery system that provides covered Medicaid benefits to eligible beneficiaries through any willing and contracted provider.

**Full Dual Eligible.** A beneficiary who is eligible for all Medicare and Medicaid covered benefits.

**Hallmark events.** means elevated episodes that seriously affect in a beneficiary's progress towards improved health outcomes. Hallmark events, include such events as an emergency hospitalization, for either a psychiatric or physical condition, that have potential to seriously affect the beneficiary's health or health outcomes.

**Health Action Plan.** The plan developed by the enrollee and the Care Coordinator identifying the beneficiary's plans to improve their health. The HAP includes the following elements:

- At least one beneficiary prioritized goal;
- Identification of the actions the beneficiary is taking to achieve the goal; and
- The actions of the Health Home Care Coordinator will take, including use of health care or community resources and services in support of the beneficiary's action plan.

**Health Home.** An entity composed of community based providers, qualified by the state to provide health home services to eligible beneficiaries. The entity is responsible for coordinating and integrating care across the continuum of services needed and used by eligible beneficiaries. Each *Health Home* has a lead entity that who is responsible for administrative and oversight functions and includes broad representation of community based organizations representing primary, acute, mental health, substance use disorder and Long Term Services and Supports that provide intensive care coordination to eligible beneficiaries

**Health Home Care Coordinator.** Staff employed by the *Health Home Care* Coordination Organizations to provide the six pre-defined *Health Home* care coordination benefits. Benefits must be provided through high touch, in-person registered nurses, licensed practical nurses, Physician's Assistants, BSW or MSW prepared social workers, and Chemical Dependency Professionals.

**Health Home (HH) Services.** Intensive services that coordinate care across several domains, as defined under Section 2703 of the Affordable Care Act of 2010. The purpose is to coordinate the full breadth of clinical and social service expertise for high cost/high risk beneficiaries with complex chronic conditions, mental health and substance use disorder issues and/or long term service needs and supports. The qualified Health Home includes providers from the local community that authorize Medicaid, state or federally funded behavioral health, long term services and supports, and primary and acute services. The six services are 1) Comprehensive care management; 2) Care coordination and health promotion; 3) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4) Individual and family support, which includes authorized representatives; 5) Referral to community and social support services, if relevant; and 6) The use of HIT to link services, as feasible and appropriate.

**Health Home Patient Information Sharing Consent Form.** *Health Home* release of information to facilitate sharing beneficiary health information.

**HealthPathWashington.** Washington's approach to integrating care for Medicare-Medicaid beneficiaries, which includes both Managed Fee-for-Service and Capitated approaches.

**HIPAA.** Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant Washington privacy laws.

**Long Term Services and Supports (LTSS).** A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in community based settings and improve the quality of their lives. Examples include personal care assistance with daily activities such as bathing, dressing and personal hygiene in in-home and licensed community residential settings, home delivered meals, personal emergency response systems, adult day services, environmental modifications and other services designed to divert individuals from nursing facility care. LTSS also includes services provided in licensed nursing facilities. LTSS are provided either in short periods of time when recovering from an injury or acute health episode or over an extended period.

**Managed Care Organizations.** Health insurance companies licensed to provide health insurance in the state of Washington.

**Medicare-Medicaid Coordination Office.** Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

**Medicaid** - The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and Waivers thereof.

**Memorandum of Understanding (MOU).** A business agreement for partnerships that do not involve a financial arrangement that describe the roles and responsibilities of each party to the agreement.

**Multidisciplinary Teams of Health Home Care Professionals.** Allied health care staff, such as community health workers, peer counselors or other non-clinical staff to facilitate work of the *Health Home* Care Coordinator. Additional members of the multidisciplinary teams can be primary care providers, mental health professionals, chemical dependency treatment providers, and social workers. Optional team members may include nutritionists/dietitians, direct care workers, pharmacists, peer specialists, family members or housing representatives.

**Outpatient Intensivist Team (OIT).** A community-based clinical team with specialized training to provide intensive primary care to cohorts of complex patients at risk for unnecessary hospitalizations and emergency department visits. The OIT team is comprised of a nurse practitioner (lead), nurse, social worker/behavioral health counselor, and community health worker and is supported by clinical specialists via Project ECHO.

**Participation.** An agreement by the beneficiary to participate in Health Home services as demonstrated by the Health Action Plan.

**Predictive Risk Intelligence System (PRISM).** A web-based tool used for predictive modeling and clinical decision support and is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected costs in the next 12 months based on the beneficiary's disease profiles and pharmacy utilization. PRISM identifies beneficiaries in most need of comprehensive care coordination based on risk scores; integrates information from primary, acute, social services, behavioral health, and long term care payment and assessment data systems; and displays health and demographic information from administrative data sources.

**Primary Care Case Management (PCCM).** PCCM is a model of health care delivery that generally requires a Medicaid enrollee to choose a primary care provider (PCP) who is responsible for coordinating the enrollee's care and is paid a monthly fee for doing so, in addition to receiving payment for providing medical services. Washington's PCCM program is only to American Indians/Alaska Natives, through contracts with tribal clinics, Urban Indian Clinics and Indian Health Service-administered clinics.

**Project ECHO™ (ECHO).** The Extension for Community Health Outcomes model of clinical mentorship, specialty training, and outcomes measurement. ECHO provides on demand training and specialty consultation (via voice, video, and in-person) to outpatient Intensivist teams managing cohorts of complex patients.

**Proposal.** A formal offer submitted in response to this solicitation.

**Readiness Review.** Prior to implementation, a Readiness Review conducted to ensure the *Health Home* provider has the necessary infrastructure and capacity to implement and oversee the proposed model. If gaps in readiness are identified, the *Health Home* provider must address these for implementation to proceed.

**Regional Support Networks (RSN).** Means a county authority or group of county authorities or other entity recognized by the secretary to administer mental health services in a defined region. RSNs are specialty behavioral health plans operating under 1915(b) Medicaid authority.

**Request for Applications (RFA).** Formal solicitation document in which services needed are identified and firms are invited to provide their qualifications to provide the services and their hourly rates.

**State.** The State of Washington

**Supporting Providers.** Entities that interface with the Health Home by virtue of providing services to the beneficiary. This may include medical, mental health, chemical dependency, long-term services and supports, hospitals, food banks, and housing programs.

## Exhibit C - ESSENTIAL REQUIREMENTS

Under Washington State's approach, Health Homes are the bridge to integrate care within existing care systems. A Health Home is the central point for directing patient-centered care and is accountable for the following:

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

Health Home Care Coordinators must be embedded in community-based settings to effectively manage the full breadth of beneficiary needs.

Health Home Provider Network – A Health Home provider network is administered by a lead entity. The lead entity contracts with one or more Care Coordination Organizations (CCOs) that will deliver Health Home services. The provider network must include local community agencies that authorize Medicaid, state or federally funded mental health, long-term services and supports, chemical dependency, and medical services, some of which will be CCOs. If the qualified Health Home supports managed care beneficiaries, the lead entity must have working agreements with all five (5) Healthy Options Managed Care Organizations (MCO) contracted with the state to ensure continuity of care if the Health Home beneficiary enrolls in a different MCO<sup>1</sup>. Other examples of providers to be included in Health Home networks are Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, Substance Use Disorder providers, Hospitals, Public Health Districts, Accountable Care Organizations, Medical Homes, Charities, Network Alliances, and community supports that assist with housing.

The Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) have identified specific administrative functions for both lead entities and CCOs. Our intent is to assure these functions are accounted for in the Health Home qualification process and documented in signed contracts and subcontracts. We are not restricting the accountability of the administrative functions. A qualified Health Home may delegate some or part of these functions to downstream contracts with proper oversight.

**Lead Entity Requirements** – The lead entity is accountable for administration of the Health Home. The lead entity:

1. Has experience operating broad-based regional provider networks.
2. Contracts directly with the state as a Qualified Health Home.<sup>2</sup>
3. Have capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network.

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<sup>1</sup> This does not mean that FFS lead entities or MCO lead entities have to contract with every other lead entity in the coverage area.

<sup>2</sup> Healthy Options MCOs may also serve as Lead Entities as long as the network is qualified by the state.

4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another CCO.
5. Subcontracts with organizations to directly provide the Health Home care coordination services.<sup>3</sup>
6. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
  - a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
  - b. Optimizes beneficiary choice.
7. Maintains a list of CCOs and their assigned Health Home population.
8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.
9. Collects and reports encounters to the HCA.
10. Disburses payment to CCOs based upon encounters.
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to-care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator.
12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

**Care Coordination Organization Requirements** – The Care Coordination Organization must:

1. Subcontract with the lead entity.
2. Assign a Health Home Care Coordinator to provide Health Home services.
3. Ensure Health Home Care Coordinators actively engage the beneficiary in developing a Health Action Plan.
4. Ensure documentation by all staff, including those complementing the work of a care coordinator.
5. Implement a systematic protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.

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<sup>3</sup> Contractual relationships between the lead entity and their Care Coordination partners must be developed and in place prior to beneficiary assignment.

6. Establish methods to share hallmark events with the Health Home Care Coordinator within established time periods, such as emergency department visits, inpatient hospitalizations, inpatient discharges, missed prescription refills, institutional placement and/or discharge, and the need for preventive care.
7. Use a system to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate recommended changes in care, as necessary, to address achievement of health action goals including the beneficiary's preferences and identified needs.<sup>4</sup>
8. Provide 24/7 availability of information and emergency consultation services to the beneficiary.
9. Assure hospitals have procedures in place for referring Health Home eligible beneficiaries who seek or need treatment in a hospital emergency department for Health Home enrollment.
10. Use informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices.
11. Provide Health Home services in a culturally competent manner that addresses health disparities. Examples of cultural competency:
  - a. Interacting directly with the beneficiary and his or her family by speaking their language,
  - b. Recognizing and applying cultural norms when creating the Health Action Plan, and
  - c. Understanding the dynamics of substance use disorder without judgment.
12. Ensure Health Home Care Coordinators (within the care coordination organization) can discuss with the treating/authorizing entities on an as-needed basis, changes in patient circumstances, condition or Health Action Plan that may necessitate timely, and in some circumstances, immediate changes in treatment or services.
  - a. A HIPAA-compliant data sharing agreement must be in place when sharing either hard copy or electronic health information;
  - b. The beneficiary must sign a "Health Home Patient Information Sharing Consent Form" before the Health Home Care Coordinator can share protected health information.
13. Ensure Health Home Care Coordinators:
  - a. Have access to PRISM, a clinical decision support tool, to view cross-system health and social service utilization to identify care opportunities.
  - b. Provide in-person beneficiary health screening and Health Action Planning, using HCA and DSHS standardized and approved screens and Health Action Plan template.

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<sup>4</sup> Preferences means an informed decision, input into a decision and decisions that have value to the beneficiary

- c. Accompany the beneficiaries to critical appointments when necessary to assist in achieving health action goals.
- d. Coordinate and mobilize treating/authorizing entities as necessary to reinforce and support the beneficiary's health action goals.
- e. Deliver culturally appropriate interventions, educational, and informational materials.
- f. Provide in-person care coordination activities.
- g. Include and leverage direct care workers (paid and unpaid) who have a role in supporting beneficiaries to achieve health action goals and access health care services.
- h. Address the full array of beneficiary needs, as reflected in the implementation of a person-centered Health Action Plan. This includes administering standardized health screening, identifying the root causes for inappropriate or gaps in health care utilization, and making referrals and coordinating communication across systems of care.

## Exhibit D - PROVIDER QUALIFICATION AND STANDARDS

Under Washington State's approach to Health Home implementation, a Health Home is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist, behavioral health and long-term care services and supports through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

Section 1945(h)(4) of the Social Security Act defines Health Home services as "comprehensive and timely high quality services" and includes the following Health Home services that must be provided by designated Health Home providers:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services, if relevant; and
6. The use of HIT to link services, as feasible and appropriate.

### I. General Qualifications

1. Health homes must be qualified by the state of Washington Medicaid program, and agree to comply with all Medicaid program requirements.
2. The Health Home provider network must:
  - a. Identify a lead entity, which will be accountable for administration of the Health Home. If the lead entity is a Medical provider, they must have a NPI on file.
  - b. Manage Administrative functions:
    - i. Collecting and submitting service encounters, payment disbursement, quality monitoring, contracting, and reporting.
    - ii. Collecting, analysis and reporting financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.
  - c. Have procedures in place for referring any Health Home beneficiary who seeks or needs treatment/services to a Medicaid designated provider.

- d. Provide access to multidisciplinary teams of health care professionals that can address the full breadth of clinical and social service expertise for individuals who require assistance due to complex Chronic Conditions, mental health and substance use disorder issues and long-term service needs and supports. Additional members of the multidisciplinary teams can be primary care providers, mental health professionals, chemical dependency treatment providers and social workers. Optional team members may include nutritionists/dieticians, direct care workers, pharmacists, peer specialists, family members or housing representatives.
  - e. Include providers from the local community that authorize Medicaid, state or federal funded mental health, long-term services and supports (including the direct care workforce), chemical dependency and medical services. For example, Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, Substance Use Disorder providers, and community supports that assist with housing.
3. Provide care coordination and integration of health care services to all Health Home beneficiaries through an assigned Care Coordinator who has access to an interdisciplinary team when necessary for care integration.
  4. Sub-contracts are in place with Health Home Care Coordination Organizations prior to the first request for reimbursement when partnerships involve a financial arrangement.
  5. Remain responsible for all Health Home program requirements, including services performed by any subcontractor.
  6. Health home interventions must be targeted to high risk/high cost beneficiaries and supported through assignment of a Care Coordinator who demonstrates the ability to:
    - a. Actively engage the beneficiary in developing a Health Action Plan; this shall be done in person whenever possible;
    - b. Reinforce and support the beneficiary's Health Action Plan;
    - c. Coordinate with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals;
    - d. Advocate, educate and support the beneficiary to attain and improve self-management skills;
    - e. Assure the receipt of evidence-based care;
    - f. Support beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and
    - g. Accompany the beneficiary to critical appointments.
  7. The beneficiary's Health Action Plan is under the direction of a dedicated Care Coordinator who is accountable for facilitating access to medical, behavioral health care, long-term services and support and community social supports and coordinating with entities that authorize these services as necessary to support the achievement of individualized health action goals.
  8. Hospitals that are part of a Health Home network must have procedures in place for transitioning care and referring beneficiaries who seek or need treatment in a hospital emergency department to the beneficiary's qualified Health Home.

## II. Comprehensive or Intensive Care Management

Policies, procedures and data collection systems are in place to create, document, execute and update an individualized, patient-centered Health Action Plan for each beneficiary that demonstrates a strong integrated network that is capable of providing the “high touch” support necessary for beneficiaries with complex, Chronic Conditions.

Most care management services should be delivered in person with periodic follow-up by phone. This includes the ability to accompany beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of individualized health goals designed to attain recovery, improve function or health status or prevent or slow declines in functioning. A Care Coordinator will help the beneficiary develop a Health Action Plan which will be accessible to the beneficiary, all Health Home team members the beneficiary’s providers, and family/caregivers.

The beneficiary’s Health Action Plan shall provide evidence of:

1. A comprehensive and culturally appropriate Health Action Plan completed within thirty (30) days of beneficiary agreement to participate in Health Home services, using evidence-based/informed practices where available. The Health Action Plan identifies Chronic Conditions, severity factors and gaps in care, the beneficiary’s activation level<sup>5</sup> and opportunities for potentially avoidable emergency room, inpatient hospital and institutional use.
2. Screening for depression and alcohol or substance use disorder appropriate to the age of the beneficiary and referral to services, as appropriate.
3. Measurement of the beneficiary’s activation level using the Patient Activation Measure tool or when appropriate the Caregiver Activation Measure (Insignia products); the beneficiary shall be reassessed every six (6) months while receiving Health Home services.
4. Active engagement of the beneficiary in goal setting, defining interventions and establishing the timeframes for goal achievement identified in the beneficiary’s Health Action Plan. Beneficiaries and their designees play a central and active role in the development, implementation and monitoring of their Health Action Plan. An individualized Health Action Plan shall reflect beneficiary and family preferences, education and support for self-management and other resources as appropriate.
5. Evidence-based/informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting health and health care choices.
6. Targeted clinical outcomes, including a description of how progress toward outcomes will be measured.
7. Use of peer supports, support groups and self-care programs to increase the beneficiary’s knowledge about their health conditions and improve adherence to prescribed treatment.

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<sup>5</sup> Training will be provided on the use of the Patient Activation Measure (PAM).

8. Routine and periodic health reassessment, at minimum every 6 months to include a reassessment of the level of Health Home services required to help the beneficiary meet clinical and patient-centered Health Action goals. Changes are made to the Health Action Plan based upon changes in beneficiary need or preferences.
9. Access to and retention of needed health care and community services and resources.

### III. Care Coordination and Health Promotion

The dedicated Care Coordinator shall play a central and active role in the development and execution of a cross-system Health Action Plan including assisting the beneficiary to access needed services. The Care Coordinator shall ensure communication is fostered between the providers of care including the designated Health Home team, the treating primary care provider, medical specialists and entities authorizing behavioral health services and long-term services and supports.

The beneficiary Health Action Plan and/or care management case file shall provide evidence of:

1. Outreach and engagement activities that support the beneficiary's participation in their care and that promote continuity of care.
2. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.
3. Communication between the dedicated Care Coordinator and the treating/authorizing entities and assurance that the Care Coordinator can discuss with these entities on an as needed basis, changes in patient circumstances, condition or Health Action Plan that may necessitate changes in treatment or service need.
4. Release of information to allow sharing of information that facilitates coordination of and transitions in care, as agreed to by the beneficiary.
5. Care coordination and collaboration through case review meetings as needed, including members of beneficiary's identified multidisciplinary team.
6. Twenty Four (24) hours/seven (7) days a week availability to provide information and emergency consultation services to the beneficiary.
7. Priority appointments for Health Home beneficiaries to medical, behavioral health, and long-term care services within the Health Home provider network to avoid unnecessary, inappropriate utilization of emergency room, inpatient hospital and institutional services.
8. Wellness and prevention education specific to the beneficiary's Chronic Conditions, including routine preventive care, support for improving social connections to community networks and linking beneficiaries with resources that support a health promoting lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing, based on individual needs and preferences.
9. Policies, procedures and accountabilities (contractual or memos of understanding/agreements) to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health, long-term services and supports and community based organizations.

#### IV. Comprehensive Transitional Care

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

The beneficiary Health Action Plan shall provide evidence of:

1. A notification system in place with hospitals, nursing homes and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of a beneficiary's admission and/or discharge from an emergency room, inpatient, nursing home or residential/rehabilitation facility and if proper permissions are in place, a substance use disorder treatment setting.
2. The use of a Health Home Care Coordinator as an active participant in all phases of care transition, including discharge visits during hospitalizations or nursing home stays, and home visits and telephone follow-up post hospital or institutional stay.
3. Beneficiary education that supports discharge care needs including medication management, follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of formal or informal caregivers when requested by the beneficiary.
4. A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.

#### V. Individual and Family Support Services (including authorized representatives and identified decision makers)

In recognition of the unique role the beneficiary may give family, identified decision makers and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support Health Action Planning, the Contractor shall ensure inclusion of these individuals in the planning and care management.

The Contractor shall ensure inclusion of peer supports, support groups, and self-management programs will be used by the Health Home provider to increase beneficiary and caregiver's knowledge of the beneficiary's Chronic Conditions, promote the beneficiary's engagement and self-management capabilities and help the beneficiary improve adherence to their prescribed treatment.

The beneficiary's Health Action Plan shall:

1. Identify and refer to resources that support the beneficiary in attaining the highest level of health and functioning in their families and in the community, including transportation to medically necessary services and housing.
2. Identify the role of formal and informal supports, including direct care providers of long-term services and supports that the beneficiary has identified to assist them in achieving health action goals.
3. Reflect and incorporate the preferences, education about and support for self-management; self-help recovery and other resources necessary for the beneficiary, their family and their caregiver to support the beneficiary's individualized health action goals.

4. Identify the role that families, informal supports and caregivers provide to achieve self-management and optimal levels of physical and cognitive function.
5. Document discussion of advance directives with beneficiaries and their families.
6. Demonstrate communication and information sharing with individuals and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

#### VI. Referral to Community and Social Support Services

The Health Home provider network identifies available community-based resources and actively manages referrals, assists the beneficiary in advocating for access to care, and engagement with community and social supports. Community and social support services include long-term services and supports, mental health, substance use disorder and other community and social services accessed by the beneficiary.

The beneficiary's Care Coordinator and identified multidisciplinary Health Home team shall:

1. Identify available community-based resources discussed with the beneficiary and actively manage appropriate referrals, advocates for access to care and services, provides coaching to beneficiaries to engage in self-care and follow-up with required services.
2. Provide assistance to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services. These services are coordinated with appropriate departments of local, state and federal governments and community based organizations.
3. Have policies, procedures, and accountabilities (through contractual or memos of understanding/agreements) to support effective collaboration with community based resources, which clearly define roles and responsibilities.
4. Provide documentation of referrals to and access by the beneficiary of community based and other social support services as well as health care services that contribute to achieving the beneficiary's health action goals.

#### VII. Use of Health Information Technology to Link Services

Health Home network providers will make use of available health information technology (HIT) and access data through the Predictive Risk Intelligence System (PRISM), Medicaid managed care organization or Fee-for-Service systems, and other processes as feasible as the state develops Electronic Medical Records standards for Medicaid providers.

The Health Home infrastructure shall:

1. Use HIT to identify and support management of high risk beneficiaries in care management.
2. Use conferencing tools to support case conferences/team based care, including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect Protected Health Information (PHI).

3. Use a system to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate changes in care, as necessary, to address beneficiary need and preferences.
4. Use web-based HIT registries and referral tracking systems.
5. Track service utilization and quality indicators and provide timely and actionable information to the Care Coordinator regarding under, over or inappropriate utilization patterns.
6. Develop a system with hospitals, nursing homes and residential/rehabilitation facilities to provide the Health Home prompt notification of a beneficiary's admission and/or discharge from an emergency room, inpatient, or residential/rehabilitation setting.
7. Develop methods to communicate real-time use of emergency room, inpatient hospitalizations, missed prescription refills and the need for evidence-based preventive care to the Care Coordinator.

VIII. Quality Measures Reporting to State

Health Homes must demonstrate the ability provide project management and oversight through their data, data sources and management systems when monitoring the Health Home delivery system. Health Homes must demonstrate the ability to collect, report, and share data with other providers, including HCA and DSHS for quality reporting purposes.

The Health Home lead entity is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes as measured by HCA and CMS required quality measures. Performance measures are identified on the following table:

Program Goals	Measure Title	Description	Numerator/Denominator	Measure Source
<b>Goal 1 - Increase Beneficiary Participation and Activation</b>		The numbers of beneficiaries willing to set a health action goal <b>(Participation Rate)</b>	<b>Numerator:</b> Number of high-risk Health Home beneficiaries willing to set a care plan goal <b>Denominator:</b> Total number of eligible high-risk Health Home beneficiaries	Enrollment data; validated in High-risk Client Assessment Database <sup>6</sup>
		Increase average PAM score of participating high-risk Health Home beneficiaries <b>(Activation Rate)</b>	<b>Numerator:</b> Sum of Patient-Activation Measure (PAM) scores <b>Denominator:</b> Total number of enrolled high-risk Health Home beneficiaries with baseline PAM score	Beneficiary reported. Insignia PAM database

<sup>6</sup> In MCO contract – “Enrollees with Special Health Care Needs Database,” page 107

<b>Goal 2 - Reduce Non-Emergent Emergency Department Visits</b>		Decrease ED visits for Ambulatory Care-sensitive conditions per 1000 enrolled Health Home member months.	<b>Numerator:</b> ED visits for Ambulatory Care sensitive conditions <b>Denominator:</b> Enrolled Health Home member months/1000	Claims and Encounter data
<b>Goal 3 - Reduce Nursing Home Placements</b>		Decrease skilled nursing facility placements per 1000 beneficiary member months	<b>Numerator:</b> Skilled nursing facility placements <b>Denominator:</b> Beneficiary member months /1000	Claims and Encounter data
<b>Goal 4 - Reduce Hospital Readmissions</b>	Plan-All Cause Readmissions (NCQA) – CMS Required Health Home measure	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.	<b>Numerator:</b> Number of 30 day all cause readmissions <b>Denominator:</b> Total enrolled high-risk Health Home beneficiary member months per 1000	Claims and Encounter data
	Ambulatory Care-Sensitive Condition Admission (NQMC Rosenthal) – CMS Required Health Home measure	Decrease selected Ambulatory Care-Sensitive Condition Admissions for PQ1 01 Diabetes and PQI 15 (adult asthma) admissions	<b>Numerator:</b> PQI 01 Diabetes & PQI 15 Adult asthma <b>Denominator:</b> Total enrolled high-risk Health Home beneficiaries member months/1000	

	Follow-up After Hospitalization for Mental Illness (NCQA) – CMS Required Health Home measure	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	<p><b>Numerator:</b> An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.</p> <p><b>Denominator:</b> Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year</p>	
	Care Transition – Transition Record Transmitted to Health care Professional (AMA-PCPI) – CMS Required Health Home measure	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	<p><b>Numerator:</b> Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</p> <p><b>Denominator:</b> All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care</p>	
<b>Goal 5 - Improve mental health identification and treatment</b>	Screening for Clinical Depression and Follow-up Plan (CMS) – CMS Required Health Home measure	<p>Percentage of patients aged 18 years and older screened for clinical depression using PHQ-9 (Patient Health Questionnaire)</p> <p>A data source is being developed so</p>	<p><b>Numerator:</b> Total number of Health home beneficiaries with PHQ-I score</p> <p><b>Denominator:</b> total number of enrolled high-risk Health Home beneficiaries aged 18 and older.</p>	

		that this measure can be collected and reported. In the first year, the collection of the measure will be reported. In the 2 <sup>nd</sup> year, the scores will be reported		
<b>Goal 6 - Improve initiation and engagement of alcohol and substance use treatment</b>	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NCQA) – CMS Required Health Home measure	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: <ul style="list-style-type: none"> <li>•Initiation of AOD treatment.</li> <li>•Engagement of AOD treatment.</li> </ul>	<p><b>Numerator:</b> Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.</p> <p><b>Denominator:</b> Members 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.</p>	Claims, encounters and High-risk Client Assessment Database <sup>7</sup>

<sup>7</sup> In MCO contract – “Enrollees with Special Health Care Needs Database,” page 107

IX. CMS HEALTH HOME CORE QUALITY MEASURE SET

Measure Title	Measure Description	Numerator/Denominator	Measure Source
<p><b>10. Adult BMI Assessment</b></p>	<p>Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year</p>	<p><b>Numerator Description</b></p> <p>Body mass index documented during the measurement year or the year prior to the measurement year</p> <p><b>Denominator Description</b></p> <p>Members 18-74 of age who had an outpatient visit</p>	<p>NCQA</p>
<p><b>11. Ambulatory Care-Sensitive Condition Admission</b></p>	<p>Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 populations under age 75 years.</p>	<p><b>Numerator Description</b></p> <p>Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years</p> <p><b>Denominator Description</b></p> <p>Total mid-year population under age 75</p>	<p>NQMC Rosenthal</p>
<p><b>12. Care Transition – Transition Record Transmitted to Health care Professional</b></p>	<p>Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.</p>	<p><b>Numerator Description</b></p> <p>Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</p> <p><b>Denominator Description</b></p> <p>All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care</p>	<p>AMA-PCPI</p>

<p><b>13. Follow-Up After Hospitalization for Mental Illness</b></p>	<p>Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.</p>	<p><b>Numerator Description</b> An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.</p> <p><b>Denominator Description</b> Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year</p>	<p>NCQA</p>
<p><b>14. Plan- All Cause Readmission</b></p>	<p>For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.</p>	<p><b>Numerator Description</b> Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination</p> <p><b>Denominator Description</b> Count the number of Index Hospital Stays for each age, gender, and total combination</p>	<p>NCQA</p>
<p><b>15. Screening for Clinical Depression and Follow-up Plan</b></p>	<p>Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented</p>	<p><b>Numerator Description</b> Total number of patients from the denominator who have follow-up documentation</p> <p><b>Denominator Description</b> All patients 18 years and older screened for clinical depression using a standardized tool</p>	<p>CMS</p>

<p><b>16. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</b></p>	<p>Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following:</p> <ul style="list-style-type: none"> <li>• Initiation of AOD treatment.</li> <li>• Engagement of AOD treatment.</li> </ul>	<p><b>Numerator Description</b></p> <p>Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.</p> <hr/> <p>Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.</p> <p><b>Denominator Description</b></p> <p>Members 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.</p>	<p>NCQA</p>
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X. Health Home Provider Functional Requirements (SMD 10-024)

Health Home providers must demonstrate their ability to perform each of the following federally-required functions, including documentation of the processes used to perform these functions and the processes and timeframes used to assure service delivery takes place in the described manner. Documentation should also include a description of the proposed multifaceted Health Home service interventions that will be provided to promote patient engagement, participation in their plan of care and that ensure patients appropriate access to the continuum of physical and behavioral health care and social services.

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services.
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
4. Coordinate and provide access to mental health and substance abuse services.
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
8. Coordinate and provide access to long-term care supports and services.
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

## **Exhibit E – EXCEL PROVIDER NETWORK WORKSHEET**

Provider networks will be scored based on the data contained in the Excel Provider Network Worksheet. The Provider Network Worksheet can be found on the RFA website.

## **Exhibit F - LIST OF PCCM CLINICS**

### Urban Indian Clinics (FQHC's)

- Seattle Indian Health Board
- Native Project (Spokane)

### Indian Health Service

- Colville Tribal clinic
- Yakama Tribal Health
- Spokane Tribes – David Wyncoop Clinic

### Tribal Clinic Contracts:

- Quinault Indian Nation
- Quileute Tribe
- Nooksack Tribe
- Lummi Nation
- Shoalwater Bay Tribe
- Confederated Tribes of the Colville Reservation – Inchelium (Colville has two clinics – one IHS and one tribal)
- Port Gamble S'Klallam
- Tulalip Nation
- Lower Elwha Klallam
- Puyallup

## Exhibit G – PROPOSAL SUBMITTAL CHECKLIST

### CHECKLIST FOR RESPONSIVENESS

This is a tool provided for Bidders to ensure they are submitting all the necessary documents required in the RFA.

- Proposal was submitted via the address listed in Section 2.3 on or before **3:00 p.m., Pacific Time on July 12, 2013**. Proposal will not be accepted if sent via email. Proposal contained the following items:
  - One (1) Original with signature in **blue** ink including one (1) CD;
  - Six (6) copies each including a CD of the Applicant's provider network, of original with copies of signatures;
  - 3.1 Letter of Submittal (LOS). If responses to questions in LOS required additional pages, those pages are attached to the LOS;
  - Exhibit H– Certifications and Assurances (C&A);
  - 3.1 C - Business References;
  - Proposal was formatted as specified in Section 3 Proposal Contents and 2.3 Submission of Proposals;
  - Proposal was formatted into the major sections: LOS, Minimum Qualifications Section, Excel Provider Network Spreadsheet, Organizational Infrastructure and Provider Network, Core Health Home Requirements, and CMS Health Home Provider Functional Requirements;
  - Letter of Submittal and Exhibit H, Certifications and Assurances were **signed** by an individual authorized to bind the organization to a contractual relationship, e.g., the President or Executive Director if a corporation, the managing partner if a partnership, or the sole proprietor if a sole proprietorship;
  - Exhibit E, Excel Spreadsheet is essentially responsive to the core requirements in the RFA;
  - Organizational Infrastructure and Provider Network is essentially responsive to core requirements of the RFA;
  - Core Health Home Requirements is essentially responsive to core requirements of the RFA;
  - CMS Core Health Home Provider Functional Requirements is essentially responsive to core requirements of the RFA;

**Exhibit H**

**CERTIFICATIONS AND ASSURANCES**

1. I/we make the following certifications and assurances as a required element of the proposal to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):
2. I/we declare that all answers and statements made in the proposal are true and correct.
3. The attached proposal is a firm offer for a period of 180 days following receipt, and it may be accepted by HCA without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 180-day period.
4. In preparing this proposal, I/we have not been assisted by any current or former employee of the state of Washington whose duties relate (or did relate) to this proposal or prospective contract, and who was assisting in other than his or her official, public capacity. (Any exceptions to these assurances are described in full detail on a separate page and attached to this document.)
5. I/we understand that HCA will not reimburse me/us for any costs incurred in the preparation of this proposal. All proposals become the property of HCA, and I/we claim no proprietary right to the ideas, writings, items, or samples, unless so stated in this proposal.
6. I/we agree that submission of the attached proposal constitutes acceptance of the solicitation contents and the attached sample contract and general terms and conditions. If there are any exceptions to these terms, I/we have described those exceptions in detail on a page attached to this document.
7. No attempt has been made or will be made by the Proposer to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.
8. I/we grant HCA the right to contact references and others, who may have pertinent information regarding the Proposer's prior experience and ability to perform the services contemplated in this solicitation.
9. If any staff member(s) who will perform work on this contract has retired from the State of Washington under the provisions of the 2008 Early Retirement Factors legislation, his/her name(s) is noted on a separately attached page.

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**Signature of Proposer**

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**Title**

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**Date**

**Exhibit I**

**SAMPLE ONLY FINAL CONTRACT TERMS SUBJECT TO NEGOTIATION**

	<h2 style="margin: 0;">CLIENT SERVICES CONTRACT</h2> <p style="margin: 0;">cL</p>	HCA Contract Number:
This Contract is by and between the State of Washington Health Care Authority ("HCA") and the Contractor identified below		Contractor Contract Number:
CONTRACTOR NAME		CONTRACTOR doing business as (DBA)
CONTRACTOR ADDRESS		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)
		CONTRACTOR FEDERAL EMPLOYER IDENTIFICATION NUMBER
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS
HCA PROGRAM AREA	HCA INDEX NUMBER	HCA CONTRACT CODE
HCA CONTACT NAME AND TITLE		HCA CONTACT ADDRESS
HCA CONTACT TELEPHONE		HCA CONTACT E-MAIL ADDRESS
IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF THIS CONTRACT?		CFDA NUMBER(S)
CONTRACT START DATE	CONTRACT END DATE	MAXIMUM CONTRACT AMOUNT
EXHIBITS. The following Exhibits are attached and are incorporated into this Contract by reference: <input checked="" type="checkbox"/> Data Security: Exhibit A: Data Security Requirements, <input checked="" type="checkbox"/> Other Exhibits (specify): Exhibit B: Federal Compliance, Certifications, and Assurances <input type="checkbox"/> No Exhibits.		
The terms and conditions of this Contract are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise regarding the subject matter of this Contract, between the parties. The parties signing below represent they have read and understand this Contract, and have the authority to execute this Contract. This Contract shall be binding on HCA only upon signature by HCA.		
CONTRACTOR SIGNATURE		PRINTED NAME AND TITLE
		DATE SIGNED
HCA SIGNATURE		PRINTED NAME AND TITLE
		DATE SIGNED

## HCA Special Terms and Conditions

1. **Definitions Specific to Special Terms.** The words and phrases listed below, as used in this Contract, shall each have the following definitions:
  - 1.1 “...” means \_\_\_\_\_.
  - 1.2 “...” means \_\_\_\_\_.
2. **Purpose.** The purpose of this Contract is to:
3. **Performance Work Statement.** The Contractor shall provide the services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:
4. **Monitoring.**
5. **Consideration.**
6. **Billing and Payment.**
7. **Background Checks.**

This requirement applies to any employees, volunteers and subcontractors who may have unsupervised access to children or vulnerable adults served under this Contract.

The Contractor shall ensure a criminal history background check pursuant to RCW 43.43.832, 43.43.834, RCW 43.20A.710 and Chapter 388-06 WAC, or its successor, has been completed for all current employees, volunteers, and subcontractors, and that a criminal history background check shall be initiated for all prospective employees, volunteers and subcontractors who may have unsupervised access to children or vulnerable adults served under this Contract. The Contractor shall assist in obtaining additional state or national criminal history and/or child abuse/neglect history, if requested by HCA. The Contractor shall ensure that no employee, volunteer or subcontractor, including those provisionally hired pursuant to RCW 43.43.832(7), has unsupervised access to children or vulnerable adults served under this Contract, until a full and satisfactory background check is completed and documentation, qualifying the individual for unsupervised access, is returned to the Contractor.

8. **Disclosure of Information on Ownership and Control**

- 8.1 The Contractor must provide the following disclosures (42 CFR §455.104):

- 8.1.1 The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

## HCA Special Terms and Conditions

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

8.1.3 Other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any subcontractor in which the Contractor has a five (5) percent or more interest.

8.2 Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Contractor has a five (5) percent or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.

8.3 The name of any other entity in which an owner of the Contractor has an ownership or control interest.

8.4 The name, address, date of birth, and Social Security Number of any managing employee of the Contractor.

8.5 Disclosures from the Contractor are due at any of the following times:

8.5.1 Upon the Contractor submitting the proposal in accordance with HCA's solicitation process;

8.5.2 Upon the Contractor executing the Contract with HCA;

8.5.3 Upon renewal or extension of the Contract; and

8.5.4 Within thirty five (35) days after any change in ownership of the Contractor.

## 9. Disputes.

9.1 Requesting dispute resolution:

The request for contract dispute resolution by either party shall:

9.1.1 Be submitted to HCA in writing and include the Contractor's name, address and the HCA contract number;

9.1.2 Be sent by certified mail or other method providing a signed receipt to the sender to prove delivery to and receipt by HCA, to the following address:

Contract Services  
Legal and Administrative Services  
Health Care Authority  
PO Box 42702  
Olympia, Washington 98504-2702

9.1.3 Be received by Contract Services no later than twenty-eight (28) calendar days after this Contract expiration or termination; and

## HCA Special Terms and Conditions

9.1.4 Identify in writing the spokesperson for the Contractor, if other than the Contractor's signatory.

9.2 Content of the dispute request:

The party requesting a dispute resolution shall submit a statement that:

9.2.1 Identifies the issue(s) in dispute;

9.2.2 Identifies the relative positions of the parties; and

9.2.3 Requests resolution through the current HCA process.

9.3 Action on the request:

9.3.1 HCA shall notify the non-requesting party that the request has been made, notify both parties of the dispute resolution process to be followed, and manage the process to its conclusion.

9.3.2 The Contractor shall provide pertinent information as requested by the person assigned to resolve the dispute.

9.4 Contractor and HCA agree that, the existence of a dispute notwithstanding, they will continue without delay to carry out all their respective responsibilities under this Contract that are not affected by the dispute.

### 10. Excluded Individuals and Entities.

The Contractor is prohibited from paying with funds received under this Contract for goods and services furnished, ordered or prescribed by excluded individuals and entities (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR §455.104, 42 CFR §455.106, and 42 CFR §1001.1901(b)).

The Contractor shall:

10.1 Monitor for excluded individuals and entities by:

10.1.1 Screening Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract.

10.1.2 Screening monthly newly added Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from funds received under this Contract.

10.1.3 Screening monthly Contractor and subcontractor's employees and individuals and entities with an ownership or control interest that would benefit from funds received under this Contract for newly added excluded individuals and entities.

## HCA Special Terms and Conditions

### 10.2 Report to HCA:

10.2.1 Any excluded individuals and entities discovered in the screening within ten (10) business days.

10.2.2 Any payments made by the Contractor that directly or indirectly benefit excluded individuals and entities and the recovery of such payments.

10.2.3 Any actions taken by the Contractor to terminate relationships with Contractor and subcontractor's employees and individuals with an ownership or control interest discovered in the screening.

10.2.4 Any Contractor and subcontractor's employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 within ten (10) business days of the Contractor becoming aware of the conviction.

10.2.5 Any subcontractor terminated for cause within ten (10) business days of the effective date of termination to include full details of the reason for termination.

10.2.6 Any Contractor and subcontractor's individuals and entities with an ownership or control interest. The Contractor must provide a list with details of ownership and control upon request by HCA and keep the list up-to-date at all times.

### 10.3 The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

10.3.1 The Contractor will immediately terminate any employment, contractual, and control relationships with an excluded individual and entity that it discovers.

10.3.2 Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees. (SSA section 1128A(a)(6) and 42 CFR §1003.102(a)(2))

10.3.3 An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR §455.104(a), and 42 CFR §1001.1001(a)(1)).

10.3.4 In addition, if HCA notifies the Contractor that an individual or entity is excluded from participation in the Health Home program by HCA, the Contractor shall terminate all beneficial, employment and contractual, and control relationships with the excluded individual or entity immediately (WAC 388-502-0030).

10.3.5 The list of excluded individuals will be found at:  
<http://www.oig.hhs.gov/fraud/exclusions.asp>

10.3.6 SSA section 1128 will be found at:  
[http://www.ssa.gov/OP\\_Home/ssact/title11/1128.htm](http://www.ssa.gov/OP_Home/ssact/title11/1128.htm)

## HCA Special Terms and Conditions

### 11. HIPAA and HITECH Compliance.

#### 11.1 Definitions.

Unless otherwise defined, the terms used in this Section shall have the definitions set forth in the HIPAA Security and Privacy Rule, as amended.

11.1.1 "Business Associate" means the "Contractor" and shall have the meaning given such term under HIPAA, the HITECH Act, applicable regulations and federal agency guidance. Any reference to Business Associate includes all Business Associate's employees, agents, officers, subcontractors, third party contractors, volunteers, and directors.

11.1.2 "Client" means an applicant, recipient, or former applicant or recipient of any service of program administered by HCA, including a Medicaid recipient or Basic Health recipient.

11.1.3 "Covered Entity" means HCA and shall have the meaning given such term under HIPAA, the HITECH, applicable regulations and federal agency guidance.

11.1.4 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191.

11.1.5 "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

11.1.6 "Individually Identifiable Health Information" means health information, including demographic information collected from an individual, and:

11.1.6.1 Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

11.1.6.2 Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

11.1.6.2.1 That identifies the individual; or

11.1.6.2.2 With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

11.1.7 "Protected Health Information" or "PHI" means Individually Identifiable Health Information;

11.1.7.1 Except as provided in paragraph (b) of this definition, that is:

11.1.7.1.1 Transmitted by electronic media;

11.1.7.1.2 Maintained in electronic media; or

11.1.7.1.3 Transmitted or maintained in any other form or medium.

## HCA Special Terms and Conditions

11.1.7.2 Protected health information excludes individually identifiable health information in:

11.1.7.2.1 Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;

11.1.7.2.2 Records described at 20 U.S.C. 1232g(a)(4)(B)(iv);  
and

11.1.7.2.3 Employment records held by a covered entity in its role as employer.

11.1.8 "Privacy Rule" means the standards for privacy of individually identifiable health information in 45 CFR Parts 160 and 164, as amended and related federal agency guidance.

11.1.9 "Security Rule" means the security standards in 45 CFR Parts 160, 162, and 164, and amended and related federal agency guidance.

11.1.10 "Unsecured protected health information" means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site.

### 11.2 Compliance.

11.2.1 Business Associate shall perform all Contract duties, activities and tasks in compliance with HIPAA and its attendant regulations enacted pursuant to its provisions, successor law and/or regulation.

11.2.2 The Business Associate shall also perform all Contract duties, activities and tasks in compliance with the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"). The HITECH Act was adopted as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and breach notification. These provisions of the HITECH Act and the regulations applicable to Business Associates are collectively referred to as the "HITECH Business Associate Provisions." The Contractor acknowledges and agrees that to the extent it is functioning as a Business Associate of HCA, the Contractor shall comply with the HITECH Business Associate Provisions and with the obligations of a Business Associate, as prescribed by HIPAA and the HITECH Act.

### 11.3. Use and Disclosure of Protected Health Information (PHI).

Business Associate is limited to the following permitted and required uses or disclosures of HCA Client PHI:

11.3.1 Duty to Protect HCA Client PHI. Business Associate shall protect PHI from, and shall establish and implement appropriate safeguards to prevent, unauthorized disclosure of PHI in accordance with the terms and conditions of this Agreement and state and federal law, including any regulations governing the security of PHI and the transmission, storage, or maintenance of electronic data that contains PHI, for as long as the PHI is within its possession and control, even after the termination or expiration of this Agreement.

## HCA Special Terms and Conditions

11.3.2 Return of HCA Client PHI. Within ten (10) working days of termination or expiration of this Agreement, Business Associate shall, in accordance with Contract Termination and Expiration Procedures, and at the discretion of Covered Entity, either return or destroy all PHI, including PHI in possession of third parties under contract to Business Associate. If return or destruction is infeasible, Business Associate shall protect such PHI and limit its further use and disclosure to those purposes that make return or destruction infeasible for as long as the PHI is within the Business Associate's possession and control, even after the termination or expiration of this Agreement.

11.3.3 Minimum Necessary Standard. Business Associate shall apply the HIPAA Minimum Necessary standard to any use or disclosure of HCA Client PHI necessary to achieve the purposes of this Agreement. See, 45 CFR §164.514 (d)(2) through (d)(5).

11.3.4 Disclosure as Part of the Provision of Services. Business Associate only shall use or disclose HCA Client PHI as required to perform the services specified in this Agreement or as required by law, and shall not use or disclose such PHI in any manner inconsistent with the use and disclosure restrictions placed on the Covered Entity by HIPAA.

11.3.5 Impermissible Use or Disclosure of HCA Client PHI. Business Associate shall report to HCA Contract Services and Security Administrator in writing all uses or disclosures of PHI not provided for by this Agreement within one (1) working day of becoming aware of the unauthorized use or disclosure of the PHI. Upon request by HCA Contract Services or Security Administrator, Business Associate shall mitigate, to the extent practicable, any harmful effect resulting from the impermissible use or disclosure.

11.3.6 Failure to Cure. If HCA learns of a pattern or practice of the Business Associate that constitutes a violation of the Business Associate's obligations under the terms of this Agreement and reasonable steps by HCA does not end the violation, HCA shall terminate this Agreement. If termination is not feasible, HCA will report the problem to the Secretary of the United States Department of Health and Human Services.

11.3.7 HCA Notice of Requests for Disclosure. HCA shall notify Business Associate when HCA Client PHI is requested from HCA that has been previously provided to Business Associate by HCA. The parties will jointly determine whether Business Associate has received a duplicate request or if Business Associate has the original or sole copy of the PHI.

11.3.8 Consent to Audit. Business Associate shall give reasonable access to HCA Client PHI, records, books, documents, electronic data, and all other business information received from, or created or received by, Business Associate on behalf of HCA, to the Secretary and to HCA for use in determining HCA compliance with HIPAA privacy requirements.

### 11.4 Individual Rights

11.4.1 Accounting of Disclosures. Business Associate agrees to maintain a record of all disclosures of Client PHI in accordance with the HIPAA Privacy and Security Rules and the HITECH Act and federal agency guidance. Business Associate shall make such record available to the Client or the Covered Entity within ten (10) working days of a request for an accounting of disclosures.

11.4.2 Amendment. If HCA amends, in whole or in part, a record or PHI contained in an Individual's Designated Record Set and HCA has previously provided the PHI or record that is the subject of the amendment to Business Associate, then HCA shall inform Business

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Associate of the amendment pursuant to 45 CFR 164.526 and Business Associate shall incorporate such amendment.

11.4.3 Requests for Restriction. Business Associate agrees to comply with any requests for restrictions on certain disclosures of PHI pursuant to the HIPAA Privacy and Security Rules.

11.4.4 Right of Access to PHI. Business Associate agrees to make available PHI to the extent and in a manner required by the HIPAA Privacy and Security Rules.

11.4.5 Third Party Agreements. Business Associate shall enter into a written contract that contains the same terms, restrictions, and conditions as the HIPAA and HITECH Compliance provision in this Agreement, with any agent, subcontractor, independent contractor, or other third party that has access to the HCA Client PHI accessible to Business Associate under the terms of this Agreement.

### 11.5 Breach Notification

11.5.1 Notice of Breach. In the event of a breach of unsecured Protected Health Information (PHI) or disclosure that compromises the privacy or integrity of PHI obtained from HCA or involved HCA Clients, Business Associate shall take all measures required by state or federal law. Business Associate shall provide Covered Entity with a copy of its investigation results and other information requested by Covered Entity. Business Associate shall report all PHI breaches to the U. S. Department of Health and Human Services, Office of Civil Rights (OCR) as required by 45 CFR Parts 160 and 164, and will also provide notification to the HCA Contract Services and Security Administrator that a report has been filed with OCR.

#### 11.5.2 Notification of Breach.

11.5.2.1 A business associate of a covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information shall, following the discovery of a breach of such information, notify the covered entity of such breach. The Business Associate shall notify Covered Entity within one (1) business day by telephone and in writing of any acquisition, access, use or disclosure of PHI and/or EPHI not allowed by the provisions of this Agreement of which it becomes aware, and of any instance where PHI is subpoenaed, copied or removed by anyone except an authorized representative of Covered Entity or the Business Associate, 45 CFR §§164.304, 164.314(a)(2)(C), 164.504(e)(2)(ii)(C), and 164.400-414.

11.5.2.1.1 Business Associate shall notify the HCA Security Administrator within one (1) business day by telephone or email of any potential breach of security or privacy.

11.5.2.1.2 Business Associate shall follow telephone or email notification with a written explanation of the breach, to include the following: date of the discovery of the breach; date and time of the breach; medium that contained the PHI; origination and destination of PHI; Business Associate unit and personnel associated with the breach, detailed description of PHI; any steps individuals should take to protect themselves from potential harm resulting from the breach; anticipated mitigation steps which includes a brief description of what the Business Associate is doing to investigate the breach, to mitigate

## HCA Special Terms and Conditions

harm to individuals, and to protect against any further breaches; the name, address, telephone number, and email of the individual who is responsible for the mitigation; any contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address. Business Associate shall address communications to:

HCA Security Administrator  
Washington State Health Care Authority  
Cherry Street Plaza  
626 Eighth Avenue SE  
PO Box 45512  
Olympia, WA 98504-5512  
Email: hrsaitsecurity@hca.wa.gov

### 11.5.3 Administrative Requirements

11.5.3.1 If Covered Entity determines that Business Associate or its agent(s) is responsible for a breach of unsecured HCA Client PHI:

11.5.3.1.1 Necessitating notification of individuals under 45 CFR §164.404, Business Associate bears the responsibility and costs for notifying the affected individuals and receiving and responding to those individuals' questions or requests for additional information;

11.5.3.1.2 Necessitating Notification of the media under 45 CFR §164.406, Business Associate bears the responsibility and costs for notifying the media and receiving and responding to media questions or requests for additional information;

11.5.3.1.3 Necessitating notification of the U. S. Department of Health and Human Services Secretary under 45 CFR §164.408, Business Associate bears the responsibility and costs of notifying the Secretary and receiving and responding to the Secretary's questions or requests for additional information; and

11.5.3.1.4 Covered Entity shall take appropriate remedial measures up to termination of this Agreement. This includes imposing a civil money penalty upon a Business Associate or its agent(s) if the Covered Entity is fined by the Secretary.

11.6 Termination of Agreement. In addition to the special terms and conditions listed in the Agreement related to terminations, the following rules also apply:

11.6.1 The Covered Entity can immediately terminate the agreement if the Covered Entity determines the Business Associate has violated a material term of the agreement.

11.6.2 The Covered Entity need not provide a cure period before termination.

11.6.3 Failure to terminate for breach in one (1) instance does not preclude the Covered Entity from terminating the contract for that breach at some point in the future or for any future material breach.

## HCA Special Terms and Conditions

### 12. Insurance.

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

#### 12.1 General Liability Insurance

The Contractor shall maintain Commercial General Liability Insurance, or Business Liability Insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The policy shall include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. The State of Washington, Health Care Authority (HCA), and its elected and appointed officials, agents, and employees of the state, shall be named as additional insureds.

In lieu of general liability insurance mentioned above, if the Contractor is a sole proprietor with less than three contracts, the Contractor may choose one of the following three general liability policies-but only if attached to a professional liability policy, and if selected, the policy shall be maintained for the life of this Contract:

Supplemental Liability Insurance, including coverage for bodily injury and property damage that will cover the contractor wherever the service is performed with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The State of Washington, Health Care Authority (HCA), its elected and appointed officials, agents, and employees shall be named as additional insureds.

Or

Workplace Liability Insurance, including coverage for bodily injury and property damage that provides coverage wherever the service is performed with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The State of Washington, Health Care Authority (HCA), and its elected and appointed officials, agents, and employees of the state, shall be named as additional insureds.

Or

Premises Liability Insurance and provide services only at their recognized place of business, including coverage for bodily injury, property damage with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The State of Washington, Health Care Authority (HCA), and its elected and appointed officials, agents, and employees of the state, shall be named as Additional Insured.

#### 12.2 Business Automobile Liability Insurance

The Contractor shall maintain a Business Automobile Policy on all vehicles used to transport Clients, including vehicles hired by the Contractor or owned by the Contractor's employees, volunteers or others, with the following minimum limits: \$1,000,000 per accident combined single limit. The Contractor's carrier shall provide HCA with a waiver of subrogation or name HCA as an Additional Insured.

## HCA Special Terms and Conditions

### 12.3 Professional Liability Insurance (PL)

The Contractor shall maintain Professional Liability Insurance or Errors & Omissions insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - \$1,000,000; Aggregate - \$2,000,000.

### 12.4 Worker's Compensation

The Contractor shall comply with all applicable Worker's Compensation, occupational disease, and occupational health and safety laws and regulations. The State of Washington and HCA shall not be held responsible for claims filed for Worker's Compensation under Title 51 RCW by the Contractor or its employees under such laws and regulations.

### 12.5 Employees and Volunteers

Insurance required of the Contractor under this Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers. In addition, the Contractor shall ensure that all employees and volunteers who use vehicles to transport clients or deliver services have personal automobile insurance and current driver's licenses.

### 12.6 Subcontractors

The Contractor shall ensure that all subcontractors have and maintain insurance with the same types and limits of coverage as required of the Contractor under this Contract.

### 12.7 Separation of Insureds

All insurance policies shall include coverage for cross liability and contain a "Separation of Insureds" provision.

### 12.8 Insurers

The Contractor shall obtain insurance from insurance companies identified as an admitted insurer/carrier in the State of Washington, with a Best's Reports' rating of B++, Class VII, or better. Surplus Lines insurance companies will have a rating of A-, Class VII, or better.

### 12.9 Evidence of Coverage

The Contractor, upon request by HCA staff, shall submit a copy of the Certificate of Insurance, policy, and additional insured endorsement for each coverage required of the Contractor under this Contract. The Certificate of Insurance shall identify the Washington State Health Care Authority (HCA) as the Certificate Holder. A duly authorized representative of each insurer, showing compliance with the insurance requirements specified in this Contract, shall execute each Certificate of Insurance. The Contractor is not required to submit to the HCA copies of Certificates of Insurance for personal automobile insurance required of the Contractor's employees and volunteers under this Contract.

The Contractor shall maintain copies of Certificates of Insurance for each subcontractor as evidence that each subcontractor maintains insurance as required by this Contract.

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### 12.10 Material Changes

The insurer shall give HCA 45 days advance written notice of cancellation or non-renewal. If cancellation is due to non-payment of premium, the insurer shall give HCA 10 days advance written notice of cancellation.

### 12.11 General

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

## 13. Notices.

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

13.1 In the case of notice to the Contractor, notice shall be sent to the point of contact identified on page one (1) of this Contract;

13.2 In the case of notice to HCA, notice shall be sent to:

Contract Services  
Legal and Administrative Services  
Washington State Health Care Authority  
P. O. Box 42702  
Olympia, Washington 98504-2702  
[Contracts@hca.wa.gov](mailto:Contracts@hca.wa.gov)

Notice shall become effective on the date delivered as evidenced by the return receipt or the date returned to sender for non-delivery other than for insufficient postage. Either party may at any time change its address for notification purposes by mailing a notice in accordance with this Section, stating the change and setting forth the new address, which shall be effective on the tenth (10th) day following the effective date of such notice unless a later day is specified in the notice.

## 14. Professional Credentialing and Licensure.

If the Contractor, its employees, and/or subcontractors who shall be in contact with HCA clients while performing work under this Contract must be accredited, certified, licensed or registered according to Washington state laws and regulations; the Contractor shall ensure that all such individuals do not have, and shall remain without during the term of this Contract, restrictions or sanctions placed on such accreditation, certification, license and/or registration. The Contractor shall notify the HCA Contact listed on page one (1) of this Contract within three (3) business days of receipt of information relating to disciplinary action against the accreditation, certification, license and/or registration of the Contractor, an employee or subcontractor.

## HCA General Terms and Conditions

1. **Definitions.** The words and phrases listed below, as used in this Contract, shall each have the following definitions:
  - 1.1 "Agent" shall mean the Washington State Health Care Authority Director and/or the Director's delegate authorized in writing to act on behalf of the Director.
  - 1.2 "Allowable Cost" means an expenditure which meets the test of the appropriate Executive Office of the President of the United States' Office of Management and Budget Circular. The most significant factors which determine whether a cost is allowable are the extent to which the cost is:
    - 1.2.1 Necessary and reasonable;
    - 1.2.2 Allocable;
    - 1.2.3 Authorized or not prohibited under Washington state or local laws and regulations;
    - 1.2.4 Adequately documented.
  - 1.3 "Authority" shall mean the Washington State Health Care Authority, any division, section, office, unit or other entity of the Authority, or any of the officers or other officials lawfully representing the Authority.
  - 1.4 "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, Personal Information.
  - 1.5 "Contract" or "Agreement" means the entire written agreement between the Authority and the Contractor, including any Exhibits, documents, or materials incorporated by reference. The parties may execute this Contract in multiple counterparts, each of which is deemed an original and all of which constitutes as one agreement. E-mail (electronic mail) or fax (facsimile) transmission of a signed copy of this Contract shall be the same as delivery of an original.
  - 1.6 "Contractor" means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, members, officers, directors, partners, employees and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, members, officers, directors, partners, employees and/or agents.
  - 1.7 "Debarment" means an action taken by a Federal agency or official to exclude a person or business entity from participating in transactions involving certain federal funds.
  - 1.8 "Encrypt" means to encode Confidential Information into a format that can only be read by those possessing a "key"; a password, digital certificate or other mechanism available only to authorized users. Encryption must use a key length of at least 128 bits.
  - 1.9 "HCA Contract Services" means the Washington State Health Care Authority central headquarters contracting office, or successor section or office.
  - 1.10 "OMB" means the Office of Management and Budget of the Executive Office of the President of the United States.

## HCA General Terms and Conditions

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

1.12 “Public Information” means information that can be released to the public. It does not need protection from unauthorized disclosure, but does need protection from unauthorized change that may mislead the public or embarrass HCA.

1.13. “Physically Secure” means that access is restricted through physical means to authorized individuals only.

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

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

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

1.17 “Sensitive Information” means information that is not specifically protected by law, but should be limited to official use only, and protected against unauthorized access.

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

1.19 “Successor” means any entity which, through amalgamation, consolidation, or other legal succession becomes invested with rights and assumes burdens of the original Contractor.

1.20 “Sub-recipient” means a non-Federal entity that expends federal awards received from a pass-through entity to carry out a federal program, but does not include an individual that is a beneficiary of such a program. A sub-recipient may also be a recipient of other Federal awards directly from a federal awarding agency. See OMB Circular A-133 for additional details.

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

1.22 “Trusted Systems” include only the following methods of physical delivery:

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

1.22.2 United States Postal Service (USPS) first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail;

## HCA General Terms and Conditions

1.22.3 Commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and

1.22.4 The Washington State Campus mail system.

For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.

1.23 "Vendor" means a dealer, distributor, merchant, or other seller providing goods or services that are required for the conduct of a federal program. These goods or services may be for an organization's own use or for the use of beneficiaries of the federal program. See OMB Circular A-133 for additional details.

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

2. **Access to Data.** The Contractor shall provide access to Data generated under this Contract to the Authority, the Joint Legislative Audit and Review Committee, and the State Auditor at no additional cost. This includes access to all information that supports the findings, conclusions and recommendations of the Contractor's reports, including computer models and methodology for those models.
3. **Advance Payment.** HCA shall not make any payments in advance or anticipation of the delivery of services to be provided pursuant to this Contract.
4. **Amendment.** Unless otherwise provided, this Contract may only be modified by a written amendment signed by both parties. Only personnel authorized to bind each of the parties may sign an amendment.
5. **Antitrust Assignment.** The 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 obtained under this Contract.
6. **Assignment.** The work to be provided under this Contract, and any claims arising there under, is not assignable or delegable by either party in whole or in part, without the express prior written consent of the other party, which consent shall not be unreasonably withheld.
7. **Assurances.** The Authority and the Contractor agree that all activity pursuant to this Contract will be in accordance with all applicable federal, state and local laws, rules, and regulations.
8. **Attorneys' Fees.** In the event of litigation or other action brought to enforce contract terms, each party agrees to bear its own attorney's fees and costs.
9. **Billing Limitations.**
  - 9.1 The Authority shall pay the Contractor only for authorized services provided in accordance with this Contract.
  - 9.2 The Authority shall not pay any claims for payment for services submitted more than twelve (12) months after the calendar month in which the services were performed. Within the Special Terms and

## HCA General Terms and Conditions

Conditions, the Authority may reduce the length of time following the provision of services in which the Contractor may submit claims for payment.

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

10. **Change in Status.** In the event of substantive change in the legal status, organization structure, or fiscal reporting responsibility of the Contractor, the Contractor agrees to notify the HCA Contract Services of the change. The Contractor shall provide notice as soon as practicable, but no later than thirty (30) days after such a change takes effect.

11. **Compliance with Applicable Law.** At all times during the term of this Contract, the Contractor shall comply with all applicable federal, state, and local laws and regulations, including but not limited to, nondiscrimination laws and regulations.

12. **Confidentiality.**

12.1 The Contractor shall not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Contract for any purpose that is not directly connected with Contractor's performance of the services contemplated hereunder, except:

12.1.1 As provided by law; or,

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

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

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

12.2.2 Physically Securing any computers, documents, or other media containing the Confidential Information.

12.2.3 Ensure the security of Confidential Information transmitted via fax (facsimile) by:

12.2.3.1 Verifying the recipient phone number to prevent accidental transmittal of Confidential Information to unauthorized persons.

12.2.3.2 Communicating with the intended recipient before transmission to ensure that the fax will be received only by an authorized person.

12.2.3.3 Verifying after transmittal that the fax was received by the intended recipient.

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12.2.4 When transporting six (6) or more records containing Confidential Information, outside a Secured Area, do one or more of the following as appropriate:

12.2.4.1 Use a Trusted System.

12.2.4.2 Encrypt the Confidential Information, including:

12.2.4.2.1 Encrypting email and/or email attachments which contain the Confidential Information.

12.2.4.2.2 Encrypting Confidential Information when it is stored on portable devices or media, including but not limited to laptop computers and flash memory devices.

**Note: If the HCA Data Security Requirements Exhibit is attached to this Contract, this item, 13.2.4, is superseded by the language contained in the Exhibit.**

12.2.5 Send paper documents containing Confidential Information via a Trusted System.

12.2.6 Following the requirements of the HCA Data Security Requirements Exhibit, if attached to this Contract.

12.3 Upon request by HCA program staff, at the end of the Contract term or when no longer needed, the Contractor shall return the Data to HCA information technology staff or the Contractor shall certify in writing that they employed a HCA approved method to destroy the information. The Contractor may obtain information regarding approved destruction methods from the HCA contact identified on the cover page of this Contract.

12.4 Paper documents with Confidential Information may be recycled through a contracted firm, provided the contract with the recycler specifies that the confidentiality of information will be protected, and the information destroyed through the recycling process. Paper documents containing Confidential Information requiring special handling (e.g. protected health information) must be destroyed on-site through shredding, pulping, or incineration.

12.5 Notification of Compromise or Potential Compromise. The compromise or potential compromise of Confidential Information must be reported to the HCA Contact designated on the cover page of this Contract within one (1) business day of discovery. The Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or the Authority.

12.6 Subsequent Disclosure. The Contractor shall not release, divulge, publish, transfer, sell, disclose, or otherwise make the Confidential Information or Sensitive Data known to any other entity or person without the express prior written consent of the Authority's Public Disclosure Office, or as required by law.

If responding to public record disclosure requests under Chapter 42.56 RCW, the Contractor agrees to notify and discuss with the Authority's Public Disclosure Officer requests for all information that are part of this Contract, prior to disclosing the information. The Authority upon request shall provide the Contractor with the name and contact information for the Authority's Public Disclosure Officer. The

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Contractor further agrees to provide the Authority with a minimum of two (2) calendar weeks to initiate legal action to secure a protective order under RCW 42.56.540.

13. **Conflict of Interest.** Notwithstanding any determination by the Executive Ethics Board or other tribunal, the Authority may, in its sole discretion, terminate this Contract by written notice to the Contractor, if it is found after due notice and examination by the Agent that there is a violation of the Ethics in Public Service Act, Chapter 42.52 RCW; or any similar statute involving the Contractor in the solicitation of, or services under this Contract.

In the event this Contract is terminated as provided above, the Authority shall be entitled to pursue the same remedies against the Contractor as it could pursue in the event of a breach of this Contract by the Contractor. The rights and remedies of the Authority provided for in this Section shall not be exclusive and are in addition to any other rights and remedies provided by the law. The existence of facts upon which the Agent makes any determination under this section shall be an issue and may be reviewed as provided in the "Disputes" Section of this Contract.

14. **Conformance.** If any provision of this Contract violates any statute or rule of law of the State of Washington, it is considered modified to conform to that statute or rule of law.
15. **Covenant against Contingent Fees.** The 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 the Contractor for the purpose of securing business. The Authority shall have the right, in the event of breach of this clause by the Contractor, to annul this Contract without liability or, in its discretion, to deduct from the contract price or consideration or recover by other means the full amount of such commission, percentage, brokerage or contingent fee.
16. **Debarment Certification.** The Contractor, by signature to this Contract, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency from participating in transactions (Debarred). The Contractor also agrees to include the above requirement in any and all Subcontracts into which it enters. The Contractor shall immediately notify the HCA Contact designated on the cover page of this Contract if, during the term of this Contract, the Contractor becomes debarred. HCA may immediately terminate this Contract by providing the Contractor written notice if Contractor becomes Debarred during the term of this Contract.
17. **Force Majeure.** If the Contractor is prevented from performing any or all of its obligations hereunder, because of a major epidemic, act of God, war, terrorist act, civil disturbance, court order, or any other cause beyond its control; such nonperformance shall not be grounds for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to directly or indirectly provide, alternate and, to the extent practicable, comparable performance of its obligations. Nothing in this Section shall be construed to prevent HCA from terminating this Contract for reasons other than for default during the period of event set forth above, or for default, if such default occurred prior to such event.
18. **Fraud and Abuse Requirements.** The Contractor shall report in writing all verified cases of fraud and abuse, including fraud and abuse by the Contractor's employees and/or subcontractors, within five (5)

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business days, to the HCA Contact designated on page one (1) of this Contract. The report shall include the following information:

- 18.1 Subject(s) of complaint by name and either provider/subcontractor type or employee position;
- 18.2 Source of complaint by name and provider/subcontractor type or employee position;
- 18.3 Nature of complaint;
- 18.4 Estimate of the amount of funds involved; and
- 18.5 Legal and administrative disposition of case.

19. **Governing Law and Venue.** This Contract shall be construed and interpreted in accordance with the laws of the state of Washington and the venue of any action brought hereunder shall be in the Superior Court for Thurston County.

20. **Health and Safety.** Contractor shall perform any and all of its obligations under this Contract in a manner that does not compromise the health and safety of any HCA client with whom the Contractor has contact.

21. **Hold Harmless and Indemnification.**

21.1 The Contractor shall be responsible for and shall indemnify, defend, and hold HCA harmless from all claims, loss, liability, damages, or fines arising out of or relating to:

21.1.1 The Contractor's or any Subcontractor's performance or failure to perform this Contract, or

21.1.2 The acts or omissions of the Contractor or any Subcontractor.

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

21.3 Nothing in this Section shall be construed as a modification or limitation on the Contractor's obligation to procure insurance in accordance with this Contract or the scope of said insurance.

22. **Independent Contractor.** The parties intend that an independent contractor relationship will be created by this Contract. The Contractor and his or her employees or agents performing under this Contract are not employees or agents of the Authority. The Contractor, his or her employees, or agents performing under this Contract will not hold himself/herself out as, nor claim to be, an officer or employee of the Authority by reason hereof, nor will the Contractor, his or her employees, or agent make any claim of right, privilege or benefit that would accrue to such officer or employee.

All payments accrued on account of payroll taxes, unemployment contributions, and other taxes, insurance or other expenses for the Contractor or its staff shall be the sole responsibility of the Contractor.

23. **Industrial Insurance Coverage.** The Contractor shall comply with the provisions of Title 51 RCW,

## HCA General Terms and Conditions

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

24. **Inspection.** The Contractor shall, at no cost, provide HCA and the Office of the State Auditor with reasonable access to the Contractor's place of business, Contractor's records, and HCA client records, wherever located. HCA and the Office of the State Auditor shall provide the Contractor with at least 48 hours' notice in writing before making such access to the Contractor's place of business or records in the Contractor's possession. These inspection rights are intended to allow HCA and the Office of the State Auditor to monitor, audit, and evaluate the Contractor's performance and compliance with applicable laws, regulations, and these Agreement terms. These inspection rights shall survive for six (6) years following this Interagency Agreement's termination or expiration.
25. **Limitation of Authority.** Only the Agent or Agent's delegate by writing (delegation to be made prior to action) shall have the express, implied, or apparent authority to alter, amend, modify, or waive any clause or condition of this Contract. Furthermore, any alteration, amendment, modification, or waiver of any Section or condition of this Contract is not effective or binding unless made in writing and signed by the Agent or Agent's delegate.
26. **Maintenance of Records.** The Contractor shall maintain records relating to this Contract and the performance of the services described herein. The records include, but are not limited to, accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Contract. All records and other material relevant to this Contract shall be retained for six (6) years after expiration or termination of this Contract.

Without agreeing that litigation or claims are legally authorized, if any litigation, claim, or audit is started before the expiration of the six (6) year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved.

27. **Notice of Overpayment.** If the Contractor receives a vendor overpayment notice or a letter communicating the existence of an overpayment from the Washington State Department of Social and Health Services, Office of Financial Recovery (OFR), the Contractor may protest the overpayment determination by requesting an adjudicative proceeding. The Contractor's request for an adjudicative proceeding must:
- 27.1 Be received by the OFR at Post Office Box 9501, Olympia, Washington 98507-9501, within twenty-eight (28) calendar days of service of the notice;
  - 27.2 Be sent by certified mail (return receipt) or other manner that proves OFR received the request;
  - 27.3 Include a statement as to why the Contractor thinks the notice is incorrect; and
  - 27.4 Include a copy of the overpayment notice.

## HCA General Terms and Conditions

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

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

28. **Order of Precedence.** In the event of any inconsistency or conflict between the General Terms and Conditions and the Special Terms and Conditions of this Contract, the inconsistency or conflict shall be resolved by giving precedence to the Special Terms and Conditions. Terms or conditions that are more restrictive, specific, or particular than those contained in the General Terms and Conditions shall not be construed as being inconsistent or in conflict.

29. **Ownership of Material.**

29.1 Unless otherwise provided, all Materials produced under this Contract shall be considered "works for hire" as defined by the U.S. Copyright Act and shall be owned by the Authority. The Authority shall be considered the author of such Materials. In the event the Materials are not considered "works for hire" under the U.S. Copyright laws, Contractor hereby irrevocably assigns all right, title, and interest in Materials, including all intellectual property rights, to the Authority effective from the moment of creation of such Materials.

29.2 Materials means all items in any format and includes, but are not limited to: data, reports, documents, pamphlets, advertisements, books, magazines, surveys, studies, computer programs, films, tapes and/or sound reproductions. Ownership includes the right to copyright, patent, register and the ability to transfer these rights.

29.3 The Contractor shall exert all reasonable effort to advise the Authority, at the time of delivery of Materials furnished under this Contract, of all known or potential invasions of privacy contained therein and of any portion of such document which was not produced in the performance of this Contract. The Authority shall receive prompt written notice of each notice or claim of copyright infringement received by the Contractor with respect to any data delivered under this Contract. The Authority shall have the right to modify or remove any restrictive markings placed upon the data by the Contractor.

30. **Publicity.** The Contractor agrees to submit to the Authority all advertising and publicity matters relating to this Contract wherein the Authority's name is mentioned or language used from which the connection of the Authority's name may, in the Authority's judgment, be inferred or implied. The Contractor agrees not to publish or use such advertising and publicity matters without the prior written consent of the Authority.

31. **Registration with State of Washington.** The Contractor shall be responsible for registering with Washington State agencies, including but not limited to, the Washington State Department of Revenue, the Washington Secretary of State's Corporations Division and the Washington State Office of Financial Management, Division of Information Services' Statewide Vendors program.

## HCA General Terms and Conditions

32. **Savings.** In the event funding from State, federal or other sources is withdrawn, reduced, or limited in any way after the effective date of this Contract and prior to its completion or termination, the Authority may terminate this Contract under the "Termination Due to Change in Funding" Section, without the ten (10) day notice requirement, subject to renegotiation at the Authority's discretion under those new funding limitations and conditions.
33. **Severability.** If any term or condition of this Contract is held invalid by any court, the remainder of this Contract remains valid and in full force and effect.
34. **Site Security.** While on the Authority's premises, the Contractor, its agents, employees, or subcontractors shall conform in all respects with physical, fire or other security policies or regulations. Failure to comply with these regulations and/or policies may be grounds for revoking or suspending security access to these facilities. The Authority reserves the right and authority to immediately revoke security access or the Contractor's agents, employees, and/or subcontractors for any real or threatened breach of this provision. Upon reassignment or termination of any Contractor staff, the Contractor agrees to promptly notify the HCA Contract Services.
35. **Survivability.** The terms and conditions contained in this Contract which, by their sense and context, are intended to survive the expiration or termination of this Contract shall survive. Surviving terms include, but are not limited to: Billing Limitations; Confidentiality, Disputes; Hold Harmless and Indemnification, Maintenance of Records, Notice of Overpayment, Ownership of Material, Termination for Default, Termination Procedure, and Treatment of Property.
36. **Subcontracting.**
- 36.1 Neither the Contractor nor any Subcontractor shall enter into subcontracts for any of the work contemplated under this contract without obtaining prior written approval of the Authority. In no event shall the existence of the subcontract operate to release or reduce the liability of the contractor to the Authority for any breach in the performance of the contractor's duties. This clause does not include contracts of employment between the contractor and personnel assigned to work under this Contract.
- 36.2 Additionally, the Contractor is responsible for ensuring that all terms, conditions, assurances and certifications set forth in this Contract are carried forward to any subcontracts. 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 the Authority or as provided by law.
- 36.3 If at any time during the progress of the work, the Authority determines in its sole judgment that any subcontractor is incompetent or undesirable, the Authority shall notify the Contractor, and the Contractor shall take immediate steps to terminate the subcontractor's involvement in the work.

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36.4 The rejection or approval by the Authority of any subcontractor or the termination of a subcontractor shall not relieve the Contractor of any of its responsibilities under this Contract, nor be the basis for additional charges to the Authority.

36.5 The Authority has no contractual obligations to any subcontractor or vendor under contract to the Contractor. The Contractor is fully responsible for all contractual obligations, financial or otherwise, to their subcontractors.

### 37. Sub-recipients.

37.1 General. If the Contractor is a sub-recipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Contract, the Contractor shall:

37.1.1 Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity;

37.1.2 Maintain internal controls that provide reasonable assurance that the Contractor is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant agreements that could have a material effect on each of its federal programs;

37.1.3 Prepare appropriate financial statements, including a schedule of expenditures of federal awards;

37.1.4 Incorporate OMB Circular A-133 audit requirements into all agreements between the Contractor and its Subcontractors who are sub-recipients;

37.1.5 Comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation;

37.1.6 Comply with the applicable requirements of OMB Circular A-87 and any future amendments to OMB Circular A-87, and any successor or replacement Circular or regulation; and

37.1.7 Comply with the Omnibus Crime Control and Safe streets Act of 1968, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and The Department of Justice Non-Discrimination Regulations, 28 C.F.R. Part 42, Subparts C.D.E. and G, and 28 C.F.R. Part 35 and 39. (Go to [www.ojp.usdoj.gov/ocr/statutes.htm](http://www.ojp.usdoj.gov/ocr/statutes.htm) for additional information and access to the aforementioned Federal laws and regulations).

37.2 Single Audit Act Compliance. If the Contractor is a sub-recipient and expends \$500,000 or more in federal awards from any and/or all sources in any fiscal year, the Contractor shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the Contractor shall:

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37.2.1 Submit to the Authority contact person the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor;

37.2.2 Follow-up and develop corrective action for all audit findings; in accordance with OMB Circular A-133, prepare a "Summary Schedule of Prior Audit Findings."

37.3 Overpayments. If it is determined by the Authority, or during the course of a required audit, that the Contractor has been paid unallowable costs under this or any Program Agreement, the Authority may require the Contractor to reimburse the Authority in accordance with OMB Circular A-87.

**Note: If the HCA Federal Compliance, Certifications, and Assurances Exhibit is attached to this Contract, this Section, is superseded by the language contained in that Exhibit.**

38. **System Security.** Unless otherwise provided, the Contractor agrees not to attach any Contractor-supplied computers, peripherals or software to the Authority Network without prior written authorization from the Authority's Security Administrator. Contractor-supplied computer equipment, including both hardware and software, must be reviewed by the Authority Security Administrator prior to being connected to any Authority network connection. Furthermore, it must have up-to-date anti-virus software and personal firewall software installed and activated on it.

Unauthorized access to Authority networks and systems is a violation of Authority Policy 06-03, or successor, and constitutes computer trespass in the first degree pursuant to RCW 9A.52.110. Violation of any of these laws or policies could result in termination of this Contract and other penalties.

39. **Termination for Convenience.** Except as otherwise provided in this Contract, the Agent, or designee, may terminate this Contract in whole or in part when it is in the best interest of the Authority, by giving ten (10) calendar days written notice, beginning on the second (2nd) day after the mailing,. If this Contract is so terminated, the Authority shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination.

40. **Termination for Default.** In the event the Authority determines the Contractor has failed to comply with the terms and conditions of this Contract, the Authority has the right to suspend or terminate this Contract. The Authority shall notify the Contractor in writing of the need to take corrective action. If corrective action is not taken within ten (10) business days, this Contract may be terminated. The Authority reserves the right to suspend all or part of this Contract, withhold further payments, or prohibit the Contractor from incurring additional obligations of funds during investigation of the alleged compliance breach and pending corrective action by the Contractor or a decision by the Authority to terminate this Contract.

In the event of termination, the Contractor shall be liable for damages as authorized by law including, but not limited to: any cost difference between the original contract and the replacement, or cover contract and all administrative costs directly related to the replacement contract (e.g., cost of the competitive bidding, mailing, advertising, and staff time). The termination shall be deemed a "Termination for Convenience" if it is determined that the Contractor:

40.1 Was not in default, or

40.2 Failure to perform was outside of his or her control, fault or negligence.

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41. **Termination Due to Change in Funding.** If the funds HCA relied upon to establish this Contract are withdrawn, reduced or limited, or if additional or modified conditions are placed on such funding, HCA may immediately terminate or unilaterally amend this Contract by providing written notice to the Contractor. The termination shall be effective on the date specified in the termination notice.
42. **Termination or Expiration Procedures.** The following terms and conditions apply upon Contract termination or expiration:
- 42.1 The Authority, in addition to any other rights provided in this Contract, may require the Contractor to deliver to the Authority any property specifically produced or acquired for the performance of such part of this contract as has been terminated.
- 42.2 The Authority shall pay to the Contractor the agreed upon price, if separately stated, for completed work and service accepted by the Authority's program staff and the amount agreed upon by the Contractor and the Authority for:
- 42.2.1 Completed work and services for which no separate price is stated;
  - 42.2.2 Partially completed work and services;
  - 42.2.3 Other property or services which are accepted by the Authority's program staff; and
  - 42.2.4 The protection and preservation of property, unless the termination is for default, in which case the Agent or designee shall determine the extent of the liability. Failure to agree with such determination shall be a dispute within the meaning of the "Disputes" Section of this contract. The Authority may withhold from any amounts due the Contractor such sum as the Agent or designee determines to be necessary to protect the Authority against potential loss or liability.
- 42.3 The rights and remedies of the Authority provided in this section shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.
- 42.4 After receipt of notice of termination, and except as otherwise directed by the Agent or designee, the Contractor shall:
- 42.4.1 Stop work under the contract on the date, and to the extent specified in the notice;
  - 42.4.2 Place no further orders or subcontracts for materials, services, or facilities except as may be necessary for completion of such portion of the work under this Contract that is not terminated;
  - 42.4.3 Assign to the Authority, in the manner, at the times, and to the extent directed by the agent or designee, all the rights, title, and interest of the Contractor under the orders and subcontracts so terminated; in which case the Authority has the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
  - 42.4.4 Settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, with the approval or ratification of the Agent or designee to the extent

## HCA General Terms and Conditions

the Agent or designee may require, which approval or ratification shall be final for all the purposes of this Section;

42.4.5 Transfer title to the Authority and deliver in the manner, at the times, and to the extent directed by the agent or designee any property which, if this Contract has been completed, would have been required to be furnished to the Authority;

42.4.6 Complete performance of such part of the work as shall not have been terminated by the Agent or designee; and

42.4.7 Take such action as may be necessary, or as the Agent or designee may direct, for the protection and preservation of the property related to this Contract which is in the possession of the Contractor and in which the Authority has or may acquire an interest.

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

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

## Exhibit A – Data Security Requirements

### 1. Definitions.

- a. “Authorized User(s)” means an individual or individuals with an authorized business requirement to access HCA Confidential Information.
- b. “Hardened Password” means a string of at least eight characters containing at least one alphabetic character, at least one number and at least one special character such as an asterisk, ampersand or exclamation point.
- c. “Transmitting” means the transferring of data electronically, such as via email.
- d. “Transporting” means the physical transferring of data that has been stored.
- e. “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 Transmitting. When transmitting HCA Confidential Information electronically, including via email, the Data shall be protected by:

- a. Transmitting the Data within the (State Governmental Network) SGN or Contractor’s internal network, or;
- b. Encrypting any Data that will be transmitted outside the SGN or Contractor’s internal network with 128-bit Advanced Encryption Standard (AES) encryption or better. This includes transit over the public Internet.

### 3. Protection of Data. The Contractor agrees to store Data on one or more of the following media and protect the Data as described:

- a. **Hard disk drives.** Data stored on local workstation hard disks. Access to the Data will be restricted to Authorized User(s) by requiring logon to the local workstation using a Unique User ID and Hardened Password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. disks
- b. **Network server disks.** Data stored on hard disks mounted on network servers and made available through shared folders. Access to the Data will be restricted to Authorized Users through the use of access control lists which will grant access only after the Authorized User has authenticated to the network using a Unique User ID and Hardened Password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

For HCA Confidential Information stored on these disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in the above paragraph. Destruction of the Data as outlined in Section 5. Data Disposition may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

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- c. **Removable Media, including Optical discs (CDs or DVDs) in local workstation optical disc drives and which will not be transported out of a secure area.** Sensitive or Confidential Data provided by HCA on removable media, such as optical discs or USB drives, which will be used in local workstation optical disc drives or USB connections shall be encrypted with 128-bit AES encryption or better. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only authorized users have the key, combination or mechanism required to access the contents of the container. Workstations which access HCA Data on optical discs must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
- d. **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers and which will not be transported out of a secure area.** Data provided by HCA on optical discs which will be attached to network servers shall be encrypted with 128-bit AES encryption or better. Access to Data on these discs will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has been authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
- e. **Paper documents.** Any paper records must be protected by storing the records in a secure area which is only accessible 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.
- f. **Access via remote terminal/workstation over the State Governmental Network (SGN).** Data accessed and used interactively over the SGN. Access to the Data will be controlled by HCA staff who will issue authentication credentials (e.g. a unique user ID and complex password) to authorized contractor staff. Contractor shall have established and documented termination procedures for existing staff with access to HCA Data. These procedures shall be provided to HCA staff upon request. The Contractor will notify HCA staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the contractor, and whenever a user's duties change such that the user no longer requires access to perform work for this Contract.
- g. **Access via remote terminal/workstation over the Internet through Secure Access Washington.** Data accessed and used interactively over the Internet. Access to the Data will be controlled by HCA staff who will issue remote access authentication credentials (e.g. a unique user ID and complex password) to authorized contractor staff. Contractor will notify HCA staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the contractor and whenever a user's duties change such that the user no longer requires access to perform work for this Contract.
- h. **Data storage on portable devices or media.**
  - (1) HCA Data shall not be stored by the Contractor on portable devices or media unless specifically authorized within the Special Terms and Conditions of the contract. If so authorized, the Data shall be given the following protections:

## HCA General Terms and Conditions

- (a) Encrypt the Data with a key length of at least 128 bits using an industry standard algorithm (e.g., AES, *Twofish*, *RC6*, etc.)
- (b) Control access to devices with a unique user ID and password or stronger authentication method such as a physical token or biometrics.
- (c) Manually lock devices whenever they are left unattended and set devices to lock automatically after a period of inactivity, if this feature is available. Maximum period of inactivity is 20 minutes.

Physically protect the portable device(s) and/or media by

- (d) Keeping them in locked storage when not in use
  - (e) Using check-in/check-out procedures when they are shared, and
  - (f) Taking frequent inventories
- (2) When being transported outside of a secure area, portable devices and media with confidential HCA Data must be under the physical control of contractor staff with authorization to access the Data.
- (3) Portable devices include any small computing device that can be transported. They include, but are not limited to; handhelds/PDAs/phones, Ultramobile PCs, flash memory devices (e.g. USB flash drives, personal media players), and laptop/notebook/tablet computers.
- (4) Portable media includes any Data storage that can be detached or removed from a computer and transported. They include, but are not limited to; optical media (e.g. CDs, DVDs), magnetic media (e.g. floppy disks, tape, Zip or Jaz disks), USB drives, or flash media (e.g. CompactFlash, SD, MMC).

#### 4. Data Segregation.

- a. HCA Data must be segregated or otherwise distinguishable from non-HCA Data. This is to ensure that when no longer needed by the contractor, all HCA Data can be identified for return or destruction. It also aids in determining whether HCA Data has or may have been compromised in the event of a security breach.
- b. HCA Data will be kept on media (e.g. hard disk, optical disc, tape, etc.) which will contain no non-HCA Data. Or,
- c. HCA Data will be stored in a logical container on electronic media, such as a partition or folder dedicated to HCA Data. Or,
- d. HCA Data will be stored in a database which will contain no non-HCA Data. Or,
- e. HCA Data will be stored within a database and will be distinguishable from non-HCA Data by the value of a specific field or fields within database records. Or,
- f. When stored as physical paper documents, HCA Data will be physically segregated from non-HCA Data in a drawer, folder, or other container.

## HCA General Terms and Conditions

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

5. **Data Disposition.** When the contracted work has been completed or when no longer needed, except as noted in 2.b above, Data shall be returned to HCA or destroyed. Media on which Data may be stored and associated acceptable methods of destruction are as follows:

<b>Data stored on:</b>	<b>Will be destroyed by:</b>
Server or workstation hard disks, or  Removable media (e.g. floppies, USB flash drives, portable hard disks, Zip or similar disks)	Using a “wipe” utility which will overwrite the Data at least three (3) times using either random or single character Data, or  Degaussing sufficiently to ensure that the Data cannot be reconstructed, or  Physically destroying the disk
Paper documents with sensitive or confidential Data	Recycling through a contracted firm provided the contract with the recycler assures that the confidentiality of Data will be protected.
Paper documents containing confidential information requiring special handling (e.g. protected health information)	On-site shredding by a method that renders the Data unreadable, pulping, or incineration
Optical discs (e.g. CDs or DVDs)	Incineration, shredding, or cutting/breaking into small pieces.
Magnetic tape	Degaussing, incinerating or crosscut shredding

6. **Notification of Compromise or Potential Compromise.** The Contractor shall have an established and documented policy to deal with the compromise or potential compromise of Data that complies with the HITECH Act of ARRA 209. The Contractor shall provide HCA staff of such policy upon request. The compromise or potential compromise of HCA shared Data must be reported to the HCA Contact designated on this Contract within one (1) business day of discovery.

7. **Data shared with Sub-contractors.** If HCA Data provided under this Contract is to be shared with a sub-contractor, the contract with the sub-contractor must include all of the Data security provisions within this Contract and within any amendments, attachments, or exhibits within this Contract. If the subcontractor cannot protect the Data as articulated within this Contract, then the contract with the sub-contractor must be submitted to the HCA Contact Services for review and approval.

**Exhibit B**  
**FEDERAL COMPLIANCE, CERTIFICATIONS, AND ASSURANCES**

In the event federal funds are included in this Agreement, the following sections apply: I. Federal Compliance and IV. Standard Federal Assurances and Certifications. In the instance of inclusion of federal funds, the Contractor may be designated as a sub-recipient and the effective date of the amendment shall also be the date at which these requirements go into effect.

- I. **FEDERAL COMPLIANCE** - The use of federal funds requires additional compliance and control mechanisms to be in place. The following represents the majority of compliance elements that may apply to any federal funds provided under this Agreement. For clarification regarding any of these elements or details specific to the federal funds in this Agreement, contact:
- a. **Source of Funds:** Federal funds to support this Agreement are identified by the **Catalog of Federal Domestic Assistance (CFDA) number** \_\_. \_\_. The sub-recipient is responsible for tracking and reporting the cumulative amount expended under **HCA Contract No.** \_\_\_\_\_.
  - b. **Single Audit Act:** A contractor who is a sub-recipient (including private, for-profit hospitals and non-profit institutions) shall adhere to the federal Office of Management and Budget (OMB) Circular A-133, as well as all applicable federal and state statutes and regulations. A contractor who is a sub-recipient who expends \$500,000 or more in federal awards during a given fiscal year shall have a single or program-specific audit for that year in accordance with the provisions of OMB Circular A-133.
  - c. **Modifications:** This Agreement may not be modified or amended, nor may any term or provision be waived or discharged, including this particular Paragraph, except in writing, signed upon by both parties.
    - 1. Examples of items requiring Health Care Authority prior written approval include, but are not limited to, the following:
      - i. Deviations from the budget and Project plan.
      - ii. Change in scope or objective of this Agreement.
      - iii. Change in a key person specified in this Agreement.
      - iv. The absence for more than three months or a 25% reduction in time by the Project Manager/Director.
      - v. Need for additional funding.
      - vi. Inclusion of costs that require prior approvals as outlined in the appropriate cost principles.
      - vii. Any changes in budget line item(s) of greater than twenty percent (20%) of the total budget in this Agreement.
    - 2. No changes are to be implemented by the Contractor/Sub-recipient until a written notice of approval is received from the Health Care Authority.
  - d. **Condition for Receipt of Health Care Authority Funds:** Funds provided by Health Care Authority to the Contractor/Sub-recipient under this Agreement may not be used by the Contractor/Sub-recipient as a match or cost-sharing provision to secure other federal monies.
  - e. **Unallowable Costs:** The Contractor's/Sub-recipients' expenditures shall be subject to reduction for amounts included in any invoice or prior payment made which determined by HCA not to constitute allowable costs on the basis of audits, reviews, or monitoring of this Agreement.

## Exhibit B

- f. **Citizenship/Alien Verification/Determination:** The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (PL 104-193) states that federal public benefits should be made available only to U.S. citizens and qualified aliens. Contractors/Sub-recipients that offer a service defined as a “federal public benefit” must make a citizenship/qualified alien determination/ verification of applicants at the time of application as part of the eligibility criteria. Non-US citizens and unqualified aliens are not eligible to receive the services. PL 104-193 also includes specific reporting requirements.
- g. **Federal Compliance:** The Contractor/Sub-recipient shall comply with all applicable State and Federal statutes, laws, rules, and regulations in the performance of this Agreement, whether included specifically in this Agreement or not.
- h. **Civil Rights and Non-Discrimination Obligations:** During the performance of this Agreement, the Contractor/Sub-recipient shall comply with all current and future federal statutes relating to nondiscrimination. These include but are not limited to: Title VI of the Civil Rights Act of 1964 (PL 88-352), Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1683 and 1685-1686), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107), the Drug Abuse Office and Treatment Act of 1972 (PL 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (PL 91-616), §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290dd-3 and 290ee-3), Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), and the Americans with Disability Act (42 U.S.C., Section 12101 et seq.) <http://www.hhs.gov/ocr/civilrights>

### HCA Federal Compliance Contact Information

\_\_\_\_\_, Contract Manager  
Washington State Health Care Authority  
Post Office Box 4\_\_\_\_\_  
Olympia, Washington 98504-\_\_\_\_\_

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**II. CIRCULARS ‘COMPLIANCE MATRIX’** - The following compliance matrix identifies the OMB Circulars that contain the requirements which govern expenditure of federal funds. These requirements apply to the Washington State Health Care Authority (HCA), as the primary recipient of federal funds and then follow the funds to the Contractor/Sub-recipient. The federal Circulars which provide the applicable administrative requirements, cost principles and audit requirements are identified by sub-recipient organization type.

**III.**

	OMB CIRCULAR		
ENTITY TYPE	ADMINISTRATIVE REQUIREMENTS	COST PRINCIPLES	AUDIT REQUIREMENTS
State, Local and Indian Tribal Governments and Governmental Hospitals	A-102 & Common Rule	A-87	A-133
Non-Profit Organizations and Non-Profit Hospitals	A-110	A-122	A-133
Colleges or Universities and Affiliated Hospitals	A-110	A-21	A-133
For-Profit Organizations	A-110	48 CFR §31.2	Requirements established by the pass-through entity, pursuant to A-133, §.210(e)

**\*Definitions:**

**“Sub-recipient”** means the legal entity to which a sub-award is made and which is accountable to the State for the use of the funds provided in carrying out a portion of the State’s programmatic effort under a sponsored project. The term may include institutions of higher education, for-profit corporations or non-U.S. based entities.

**“Sub-award and Sub-grant”** are used interchangeably and mean a lower tier award of financial support from a prime awardee (e.g., Washington State Health Care Authority) to a contractor/sub-recipient for the performance of a substantive portion of the program. These requirements do not apply to the procurement of goods and services for the benefit of the Washington State Health Care Authority.

**IV. STANDARD FEDERAL CERTIFICATIONS AND ASSURANCES** - Following are the Assurances, Certifications, and Special Conditions that apply to all federally-funded (in whole or in part) agreements administered by the Washington State Health Care Authority.

## Exhibit B

### CERTIFICATIONS

#### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the Contractor) certifies to the best of his or her knowledge and belief, that the Contractor, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b) have not within a 3-year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d) have not within a 3-year period preceding this Agreement had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the Contractor not be able to provide this certification, an explanation as to why should be placed after the assurances page in this Agreement.

The Contractor agrees by signing this Agreement that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-- Lower Tier Covered Transactions" in all lower tier

covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

#### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the Contractor) certifies that the Contractor will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- b) Establishing an ongoing drug-free awareness program to inform employees about
  - (1) The dangers of drug abuse in the workplace;
  - (2) The Contractor's policy of maintaining a drug-free workplace;
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c) Making it a requirement that each employee to be engaged in the performance of this Agreement be given a copy of the statement required by paragraph (a) above;
- d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the Agreement, the employee will—
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than

## Exhibit B

five calendar days after such conviction;

- e) Notifying the Agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every contract officer or other designee on whose contract activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted—
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding Agency notification of criminal drug convictions, Authority has designated the following central point for receipt of such notices:

Legal Services Manager  
WA State Health Care Authority  
PO Box 42702  
Olympia, WA 98504-2700

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from

using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the contracting organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subcontracts at all tiers (including subcontracts, subcontracts, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

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This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### **4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)**

The undersigned (authorized official signing for the Contractor) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the Contractor will comply with the Public Health Service terms and conditions of award if a contract is awarded.

### **5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned

certifies that the Contractor will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The Contractor agrees that it will require that the language of this certification be included in any subcontracts which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Public Health Services strongly encourages all recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **6. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS INSTRUCTIONS FOR CERTIFICATION**

- 1) By signing and submitting this proposal, the prospective contractor is providing the certification set out below.
- 2) The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective contractor shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective contractor to furnish a certification or an explanation shall disqualify such person from participation in this transaction.
- 3) The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective contractor knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause of default.
- 4) The prospective contractor shall provide immediate written notice to the department

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or agency to whom this Agreement is submitted if at any time the prospective contractor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

- 5) The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. You may contact the person to whom this contract is submitted for assistance in obtaining a copy of those regulations.
- 6) The prospective contractor agrees by submitting this Agreement that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by Authority.
- 7) The prospective contractor further agrees by submitting this contract that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Covered Transaction," provided by HHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
- 8) A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non-procurement List (of excluded parties).
- 9) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this

clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

- 10) Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, Authority may terminate this transaction for cause or default.

### 7. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS -- PRIMARY COVERED TRANSACTIONS

- 1) The prospective contractor certifies to the best of its knowledge and belief, that it and its principals:
  - a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
  - b) Have not within a three-year period preceding this contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
  - c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and
  - d) Have not within a three-year period preceding this contract had one or more public transactions (Federal, State or

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local) terminated for cause or default.

- 2) Where the prospective contractor is unable to certify to any of the statements in this certification, such prospective contractor shall attach an explanation to this proposal.

CONTRACTOR SIGNATURE REQUIRED

<b>SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</b>	<b>TITLE</b>
<b>Please also print or type name:</b>	
<b>ORGANIZATION NAME: (if applicable)</b>	<b>DATE</b>