NORTH SOUND MENTAL HEALTH ADMINISTRATION
SPECIAL MEETING OF THE BOARD OF DIRECTORS
NSMHA Conference Room
Mount Vernon, WA
August 15, 2006
12:00 PM

AGENDA

The purpose of this Special Meeting is to review and approve the following contracts:

- **MHD-NSMHA-Medicaid Contract #0669-01989**
- **MHD-NSMHA-State Mental Health Contract #0669-02157**
- **NSMHA-CCSNW Chemical Dependency Case Management Contract**
- **Contract with Northwest Computer to purchase new phone system**

1. Open the Meeting – Chair Gossett

2. Review and Approval of Motions 06-079, 06-080, 06-081 and 06-082 – Chair Gossett

Motion # 06-079
To review and approve the MHD-NSMHA-Medicaid Contract #0669-01989. Whereby this contract requires NSMHA to operate a Prepaid Inpatient Health Plan for medically necessary mental health services for all enrollees in accordance with the Medicaid State Plan. The term of this contract is September 1, 2006 through June 30, 2007. Estimated financial consideration is $39,335,338. (Please note that WMIP will be deducted monthly based on the number of enrollees. Current estimate is a minimum of $3,163,385.64 will be deducted for WMIP clients, reducing estimated financial consideration to $36,171,952.36)

Motion #06-080
To review and approve the MHD-NSMHA State Mental Health Contract #0669-02157. Whereby NSMHA agrees to provide state funded mental health services for the period of September 1, 2006 through June 30, 2007. Services include involuntary and voluntary crisis services, Medicaid Personal Care (MPC), residential programs, outpatient services, jail services and disaster planning and response. Estimated financial consideration $17,351,686.

Motion #06-081
To review and approve the NSMHA-CCSNW Chemical Dependency Case Management Contract for chemical dependency case management services to be provided to detainees released from the North Cascade Secure Detoxification Center. The contract term is August 16, 2006 through December 31, 2006. Maximum consideration is $23,884.50

Motion #06-082
To review and approve the purchase of a new phone system from Northwest Computer not to exceed $21,939.40. In order to comply with MHD's Request For Qualifications Customer Service Tracking Requirements, this system best meets our needs within available resources.

3. Adjourn – Chair Gossett

RSN INTERLOCAL AGREEMENT

Prepaid Inpatient Health Plan

Washington State Department of Social & Health Services

DSHS Agreement Number: 0669-01989

Program Contract Number:

Contractor Contract Number:

This Agreement is by and between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below, and is issued pursuant to the Interlocal Cooperation Act, chapter 39.34 RCW.

CONTRACTOR NAME	CONTRACTOR doing business as (DBA)		
North Sound Regional Support Network	North Sound RSN		
CONTRACTOR ADDRESS 117 North First Street, Suite 8 Mount Vernon, WA 98273-2858	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) 601-291-840	DSHS INDEX NUMBER 1553	
CONTRACTOR CONTACT Charles R. Benjamin, Executive Dir.	CONTRACTOR TELEPHONE (360) 416-7013 Ext:	CONTRACTOR FAX (360) 416-7017	CONTRACTOR E-MAIL ADDRESS executivedirector@nsrsn.org

DSHS ADMINISTRATION	DSHS DIVISION	DSHS CONTRACT CODE
Health and Rehabilitative Services Administration	Mental Health Division	4000LC

DSHS CONTACT NAME AND TITLE	DSHS CONTACT ADDRESS
Melena Thompson Program Administrator	PO Box 45320 Olympia, WA 98504-5320

DSHS CONTACT TELEPHONE	DSHS CONTACT FAX	DSHS CONTACT E-MAIL ADDRESS
(360) 902-0840	(360) 902-0809	thompml@dshs.wa.gov

IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT?	CFDA NUMBER(S)
Yes	93.778

AGREEMENT START DATE	**AGREEMENT END DATE**	MAXIMUM AGREEMENT AMOUNT
09/01/2006	**06/30/2007**	$0.00

EXHIBITS. The following Exhibits are attached and are incorporated into this Agreement by reference:

☒ **Exhibits (specify): Exhibit A, Access to Care Standards; Exhibit B, Tribal Collaboration**

☐ **No Exhibits.**

The terms and conditions of this Agreement 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 Agreement, between the parties. The parties signing below represent they have read and understand this Agreement, and have the authority to execute this Agreement. This Agreement shall be binding on DSHS only upon signature by DSHS.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
	Charles R. Benjamin Executive Director	

DSHS SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
	Travis Sugarman HRSA Contracts Administrator	

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PURPOSE OF AGREEMENT

Operate a Prepaid Inpatient Health Plan (PIHP) to provide medically necessary mental health services to enrollees. Provide or purchase age, linguistic and culturally competent community mental health services for enrollees for whom services are medically necessary and clinically appropriate pursuant to:

(1) CFR 42 CFR 438, or any successors and Federal 1915 (b) Mental Health Waiver, Medicaid State plan or any successors;

(2) Other provisions of Title XIX of the Social Security Act, or any successors;

(3) RCW 70.02, 71.05, 71.24, and 71.34, or any successors;

(4) WAC 388-865 or any successors;

1. DEFINITIONS

1.1. **Action** in the context of PIHP services means

1.1.1. The denial or limited authorization of a requested service, including the type or level of service;

1.1.2. The reduction, suspension, or termination of a previously authorized service;

1.1.3. The denial in whole or in part, of payment for a service;

1.1.4. The failure to provide services in a timely manner, as defined by the state;

1.1.5. The failure of a PIHP to act within the timeframes provided in section 42 CFR 438(b) or;

1.1.6. For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b)(2)(ii), to obtain services outside the network.

1.2. **Administrative Cost** means costs for the general operation of the public mental health system. These activities cannot be identified with a specific direct services or direct services support function.

1.3. **Annual Revenue** means all revenue received by the Contractor pursuant to the Agreement for July of any year through June of the next year.

1.4. **Appeal** means a request for review of an action as "action" is defined above.

1.5. **Capitation Payment** means a payment the Department of Social and Health Services (DSHS) makes monthly to a PIHP on behalf of each recipient enrolled under a contract for the provision of mental health services under the State Medicaid Plan. MHD makes the payment regardless of whether the particular recipient receives the services during the period covered by the payment.

1.6. **Central Contract Services ("CCS")** means the Department of Social and Health Services (DSHS) office of Central Contract Services.

1.7. **CFR** means the Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation.

1.8. **Children's Long Term Inpatient Programs ("CLIP")** means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from Children's Long Term Inpatient Programs (Child Study and Treatment Center, Pearl Street Center, McGraw Center, Tamarack Center)

1.9. **Community Mental Health Agency ("CMHA")** means Community Mental Health Agency that is licensed by the State of Washington to provide mental health services and subcontracted to provide services covered under this Agreement.

1.10. **Consumer** means a person who has applied for, is eligible for or who has received mental health services. For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

1.11. **Contractor** means the Contractor, its employees, agents and subcontractors

1.12. **Cultural Competence** means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

1.13. **Day** for purposes of this agreement means calendar days unless otherwise indicated in the agreement.

1.14. **Denial** means the decision not to offer an intake is a denial. The decision by a PIHP, or their formal designee, not to authorize covered Medicaid mental health services that meet medical necessity is a denial.

1.15. **Early Periodic Screening Diagnosis and Treatment ("EPSDT")** means the Early Periodic Screening Diagnosis and Treatment program under Title XIX of the Social Security Act as amended. All enrollees under the age of 21 are entitled to EPSDT services.

1.16. **Emergent Care** means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

1.17. **Emerging Best Practice or Promising Practice** means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.

1.18. **Enrollee** means a Medicaid recipient who is currently enrolled in a PIHP.

1.19. **Evidence Based Practice** means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

1.20. **Fair Hearing** means a hearing before the Washington State Office of Administrative Hearings.

1.21. **Family** means those the consumer defines as family or those appointed/assigned (e.g. parents, foster parents, guardians, siblings, caregivers, and significant others).

1.22. **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 CFR 438.400(b)).

1.23. **Large Rural Area** means areas with a population density of less than 20 people per square miles.

1.24. **Medicaid Funds** means funds provided by CMS Authority under the Title XIX program.

1.25. **Medical Necessity or Medically Necessary** means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

1.26. **Mental Health Care Provider ("MHCP")** means the individual with primary responsibility for implementing an individualized service plan for mental health rehabilitation services.

1.27. **Mental Health Division ("MHD")** means the Mental Health Division of the Washington State Department of Social and Health Services ("DSHS"). DSHS has designated the Mental Health Division as the state mental health authority to administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.

1.28. **Mental Health Professional** means;

1.28.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;

1.28.2. A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

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

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

1.28.5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.

1.29. **Quality Assurance** means a focus on compliance to minimum requirements (e.g. rules, regulations, and contract terms) as well as reasonably expected levels of performance, quality, and practice.

1.30. **Quality Improvement** means a focus on activities to improve performance above minimum standards/ reasonably expected levels of performance, quality, and practice.

1.31. **Quality Strategy** means an overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations

1.32. **Recovery** means the processes in which people are able to live, work, learn, and participate fully in their communities.

1.33. **Reduction** means the decision by a PIHP to decrease a previously authorized covered Medicaid mental health service described in the Level of Care Guidelines. The decision by a Community Mental Health Agency to decrease or change a covered service in the Individualized Service Plan is not a reduction.

1.34. **Regional Support Network ("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.

1.35. **Resilience** means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

1.36. **RCW** means the Revised Code of Washington. All references to RCW chapters or sections shall include any successor, amended, or replacement statute.

1.37. **Routine Services** means services that are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward mental health. These services do not meet the definition of urgent or emergent care.

1.38. **Rural Area** means areas with a population density of at least 20 and less than 500 people per square mile

1.39. **Service Areas** means the geographic area described in the section titled Service Areas for which the Contractor is responsible.

1.40. **Subcontract** means a separate contract between the RSN and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations, which the RSN is obligated to perform pursuant to this Agreement.

1.41. **Suspension** means the decision by a PIHP, or their formal designee, to temporarily stop your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The decision by a Community Mental Health Agency to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

1.42. **Termination** means the decision by a PIHP, or their formal designee, to stop a previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The decision by a Community Mental Health Agency to stop or change a covered service in the Individualized Service Plan is not a termination.

1.43. **Urban Area** means areas that have a population density of at least 500 people square mile.

1.44. **Urgent Care** means a service to be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary

1.45. **WAC** means the Washington Administrative Code. All references to WAC chapters or sections shall include any successor, amended, or replacement regulation.

2. ENROLLMENT

2.1. Enrollees of all ages who reside within the Contractor's service area and are enrolled in any of the following programs or are members of any of the following

groups are eligible for medically necessary mental health services provided under this contract:

2.1.1. Children and Related Poverty Level Populations (TANF/AFDC);

2.1.2. Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC) except for those women who in the family planning waiver program (program S, medical code P and Z)

2.1.3. Blind/Disabled Children or Adults and Related Populations (who qualify for SSI);

2.1.4. Aged and Related Populations;

2.1.5. Foster Care Children;

2.1.6. Title XXI SCHIP Children, targeted low income children who are eligible to participate in Medicaid;

2.1.7. Individuals with serious and persistent mental illness; and

2.1.8. Enrolled children with "D" coupons or other evidence of placement by DSHS, who currently reside in the Contractor's service area without regard to the child's original residence.

3. INFORMATION REQUIREMENTS

3.1. **Enrollee Information:** The Contractor must provide information to enrollees that complies with the requirements of 42 CFR §438.100, §438.6(i)(3), and WAC 388-865-0410.

3.1.1. The Contractor shall maintain written policy and procedures addressing all information requirements, and shall:

3.1.1.1. Provide to MHD the information necessary to update the Benefits Booklet for Medicaid Enrollees. The booklet is the mechanism by which enrollees are notified of their benefits, rights, and responsibilities; and

3.1.1.2. Inform every enrollee at the time of an intake evaluation that the Benefits Booklet produced by MHD is available anytime upon request. If requested the booklet must be provided. The booklet can be downloaded from: http://www1.dshs.wa.gov/Mentalhealth/benefits.shtml.

3.1.2. Provide interpreter services for enrollees with a primary language other than English for all interactions between the enrollee and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a grievance or appeal.

3.1.3. Post a multilingual notice that advises consumers that all written materials are available in Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese.

3.1.4. Provide translations of the mental health consumer rights identified in section 3.1 readily accessible in public areas and conspicuously marked.

3.1.5. The Contractor shall provide information that clearly explains to enrollees how the enrollee can request and be provided written materials in alternate formats. Information explaining to the enrollee how to access these materials must be provided prior to an intake evaluation in an easily understood format.

3.1.6. Upon an enrollee's request, the Contractor shall provide:

3.1.6.1. Identification of individual Mental Health Care Providers (MHCP) who are not accepting new enrollees;

3.1.6.2. Community Mental Health Agency (CMHA) licensure, certification and accreditation status; and

3.1.6.3. Information that includes but is not limited to, education, licensure, and Board certification and/or re-certification of mental health professionals and MHCPs.

3.1.7. The Contractor shall not refer a Healthy Options enrollee to the enrollee's Healthy Options managed care plan for mental health services if the enrollee is determined to be eligible for mental health services based on medical necessity and the Access to Care Standards.

3.2. **Customer Service**

3.2.1. The Contractor shall provide Customer Service that is customer friendly, flexible, proactive, and responsive to consumers, families, and stakeholders. The Contractor shall provide a toll free number for customer service inquiries. A local telephone number may also be provided for enrollees within the local calling area.

3.2.2. At a minimum, Customer Service staff shall:

3.2.2.1. Promptly answer telephone calls from consumers, family members and stakeholders from 8 a.m. until 5:00 p.m. Monday through Friday, holidays excluded;

3.2.2.2. Respond to consumers, family members and stakeholders in a manner that resolves their inquiry. Staff must have the ability to respond to those with limited English proficiency or hearing loss.

3.2.3. The Contractor shall train Customer Service staff to distinguish between a Third Party Insurance issue, appeal or grievances and how to route these to the appropriate party. Logs shall be kept that at a minimum to track the date

of the initial call, type of call and date of attempted resolution. This log will be provided to MHD for review upon request.

4. PAYMENT

4.1. Contractor shall use all funds provided pursuant to this Agreement including interest earned to support the public mental health system.

4.2. Rates of Payment:

Eligible Rates	FY07 (September '06-June '07)
Non-Disabled Children	10.40
Disabled Children	71.96
Non-Disabled Adults	13.21
Disabled Adults	109.95

The Contractor acknowledges and agrees that the Department, in its sole discretion, and in accordance with legislative authority, will operate the Washington Medicaid Integration Partnership (WMIP) in Snohomish County. The Contractor also acknowledges and agrees that WMIP will include both inpatient and outpatient mental health services. Except for detention services pursuant to 71.05 RCW and crisis hot line, the Contractor is not obligated to furnish services to WMIP enrollees.

The Contractor will not receive capitation payments for WMIP enrollees except for the crisis hotline component. The rates to be applied as a reduction are as follows:

WMIP Rates	FY07 (Sept 06 to June 07)
Disabled Adults	$108.47
Non Disabled Adults	$13.04

Mental health capitation rates were developed using Evaluation and Treatment (E&T), outpatient, residential, and professional encounter data collected from the Regional Support Networks (RSNs) by MHD; Medicaid eligibility records obtained from the Medical Assistance Administration (MAA); RSN-specific revenue and expense reports provided by MHD; community inpatient claim records from the State's Medicaid Management Information System (MMIS) system. The MMIS inpatient data for services incurred July 2003 to June 2004 and RSN encounter data for services incurred January 1, 2004 through December 31, 2004 formed the primary basis for the capitation rate development. Revenue and expense reports were used to validate the reasonableness of data sources and used to develop the administrative cost assumptions.

Critical steps in the rate development process included the following:

- Inpatient, residential and outpatient utilization was summarized by major service category separately by RSN, adult/child, and disabled/non-disabled status.
- Utilization date was limited to Title XIX services only.
- A Unit Cost Survey was completed by most mental health providers, which was used to construct outpatient unit costs.
- Cost models were constructed using the utilization data and assigning unit price estimates.
- Adjustments for claim lag, seasonality, and utilization and cost trends were analyzed and performed as necessary.
- Assumptions for administrative costs, including some direct support services, were developed as a percentage of projected capitation revenue and implemented proportionately across rate cells.

Final rates were set within the actuarially constructed ranges based on policy goals of MHD. The Contractor acknowledges that the Agreement may be amended to reflect any required changes.

4.3. During the term of this contract, capitation payments are made at the beginning of each month of service. The Contractor shall be responsible to provide all mental health services through the end of the month for which it has received a capitation payment.

4.4. Capitation payments are calculated based on Medicaid enrollee count. The information is compiled to fit the Mental Health Division's categories of eligibles, which are shown in the Rates section of the contract. Enrollees are assigned to the Community Services Office (CSO) at the time of eligibility. In cases where the services are provided by a statewide CSO, and also in cases of TANF reinstatement enrollees are distributed by the zip code.

Capitation Payments are entered into the accounting payment system the on first working day of the month. Two types of capitation payments are made the Initial Estimate and the 6-month Reconciliation.

4.4.1. <u>Initial Estimate</u>:

Estimated Gross Medicaid Payment: The initial estimate payment uses Medicaid enrollee data from two months prior to the first day of a particular month and applies the corresponding rate to calculate a gross Medicaid payment estimate for that month.

4.4.2. <u>6-Month Reconciliation</u>:

The 6-Month Reconciliation payment is an adjustment for Medicaid enrollees for a particular month of service. After six months, Medicaid enrollee counts are final. MHD pays for any increase in Medicaid enrollees or collects for any decrease in Medicaid enrollees. Reconciliation ends 6 months after the last month of the contract term.

4.4.3. Each capitation payment will be reduced by the amount paid by MHD on behalf of the Contractor for unpaid assessments, penalties, damages, and other payments pending a dispute resolution process. If the dispute is still pending June 1, 2007, MHD will withhold the amount in question from the final payment until the dispute is resolved.

4.4.4. MHD will withhold 50 percent of the final payment under this Contract until all final reports and data are received and accepted by DSHS, and until all pending corrective actions, penalties, or unpaid assessments are satisfied.

4.5. If the Contractor terminates this agreement or will not be entering into any subsequent agreements, the MHD will require that all remaining reserves and fund balances be spent within a reasonable timeframe developed with MHD. Funds will be deducted from the monthly payments until all reserves and fund balances are spent. Any funds not spent for the provision of services under this contract shall be returned to MHD with 60 days of the last day this agreement is in effect.

4.6. The Contractor is required to limit Administration costs to no more than 10 percent of the annual revenue supporting the public mental health system operated by the Contractor. Administration costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by MHD

4.7. Contractor shall reimburse the subcontracted CMHA network and any crisis service provider accessed by enrollees while the enrollee is in or out of the State within 60 calendar days from the date the bill is received from the service provider.

4.8. If Federal Financial Participation (FFP) is recouped from the Contractor, the Contractor must reimburse the amount recouped to MHD within 30 days of notification by MHD.

4.9. If the contractor chooses to use the MMIS system for inpatient claims processing, MHD or its designee will provide a bill to the Contractor on a monthly basis for claims paid on behalf of the Contractor. The Contractor has 30 days from the receipt of the inpatient claims bill to pay the costs assessed.

4.10. The Contractor must maintain risk reserves at 4.5% of the Contractor's annual Medicaid premium payment. If the Contractor spends a portion of the risk reserve, the funds must be replenished within one year, or at the end of the fiscal year in which the funds were spent, whichever is longer. Risk Reserve funds are designated into a risk reserve account by official action of the RSN's governing body. Risk reserve funds may only be used in the event costs of providing service exceed the revenue the RSN receives.

4.11. The Contractor must ensure the existence of inpatient reserve at 5.7% of the Contractor's annual Medicaid premium payment. The Inpatient Reserves are funds that are set aside into an account by official action of the RSN/PIHP governing body. Inpatient reserve funds may only be set aside for anticipated psychiatric inpatient costs.

4.12. The Contractor may have an additional Operating Reserve not to exceed 5.0% of the PIHP annual Medicaid premium payments. The Operating Reserves are funds that are set aside into an account by official action of the RSN/PIHP governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.

5. REPORTING AND DELIVERABLES:

5.1. Advisory Board and Governing Body Membership

5.1.1. The Contractor shall submit the Advisory Board membership rosters showing compliance with WAC 388-865-0222 to the MHD within 30 days of the execution of this contract. Any change in membership must be reported within 30 days of the change.

5.1.2. The Contractor must establish a Governing Body responsible for oversight of the Regional Support Network. The Governing Body can be an existing legislative body within a county government. The Governing Body must be free from conflicts of interest and from any appearance of conflicts of interest between personal, professional and fiduciary interests of a Governing Body member and best interests of the RSN and the consumers it serves. The Contractor must submit membership roster(s) and by-laws of the Governing Body demonstrating compliance. These must be submitted to MHD for review 30 days after execution of this agreement. The Governing Body by-laws must include:

5.1.2.1. Actions to be taken when a conflict of interest, or the appearance of a conflict of interest, becomes evident;

5.1.2.2. Requirements that members refrain from voting or joining a discussion when a conflict of interest is present; and

5.1.2.3. A process for the Governing Body to assign the matter to others, such as staff or advisory bodies to avoid a conflict of interest.

5.1.3. The Contractor shall maintain Level of Care Guidelines that meet the requirements described in the Resource Management Section. Level of care guidelines must be submitted for review and approval upon request.

5.1.4. The Contractor shall submit in the format provided by MHD the number and types of incidents described in section 7.11.5 These reports will be filled out monthly and submitted within 45 days of the quarter end (September, December, March, and June of each year). For the first report of the contract period the months of September through December may be combined and submitted 45 days after December 30, 2006. The MHD reserves the right to require more frequent submission of the Incident Data reports.

5.1.5. The Contractor shall submit the Allied System Coordination plan developed with any DMIO program within the contracted service area on or before 90 days after the execution of this Agreement.

5.2. **Financial Reporting and Certification:** Reports are due within 45 days of the quarter end (September, December, March, and June of each year). The first report is due 45 days after September 30, 2006. These reports may be combined with the reports for the months of August 2006 and July 2006 that were required in the September 2005 to August 2006 PIHP Agreement. The MHD reserves the right to require more frequent submission of the Revenue and Expenditure report. The following reports and certifications, in formats provided by MHD, must be submitted on a quarterly basis:

5.2.1. PIHP Revenue, Expenditure, Reserves and Fund Balance report in compliance with the BARS Supplemental for Mental Health Services promulgated by the Washington State Auditor's Office and the Revenue and Expenditure Report Instructions published by MHD.

5.2.2. Balance Sheets

5.2.3. The amounts paid to Federally Qualified Health Centers for services must be tracked and reported.

5.2.4. A report of any revenue collected by subcontractors for services provided under this agreement. This includes revenue collected from Medicare, insurance companies, co-payments, and other sources. The Contractor must certify that a process is in place to demonstrate that all third party revenue resources for services provided under this agreement are identified, pursued, and recorded by the subcontractor, in accordance with Medicaid being the payer of last resort.

5.2.5. Certification that administrative costs, as defined in the Revenue and Expenditure Report Instructions for Mental Health Services, incurred by the Contractor are no more than 10 percent of the annual revenue supporting the public mental health system operated by the Contractor. Administration costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by MHD.

5.2.6. If the Contractor is unable to certify the validity of the certifications or if DSHS finds discrepancies in the Revenue and Expenditure Report, DSHS may initiate remedial action. Remedial action may include recoupment from funds disbursed during the current or successive Agreement period. Recoupment shall occur within 90 days of the close of the State fiscal year or within 90 days of the MHD's receipt of the certification, whichever is later..

5.2.7. MHD reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data. MHD agrees to involve the RSN in the decision process prior to implementing changes in format, and will request the RSN to review and comment on format changes before they go into effect whenever possible.

6. ACCESS AND CAPACITY

6.1. Network Capacity

6.1.1. The Contractor shall maintain sufficient capacity, including the number, mix, and geographic distribution of Mental Health Clubhouses, Community Mental Health Agencies (CMHA), and Mental Health Care Providers (MHCPs) to meet the needs of the anticipated number of enrollees in the service area. At a minimum the Contractor shall provide:

6.1.1.1. Access to an intake evaluation by a MHP;

6.1.1.2. Age-appropriate medically necessary mental health services as identified in the Medicaid state plan and the 1915(b) Medicaid Waiver; and

6.1.1.3. A geographic distribution and mix of CMHA's to meet the access and travel standards in section 6.2.

6.1.2. The Contractor shall notify MHD in writing of any change in capacity that results in the Contractor being unable to meet any of the Access Standards as required in this agreement. Events that may affect capacity include; loss of a CMHA, decrease in the number or frequency of a required service, or any changes that result in the Contractor being unable to provide medically necessary services.

6.2. **Access Standards** The Contractor shall make available crisis mental health services and medically necessary mental health services on a 24-hour, 7 days per week basis.

6.2.1. Service Requests: A request for mental health services occurs when mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request for mental health services.

6.2.1.1. An intake evaluation must be initiated within 10 working days of the request for mental health services.

6.2.1.2. Emergent mental health care must occur within 2 hours of a request for mental health services from any source;

6.2.1.3. Urgent care must occur within 24 hours of a request for mental health services from any source; and

6.2.1.3.1. Urgent and emergent medically necessary mental health services (e.g. crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes.

6.2.1.4. Routine mental health services must be offered to occur within 14 calendar days of a decision to authorize mental health services. The time from request for mental health services to first routine appointment

must not exceed 28 calendar days unless the Contractor documents a reason for the delay.

6.2.2. **Authorization**:

6.2.2.1. The Contractor must provide an intake evaluation upon request by an enrollee. A new intake evaluation is not required if an intake was completed in the 12 months prior to the current request and medical necessity was established. The previously completed intake may be used to authorize care.

6.2.2.2. The Contractors determination of eligibility for authorization of routine services shall be based on medical necessity and the Access to Care Standards following an intake evaluation.

6.2.2.3. A decision whether to authorize routine mental health services must occur within 14 days from the date of request for mental health services unless the enrollee or the CMHA request an extension from the PIHP. An extension of up to 14 additional calendar days to make the authorization decision is possible upon request by the enrollee or the CMHA. The Contractor must have a written policy and procedure to ensure consistent application of requests within the service area. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary.

6.2.2.4. The Contractor or its formal designee shall notify enrollees or their legal guardian of authorization decisions within 14 working days of the decision through written communication. This includes notice to enrollees under 21 or their legal guardian of the availability of services under EPSDT. A decision to deny an intake evaluation or ongoing services that are medically necessary must be provided with a written Notice of Action to the enrollee.

6.2.2.5. The Contractor shall hire or designate at least one Children's Care Manager. The Children's Care Manager must:

6.2.2.5.1. Be a children's mental health specialist or be supervised by a children's mental health specialist;

6.2.2.5.2. Review initial intake evaluations of all enrollees under the age of 21 for medical necessity and complete level 1 or level 2 assignments according to the Access to Care Standards and EPSDT section of this agreement.

6.2.2.6. The Children's Care Manager must authorize Level II services described in the Access to Care Standards for children are:

- Involved with one or more of the following in addition to mental health;
    - Children's Administration

- Division of Developmental Disabilities
- Juvenile Rehabilitation Administration/Department of Corrections

- Diagnosed with substance abuse or addiction;
- Receiving special education services; or,
- A chronic and disabling medical condition.

6.2.2.7. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or described in the individual service plan must be determined by a Mental Health Professional with the appropriate clinical expertise to make that decision.

6.2.2.8. If the Contractor or its formal designee: a) denies a service authorization request; or b) authorizes a service in an amount, duration, or scope that is less than requested, the Contractor shall notify the requesting CMHA and the enrollee in writing within 14 working days of the decision.

6.2.3. **Distance Standards**

6.2.3.1. The Contractor shall ensure that when enrollees must travel to service sites, the sites are accessible as follows:

6.2.3.1.1. In Rural Areas, a 30-minute drive from the primary residence of the enrollee to the service site;

6.2.3.1.2. In Large Rural Geographic Areas, a 90-minute drive from the primary residence of the enrollee to the service site; and

6.2.3.1.3. In Urban Areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed 90-minutes each way.

6.2.3.2. Travel standards do not apply: a) when the enrollee chooses to use service sites that require travel beyond the travel standards; b) to psychiatric inpatient services; c) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

7. QUALITY OF CARE

7.1. The Contractor shall participate with MHD in the implementation, update, and evaluation of the Quality Strategy, located on the MHD website.

7.2. The Contractor shall use its collected data, monitoring results, and services verification to review its ongoing quality management program. The Contractor shall engage in ongoing assessment and improvement of the quality of public

mental health services in its service area, as well as evaluate the effectiveness of the overall regional system of care. At a minimum, the Contractor shall:

7.2.1. Assess the degree to which mental health services and planning is driven by and incorporates enrollee and family voice;

7.2.2. Assess the degree to which mental health services are age, culturally and linguistically competent;

7.2.3. Assess the degree to which mental health services are provided in the least restrictive environment;

7.2.4. Assess the degree to which mental health services assist enrollees' progress toward recovery and resiliency; and

7.2.5. Assess the continuity in service and integration with other formal/informal systems and settings.

7.3. The Contractor shall incorporate results of grievances, fair hearings, incidents identified in section 7.11, appeals and actions into system improvement.

7.4. The Contractor shall provide quality improvement feedback to CMHAs, the advisory board, and other interested parties.

7.5. The Contractor shall invite enrollees and enrollees' families that are representative of the community being served, including all age groups, to participate in planning activities and in the implementation and evaluation of the public mental health system. The Contractor must be able to demonstrate how this requirement is implemented.

7.6. **Performance Measures**

7.6.1. The Contractor shall monitor the following performance measures for maintenance of baselines provided by MHD. MHD will calculate and review the following indicators two times during this contract period: September through December and January through April. If the Contractor does not meet MHD defined target baselines on any measure, the Contractor must submit a plan to increase performance to meet baseline. If requested by MHD the Contractor's plan will include the submission and implementation of a formal Performance Improvement Project.

7.6.1.1. Non-Crisis services must be offered within seven days of discharge from a psychiatric inpatient hospital or evaluation and treatment program. This will be calculated as number of enrollees who receive an outpatient service within seven days of discharge divided by the total number of enrollees discharged.

7.6.1.2. Telesage Outcome Assessment initiated at time of an intake evaluation. This will be calculated as the number of enrollees that complete or are offered an outcome assessment divided by the number of enrollees that receive an intake evaluation.

7.6.2. An additional measure will be added beginning January 1, 2007. This contract period will be used to establish baselines.

7.6.2.1. Time from request for services to first routine service shall not exceed 28 days.

7.6.3. The Contractor shall participate with MHD in the development and implementation of a standard set of performance indicators to measure access, quality and appropriateness. Participation must include:

7.6.3.1. Provision of all necessary data;

7.6.3.2. The analysis of results and development of system improvements based on that analysis on a local and statewide basis; and

7.6.3.3. Incorporation of the results into quality improvement activities.

7.7. The Contractor shall participate with MHD in completing annual Mental Health Statistics Improvement Project (MHSIP) surveys. The schedule will rotate annually between adults and youth/families. Participation must include at a minimum:

7.7.1. Provision of enrollee contact information to MHD;

7.7.2. Involvement in the analysis of results and development of system improvements based on that analysis on a statewide basis; and

7.7.3. Incorporation of results into the Contractor specific quality improvement activities.

7.8. The Contractor shall attempt to complete a TeleSage outcome survey on every individual at the time of the intake evaluation and attempt to complete a follow-up assessment after 180 days.

7.9. The Contractor must identify where improvement is needed and continue or implement at least four Performance Improvement Projects (PIP). At all times during the contract period this must include at least two clinical and two non-clinical projects. The PIPs can be a mix of PIPs identified by the MHD for statewide improvement and projects identified by the RSN for local improvements. The Contractor shall evaluate the PIPs for increased or sustained improvement over time.

7.10. The Contractor shall participate with MHD in review activities. Participation will include at a minimum:

7.10.1. The submission of requested materials necessary for a MHD initiated review within 30 days of the request;

7.10.2. The completion of site visit protocols provided by MHD; and

7.10.3. Assistance in scheduling interviews and agency visits required for the completion of the review.

7.11. **Quality Review Activities**

7.11.1. The Department of Social and Health Services (DSHS), Office of the State Auditor, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives, may conduct announced and unannounced:

7.11.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement;

7.11.1.2. Reviews regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement; and

7.11.1.3. Audits and inspections of financial records.

7.11.2. The Contractor shall notify MHD when an entity other than DSHS performs any audit or review described above related to any activity contained in this Agreement.

7.11.3. At least annually the following required activities will be reviewed by DSHS, its agent, or an External Quality Review Organization:

7.11.3.1. Encounter Data Validation; and

7.11.3.2. Performance Improvement Projects.

7.11.4. The Contractor shall submit to an annual EQRO monitoring review. The monitoring review process uses standard methods and data collection tools and methods found in the CMS External Quality Review Protocols and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by the Contractor.

7.11.4.1. The Contractor shall, upon request provide evidence of how external quality review findings, agency audits, contract monitoring activities and consumer grievances are used to identify and correct problems and to improve care and services to enrollees.

7.11.4.2. DSHS will provide a copy of the EQRO Report to the Contractor, through print or electronic media and upon request to interested parties such as enrollees, mental health advocacy groups, and members of the general public.

7.11.5. **Incident Reporting**:

7.11.5.1. The contractor must notify the Mental Health Services Chief or designee during the first working day the Contractor becomes aware of an incident

related to the provision of mental health services that is likely to result in news coverage.

7.11.5.2. The Contractor must notify the Mental Health Services Chief or designee during the first working day the Contractor becomes aware that any Consumer is the alleged victim or perpetrator of any of the following:

Homicide or attempted homicide

Completed Suicide

Physical or sexual assault

Abuse or neglect

Abandonment of a child or vulnerable adult

Financial Exploitation

Accidental Death

Notification must be made to the Mental Health Services Chief or designee during the working day in which the Contractor becomes aware of such an event. If the event occurs after business hours, notice must be given as soon as possible, during the next working day.

7.11.5.3. Notification must include a description of the event, any actions taken in response to the incident, the purpose for which any action was taken, and any implications to the service delivery system.

7.11.5.4. When requested by MHD, a written report will be submitted within two weeks of the original notification to provide information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

7.12. **Practice Guidelines:** Practice Guidelines are systematically developed statements designed to assist in decisions about appropriate mental health treatment. The guidelines are intended to assist practitioners in the prevention, diagnosis, treatment, and management of clinical conditions.

7.12.1. The Contractor shall adopt and implement a minimum of two Practice Guidelines. The Contractor shall provide documentation describing the chosen guidelines to the MHD within 90 days of the execution of this Agreement. The Practice Guidelines must:

7.12.1.1. Be based on valid and reliable clinical evidence or a generally accepted practice among the mental health professionals in the community;

7.12.1.2. Consider the needs of the enrollees;

7.12.1.3. Be adopted in consultation with mental health professionals in the contracted network of CMHAs, when applicable;

7.12.1.4. Be disseminated to all affected providers and, upon request, to enrollees; and

7.12.1.5. Be chosen with regard to utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply.

8. SUBCONTRACTS

8.1. Provider Discrimination

8.1.1. The Contractor must ensure there is no discrimination with respect to: a) the participation, reimbursement, or indemnification of any CMHA that is acting within the scope of its license or certification under applicable State law solely upon the basis of that license or certification; and b) particular CMHAs who serve high risk mental health enrollees or specialize in mental health conditions that require costly treatment.

8.1.2. The Contractor must provide written notice to individual CMHAs or to groups of CMHAs as to the reason for the Contractor's decision if they are not selected for the Contractor's authorized network of providers.

8.1.3. All contracts with CMHAs must comply with 42 CFR §438.214.

8.2. Delegation

8.2.1. A subcontract does not terminate the legal responsibility of the Contractor to perform the terms of this agreement. The Contractor must oversee, be accountable for, and monitor functions and responsibilities performed by or delegated to a subcontractor on an ongoing basis including the completion of an annual formal review.

8.2.2. Prior to any delegation of responsibility or authority to a subcontractor, the Contractor shall use a formal delegation plan, consistent with the requirements of 42 CFR §438.230, to evaluate the subcontractor's ability to perform delegated activities. Within 90 days of execution of this Agreement the Contractor shall submit its delegation plan to the MHD for approval. The delegation plan must include the following:

8.2.2.1. An evaluation of the prospective subcontractor's ability to perform delegated activities;

8.2.2.2. A detailed description of the proposed subcontracting arrangements, including (1) name, address, and telephone number of the sub-contractor(s), (2) specific contracted services, (3) compensation arrangement, and (4) monitoring plan; and

8.2.2.3. A copy of the existing or draft subcontract that specifies the activities and reporting responsibilities delegated and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is not adequate.

8.2.2.4. The Care Management functions as described in this contract cannot be delegated to a subcontracted CMHA within the Contractor's service area.

8.3. **Subcontract Submission and Required Provisions**

8.3.1. All Subcontracts must be in writing and specify all duties, reports, and responsibilities delegated under this Agreement. Within 30 days of execution of a subcontract to perform any function under this Agreement, the Contractor shall submit copies of the subcontracts to MHD

8.3.1.1. When substantially similar contracts are executed with multiple subcontractors an example contract may be provided with a list by subcontractor of any terms that deviate from the example.

8.3.1.2. Amendments to subcontracts must be submitted with a summary of the changes made to the original subcontracts within 45 days following the end of a reporting period. Reporting periods are October to March and April to September. In the event that the contract performance period does not encompass a full report period the Contractor shall provide a report for the partial period.

8.3.1.3. Copies are to be provided in word processing format on a portable memory device.

8.3.2. Subcontracts must require subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the services to be performed under this Agreement.

8.3.3. Subcontracts must require adherence to the Americans with Disabilities Act.

8.3.4. Subcontracts must require compliance and implementation of the Mental Health Advance Directive statutes.

8.3.5. Subcontracts must require subcontractors to cooperate with Quality Review Activities and provide access to their facilities, personnel and records.

8.3.6. Subcontracts must require subcontractors to participate in MHD offered training on the implementation of Evidence-based Practices and Promising Practices.

8.3.7. Subcontracts must require subcontractors to provide enrollees access to translated information and interpreter services as described in the Information Requirements section.

8.3.8. Subcontracts must require subcontractors to notify the Contractor in the event of a change in status of any required license or certification.

8.3.9. Subcontracts must require subcontractors to participate in training when requested by MHD.

8.3.10. Subcontracts must require compliance with State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and the MHD-CIS Data Dictionary.

8.3.11. Subcontracts must define a clear process to be used to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.

8.3.12. Subcontracts must require that the subcontractor correct any areas of deficiencies in the subcontractor's performance that are identified by the Contractor or the Mental Health Division as part of a subcontractor review.

8.3.13. Subcontracts must require best efforts to provide written or oral notification no later than 15 working days after termination of a MHCP to enrollees currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the CMHA.

8.3.14. Subcontracts must require that the subcontracted CMHAs comply with the Contractor's policy and procedures for utilization of Access to Care Standards, travel standards, and Access Standards.

8.3.15. Subcontracts must require that the subcontractor implement a Grievance process that complies with 42 CFR §438.400 or any successors as described in Section 12 of this agreement.

8.3.16. In accordance with Medicaid being the payer of last resort, subcontracts must require the pursuit and reporting of all Third Party Revenue related to services provided under this agreement.

8.3.17. Subcontracts must require the use of the MHD provided, Integrated Co-Occurring Disorder Screening and Assessment Tool by January 1, 2007 and require staff that will be using the tool attend trainings on the use and implementation of the tool.

8.4. **Termination:** The termination of a subcontract with an entity that provides mental health services is considered a significant change in the provider network. The Contractor must notify MHD 30 days prior to terminating any of its subcontracts with entities that provide direct service. This notification must occur prior to any public announcement of this change.

8.4.1. If either the Contractor or the Sub-Contractor terminates a subcontract in less than 30 days, the Contractor must notify MHD as soon possible and prior to a public announcement.

8.4.2. If a CMHA contract is terminated, the Contractor must submit a transition plan for enrollees and services that includes at least:

- Notification to Ombuds services
- Crisis services plan
- Client notification plan
- Plan for provision of uninterrupted services

- Any information released to the media

8.4.3. **Annual Review:** An annual formal review of subcontractors must be performed by the Contractor. This review may be combined with a formal review of services performed pursuant to the State Mental Health Agreement between the Contractor and MHD. The review must include the requirements set forth in this contract, the WAC and the RCW. The annual review results must at least address the following:

8.4.3.1. Quality clinical care;

8.4.3.2. Timely access;

8.4.3.3. Referrals for Healthy Child screens for EPSDT

8.4.3.4. The pursuit of third party revenue;

8.4.3.5. Quality Assessment and PIPs;

8.4.3.6. Intake Evaluations and Individual Treatment Plans; and

8.4.3.7. Practice Guidelines.

8.5. **Excluded Providers**

8.5.1. The Contractor, by signature to this Agreement certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal department or agency. The Contractor also agrees to include the above requirement into any subcontracts entered into, resulting directly from the Contractor's duty to provide services under this Agreement.

8.5.2. The Contractor is required to ensure that the subcontractor neither employs any person nor contracts with any person or Community Mental Health Agency (CMHA) excluded from participation in federal health care programs under either 42 U.S.C. 1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Agreement's General Terms and Conditions;

8.5.3. The Contractor and any subcontractors must comply with 42-USC §1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of the Contractor's equity, or an employee, contractor, or consultant who is significant or material to the provision of services under this Agreement, who has been, or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any federal agency.

8.6. **Physician Incentive Plans**

8.6.1. The Contractor must ensure it does not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) does not contract with any subcontractor operating such a plan.

8.7. **Provider Credentialing**

8.7.1. The Contractor shall have written policies that require monitoring of provider credentials. The Contractor shall only use CMHAs that are licensed and/or certified by the State with the exception of services that are provided by a subcontracted Mental Health Clubhouse.

8.7.2. The Contractor shall require a criminal history background check though the Washington State Patrol for employees and volunteers of the contractor who may have unsupervised access to children, people with developmental disabilities or vulnerable adults.

9. **ENROLLEE RIGHTS AND PROTECTIONS**

9.1. The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff takes those rights into account when furnishing services to enrollees.

9.2. The Contractor shall require that mental health professionals and MHCPs, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee with respect to:

9.2.1. The enrollee's mental health status;

9.2.2. Receiving all information regarding mental health treatment options including any alternative or self-administered treatment, in a culturally-competent manner;

9.2.3. Any information the enrollee needs in order to decide among all relevant mental health treatment options;

9.2.4. The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment);

9.2.5. The enrollee's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions;

9.2.6. The enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy;

9.2.7. The enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

9.2.8. The enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164;

9.2.9. The enrollee's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the Contractor, CMHA or MHCP treats the enrollee;

9.2.10. Ensure that mental health professionals and MHCPs have an effective method of communication with enrollees who have sensory impairments; and

9.2.11. Provide or purchase age, linguistic and culturally competent community mental health services for enrollees for whom services are medically necessary and clinically appropriate.

9.3. Individual Service Plans must be developed in compliance with WAC 388-865-0425.

9.3.1. The Contractor shall require that consumers are included in the development of their individualized service plans, advance directives and crisis plans. This shall include but not be limited to children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings). At a minimum, treatment goals must include the words of the individual receiving services and documentation must be included in the clinical record, as part of the 180 day progress review, describing how the consumer sees progress. An individual peer support plan may be incorporated in the individual service plan.

9.4. The Contractor shall ensure enrollees are not held liable for any of the following:

9.4.1. Covered mental health services provided by insolvent community psychiatric hospitals with which the Contractor has directly contracted;

9.4.2. Covered mental health services, including those purchased on behalf of the enrollee;

9.4.3. Covered mental health services for which the State does not pay the Contractor;

9.4.4. Covered services provided to the enrollee, for which the State or the Contractor does not pay the MHCP or CMHA that furnishes the services under a contractual, referral, or other arrangement; or

9.4.5. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Contractor provided the services directly.

9.5. **Ombuds**

9.5.1. The Contractor shall provide a mental health Ombuds as described in WAC 388-865-0250 and RCW 71.24. An entity or subcontractor independent of the RSN Administration must employ the Ombuds and provide for the following:

9.5.1.1. Separation of personnel functions (e.g. hiring, salary and benefits determination, supervision, accountability and performance evaluations).

9.5.1.2. Independent decision making to include all investigation activities, findings, recommendations and reports.

9.6. **Advance Directives**

9.6.1. The Contractor shall maintain a written Advance Directive policy and procedure that respects enrollees' Advance Directives for psychiatric care. Policy and procedures must comply with RCW 71.32 and the requirements of 42 CFR §422.128, Subpart I of part 489, and 42 CFR §438.6 as they pertain to psychiatric care. If State law changes, MHD will send notice to the Contractor who must then ensure the provision of notice to enrollees within 90 days of the change.

9.6.2. The Contractor shall inform enrollees that complaints concerning noncompliance with the Advance Directive for psychiatric care requirements may be filed with MHD by contacting the Quality Improvement and Assurance section at 1-888-713-6010.

9.7. **Choice of MHCP**

9.7.1. The Contractor shall offer each enrollee a choice of participating MHCPs in accordance with WAC 388-865-0345. If the enrollee does not make a choice, the Contractor or its designee must assign an MHCP no later than 14 working days following the request for mental health services. The enrollee may change MHCPs during the first 30 days of enrollment and once during a twelve-month period for any reason. Any additional change of an MHCP requested by an enrollee during a twelve-month period may be approved at the Contractor's discretion, provided that justification for the change is documented.

10. **CARE MANAGEMENT** Care management is a set of clinical management oversight functions that shall be performed by the Contractor. Care Management functions shall not be delegated to a network CMHA. Care management focuses on access, referrals, oversight of care coordination, utilization review, resource management, risk management, and quality improvement. These activities must be performed by a Mental Health Professional.

10.1. Utilization Management Program

10.1.1. The Contractor shall have a psychiatric medical director (consultant or staff) and sufficient care managers to carry out essential care management functions including:

10.1.1.1. A process for enrollees to access an intake evaluation and a process for referral to crisis intervention services. The Contractor must verify eligibility for Title XIX prior to the provision of services to an enrollee;

10.1.1.2. A utilization review of requested services against medical necessity criteria, authorization of necessary care, and administration of denials and appeals including access to expedited appeals;

10.1.1.3. Review of assessment and treatment services against clinical practice standards. Clinical practice standards include but are not limited to evidenced based practice guidelines, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals and other consumer serving agencies;

10.1.1.4. Monitoring for over-utilization and under-utilization of services and ensure that resource management and utilization management activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary mental health services to any enrollee; and

10.1.1.5. Maintenance of written policies and procedures implementing level of care guidelines for determining for continuing stay and discharge within the Contractor's service area. The policies and procedures must demonstrate:

- Consistent application of review criteria for authorization decisions;
- Consistent application of medical necessity criteria and the Access to Care Standards; and
- Consultation with providers, when appropriate.

10.1.2. The Contractor shall maintain the ability to adjust the number, mix, and geographic distribution of MHCPs to meet Access and Distance Standards as the population or enrollees needing mental health services shift within the service area.

10.1.3. The Contractor shall monitor and adjust to situations in which there is:

10.1.3.1. Unanticipated need for MHCPs with particular types of experience; or

10.1.3.2. Unanticipated limitation of the availability of such MHCPs including identifying the numbers of MHCPs who are not accepting new enrollees.

10.2. **Resource Management:**

10.2.1. The Contractor must have a Resource Management plan that incorporates coordination and authorization of outpatient mental health services administered pursuant to an individual service plan.

10.2.2. The Contractor must ensure that the Access to Care Standards are incorporated into the Contractor's Level of Care Guidelines as the eligibility criteria for initial authorization of outpatient mental health services. In addition to the Access to Care Standards, the Contractor's Level of Care Guidelines must also include: criteria for use in determining continued or re authorization following the exhaustion of previously authorized benefits by the enrollee; and criteria for use in determining when an enrollee shall be discharged from outpatient community mental health services.

10.2.3. The Contractor must ensure that eligibility criteria for initial authorization of outpatient mental health services are consistent with the Access to Care Standards. From the time mental health services are authorized, the Contractor is responsible for providing uninterrupted access to a range of activities identified in the Medicaid State Plan to promote resiliency and recovery.

10.2.4. The Contractor's care management system must include a review of the Individual Service Plan to ensure the requirements of WAC 388-865-0425 are being met and that:

10.2.4.1. The enrollee's identified needs are being addressed;

10.2.4.2. The enrollee and those the enrollee identifies as family are participating, when appropriate, in the in the treatment planning; and

10.2.4.3. Input from other health, education, social service, and justice agencies is included, as appropriate and consistent with privacy requirements.

10.2.5. Review criteria used to determine continued or re-authorization following the exhaustion of previously authorized services by the individual must include:

10.2.5.1. An evaluation of the effectiveness of each service modality provided during the benefit period;

10.2.5.2. An evaluation of the progress the enrollee made towards recovery or resiliency;

10.2.5.3. An identification of unmet goals in the individual service plan including those identified by the enrollee; and

10.2.5.4. A method for determining if an enrollee has met discharge criteria.

10.2.5.5. If an enrollee under the age of 21 receives the maximum services allowed under Level I and there is a request for additional services Children's Care Manager must review the individual treatment plan and

determine if Level 1 should be re-authorized or if Level II is the appropriate level of care.

10.2.5.5.1. The Children's Care Manager must be notified at the time any of the circumstances in section 6.2.2.6 occur; this would require a Level II authorization.

10.2.5.5.2. If additional services are medically necessary after one re-authorization of Level I services, the Children's Care manager must authorize Level II services.

10.2.5.5.3. Any time that Level II services are authorized and other service systems identified in 6.2.2.6 are involved or need to be involved the child and the family must be referred to an individual support team for development of an Individual Treatment plan that addresses cross system needs.

10.2.6. The Contractor shall maintain written policies and procedures, and be able to demonstrate, upon request, the consistent application of the Level of Care Guidelines within the Contractor's service area.

10.2.7. The Contractor must provide a written Notice of Action, in accordance with 42 CFR §438.404, when there is a denial, reduction, termination or suspension based on the PIHP Level of Care Guidelines.

10.2.8. The Contractor must have Care Managers available 24 hours a day, 7 days a week to respond to requests for certification of psychiatric inpatient care in community hospitals. A decision regarding certification of psychiatric inpatient care must be made within twelve hours of the initial request.

10.2.8.1. If the authorization is denied, a Notice of Action must be provided to the enrollee or their legal guardian.

10.2.8.2. Denials for certification of a psychiatric inpatient stay are reviewed by a psychiatrist. This must occur within three days of the initial denial.

10.2.9. If the Contractor denies payment of any portion of a psychiatric inpatient stay for enrollees and the inpatient facility appeals, the Contractor must respond to the appeal within 14 calendar days. The inpatient facility may appeal the Contractor's decision(s) to MHD after all reasonable effort is made to resolve the dispute between the Contractor and the inpatient facility.

10.2.10. The Contractor shall adhere to the requirements set forth in the Community Hospitalization authorization procedures available on the MHD Intranet or upon request.

10.2.11. The Contractor shall ensure that community psychiatric inpatient services are continued through an enrollee's discharge should a community hospital become insolvent, including any requirement for transfer.

11. MANAGEMENT INFORMATION SYSTEM –

11.1. Data Submission and Error Correction

11.1.1. The Contractor shall provide the MHD with all data described in the data dictionary for the Mental Health Division Consumer Information System (MHD-CIS), or any successor, incorporated herein by reference.

11.1.2. The Contractor shall submit encounters within 60 days of the close of each calendar month in which the encounters occurred.

11.1.3. The Contractor shall submit all other required data about enrollees to the MHD within 60 days of collection or receipt from subcontracted providers.

11.1.4. Upon receipt of data submitted to the MHD, the MHD will generate an error report. The Contractor shall have in place documented policies and procedures that assure that data submitted and rejected due to errors are corrected and resubmitted within 30 calendar days of when the MHD error report was produced. All transactions will be final 180 days after the close of the submission month.

11.1.5. The Contractor shall require subcontractors to resubmit data when rejected by MHD due to errors. The subcontractor must resubmit corrected data within 30 calendar days of when an error report was produced.

11.1.6. The Contractor shall attend meetings and respond to inquiries to assist in MHD decisions about changes to data collection and information systems to meet the terms of this contract. This may include requests to add, delete or change data elements that may include projected cost analysis.

11.1.6.1. The Contractor shall implement changes made to the MHD data dictionary within 120 days from the date of published changes. When MHD makes changes to the Data Dictionary the contractor shall send at least one test batch of data containing the required changes described in the data dictionary. The test batch must be received no later than 15 days following the implementation date.

- The test batch must include a quantity of transactions that is at least 50% of the number of successful transactions posted to the MHD –CIS in the six months prior to the change and contain information effected by the change.

- The processed test batch must result in at least 80% successfully posted transaction or an additional test batch is required.

11.1.7. The Contractor shall respond to requests for information not covered by the data dictionary in a timeframe determined by the MHD that will allow for a timely response to inquiries from CMS, the legislature, the MHD, and other parties.

11.1.8. The Contractor shall be liable for any costs associated with additional data processing once transactions are final. The Contractor will not be held liable for costs associated with making changes requested in writing by the MHD director, an office chief or their designee.

11.2. **Business Continuity and Disaster Recovery**

11.2.1. The Contractor shall demonstrate a primary and backup system for electronic submission of data requested by the MHD. This must include the use of the Inter-Governmental Network (IGN), Information Systems Services Division (ISSD) approved secured Virtual Private Network (VPN) or other ISSD- approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on MHD approval. Documentation of the system to be used and its capabilities must be submitted to the MHD for approval.

11.2.2. The Contractor shall provide a business continuity and disaster recovery plan that insures timely reinstitution of the consumer information system following total loss of the primary system or a substantial loss of functionality. The plan must be submitted to the MHD for approval.

11.2.3. The Contractor will require all subcontractors to provide a business continuity and disaster recovery plan that insures timely reinstitution of the subcontractor's consumer information system following total loss of the primary system or a substantial loss of functionality.

11.2.4. Documentation required in this section must be submitted to MHD within 60 days of the execution of this agreement.

11.3. **Information System Security and Protection of Confidential Information**

11.3.1. The Contractor shall comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified in 42 USC §1320(d) et.seq. and 45 CFR parts 160, 162 and 164.

11.3.2. The Contractor shall maintain a statement on file for each individual service provider and contractor staff who have access to the Contractor's mental health information system that is signed by the provider and attested to by a witness's signature, acknowledging that the provider understands and agrees to follow all regulations on confidentiality.

11.3.3. The Contractor shall take appropriate action if a subcontractor or Contractor employee willfully releases confidential information.

11.4. **Subcontractor Data Quality Verification**

11.4.1. The Contractor shall maintain and either provide to subcontractors, or require subcontractors to also maintain, a health information system that complies with the requirements of 42 CFR §438.242 and provides the

information necessary to meet the Contractor's obligations under this agreement. The Contractor shall have in place mechanisms to verify the health information received from subcontractors. Mechanisms shall include the following:

11.4.1.1. Verifying the accuracy and timeliness of reported data; and screening the data for completeness, logic and consistency of the data received from subcontractors.

11.4.1.2. The Contractor shall conduct encounter validation checks for all subcontractors that submit encounters to the Contractor, using the following method:

11.4.1.2.1. A review of 1% of all encounters provided under this agreement or 250 encounters provided under this agreement, whichever is less during the first 6 months of the Agreement period;

11.4.1.2.2. Compare the clinical record against the subcontractor's encounter data to determine agreement in type of service, date of service and service provider. This review must verify that the service reported actually occurred; and

11.4.1.2.3. Develop a report based on this information to be used by the Contractor in its data-monitoring activities. The report shall be submitted to the MHD 30 days prior to the end of this Agreement.

11.5. **Data Certification**

11.5.1. The Contractor shall provide certification of encounter data by one of the following: Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer. The certification will attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of data. Batches that contain data errors will not be considered certified until corrections for all errors are successfully received by the MHD.

11.5.2. The Contractor shall use only the MHD-supplied certification form and in the manner described in 42 CFR §§438.604 & 438.606.

11.5.3. The Contractor shall submit an electronic copy (e-mail is sufficient) of each certification on same the day that the certified data is submitted. The Contractor must send the original signed certification to the MHD Information Services Manager by mail as soon as possible.

11.5.4. The Contractor shall ensure that each certification contains an original signature of the signing authority.

11.5.4.1. If the signing authority is other than the CEO or CFO, the Contractor shall ensure a letter is submitted to the MHD containing an original

signature by the CEO or CFO and indicates the name(s) of people delegated to sign. MHD must be notified by similar letter when delegation changes.

12. GRIEVANCE SYSTEM

12.1. **Procedures.** The contractor shall have a grievance system that has the following procedures.

12.1.1. The enrollee or representative may file an appeal or grievance, with the Contractor, either orally or in writing.

12.1.2. If an initial request for a grievance is made orally, a written, signed request for a grievance must be submitted within 7 days.

12.1.3. If an initial request for an appeal is made orally, a written, signed request for appeal must be submitted within 7 days.

12.1.4. The enrollee or representative may file a request for expedited appeal if the enrollee and/or representative believe that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum functioning.

12.1.5. The enrollee must be given reasonable assistance in pursuing an appeal, grievance or administrative hearing, including access to the Ombuds service and oral or manual interpreter services. Toll free numbers that have adequate TTY/TTD and interpreter capability are required.

12.2. **Notice of Action**

12.2.1. Notices of Action must be in writing, provided in prevalent non-English languages and meet the language and format requirements of 42 CFR §438.10 (c &d).

12.2.2. The Notice of Action must include:

12.2.2.1. A statement of what action the Contractor or its Contractor intends to take;

12.2.2.2. The reasons for the intended action;

12.2.2.3. An explanation of the enrollee's right to request an appeal or a State administrative hearing; and

12.2.2.4. Definitions of reduction, termination, suspension and denial.

12.2.2.5. Statement that the enrollee has 20 days from the date on the Notice of Action to file an appeal.

12.2.3. The Contractor or its agent must mail the notice within the following timeframes:

12.2.3.1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten days before effective date of the action except if the criteria noted in 42 CFR §431.213 or §431.214 are met;

12.2.3.2. For denial of payment, at the time of any action affecting the payment; and

12.2.3.3. For standard service authorization decisions that deny or limit services, as expeditiously as the enrollee's mental health condition requires, and no longer than fourteen (14) days from request for service. Under the following circumstances, 14 additional days are possible:

- The enrollee or the CMHA requests an extension
- The Contractor justifies to the MHD (upon request) the need for additional information to make authorization decisions and how the extension is in the enrollee's best interest.

12.2.4. Standard authorization decisions not reached in accordance with the timeframes established in Access Standards above constitute a denial and an adverse action that are subject to appeal.

12.3. **Handling of Grievances and Appeals**

12.3.1. General requirements. In handling grievance and appeals, each Contractor or agent must meet the following requirements:

12.3.1.1. Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, provision of Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability;

12.3.1.2. Acknowledge receipt of each grievance and appeal, received either orally or in writing within one working day. If notification is made orally, it must be followed-up in writing within five working days;

12.3.1.3. Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making;

12.3.1.4. Ensure that the individuals who make decisions on appeals regarding medical necessity, expedited resolution, or involving clinical issues are qualified mental health care professionals who have the appropriate clinical expertise; and

12.3.1.5. Ensure that no retaliation against enrollees or providers who on behalf of an enrollee who files a grievance or appeal or supports an expedited resolution of an appeal.

12.3.2. The process for appeals must:

12.3.2.1. Provide that oral inquiries seeking to appeal an action are treated as appeals and therefore establish the earliest possible filing date for the appeal.

12.3.2.2. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing; In the case of an expedited appeal the Contractor must inform the enrollee of the limited time available for this process.

12.3.2.3. Provide the enrollee opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process; and

12.3.2.4. Provide the enrollee with an expedited appeal process when it is determined that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum functioning.

12.4. **Resolution and Notification**

12.4.1. General Requirements for Resolution

12.4.1.1. The Contractor must resolve each grievance and appeal, and provide written notice, as expeditiously as the enrollee's mental health condition requires, and not more than thirty (30) days from statement of grievance; or forty-five (45) days from receipt of notice of appeal.

12.4.1.2. The Contractor may extend the timeframes by up to 14 calendar days if—

- The enrollee requests the extension; or
- The Contractor shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

12.4.1.3. If the Contractor extends the timeframes, it must, for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.

12.4.1.4. For all appeals, the Contractor must provide written notice of disposition within prescribed timeframes for normal disposition or extension.

12.4.1.5. For notice of expedited resolution the Contractor must provide written notice of the disposition within three working days. The Contractor shall also make reasonable effort to provide oral notice of the disposition prior to written notice.

12.4.1.6. Following notice of disposition of appeal, the enrollee may request an Administrative Hearing, conducted by an independent State agency in accordance with WAC 388-02 and provisions of mental health services, per WAC 388-865. The parties to the Administrative Hearing include the Contractor as well as the enrollee and his or her representative.

12.4.1.7. If the enrollee elects to request an Administrative Hearing, the request must be filed within 20 days from date of notice of adverse ruling.

12.4.1.8. The Administrative Hearing process must be completed within ninety (90) days of the date the appeal was initially filed, excluding any time taken by the enrollee to file for an Administrative Hearing following receipt of the notice of disposition of appeal.

12.4.2. General Requirements for Notification

12.4.2.1. The written notice of the resolution must include the following:

12.4.2.1.1. The results of the resolution process and the date it was completed.

12.4.2.2. For appeals not resolved wholly in favor of the enrollees, the notice must include:

12.4.2.2.1. The right to request a State Administrative hearing, and how to do so;

12.4.2.2.2. The right to request to receive benefits while the hearing is pending;

12.4.2.2.3. How to make the request; and

12.4.2.2.4. Notice that the enrollee may be asked to pay for the cost of those benefits if the hearing decision upholds the original action.

12.5. **Continuation of Benefits**

12.5.1. The Contractor must continue the enrollee's benefits all of the following conditions are met:

12.5.1.1. The enrollee or the Community Mental Health Agency files the appeal timely;

12.5.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

12.5.1.3. The services were provided by a network Community Mental Health Agency;

12.5.1.4. The original period covered by the original authorization has not expired; and

12.5.1.5. The enrollee requests a continuation of benefits.

12.5.2. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

12.5.2.1. The enrollee withdraws the appeal;

12.5.2.2. Ten days pass after the Contractor mails notice of disposition of an appeal or grievance and the resolution is not in favor of the enrollee, unless the enrollee requests a State Administrative hearing; or

12.5.2.3. The enrollee requests an Administrative hearing and the decision is adverse to the enrollee.

12.5.2.4. The current authorization expires or the current authorization service limits are met.

12.5.2.5. Enrollees who request continuation of benefits must be notified that, if the final resolution of the appeal is adverse to the enrollee (upholds the Contractor's action) the Contractor may request the enrollee to reimburse the cost of the services furnished to the enrollee while the appeal is pending.

12.5.3. Effect of Reversed Appeal Resolutions

12.5.3.1. If the Contractor or the State Administrative hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the enrollee's mental health condition requires.

12.5.3.2. If the Contractor or the State Administrative hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Contractor must pay for those services.

12.5.4. Information to sub-contractors

12.5.4.1. The Contractor must provide information about the grievance system to all Community Mental Health Agencies and subcontractors at the time they enter into a contract. A condition of the contract will be that all Community Mental Health Agencies and sub-contractors will abide by all appeals, grievances and administrative hearing decisions.

12.6. **Recordkeeping and Reporting Requirements**

12.6.1. The Contractor must maintain records of appeals, actions, grievances and administrative fair hearings.

12.6.2. The Contractor must submit a report in a format provided by MHD that includes:

12.6.2.1. The number and nature of actions, administrative fair hearings, grievances and appeals;

12.6.2.2. The timeframes within which they were disposed of or resolved;

12.6.2.3. The nature of the decisions; and

12.6.2.4. A summary and analysis of the implications of the data, including what measures will be taken to address undesirable patterns.

12.6.2.5. The report periods are October to March and April to September. In the event that the contract term does not encompass a full report period the Contractor shall provide a report for the partial period. Reports are due 45 days following the end of a report period.

13. **BENEFITS**

13.1. All Medicaid enrollees requesting covered mental health services must be offered an intake evaluation as outlined in Access Standards. Authorization for further services must be based on medical necessity and the Access to Care Standards.

13.2. The Contractor shall provide, upon request, a second opinion from a CMHA within the Service Area. If an additional CMHA is not currently available within the network or the enrollee requests an out of network provider, the Contractor must provide or pay for a second opinion provided by a CMHA outside the network at no cost to the enrollee. The CMHA providing the second opinion must be currently contracted with an RSN. The appointment for a second opinion must occur within 30 days of the request. The enrollee may request to postpone the second opinion to a date later than 30 days.

13.3. The Contractor shall ensure benefits are provided in accordance with the Contractors Level of Care Guidelines and are not arbitrarily denied or reduced (e.g. the amount, duration, or scope of a required service) based solely upon the diagnosis, type of mental illness, or the enrollee's mental health condition.

13.3.1. The contractor or designee shall prepare a written notification for enrollees of the services for which they are eligible. While preparation of the Notification cannot be delegated to a subcontracted CMHA, the CMHA may deliver the notification.

13.4. The Contractor must provide the following mental health services for each enrollee when they are medically necessary:

13.4.1. Brief Intervention Treatment: Solution-focused and outcomes-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of

general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific timeframe for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

13.4.2. Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid-enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

13.4.3. Day Support: An intensive rehabilitative program, which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

13.4.4. Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid-enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and his/her family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family

structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in his/her individual service plan. This service is provided by or under the supervision of a mental health professional.

13.4.5. Freestanding Evaluation and Treatment: Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid-enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow him/her to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

13.4.6. Group Treatment Services: Services provided to Medicaid-enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible

for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid-enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

13.4.7. High Intensity Treatment: Intensive levels of service otherwise furnished under this State plan amendment that is provided to Medicaid-enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individuals' needs. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

13.4.8. Individual Treatment Services: A set of treatment services designed to help a Medicaid-enrolled individual attain goals as prescribed in his/her individual service plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be

conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid-enrolled individual. This service is provided by or under the supervision of a mental health professional.

13.4.9. Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and freestanding evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

13.4.10. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but include only minimal psychotherapy.

13.4.11. Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid-enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid-enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

13.4.12. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the

residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

13.4.13. Peer Support: Services provided by peer counselors to Medicaid-enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumers ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plan, which delineates specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available to each enrollee for no more than four hours per day. The ratio for this service is no more than 1:20.

13.4.14. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumers continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

13.4.15. Rehabilitation Case Management: A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned read mission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

13.4.16. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

13.4.17. Stabilization Services: Services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

13.4.18. Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid-enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the

individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the Medicaid-enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

13.4.19. Respite Care: A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional. Respite under the Medicaid Waiver is only available to those consumers who do not have this coverage under some other federal program

13.4.20. Supported Employment: A service for Medicaid enrollees who are currently not receiving federally funded vocational services such as those provided through the Division of Vocational Rehabilitation. Services will include:

- An assessment of work history, skills, training, education, and personal career goals.
- Information about how employment will affect income and benefits the consumer is receiving because of their disability.
- Preparation skills such as resume development and interview skills.
- Involvement with consumers served in creating and revising individualized job and career development plans that include;

(a) Consumer strengths
(b) Consumer abilities
(c) Consumer preferences
(d) Consumer's desired outcomes

- Assistance in locating employment opportunities that is consistent with the consumer's strengths abilities, preferences, and desired outcomes.
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.
- Services are provided by or under the supervision of a mental health professional.

13.4.21. Mental Health Clubhouse - is a service specifically contracted by the PIHP to provide a consumer directed program to Medicaid enrollees where they receive multiple services. These services may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must use International Center for Clubhouse Development (ICCD) standards as guidelines. Services include the following:

- o Opportunities to work within the clubhouse, such work contributes to the operation and enhancement of the clubhouse community;
- o Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness;
- o Assistance with employment opportunities: housing, transportation, education and benefits planning;
- o Operate at least ten hours a week after 5:30pm Monday through Friday, or anytime on Saturday or Sunday, and
- o Opportunities for socialization activities.

13.4.22. The Contractor shall ensure services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

13.4.23. If the Contractor is unable to provide the services covered under this Agreement, the services must be purchased within 28 days for an enrollee with an identified need. The Contractor must continue to pay for medically necessary mental health services outside the service area until the Contractor is able to provide them within its service area.

13.5. Enrollees are entitled to access Crisis Services, Freestanding Evaluation and Treatment, Stabilization and Rehabilitation Case Management prior to an intake evaluation and without prior authorization.

13.6. DSHS may petition CMS to amend the Medicaid State Plan during this contract period. If the Medicaid State Plan is amended the Contractor shall implement any changes to the provision of medically necessary mental health services no later than 30 days following CMS approval of the plan.

13.7. **Coordination of Care**

13.7.1. Psychiatric Inpatient Services:

13.7.1.1. The Contractor or its designee shall contact the inpatient unit within three working days for all enrollee admissions.

13.7.1.2. The Contractor or its designee shall provide to the inpatient unit any available information regarding the enrollee's treatment history at the time of admission. The Contractor or its designee must provide all available information related to payment resources and coverage.

13.7.1.3. The Contractor's liaison or designated CMHA must participate in treatment and discharge planning with the inpatient treatment team. A CMHA must be designated prior to discharge for enrollees and their families seeking community support services.

13.7.1.4. For enrollees on Less Restrictive Alternatives (LRA) who meet medical necessity and the Access to Care Standards, the Contractor or designee shall offer covered mental health services to assist with compliance with LRA requirements.

13.7.1.5. The Contractor or its designee shall respond to requests for participation, implementation, and monitoring of enrollees on Conditional Releases (CR) consistent with RCW 71.05.340. The Contractor or designee shall provide covered mental health services for enrollees who meet medical necessity and the Access to Care Standards.

13.7.1.6. The Contractor shall ensure provision of services to enrollees on a Conditional Release under RCW 10.77.150 for enrollees who meet medically necessity and the Access to Care Standards.

13.7.1.7. The Contractor shall use best efforts to utilize community resources and covered mental health services to minimize State Hospital admissions.

13.7.2. The Contractor shall coordinate with the Children's Long-term Inpatient Programs ("CLIP") Administration to develop CLIP resource management guidelines and admissions procedures. The Contractor shall enter into, and comply with, a written agreement with the CLIP Administration regarding resource management guidelines and admissions procedures.

13.8. **Early Periodic Screening Diagnosis and Treatment (EPSDT)**

13.8.1. EPSDT services must be structured in ways that are culturally and age appropriate, involve the family and are available to all enrollees under the age of 21. Intake evaluations provided under EPSDT must include an assessment of the family's needs.

13.8.2. EPSDT requires the contractor to facilitate communication between physicians and mental health clinicians. This must include at least:

13.8.2.1. A written notice replying to the Physician, ARNP, Physician Assistant, trained public health nurse or RN who made the EPSDT referral. This notice must include at least the date of intake, diagnosis and level of care assignment.

13.8.2.2. When mental health services are requested without an EPSDT referral the contractor or designee must send a formal written notice to the enrollee's medical care provider. The notice shall request that either documentation is provided that a Healthy Child screening has been provided or that one will be provided if one has not occurred. A copy of this notice shall be provided to the enrollee or family. If the enrollee does not identify a medical care provider the contractor or designee must provide a copy of the EPSDT rights contained in the MHD Mental Health Benefits booklet to the enrollee and identify the following contact information to assist with the selection of a medical provider:

Toll free number: 1-800-562-3022
Web site: http://fortress.wa.gov/dshs/maa/CHIP/

13.8.3. Children authorized who are involved with one or more service system identified in section 6.2.2.6 for Level II must be provided with an Individual Service Team (IST).

13.8.3.1. The IST may include, but is not limited to, representatives from education, child welfare, mental health, drug and alcohol, developmental disabilities, and juvenile justice as appropriate. The parent or guardian of the child may be included as appropriate. The child must be included if age 13 or older. Younger children may be included if the IST agrees.

13.8.3.2. The IST must develop a cross-system individual service plan. The cross-system individual service plan must address the overall needs of the child and family, not just Medicaid reimbursable services, in all life areas including when appropriate residential, family, social, and medical needs. The individual service plan must clearly identify which system is responsible for each identified need.

13.8.3.3. The Contractor's Children's Care Manager shall review a representative sample at least once during the period of this Agreement of the clinical

records for children provided Level 2 mental health services. The review will focus on the use of a cross-system Individual Treatment Plan for children identified under EPSDT. This review shall verify the participation of other appropriate systems per the allied system coordination plans in Section 13.10. After review, the Children's Care Manager will provide a report to the CMHA's and require corrective action if other systems are not included or attempted to be included in the treatment planning activities. This report and any corrective action and plans that result shall be provided to MHD upon request.

13.9. **Allied System Coordination**:

13.9.1. The Contractor shall develop an allied system coordination plan for each of the following programs:

13.9.1.1. Aging and Disability Services Administration (ADSA)

13.9.1.2. Chemical Dependency and Substance Abuse services

13.9.1.3. Children's Administration

13.9.1.4. Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Healthy Options Plans

13.9.1.5. Criminal Justice (courts, jails, law enforcement, pubic defender, Department of Corrections)

13.9.1.6. Division of Vocational Rehabilitation

13.9.1.7. Juvenile Rehabilitation Administration

13.9.1.8. K-12 Education System

13.10. **Allied System Coordination Plan**. Each allied system coordination plan must contain the following:

13.10.1. Clarification of roles and responsibilities of the allied systems in serving multi-system consumers. For children this includes EPSDT coordination for any child serving agency, including a process for participation by the agency in the Individual Services Team for the development of a cross-system treatment plan when indicated by EPSDT.

13.10.2. Processes for the sharing of information related to eligibility, access and authorization.

13.10.3. Identification of needed local resources, including initiatives to address those needs;

13.10.4. A process for facilitation of community reintegration from out-of-home placements (e.g. State hospitals, Children's Long- term Inpatient facilities, Juvenile Rehabilitation Administration facilities, foster care, nursing homes, acute inpatient settings) for consumers of all ages;

13.10.5. A process or format to address disputes related to service or payment responsibility; and

13.10.6. A process to evaluate progress in cross-system coordination and integration of services.

14. TRIBAL RELATIONSHIPS

14.1. The Contractor must develop a plan in collaboration with each Tribal Authority in the Contractor's service area. The plan must be submitted to MHD within 90 days of the execution of this contract for review and approval. The Contractor shall provide documentation if the Tribal Authority declines to participate in the collaboration plan. The Contractor shall use the attached RSN/ Tribal Collaboration Planning Checklist as Exhibit B and the plan must contain:

14.1.1. Identification of Tribal Authority and relevant provider contacts for each Tribal Authority in the Contractor's service area;

14.1.2. A description of completed and planned collaboration activities with each Tribal Authority in the Contractors service area;

14.1.3. A list of any culturally sensitive issues or culturally specific needs identified during collaboration planning;

14.1.4. A description of any completed or planned Tribal collaboration training to be provided to the RSN Administration and staff by the Contractor; and

14.1.5. Any performance measures which will be used to measure and evaluate the implementation and effectiveness of the RSN/ Tribal Collaboration plan.

14.2. The Contractor shall develop a written coordination plan with any Tribal health clinic within the boundaries of the contractor's service area. The coordination plan must address the following:

14.2.1. The reduction of duplicative screening and evaluation processes and ongoing coordination of care.

14.2.2. Identification and process for the provision of culturally appropriate, sensitive, and relevant medically necessary mental health services for eligible Tribal MH clients needing services through the RSN.

14.2.3. Coordination of care with Tribes that have members in multiple RSN service areas.

15. **REMEDIAL ACTIONS**

15.1. MHD may initiate remedial action if it is determined that any of the following situations exist:

15.1.1. A problem exists that negatively impacts individuals receiving services;

15.1.2. The Contractor has failed to perform any of the mental health services required in this Agreement;

15.1.3. The Contractor has failed to develop, produce, and/or deliver to MHD any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Agreement;

15.1.4. The Contractor has failed to perform any administrative function required under this Agreement. For the purposes of this section, “administrative function” is defined as any obligation other than the actual provision of mental health services; or

15.1.5. The Contractor has failed to implement corrective action required by the State and within MHD prescribed timeframes.

15.2. MHD may impose any of the following remedial actions:

15.2.1. Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to MHD within 30 calendar days of notification. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Agreement. MHD may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

15.2.1.1. Corrective action plans must include:

15.2.1.1.1. A brief description of the situation requiring corrective action;

15.2.1.1.2. The specific actions to be taken to remedy the situation;

15.2.1.1.3. A timetable for completion of the actions; and

15.2.1.1.4. Identification of individuals responsible for implementation of the plan.

15.2.1.2. Corrective action plans are subject to approval by MHD, which may:

15.2.1.2.1. Accept the plan as submitted;

15.2.1.2.2. Accept the plan with specified modifications;

15.2.1.2.3. Request a modified plan; or

15.2.1.2.4. Reject the plan.

15.2.2. Withhold up to five percent of the next monthly capitation payment and each monthly capitation payment thereafter until the corrective action has achieved resolution. MHD, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

15.2.3. Increase withholdings identified above by up to an additional three percent for each successive month during which the remedial situation has not been resolved.

15.2.4. Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which MHD provides incentives.

15.2.5. Terminate for Default as described in the General Terms and Conditions; this may include releasing a Request for Proposals to re-procure the services provided under this agreement.

16. GENERAL TERMS AND CONDITIONS

16.1. **Definitions.** The words and phrases listed below, as used in the Agreement, shall each have the following definitions:

16.1.1. **"Agreement"** means this document, the General Terms and Conditions, and the Special Terms and Conditions, including any Exhibits and other documents attached or incorporated by reference.

16.1.2. **"Central Contract Services"** means the DSHS statewide agency headquarters contracting office, or successor section or office.

16.1.3. **"CFR" means Code of Federal Regulations.** All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation. The CFR may be accessed at http://www.gpoaccess.gov/cfr/index.html

16.1.4. **"Contracts Administrator"** means the manager, or successor, of Central Contract Services or successor section or office.

16.1.5. **"Contractor"** means the regional support network (RSN) designated by the county authority, group of county authorities or nonprofit entity recognized by the secretary, and has authority to establish and operate a community mental health program.

16.1.6. **"Debarment"** means an action taken by a federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

16.1.7. **"DSHS" or "the department" or "the Department"** means the Department of Social and Health Services of the State of Washington and its Secretary, officers, employees, and authorized agents.

16.1.8. **"DSHS Representative"** means any DSHS employee who has been delegated contract-signing authority by the DSHS Secretary or his/her designee.

16.1.9. **"General Terms and Conditions"** means the contractual provisions contained within this Agreement, which govern the contractual relationship between DSHS and the Contractor, under this Agreement.

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

16.1.11. **"RCW"** means the Revised Code of Washington. All references in this Agreement to RCW chapters or sections shall include any successor, amended, or replacement statute. The RCW can be accessed at http://slc.leg.wa.gov

16.1.12. **"Secretary"** means the individual appointed by the Governor, State of Washington, as the head of DSHS, or his/her designee.

16.1.13. **"Subcontract"** means a separate contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor shall perform pursuant to this Agreement.

16.1.14. **"USCA"** means United States Code Annotated. All references to USCA chapters or sections in this Agreement, shall include any successor, amended, or replacement statute. The USCA may be accessed at http://www.gpoaccess.gov/uscode/

16.1.15. **"WAC"** means the Washington Administrative Code. All references in this Agreement to WAC chapters or sections shall include any successor, amended, or replacement regulation. The WAC can be accessed at http://slc.leg.wa.gov

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

16.3. **Assignment.** Except as otherwise provided herein, the Contractor shall not assign rights or obligations derived from this Agreement to a third party without the prior, written consent of the DSHS Contracts Administrator and the written assumption of the Contractor's obligations by the third party.

16.4. **Billing Limitations.** Unless otherwise specified in this Agreement, DSHS shall not pay any claims for services submitted more than twelve (12) months after the calendar month in which the services were performed.

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

16.6. **Confidentiality.** The parties shall use Personal Information and other confidential information gained by reason of this Agreement only for the purpose of this Agreement. DSHS and the Contractor shall not disclose, transfer, or sell any such information to any other party, except as provided by law or, in the case of Personal Information except as provided by law or with the prior written consent of the person to whom the Personal Information pertains. The parties shall maintain the confidentiality of all Personal Information and other confidential information gained by reason of this Agreement and shall return or certify the destruction of such information if requested in writing by the party to this Agreement that provided the information.

16.7. **Contractor Certification Regarding Ethics.** By signing this Agreement, the Contractor certifies that the Contractor is in compliance with Chapter 42.23 RCW and shall comply with Chapter 42.23 RCW throughout the term of this Agreement.

16.8. **Debarment Certification.** The Contractor, by signature to this Agreement, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal department or agency. The Contractor also agrees to include the above requirement in all subcontracts into which it enters.

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

16.10. **Governing Law and Venue.** The laws of the State of Washington govern this Agreement. In the event of a lawsuit by the Contractor against DSHS involving this Agreement, venue shall be proper only in Thurston County, Washington. In the event of a lawsuit by DSHS against the Contractor involving this Agreement, venue shall be proper only as provided in RCW 36.01.050.

16.11. **Independent Status.** For purposes of this Agreement, the Contractor acknowledges that the Contractor is not an officer, employee, or agent of DSHS or the State of Washington. The Contractor shall not hold out itself or any of its employees as, nor claim status as, an officer, employee, or agent of DSHS or the State of Washington. The Contractor shall not claim for itself or its employees any rights, privileges, or benefits, which would accrue to an employee of the State of Washington. The Contractor shall indemnify and hold harmless DSHS from all

obligations to pay or withhold federal or state taxes or contributions on behalf of the Contractor or the Contractor's employees.

16.12. **Inspection.** Either party may request reasonable access to the other party's records and place of business for the limited purpose of monitoring, auditing, and evaluating the other party's compliance with this Agreement, and applicable laws and regulations. During the term of this Agreement and for one (1) year following termination or expiration of this Agreement, the parties shall, upon receiving reasonable written notice, provide the other party with access to its place of business and to its records which are relevant to its compliance with this Agreement, and applicable laws and regulations. This provision shall not be construed to give either party access to the other party's records and place of business for any other purpose. Nothing herein shall be construed to authorize either party to possess or copy records of the other party.

16.13. **Insurance.** DSHS certifies that it is self-insured under the State's self-insurance liability program, as provided by RCW 4.92.130, and shall pay for losses for which it is found liable. The Contractor certifies that it is self-insured, is a member of a risk pool, or maintains insurance coverage as required in this Agreement. The Contractor shall pay for losses for which it is found liable.

16.14. **Lawsuits.** Nothing in this Agreement shall be construed to mean that the Contractor, a County, RSN, or their subcontractors, agents or employees, can bring a legal claim for declaratory relief, injunctive relief, judicial review under RCW 34.05, or civil liability against the state or state agencies for actions or inactions performed pursuant to the administration of RCW 71.05 or RCW 71.24 with regard to the following: (a) allocation or payment of federal or state funds; (b) the use or allocation of state hospital beds; or (c) financial responsibility for the provision of long term or short term inpatient mental health care.

16.15. **Maintenance of Records.** During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, both parties shall maintain records sufficient to:

16.15.1. Document performance of all acts required by law, regulation, or this Agreement;

16.15.2. Demonstrate accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Agreement.

16.15.3. For the same period, the Contractor shall maintain records sufficient to substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance.

16.16. **Order of Precedence.** In the event of an inconsistency in this Agreement, unless otherwise provided herein, the inconsistency shall be resolved by giving precedence, in the following order, to:

16.16.1. **Applicable federal and State of Washington statutes and regulations;**

16.16.2. **The General Terms & Conditions of this Agreement;**

16.16.3. **The Special Terms & Conditions of this Agreement:**

16.16.4. **Any Exhibits attached or incorporated into this Agreement by reference.**

16.17. **Ownership of Material**. Material created by the Contractor and paid for by DSHS as a part of this Agreement shall be owned by DSHS and shall be "work made for hire" as defined by Title 17 USCA, Section 101. This material includes, but is not limited to: books; computer programs; documents; films; pamphlets; reports; sound reproductions; studies; surveys; tapes; and/or training materials. Material which the Contractor uses to perform this Agreement but is not created for or paid for by DSHS is owned by the Contractor and is not "work made for hire"; however, DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.

16.18. **Responsibility.** Each party to this Agreement shall be responsible for the negligence of its officers, employees, and agents in the performance of this Agreement. No party to this Agreement shall be responsible for the acts and/or omissions of entities or individuals not party to this Agreement. DSHS and the Contractor shall cooperate in the defense of tort lawsuits, when possible. Both parties agree and understand that this provision may not be feasible in all circumstances. DSHS and the Contractor agree to notify the attorneys of record in any tort lawsuit where both are parties if either DSHS or the Contractor enters into settlement negotiations. It is understood that the notice shall occur prior to any negotiations, or as soon as possible, and the notice may be either written or oral.

16.19. **Severability.** The provisions of this Agreement are severable. If any court holds any provision of this Agreement, including any provision of any document incorporated by reference, invalid, that invalidity shall not affect the other provisions this Agreement.

16.20. **Subcontracting.** The Contractor may subcontract services to be provided under this Agreement. If DSHS, the Contractor, and a subcontractor of the Contractor are found by a jury or trier of fact to be jointly and severally liable for personal injury damages rising from any act or omission from the contract, then DSHS shall be responsible for its proportionate share, and the Contractor shall be responsible for its proportionate share. Should the subcontractor be unable to satisfy its joint and several liability, DSHS and the Contractor shall share in the subcontractor's unsatisfied proportionate share in direct proportion to the respective percentage of their fault as found by the jury or trier of fact. Nothing in this term shall be construed as creating a right or remedy of any kind or nature in any person or party other than DSHS and the Contractor. This term shall not apply in the event of a settlement by either DSHS or the Contractor.

16.21. **Subrecipients.**

16.21.1. **General.** If the Contractor is a subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Agreement, the Contractor shall:

16.21.1.1. 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;

16.21.1.2. 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;

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

16.21.1.4. Incorporate OMB Circular A-133 audit requirements into all agreements between the Contractor and its Subcontractors who are subrecipients;

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

16.21.1.6. 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

16.21.1.7. 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 Part 39. (See www.ojp.usdoj/gov/ocr for additional information and access to the aforementioned Federal laws and regulations.)

16.21.2. **Single Audit Act Compliance.** If the Contractor is a subrecipient and expends $500,000 or more in federal awards from 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:

16.21.2.1. Submit to the DSHS contact person, listed on the first page of this Agreement, 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;

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

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

16.23. **Survivability.** The terms and conditions contained in this Agreement, which by their sense and context, are intended to survive the expiration of the particular agreement shall survive. Surviving terms include, but are not limited to: Confidentiality, Disputes, Inspection, Lawsuits, Maintenance of Records, Ownership of Material, Responsibility, Termination for Default, Termination Procedure, and Title to Property.

16.24. **Termination Due to Change in Funding.** If the funds upon which DSHS relied to establish this Agreement are withdrawn, reduced, or limited, or if additional or modified conditions are placed on such funding, DSHS may terminate this Agreement by providing at least five (5) business days' written notice to the Contractor. The termination shall be effective on the date specified in the notice of termination.

16.25. **Termination for Convenience.** DSHS may terminate this Agreement in whole or in part for convenience by giving the Contractor at least thirty (30) calendar days' written notice. The Contractor may terminate this Agreement for convenience by giving DSHS at least thirty (30) calendar days' written notice addressed to the DSHS contact person (or to his or her successor) listed on the first page of this Agreement.

16.26. **Termination for Default.**

16.26.1. The Contracts Administrator may terminate this Agreement for default, in whole or in part, by written notice to the Contractor, if DSHS has a reasonable basis to believe that the Contractor has:

16.26.1.1. Failed to meet or maintain any requirement for contracting with DSHS;

16.26.1.2. Failed to perform under any provision of this Agreement;

16.26.1.3. Violated any law, regulation, rule, or ordinance applicable to this Agreement; and/or

16.26.1.4. Otherwise breached any provision or condition of this Agreement.

16.26.2. Before the Contracts Administrator may terminate this Agreement for default, DSHS shall provide the Contractor with written notice of the Contractor's noncompliance with the agreement and provide the Contractor a reasonable opportunity to correct the Contractor's noncompliance. If the Contractor does not correct the Contractor's noncompliance within the period of time specified in the written notice of noncompliance, the Contracts Administrator may then terminate the agreement. The Contracts Administrator may terminate the agreement for default without such written notice and without opportunity for correction if DSHS has a reasonable basis to believe that a client's health or safety is in jeopardy.

16.26.3. The Contractor may terminate this Agreement for default, in whole or in part, by written notice to DSHS, if the Contractor has a reasonable basis to believe that DSHS has:

16.26.3.1. Failed to meet or maintain any requirement for contracting with the Contractor;

16.26.3.2. Failed to perform under any provision of this Agreement;

16.26.3.3. Violated any law, regulation, rule, or ordinance applicable to this Agreement; and/or

16.26.3.4. Otherwise breached any provision or condition of this Agreement.

16.26.4. Before the Contractor may terminate this Agreement for default, the Contractor shall provide DSHS with written notice of DSHS' noncompliance with the Agreement and provide DSHS a reasonable opportunity to correct DSHS' noncompliance. If DSHS does not correct DSHS' noncompliance within the period of time specified in the written notice of noncompliance, the Contractor may then terminate the Agreement.

16.27. **Termination Procedure.** The following provisions apply in the event this Agreement is terminated:

16.27.1. The Contractor shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of clients, distribution of property, and termination of services.

16.27.2. The Contractor shall promptly deliver to the DSHS contact person (or to his or her successor) listed on the first page of this Agreement, all DSHS assets (property) in the Contractor's possession, including any

material created under this Agreement. Upon failure to return DSHS property within ten (10) working days of this Agreement termination, the Contractor shall be charged with all reasonable costs of recovery, including transportation. The Contractor shall take reasonable steps protect and preserve any property of DSHS that is in the possession of the Contractor pending return to DSHS.

16.27.3. DSHS shall be liable for and shall pay for only those services authorized and provided through the effective date of termination. DSHS may pay an amount mutually agreed by the parties for partially completed work and services, if work products are useful to or usable by DSHS.

16.27.4. If the Contracts Administrator terminates this Agreement for default, DSHS may withhold a sum from the final payment to the Contractor that DSHS determines is necessary to protect DSHS against loss or additional liability. DSHS shall be entitled to all remedies available at law, in equity, or under this Agreement due to Contractors default. If it is later determined that the Contractor was not in default, or if the Contractor terminated this Agreement for default, the Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement except as to the limitations set forth in Section 14 entitled "Lawsuits".

16.28. **Treatment of Client Property.** Unless otherwise provided in this Agreement, the Contractor shall ensure that any adult client receiving services from the Contractor under this Agreement has unrestricted access to the client's personal property. The Contractor shall not interfere with any adult client's ownership, possession, or use of the client's property. The Contractor shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon termination or completion of this Agreement, the Contractor shall promptly release to the client and/or the client's guardian or custodian all of the client's personal property. This section does not prohibit the Contractor from implementing such lawful and reasonable policies, procedures and practices as the Contractor deems necessary for safe, appropriate, and effective service delivery (for example, appropriately restricting clients' access to, or possession or use of, lawful or unlawful weapons and drugs).

16.29. **Title to Property.** Title to all property purchased or furnished by DSHS for use by the Contractor during the term of this Agreement shall remain with DSHS. Title to all property purchased or furnished by the Contractor for which the Contractor is entitled to reimbursement by DSHS under this Agreement shall pass to and vest in DSHS. The Contractor shall take reasonable steps to protect and maintain all DSHS property in its possession against loss or damage and shall return DSHS property to DSHS upon Agreement termination or expiration, reasonable wear and tear excepted.

16.30. **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 Agreement unless amended

as set forth in Section 2, Amendment. Only the Contracts Administrator or designee has the authority to waive any term or condition of this Agreement on behalf of DSHS.

17. SPECIAL TERMS AND CONDITIONS

17.1. **Advisory Board**: The Contractor shall maintain an advisory board that is broadly representative of the demographic character of the region which shall include, but not be limited to, representatives of consumers and families, and law enforcement. Composition and length of terms of board members may differ between regional support networks. Membership shall be comprised of at least 51% consumers or consumer family members as defined in WAC 388-865-0222.

17.2. **Compliance with Applicable Law**. At all times during the term of this Agreement, the Contractor shall comply with all applicable federal, State, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations, and the following, whether or not a specific citation is identified in various sections of this Agreement:

17.2.1. Title XIX and Title XXI of the Social Security Act and Title 42 of the Code of Federal Regulations;

17.2.2. All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement;

17.3. **Confidentiality of Personal Information**

17.3.1. The Contractor shall protect all Personal Information, records, and data from unauthorized disclosure in accordance with 42 CFR §431.300 through §431.307, RCWs 70.02, 71.05, 71.34, and for individuals receiving substance abuse services, in accordance with 42 CFR Part 2 and RCW 70.96A. The Contractor shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services. Pursuant to 42 CFR §431.301 and §431.302, personal information concerning applicants and recipients may be disclosed for purposes directly connected with the administration of this Agreement and the State Medicaid Plan. Such purposes include, but are not limited to:

17.3.1.1. Establishing eligibility;

17.3.1.2. Determining the amount of medical assistance;

17.3.1.3. Providing services for recipients;

17.3.1.4. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan;

17.3.1.5. Assuring compliance with federal and State laws and regulations, and with terms and requirements of the Agreement; and

17.3.1.6. Improving quality.

17.3.2. The Contractor shall comply with all confidentiality requirements of the Health Insurance Portability and Accountability Act (42 CFR §§ 160 -164).

17.4. **Construction**
Nothing in this Agreement shall be construed as creating or conferring a cause of action under federal or state law that does not exist independent of this Agreement. An alleged violation of a federal or state law by the Department shall not give rise to a contractual cause of action by the Contractor.

17.5. **Declaration That Individuals Served Under the Medicaid and Other Mental Health Programs Are Not Third-Party Beneficiaries Under this Agreement.**
Although DSHS and the Contractor mutually recognize that services under this Agreement will be provided by the Contractor to individuals receiving services under the Medicaid program, and RCW 71.05, RCW 71.24, and RCW 71.34, it is not the intention of either DSHS or the Contractor that such individuals, or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement.

17.6. **Disputes** When a dispute arises over an issue concerning the terms of this Agreement, the parties agree to the following process to address the dispute.

17.6.1. The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and DSHS Contact listed on page one (1) of this Agreement.

17.6.2. If the Contractor is not satisfied with the outcome, the Contractor may submit the disputed issue, in writing to Mental Health Division at, Mental Health Division, P.O. Box 45320, Olympia, WA 98504-5320, to be reviewed by the appropriate Office Chief (Chief). The written submission must contain the following information:

17.6.2.1. The Contractor's Contact for the issue.

17.6.2.2. The Issue in dispute.

17.6.2.3. The Contractor's position on the issue.

17.6.3. The Chief may request additional information from the DSHS Contact and/or the Contractor. The Chief shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor.

17.6.4. If the Contractor disagrees with the written review decision of the Chief, the Contractor may request the Division Director to review all information supplied by both parties up to that point. The Division Director may request any additional information necessary to make the final decision for the Mental Health Division. Timelines for production of any such additional information will be clearly marked within the request. The Division Director shall issue a final written decision to the Contractor within thirty (30) calendar days of receipt of all requested information.

17.6.5. Both parties agree to make their best efforts to resolve disputes arising from this Agreement and agree that this dispute resolution process is the sole administrative remedy available under this Agreement.

17.7. **Duplicative Reports and Deliverables.** If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties the Contractor may provide one report or deliverable that contains the information required by both Agreements.

17.8. **Fraud and Abuse.** Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person and includes any act that constitutes fraud under applicable Federal or State law. Abuse means provider actions that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. The Contractor shall do the following to guard against Fraud and Abuse:

17.8.1. Create and maintain a mandatory compliance plan that includes provisions to educate staff and providers of the false claim act and whistle blower protections;

17.8.2. Develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards;

17.8.3. Designate a compliance officer and a compliance committee that is accountable to senior management;

17.8.4. Provide effective ongoing training and education for the compliance officer, staff of the Contractor, and selected staff of the CMHAs;

17.8.5. Facilitate effective communication between the compliance officer, the Contractor's employees, and the Contractor's network of CMHAs;

17.8.6. Enforce standards through well-publicized disciplinary guidelines;

17.8.7. Conduct internal monitoring and auditing;

17.8.8. Respond promptly to detected offenses and develop corrective action initiatives; and

17.8.9. Report fraud and/or abuse information to MHD as soon as it is discovered including the source of the complaint, the involved CMHA, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

17.9. **Information Requests**: The Contractor shall maintain information necessary to promptly respond to written requests by the MHD Director, an Office Chief or their designee. The Contractor shall submit information detailing the amount spent throughout its service area on specific items upon request by MHD Director, an Office Chief or their designee.

17.10. **Commercial General Liability Insurance (CGL).** If the Contractor is not a member of a risk pool, the Contractor shall carry CGL to include coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. The State of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds.

17.11. **Lobby Activities Prohibited.** Federal Funds must not be used for Lobbying activities.

17.12. **Records Retention.** During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records is started before expiration of the six year period, the records shall be retained until completion and resolution of all issues arising there from or until the end of the six year period, whichever is later.

17.12.1. The Contractor shall maintain records sufficient to:

17.12.1.1. Maintain the content of all medical records in a manner consistent with utilization control requirements of 42 CFR §456, 42 CFR §434.34 (a), 42 CFR §456.111, and 42 CFR §456.211;

17.12.1.2. Document performance of all acts required by law, regulation, or this Agreement;

17.12.1.3. Substantiate the Contractor’s statement of its organization’s structure, tax status, capabilities, and performance; and

17.12.1.4. Demonstrate the accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Agreement.

17.12.2. The Contractor and its subcontractors shall cooperate in all reviews, including but not limited to, surveys, and research conducted by DSHS or other Washington State Departments.

17.12.3. Evaluations under this Agreement shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services, and to determine whether the Contractor and its subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable State and federal regulations as existing or hereafter amended.

17.12.4. DSHS shall maintain books, records, documents, and other materials relevant to this Agreement which sufficiently and properly reflect all payments made, including the Department's rate setting activities related to the Contractor, or other actions taken in regard to the Contractor's performance of the services described herein.

17.13. **Subcontracting**. The Contractor shall not subcontract with an individual provider or an entity with an individual who is an officer, director, agent, or manager, or who owns or has a controlling interest in the entity, and who has been convicted of crimes as specified in 42 USC §1320a.

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES	**RSN INTERLOCAL AGREEMENT** **State Mental Health Contract**	DSHS Agreement Number: 0669-02157
This Agreement is by and between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below, and is issued pursuant to the Interlocal Cooperation Act, chapter 39.34 RCW.		Program Contract Number: Contractor Contract Number:

CONTRACTOR NAME North Sound Regional Support Network		CONTRACTOR doing business as (DBA) North Sound RSN	
CONTRACTOR ADDRESS 117 North First Street, Suite 8 Mount Vernon, WA 98273-2858		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) 601-291-840	DSHS INDEX NUMBER 1553
CONTRACTOR CONTACT Charles R. Benjamin, Executive Dir.	CONTRACTOR TELEPHONE (360) 416-7013 Ext:	CONTRACTOR FAX (360) 416-7017	CONTRACTOR E-MAIL ADDRESS executivedirector@nsrsn.org
DSHS ADMINISTRATION Health and Rehabilitative Services Administration	DSHS DIVISION Mental Health Division	DSHS CONTRACT CODE 4000LC	
DSHS CONTACT NAME AND TITLE Melena Thompson Program Administrator	DSHS CONTACT ADDRESS PO Box 45320 Olympia, WA 98504-5320		
DSHS CONTACT TELEPHONE (360) 902-0840	DSHS CONTACT FAX (360) 902-0809	DSHS CONTACT E-MAIL ADDRESS thompml@dshs.wa.gov	
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? No	CFDA NUMBER(S)		
AGREEMENT START DATE **09/01/2006**	**AGREEMENT END DATE** **06/30/2007**	MAXIMUM AGREEMENT AMOUNT $0.00	

EXHIBITS. The following Exhibits are attached and are incorporated into this Agreement by reference:

☒ **Exhibits (specify): Exhibit A, Access to Care Standards; Exhibit B, Tribal Collaboration**

☐ **No Exhibits.**

The terms and conditions of this Agreement 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 Agreement, between the parties. The parties signing below represent they have read and understand this Agreement, and have the authority to execute this Agreement. This Agreement shall be binding on DSHS only upon signature by DSHS.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE Charles R. Benjamin Executive Director	DATE SIGNED
DSHS SIGNATURE	PRINTED NAME AND TITLE Travis Sugarman HRSA Contracts Administrator	DATE SIGNED

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1. DEFINTIONS

1.1. **Administrative Cost** means costs for the general operation of the public mental health system. These activities cannot be identified with a specific direct services or direct service support function.

1.2. Allen and Marr Class Members means any DDD enrolled client who was admitted to or in Western State Hospital on or after June 1, 1997 or any DDD enrolled client who was admitted to or in Eastern State Hospital on or after December 2, 1999. The class members are established based on ***Allen, et al. v. WSH, et al. and Marr, et al. v. ESH, et al. cases.***

1.3. **Available Resources** means funds appropriated for the purpose of providing community MH programs, federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under RCW 71.24 or 71.05 RCW by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other MH services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

1.4. **Central Contract Services ("CCS")** means the Department of Social and Health Services (DSHS) office of Central Contract Services.

1.5. **CFR** means the Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation.

1.6. **Children's Long Term Inpatient Programs ("CLIP")** means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from Children's Long Term Inpatient Programs (Child Study and Treatment Center, Pearl Street Center, McGraw Center, Tamarack Center)

1.7. **Community Mental Health Agency ("CHMA")** means Community Mental Health Agency that is licensed by the State of Washington to provide mental health services and subcontracted to provide services covered under this Agreement.

1.8. **Consumer** means a person who has applied for, is eligible for, or who has received mental health services. For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

1.9. **Contractor** means the Contractor, its employees, agents and subcontractors

1.10. **Cultural Competence** means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of

dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

1.11. **Day** for purposes of this agreement means calendar days unless otherwise indicated in the agreement.

1.12. **Eastern Washington RSNs** includes RSNs contracted by DSHS to provide services in the following Washington counties: Ferry, Stevens, Pend Oreille, Lincoln, Okanogan, Grant, Adams, Chelan, Douglas, Spokane, Skamania, Klickitat, Yakima, Kittitas, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin, and Whitman.

1.13. **Emergent Care** means services provided for a person, that, if not provided, would likely result in the need for crisis intervention, or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

1.14. **Emerging Best Practice or Promising Practice** means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.

1.15. **Enrollee** means a Medicaid recipient who is currently enrolled in a PIHP.

1.16. **Evidence Based Practice** means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

1.17. **Fair Hearing** means a hearing before the Washington State Office of Administrative Hearings.

1.18. **Family** means those the consumer defines as family or those appointed/assigned (e.g. parents, foster parents, guardians, siblings, caregivers, and significant others).

1.19. **Grievance** means an expression of dissatisfaction about any matter. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the mental health consumer's rights.

1.20. **Medical Necessity or Medically Necessary** means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s)

and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

1.21. **Mental Health Care Provider ("MHCP")** means the individual with primary responsibility for implementing an individualized service plan for mental health rehabilitation services.

1.22. **Mental Health Division ("MHD")** means the Mental Health Division of the Washington State Department of Social and Health Services ("DSHS"). DSHS has designated the Mental Health Division as the state mental health authority to administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.

1.23. **Mental Health Professional** means:

1.23.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;

1.23.2. A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

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

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

1.23.5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.

1.24. **Patient Days of Care** includes all voluntary patients and residents and involuntarily committed patients (RCW 71.05), regardless of where in the hospital they reside. This includes all patients committed by a municipal or district court (misdemeanor charge) for a 72 hour civil commitment evaluation after a failed competency restoration RCW 71.05.235(2) and patients civilly committed after a felony criminal charge is dismissed following a failed competency restoration RCW 71.05.280(3). Patients admitted under RCW 10.77 are not included in the calculation of patient days of care.

1.25. **Quality Assurance** means a focus on compliance to minimum requirements (e.g. rules, regulations, and contract terms) as well as reasonably expected levels of performance, quality, and practice.

1.26. **Quality Improvement** means a focus on activities to improve performance above minimum standards/ reasonably expected levels of performance, quality, and practice.

1.27. **Quality Strategy** means an overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations

1.28. **Recovery** means the processes in which people are able to live, work, learn, and participate fully in their communities.

1.29. **Regional Support Network ("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.

1.30. **Resilience** means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

1.31. **RCW** means the Revised Code of Washington. All references to RCW chapters or sections shall include any successor, amended, or replacement statute.

1.32. **Routine Services** means non-emergent and non-urgent services are offered within fourteen (14) calendar days to individuals authorized to receive services as defined in the access to care standards. Routine services are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward mental health. These services do not meet the definition of urgent or emergent care.

1.33. **Service Areas** means the geographic area covered by this Agreement for which the Contractor is responsible.

1.34. **Subcontract** means a separate contract between the RSN and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations, which the RSN is obligated to perform pursuant to this Agreement.

1.35. **Urgent** means a service to be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

1.36. **WAC** means the Washington Administrative Code. All references to WAC chapters or sections shall include any successor, amended, or replacement regulation.

1.37. **Western Washington RSNs** includes RSNs contracted by DSHS to provide services in the following Washington counties: San Juan, Whatcom, Island, Skagit, Snohomish, Clallum, Jefferson, Kitsap, King, Pierce, Thurston, Mason, Grays Harbor, Lewis, Pacific, Wahkiakum, Cowlitz, and Clark.

2. **POPULATIONS SERVED** - Within the resources provided under this agreement the Contractor shall provide access to:

2.1. **Crisis Mental Health Services** for all individuals within the contracted services area.

2.2. **Involuntary Psychiatric Inpatient Services** for individuals who are involuntarily detained in accordance with RCW 71.05 or 71.34, and who are either eligible under General Assistance-Unemployable (GA-U), or who are not eligible for any other medical assistance program that would cover this hospitalization.

2.3. **Voluntary Psychiatric Inpatient Services** for individuals who are beneficiaries of the following State-funded assistance programs: Psychiatric Indigent Inpatient (PII) and General Assistance Unemployable (GA-U) and reside within the contracted service area.

2.4. **Rehabilitation Case Management Services in State Hospitals and CLIP Programs** for individuals who reside within the contracted service area.

2.5. **Medicaid Personal Care** for individuals who reside within the contracted service area and are Medicaid-Enrollees.

2.6. **Residential and Outpatient Mental Health Services** for individuals who reside within the contracted service area who are not eligible to receive these services under a Medicaid entitlement program and who are members of priority populations (RCW 71.24).

3. **INFORMATION REQUIREMENTS**

3.1. **Information Requirements**: The Contractor must provide information to consumers consistent with WAC 388-865-0410. The Contractor shall maintain written policy and procedures addressing all information requirements, and shall,

3.1.1. Provide interpreter services for individuals with a primary language other than English for all interactions between the individual and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a grievance;

3.1.2. Post a multilingual notice that advises consumers that all written materials are available in Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese.

3.1.3. The translations of the mental health consumer rights under WAC 388-865-0410 must also be conspicuously marked and readily accessible in public areas.

3.1.4. Provide information that clearly explains to individuals how the individual can request and be provided written materials in alternate formats. Information explaining to the individual how to access these materials must be provided prior to an intake evaluation in an easily understood format.

3.1.5. Upon an individual's request, the Contractor shall provide:

3.1.5.1. Community Mental Health Agency (CMHA) licensure, certification and accreditation status; and

3.1.5.2. Information that includes but is not limited to, education, licensure, and Board certification or re-certification or registration of mental health professionals and MHCPs.

3.2. **Customer Services**

3.2.1. The Contractor shall provide Customer Services that are customer friendly, flexible, proactive, and responsive to consumers, families, and stakeholders. The Contractor shall provide a toll free number for Customer Service. A local telephone number may also be provided for those consumers within the local calling area.

3.2.2. At a minimum, Customer Services staff shall:

3.2.2.1. Promptly answer telephone calls from consumers, family members and stakeholders must be answered from at least 8 a.m. until 5:00 p.m. Monday through Friday, holidays excluded;

3.2.2.2. Respond to consumers, family members and stakeholders in a manner that resolves their inquiry;

3.2.2.3. Possess the ability to respond to those with limited English proficiency or hearing loss.

3.2.3. The Contractor shall train Customer Services staff to distinguish between a Third Party Insurance issue, appeal or grievances and how to refer these calls to the appropriate party. Logs shall be kept that at a minimum to track the date of the initial call, type of call and date of attempted resolution. This log will be provided to MHD for review upon request.

4. **Payment**

4.1. Contractor shall ensure that all funds, including interest earned, provided pursuant to this Agreement are used to support the public mental health system.

4.2. State funds will be paid in the amount of $1,464,830 per month, not to exceed the maximum amount of $14,648,300 for this Agreement's period of performance. Payments are entered into the accounting payment system the first working day of the month.

4.2.1. Additional State funds will be paid in the amount of $60,198.60 per month not to exceed $601,986 solely for the provision of Jail Coordination Services. This funding shall supplement, and not supplant, local or other funding or in-kind resources.

4.2.2. Additional state funds will be paid in the amount of $1,042 per month per Expanded Community Services slot. The Contractor has been allocated 15 slots for the Expanded Community Service described in section 12.14 Contractor shall receive a monthly payment of **$15,630** for a maximum consideration of **$156,300**.

In the event that the Contractor does not meet the minimum ECS days of service in the community described in section 12.14.4, the MHD reserves the right to deduct from future payments up to $34 multiplied by the number of ECS days below the minimum.

4.2.3. A one-time payment in the amount of $11,596 will be paid to the contractor on September 1, 2006 to refund fifty percent of the "liquidated damages" amount withheld from payments to the contractor during state fiscal years 2002 through 2005 because the contractor used more than its allocated number of state hospital beds. Pursuant to Ch. 372, Laws of 2006, § 204(1)(g), the contractor agrees that these funds shall be used only for mental health services.

4.2.4. A one-time start-up cost payment in the amount of $272,000 in state funds shall be paid to the contractor for to develop an adolescent evaluation and treatment facility as described in the Contractors proposal for a Youth Inpatient Program submitted to the MHD on June 9, 2006. The contractor shall submit to the MHD a budget for start-up costs not later than October 1, 2006. Funds will be dispersed on before November 1, 2006. The contractor shall submit to the MHD a report detailing how these funds were expended not later than June 30, 2007.

4.2.5. The Contractor acknowledges and agrees that the Department, in its sole discretion, and in accordance with legislative authority, will operate the Washington Medicaid Integration Partnership (WMIP) in Snohomish County. The Contractor also acknowledges and agrees that WMIP will include both inpatient and outpatient mental health services. Except for detention services pursuant to 71.05 RCW and crisis hot line, the Contractor is not obligated to furnish services to WMIP enrollees.

Non-Medicaid funding will be reduced by $18,856 per month, with a maximum amount of $188,560 for non-Medicaid allowable costs associated with providing services for WMIP enrollees.

4.2.6. DSHS shall pay additional funds of $3,980 per month for the provision of services in accordance with the Integrated Crisis Response Pilot Program section. Maximum consideration for the Integrated Crisis Response Pilot Program is $39,800 for this Agreement’s period of performance.

4.2.7. A one time payment in the amount of $100,000 on September 1, 2006 for implementation and planning activities in the development of a Program for Assertive Community Treatment (PACT). The Contractor shall:

4.2.7.1. Designate and identify a PACT Implementation Project Director and any other key RSN personnel who will be involved in local PACT implementation planning. The director and any key staff shall be identified no later than October 1, 2006.

4.2.7.2. Participate regularly in statewide PACT implementation planning meetings, training, and activities coordinated by the Mental Health Division.

4.2.7.3. Coordinate local PACT implementation planning activities and include consumers, advocates and family members in these planning activities.

4.3. If the Contractor elects to use MMIS system for inpatient claim processing, MHD or its designee will bill the Contractor on a monthly basis for claims paid on behalf of the RSN. The Contractor has 30 days from receipt of the inpatient claim bill to pay the costs assessed.

4.4. The contract shall provide the DSHS Aging and Disabilities Services Administration program funds equal to the general-fund state cost of Medicaid Personal Care Services used by the Contractor for individuals who are disabled (as per the CARE assessment) due solely to a psychiatric disability when such payments have been authorized by the Contractor.

4.5. MHD will withhold 50 percent of the final payment under this Agreement until all final reports and data are received and accepted by DSHS, and until all pending corrective actions, penalties, or unpaid assessments are satisfied.

4.6. Each payment will be reduced by the amount paid by MHD on behalf of the Contractor for unpaid assessments, penalties, and other payments pending a dispute resolution process. If the dispute is still pending June 1, 2007, MHD will withhold the amount in question from the final payment until the dispute is resolved.

4.7. State Hospital reimbursement and State hospital related payments.

4.7.1. The Contractor shall pay a reimbursement rate of $ 414.47 for each state hospital patient days of care that exceed the contractor's daily allocation of state hospital beds identified in section 12.4.1.

DSHS will bill the contractor on a monthly basis for state hospital patient days of care, which exceed the contractor's daily allocation of state hospital beds. Bills will be processed and sent two months after the last day of each month the contractor exceeds their daily allocation. (For example, the September month of service will be billed in December) The RSN has 30 days from receipt of the reimbursement bill to pay the costs assessed.

4.7.2. On any day that the contractor utilizes less than the contractor's daily allocation of state hospital beds and reimbursements have been collected

from other RSNs in accordance with section 12.4.1, the contractor shall receive a payment in accordance with the following methodology:

4.7.2.1. 50% of the reimbursements collected per section 4.7.1 by DSHS from Western Washington RSNs for use of more state hospital patient days of care than their daily allocation of state hospital beds will be distributed to all Western Washington RSNs that used fewer patient days of care than the daily allocation of state hospital beds.

4.7.2.2. Each of the Western Washington RSNs using less patient days of care than their daily allocation of state hospital beds will receive a portion of the funding collected per section 4.7.1 and 4.7.2.1 proportional to their share of the total number of patient days of care that were not used.

4.7.3. Payment of funds identified in section 4.7.2.2 will be made approximately five months after the end of the applicable month. (For example the September month of service will be billed in December and reimbursed the following February.)

4.8. If the Contractor terminates this agreement or will not be entering into any subsequent agreements, the MHD will require that all remaining reserves and fund balances be spent within a reasonable timeframe developed with MHD. Funds will be deducted from the monthly payments until all reserves and fund balances are spent. Any funds not spent for the provision of services under this contract shall be returned to MHD with 60 days of the last day this agreement is in effect.

4.9. The Contractor is required to limit Administration costs to no more than 10 percent of the annual revenue supporting the public mental health system operated by the Contractor. Administration costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by MHD.

4.10. The Contractor must ensure the existence of inpatient reserve at 5.4% of the Contractor's annual payment. The Inpatient Reserves are funds set aside into an account by official action of the RSN governing body. Inpatient reserve funds may only be set aside for anticipated psychiatric inpatient costs.

4.11. The Contractor may have an Operating Reserve not to exceed 5.0% of the maximum consideration for this agreement. The Operating Reserves are funds set aside into an account by official action of the RSN governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.

5. REPORTING AND DELIVERABLES

5.1. Advisory Board and Governing Body Membership

5.1.1. The Contractor shall submit membership rosters of the advisory board showing compliance with WAC 388-865-0222 to the MHD within 60 days of the execution of this Agreement. Any change in membership must be reported within 30 days of the change.

5.1.2. The Contractor must establish a Governing Body responsible for oversight of the Regional Support Network. The Governing Body can be an existing legislative body within a county government. The governing body must be free from conflicts of interest and from any appearance of conflicts of interest between personal, professional and fiduciary interests of a governing body member and best interests of the RSN and the consumers it serves. The Contractor must submit membership roster(s) and by-laws of the governing body demonstrating compliance. These must be submitted to MHD for review 60 days after execution of this agreement. The Governing body by-laws must include:

5.1.2.1. Actions to be taken when a conflict of interest, or the appearance of a conflict of interest, becomes evident;

5.1.2.2. Requirements that members refrain from voting or joining a discussion when a conflict of interest is present; and

5.1.2.3. A process for the Governing Body to assign the matter to others, such as staff or advisory bodies to avoid a conflict of interest.

5.2. The Contractor shall maintain Level of Care Guidelines that meet the requirements described in the Resource Management Section. Level of care guidelines must be submitted for review and approval upon request.

5.3. For any 24-hour supervised crisis respite, hospital diversion beds, or other types of residential services identified in Residential Programs that are described in section 12.12 the Contractor must submit an update to the Residential Resources report that was provided under the RSN agreement for September 2005 to August 2006. If no changes have occurred the contractor may submit of statement of no change. This update must be submitted to the MHD 60 days after the execution of this Agreement.

5.4. The Contractor shall submit in the format provided by MHD the number and types of incidents described in section 6.7.5. These reports will be filled out monthly and submitted within 45 days of the quarter end (September, December, March, and June of each year). For the first report of the contract period the months of September through December may be combined and submitted 45 days after December 30, 2006. The MHD reserves the right to require more frequent submission of the Incident Data reports.

5.5. The Contractor shall submit Expanded Community Support (ECS) reports on the outcomes of ECS consumers in accordance with the ECS report form provided by MHD. The report must be submitted April 1, 2007 for the period of September 1,

2006 through February 28, 2007 and August 2007 for the period of March 1, 2007 through June 30, 2007.

5.6. The Contractor shall provide a quarterly report in a format provided by the MHD on services provided under the Jail Services Coordination Section in accordance with the following schedule.

Quarter	Service Period	Due Date
Q4	September – December 2006	January 20, 2007
Q1	January, 2007– March, 2007	April 20, 2007
Q2	April, 2007 – June 2007	July 20, 2007

5.7. The Contractor shall provide a PACT Implementation Plan by November 1, 2006. The format will be developed in coordination with the Mental Health Division. Future funding of start-up and operational costs of PACT teams shall be dependent on MHD approval of the contractor's PACT implementation plan. In addition the Contractor shall provide:

5.7.1. Updates on the status of the local PACT implementation plan in a format developed in coordination with the Mental Health Division on the following schedule:

5.7.1.1. Status report covering November – December 2006: due January 15, 2007

5.7.1.2. Status report covering January – February 2007: due March 15, 2007

5.7.1.3. Status report covering March – April 2007: due May 15, 2007

5.7.1.4. Status report covering May – June 2007: due July 15, 2007

5.8. **Financial Reporting and Certification:** Reports are due within 45 days of the quarter end (September, December, March, and June of each year). The first report is due 45 days after September 30, 2006. These reports may be combined with the reports for the months of August 2006 and July 2006 that were required in the September 2005 to August 2006 State Mental Health Agreement. The MHD reserves the right to require more frequent submission of the Revenue and Expenditure report. The following reports and certifications, in formats provided by MHD, must be submitted on a quarterly basis:

5.8.1. Revenue, expenditure, reserves and fund balance report in compliance with the BARS Supplemental for Mental Health Services promulgated by the Washington State Auditor's Office and the Revenue and Expenditure Report instructions published by MHD

5.8.2. Balance Sheets

5.8.3. The amounts paid to Federally Qualified Health Centers for services must be tracked and reported.

5.8.4. A report of any revenue collected by subcontractors for services provided under this agreement. This includes revenue collected from Medicare, insurance companies, co-payments, and other sources. The Contractor must certify that a process is in place to demonstrate that all third party revenue resources for services provided under this agreement are identified, pursued, and recorded by the subcontractor.

5.8.5. Certification that administrative costs, as defined in the Revenue and Expenditure Report Instructions for Mental Health Services, incurred by the Contractor are no more than 10 percent of the annual revenue supporting the public mental health system operated by the Contractor. Administration costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by MHD.

5.8.6. If the Contractor is unable to certify the validity of the certifications or if DSHS finds discrepancies in the Revenue and Expenditure Report, DSHS may initiate remedial action. Remedial action may include recoupment from funds disbursed during the current or successive Agreement period. Recoupment shall occur within 90 days of the close of the State fiscal year or within 90 days of the MHD's receipt of the certification, whichever is later.

5.8.7. MHD reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data. MHD agrees to involve the RSN in the decision process prior to implementing changes in format, and shall request the RSN to review and comment on format changes before they go into effect whenever possible.

6. QUALITY OF CARE

6.1. The Contractor shall participate with MHD in the implementation, update and evaluation of the Quality Strategy, located on the MHD website.

6.2. The Contractor shall use its collected data, monitoring results, and services verification to review its ongoing quality management program. The Contractor shall engage in ongoing assessment and improvement of the quality of public mental health services in its service area, as well as evaluate the effectiveness of the overall regional system of care. At a minimum the Contractor shall:

6.2.1. Assess the degree to which mental health services and planning is driven by and incorporates individual and family voice;

6.2.2. Assess the degree to which mental health services are age, culturally and linguistically competent;

6.2.3. Assess the degree to which mental health services are provided in the least restrictive environment;

6.2.4. Assess the degree to which provided mental health services assist individuals' progress toward recovery and resiliency; and,

6.2.5. Assess the continuity in service and integration with other formal/informal systems and settings;

6.3. The Contractor shall incorporate relevant results of grievances, fair hearings and incidents identified in section 6.7.5 into system improvement.

6.4. The Contractor shall provide quality improvement feedback to CMHAs, the advisory board, and other interested parties.

6.5. The Contractor shall invite consumers and consumers' families that are representative of the community being served, including all age groups, to participate in planning activities and in the implementation and evaluation of the public mental health system. The Contractor must be able to demonstrate how this requirement is implemented

6.6. **Quality Review Activities**

6.6.1. The Department of Social and Health Services (DSHS), Office of the State Auditor, or any of their duly-authorized representatives, may conduct announced and unannounced:

6.6.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement;

6.6.1.2. Audits regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement; and

6.6.1.3. Audits and inspections of financial records.

6.6.2. The Contractor shall notify MHD when an entity other than DSHS performs any audit described above related to any activity contained in this Agreement.

6.6.3. The Contractor shall participate with MHD in review activities. Participation will include at a minimum:

6.6.3.1. The submission of requested materials necessary for a MHD initiated review within 30 days of the request;

6.6.3.2. The completion of site visit protocols provided by MHD; and

6.6.3.3. Assistance in scheduling interviews and agency visits required for the completion of the review.

6.7. **Performance Measures**

6.7.1. The Contractor must monitor the following performance measures for maintenance of baselines provided by MHD. MHD will calculate and review the following indicators two times during this contract period September through December and January through April. If the Contractor does not meet MHD defined target baselines on any measure, the Contractor must submit a plan to increase performance to meet baseline. If requested by MHD the contractor's plan will include the submission and implementation of a formal Performance Improvement Project.

6.7.1.1. Non-Crisis services must be offered within seven days of discharge from a psychiatric inpatient hospital or evaluation and treatment program. This will be calculated as number of enrollees who receive an outpatient service within seven days of discharge divided by the total number of enrollees discharged.

6.7.1.2. Telesage Outcome Assessment initiated at time of an intake evaluation. This will be calculated as the number of enrollees that complete or are offered an outcome assessment divided by the number of enrollees that receive an intake evaluation.

6.7.2. The Contractor shall participate with MHD in the development and implementation of a standard set of performance indicators to measure access, quality and appropriateness. Participation must include:

6.7.2.1. Provision of all necessary data;

6.7.2.2. The analysis of results and development of system improvements based on that analysis on a local and statewide basis; and

6.7.2.3. Incorporation of the results into quality improvement activities.

6.7.3. The Contractor shall participate with MHD in completing annual Mental Health Statistics Improvement Project (MHSIP) survey for youth and families. Participation must include at a minimum:

6.7.3.1. Provision of individual contact information to MHD;

6.7.3.2. Involvement in the analysis of results and development of system improvements based on that analysis on a statewide basis; and

6.7.3.3. Incorporation of results into RSN specific quality improvement activities.

6.7.4. The Contractor shall attempt to initiate and complete a TeleSage outcome survey on every individual.

6.7.5. **Incident Reporting**:

6.7.5.1. The contractor must notify the Mental Health Services Chief or designee during the first working day the Contractor becomes aware of an incident related to the provision of mental health services that is likely to result in news coverage.

6.7.5.2. The Contractor must notify the Mental Health Services Chief or designee during the first working day the Contractor becomes aware that any Consumer is the alleged victim or perpetrator of any of the following:

Homicide or attempted homicide

Completed Suicide

Physical or sexual assault

Abuse or neglect

Abandonment of a child or vulnerable adult

Financial Exploitation

Accidental Death

Notification must be made to the Mental Health Services Chief or designee during the working day in which the Contractor becomes aware of such an event. If the event occurs after business hours, notice must be given as soon as possible during the next working day.

6.7.5.3. Notification must include a description of the event, any actions taken in response to the incident, the purpose for which any action was taken, and any implications to the service delivery system.

6.7.5.4. When requested by MHD, a written report will be submitted within two weeks of the original notification to provide information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

7. SUBCONTRACTS

7.1. Delegation

7.1.1. A subcontract does not terminate the legal responsibility of the Contractor to perform the terms of this agreement. The Contractor must oversee, be accountable for, and monitor functions and responsibilities performed by or delegated to a subcontractor on an ongoing basis including the completion of an annual formal review.

7.1.2. Prior to any delegation of responsibility or authority to a subcontractor, the Contractor shall use a formal delegation plan, to evaluate the subcontractor's ability to perform delegated activities. The Contractor shall submit its delegation plan to the MHD for approval within 90 days of execution of this Agreement. The delegation plan must include the following:

7.1.2.1. An evaluation of the prospective subcontractor's ability to perform delegated activities;

7.1.2.2. A detailed description of the proposed subcontracting arrangements, including (1) name, address, and telephone number of the sub-contractor(s), (2) specific contracted services, (3) compensation arrangement, and (4) monitoring plan;

7.1.2.3. A copy of the existing or draft subcontract that specifies the activities and report responsibilities delegated and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is not adequate; and

7.1.3. The Care Management functions as described in this Agreement cannot be delegated to a subcontracted CMHA within the Contractor's service area.

7.2. Subcontract Submission and Required Provisions

7.2.1. All subcontracts must be in writing and specify all duties, reports, and responsibilities delegated under this Agreement. Within 30 days of execution of a subcontract to perform any function under this Agreement, the Contractor shall submit copies of the subcontracts to MHD.

7.2.1.1. When substantially similar subcontracts are executed with multiple subcontractors an example contract may be provided with a list by subcontractor of any terms that deviate from the example.

7.2.1.2. Amendments to subcontracts must be submitted with a summary of the changes made to the original subcontracts within 45 days following the end of a reporting period. Reporting periods are October to March and April to September. In the event that the contract performance period does not encompass a full report period the Contractor shall provide a report for the partial period.

7.2.1.3. Copies are to be provided in a word processing format on a portable memory device.

7.2.2. Subcontracts must require subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the services to be performed under this Agreement.

7.2.3. Subcontracts must adhere to the Americans with Disabilities Act.

7.2.4. Subcontract must require compliance and implementation of the Mental Health Advance Directive statutes.

7.2.5. Subcontracts must require subcontractors to cooperate with Quality Review Activities and provide access to their facilities, personnel and records.

7.2.6. Subcontracts must require subcontractors to participate in MHD-offered training on the implementation of Evidence Based Practices and Promising Practices.

7.2.7. Subcontracts must require subcontractors to provide consumers access to translated information and interpreter services as described in the Information Requirements section.

7.2.8. Subcontracts must require subcontractors to notify the Contractor in the event of a change of status of any required license or certification.

7.2.9. Subcontracts must require subcontractors to participate in training when requested by MHD.

7.2.10. Subcontracts must require compliance with State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and the MHD-CIS Data Dictionary.

7.2.11. Subcontracts must define a clear process to be used to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.

7.2.12. Subcontracts must require that the subcontractor correct any areas of deficiencies in the subcontractor's performance that are identified by the Contractor or the Mental Health Division as part of a subcontractor review.

7.2.13. Subcontracts must require best efforts to provide written or oral notification within 15 working days after the termination of a MHCP to individuals currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the CMHA.

7.2.14. Subcontracts must require that the subcontracted CMHAs comply with the Contractor's policies and procedures for utilization of Access to Care Standards, and Access Standards.

7.2.15. Subcontracts must require that the subcontractor implement a Grievance process that complies with Section 11. Grievance System of this Agreement.

7.2.16. Subcontracts must require the pursuit of all Third Party Revenue.

7.2.17. Subcontracts must require the use of the MHD provided Integrated Co-Occurring Disorder Screening and Assessment Tool by January 1, 2007 and require staff that will be using the tool attend MHD trainings on the use and implementation of the tool.

7.3. **Termination:** The termination of a subcontract with an entity that provides mental health services is considered a significant change in the provider network.

The Contractor must notify MHD 30 days prior to terminating any of its subcontracts with entities that provide mental health services. This notification must occur prior to any public announcement of the change.

7.3.1. If either the Contractor or the Sub-Contractor terminates a subcontract in less than 30 days, the Contractor must notify MHD as soon possible and prior to any public announcement.

7.3.2. If a CMHA contract is terminated, the Contractor must submit a transition plan for consumers and services that includes at least:

- Notification to Ombuds services
- Crisis services plan
- Client notification plan
- Plan for provision of uninterrupted services
- Any information released to the media

7.4. **Annual Review:** An annual formal review of subcontractors must be performed by the Contractor. This review may be combined with a formal review of services performed pursuant to the State Mental Health Agreement between the Contractor and MHD. The review must include the requirements set forth in this contract, the WAC and the RCW. The annual review results must at least address the following.

7.4.1.1. Quality clinical care;

7.4.1.2. Timely access;

7.4.1.3. The pursuit of third party revenue;

7.4.1.4. Quality Assessment;

7.4.1.5. Intake Evaluations and Individual Treatment Plans; and

7.5. **Provider Credentialing**

7.5.1. The Contractor shall have written policies that require monitoring of provider credentials. The Contractor shall only use CMHAs or others who are licensed or certified by the State for the services for which they perform with the exception of services that are provided by a subcontracted Mental Health Clubhouse.

7.5.2. The Contractor shall require a criminal history background check though the Washington State Patrol for employees and volunteers of the contractor who may have unsupervised access to children, people with developmental disabilities or vulnerable adults.

8. CONSUMER RIGHTS AND PROTECTIONS

8.1. The Contractor shall comply with any applicable Federal and State laws that pertain to individual rights and require that its staff take those rights into account when furnishing services to consumers.

8.2. The Contractor shall require that mental health professionals and MHCPs, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an individual with respect to:

8.2.1. The individual's mental health status;

8.2.2. Receiving all information regarding mental health treatment options including any alternative or self administered treatment, in a culturally-competent manner;

8.2.3. Any information the consumer needs in order to decide among all relevant mental health treatment options;

8.2.4. The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment);

8.2.5. The consumer's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions;

8.2.6. The consumer's right to be treated with respect and with due consideration for his or her dignity and privacy;

8.2.7. The consumer's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

8.2.8. The consumer's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164;

8.2.9. The consumer's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the RSN, CMHA or MHCP treats the individual;

8.3. The Contractor shall require that mental health professionals and MHCPs have an effective method of communication with individuals who have sensory impairments, and limited English proficiency; and

8.4. The Contractor shall provide or purchase age, linguistic and culturally competent community mental health services for consumers for whom services are medically necessary and clinically appropriate.

8.5. Individual service plans must be developed in compliance with WAC 388-865-0425.

8.5.1. The Contractor shall require that consumers are included in the development of their individualized service plans, advance directives and crisis plans. This shall include but not be limited to children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings). At a minimum, treatment goals must include the words of the individual receiving services and documentation must be included in the clinical record, as part of the 180-day progress review, describing how the consumer sees progress.

8.5.2. An individual peer support plan may be incorporated in the individual service plan.

8.6. **Ombuds**

8.6.1. The Contractor shall provide a mental health Ombuds as described in WAC 388-865-0250 and RCW 71.24. An entity or subcontractor independent of the RSN Administration must employ the Ombuds and provide for the following:

8.6.1.1. Separation of personnel functions (e.g., hiring, salary and benefits determination, supervision, accountability and performance evaluations).

8.6.1.2. Independent decision making to include all investigation activities, findings, recommendations and reports.

8.7. **Advance Directives**

8.7.1. The Contractor shall maintain a written Advance Directive policy and procedure that respects individuals' Advance Directives for psychiatric care. Policy and procedures must comply with RCW 71.32. If State law changes, MHD will send notice to the Contractor who must then ensure the provision of notice to individuals within 90 days of the change.

8.7.2. The Contractor shall inform individuals that complaints concerning noncompliance with the Advance Directive for psychiatric care requirements may be filed with MHD by contacting the Quality Improvement and Assurance section at 1-888-713-6010.

9. **CARE MANAGEMENT PROGRAM –** Care management is a set of clinical management oversight functions that shall be performed by the Contractor. Care Management functions shall not be delegated to a network CMHA. Care management focuses on access, referrals, oversight of care coordination, utilization review, resource management, risk management, and quality improvement. These activities must be performed by a Mental Health Professional.

9.1. **Utilization Management Program**

9.1.1. The Contractor shall have a psychiatric medical director (consultant or staff) and sufficient care managers to carry out essential care management functions including:

9.1.1.1. A process for access to an intake evaluation and a process for referral to crisis intervention services;

9.1.1.2. A utilization review of requested services against medical necessity criteria, and authorization of necessary care;

9.1.1.3. A review of assessment and treatment services against clinical practice standards. Clinical practice standards include but are not limited to evidenced-based practice guidelines, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals and other consumer serving agencies;

9.1.1.4. A monitoring process for over-utilization and under-utilization of services. The Contractor shall ensure that resource management and utilization management activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary mental health services to any individual; and

9.1.1.5. Maintenance of written policies and procedures for determining level of care guidelines for mental health services within the Contractor's service area. The policies and procedures must demonstrate:

9.1.1.5.1. Consistent application of review criteria for authorization decisions;

9.1.1.5.2. Consistent application of medical necessity criteria and the Access to Care Standards; and,

9.1.1.5.3. Consultation with providers, when appropriate.

9.2. **Resource Management**

9.2.1. The Contractor must have a Resource Management review process that incorporates coordination and authorization of outpatient mental health services administered pursuant to an individual service plan.

9.2.2. The Contractor shall have eligibility criteria for initial authorization of outpatient mental health services and residential programs. The criteria may be more restrictive than the Access to Care Standards.

9.2.3. In addition to the Access to Care Standards, the Contractor's Level of Care Guidelines must also include: criteria for use in determining continued care or re-authorization following the exhaustion of previously authorized services by the individual, and must include criteria for use in determining when an consumer shall be discharged from outpatient community mental health services.

9.2.4. Review criteria used to determine continued or re-authorization following the exhaustion of previously authorized services by the individual must include:

9.2.4.1. An evaluation of the progress achieved and the effectiveness of each service modality provided;

9.2.4.2. An evaluation of the progress the individual made towards recovery or resiliency;

9.2.4.3. An identification of unmet needs including those identified by the individual; and

9.2.4.4. A method for determining if an individual has met discharge criteria.

9.2.5. The Contractor shall maintain written policy and procedures, and be able to demonstrate upon request, the consistent application of the Level of Care Guidelines within the Contractor's service area.

9.2.6. The Contractor shall have a protocol for verifying that authorized outpatient mental health services are consistent with the individual service plan.

9.2.7. The Contractor's care management system must include a review of Individual Treatment plans. The sample must large enough to ensure the requirements of WAC 388-865-0425, Individual Service Plan, are being met and that:

9.2.7.1. The individual identified needs are being met;

9.2.7.2. The individual's participation in the service planning;

9.2.7.3. Involvement of family members as defined in this document, when appropriate, in the assessment and services planning processes; and

9.2.7.4. Input from other health, education, social service, and justice agencies, as appropriate and consistent with privacy requirements.

9.2.8. The Contractor must have Care Managers available 24 hours a day, 7 days a week to respond to requests for certification of psychiatric inpatient care in community hospitals. A decision regarding certification of psychiatric inpatient care must be made within twelve hours of the initial request.

9.2.8.1. Denials for certification of a psychiatric inpatient stay must be reviewed by a psychiatrist within 3 days of the initial denial.

9.2.9. If the Contractor denies payment to the inpatient facility for any portion of a psychiatric inpatient stay and the inpatient facility appeals, a response to the appeal must occur within 14 calendar days. The inpatient facility may appeal the Contractor's decision(s) to MHD after all reasonable efforts are made to resolve the dispute between the Contractor and the inpatient facility.

9.2.10. The Contractor shall adhere to the requirements set forth in the Community Hospitalization authorization procedures available on the MHD Intranet or upon request.

9.2.11. Community psychiatric inpatient services are continued through the individual's discharge should a community hospital become insolvent, including any requirement for transfer.

10. MANAGEMENT INFORMATION SYSTEM

10.1. Data Submission and Error Correction

10.1.1. The Contractor shall provide the MHD all data described in the data dictionary for the Mental Health Division Consumer Information System (MHD-CIS), or any successor, incorporated herein by reference.

10.1.2. The Contractor shall submit encounters within 60 days of the close of each calendar month in which the encounters occurred.

10.1.3. The Contractor shall submit all other required data about individuals receiving services to the MHD within 60 days of collection or receipt from subcontracted providers.

10.1.4. Upon receipt of data submitted to the MHD, the MHD will generate an error report. The Contractor shall have in place documented policies and procedures that assure that data submitted and rejected due to errors are corrected and resubmitted within 30 calendar days of when the MHD error report was produced. All transactions will be final 180 days after the close of the submission month.

10.1.5. The Contractor shall require subcontractors to resubmit data when rejected by MHD due to errors. The subcontractor must resubmit corrected data within 30 calendar days of when an error report was produced.

10.1.6. The Contractor shall attend meetings and respond to inquiries to assist in MHD decisions about changes to data collection and information systems to meet the terms of this Agreement. This may include requests to add, delete or change data elements that may include projected cost analysis.

10.1.6.1. The Contractor shall implement changes made to the MHD data dictionary within 120 days from the date of published changes. When MHD makes changes to the Data Dictionary the contractor shall send at least one test batch of data containing the required changes described in the data dictionary. The test batch must be received no later than 15 days following the implementation date:

- The test batch must include a quantity of transactions that is at least 50% of the number of successful transactions posted to the MHD –CIS in the six months prior to the change and contain information effected by the change.

- The processed test batch must result in at least 80% successfully posted transaction or an additional test batch is required.

10.1.7. The Contractor shall respond to requests for information not covered by the data dictionary in a timeframe determined by the MHD that will allow for a timely response to inquiries from CMS, the legislature, the MHD, and other parties.

10.1.8. The Contractor shall be liable for any costs associated with additional data processing once transactions are final. The Contractor will not be held liable for costs associated with making changes requested in writing by the MHD director, an office chief or their designee.

10.2. **Business Continuity and Disaster Recovery**

10.2.1. The Contractor shall demonstrate a primary and backup system for electronic submission of data requested by the MHD. This must include the use of the Inter-Governmental Network (IGN), Information Systems Services Division (ISSD)-approved secured Virtual Private Network (VPN) or other ISSD- approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on MHD approval.

10.2.2. The Contractor shall provide a business continuity and disaster recovery plan that insures timely reinstitution of the consumer information system following total loss of the primary system or a substantial loss of functionality.

10.2.3. The Contractor will require all subcontractors to provide a business continuity and disaster recovery plan that insures timely reinstitution of the subcontractor's consumer information system following total loss of the primary system or a substantial loss of functionality.

10.2.4. Documentation required in this section must be submitted to MHD within 60 days of the execution of this agreement.

10.3. **Information System Security and Protection of Confidential Information**

10.3.1. The Contractor shall comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified in 42 USC §1320(d) et.seq. and 45 CFR parts 160, 162 and 164.

10.3.2. The Contractor shall maintain a statement on file for each individual service provider and contractor staff that have access to the Contractor's mental health information system that is signed by the provider and attested to by a witness's signature, acknowledging that the provider understands and agrees to follow all regulations on confidentiality.

10.3.3. The Contractor shall take appropriate action if a subcontractor or Contractor employee willfully releases confidential information.

10.4. **Subcontractor Data Quality Verification**

10.4.1. The Contractor shall maintain and either provide to subcontractors, or require subcontractors to also maintain, a health information system that provides the information necessary to meet the Contractor's obligations under this Agreement.

10.4.2. The Contractor shall have in place mechanisms to verify the health information received from subcontractors is accurate and complete. Mechanisms shall include the following:

10.4.2.1. Verifying the accuracy and timeliness of reported data; and

10.4.2.2. Screening the data for completeness, logic and consistency of the data received from subcontractors.

10.4.3. For all subcontractors that submit encounters to the Contractor, the Contractor shall conduct encounter validation checks using the following method:

10.4.3.1. A review of 1% of all encounters provided under this agreement or 250 encounters provided under this agreement, whichever is less during the first 6 months of the Agreement period;

10.4.3.2. Compare the clinical record against the subcontractor's encounter data to determine agreement in type of service, date of service and service provider. This review must verify that the service reported actually occurred; and

10.4.3.3. Develop a report based on this information to be used in the Contractor's data monitoring activities. The report shall be submitted to MHD 30 days prior to the end of this Agreement.

10.5. **Data Certification**

10.5.1. The Contractor shall provide certification of encounter data by one of the following: Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer. The certification will attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of data. Batches that contain data errors will not be considered certified until corrections for all errors are successfully received by the MHD.

10.5.2. The Contractor shall use only the MHD-supplied certification form.

10.5.3. The Contractor shall submit an electronic copy (e-mail is sufficient) of each certification on same the day that the certified data is submitted. Send the original signed certification to the MHD Information Services Manager by mail as soon as possible.

10.5.4. The Contractor shall ensure that each certification contains an original signature of the signing authority.

10.5.5. If the signing authority is other than the CEO or CFO, the Contractor shall ensure that, a letter is submitted to the MHD containing an original signature by the CEO or CFO that indicates the name(s) of people delegated to sign. MHD must be notified by similar letter when delegation changes.

11. GRIEVANCE SYSTEM

11.1. **Procedures.** The contractor shall have a grievance system that has the following procedures.

11.1.1. The individual or representative may file a grievance either orally or in writing.

11.1.2. If an initial request for a grievance is made orally, a written, signed request for a grievance must be submitted within 7 days.

11.2. **Handling of Grievances**

11.2.1. General requirements: In handling grievances, each RSN or agent must meet the following requirements:

11.2.1.1. Give individuals any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, provision of Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability;

11.2.1.2. Acknowledge receipt of each grievance received either orally or in writing within one working day. If acknowledgement is made orally, it must be followed-up in writing within five working days;

11.2.1.3. Ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making; and

11.2.1.4. Ensure that no retaliation is taken against individuals who file a grievance.

11.3. **Resolution and Notification:** Individuals who file a grievance shall be notified:

11.3.1. Of their right to request a Fair Hearing, and how to do so;

11.3.2. Of their right to request to receive medically necessary services while the hearing is pending;

11.3.3. How to make the request; and

11.3.4. That an individual may be asked to pay for the cost of those services if the hearing decision upholds the original decision.

11.4. **Continuation of Services**

11.4.1. The RSN must continue the individual's Medically Necessary services within available resources and if all of the following conditions are met:

11.4.1.1. The grievance involves the termination, suspension, or reduction of a previously authorized course of treatment;

11.4.1.2. The services were provided by an authorized Community Mental Health Agency;

11.4.1.3. The original period covered by the original authorization has not expired; and

11.4.1.4. The individual requests a continuation of services.

11.5. **Information to RSNs and Sub-contractors**

11.5.1. The RSN must provide information about the grievance system to all Community Mental Health Agencies and sub-contractors at the time they enter into a contract. A condition of the contract will be that all Community Mental Health Agencies and sub-contractors will abide by all grievances and administrative hearing decisions.

11.6. **Record-keeping and Reporting Requirements**

11.6.1. The Contractor must maintain records of grievances and administrative fair hearings and must review the information per the timelines listed below.

11.6.2. The Contractor must submit a report in a format provided by MHD that includes:

11.6.2.1. The number and nature of, administrative fair hearings and grievances;

11.6.2.2. The timeframes within which they were disposed of or resolved;

11.6.2.3. The nature of the decisions; and

11.6.2.4. A summary and analysis of the implications of the data, including what measures will be taken to address undesirable patterns.

11.6.2.5. The report periods are October to March and April to September. In the event that the terms of this Agreement do not encompass a full report period the Contractor shall provide a report for the partial period. Reports are due 45 days following the end of a report period.

12. SERVICES

12.1. **Required Services**. The Contractor is required to provide all of the following services as described in the Crisis Mental Health, Medicaid Personal Care and Inpatient sections, unless otherwise specified in this Agreement. These services must be prioritized for the use of funds provided in this Agreement.

12.1.1. **Crisis Mental Health Services**: The Contractor must provide 24-hour, 7 day a week crisis mental health services to individuals who are within the Contractor's service area and report they are experiencing a mental health crisis. There must be sufficient staff available, including Designated Mental Health Professionals, to respond to requests for crisis services. Crisis services must be provided regardless of the individual's ability to pay. Crisis mental health services must include each of the following:

12.1.1.1. Crisis Services: Evaluation and treatment of mental health crisis to all individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, the outcome of which decides whether possible bad consequences will follow. Crisis services must be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services must be provided by or under the supervision of a mental health professional.

12.1.1.2. Stabilization Services: Services provided to individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services. This service may include cost for room and board.

12.1.1.3. Involuntary Treatment Act Services: Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05 RCW 71.24. 300 and RCW 71.34. This includes all clinical services, costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional (DMHP) determines an individual must be evaluated for involuntary treatment. The decision-making authority of the

DMHP must be independent of the RSN administration. ITA services continue until the end of the involuntary commitment.

12.1.1.4. Ancillary Crisis Services: Includes costs associated with providing medically necessary crisis services not included in the Medicaid State Plan. Costs include but are not limited to the cost of room and board in hospital diversion settings or in freestanding Evaluation and Treatment facilities.

12.1.1.5. Freestanding Evaluation and Treatment Services provided in freestanding inpatient residential (non-hospital) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

12.1.2. Crisis mental health services may be provided without an intake evaluation or screening process. The Contractor must provide:

12.1.2.1. Emergent care within 2-hours of the request received from any source for crisis mental health services.

12.1.2.2. Urgent care within 24-hours of the request received from any source for crisis mental health services.

12.1.3. The Contractor must provide access to all components of the Involuntary Treatment Act to persons who have mental disorders in accordance with State law (RCW 71.05 and RCW 71.34) and without regard to ability to pay.

12.1.4. The Contractor must incorporate the statewide protocols for Designated Mental Health Professionals (DMHP) or its successor into the practice of Designated Mental Health Professionals. The protocols can be accessed on the MHD intranet and copies can be provided upon request.

12.1.5. **Integrated Crisis Response Pilot Program** – Integrated Crisis Response Pilot Programs were established with RCW 70.96B. The purpose of the pilot programs is to provide integrated crisis response and involuntary treatment to persons with a chemical dependency, a mental disorder, or both.

The contractor shall provide integrated crisis response, involuntary treatment, and case management services to persons with a chemical dependency disorder, a mental disorder, or both. To implement this pilot the Contractor shall:

12.1.5.1. Combine the functions of a designated mental health professional under chapter 71.05 RCW and a designated chemical dependency specialist under chapter 70.96A RCW by establishing a new designated crisis responder who is authorized to conduct investigations and detain persons up to seventy-two hours to the proper facility.

12.1.5.2. Require that evaluation, detention, and commitment of individuals related to a mental disorder is carried out by crisis responders in accordance with the requirements of RCW 70.96B and 71.05.

12.1.5.3. Require that evaluation, detention, and commitment of individuals related to a chemical dependency is carried out by crisis responders in accordance with the requirements of 70.96B and 70.96A.

12.1.5.4. Require that crisis responders complete all training required by the DSHS and meet all qualifications of 70.96B.

12.1.5.5. Provide crisis response services twenty-four hours a day, seven days a week.

12.1.5.6. Provide the necessary transportation services for individuals detained under R.C.W. 70.96B including transportation to and from commitment hearings and to and from secure detoxification facilities. While an individual is held in a secure detoxification facility the Contractor shall also provide transportation for individuals as needed from the secure detoxification facility to follow-up treatment programs, or services dictated in the individual's treatment plan.

12.1.5.7. Participate in an evaluation with Washington State Institute for Public Policy to assess the outcome of the pilot program including providing data and information as requested.

12.1.5.8. Collaborate with the Department of Corrections in cases where persons detained or committed under RCW 70.96B are also subject to supervision by the Department of Corrections.

12.1.5.9. Develop a process to monitor and evaluate whether the initial detentions to the secure detoxification facility are utilized to serve individuals that cannot be served in any other less restrictive detoxification setting.

12.1.5.10. Identify in their Revenue and Expenditure Reports the amount of funding expended for pilot program activities including: known transportation costs, court related costs, and other costs which have been selected by MHD and DASA for identification.

12.1.5.11. Provide monthly reports, on the electronic form provided, on the number and type of case management, transportation and court related services, provided.

12.1.5.12. Provide chemical dependency case management services within available resources for persons discharged from the secure detoxification facility who:

- Need ongoing chemical dependency treatment and support services and have a primary diagnosis of:
  - Chemical dependency or
  - Chemical dependency and mental illness, and,
- Have a history of high utilization of crisis services and/or detoxification services.

12.1.5.13. Require that chemical dependency case managers are trained in, and use, the integrated comprehensive screening and assessment tool when it becomes available from the DSHS.

12.1.5.14. Require that chemical dependency case managers are supervised by and have workspace provided by an agency other than the agency responsible for the operation of the secure detoxification facility. Chemical dependency case managers provide the following services when appropriate and within available resources:

12.1.5.14.1. Coordination with treatment providers, housing advocates and therapeutic courts to increase the likelihood of positive outcomes for participants in the pilot project.

12.1.5.14.2. Assistance in accessing and remaining enrolled in benefit programs to which the participant may be entitled;

12.1.5.14.3. Reduction of the duplication of services and conflicts in case approach by coordinating with medical care providers including federally qualified health centers, Indian health programs, and veterans' health programs for which the participant is eligible; and,

12.1.5.14.4. Advocacy for the participant's needs to assist achieving and maintaining stability and progress toward recovery.

12.2. **Psychiatric Inpatient Services: Community Hospitals and Evaluation and Treatment Facilities**: The Contractor shall:

12.2.1. Develop, maintain or purchase Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.300 (6) (c).

12.2.2. Provide or purchase psychiatric inpatient services for the following:

12.2.2.1. When it is determined to be medically necessary individuals who agree to be admitted voluntarily and who are beneficiaries of the following State-funded assistance programs: Psychiatric Indigent Inpatient (PII) and General Assistance Unemployable (GA-U).

12.2.2.2. Individuals who are involuntarily detained in accordance with RCW 71.05 or RCW 71.34, and who are either eligible under General Assistance-Unemployable (GA-U), or who are not eligible for any other medical assistance program that would cover this hospitalization.

12.2.2.3. Individuals at least 22 years of age and under 65 years of age who are Medicaid-enrollees and are admitted to an Institute for Mental Diseases (IMD) defined in 42CFR435.1009.

12.3. **Community Hospital Certification Process**: Adhere to the requirements set forth in the Community Psychiatric Inpatient Process as provided by MHD.

12.3.1. The Contractor shall have a Care Manager available 24 hours a day to respond to requests for inpatient certification. Certification decisions for psychiatric inpatient care must be made within twelve hours of the initial call.

12.4. **Psychiatric Inpatient Services: State Hospitals and CLIP**: The Contractor shall:

12.4.1. The following is the daily allocation of state hospital beds. This allocation was established as described in Section 107, Chapter 333, Laws of 2006.

12.4.2. The contractor shall reimburse DSHS for state hospital days of care that exceed the daily allocation of state hospital beds.

12.4.2.1. If the Contractor disagrees with the RSN/patient assignment, it must request a reassignment within 30 days of admission. If a request to change the assignment is made within 30 days of admission and the request is granted, the reassignment will be retroactive to the date of

RSN	Allocation 9/1/06-11/30/06	Allocation 12/1/06-6/30/07
Clark County RSN	**53**	**56**
Grays Harbor RSN	**12**	**12**
King County RSN	**257**	**267**
North Sound RSN	**143**	**149**
Peninsula RSN	**47**	**49**
Pierce County RSN	**166**	**173**
Southwest RSN	**16**	**16**
Thurston-Mason RSN	**38**	**40**
Timberlands RSN	**15**	**15**
Total	**747**	**777**

admission.

12.4.2.2. If a request comes in after the 30th day of admission and is granted, the effective date of the reassignment will be based on the date DSHS receives the reassignment request form. All reassignment requests are to be made using the hospital correction request form. The form is attached to the state hospital/RSN Working Agreement. This process shall be described in the working agreement between the Contractor and the state hospital

12.4.3. Ensure consumers are medically cleared, if possible prior to admission to a State psychiatric hospital.

12.4.4. Respond to State hospital census alerts by using best efforts to divert admissions and expedite discharges by utilizing alternative community resources and mental health services.

12.4.5. The Contractor or its designee shall monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320.

12.4.6. The Contractor or its designee shall offer covered mental health services to assist with compliance with LRA requirements for individuals who meet medical necessity and the Access to Care Standards.

12.4.7. The Contractor or its designee shall respond to requests for participation, implementation, and monitoring of individuals receiving services on Conditional Releases (CR) consistent with RCW 71.05.340. The Contractor or designee shall provide covered mental health services for individuals that meet medical necessity and the Access to Care Standards.

12.4.8. The Contractor or designee shall ensure provision of covered mental health services to individuals on a Conditional Release under RCW 10.77.150 for individuals that meet medically necessity and the Access to Care Standards

12.4.9. For conditional releases under RCW 10.77, if the individual is placed on a transitional status in the RSN, which holds the State psychiatric hospital, it is expected that the individual will transfer back to the RSN for the individual's county of residence once transitional care is complete. The Inter-RSN Transfer process described in the State hospital working agreement will be used when an individual is on conditional release or discharged to an area other than the RSN responsible for the individual's county of residence.

12.4.10. Maintain or develop a written working agreement with the State hospital in its service area within 90 days of the effective date of this Agreement. The agreements must include:

12.4.10.1. Specific roles and responsibilities of the parties related to transitions between the community and the hospital;

12.4.10.2. A process for the completion and processing of the Inter-RSN transfer request form for individuals requesting placement outside of the RSN of residence;

12.4.10.3. A process for resolution of disputes between RSNs and the assignment of individual costs when individuals are transferred between RSNs;

12.4.10.4. Collaborative discharge planning and coordination with cross-system partners; and

12.4.10.5. Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's service area.

12.5. **Children's Long-Term Inpatient Programs (CLIP)**

12.5.1. The Contractor shall coordinate with the Children's Long-term Inpatient Programs ("CLIP") Administration to develop CLIP resource management guidelines and admissions procedures. The Contractor shall enter into, and comply with, a written agreement with the CLIP Administration regarding resource management guidelines and admissions procedures.

12.6. **Inpatient Coordination of Care**

12.6.1. The Contractor must provide Rehabilitation Case Management: which includes a range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of an individual in the State mental health system.

Rehabilitation Case Management activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. Services are provided by or under the supervision of a mental health professional.

12.6.2. The Contractor shall ensure that contact with the inpatient staff occurs within 3 working days of a voluntary or involuntary admission. The Contractor's liaison or CMHA must participate in treatment and discharge planning with the hospital staff.

12.6.3. The Contractor or its designee shall provide to the inpatient unit any available information regarding the individual's treatment history at the time of admission. The Contractor or its designee must provide all available information related to payment resources and coverage.

12.6.4. The Contractor's liaison or designated CMHA must participate in treatment and discharge planning with the inpatient treatment team. A CMHA must be designated prior to discharge for individuals and their families seeking

community support services. The assigned CMHA must offer, at minimum, one follow – up service within 14 days from discharge.

12.6.5. The Contractor's liaison or designated CMHA must participate throughout the inpatient admission to assist with appropriate and timely discharge for all individuals regardless of diagnosis.

12.6.6. The Contractor's liaison or designated CMHA must coordinate with State hospital staff to develop appropriate community placement and treatment service plans.

12.6.7. The Contractor must designate a CMHA who has the primary responsibility to coordinate outpatient and residential services per section 2.4 to be provided to the individual based on medical necessity and available resources. The assigned CMHA must offer, at minimum, one follow – up service within 14 days from discharge.

12.7. **Medicaid Personal Care**: The Contractor or its designee must respond to requests for Medicaid Personal Care (MPC) from the DSHS Aging and Disability Services Administration (ADSA) within five working days of the request. The Contractor and the local ADSA office may mutually agree in writing to extend the five working day requirement. ADSA will use the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine service needed. The Contractor may not limit or restrict authorization for these services due to insufficient resources. Authorization decisions must be based on the following:

12.7.1. A review of the request to determine if the individual is currently authorized to receive services from the Prepaid Inpatient Health Plan in the Contractor's service area;

12.7.1.1. A verification that need for MPC services is based solely on the presence of a psychiatric disability; and

12.7.1.2. A review of the requested MPC services to determine if the individual's needs could be met through provision of other available RSN services.

12.7.2. If the Contractor denies authorization for MPC, the reason for the determination must be documented in the written response provided to ADSA.

12.7.2.1. When the Contractor denies authorization based on provision of other RSN services, a plan (e.g., Individual Service Plan) must be developed and implemented to meet the needs identified in the CARE assessment.

12.7.3. The Contractor must provide the following documentation to MHD on request:

12.7.3.1. The original ADSA referral and request for authorization;

12.7.3.2. Any information provided by ADSA including the CARE assessment;

12.7.3.3. A copy of the Contractor's determination and written response provided to ADSA; and

12.7.3.4. A copy of the plan developed and implemented to meet the individual's needs through provision of other available RSN services when the MPC request has been denied based on this determination.

12.8. **Outpatient Mental Health Services and Residential Programs**: When the Contractor has available resources, the Contractor shall provide Intake evaluations and other services including but not limited to those described in this section that are medically necessary to members of priority populations (RCW 71.24). The Contractor must have policies and procedures that determine how the availability of resources for these services is determined, including how decisions are made to authorize intake evaluations or deny provision of services due to insufficient resources.

12.9. **Access to Outpatient Mental Health Services**: Once it is determined resources are available for Outpatient services, access must be based on the following:

12.9.1. An intake evaluation provided by a mental health professional that is consistent with WAC 388-865-0420 and that is culturally relevant and age appropriate. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

12.9.1.1. An intake evaluation must be initiated within 14 days of the request for mental health services. A request for mental health services is defined as a point in time when mental health services are sought or applied for through a telephone call, walk-in, or written request.

12.9.2. Authorization of intake shall be based on the Contractors policies and procedures. Authorization of initial services shall be based on medical necessity, Access to Care Standards and the Contractors Level of Care Guidelines following an intake evaluation. A decision to authorize routine mental health services must occur within 14 calendar days from the date of request for mental health services unless the individual or the CMHA request an extension from the RSN.

12.9.2.1. An extension of up to 14 additional calendar days to make the authorization decision is possible upon request by the individual or the *CMHA*. *The Contractor must have a written policy and procedure to ensure consistent application of requests within the service area. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary.*

12.9.3. The Contractor or its designee must provide a notification of authorization decisions within 14 working days of the decision to the individual requesting services. This notification must be in writing and may not be delegated to a

network CMHA. This contractor may use the provider agency to deliver the document containing the authorization decision.

12.9.4. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or described in the individual service plan must be determined by a Care Manager who is a Mental Health Professional with the appropriate clinical expertise to make that decision.

12.9.5. If the Contractor or their formal designee: a) denies a service authorization request; or b) authorizes a service in an amount, duration, or scope that is less than requested, the Contractor shall notify the requesting CMHA and the individual in writing within 14 working days of the decision.

12.9.6. Authorization for outpatient services from the time of request must not take longer than 14 calendar days, unless the individual requests an extension.

12.10. Routine mental health services offered shall occur within 14 calendar days of a determination of an authorization. The time from request for services to first routine appointment must not exceed 28 calendar days unless the Contractor documents a reason for the delay.

12.11. **Outpatient Mental Health Services**: The following Outpatient Service Modalities may be provided based on the individual's needs and medical necessity, within available resources per the Contractor's policies and procedures. The full range of outpatient mental health services are below:

12.11.1. Brief Intervention Treatment: Solution-focused and outcome-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of an individual's current level of functioning or assistance with self/care or life skills training. An individual may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

12.11.2. Day Support: An intensive rehabilitative program, which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in

the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, schools, clubhouses, community centers). This service is available up to 5 hours per day, 5 days per week.

12.11.3. Family Treatment: Counseling provided for the direct benefit of an individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment is intended to benefit the client to obtain reintegration and recovery into the community. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their Individual Service Plan. This service is provided by or under the supervision of a mental health professional.

12.11.4. Group Treatment Services: Services provided to individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self-care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and/or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

12.11.5. High Intensity Treatment: Intensive service that is provided to individuals who require a multi-disciplinary treatment team in the community that is available during extended hours. Twenty-four hours per day, seven days per week, access is required if necessary for the individual. The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated

treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The team also has the ability to promptly assess, re-assess, and modify the individual service plan if the need arises. The team closely monitors symptoms and provides immediate feedback to the individual and to other team members. The team service intensity is individualized based upon continual assessment of need and adjustment to the individual service plan. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement. Services provided by the mental health professionals, mental health care providers and peer counselors are reportable components of this modality. The staff to consumer ratio for this service is no more than 1:15. Although they participate, these team members are paid staff of other Departments.

12.11.6. Individual Treatment Services: A set of treatment services designed to help an individual attain goals as prescribed in their Individual Service Plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the individual. This service is provided by or under the supervision of a mental health professional.

12.11.7. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but include only minimal psychotherapy.

12.11.8. Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging an individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Individuals with low medication compliance history or newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional.

12.11.9. Mental Health Clubhouse: A service specifically contracted by the RSN to provide a consumer-directed program to individuals where they receive multiple services. These services may be in the form of support groups,

related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must use International Center for Clubhouse Development (ICCD) standards as guidelines. Services include the following:

12.11.9.1. Opportunities to work within the clubhouse. Such work contributes to the operation and enhancement of the clubhouse community;

12.11.9.2. Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness;

12.11.9.3. Assistance with employment opportunities, housing, transportation, education and benefits planning; and

12.11.9.4. Operate at least ten hours a week after 5:30pm Monday through Friday, or anytime on Saturday or Sunday, and

12.11.9.5. Opportunities for socialization activities

12.11.10. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non-hospital) that offers a sub-acute psychiatric management environment. Individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness and do treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to individual. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service differs from other services in the terms of location and duration.

12.11.11. Peer Support: Services provided by certified peer counselors to individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. These services may include self-help support groups, telephone support lines, drop-in centers, and engaging activities to locations where consumers are known to gather. Drop-in centers are required to maintain a log documenting identification of the consumers. This includes locations

such as churches, parks, community centers, etc. Services are geared toward consumers with severe and persistent mental illness. Consumers actively participate in decision-making and the operation of the programmatic supports. Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plans which delineate specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, but treatment goals have not yet been achieved. Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams. Peer support is available to an individual for no more than four hours per day. The ratio for this service is no more than 1:20.

12.11.12. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

12.11.13. Respite Care: A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home, etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional.

12.11.14. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist who considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral component of this service.

12.11.15. Supported Employment - Services will include:

12.11.15.1. An assessment of work history, skills, training, education, and personal career goals;

12.11.15.2. Information about how employment will affect income and benefits the consumer is receiving because of their disability;

12.11.15.3. Preparation skills such as resume development and interview skills;

12.11.15.4. Involvement with consumers served in creating and revising individualized job and career development plans that include;

- Consumer strengths
- Consumer abilities
- Consumer preferences
- Consumer's desired outcomes

12.11.15.5. Assistance in locating employment opportunities that is consistent with the consumer's strengths, abilities, preferences, and desired outcomes

12.11.15.6. Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.

12.11.15.7. Services are provided by or under the supervision of a mental health professional.

12.11.16. Therapeutic Psychoeducation: Informational and experiential services designed to aid individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the individual and are included in the Individual Service Plan.

12.11.16.1. The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc. Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional.

12.11.17. In addition to these services the Contractor may provide or purchase other outpatient services including, but not limited to, the following:

12.11.17.1. Assistance with application for entitlement programs;

12.11.17.2. Assistance with meeting the requirements of the Medically Needy spend down program; and

12.11.17.3. Services provided to Medicaid enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver.

12.12. **Residential Programs**: The full range of residential settings and programs shall be available and provided based on the individual's needs, medical necessity and within available resources per the Contractor's policies and procedures. The Contractor must a detailed plan to meet individual needs for residential programs. This plan may include memorandums of understanding or contracts to purchase or provide a residential program outside of the Contractor's service area when an individual requires a level of residential support, which is not available within the Contractor's service area. The full range of residential programs and settings include the following:

12.12.1. Long-term intensive adaptive and rehabilitative psychiatric care such as is provided in Adult Residential Rehabilitation Centers;

12.12.2. Supervised living such as residential programs developed to serve individuals diagnosed with a major mental illness in nursing homes, boarding homes or adult family homes; and

12.12.3. Supported housing services such as intensive services provided to maintain individuals in unlicensed individual or group home settings including transitional or permanent housing.

12.13. The Contractor shall notify DSHS in writing of any change in capacity that results in the Contractor being unable to provide any of the services in this agreement. Events that may affect capacity include: loss of a CMHA, decrease in the number or frequency of a service, or any change that results in the Contractor being unable to provide medically necessary services.

12.14. **Expanded Community Services (ECS)** ECS funding is provided for the provision of enhanced community support services for long term state hospital patients.

12.14.1. The Contractor shall provide or maintain community residential and support services for consumers with treatment needs that constitute substantial barriers to community placement. The consumer must no longer need an inpatient level of care and be determined to be clinically ready for discharge from a state psychiatric hospital.

12.14.2. Consumers are determined to be eligible for services under ECS by the statewide ECS screening committee or by special approval of the

MHD. Additional consumers may be identified during this contract period to participate in ECS if there is capacity.

12.14.3. Prior to placement of a new ECS consumer the Contractor must convene and participate in a team of community professionals who will become familiar with the consumer and treatment plan. This includes:

12.14.3.1. Assessment of the consumer's strengths, preferences and needs;

12.14.3.2. Arrangement of a safe, clinically-appropriate, and stable residence, and

12.14.3.3. Assessment and planning for other needed medical, behavioral, and social services.

12.14.3.4. Prior to placement into the community a complete written comprehensive transition plan must be developed. The process to develop the plan must include the participation of the consumer and focus on the consumer's strengths and needs.

12.14.3.5. RSNs shall utilize the ECS transition guidelines developed by the ECS Implementation Committee or other comparable local tools to assure transition needs of ECS consumers will be met.

12.14.3.6. The Contractor must provide for face-to-face visits to the identified ECS consumer during the last months of hospitalization. The purpose of the visits at to assess the consumers mental health needs and any other service needs.

12.14.4. The Contractor shall provide a minimum of **4545** ECS days of service during this agreement period. ECS days of service include any day an ECS resident is living outside of a state hospital and being supported by the RSN in community residential or other supported living settings. ECS days of service do not include days in which a patient is residing in a state hospital, in jail or in a Department of Corrections facility.

13. COMMUNITY COORDINATION

13.1. Tribal Relationships

13.1.1. The Contractor must develop a plan in collaboration with each Tribal Authority in the Contractor's service area. The plan must be submitted to MHD within 90 days of the execution of this contract for review and approval. The Contractor shall provide documentation if the Tribal Authority declines to participate in the collaboration plan. The Contractor shall use the RSN/ Tribal Collaboration Planning Checklist attached as Exhibit B and the plan must contain:

13.1.1.1. Identification of Tribal Authority and relevant provider contacts for each Tribal Authority in the Contractor's service area;

13.1.1.2. A description of completed and planned collaboration activities with each Tribal Authority in the Contractors service area;

13.1.1.3. A list of any culturally sensitive issues or culturally specific needs identified during collaboration planning;

13.1.1.4. A description of any completed or planned Tribal collaboration training to be provided to the RSN Administration and staff by the Contractor; and

13.1.1.5. Any performance measures which will be used to measure and evaluate the implementation and effectiveness of the RSN/ Tribal Collaboration plan.

13.1.2. The Contractor shall develop a written coordination plan with any Tribal health clinic within the boundaries of the contractor's service area. The coordination plan must address the following:

13.1.2.1. The reduction of duplicative screening and evaluation processes and ongoing coordination of care.

13.1.2.2. Identification and process for the provision of culturally appropriate, sensitive, and relevant medically necessary mental health services for eligible Tribal MH clients needing services through the RSN.

13.1.2.3. Coordination of care with Tribes that have members in multiple RSN service areas.

13.2. **Disaster Response**

13.2.1. The Contractor must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by MHD. The Contractor shall:

13.2.1.1. Attend MHD-sponsored training regarding the role of the public mental health system in disaster preparedness and response;

13.2.1.2. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration;

13.2.1.3. Provide Disaster Outreach in Contractor's service area in the event of a disaster/emergency; "Disaster Outreach" means contacting person's in their place of residence or in non-traditional settings for the purpose of

assessing their mental health and social functioning following a disaster or increasing the utilization of human services and resources.

13.2.1.4. There are two basic approaches to outreach: mobile (going to person to person) and community settings (e.g., temporary shelters, disaster assistance sites, disaster information forums). The Outreach Process must include the following:

13.2.1.4.1. Locating persons in need of disaster relief services;

13.2.1.4.2. Assessing their needs;

13.2.1.4.3. Engaging or linking persons to an appropriate level of support or disaster relief services; and,

13.2.1.4.4. Providing follow-up mental health services when clinically indicated.

13.2.1.5. Disaster Outreach can be performed by trained volunteers, peers and/or persons hired under a federal Crisis Counseling Grant. These persons should be trained in disaster crisis outreach, which is different than traditional mental health crisis intervention.

13.2.1.6. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs;

13.2.1.7. Provide the name and contact information to MHD for person(s) coordinating the RSN disaster/emergency preparedness and response upon request;

13.2.1.8. Provide information and preliminary disaster response plans to MHD within 7 days following a disaster/emergency or upon request; and

13.2.1.9. Partner in disaster preparedness and response activities with MHD and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations. This must include:

13.2.1.9.1. Participation when requested in local and regional disaster planning and preparedness activities; and

13.2.1.9.2. Coordination of disaster outreach activities following an event.

13.3. **Jail Coordination Services**

13.3.1. The Contractor shall coordinate with local law enforcement and jail personnel including the maintenance or development and execution of Memorandum of Understandings with local county and city jails in the Contractors' service area which detail a referral process for persons who are incarcerated who have been diagnosed with a mental illness or identified as in need of mental health services.

13.3.2. The Contractor shall identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.

13.3.3. The Contractor shall accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24. The Contractor shall conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.

13.3.4. The Contractor shall develop and execute a Memorandum of Understanding with local community service offices (CSO) for expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs. The Contractor shall assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.

13.3.5. After providing the services in 13.3 the Contractor may use the Jail Coordination Services funds provided to facilitate any of the following activities if there are sufficient resources:

13.3.5.1. Daily cross-reference between new bookings and the RSN data base to identify newly booked, persons known to the RSN;

13.3.5.2. Development of individual alternative service plans (alternative to the jail) for submission to the courts.

13.3.5.3. Pre-release transition planning (e.g., assessments, mental health services, co-occurring services, and housing);

13.3.5.4. Intensive post-release outreach to ensure there is follow up with the CSO and appointments for mental health and other services (e.g., substance abuse);

13.3.5.5. Inter-local agreements with juvenile detentions facilities;

13.3.5.6. Provision of up to a seven-day supply of medications prescribed for the treatment of mental heath symptoms following the release from jail.

13.3.5.7. Training to local law enforcement and jail services personnel; and

13.3.5.8. Provision of direct mental health services to individuals who are in jails that have no mental health staff.

13.4. **Allen and Marr Class Members-** For Allen and Marr Class members as defined who are in the contracted service area the contractor shall:

13.4.1. Participate in quarterly monitoring review process in conjunction with the DSHS self-monitoring team for Allen and Marr class members.

13.4.2. Based on the results of a review, a subcontractor may need to develop and implement a corrective action plan to address deficiencies. When necessary, the Contractor shall notify the subcontractor immediately and ensure that the subcontractor develops a corrective action plan and delivers it to the Contractor within 45 days of notification by the Contractor. The Contractor shall submit the subcontractor's corrective action plan to the MHD within five days of receipt. MHD then has 10 days to approve or reject the subcontractor's corrective action plan.

13.4.3. Provide a report of all Allen and Marr Class Members who are identified on the MHD intranet that are receiving services in the contracted service area. The report must include a list of all class members served during the quarter indicating if they were opened, closed, or continued during the reporting period.

The report periods are October to March and April to September. In the event that the Agreement term does not encompass a full report period the Contractor shall provide a report for the partial period. Reports are due 45 days following the end of a report period.

13.4.4. Collaborate with the Regional Office of the Division of Developmental (DDD) Disabilities to conduct comprehensive reviews of Allen and Marr Class Members that uses the following process:

13.4.4.1. DSHS Form 10-349 is used for completing these reviews. The Contractor shall attend trainings provided for implementation of this review process.

13.4.4.2. A RSN sample size is determined by the DDD regional office that results in reviews of not less than 10% of class members in the total DDD region annually.

13.4.4.3. Subcontractors are provided with written report findings and corrective action using DSHS form 10-349 within 10 days of the review.

13.4.4.4. The subcontractor must respond to the corrective action request within 45 days of receipt of DSHS form 10-349.

13.4.4.5. The Contractor shall submit to the MHD findings and recommendations including the subcontractor's corrective action plan within 10 days of receipt of the subcontractor's response.

13.4.5. The Contractor may not delegate these monitoring activities to a subcontracted CMHA within the contractor's service area, or any other entity perceived as having a conflict of interest.

14. **REMEDIAL ACTIONS**:

14.1. MHD may initiate remedial action if it is determined that any of the following situations exist:

14.1.1. A problem exists that negatively impacts consumers receiving services.

14.1.2. The Contractor has failed to perform any of the mental health services required in this Agreement.

14.1.3. The Contractor has failed to develop, produce, and/or deliver to MHD any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Agreement.

14.1.4. The Contractor has failed to perform any administrative function required under this Agreement. For the purposes of this section, "administrative function" is defined as any obligation other than the actual provision of mental health services.

14.1.5. The Contractor has failed to implement corrective action required by the State and within MHD prescribed timeframes.

14.2. MHD may impose any of the following remedial actions:

14.2.1. Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to MHD within 30 calendar days of notification. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Agreement. MHD may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

14.2.1.1. Corrective action plans must include:

14.2.1.1.1. A brief description of the situation requiring corrective action;

14.2.1.1.2. The specific actions to be taken to remedy the situation;

14.2.1.1.3. A timetable for completion of the actions; and

14.2.1.1.4. Identification of individuals responsible for implementation of the plan;

14.2.1.2. Corrective action plans are subject to approval by MHD. MHD may:

14.2.1.2.1. Accept the plan as submitted;

14.2.1.2.2. Accept the plan with specified modifications;

14.2.1.2.3. Request a modified plan; or

14.2.1.2.4. Reject the plan.

14.2.2. Withhold up to five percent of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. MHD, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

14.2.3. Increase withholdings identified above by up to an additional three percent for each successive month during which the remedial situation has not been resolved.

14.2.4. Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which MHD provides incentives.

14.2.5. Terminate for Default as described in the General Terms and Conditions; this may include releasing a Request for Proposals to re-procure the services provided under this agreement.

15. GENERAL TERMS AND CONDITIONS

15.1. **Definitions.** The words and phrases listed below, as used in the Agreement, shall each have the following definitions:

15.1.1.1. "Agreement" means this document, the General Terms and Conditions, and the Special Terms and Conditions, including any Exhibits and other documents attached or incorporated by reference.

15.1.1.2. "Central Contract Services" means the DSHS statewide agency headquarters contracting office, or successor section or office.

15.1.1.3. "CFR" means Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation. The CFR may be accessed at http://www.gpoaccess.gov/cfr/index.html.

15.1.1.4. "Contracts Administrator" means the manager, or successor, of Central Contract Services or successor section or office.

15.1.1.5. "Contractor" means the regional support network (RSN) designated by the county authority, group of county authorities or nonprofit entity recognized by the secretary, and has authority to establish and operate a community mental health program.

15.1.1.6. "Debarment" means an action taken by a federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

15.1.1.7. "DSHS" or "the department" or "the Department" means the Department of Social and Health Services of the State of Washington and its Secretary, officers, employees, and authorized agents.

15.1.1.8. "DSHS Representative" means any DSHS employee who has been delegated contract-signing authority by the DSHS Secretary or his/her designee.

15.1.1.9. "General Terms and Conditions" means the contractual provisions contained within this Agreement, which govern the contractual relationship between DSHS and the Contractor, under this Agreement.

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

15.1.1.11. "RCW" means the Revised Code of Washington. All references in this Agreement to RCW chapters or sections shall include any successor, amended, or replacement statute. The RCW can be accessed at http://slc.leg.wa.gov.

15.1.1.12. "Secretary" means the individual appointed by the Governor, State of Washington, as the head of DSHS, or his/her designee.

15.1.1.13. "Subcontract" means a separate contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor shall perform pursuant to this Agreement.

15.1.1.14. "USCA" means United States Code Annotated. All references to USCA chapters or sections in this Agreement shall include any successor, amended, or replacement statute. The USCA may be accessed at http://www.gpoaccess.gov/uscode/.

15.1.1.15. "WAC" means the Washington Administrative Code. All references in this Agreement to WAC chapters or sections shall include any successor, amended, or replacement regulation. The WAC can be accessed at http://slc.leg.wa.gov.

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

15.3. **Assignment.** Except as otherwise provided herein, the Contractor shall not assign rights or obligations derived from this Agreement to a third party without the prior, written consent of the DSHS Contracts Administrator and the written assumption of the Contractor's obligations by the third party.

15.4. **Billing Limitations.** Unless otherwise specified in this Agreement, DSHS shall not pay any claims for services submitted more than twelve (12) months after the calendar month in which the services were performed.

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

15.6. **Confidentiality.** The parties shall use Personal Information and other confidential information gained by reason of this Agreement only for the purpose of this Agreement. DSHS and the Contractor shall not disclose, transfer, or sell any such information to any other party, except as provided by law or, in the case of Personal Information except as provided by law or with the prior written consent of the person to whom the Personal Information pertains. The parties shall maintain the confidentiality of all Personal Information and other confidential information gained by reason of this Agreement and shall return or certify the destruction of such information if requested in writing by the party to this Agreement that provided the information.

15.7. **Contractor Certification Regarding Ethics.** By signing this Agreement, the Contractor certifies that the Contractor is in compliance with Chapter 42.23 RCW and shall comply with Chapter 42.23 RCW throughout the term of this Agreement.

15.8. **Debarment Certification.** The Contractor, by signature to this Agreement, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal department or agency. The Contractor also agrees to include the above requirement in all subcontracts into which it enters.

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

15.10. **Governing Law and Venue.** The laws of the State of Washington govern this Agreement. In the event of a lawsuit by the Contractor against DSHS involving this Agreement, venue shall be proper only in Thurston County, Washington. In the event of a lawsuit by DSHS against the Contractor involving this Agreement, venue shall be proper only as provided in RCW 36.01.050.

15.11. **Independent Status.** For purposes of this Agreement, the Contractor acknowledges that the Contractor is not an officer, employee, or agent of DSHS or

the State of Washington. The Contractor shall not hold out itself or any of its employees as, nor claim status as, an officer, employee, or agent of DSHS or the State of Washington. The Contractor shall not claim for itself or its employees any rights, privileges, or benefits, which would accrue to an employee of the State of Washington. The Contractor shall indemnify and hold harmless DSHS from all obligations to pay or withhold federal or state taxes or contributions on behalf of the Contractor or the Contractor's employees.

15.12. **Inspection.** Either party may request reasonable access to the other party's records and place of business for the limited purpose of monitoring, auditing, and evaluating the other party's compliance with this Agreement, and applicable laws and regulations. During the term of this Agreement and for one (1) year following termination or expiration of this Agreement, the parties shall, upon receiving reasonable written notice, provide the other party with access to its place of business and to its records which are relevant to its compliance with this Agreement, and applicable laws and regulations. This provision shall not be construed to give either party access to the other party's records and place of business for any other purpose. Nothing herein shall be construed to authorize either party to possess or copy records of the other party.

15.13. **Insurance.** DSHS certifies that it is self-insured under the State's self-insurance liability program, as provided by RCW 4.92.130, and shall pay for losses for which it is found liable. The Contractor certifies that it is self-insured, is a member of a risk pool, or maintains insurance coverage as required in this Agreement. The Contractor shall pay for losses for which it is found liable.

15.14. **Lawsuits.** Nothing in this Agreement shall be construed to mean that the Contractor, a County, RSN, or their subcontractors, agents or employees, can bring a legal claim for declaratory relief, injunctive relief, judicial review under RCW 34.05, or civil liability against the state or state agencies for actions or inactions performed pursuant to the administration of RCW 71.05 or RCW 71.24 with regard to the following: (a) allocation or payment of federal or state funds; (b) the use or allocation of state hospital beds; or (c) financial responsibility for the provision of long term or short term inpatient mental health care.

15.15. **Maintenance of Records.** During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, both parties shall maintain records sufficient to:

15.15.1. Document performance of all acts required by law, regulation, or this Agreement;

15.15.2. Demonstrate accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Agreement.

15.15.3. For the same period, the Contractor shall maintain records sufficient to substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance.

15.16. **Order of Precedence.** In the event of an inconsistency in this Agreement, unless otherwise provided herein, the inconsistency shall be resolved by giving precedence, in the following order, to:

15.16.1. Applicable federal and State of Washington statutes and regulations;

15.16.2. The General Terms & Conditions of this Agreement;

15.16.3. The Special Terms & Conditions of this Agreement:

15.16.4. Any Exhibits attached or incorporated into this Agreement by reference.

15.17. **Ownership of Material**. Material created by the Contractor and paid for by DSHS as a part of this Agreement shall be owned by DSHS and shall be "work made for hire" as defined by Title 17 USCA, Section 101. This material includes, but is not limited to: books; computer programs; documents; films; pamphlets; reports; sound reproductions; studies; surveys; tapes; and/or training materials. Material which the Contractor uses to perform this Agreement but is not created for or paid for by DSHS is owned by the Contractor and is not "work made for hire"; however, DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.

15.18. **Responsibility.** Each party to this Agreement shall be responsible for the negligence of its officers, employees, and agents in the performance of this Agreement. No party to this Agreement shall be responsible for the acts and/or omissions of entities or individuals not party to this Agreement. DSHS and the Contractor shall cooperate in the defense of tort lawsuits, when possible. Both parties agree and understand that this provision may not be feasible in all circumstances. DSHS and the Contractor agree to notify the attorneys of record in any tort lawsuit where both are parties if either DSHS or the Contractor enters into settlement negotiations. It is understood that the notice shall occur prior to any negotiations, or as soon as possible, and the notice may be either written or oral.

15.19. **Severability.** The provisions of this Agreement are severable. If any court holds any provision of this Agreement, including any provision of any document incorporated by reference, invalid, that invalidity shall not affect the other provisions this Agreement.

15.20. **Subcontracting.** The Contractor may subcontract services to be provided under this Agreement. If DSHS, the Contractor, and a subcontractor of the Contractor are found by a jury or trier of fact to be jointly and severally liable for personal injury damages rising from any act or omission from the contract, then DSHS shall be responsible for its proportionate share, and the Contractor shall be responsible for its proportionate share. Should the subcontractor be unable to satisfy its joint and

several liability, DSHS and the Contractor shall share in the subcontractor's unsatisfied proportionate share in direct proportion to the respective percentage of their fault as found by the jury or trier of fact. Nothing in this term shall be construed as creating a right or remedy of any kind or nature in any person or party other than DSHS and the Contractor. This term shall not apply in the event of a settlement by either DSHS or the Contractor.

15.21. **Subrecipients.**

15.21.1. **General.** If the Contractor is a subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Agreement, the Contractor shall:

15.21.1.1. 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;

15.21.1.2. 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;

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

15.21.1.4. Incorporate OMB Circular A-133 audit requirements into all agreements between the Contractor and its Subcontractors who are subrecipients;

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

15.21.1.6. 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

15.21.1.7. 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 Part 39. (See www.ojp.usdoj/gov/ocr for additional information and access to the aforementioned Federal laws and regulations.)

15.21.2. **Single Audit Act Compliance.** If the Contractor is a subrecipient and expends $500,000 or more in federal awards from 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:

15.21.2.1. Submit to the DSHS contact person, listed on the first page of this Agreement, 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;

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

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

15.23. **Survivability.** The terms and conditions contained in this Agreement, which by their sense and context, are intended to survive the expiration of the particular agreement shall survive. Surviving terms include, but are not limited to: Confidentiality, Disputes, Inspection, Lawsuits, Maintenance of Records, Ownership of Material, Responsibility, Termination for Default, Termination Procedure, and Title to Property.

15.24. **Termination Due to Change in Funding.** If the funds upon which DSHS relied to establish this Agreement are withdrawn, reduced, or limited, or if additional or modified conditions are placed on such funding, DSHS may terminate this Agreement by providing at least five (5) business days' written notice to the Contractor. The termination shall be effective on the date specified in the notice of termination.

15.25. **Termination for Convenience.** DSHS may terminate this Agreement in whole or in part for convenience by giving the Contractor at least thirty (30) calendar days' written notice. The Contractor may terminate this Agreement for convenience by giving DSHS at least thirty (30) calendar days' written notice addressed to the DSHS contact person (or to his or her successor) listed on the first page of this Agreement.

15.26. **Termination for Default.**

15.26.1. The Contracts Administrator may terminate this Agreement for default, in whole or in part, by written notice to the Contractor, if DSHS has a reasonable basis to believe that the Contractor has:

15.26.1.1. Failed to meet or maintain any requirement for contracting with DSHS;

15.26.1.2. Failed to perform under any provision of this Agreement;

15.26.1.3. Violated any law, regulation, rule, or ordinance applicable to this Agreement; and/or

15.26.1.4. Otherwise breached any provision or condition of this Agreement.

15.26.2. Before the Contracts Administrator may terminate this Agreement for default, DSHS shall provide the Contractor with written notice of the Contractor's noncompliance with the agreement and provide the Contractor a reasonable opportunity to correct the Contractor's noncompliance. If the Contractor does not correct the Contractor's noncompliance within the period of time specified in the written notice of noncompliance, the Contracts Administrator may then terminate the agreement. The Contracts Administrator may terminate the agreement for default without such written notice and without opportunity for correction if DSHS has a reasonable basis to believe that a client's health or safety is in jeopardy.

15.26.3. The Contractor may terminate this Agreement for default, in whole or in part, by written notice to DSHS, if the Contractor has a reasonable basis to believe that DSHS has:

15.26.3.1. Failed to meet or maintain any requirement for contracting with the Contractor;

15.26.3.2. Failed to perform under any provision of this Agreement;

15.26.3.3. Violated any law, regulation, rule, or ordinance applicable to this Agreement; and/or

15.26.3.4. Otherwise breached any provision or condition of this Agreement.

15.26.4. Before the Contractor may terminate this Agreement for default, the Contractor shall provide DSHS with written notice of DSHS' noncompliance with the Agreement and provide DSHS a reasonable opportunity to correct DSHS' noncompliance. If DSHS does not correct DSHS' noncompliance within the period of time specified in the written notice of noncompliance, the Contractor may then terminate the Agreement.

15.27. **Termination Procedure.** The following provisions apply in the event this Agreement is terminated:

15.27.1. The Contractor shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of clients, distribution of property, and termination of services.

15.27.2. The Contractor shall promptly deliver to the DSHS contact person (or to his or her successor) listed on the first page of this Agreement, all DSHS assets (property) in the Contractor's possession, including any material created under this Agreement. Upon failure to return DSHS property within ten (10)

working days of this Agreement termination, the Contractor shall be charged with all reasonable costs of recovery, including transportation. The Contractor shall take reasonable steps protect and preserve any property of DSHS that is in the possession of the Contractor pending return to DSHS.

15.27.3. DSHS shall be liable for and shall pay for only those services authorized and provided through the effective date of termination. DSHS may pay an amount mutually agreed by the parties for partially completed work and services, if work products are useful to or usable by DSHS.

15.27.4. If the Contracts Administrator terminates this Agreement for default, DSHS may withhold a sum from the final payment to the Contractor that DSHS determines is necessary to protect DSHS against loss or additional liability. DSHS shall be entitled to all remedies available at law, in equity, or under this Agreement due to Contractors default. If it is later determined that the Contractor was not in default, or if the Contractor terminated this Agreement for default, the Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement except as to the limitations set forth in Section 15.14 entitled “Lawsuits”.

15.28. **Treatment of Client Property.** Unless otherwise provided in this Agreement, the Contractor shall ensure that any adult client receiving services from the Contractor under this Agreement has unrestricted access to the client’s personal property. The Contractor shall not interfere with any adult client’s ownership, possession, or use of the client’s property. The Contractor shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client’s age, development, and needs. Upon termination or completion of this Agreement, the Contractor shall promptly release to the client and/or the client’s guardian or custodian all of the client’s personal property. This section does not prohibit the Contractor from implementing such lawful and reasonable policies, procedures and practices as the Contractor deems necessary for safe, appropriate, and effective service delivery (for example, appropriately restricting clients’ access to, or possession or use of, lawful or unlawful weapons and drugs).

15.29. **Title to Property.** Title to all property purchased or furnished by DSHS for use by the Contractor during the term of this Agreement shall remain with DSHS. Title to all property purchased or furnished by the Contractor for which the Contractor is entitled to reimbursement by DSHS under this Agreement shall pass to and vest in DSHS. The Contractor shall take reasonable steps to protect and maintain all DSHS property in its possession against loss or damage and shall return DSHS property to DSHS upon Agreement termination or expiration, reasonable wear and tear excepted.

15.30. **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 Agreement unless amended as set forth in Section 15.2, Amendment. Only the Contracts Administrator or designee has the authority to waive any term or condition of this Agreement on behalf of DSHS.

16. SPECIAL TERMS AND CONDITIONS

16.1. **Advisory Board**: The Contractor shall maintain an advisory board that is broadly representative of the demographic character of the region, which shall include, but not be limited to, representatives of consumers and families, and law enforcement. Composition and length of terms of board members may differ between regional support networks. Membership shall be comprised of at least 51% consumers or consumer family members as defined in WAC 388-865-0222. Composition of the advisory board and the length of terms must be submitted to MHD by within 90 days of the execution of the agreement for approval.

16.2. **Compliance with Applicable Law**. At all times during the term of this Agreement, the Contractor shall comply with all applicable federal, State, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations, and the following, whether or not a specific citation is identified in various sections of this Agreement:

16.2.1. All applicable Office of Insurance Commissioner's (OIC) statutes and regulations;

16.2.2. All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement;

16.2.3. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC §1857(h)), Section 508 of the Clean Water Act (33 USC §1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, Department of Health and Human Service (DHHS), and the EPA;

16.2.4. Any applicable mandatory standards and policies relating to energy efficiency which are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act;

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

16.2.6. Those specified in Title 18 RCW for professional licensing;

16.2.7. Reporting of abuse as required by RCW 26.44.030;

16.2.8. Industrial insurance coverage as required by Title 51 RCW; and

16.2.9. Any other requirements associated with the receipt of federal funds.

16.2.10. Any provision of this Agreement which conflicts with State and federal statutes, or regulations, or Centers for Medicare and Medicaid Services

(CMS) policy guidance is hereby amended to conform to the provisions of State and federal law and regulations.

16.3. **Confidentiality of Personal Information**

16.3.1. The Contractor shall protect all Personal Information, records, and data from unauthorized disclosure in accordance with 42 CFR §431.300 through §431.307, RCWs 70.02, 71.05, 71.34, and for individuals receiving substance abuse services, in accordance with 42 CFR Part 2 and RCW 70.96A. The Contractor shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services. Pursuant to 42 CFR §431.301 and §431.302, personal information concerning applicants and recipients may be disclosed for purposes directly connected with the administration of this Agreement. Such purposes include, but are not limited to:

16.3.1.1. Establishing eligibility;

16.3.1.2. Determining the amount of medical assistance;

16.3.1.3. Providing services for recipients;

16.3.1.4. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan;

16.3.1.5. Assuring compliance with federal and State laws and regulations, and with terms and requirements of the Agreement; and

16.3.1.6. Improving quality.

16.3.2. The Contractor shall comply with all confidentiality requirements of the Health Insurance Portability and Accountability Act (42 CFR §§ 160 -164).

16.4. **Disputes.** When a dispute arises over an issue concerning the terms of this Agreement, the parties agree to the following process to address the dispute.

16.4.1. The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and DSHS Contact listed on page one (1) of this Agreement.

16.4.2. If the Contractor is not satisfied with the outcome, the Contractor may submit the disputed issue, in writing to Mental Health Division at, Mental Health Division, P.O. Box 45320, Olympia, WA 98504-5320, to be reviewed by the appropriate Office Chief (Chief). The written submission must contain the following information:

16.4.2.1. The Contractor’s Contact for the issue.

16.4.2.2. The Issue in dispute.

16.4.2.3. The Contractor's position on the issue.

16.4.3. The Chief may request additional information from the DSHS Contact and/or the Contractor. The Chief shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor.

16.4.4. If the Contractor disagrees with the written review decision of the Chief, the Contractor may request the Division Director to review all information supplied by both parties up to that point. The Division Director may request any additional information necessary to make the final decision for the Mental Health Division. Timelines for production of any such additional information will be clearly marked within the request. The Division Director shall issue a final written decision to the Contractor within thirty (30) calendar days of receipt of all requested information.

16.4.5. Both parties agree to make their best efforts to resolve disputes arising from this Agreement and agree that this dispute resolution process is the sole administrative remedy available under this Agreement.

16.5. **Duplicative Reports and Deliverables.** If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties the Contractor may provide one report or deliverable that contains the information required by both Agreements.

16.6. **Fraud and Abuse.** Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person and includes any act that constitutes fraud under applicable Federal or State law. Abuse means provider actions that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. The Contractor shall do the following to guard against Fraud and Abuse:

16.6.1. Create and maintain a mandatory compliance plan that includes provisions to educate staff and providers of the false claim act and whistle blower protections;

16.6.2. Develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards;

16.6.3. Designate a compliance officer and a compliance committee that is accountable to senior management;

16.6.4. Provide effective ongoing training and education for the compliance officer, staff of the PIHP, and selected staff of the CMHAs;

16.6.5. Facilitate effective communication between the compliance officer, the PIHP employees, and the Contractor's network of CMHAs;

16.6.6. Enforce standards through well-publicized disciplinary guidelines;

16.6.7. Conduct internal monitoring and auditing;

16.6.8. Respond promptly to detected offenses and develop corrective action initiatives; and

16.6.9. Report fraud and/or abuse information to MHD as soon as it is discovered including the source of the complaint, the involved CMHA, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

16.7. **Information Requests.** The Contractor shall maintain information necessary to promptly respond to written requests by the MHD Director, an Office Chief or their designee. The Contractor shall submit information detailing the amount spent throughout its service area on specific items upon request by MHD Director, an Office Chief or their designee.

16.8. **Commercial General Liability Insurance (CGL).** If the Contractor is not a member of a risk pool, the Contractor shall carry CGL to include coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. The State of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds.

16.9. **Records Retention.** During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records is started before expiration of the six year period, the records shall be retained until completion and resolution of all issues arising there from or until the end of the six year period, whichever is later.

16.9.1. The Contractor shall maintain records sufficient to:

16.9.1.1. Maintain the content of all medical records in a manner consistent with utilization control requirements of 42 CFR §456, 42 CFR §434.34 (a), 42 CFR §456.111, and 42 CFR §456.211;

16.9.1.2. Document performance of all acts required by law, regulation, or this Agreement;

16.9.1.3. Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance; and

16.9.1.4. Demonstrate the accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Agreement.

16.9.2. The Contractor and its subcontractors shall cooperate in all reviews, including but not limited to, surveys, and research conducted by DSHS or other Washington State Departments.

16.9.3. Evaluations under this Agreement shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services, and to determine whether the Contractor and its subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable State and federal regulations as existing or hereafter amended.

16.9.4. DSHS shall maintain books, records, documents, and other materials relevant to this Agreement which sufficiently and properly reflect all payments made, including the Department's rate setting activities related to the Contractor, or other actions taken in regard to the Contractor's performance of the services described herein.

PROFESSIONAL SERVICES AGREEMENT
NORTH SOUND MENTAL HEALTH ADMINISTRATION
AND
CATHOLIC COMMUNITY SERVICES
CONTRACT # - PSC-06

THIS AGREEMENT is entered into between NORTH SOUND MENTAL HEALTH ADMINISTRATION, 117 N. 1st Street, Suite 8, Mount Vernon, Washington 98273 ("NSMHA"), and Catholic Community Services, Chemical Dependency Services, with a principal place of business at 918 Everett Ave., Everett, WA 98201.

THE PARTIES MUTUALLY AGREE AS FOLLOWS:

I. Terms and Conditions

A. Term. This Agreement shall take effect August 16, 2006 and shall continue in full force and effect through December 31, 2006...

B. Termination. This Agreement may be terminated in whole or in part by either party for any reason by giving thirty- (30) calendar days written notice to the other party.

1. Loss of Funding. In the event funding from any source is withdrawn, reduced or limited in any way after the effective date of this Agreement and prior to termination, NSMHA may terminate this Agreement by written notice effective upon Contractor's receipt of written notice. The parties may re-negotiate under new funding limitations and conditions.
2. Breach. This Agreement may be terminated for any breach by either party. The terminating party shall give the breaching party five-calendar days written notice to cure the breach. Failure to cure shall cause this agreement to terminate immediately at the end of the five- (5) day period.

C. Amendments. This Agreement may only be amended by written consent of both parties.

D. Compliance with Laws. Contractor shall comply with all applicable federal, state and local laws, rules and regulations in performing this Agreement, including, but not limited to, laws against discrimination and conflict of interest laws.

E. Relationship of Parties. Contractor agrees that Contractor shall perform the services under this Agreement as an independent contractor and not as an agent, employee or servant of NSMHA. The parties agree that Contractor is not entitled to any benefits or rights enjoyed by employees of NSMHA. Contractor specifically has the right to direct and control Contractor's own activities in providing the agreed upon services in accordance with the specifications set forth herein. NSMHA shall only have the right to ensure performance.

F. Indemnification. Contractor shall defend, hold harmless and indemnify NSMHA and its member counties and employees against any and all claims, liabilities, damages or judgements asserted against, imposed upon, or incurred by NSMHA and its member counties and employees alleged to arise out of the acts or omissions of CONTRACTOR or CONTRACTOR's officers and employees, agents or volunteers.

NSMHA shall release CONTRACTOR from all claims, liabilities, damages or judgements asserted against, imposed upon, or incurred by CONTRACTOR to the extent based on the acts or omissions of the NSMHA or the NSMHA employees.

G. Resolution of Disputes

1. The parties wish to provide for prompt, efficient, final and binding resolution of disputes or controversies, which may arise under this Agreement and therefore establish this dispute resolution procedure.
2. All claims, disputes and other matters in question between the parties arising out of, or relating to, this Agreement shall be resolved exclusively by the following dispute resolution procedure unless the parties mutually agree in writing otherwise:

    a) The parties shall use their best efforts to resolve issues prior to giving written Notice of Dispute.
    b) Within ten (10) working days of receipt of the written Notice of Dispute, the parties (or their designated representatives) shall meet, confer, and attempt to resolve the claim within the next five (5) working days.
    c) The terms of the resolution of all claims concluded in meetings shall be memorialized in writing and signed by each party.
    d) Arbitration. If the claim is not resolved, the parties shall proceed to arbitration as follows:

        1) The parties shall each select one (1) person as arbitrator. Those two (2) arbitrators shall agree on the selection of a third (3rd) arbitrator.
        2) The dispute shall be promptly resolved on the basis approved by any two (2) of the three (3) arbitrators.
        3) If there is a delay of more than ten (10) days in the naming of any arbitrator, either party can ask the presiding judge of Skagit County to name any remaining arbitrator(s).
        4) The prevailing party shall be entitled to recover from the other party all costs and expenses, including reasonable attorney fees. The arbitrators shall determine which party, if any, is the prevailing party.
        5) The parties agree that in the absence of fraud by one of the parties, the arbitrators' decision shall be binding, final and not appealable to any court of law.
        6) Unless the parties agree in writing otherwise, each unresolved claim shall be considered at an arbitration session which shall occur in Skagit County no later than thirty (30) days after the close of the meeting descried in paragraph (b) above.

3. The provisions of this section shall, with respect to any controversy or claim, survive the termination or expiration of this Agreement.
4. Nothing contained in this Agreement shall be deemed to give the arbitrators the power to change any of the terms and conditions of this Agreement in any way.
5. Any required advance expenses ordered by the arbitrator and connected with the arbitration proceedings will be paid equally by the parties subject to the later arbitrator's decision which may change the percentage of advance expenses to be paid by either party.

6. If the underlying contract is for employment, any termination clause takes precedence over any other clause in the contract including the dispute resolution clause.

H. Records and Reports. Contractor shall maintain books, records, documents and other evidence, which sufficiently and properly reflect all direct and indirect costs expended in the performance of the services described herein. Contractor shall retain all books; records, documents and other material relevant to this Agreement for five years after its expiration and all payment for the contract have been made. The later of the two dates initiates the five-year time frame. All books, records, documents, reports and other data related to this contract shall be subject to inspection, review and/or audit by NSMHA personnel or other parties authorized by NSMHA, DSHS, the Office of the State Auditor, and authorized federal officials during regular business hours and upon demand.

II. Compensation

A. Consideration. Contractor shall be paid only if NSMHA has a fully executed contract on file. NSMHA shall pay to Contractor no more than $23,884.50 for Professional Services through December 31, 2006 and no more than $7,961.50 for Professional Services through September 1, 2006, for a total maximum consideration of $23,884.50.

B. Payment Procedures. Contractor shall submit an invoice by the tenth (10th) of the month after the month in which services were provided. Invoice shall document actual number of individuals placed after receiving treatment at the Secure Detox Facility listed in Exhibit A and as by the NSMHA. Failure to submit an invoice by the tenth (10th) may delay payment for one (1) month.

No invoices will be accepted 30 days after the service. Contractor shall submit a final billing for this Agreement no later than 30 days after the contract expiration date.

Invoices for services completed but contractually authorized in a retroactive manner must be submitted within fifteen (15) days after the execution of the appropriate contract.

Until notified otherwise, Contractor shall submit all requests for reimbursement to:

North Sound Mental Health Administration
Attn.: Fiscal Officer
117 North 1st Street, Suite 8
Mount Vernon, WA 98273-3806

III. Service Expectations

Contractor shall provide services as set forth in Exhibit A, attached.

IV. Miscellaneous

A. Assignments. Neither party may assign its rights or delegate its performance hereunder to any person or entity without the prior written consent of the other party.

B. Entire Agreement. This Agreement constitutes the entire agreement with respect to the subject matter hereof and there are no other agreements, written or oral, relating to the subject matter hereof.

C. Headings. Paragraphs headings are for convenience and reference only and shall have no effect upon the construction or interpretation of any party of this Agreement.

D. Severability. If any provision of this Agreement is found by a court to be invalid, unenforceable or contrary to applicable law, the remainder of this Agreement or the application of such provision to persons or circumstances other than those to which it is held invalid, unenforceable or contrary to applicable law, shall not be affected and shall continue in full force and effect.

E. Notices. All notices pertaining to this agreement shall be written and delivered, by certified U.S. mail or by hand delivery to the addresses shown below. Notices shall be deemed served upon receipt, or three days after postmark if mailed. Notices transmitted by facsimile, which are followed immediately by mailing, shall be deemed received on the date of the facsimile transmission.

F. Venue. This Agreement shall be construed, both as to validity and performance, and enforced, subject to Paragraph I.H, in accordance with the laws of the State of Washington. The venue of any action brought hereunder shall be Skagit County.

G. Power to Execute. Both parties warrant they have the power and authorization to execute this Agreement and any other documents executed pursuant to this Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement on the dates set forth below.

FOR NSMHA

Charles R. Benjamin, Executive Director Date

FOR CONTRACTOR:

Thomas L. MacIntyre, Executive Director Date
1918 Everett Avenue
Everett, WA 98201

Tax ID#:

EXHIBIT A

CHEMICAL DEPENDENCY CASE MANAGMENT SERVICES

SCOPE OF WORK

SCOPE OF SERVICES
Contractor shall complete the following Chemical Dependency Case Management Services:

1. Require that chemical dependency case managers are trained in, and use, the integrated comprehensive screening and assessment process when it becomes available from the Department of Social and Health Services.

2. Provide chemical dependency case management services within available resources for persons discharged from the North Cascade Secure Detoxification Facility who:
    a. Need ongoing chemical dependency treatment and support services and have a primary diagnosis of :
        i. Chemical dependency or
        ii. Chemical dependency and mental illness and
        iii. Have a history of high utilization of crisis services and/or detoxification services

3. Require that the chemical dependency case managers:

    a. Are supervised by and have workspace provided by an agency other than the agency responsible for the operation of the secure detoxification facility.
    b. Provide the following services when appropriate and within available resources:
        i. Coordination with treatment providers, housing advocates and therapeutic courts to increase the likelihood of positive outcomes for participants in the pilot project.
        ii. Assistance in accessing and remaining enrolled in benefit programs to which the participant may be entitled;
        iii. Reduction of the duplication of services and conflicts in case approach by coordinating with medical care providers including federally qualified health centers, Indian health programs, and veterans' health programs for which the participant is eligible; and,
        iv. Advocacy for the participant's needs to assist achieving and maintaining stability and progress toward recovery.
        v. Provide case management services for a minimum of thirty (30) days post stay at the secure detox facility.

It is anticipated that Catholic Community Chemical Dependency Services will staff the case management position with a professional specializing in chemical dependency in fulfilling its obligation under this Agreement. With the prior consent of the NSMHA, work may be performed by a subcontractor.

Deliverable/Phase	Number
The number of individuals placed, after receiving treatment in the secure detox Facility at:	
Supported or Transitional Housing	
Outpatient Chemical Dependency Treatment	
Voluntary Inpatient Chemical Dependency Treatment Facility	
Recovery House Residential Facility	
Long Term Chemical Dependency Residential Facility	
Co-Occurring Residential Treatment Facility	

COSTS:

Start up costs, one time payment, for this Exhibit shall not exceed **$7,961.50.**

- To include the following, but not limited to:
  - Training on Integrated Crisis Response and Secure Detox Pilot
  - Attend Steering Committee Meetings for the Integrated Crisis Response and Secure Detox Pilot
  - Training on the Integrated Comprehensive Co-Occurring Screening and Assessment Tool

Maximum consideration for this Exhibit shall not exceed **$23,884.50** through December 31, 2006.

Phone System Review and Recommendations:

NSMHA, in order to comply with the Mental Health Division's (MHD's) Request For Qualifications (RFQ) Customer Service Requirements, must have a phone system that has the ability to track, monitor and produce call reports. Our current phone system is too old to upgrade and we are unable to add software to meet the requirements. We researched and received demonstrations, as well as quotes on several different phone systems. Greater Columbia RSN installed a new Cisco phone system to meet the MHD requirements and the cost was $60,000. Due to budget constraints we chose not to pursue a quote from Cisco Systems.

We have received 4 quotes ranging from $11,500 to $22,000. The lowest cost quote is for a system that is slightly better than our current system, and will not be able to meet future requirements by MHD. Three quotes have associated ongoing costs that range from $615.00 per year to $1,800 per year for maintenance agreements and software updates; and some have on going monthly expenses in excess of $1,300 per month for the Voice-over Internet Protocol (VoIP) systems. If a VoIP system with an ongoing monthly subscription were purchased, installation and first year expenses would exceed $27,000, with an ongoing monthly expense of $1,300 or more thereafter at current proposed rates.

NSMHA has chosen to pursue a ShoreTel phone system. This system will best meet our need and has the lowest ongoing yearly costs of $615 per year for maintenance and software upgrades. This system allows us to continue the use of the State of Washington Department of Information Systems SCAN system for long distance at low, state approved long distance rates. This system will be able to handle conference calls up to six lines; which would reduce our conference call charges. It will meet current contract requirements with the ability to expand and has built in reports for potential future requirements. It is also considered the most reliable system of those we received demonstrations on. Many users of a worldwide system administration list rated the ShoreTel system very highly.

It is the recommendation of the NSMHA Management Team that the Board of Directors approve the purchase of the new ShoreTel phone system. Total financial consideration: $21,939.40.

Northwest Computer
1419 Cornwall Ave
Bellingham, WA 98226
John Walstad
360.734.3400

Enter PO # Here
Attach Purchase Order to this Quote

Date: 8/8/2006
Requested Ship Date: 8/18/2006

ShoreTel Product and Services Quote

Customer: **NSMHA**
117 N. 1st St
Mount Vernon, WA 98273
Attn: **Annette Calder**
Date: **08-Aug-06**

Quote No : **NWCNSMHA001**

Order Status: New Customer
Service Term: 12 Months

Description		Quantity	SKU #	Unit List	List Price	Net Price
ShoreGear Voice Switches:						
	ShoreGear 60/12	1	10168	$ 2,995.00	$ 2,995.00	$ 2,096.50
ShorePhone Telephones:						
	ShorePhone IP230 - Silver (6.1 only)	27	10197	$ 259.00	$ 6,993.00	$ 5,594.40
	ShorePhone IP560 - Silver	2	10148	$ 349.00	$ 698.00	$ 558.40
	ShorePhone Power Adaptor (minimum 10 w/o phone order	29	10157	$ 35.00	$ 1,015.00	$ 1,015.00
ShoreWare Application Server:						
	ShoreTel 6.1 Software (Controlled Release)	1	29121	$ 1,000.00	$ 1,000.00	N/C
	Extension & Mailbox License	19	30035	$ 200.00	$ 3,800.00	$ 3,230.00
ShoreWare Client Software:						
	Personal Call Manager	29	30001	$ 125.00	$ 3,875.00	N/C
Small Business Edition:						
	Sm. Business Edition w/ShoreGear 60/12 and Serve	1	60002	$ 4,495.00	$ 4,495.00	$ 4,495.00
				System Subtotal	$ 24,871.00	$ 16,989.30
ShoreCare Annual Support Plan						
	Reseller Support Program:					
	1 Year (SW Only)	1	91069		$ 683.50	$ 580.98
Professional Services						
	Full Day - PLUS T&E	1	92010	$ 1,800.00	$ 1,800.00	$ 1,800.00
	One Half Day - Half Day Rate - PLUS T&E	1	92011	$ 1,000.00	$ 1,000.00	$ 1,000.00
				Total	$ 28,354.50	$ 20,370.28
Other Equipment Pricing Estimate:						
	Harmonica for SG-8	2	10151	$ 43.00	$ 86.00	$ 86.00
	Terms: 50% down at time of acceptance balance due on cutover date and final acceptance by NSMHA			***Other Equipment Total***	$ 86.00	$ 86.00
				Total Purchase	$ 28,440.50	$ 20,456.28
				Sales Tax 8.40%		$ 1,483
				Grand Total	**$ 28,440.50**	**$ 21,939.40**

Prepared by: John Walstad

Accepted by: _____

This quote is valid through: **07-Sep-06**

Revised July 1, 2006

Note: This sales quote does not reflect shipping charges which will be applied to your final invoice. Shipping charges are based on shipping method, size of order, ar geographic location.