



**WASHINGTON
BEHAVIORAL HEALTH – ADMINISTRATIVE
SERVICES ORGANIZATION CONTRACT**

HCA Contract Number: K3185

This Contract is between the State of Washington Health Care Authority (HCA) and the Contractor identified below, and is governed by chapter 41.05 RCW and Title 182 WAC.

CONTRACTOR NAME North Sound Behavioral Health – Administrative Services Organization		CONTRACTOR doing business as (DBA) North Sound BH-ASO	
CONTRACTOR ADDRESS 301 Valley Mall Way, Suite 110 Mount Vernon, WA 98273		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) 603-583-336	
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IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF THIS CONTRACT? No		CFDA NUMBER(S) N/A	
CONTRACT START DATE June 1, 2019	CONTRACT END DATE December 31, 2019	MAXIMUM CONTRACT AMOUNT \$14,937,493.00	

EXHIBITS. The following Exhibits are attached and are incorporated into this Contract by reference:
 Exhibits: Exhibit A, Non-Medicaid Funding Allocation; Exhibit B, Non-Medicaid Expenditure Report; Exhibit C, Reporting Requirements; Exhibit D, SABG Capacity Management Form; Exhibit E, Crisis Reporting Metrics and Reporting; Exhibit F, Federal Block Grant Annual Progress Report; Exhibit G, SUD Service; Exhibit H, Peer Bridger Program; Exhibit I, MHBG Project Plan Template; Exhibit J, SABG Project Plan Template; Exhibit K, RSA Spend Down; Exhibit L- Service Area Matrix; Exhibit M, State Hospital Bed Targets and Allocations, Exhibit N- Triage/Stabilization and Increasing Inpatient Reporting, Exhibit O, Data Use, Security, Confidentiality, Exhibit P, Federal Award Identification for Subrecipients.

The terms and conditions of this Contract are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise regarding the subject matter of this Contract, between the parties. The parties signing below represent they have read and understand this Contract, and have the authority to execute this Contract. This Contract shall be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE Joe Valentine, Executive Director	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE Annette Schuffenhauer, Chief Legal Officer	DATE SIGNED

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Exhibits

- Exhibit A: Non-Medicaid Funding Allocation;
- Exhibit B: Non-Medicaid Expenditure Report;
- Exhibit C: Reporting Requirements;
- Exhibit D: SABG Capacity Management Form;
- Exhibit E: Crisis Reporting Metrics and Reporting;
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- Exhibit O: Data Use, Security, and Confidentiality
- Exhibit P: Federal Award Identification for Subrecipients

1 DEFINITIONS

In any subcontracts and in any other documents that relate to this Contract, the Contractor shall use the definitions as they appear in this Contract.

1.1 **Accountable Community of Health (ACH)**

“Accountable Community of Health (ACH)” means a regionally governed, public-private collaborative that is tailored by the region to achieve healthy communities and a Healthier Washington. ACHs convene multiple sectors and communities to coordinate systems that influence health, public health, the health care delivery providers, and systems that influence social determinations of health.

1.2 **Action**

“Action” means the denial or limited authorization of a Contracted Service based on medical necessity.

1.3 **Acute Withdrawal Management**

“Acute Withdrawal Management” means services provided to an individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner. Medically monitored withdrawal management provides medical care and physician supervision for withdrawal from alcohol or other drugs.

1.4 **Administrative Hearing**

“Administrative Hearing” means an adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by Chapter 34.05 RCW or the Agency’s hearings rules found in Chapter 182 WAC.

1.5 **Advance Directive**

“Advance Directive” means a written instruction, such as a living will or durable power of attorney for health care relating to the provision of health care when an individual is incapacitated (WAC 182-501-0125).

1.6 **Administrative Function**

“Administrative Function” means any obligation other than the actual provision of behavioral health services.

1.7 **Alcohol/Drug Information School**

“Alcohol/Drug Information School” means a program that provides information regarding the use and abuse of alcohol/drugs in a structured educational setting. Alcohol/Drug Information Schools must meet the certification standards in WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 0.5).

1.8 **Allegation of Fraud**

“Allegation of Fraud” means an unproved assertion: an assertion, especially relating to wrongdoing or misconduct on the part of the individual. An allegation has yet to be proved or supported by evidence.

An Allegation of Fraud is an allegation, from any source, including but not limited to the following:

1.8.1 Fraud hotline complaints;

1.8.2 Claims data mining; and

1.8.3 Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

1.9 **American Society of Addiction Medicine (ASAM)**

“American Society of Addiction Medicine (ASAM)” means a professional medical society dedicated to increasing access and improving the quality of addiction treatment.

1.10 **American Society of Addiction Medicine (ASAM) Criteria**

“ASAM Criteria” are a comprehensive set of guidelines for determining placement, continued stay and transfer or discharge of Individuals with addiction conditions.

1.11 **Appeal**

“Appeal” means a request for review of an action.

1.12 **Appeal Process**

“Appeal Process” means the Contractor’s procedures for reviewing an action.

1.13 **Assessment Substance Use Disorder (SUD)**

“Assessment (SUD)” means the activities conducted to evaluate an individual to determine if the individual has a Substance Use Disorder and determine placement in accordance with the ASAM Criteria (WAC 182-538C-050).

1.14 **Available Resources**

“Available Resources” means funds appropriated for the purpose of providing behavioral health programs. This includes federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated by the Legislature.

1.15 **Behavioral Health**

“Behavioral Health” means mental health and SUD conditions and related services.

1.16 **Behavioral Health Administrative Services Organization (BH-ASO)**

“Behavioral Health Administrative Services Organization” means an entity selected by HCA to administer behavioral health programs, including Crisis Services and Ombuds for individuals in a defined Regional Service Area. The BH-ASO administers Crisis Services and Ombuds services for all individuals in its defined service area, regardless of an individual's ability to pay, including Medicaid eligible members.

1.17 Behavioral Health Organization (BHO)

“Behavioral Health Organization (BHO)” means -county authority or group of county authorities or other entity recognized by the Secretary that contracts for mental health and substance use disorder treatment services within a defined Regional Service Area.

1.18 Behavioral Health Professional

“Behavioral Health Professional” means a licensed physician board certified or board eligible in Psychiatry or Child and Adolescent Psychiatry, Addiction Medicine or Addiction Psychiatry, licensed doctoral level psychologist, Psychiatric Advanced Registered Nurse Practitioner (ARNP) or a licensed pharmacist.

1.19 Breach

“Breach” means the acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of PHI, with the exclusions and exceptions listed in 45 C.F.R. § 164.402.

1.20 Brief Intervention for SUD

“Brief Intervention for SUD” means a time limited, structured behavioral intervention using techniques such as evidence-based motivational interviewing, and referral to treatment services when indicated. Services may be provided at sites exterior to treatment facilities such as hospitals, medical clinics, schools or other non-traditional settings.

1.21 Brief Outpatient Treatment for SUD

“Brief Outpatient Treatment for SUD” means a program of care and treatment that provides a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. (The services as described satisfy the level of intensity in ASAM Level 1).

1.22 Business Associate Agreement

“Business Associate Agreement” means an agreement under the federal Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), between a HIPAA covered entity HIPAA business associate. The agreement protects Personal Health Information (PHI) in accordance with HIPAA guidelines.

1.23 Business Hours

“Business Hours” means 8:00 am to 5:00 pm Pacific Time, Monday through Friday.

1.24 **Care Coordination**

“Care Coordination” means an Individual’s healthcare needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the Individual and the Individual’s caregivers, and works with the Individual to ensure the Individual receives the most appropriate treatment, while ensuring that care is not duplicated.

1.25 **Case Management Services (SUD)**

“Case Management Services” means services provided by a Chemical Dependency Professional (CDP), Certified Chemical Dependency Professional Trainee (CDPT), or person under the clinical supervision of a CDP who will assist Individuals in gaining access to needed medical, social, education, and other services.

1.26 **Certified Chemical Dependency Professional (CDP)**

“Certified Chemical Dependency Professional (CDP)” means an individual who is certified according to RCW 18.205.020 and the certification requirements of WAC 246-811-030 to provide SUD services.

1.27 **Certified Peer Counselor (CPC)**

“Certified Peer Counselor (CPC)” means individuals that have met the requirements to help individuals and families identify goals that promote recovery and resiliency and help to identify services and activities to reach these goals.

1.28 **Chemical Dependency Professional Trainee (CDPT)**

“Chemical Dependency Professional Trainee (CDPT)” means an individual working toward the education and experience requirements for certification as a chemical dependency professional, and who has been credentialed as a CDPT.

1.29 **Childcare Services**

“Childcare Services” means the provision of child care services to children of parents in treatment in order to complete the parent’s plan for treatment services. Childcare services must be provided by licensed childcare providers.

1.30 **Child and Family Team (CFT)**

“Child and Family Team (CFT)” means a group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family’s care plan, address unmet needs, and work toward the family’s vision and team mission.

1.31 **Children’s Long Term Inpatient Program (CLIP)**

“Children’s Long Term Inpatient Program (CLIP)” is a medically based treatment approach, available to all Washington State residents, ages 5 to 18 years of age, providing 24 hour psychiatric treatment in a highly structured setting designed to assess, treat, and stabilize youth diagnosed with psychiatric and behavioral disorders.

1.32 Children’s Long Term Inpatient Programs Administration (CLIP Administration)

“Children’s Long Term Inpatient Programs Administration (CLIP Administration)” means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from Children’s Long Term Inpatient Programs.

1.33 Code of Federal Regulations (CFR)

“Code of Federal Regulations (CFR)” means the codification of the general and permanent rules and Regulations, sometimes called administrative law, published in the Federal Register by the executive departments and agencies of the federal government of the United States.

1.34 Community Behavioral Health Advisory (CBHA) Board

“Community Behavioral Health Advisory (CBHA) Board” means an advisory board representative of the demographic characteristics of the RSA in accordance with WAC 182-538D-0252.

1.35 Community Health Workers (CHW)

“Community Health Workers (CHW)” means individuals who serve as a liaison and advocate between social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHW include Community Health Representatives (CHR) in the Indian Health Service funded, tribally contracted program.

1.36 Community Mental Health Agency (CMHA)

“Community Mental Health Agency (CMHA)” means a behavioral health agency that is licensed by the state of Washington, and certified to provide mental health services.

1.37 Confidential Information

“Confidential Information” means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or State law. Confidential Information includes, but is not limited to, personal information.

1.38 Continuity of Care

“Continuity of Care” means the provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one (1) setting as the Individual transitions between: facility to home; facility to facility; providers or service areas; managed care Contractors; and Medicaid fee-for-service and managed care arrangements.

1.39 Contract

“Contract” means this entire written agreement between HCA and the Contractor, including any exhibits, documents, and materials incorporated by reference.

1.40 Contractor

“Contractor” means the individual or entity performing services pursuant to this Contract and includes the Contractor’s owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, “Contractor” includes any Subcontractor and its owners, officers, directors, partners, employees, and/or agents.

1.41 Continuing Education and Training

“Continuing Education and Training” means activities to support educational programs, training projects, or other professional development programs.

1.42 Contracted Services

“Contracted Services” means services that are to be provided by the Contractor under the terms of this Contract within Available Resources.

1.43 Cost Reimbursement

“Cost Reimbursement” means the Subcontractor is reimbursed for actual costs up to the maximum consideration allowed in this Contract.

1.44 Cost Sharing

“Cost Sharing” means the costs an Individual pays for services not covered by the BH-ASO. Block grant funds may be used to cover health insurance deductibles, coinsurance, and copayments to assist eligible Individuals in meeting their cost-sharing responsibilities.

1.45 Criminal Justice Treatment Account (CJTA)

“Criminal Justice Treatment Account” means an account created by the state for expenditure on: a) SUD treatment and treatment support services for offenders with a SUD that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; b) the provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program (RCW 71.24.580).

1.46 Crisis

“Crisis” means a behavioral health crisis, defined as a turning point, or a time, a stage, or an event, whose outcome includes a distinct possibility of an undesirable outcome.

1.47 Crisis Services (Behavioral Health)

“Crisis Services (Behavioral Health) means providing evaluation and short term treatment and other services to individuals with an emergent mental health condition or are intoxicated or incapacitated due to substance use and when there is an immediate threat to the individual’s health or safety.

1.48 Day Support

“Day Support” means 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 Individuals to promote improved functioning or a restoration to a previous higher level of functioning.

1.49 Debarment

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

1.50 Department of Children, Youth and Families (DCYF)

“Department of Children, Youth and Families (DCYF) means the Washington State agency responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.

1.51 Department of Health (DOH)

“Department of Health (DOH)” means the Washington State agency responsible for the licensing and certification of health service providers.

1.52 Department of Social and Health Services (DSHS)

“Department of Social and Health Services (DSHS)” means the Washington State agency responsible for providing a broad array of health care and social services.

1.53 Designated Crisis Responder (DCR)

“Designated Crisis Responder (DCR)” means a person designated by the county or other authority authorized in rule, to perform the civil commitment duties described in Chapters 71.05 RCW and 71.34 RCW.

1.54 Disaster Outreach

“Disaster Outreach” means contacting persons in their place of residence or other settings to provide support, education, information and referral to resources in the event of a disaster.

1.55 Direct Service Support Costs

“Direct Service Support Costs” are BH-ASO level costs incurred to provide services and activities to Individuals, as defined in the instructions of Exhibit B, Non-Medicaid Expenditure Report.

1.56 Director

“Director” means the Director of HCA. In his or her sole discretion, the Director may designate a representative to act on the Director’s behalf. Any designation may include the representative’s authority to hear, consider, review, and/or determine any matter.

1.57 Division of Behavioral Health and Recovery (DBHR)

“Division of Behavioral Health and Recovery” or “DBHR” means the HCA behavioral health division.

1.58 Emergency Medical Condition

“Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.59 Emergency Services

“Emergency Services” means inpatient and outpatient Contracted Services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition.

1.60 Encrypt

“Encrypt” means to encipher or encode electronic data using software that generates a minimum key length of one hundred twenty-eight (128) bits.

1.61 Evaluation and Treatment

“Evaluation and Treatment” means services 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. Services are provided in freestanding inpatient residential (non-hospital/non-Institution for Mental Disease (IMD) facilities) licensed and certified by DOH to provide medically necessary evaluation and treatment to the Individual who would otherwise meet hospital admission criteria.

1.62 Evaluation and Treatment Facility

"Evaluation and treatment facility" means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by DOH. (RCW 71.05.020)

1.63 Evidence-Based Practices

“Evidence-Based Practices” means a program or practice that has been tested where the weight of the evidence from review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.

1.64 External Entities (EE)

“External Entities (EE)” means organizations that serve eligible Individuals and includes DSHS, DOH, Local Health Jurisdictions (LHJ), community-based service providers and services/programs defined in this Contract.

1.65 Facility

“Facility” means but is not limited to: a hospital, an inpatient rehabilitation center, Long-Term and Acute Care (LTAC) center, skilled nursing facility, and nursing home.

1.66 Family Treatment

“Family Treatment” means behavioral health counseling provided by or under the supervision of a Mental Health Professional for the direct benefit of an Individual. Service is provided with family members and/or other relevant persons in attendance as active participants.

1.67 Federally Qualified Health Center (FQHC)

“Federally Qualified Health Center (FQHC)” means a community-based organization that provides comprehensive primary care and preventive care, including health, dental, and behavioral health services to people of all ages, regardless of their ability to pay or health insurance status.

1.68 First Responders

“First Responders” means police, sheriff, fire, emergency, medical and hospital emergency rooms, and 911 call centers.

1.69 Fraud

“Fraud” means an intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

1.70 Global Appraisal of Individual Needs Shorter Screener (GAIN-SS)

“Global Appraisal of Individual Needs Shorter Screener (GAIN-SS)” means the integrated, comprehensive screening for behavioral health conditions.

1.71 General Fund State/Federal Block Grants (GFS/FBG)

“General Fund State/Federal Block Grants (GFS/FBGs)” means the services provided by the Contractor under this Contract and funded by Federal Block Grants or General Fund State (GFS).

1.72 Grievance

“Grievance” means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances may 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 Individual’s rights.

1.73 Grievance Process

“Grievance Process” means the procedure for addressing Individuals’ grievances.

1.74 Grievance System

“Grievance System” means the overall system that includes Grievances and Appeals handled by the Contractor and access to the Administrative Hearing system.

1.75 Guideline

“Guideline” means a set of statements used to determine a course of action. A guideline streamlines utilization management decision-making processes according to a set routine or sound evidence-based clinical practice.

1.76 Hardened Password

“Hardened Password” prior to July 1, 2019 means a string of at least eight (8) characters containing at least one (1) alphabetic character, at least one (1) number, and at least one (1) special character such as an asterisk, ampersand, or exclamation point.

1.77 Health Care Authority (HCA)

“Health Care Authority (HCA)” means the Washington State Health Care Authority, any division, section, office, unit or other entity of HCA or any of the officers or other officials lawfully representing HCA.

1.78 Health Care Professional

“Health Care Professional” means a physician or any of the following acting within his or her scope of practice; an applied behavior analyst, certified registered dietician, naturopath, podiatrist, optometrist, optician, osteopath, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner or clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed midwife, licensed clinical social worker, licensed mental health counselor, licensed marriage and family therapist, registered respiratory therapist, pharmacist, and certified respiratory therapy technician.

1.79 High Intensity Treatment

“High Intensity Treatment” means intensive levels of service provided to Individuals who require a multi-disciplinary treatment team in the community that is available upon demand twenty-four hours per day, seven days per week.

1.80 Independent Peer Review

“Independent Peer Review” means to assess the quality, appropriateness, and efficacy of treatment services provided to Individuals under the program involved.

1.81 Individual

“Individual” means any person in the RSA regardless of income, ability to pay, insurance status or county of residence. With respect to non-Crisis Services, “Individual” means a person who has applied for, is eligible for, or who has received GFS/FBG services through this contract.

1.82 Institute for Mental Disease (IMD)

“Institute for Mental Disease (IMD)” means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

1.83 Indian Health Care Provider (IHCP)

“Indian Health Care Provider (IHCP)” means the Indian Health Service and/or any Tribe, Tribal organization, or Urban Indian Health Program (UIHP) that provides Medicaid-reimbursable services.

1.84 Individuals with Intellectual or Developmental Disability (I/DD)

“Individuals with Intellectual or Developmental Disability (I/DD)” means people with a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.

1.85 Inpatient/Residential Substance Use Treatment Services

“Inpatient/Residential Substance Use Treatment Services” means rehabilitative services, including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward individuals who are harmfully affected by the use of mood-altering chemicals or have been diagnosed with a Substance Use Disorder (SUD). Techniques have a goal of abstinence for individuals with SUDs. Provided in certified residential treatment facilities with sixteen (16) beds or less. Excludes room and board. Residential treatment services require additional program-specific certification by HCA, Division of Behavioral Health and Recovery and include:

1.85.1 Intensive inpatient services;

1.85.2 Recovery house treatment services;

1.85.3 Long-term residential treatment services; and

1.85.4 Youth residential services.

1.86 Intake Evaluation

“Intake Evaluation” means an evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except Crisis Services, Stabilization Services, and free-standing evaluation and treatment.

1.87 Interim Services

“Interim Services” means services to Individuals who are currently waiting to enter a treatment program to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease.

1.88 Intensive Inpatient Residential Services

“Intensive Inpatient Residential Services” means a concentrated program of SUD treatment, individual and group counseling, education, and related activities including room and board in a twenty-four (24)hour-a-day supervised facility in accordance with Chapter 246-341 WAC (The service as described satisfies the level of intensity in ASAM Level 3.5).

1.89 Intensive Outpatient SUD Treatment

“Intensive Outpatient SUD Treatment” means services provided in a non-residential intensive patient centered outpatient program for treatment of SUD (The service as described satisfies the level of intensity in ASAM Level 2.1).

1.90 Involuntary Treatment Act (ITA)

“Involuntary Treatment Act (ITA)” are state laws that allow for individuals to be committed by court order to a Facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to seventy-two (72) hours, but, if necessary, individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days (RCW 71.05.180, RCW 71.05.230 and RCW 71.05.290).

1.91 Involuntary Treatment Act Services

“Involuntary Treatment Act Services” includes all services and Administrative Functions required for the evaluation and treatment of individuals civilly committed under the ITA in accordance with Chapters 71.05 and 71.34 RCW, and RCW 71.24.300.

1.92 Juvenile Drug Court

"Juvenile Drug Court" means a specific juvenile court docket, dedicated to a heightened and intensified emphasis on therapy and accountability, as described by the U.S. Department of Justice, Bureau of Justice Assistance in the monograph, Juvenile Drug Courts: Strategies in Practice, March 2003.

1.93 Less Restrictive Alternative Treatment

“Less Restrictive Alternative (LRA) Treatment” means a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.05.585.

1.94 Level of Care Guidelines

“Level of Care Guidelines” is a set of guidelines for placement, continued stay and transfer or discharge of individuals with SUD and co-occurring conditions.

1.95 List of Excluded Individuals/Entities (LEIE)

“List of Excluded Individuals/Entities (LEIE)” means an Office of Inspector General’s List of Excluded Individuals/Entities and provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

1.96 Long-Term Care Residential SUD Services

“Long-Term Care Residential SUD Services” means the care and treatment of chronically impaired Individuals diagnosed with SUD who also have impaired self-maintenance capabilities who reside in a twenty-four (24) hour-a-day, supervised facility in accordance with Chapter 246-341 WAC (The service as described satisfies the level of intensity in ASAM Level 3.3).

1.97 Lump Sum

“Lump Sum” means the Subcontractor is reimbursed a negotiated amount for completion of requirements under the Subcontract.

1.98 Managed Care

“Managed Care” means a prepaid, comprehensive system of medical and behavioral health care delivery including preventive, primary, specialty, and ancillary health services.

1.99 Managed Care Organization (MCO)

“Managed Care Organization (MCO)” means an organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA Enrollees under HCA managed care programs.

1.100 Materials

“Materials” means any promotional activity or communication with an Individual that is intended to “brand” a Contractor’s name or organization.

Materials include written, oral, in-person (telephonic or face-to-face) or electronic methods of communication, including email, text messaging, and social media (i.e. Facebook, Instagram, and Twitter).

1.101 Medically Necessary Services

"Medically Necessary Services" means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Individual that endanger life, cause suffering of pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.

1.102 Medication Assisted Treatment (MAT)

"Medication Assisted Treatment (MAT)" means the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUDs.

1.103 Medication Management

"Medication Management" means the prescribing and/or administering and reviewing of medications and their side effects.

1.104 Medication Monitoring

"Medication Monitoring" means face-to-face, one-on-one cueing, observing, and encouraging an Individual to take medications as prescribed.

1.105 Mental Health Advance Directive

"Mental Health Advance Directive" means a written document in which the Individual makes a declaration of instructions, or preferences, or appoints an agent to make decisions on behalf of the Individual regarding the Individual's mental health treatment that is consistent with Chapter 71.32 RCW.

1.106 Mental Health Block Grant or MHBG

"Mental Health Block Grant (MHBG)" means those funds granted by the Secretary of the Department of Health and Human Services (DHHS), through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), to states to establish or expand an organized community-based system for providing mental health services for adults with Serious Mental Illness (SMI) and children who are seriously emotionally disturbed (SED).

1.107 Mental Health Parity

"Mental Health Parity" means the Washington state Office of the Insurance Commissioner rules for behavioral health parity, inclusive of mental health and SUD benefits that apply to this Contract (WAC 284-43-7000 through 284-43-7080).

1.108 Mental Health Professional

"Mental Health Professional" means:

- 1.108.1 A psychiatrist, psychologist, psychiatric nurse, psychiatric nurse practitioner, physician assistant supervised by a psychiatrist, or social worker as defined in RCW 71.05.020;

- 1.108.2 A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such persons shall have, in addition, at least two (2) 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;
- 1.108.3 A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;
- 1.108.4 A person who is licensed by DOH as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;
- 1.108.5 A person who has an approved exception to perform the duties of a Mental Health Professional; or
- 1.108.6 A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional.

1.109 National Correct Coding Initiative (NCCI)

“National Correct Coding Initiative (NCCI)” means CMS-developed coding policies based on coding conventions defined in the American Medical Association’s Current Procedural Terminology (CPT) manual, national and local policies, and edits.

1.110 Network Adequacy

“Network Adequacy” means a network of providers for the Contractor that is sufficient in numbers and types of providers/facilities to ensure that all services are accessible to Individuals in this Contract and within Available Resources.

1.111 Non-Participating Provider

“Non-Participating Provider” means a person, Health Care Provider, practitioner, facility, or entity acting within their scope of practice and licensure that does not have a provider service agreement with the Contractor but provides services to Individuals.

1.112 Notice of Action

“Notice of Action” means a written notice that must be provided to Individuals to inform them that a requested Contracted Service was denied or received only a limited authorization based on medical necessity.

1.113 Office of Inspector General (OIG)

“Office of Inspector General (OIG)” means the Office of Inspector General within the United States Department of Health and Human Services (DHHS).

1.114 Opiate Dependency/HIV Services Outreach

“Opiate Dependency/HIV Services” means the provision of outreach and referral services to special populations to include opiate use disorder, Injecting Drug Users (IDU), HIV or Hepatitis C-positive individuals.

1.115 Opiate Substitution Treatment

“Opiate Substitution Treatment” means assessment and treatment to opiate dependent patients. Services include prescribing and dispensing of an approved medication, as specified in 21 C.F.R. Part 291, for opiate substitution services in accordance with WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 1).

1.116 Opioid Treatment Program (OTP)

“Opioid Treatment Program (OTP)” means a designated program that dispenses approved medication as specified in 21 C.F.R. Part 291 for opioid treatment in accordance with WAC 246-341-0100.

1.117 Outreach and Engagement

“Outreach and Engagement” means identification of hard-to-reach Individuals with a possible SUD and/or SMI and engagement of these individuals in assessment and ongoing treatment services as necessary.

1.118 Overpayment

“Overpayment” means any payment from HCA to the Contractor in excess of that to which the Contractor is entitled by law, rule, or this Contract, including amounts in dispute.

1.119 Participating Provider

“Participating Provider” means a person, Health Care Provider, practitioner, or entity, acting within their scope of practice and licensure, with a written agreement with the Contractor to provide services to Individuals under the terms of this Contract.

1.120 Peer Bridger

“Peer Bridger” means a trained Peer Support specialist who offers Peer Support services to participants in state hospitals and inpatient mental health facilities prior to discharge and after their return to their communities. The Peer Bridger must be an employee of a behavioral health agency licensed by DOH that provides recovery services.

1.121 Peer Support

“Peer Support” means behavioral health services provided by peer counselors to individuals under the consultation, facilitation, or supervision of a Behavioral Health Professional, including Mental Health or Chemical Dependency Professional.

1.122 Personal Information

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

1.123 Predictive Risk Intelligence System (PRISM)

“Predictive Risk Intelligence System (PRISM)” means a DSHS-secure web-based predictive modeling and clinical decision support tool. It provides a unified view of medical, behavioral health, and long-term care service data that is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next twelve (12) months based on the patient’s disease profile and pharmacy utilization.

1.124 Pregnant and Post-Partum Women (PPW)

“Pregnant and Post-Partum Women and Women with Dependent Children (PPW)” means: (i) women who are pregnant; (ii) women who are postpartum during the first year after pregnancy completion regardless of the outcome of the pregnancy or placement of children; or (iii) women who are parenting children, including those attempting to gain custody of children supervised by DCYF.

1.125 Pregnant, Post-Partum or Parenting (PPW) Women’s Housing Support Services

“Pregnant, Post-Partum or Parenting (PPW) Women’s Housing Support Services” means the costs incurred to provide support services to PPW individuals with children under the age of six (6) in a transitional residential housing program designed exclusively for this population.

1.126 Prior Authorization

“Prior Authorization” means the requirement that a provider must request, on behalf of an individual and when required by HCA or the HCA’s designee's approval to provide a health care service before the individual receives the health care service.

1.127 Provider

“Provider” means an individual medical or Behavioral Health Professional, Health Care Professional, hospital, skilled nursing facility, other facility, or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

1.128 ProviderOne

“ProviderOne” means the HCA’s Medicaid Management Information Payment Processing System, or any superseding platform as may be designated by HCA.

1.129 Psychological Assessment

“Psychological Assessment” means all psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist.

1.130 **Recovery**

“Recovery” means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

1.131 **Recovery House Residential Treatment**

“Recovery House Residential Treatment” means a program of care and treatment with social, vocational, and recreational activities designed to aid individuals diagnosed with SUD in the adjustment to abstinence and to aid in job training, reentry to employment, or other types of community activities, excluding Room and Board in a twenty-four (24) hour-a-day supervised facility in accordance with WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 3.1).

1.132 **Recovery Support Services**

“Recovery Support Services” means a broad range of non-clinical services that assist individuals and families to initiate, stabilize, and maintain long-term Recovery from behavioral health disorders including mental illness and substance use disorders.

1.133 **Regional Service Area (RSA)**

“Regional Service Area (RSA)” means a single county or multi-county grouping formed for the purpose of health care purchasing.

1.134 **Regulation**

“Regulation” means any federal, State, or local Regulation or ordinance.

1.135 **Rehabilitation Case Management**

“Rehabilitation Case Management” means a range of activities by the outpatient CMHA’s liaison conducted in or with a facility for the direct benefit of an Individual in the public mental health system.

1.136 **Resilience**

“Resilience” means the capacity of individuals to recover from adversity, trauma, tragedy, threats, or other stresses or behavioral health challenges, and to live productive lives.

1.137 **Revised Code of Washington (RCW)**

“Revised Code of Washington (RCW)” means the laws of the state of Washington.

1.138 **Room and Board**

“Room and Board” means provision for services in a twenty-four (24) hour-a-day setting consistent with the requirements for Residential Treatment Facility Licensing through DOH (Chapter 246-337 WAC).

1.139 **Substance Abuse Block Grant (SABG)**

“Substance Abuse Block Grant (SABG)” means the Federal Substance Abuse Block Grant Program) authorized by Section 1921 of Title XIX, Part B, Subpart II and III of the Public Health Service Act.

1.140 Secure Detox Facility

“Secure Detox Facility” means a facility operated by either a public or private agency as defined in RCW 71.05.020 that provides involuntary treatment to individuals detained for SUD ITA up to ASAM withdrawal management level 3.7.

1.141 Secured Area

“Secured Area” means an area such as a building, room, or locked storage container to which only authorized representatives of the entity possessing Confidential Information have access.

1.142 Security Incident

“Security Incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.143 Serious Emotionally Disturbed (SED)

“Serious Emotionally Disturbed (SED)” means children from birth up to age eighteen (18) who have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.

1.144 Serious Mental Illness (SMI)

“Serious Mental Illness (SMI)” means persons age eighteen (18) and over who currently, or at any time during the past year, have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders (DSM) that has resulted in functional impairment which substantially limits one (1) or more major life activities such as employment, school, social relationships, etc.

1.145 Single Case Agreement

“Single Case Agreement” means a written agreement between the Contractor and a non-Participating Provider to deliver services to an Individual.

1.146 Sobering Services

“Sobering Services” means short-term (less than twenty-four (24) consecutive hours) emergency shelter, screening, and referral services to persons who are intoxicated or in active withdrawal.

1.147 Special Population Evaluation

“Special Population Evaluation” means an 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.

1.148 **Stabilization Services**

“Stabilization Services” means services provided to Individuals who are experiencing a mental health crisis. These services are provided in the person's home, or another home-like setting, or a setting which provides safety for the individual and the Mental Health Professional. Stabilization Services may be provided prior to an Intake Evaluation for mental health services.

1.149 **Sub-Acute Withdrawal Management (Detoxification)**

“Sub-Acute Withdrawal Management (Detoxification)” means detoxification services provided to an Individual to assist in the withdrawal from a psychoactive substance in a safe and effective manner. Sub-Acute is nonmedical detoxification or patient self-administration of withdrawal medications ordered by a physician, provided in a home-like environment.

1.150 **Subcontract**

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

1.151 **Substance Use Disorder (SUD)**

“Substance Use Disorder (SUD)” means a problematic pattern of use of alcohol and/or drugs that causes a clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school or home.

1.152 **Substance Use Disorder Outpatient Treatment**

“Substance Use Disorder Outpatient Treatment” means services provided in a non-residential SUD treatment facility. Outpatient treatment services must meet the criteria in Chapter 246-341 WAC (The service as described satisfies the level of intensity in ASAM Level 1).

1.153 **Therapeutic Interventions for Children**

“Therapeutic Interventions for Children” means services promoting the health and welfare of children that include: developmental assessment using recognized, standardized instruments; play therapy; behavioral modification; individual counseling; self-esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior.

1.154 **Therapeutic Psychoeducation**

“Therapeutic Psychoeducation” means informational and experiential services designed to aid Individuals, their family members (e.g., spouse, parents, siblings) and others identified by the Individuals as a primary support in the management of psychiatric conditions.

1.155 **Tracking**

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

1.156 **Transitional Age Youth (TAY)**

“Transition Age Youth (TAY)” means an individual between the ages of fifteen (15) and twenty-five (25) years who present unique service challenges because they are too old for pediatric services but are often not ready or eligible for adult services.

1.157 **Transport**

“Transport” means the movement of Confidential Information from one entity to another or within an entity that places the Confidential Information outside of a Secured Area or system (such as a local area network), and is accomplished other than via a Trusted System.

1.158 **Transportation**

“Transportation” means the transport of individuals to and from behavioral health treatment facilities.

1.159 **Tribal Land**

“Tribal Land” means any territory within the state of Washington over which a Tribe has legal jurisdiction, including any lands held in trust for the Tribe by the federal government.

1.160 **Trusted Systems**

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

1.161 **Unique User ID**

“Unique User ID” means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase, or other mechanism authenticates a user to an information system.

1.162 **Validation**

“Validation” means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, and free from bias and in accord with standards for data collection and analysis.

1.163 Waiting List

“Waiting List” means a list of clients who qualify for SABG-funded services for whom services have not been scheduled due to lack of capacity.

1.164 Washington Administrative Code (WAC)

“Washington Administrative Code (WAC)” means the rules adopted by state agencies to implement legislation.

1.165 Washington Apple Health – Fully Integrated Managed Care (AH-FIMC)

“Washington Apple Health – Fully Integrated Managed Care (AH-FIMC)” means the program under which a MCO provides GFS services and Medicaid-funded physical and behavioral health services.

1.166 Wraparound with Intensive Services (WISe)

“Wraparound with Intensive Services (WISe)” means a range of services that are individualized, intensive, coordinated, comprehensive, culturally competent, and provided in the home and community. The WISe Program is for individuals up to age 21 who are experiencing mental health symptoms that are causing severe disruptions in behavior and/or interfering with their functioning in family, school, or with peers requiring: a) the involvement of the mental health system and other child-serving systems and supports; b) intensive care collaboration; and c) ongoing intervention to stabilize the youth and family in order to prevent more restrictive or institutional placement.

1.167 Youth

“Youth” means a person from age ten (10) through seventeen (17).

2 GENERAL TERMS AND CONDITIONS

2.1 Amendment

Except as described below, an amendment to this Contract shall require the approval of both HCA and the Contractor. The following shall guide the amendment process:

- 2.1.1 Any amendment shall be in writing and shall be signed by the Contractor's authorized officer and an authorized representative of HCA. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.
- 2.1.2 HCA reserves the right to issue unilateral amendments which provide corrective or clarifying information.
- 2.1.3 The Contractor shall submit all feedback or questions to HCA at contracts@hca.wa.gov or other email address as expressly stated.
- 2.1.4 The Contractor shall submit written feedback within the expressed deadline provided to the Contractor upon receipt of any amendments. HCA is not obligated to accept Contractor feedback after the written deadline provided by HCA.
- 2.1.5 The Contractor shall return all signed amendments within the written deadline provided by HCA contracts administration.

2.2 Assignment

The Contractor shall not assign this Contract to a third party without the prior written consent of HCA.

2.3 Billing Limitations

- 2.3.1 HCA shall pay the Contractor only for services provided in accordance with this Contract.
- 2.3.2 HCA shall not pay any claims for payment for services submitted more than one hundred and twenty (120) calendar days after the end of the state fiscal year in which the services were performed unless otherwise specified in this Contract.

2.4 Compliance with Applicable Law

In the provision of services under this Contract, the Contractor and its Subcontractors shall comply with all applicable federal, State and local laws and Regulations, and all amendments thereto, that are in effect when the Contract is signed or that come into effect during the term of this Contract. The provisions of this Contract that are in conflict with applicable State or federal laws or Regulations are hereby amended to conform to the minimum requirements of such laws or Regulations.

A provision of this Contract that is stricter than such laws or Regulations will not be deemed a conflict. Applicable laws and Regulations include, but are not limited to:

- 2.4.1 Title XIX and Title XXI of the Social Security Act.
- 2.4.2 Title VI of the Civil Rights Act of 1964.
- 2.4.3 Title IX of the Education Amendments of 1972, regarding any education programs and activities.
- 2.4.4 The Age Discrimination Act of 1975.
- 2.4.5 The Rehabilitation Act of 1973.
- 2.4.6 The Budget Deficit Reduction Act of 2005.
- 2.4.7 The Washington Medicaid False Claims Act and Federal False Claims Act (FCA).
- 2.4.8 The Health Insurance Portability and Accountability Act (HIPAA).
- 2.4.9 The American Recovery and Reinvestment Act (ARRA).
- 2.4.10 The Patient Protection and Affordable Care Act (PPACA or ACA).
- 2.4.11 The Health Care and Education Reconciliation Act.
- 2.4.12 The Mental Health Parity and Addiction Equity Act (MHPAEA) and final rule.
- 2.4.13 21 C.F.R. Food and Drugs, Chapter 1 Subchapter C – Drugs – General.
- 2.4.14 42 C.F.R. Subchapter A, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.
- 2.4.15 42 C.F.R. Subchapter A, Part 8 – Certification of Opioid Treatment Programs.
- 2.4.16 45 C.F.R. 96 Block Grants.
- 2.4.17 45 C.F.R. 96.126 Capacity of Treatment for Intravenous Substance Abusers who Receive Services under Block Grant funding.
- 2.4.18 Chapter 70.02 RCW Medical Records – Health Care Information Access and Disclosure.
- 2.4.19 Chapter 71.05 RCW Mental Illness.
- 2.4.20 Chapter 71.24 RCW Community Mental Health Services Act.
- 2.4.21 Chapter 71.34 RCW Mental Health Services for Minors.
- 2.4.22 Chapter 246-341 WAC.
- 2.4.23 Chapter 388-810 WAC Administration of County Chemical Dependency Prevention Treatment and Support Programs.

- 2.4.24 Chapter 43.20A RCW Department of Social and Health Services.
- 2.4.25 Senate Bill 6312 (Chapter 225. Laws of 2014) State Purchasing of Mental Health and Chemical Dependency Treatment Services.
- 2.4.26 All federal and State professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including but not limited to:
 - 2.4.26.1 All applicable standards, orders, or requirements issued under Section 306 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) Regulations (40 C.F.R. Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to HCA, DHHS, and the EPA.
 - 2.4.26.2 Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.
 - 2.4.26.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
 - 2.4.26.4 Those specified in Title 18 RCW for professional licensing.
- 2.4.27 Industrial Insurance – Title 51 RCW.
- 2.4.28 Reporting of abuse as required by RCW 26.44.030.
- 2.4.29 Federal Drug and Alcohol Confidentiality Laws in 42 C.F.R. Part 2.
- 2.4.30 EEO Provisions.
- 2.4.31 Copeland Anti-Kickback Act.
- 2.4.32 Davis-Bacon Act.
- 2.4.33 Byrd Anti-Lobbying Amendment.
- 2.4.34 All federal and State nondiscrimination laws and Regulations.
- 2.4.35 Americans with Disabilities Act: The Contractor shall make reasonable accommodation for Individuals with disabilities, in accord with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit Individuals with disabilities from obtaining contracted services.
- 2.4.36 Any other requirements associated with the receipt of federal funds.
- 2.4.37 Any services provided to an individual enrolled in Medicaid are subject to applicable Medicaid rules.

2.5 Confidentiality

- 2.5.1 The Contractor shall protect and preserve the confidentiality of HCA's data or information that is defined as confidential under State or federal law or Regulation or data that HCA has identified as confidential.
- 2.5.2 The Contractor shall comply with all applicable federal and state laws and Regulations concerning collection, use, and disclosure of Personal Information set forth in Governor Locke's Executive Order 00-03 and Protected Health Information (PHI), defined at 45 C.F.R. § 160.103, as may be amended from time to time.
- 2.5.3 The Contractor shall not release, divulge, publish, transfer, sell, or otherwise make known to unauthorized third parties Personal Information or PHI without the advance express written consent of the individual who is the subject matter of the Personal Information or PHI or as otherwise required in this Contract or as permitted or required by state or federal law or Regulation.
- 2.5.4 The Contractor shall implement appropriate physical, electronic and managerial safeguards to prevent unauthorized access to Personal Information and PHI. The Contractor shall require the same standards of confidentiality of all its Subcontractors.
- 2.5.5 The Contractor agrees to share Personal Information regarding Individuals in a manner that complies with applicable state and federal law protecting confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 U.S.C. § 1320(d) et. seq. and 45 C.F.R. parts 160, 162, and 164., the HIPAA Regulations, 42 C.F.R. § 431 Subpart F, RCW 5.60.060(4), and Chapter 70.02 RCW). The Contractor and the Contractor's Subcontractors shall fully cooperate with HCA efforts to implement HIPAA requirements.
- 2.5.6 The Contractor shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss.
 - 2.5.6.1 This duty requires that Contractor employ reasonable security measures, which include restricting access to the Confidential Information by:
 - 2.5.6.1.1 Encrypting electronic Confidential Information during Transport;
 - 2.5.6.1.2 Physically securing and tracking media containing Confidential Information during Transport;
 - 2.5.6.1.3 Limiting access to staff that have an authorized business requirement to view the Confidential Information;
 - 2.5.6.1.4 Using access lists, Unique User ID and Hardened Password authentication to protect Confidential Information;

- 2.5.6.1.5 Physically securing any computers, documents or other media containing the Confidential Information; and
 - 2.5.6.1.6 Encrypting all Confidential Information that is stored on portable devices including but not limited to laptop computers and flash memory devices.
 - 2.5.6.2 Upon request by HCA the Contractor shall return the Confidential Information or certify in writing that the Contractor employed a HCA approved method to destroy the information. Contractor may obtain information regarding approved destruction methods from the HCA contact identified in this Contract.
- 2.5.7 In the event of a breach, meaning an acquisition, access, use, or disclosure of PHI in a manner not permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule which compromises the security or privacy of a Individual's PHI, the Contractor shall notify HCA in writing, as described in the Notices section of the General Terms and Conditions, within two (2) business days after determining notification must be sent to Individuals. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirement imposed by law (45 C.F.R. Part 164, Subpart D, WAC 284-04-625, RCW 19.255.010).
- 2.5.8 HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Individuals collected, used, or acquired by Contractor during the term of this Agreement to the extent permitted by law. All HCA representatives conducting onsite audits of Contractor agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.
- 2.5.9 Any material breach of this confidentiality provision may result in termination of this Contract. The Contractor shall indemnify and hold HCA harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Individuals.

2.6 **Covenant Against Contingent Fees**

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

2.7 **Debarment Certification**

- 2.7.1 The Contractor, by signature to this Contract, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded in any Washington State or federal department or agency from participating in transactions (debarred).
- 2.7.2 The Contractor agrees to include the above requirement in any and all Subcontracts into which it enters concerning the performance of services hereunder, and also agrees that it shall not employ debarred individuals or Subcontract with any debarred providers, persons, or entities.
- 2.7.3 The Contractor shall immediately notify HCA if, during the term of this Contract, the Contractor becomes debarred. HCA may immediately terminate this Contract by providing Contractor written notice in accord with Subsection 2.38 of this Contract if the Contractor becomes debarred during the term hereof.

2.8 **Defense of Legal Actions**

Each party to this Contract shall advise the other as to matters that come to its attention with respect to potential substantial legal actions involving allegations that may give rise to a claim for indemnification from the other. Each party shall fully cooperate with the other in the defense of any action arising out of matters related to this Contract by providing without additional fee all reasonably available information relating to such actions and by providing necessary testimony.

2.9 **Disputes**

When a dispute arises over an issue that pertains in any way to this Contract (other than overpayments, as described below), the parties agree to the following process to address the dispute:

- 2.9.1 The Contractor shall request a dispute resolution conference with the Agency Director. The request for a dispute resolution conference must be in writing and shall clearly state all of the following:
 - 2.9.1.1 The disputed issue(s).
 - 2.9.1.2 An explanation of the positions of the parties.
 - 2.9.1.3 Any additional facts necessary to explain completely and accurately the nature of the dispute.
- 2.9.2 Requests for a dispute resolution conference must be mailed to the Director, Washington State HCA, P.O. Box 45502, Olympia, WA 98504-5502. Any such requests must be received by the Director within thirty (30) calendar days after the Contractor receives notice of the disputed issue(s).

- 2.9.2.1 The Director, in his or her sole discretion, shall determine a time for the parties to present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's discretion. The Director shall provide written notice of the time, format, and location of the conference. The conference is informal in nature and is not governed in any way by the Administrative Procedure Act, chapter 34.05 RCW.
- 2.9.2.2 The Director shall consider all of the information provided at the conference and shall issue a written decision on the disputed issue(s) within thirty (30) calendar days after the conclusion of the conference. However, the Director retains the option of taking up to an additional sixty (60) calendar days to consider the disputed issue(s) or taking additional steps to attempt to resolve them. If the Director determines, in his or her sole discretion, that an additional period of up to sixty (60) calendar days is needed for review, he or she shall notify the Contractor, in writing, of the delay and the anticipated completion date before the initial thirty-day period expires.
- 2.9.2.3 The Director, at his or her sole discretion, may appoint a designee to represent him or her at the dispute conference. If the Director does appoint a designee to represent him or her at the dispute conference, the Director shall retain all final decision-making authority regarding the disputed issue(s). Under no circumstances shall the Director's designee have any authority to issue a final decision on the disputed issue(s).

- 2.9.3 The parties hereby agree that this dispute process shall precede any judicial or quasi-judicial proceeding and is the sole administrative remedy under this Contract.
- 2.9.4 Disputes regarding overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Section.

2.10 **Force Majeure**

If the Contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of a major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, such nonperformance shall not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to provide, directly or indirectly, alternative and, to the extent practicable, comparable performance. Nothing in this section shall be construed to prevent HCA from terminating this Contract for reasons other than for default during the period of events set forth above, or for default, if such default occurred prior to such event.

2.11 **Governing Law and Venue**

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

2.12 **Independent Contractor**

The parties intend that an independent Contractor relationship shall be created by this Contract. The Contractor and its employees or agents performing under this Contract are not employees or agents of the HCA or the State of Washington. The Contractor, its employees, or agents performing under this Contract shall not hold himself/herself out as, nor claim to be, an officer or employee of the HCA or the state of Washington by reason hereof, nor shall the Contractor, its employees, or agent make any claim of right, privilege or benefit that would accrue to such employee.

The Contractor acknowledges and certifies that neither HCA nor the state of Washington are guarantors of any obligations or debts of the Contractor.

2.13 **Insolvency**

If the Contractor becomes insolvent during the term of this Contract:

- 2.13.1 The state of Washington and Individuals shall not be, in any manner, liable for the debts and obligations of the Contractor.
- 2.13.2 The Contractor shall, in accordance with RCW 48.44.055, provide for the continuity of care for Individuals and shall provide Crisis Services and Involuntary Treatment Act services in accordance with Chapters 71.05 and 71.34.
- 2.13.3 The Contractor shall cover continuation of services to Individuals for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.
- 2.13.4 The above obligations shall survive the termination of this contract.

2.14 **Inspection**

- 2.14.1 The Contractor and its Subcontractors shall cooperate with all audits and investigations performed by duly authorized representatives of the state of Washington, HCA and Washington State Medicaid Fraud Control Division (MFCD), as well as the federal DHHS, auditors from the federal Government Accountability Office, federal Office of the Inspector General and federal Office of Management and Budget.
- 2.14.2 The Contractor and its Subcontractors shall provide access to their facilities and the records documenting the performance of this Contract, for purpose of audits, investigations, and for the identification and recovery of overpayments within thirty (30) calendar days, and access to its facilities and the records pertinent to this Contract to monitor and evaluate performance under this Contract, including, but not limited to, claims payment and the quality, cost, use, health and safety and timeliness of services, provider Network Adequacy, including panel capacity or willingness to accept new patients, and assessment of the Contractor's capacity to bear the potential financial losses.
- 2.14.3 The Contractor and its Subcontractors shall provide immediate access to facilities and records pertinent to this Contract for state or federal fraud investigators.

2.15 Insurance

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

- 2.15.1 Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. The state of Washington, HCA, its elected and appointed officials, agents, and employees shall be named as additional insured's expressly for, and limited to, Contractor's services provided under this Contract.
- 2.15.2 Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000.
- 2.15.3 Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and Regulations. The state of Washington and HCA shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and Regulations.
- 2.15.4 Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.
- 2.15.5 Subcontractors: The Contractor shall ensure that all Subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for Subcontractors, to HCA if requested.
- 2.15.6 Separation of Insured's: All insurance Commercial General Liability policies shall contain a "separation of insured's" provision.
- 2.15.7 Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the state of Washington, with a "Best's Reports" rating of A-, Class VII or better. Any exception must be approved by HCA. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.
- 2.15.8 Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accord with the Notices section of the General Terms and Conditions, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

- 2.15.9 **Material Changes:** The Contractor shall give HCA, in accord with the Notices section of the General Terms and Conditions, forty-five (45) calendar days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give HCA ten (10) calendar days advance notice of cancellation.
- 2.15.10 **General:** By requiring insurance, the state of Washington and HCA do not represent that the coverage and limits specified shall be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and HCA in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.
- 2.15.11 The Contractor may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers and Evidence of Coverage Provisions of this section if self-insured. In the event the Contractor is self-insured, the Contractor must send to HCA by the third Wednesday of January in each Contract year, a signed written document, which certifies that the Contractor is self-insured, carries coverage adequate to meet the requirements of this section, shall treat HCA as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA.
- 2.15.12 **Privacy Breach Response Coverage:** For the term of this Contract and three (3) years following its termination, the Contractor shall maintain insurance to cover costs incurred in connection with a Security Incident, privacy Breach, or potential compromise of data including:
- 2.15.12.1 Computer forensics assistance to assess the impact of a data Breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach notification laws (45. C.F.R. Part 164, Subpart D; RCW 42.56.590, RCW 19.255.010; and WAC 284-04-625).
 - 2.15.12.2 Notification and call center services for individuals affected by a Security Incident or privacy Breach.
 - 2.15.12.3 Breach resolution and mitigation services for individuals affected by a Security Incident or privacy Breach including fraud prevention, credit monitoring and identity theft assistance.
 - 2.15.12.4 Regulatory defense, fines and penalties from any claim in the form of a regulatory proceeding resulting from a violation of any applicable privacy or security law(s) or regulation(s).

2.16 **Records**

- 2.16.1 The Contractor and its Subcontractors shall maintain all financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.
- 2.16.2 All records and reports relating to this Contract shall be retained by the Contractor and its Subcontractors for a minimum of ten (10) years after final payment is made under this Contract. When an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of ten (10) years following resolution of such action.
- 2.16.3 The Contractor acknowledges the HCA is subject to the Public Records Act (Chapter 42.56 RCW). This Contract shall be a "public record" as defined in Chapter 42.56 RCW. Any documents submitted to HCA by the Contractor may also be construed as "public records" and therefore subject to public disclosure.

2.17 **Mergers and Acquisitions**

If the Contractor is involved in an acquisition of assets or merger with another HCA Contractor after the effective date of this Contract, HCA reserves the right, to the extent permitted by law, to require that each Contractor maintain its separate business lines for the remainder of the Contract period. The Contractor does not have an automatic right to a continuation of the Contract after any such acquisition of assets or merger.

2.18 **Notification of Organizational Changes**

The Contractor shall provide HCA with ninety (90) calendar days' prior written notice of any change in the Contractor's ownership or legal status. The Contractor shall provide HCA written notice of any changes to the Contractor's executive officers, executive board members, or medical directors within seven (7) days.

2.19 **Order of Precedence**

In the interpretation of this Contract and incorporated documents, the various terms and conditions shall be construed as much as possible to be complementary. In the event that such interpretation is not possible the following order of precedence shall apply:

- 2.19.1 Federal statutes and Regulations applicable to the services provided under this Contract.
- 2.19.2 State of Washington statutes and Regulations concerning the operation of HCA programs participating in this Contract.
- 2.19.3 Applicable state of Washington statutes and Regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers.
- 2.19.4 General Terms and Conditions of this Contract.
- 2.19.5 Any other term and condition of this Contract and exhibits.

2.19.6 Any other material incorporated herein by reference.

2.20 Severability

If any term or condition of this Contract is held invalid by any court of competent jurisdiction, and if all Appeals have been exhausted, such invalidity shall not affect the validity of the other terms or conditions of this Contract.

2.21 Survivability

The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: Fraud, Overpayment, Indemnification and Hold Harmless, Inspection, Maintenance of Records, and Data Use, Security, and Confidentiality. After termination of this Contract, the Contractor remains obligated to:

2.21.1 Submit reports required in this Contract.

2.21.2 Provide access to records required in accord with the Inspection provisions of this section.

2.21.3 Provide the administrative services associated with Contracted services (e.g., claims processing, Individual Appeals) provided to Individuals prior to the effective date of termination under the terms of this Contract.

2.21.4 Repay any overpayments that:

2.21.4.1 Pertain to services provided at any time during the term of this Contract; and

2.21.4.2 Are identified through an HCA audit or other HCA administrative review at any time on or before ten (10) years from the date of the termination of this Contract; or

2.21.4.3 Are identified through a fraud investigation conducted by the Medicaid Fraud Control Division (MFCD) or other law enforcement entity, based on the timeframes provided by federal or State law.

2.22 Waiver

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

2.23 Contractor Certification Regarding Ethics

The Contractor certifies that the Contractor is now, and shall remain, in compliance with Chapter 42.52 RCW, Ethics in Public Service, throughout the term of this Contract.

2.24 Health and Safety

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

2.25 Indemnification and Hold Harmless

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

2.25.2 The Contractor shall indemnify and hold harmless HCA from any claims by Participating Providers related to the provision of services to Individuals according to the terms of this Contract; this obligation shall not apply to any services that were unpaid due to non-payment of installment moneys by HCA. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees.

2.26 Industrial Insurance Coverage

The Contractor shall comply with the provisions of Title 51 RCW, Industrial Insurance. If the Contractor fails to provide industrial insurance coverage or fails to pay premiums or penalties on behalf of its employees, as may be required by law, HCA may collect from the Contractor the full amount payable to the Industrial Insurance accident fund. HCA may deduct the amount owed by the Contractor to the accident fund from the amount payable to the Contractor by HCA under this Contract, and transmit the deducted amount to the Department of Labor and Industries, (L&I) Division of Insurance Services. This provision does not waive any of L&I's rights to collect from the Contractor.

2.27 No Federal or State Endorsement

The award of this Contract does not indicate an endorsement of the Contractor by the federal government, or the state of Washington. No federal or state funds have been used for lobbying purposes in connection with this Contract.

2.28 Notices

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

2.28.1 In the case of notice to the Contractor, notice will be sent to:

Attn: Joe Valentine

North Sound Behavioral Health – Administrative Services Organization

301 Valley Mall Way, Suite 110

Mount Vernon, WA 98273

2.28.2 In the case of notice to HCA, send notice to:

HCA Contract Administrator

Division of Legal Services/Contracts Office

P.O. Box 42702

Olympia, WA 98504-2702

2.28.3 Notices shall be effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage.

2.28.4 Either party may at any time change its address for notification purposes by mailing a notice in accord with this section, stating the change and setting for the new address, which shall be effective on the tenth (10th) day following the effective date of such notice unless a later date is specified.

2.29 **Notice of Overpayment**

2.29.1 A Notice of Overpayment to the Contractor will be issued if HCA determines an overpayment has been made.

2.29.2 The Contractor may contest a Notice of Overpayment by requesting an adjudicative proceeding. The request for an adjudicative proceeding must:

2.29.2.1 Comply with all of the instructions contained in the Notice of Overpayment;

2.29.2.2 Be received by HCA within twenty-eight (28) calendar days of service receipt of the Notice of Overpayment by the Contractor;

2.29.2.3 Be sent to HCA by certified mail (return receipt), to the location specified in the Notice of Overpayment;

2.29.2.4 Include a statement and supporting documentation as to why the Contractor thinks the Notice of Overpayment is incorrect; and

2.29.2.5 Include a copy of the Notice of Overpayment.

- 2.29.3 If the Contractor submits a timely and complete request for an adjudicative proceeding, then the Office of Administrative Hearings will schedule the proceeding. The Contractor may be offered a pre-hearing or alternative dispute resolution conference in an attempt to resolve the dispute prior to the adjudicative proceeding. The adjudicative proceeding will be governed by the administrative procedure act, Chapter 34.05 RCW, and Chapter 182-526 WAC.
- 2.29.4 If HCA does not receive a request for an adjudicative proceeding within twenty-eight (28) calendar days of service of a Notice of Overpayment, then the Contractor will be responsible for repaying the amount specified in the Notice of Overpayment. This amount will be considered a final debt to HCA from the Contractor. HCA may charge the Contractor interest and any costs associated with the collection of the debt. HCA may collect an overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; withholding the amount of the debt from any future payment to the Contractor under this contract; or any other collection action available to HCA to satisfy the overpayment debt.
- 2.29.5 Nothing in this Agreement limits HCA's ability to recover overpayments under applicable law.

2.30 Proprietary Data or Trade Secrets

- 2.30.1 Except as required by law, Regulation, or court order, data identified by the Contractor as proprietary trade secret information shall be kept strictly confidential, unless the Contractor provides prior written consent of disclosure to specific parties. Any release or disclosure of data shall include the Contractor's interpretation.
- 2.30.2 The Contractor shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. If HCA anticipates releasing data that is identified as proprietary or trade secrets, HCA will notify the Contractor upon receipt of any request under the Public Records Act (Chapter 42.56 RCW) or otherwise for data or Claims Data identified by the Contractor as proprietary trade secret information and will not release any such information until five (5) business days after it has notified the Contractor of the receipt of such request. If the Contractor files legal proceedings within the aforementioned five (5) business day period in an attempt to prevent disclosure of the data, HCA agrees not to disclose the information unless it is ordered to do so by a court, the Contractor dismisses its lawsuit, or the Contractor agrees that the data may be released.
- 2.30.3 Nothing in this section shall prevent HCA from filing its own lawsuit or joining any other lawsuit in an attempt to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will promptly notify the Contractor of the filing of any such lawsuit.

2.31 Ownership of Material

HCA recognizes that nothing in this Contract shall give HCA ownership rights to the systems developed or acquired by the Contractor during the performance of this Contract. The Contractor recognizes that nothing in this Contract shall give the Contractor ownership rights to the systems developed or acquired by HCA during the performance of this Contract.

2.32 Solvency

- 2.32.1 The Contractor understands and agrees that it is required to make some advance payments under this contract prior to reimbursement from the state, and that the amount of such payments may vary on a month to month basis.
- 2.32.2 The Contractor understands and agrees that it must remain solvent at all times during the term of this contract, including any extensions to the term, and that the failure to remain solvent at all times is grounds for immediate termination by default.
- 2.32.3 The Contractor agrees that HCA at any time may access any information related to the Contractor's financial condition, and upon HCA's request, the Contractor shall furnish to HCA all such financial information and documentation they have concerning their current financial condition. This shall also include the production of financial information that may be held by a third party agent of the contractor; the Contractor hereby agrees to sign any necessary authorization to allow for the distribution of such information to HCA.
- 2.32.4 The Contractor shall notify HCA within ten (10) business days after the end of any month in which the Contractor's reserves reaches a level representing two (2) or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Contract or which may otherwise materially affect the relationship of the parties under this Contract.

2.33 Surety Bond

In RSAs where HCA approved use of a surety bond, the Contractor shall furnish to HCA a surety bond in the amount of \$1,000,000.00, or in an amount equal to the total minimum balance per region, found in the Region Reserve table, whichever is greater. The surety bond shall be provided to HCA within thirty (30) calendar days of the effective date, in a form satisfactory to HCA. The Contractor shall maintain the surety bond in effect until expiration or termination of the Contract. Any change or extension of time of this Contract shall in no way release the Contractor or any of its sureties from any of their obligations under the bond. Such bond shall contain a waiver of notice of any changes to this Contract. The Contractor shall notify its sureties and any bonding organizations of changes to this Contract.

No payment shall be made to the Contractor until this surety bond is in place and reviewed by HCA. The surety bond shall be issued by a licensed insurance company authorized to do business in the state of Washington and made payable to the Health Care Authority. The Contract number and dates of performance shall be specified in the surety bond. In the event that HCA exercises an option to extend the Contract for any additional period(s), Contractor shall extend the validity and enforcement of the surety bond for said periods.

An amount up to the full amount of the surety bond may also be applied to Contractor's liability for any administrative costs and/or excess costs incurred by HCA in obtaining similar products and services to replace those terminated as a result of Contractor's default. HCA may seek other remedies in addition to this stated liability.

2.34 Reserves

In RSAs where HCA has authorized reserves, the Contractor shall maintain a reserve, within the levels specified in the table found in this Section, for non-Medicaid services within the region. The funds must be deposited into a designated reserve account and may only drop below the minimum in the event the cost of providing psychiatric inpatient services or crisis services exceeds the revenue the Contractor receives. The Contractor may also use the allocated reserve funds that are in excess of the minimum required reserve level to ensure a smooth transition to integrated managed care. This includes: maintaining existing levels of regional BH crisis and diversion programs, and other required BH-ASO services, and to stabilize the crisis services system.

<u>Region Reserve</u>		
	<u>Minimum</u>	<u>Maximum</u>
King	\$3,112,709	\$5,370,943
Pierce	\$447,832	\$2,143,190
Spokane	\$502,787	\$1,486,293
Greater Columbia	\$450,353	\$1,796,025
North Central	\$201,757	\$638,393
North Sound	\$1,040,908	\$3,065,156

If the Contractor spends a portion of these funds, and the reserve balance drops below the minimum reserve amount, the Contractor must replenish the reserve account within one year, or at the end of the state fiscal year in which the funds were spent, whichever is longer. If HCA determines the reserves are outside the range found in the table in this Section, HCA may require a corrective action plan.

All expenditures of reserve funds shall be documented and included on Exhibit B, Non-Medicaid Expenditure Report.

If the Contractor terminates this contract for any reason or will not enter into any subsequent contracts, HCA shall require that all remaining reserves and fund balances be spent within a reasonable timeframe determined by HCA. Funds will be deducted from the monthly payments made by HCA to the BH-ASO until all reserves and fund balances are spent. Any funds not spent for the provision of services under this contract shall be returned to HCA within sixty (60) calendar days of the last day this contract is in effect.

2.35 Conflict of Interest Safeguards

The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public Contracting (42 C.F.R. 438.58).

2.36 **Reservation of Rights and Remedies**

A material default or breach in this Contract will cause irreparable injury to HCA. In the event of any claim for default or breach of this Contract, no provision in this Contract shall be construed, expressly or by implication, as a waiver by the State of Washington to any existing or future right or remedy available by law. Failure of the State of Washington to insist upon the strict performance of any term or condition of this Contract or to exercise or delay the exercise of any right or remedy provided in this Contract or by law, or the acceptance of (or payment for) materials, equipment or services, shall not release Contractor from any responsibilities or obligations imposed by this Contract or by law, and shall not be deemed a waiver of any right of the State of Washington to insist upon the strict performance of this Contract. In addition to any other remedies that may be available for default or breach of this Contract, in equity or otherwise, HCA may seek injunctive relief against any threatened or actual breach of this Contract without the necessity of proving actual damages. HCA reserves the right to recover any or all administrative costs incurred in the performance of this Contract during or as a result of any threatened or actual breach.

2.37 **Termination by Default**

2.37.1 Termination by Contractor. The Contractor may terminate this Contract whenever HCA defaults in performance of the Contract and fails to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after proper receipt from the Contractor of a written notice specifying the full nature of the default. For purposes of this section, "default" means failure of HCA to meet one or more material obligations of this Contract. In the event it is determined that HCA was not in default, HCA may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction.

2.37.2 Termination by HCA. HCA may terminate this Contract whenever HCA determines the Contractor has defaulted in performance of the Contract and has failed to cure the default within a reasonable period of as set by HCA, based on the nature of the default and how such default impacts possible Individuals. For purposes of this section, "default" means failure of Contractor to meet one or more material obligations of this Contract; this may minimally include the following:

2.37.2.1 The Contractor did not fully and accurately make any disclosure as required by the HCA.

2.37.2.2 The Contractor failed to timely submit accurate information as required by the HCA.

2.37.2.3 One of the Contractor's owners failed to timely submit accurate information as required by the HCA.

2.37.2.4 The Contractor's agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the Contractor, failed to timely submit accurate information as required by the HCA.

- 2.37.2.5 One of the Contractor's owners/administrators did not cooperate with any screening methods as required by the HCA.
- 2.37.2.6 One of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years.
- 2.37.2.7 The Contractor has been terminated under title XVIII of the Social Security Act, or under any states' Medicaid or CHIP program.
- 2.37.2.8 One of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by HCA within thirty (30) days of a HCA request.
- 2.37.2.9 The Contractor failed to permit access to one of the Contractor's locations for site visits.
- 2.37.2.10 The Contractor has falsified any information provided on its application.

2.38 Termination for Convenience

Notwithstanding any other provision of this Contract, the HCA may, by giving thirty (30) calendar days written notice, beginning on the second (2nd) day after the mailing, terminate this Contract in whole or in part when it is in the best interest of HCA, as determined by HCA in its sole discretion. If this Contract is so terminated, HCA shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination.

If the Contractor terminates this contract for convenience, the Contractor is required to provide no less than six (6) months advance notice in writing to HCA.

2.39 Terminations: Pre-termination Processes

- 2.39.1 Either party to the Contract shall give the other party to the Contract written notice, as described in the Notices section of the General Terms and Conditions of this Contract, of its intent to terminate this Contract and the reason for termination.
- 2.39.2 If either party disagrees with the other party's decision to terminate this Contract, that party will have the right to a dispute resolution as described in the Disputes section of this Contract.

2.40 Termination Due to Funding

In the event funding from any state, federal, or other source is withdrawn, reduced, or limited in any way after the date this Contract is signed and prior to the termination date, HCA may, in whole or in part, suspend or terminate this Contract upon fifteen (15) calendar days' prior written notice to Contractor or upon the effective date of withdrawn or reduced funding, whichever occurs earlier. At HCA's sole discretion the Contract may be renegotiated under the revised funding conditions. If this Contract is so terminated or suspended, HCA shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date.

2.41 Termination - Information on Outstanding Claims

In the event this Contract is terminated, the Contractor shall provide HCA, within ninety (90) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims or bills for contracted services to Individuals. Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions section of this Contract.

2.42 Administrative Simplification

The Contractor shall comply with the requirements of RCW 70.14.155 and Chapter 48.165 RCW.

2.42.1 To maximize understanding, communication, and administrative economy among all Contractors, their Subcontractors, governmental entities, and Individuals, Contractor shall use and follow the most recent updated versions of:

2.42.1.1 Current Procedural Terminology (CPT).

2.42.1.2 International Classification of Diseases (ICD).

2.42.1.3 Healthcare Common Procedure Coding System (HCPCS).

2.42.1.4 The Diagnostic and Statistical Manual of Mental Disorders.

2.42.1.5 National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard D.O.

2.42.1.6 Medi-Span® Master Drug Data Base or other nationally recognized drug data base with approval by HCA.

2.42.2 The Contractor must follow National Correct Coding Initiative (NCCI) policies to control improper coding that leads to inappropriate payments. The Contractor must incorporate compatible NCCI methodologies in its payment systems for processing claims. The NCCI editing should occur in addition to current procedure code review and editing by the Contractor's claims payment systems.

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

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

3 MATERIALS AND INFORMATION REQUIREMENTS

3.1 Media Materials and Publications

- 3.1.1 Media materials and publications developed with state funds shall be submitted to the HCA for written approval prior to publication. HCA must be cited as the funding source in news releases, publications, and advertising messages created with or about HCA funding. The funding source shall be cited as: The state of Washington Health Care Authority. The HCA logo may also be used in place of the above citation.
- 3.1.2 Materials described in 3.1.1 but not paid for by funds provided under this contract must be submitted to HCA for prior approval.
- 3.1.3 The Contractor is encouraged but is not required to submit the following items to HCA for approval:
 - 3.1.3.1 News coverage resulting from interviews with reporters including online news coverage;
 - 3.1.3.2 Pre-scheduled posts on electronic / social media sites;
 - 3.1.3.3 When a statewide media message developed by HCA is localized; and
 - 3.1.3.4 When SAMHSA-sponsored media campaign are localized.
- 3.1.4 Materials for Crisis Services
 - 3.1.4.1 The Contractor shall develop and implement a plan that educates and informs community stakeholders to include: residents of the RSA, Health Care Providers, First Responders, the criminal justice community, educational systems, and faith-based organizations.
 - 3.1.4.2 After the initial contract period, provide an update by March 31 on a two (2) year cycle as determined by HCA.
 - 3.1.4.3 Publicize the regional crisis system services and facilitate awareness of the existence of the Behavioral Health Crisis Services for all stakeholders.

3.2 Information Requirements for Individuals

- 3.2.1 Upon an Individual's request, the Contractor shall provide all relevant licensure, certification and accreditation status and information for any contracted provider.

3.3 Equal Access for Individuals with Communication Barriers

The Contractor shall assure equal access for all Individuals when oral or written language creates a barrier to such access.

- 3.3.1 Oral Information:

3.3.1.1 The Contractor shall assure that interpreter services are provided for Individuals with a preferred language other than English, free of charge. This includes the provision of interpreters for Individuals who are deaf or hearing impaired, including American Sign Language (ASL). Interpreter services shall be provided for all interactions between such Individuals and the Contractor or any of its providers including, but not limited to:

3.3.1.1.1 Customer service;

3.3.1.1.2 All appointments with any provider for any covered service; and

3.3.1.1.3 All steps necessary to file Grievances and Appeals.

3.3.2 Written Information:

3.3.2.1 The Contractor shall provide all generally available and Individual-specific written materials in a language and format which may be understood by each Individual in each of the prevalent languages that are spoken by five percent (5%) or more of the population of the RSA based on information obtained from HCA.

3.3.2.2 For Individuals whose preferred language has not been translated as required in this Section, the Contractor may meet the requirement of this section by doing any one of the following:

3.3.2.2.1 Translating the material into the Individual's preferred reading language;

3.3.2.2.2 Providing the material in an audio format in the Individual's preferred language;

3.3.2.2.3 Having an interpreter read the material to the Individual in the Individual's preferred language;

3.3.2.2.4 Providing the material in another alternative medium or format acceptable to the Individual. The Contractor shall document the Individual's acceptance of the material in an alternative medium or format; or

3.3.2.2.5 Providing the material in English, if the Contractor documents the Individual's preference for receiving material in English.

3.3.3 The Contractor shall ensure that all written information provided to Individuals is accurate, is not misleading, is comprehensible to its intended audience, is designed to provide the greatest degree of understanding, is written at the sixth (6th) grade reading level, and fulfills other requirements of the Contract as may be applicable to the materials.

- 3.3.4 HCA may make exceptions to the sixth (6th) grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth (6th) grade reading level or the Individual's needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth (6th) grade reading level must be in writing.
- 3.3.5 Educational materials about topics or other information used by the Contractor for health promotion efforts must be submitted to HCA, but do not require HCA approval as long as they do not specifically mention the Contracted Services.
- 3.3.6 Educational materials that are not developed by the Contractor or by the Contractor's Subcontractors are not required to meet the sixth (6th) grade reading level requirement and do not require HCA approval.
- 3.3.7 For Individual-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved materials in final form.

4 SERVICE AREA AND INDIVIDUAL ELIGIBILITY

4.1 Service Areas

The Contractor's policies and procedures related to eligibility shall ensure compliance with the requirements described in this section. The Contractor's RSAs are described in Exhibit L, Service Area Matrix.

4.2 Service Area Changes

- 4.2.1 The Contractor must offer services to all Individuals within the boundaries of the RSA covered by this Contract.
- 4.2.2 The Contractor may not decrease its service areas or its level of participation in any service area except during Contract renewal.
- 4.2.3 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's RSA, HCA shall alter the service area zip code numbers or the boundaries of the service areas with input from the Contractor.
- 4.2.4 HCA shall determine, in its sole judgment, which zip codes fall within each service area.
- 4.2.5 HCA will use the Individual's residential zip code to determine whether an Individual resides within a service area.

4.3 Eligibility

- 4.3.1 All individuals in the Contractor's RSA regardless of insurance status, ability to pay, county of residence, or level of income are eligible to receive medically necessary Behavioral Health Crisis Services, and services related to the administration of the Involuntary Treatment Act and Involuntary Commitment Act (Chapters 71.05 and 71.34 RCW).
- 4.3.2 The Contractor has discretion on the use of funds for the provision of non-crisis behavioral health services including crisis stabilization and voluntary Behavioral Health admissions for Individuals in the Contractor's RSA who are not eligible for Medicaid and/or do not have third party insurance.
- 4.3.3 To be eligible for any non-crisis Behavioral Health service under this Contract, an individual must meet the financial eligibility criteria and the clinical or program eligibility criteria for the GFS/FBG service:
 - 4.3.3.1 Individuals who do not qualify for Medicaid and have income up to two hundred twenty percent (220%) of the federal poverty level meet the financial eligibility for all of the GFS/FBG services.
 - 4.3.3.2 For services in which medical necessity criteria applies, all services must be medically necessary.

- 4.3.3.3 As defined in this Contract, certain populations have priority to receive services.
- 4.3.4 Meeting the eligibility requirements under this Contract does not guarantee the Individual will receive a non-crisis behavioral health service. Services other than Behavioral Health Crisis Services and ITA-related services are contingent upon Available Resources as managed by the Contractor.
- 4.3.5 Eligibility functions may be done by the Contractor or delegated to providers. If delegated to providers, the Contractor shall monitor the providers' use of such protocols and ensure appropriate compliance in determining eligibility.
 - 4.3.5.1 The Contractor shall develop eligibility data collection protocols for providers to follow to ensure that the provider checks the individual's Medicaid eligibility prior to providing a service and captures sufficient demographic, financial, and other information to support eligibility decisions and reporting requirements.
 - 4.3.5.2 At HCA's direction, the Contractor shall participate with the regional IMC MCOs in a regional initiative to develop and implement consistent protocols to determine clinical or program eligibility for the non-crisis Behavioral Health services.
 - 4.3.5.3 The Contractor shall participate in developing protocols for individuals with frequent eligibility changes. The protocols will address, at a minimum, coordination with the AH-IMC MCOs, referrals, reconciliations, and potential transfer of GFS/FBG funds to promote Continuity of Care for the individual. Any reconciliation will occur at a frequency determined by HCA, but no less than semiannually, with potential for up to monthly reconciliations in the last quarter of the allocation year.

5 PAYMENT AND SANCTIONS

5.1 Funding

- 5.1.1 The funds under this Contract are dependent upon HCA's receipt of continued state and federal funding. If HCA does not receive continued state and federal funding, HCA may terminate this Contract in accordance with this Contract's General Terms and Conditions.
- 5.1.2 HCA will provide the Contractor with its budget of State-Only, proviso, and FBG funds prior to the beginning of the state fiscal year as identified in Exhibit A. As regions integrate, the Contractor's budget will be based upon available funding for the RSA. At HCA's discretion, the Contractor's budget of GFS and proviso funds may be amended as described in Section 5.1.7.
- 5.1.3 A maximum of ten percent (10%) of available funds paid to the Contractor may be used for administrative costs, taxes and other fees per RCW 71.24.330. A maximum of five percent (5%) of State-Only and proviso funds paid to the Contractor may be used for direct service support costs. The Contractor shall not use FBG funds for administrative costs or direct service support costs. Administrative and direct service support costs must be reported on the Exhibit B, Non-Medicaid Expenditure Report.
- 5.1.4 HCA will pay the allocation of State-Only and proviso funds, including the administrative portion, to the Contractor in equal monthly installments at the beginning of each calendar month.
- 5.1.5 HCA will pay the Contractor FBG funds monthly based upon receipt of the Forms A-19.
- 5.1.6 The Contractor shall send Exhibit B, Non-Medicaid Expenditure Report to the HCA Contract Manager no later than thirty (30) calendar days after the last day of the quarter. The expenditures reported shall represent the payments made for services under this contract during the quarter being reported. The ten percent (10%) administrative load identified in this Section will be included on the report.
- 5.1.7 After July 1, 2019, HCA will perform a reconciliation of the Contractor's expenditure reports to its budget. Based upon the results of the reconciliation, at HCA's discretion, the allocation and distribution of GFS and proviso funds may be re-evaluated and unspent funds may be reallocated retrospectively. If the expenditures reported by the Contractor on the expenditure report exceed the Contractor's budget identified in Exhibit A, HCA will not reimburse the Contractor for the amount that exceeds the budget.
- 5.1.8 For all services, the Contractor must determine whether the Individual receiving services is eligible for Medicaid or has other insurance coverage.
- 5.1.8.1 For individuals eligible for Medicaid or other insurance, the Contractor must submit the claim for services to the appropriate party.

- 5.1.8.2 For those individuals who are not eligible for Medicaid coverage, or are unable to pay co-pays or deductibles, the Contractor may offer a sliding fee schedule in accordance with this Contract.
- 5.1.9 For FBG services, the Contractor shall comply with the utilization funding agreement guidelines within the State's most recent FBG plan. The Contractor agrees to comply with Title V, Section 1913 of the Public Health Services Act [42 U.S.C. 300x-1 et seq.]. The Contractor shall not use MHBG funds for the following:
 - 5.1.9.1 The Contractor's administrative costs associated with salaries and benefits at the Contractor's organization level.
 - 5.1.9.2 Inpatient mental health services.
 - 5.1.9.3 Construction and/or renovation.
 - 5.1.9.4 Capital assets or the accumulation of operating reserve accounts.
 - 5.1.9.5 Equipment costs over \$5,000.
 - 5.1.9.6 Cash payments to Individuals.
- 5.1.10 Unless otherwise obligated, funds allocated under this Contract that are not expended by the end of the applicable state fiscal year may be used or carried forward to the subsequent state fiscal year. Unspent allocations shall be reported to HCA at the end of the applicable state fiscal year, as specified in this Contract. In order to expend these funds the Contractor shall submit a Plan to HCA for approval.
- 5.1.11 The Contractor shall ensure that all funds provided pursuant to this Contract, (other than the ten percent (10%) allowed for administration and five percent (5%) for direct service supports) including interest earned, are to be used to provide services as described in this contract.

5.2 State Hospital Beds

- 5.2.1 HCA will provide a target for the utilization of State Hospital beds to the Contractor as described in this contract for each RSA in which the Contractor operates under the Contract. The utilization target will be determined by HCA. The Contractor for each RSA will not be held accountable in the event of a regional overage fee and will not collect any portion of an incentive payment. HCA will notify the Contractor of changes to the hospital bed allocation.
- 5.2.2 The Contractor may not enter into any agreement or make other arrangements for use of State Hospital beds outside of this Contract.

5.3 Inpatient Psychiatric Stays Outside the State Hospital System

HCA will pay professional fees on a fee-for-service basis directly to the hospital for inpatient psychiatric stays that are authorized by the Contractor. The inpatient hospital claim(s) will be paid by the Contractor. If the Contractor chooses to use the ProviderOne system for inpatient claims processing, HCA, for calendar year 2019, will provide a bill to the Contractor on a monthly basis for claims paid on behalf of the Contractor. The Contractor shall reimburse HCA within thirty (30) calendar days from the receipt of the inpatient claims to pay the applicable costs.

5.4 Non-Compliance

5.4.1 Failure to Maintain Reporting Requirements

In the event the Contractor fails to maintain its reporting obligations under this Contract, HCA reserves the right to withhold reimbursements to the Contractor until the obligations are met.

5.4.2 Recovery of Costs Claimed in Error

If HCA reimburses the Contractor for expenditures under this Contract which HCA later finds were claimed in error or were not allowable costs under the terms of the Contract, HCA shall recover those costs and the Contractor shall fully cooperate with the recovery.

5.4.3 Stop Placement:

DOH, HCA or DSHS may stop the placement of an Individual in a treatment facility immediately upon finding that the Contractor or a Subcontractor is not in substantial compliance, with provisions of this Contract or any WAC related to SUD treatment as determined by DOH. The treatment facility will be notified of this decision in writing.

5.4.4 Additional Remuneration Prohibited

5.4.4.1 The Contractor and its Subcontractors shall not charge or accept additional fees from any patient, relative, or any other person, for FBG services provided under this Contract other than those specifically authorized by HCA. In the event the Contractor or Subcontractor charges or accepts prohibited fees, HCA shall have the right to assert a claim against the Contractor or Subcontractors on behalf of the client, per Chapter 74.09 RCW. Any violation of this provision shall be deemed a material breach of this Contract.

5.4.4.2 The Contractor must reduce the amount paid to providers by any sliding fee schedule amounts collected from Individuals in accordance with this Contract.

5.5 Overpayments or Underpayments

5.5.1 If, at HCA's sole discretion, HCA determines as a result of data errors or inadequacies, policy changes beyond the control of the Contractor, or other causes, there are material errors or omissions in the allocation of GFS/FBG funds, HCA may make prospective and/or retrospective modifications to the funding allocations.

5.6 Sanctions

If the Contractor fails to meet one or more of its obligation under the terms of this Contract or other applicable law, HCA may:

- 5.6.1 Initiate remedial action if it is determined that any of the following situations exist:
 - 5.6.1.1 A problem exists that negatively impacts Individuals receiving services.
 - 5.6.1.2 The Contractor has failed to perform any of the Contracted Services.
 - 5.6.1.3 The Contractor has failed to develop, produce, and/or deliver to HCA any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described in this Contract.
 - 5.6.1.4 The Contractor has failed to perform any Administrative Function required under this Contract.
 - 5.6.1.5 The Contractor has failed to implement corrective action required by the State and within HCA prescribed timeframes.
- 5.6.2 Impose any of the following remedial actions:
 - 5.6.2.1 Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to HCA within thirty (30) calendar days of notification. HCA may accept the plan, require modifications or reject the plan. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Contract. HCA may extend or reduce the time allowed for corrective action depending upon the nature of the situation. Corrective action plans shall include:
 - 5.6.2.1.1 A brief description of the situation requiring corrective action.
 - 5.6.2.1.2 The specific actions to be taken to remedy the situation.
 - 5.6.2.1.3 A timetable for completion of the action(s).
 - 5.6.2.1.4 Identification of individuals responsible for implementation of the plan.
 - 5.6.2.2 Withhold up to five percent (5%) of the next payment and each payment thereafter if the Contractor fails to submit, gain HCA approval of or implement the requested corrective action plan within agreed upon timeframes. The amount of withhold will be based on the severity of the situation as detailed in this section. HCA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

5.6.2.3 Increase withholdings identified in this section by up to an additional three percent (3%) for each successive month during which the corrective action plan has not been submitted or implemented.

5.6.3 Deny any incentive payment to which the Contractor might otherwise have been entitled under this Contract.

5.6.4 Terminate for Default as described in the General Terms and Conditions.

5.7 Mental Health Payer

The Contractor shall follow the rules for payer of responsibility set forth in the table labelled "How do providers identify the correct payer?" in the Apple Health Mental Health Services Billing Guide.

6 ACCESS TO CARE AND PROVIDER NETWORK

6.1 Network Capacity

6.1.1 The Contractor shall maintain and monitor an appropriate and adequate provider network, supported by written agreements, sufficient to provide all contracted services under this Contract.

6.1.1.1 The Contractor may provide contracted services through Non-Participating Providers, at a cost to the individual that is no greater than if the contracted services were provided by Participating Providers, if its network of Participating Providers is insufficient to meet the Behavioral Health needs of individuals in a manner consistent with this Contract.

6.1.1.2 This provision shall not be construed to require the Contractor to cover such services without authorization.

6.1.1.3 To the extent necessary to provide non-crisis Behavioral Health services covered under this Contract, the Contractor may offer contracts to providers in other RSAs in the state of Washington and to providers in bordering states.

6.1.1.4 The Contractor may not contract for Crisis Services (SUD or Mental Health) or ITA-related services out of Washington State.

6.1.2 The Contractor must submit a network of crisis service providers adequate to serve the population in the Contractor's RSA annually by November 1. If the Contractor fails to provide evidence of or HCA is unable to validate contracts with a sufficient number of providers, HCA may terminate this contract. The network must have sufficient capacity to serve the RSA and include, at a minimum:

6.1.2.1 Designated Crisis Responder (DCR);

6.1.2.2 Evaluation and treatment (E&T) and [Secure Withdrawal Management and Stabilization](#) capacity to serve the RSA's non-Medicaid population;

6.1.2.3 Psychiatric inpatient beds to serve the RSA's non-Medicaid population;

- 6.1.2.4 Staff to provide mobile crisis outreach in the RSA.
- 6.1.3 The Contractor shall notify HCA ninety (90) calendar days prior to terminating any of its Subcontracts or entering into new Subcontracts with entities that provide direct services, including Crisis Services providers. This notification shall occur prior to any public announcement of this change.
 - 6.1.3.1 If a Subcontract is terminated or a site closure occurs in less than the ninety (90) calendar days, the Contractor shall notify HCA as soon as possible.
 - 6.1.3.2 If a Subcontract is terminated or a site closes unexpectedly, the Contractor shall submit a plan within seven (7) calendar days to HCA that includes:
 - 6.1.3.2.1 Notification to Ombuds services and Individuals;
 - 6.1.3.2.2 A provision for uninterrupted services; and
 - 6.1.3.2.3 Any information released to the media.
 - 6.1.3.3 HCA reserves the right to impose sanctions, in accordance with the Sanctions subsection of this Contract, if the Contractor was notified by the terminating provider in a timely manner and does not comply with the notification requirements of this section.
 - 6.1.3.3.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor shall provide documentation of the date of notification along with the notice of loss of a terminating provider.
 - 6.1.3.4 Provider network information will be reviewed by HCA for:
 - 6.1.3.4.1 Completeness and accuracy;
 - 6.1.3.4.2 Removal of providers who no longer contract with the Contractor; and
 - 6.1.3.4.3 The effect the change(s) in the provider network will have on the Contractor's compliance with the network requirements of this section.
- 6.1.4 The Contractor shall meet the following requirements when developing its network:
 - 6.1.4.1 Only licensed or certified Behavioral Health Providers shall provide behavioral health services. Licensed or certified Behavioral Health Providers include, but are not limited to: Health Care Professionals, licensed agencies or clinics, or professionals operating under an agency affiliated license.

- 6.1.4.2 Within available resources, establish and maintain contracts with office-based opioid treatment providers that have obtained a waiver under the Drug Addiction Treatment Act of 2000 to practice medication-assisted opioid addiction therapy.
 - 6.1.4.3 Assist the State in expanding community-based alternatives for crisis stabilization, such as mobile crisis outreach or crisis residential and respite beds.
 - 6.1.4.4 Assist the State in expanding community-based, recovery-oriented services, use of Certified Peer Counselors and Research- and Evidence-Based Practices.
- 6.1.5 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network for Crisis Services, HCA reserves the right to immediately terminate this contract.

6.2 **Priority Population Considerations**

- 6.2.1 In establishing, maintaining, monitoring and reporting of its network, the Contractor must consider the following:
- 6.2.1.1 The expected utilization of services, the characteristics and health care needs of the population, the number and types of providers (training, experience and specialization) able to furnish services, and the geographic location of providers and individuals (including distance, travel time, means of transportation ordinarily used by Individuals, and whether the location is ADA accessible) for all Contractor funded behavioral health programs and services based on Available Resources.
 - 6.2.1.2 The anticipated needs of priority populations identified in this Contract.
- 6.2.2 The Contractor and its Subcontractors shall:
- 6.2.2.1 Ensure that all services and activities provided under this Contract shall be designed and delivered in a manner sensitive to the needs of the diverse population;
 - 6.2.2.2 Initiate actions to develop or improve access, retention, and cultural relevance of treatment, relapse prevention or other appropriate services, for ethnic minorities and other diverse populations in need of services under this Contract as identified in their needs assessment.

6.3 **Hours of Operation for Network Providers**

The Contractor shall require that providers offer hours of operation for Individuals that are no less than the hours of operation offered to any other patient.

6.4 **Customer Service**

The Contractor shall have a single toll-free number for Individuals to call regarding services, at its expense, which shall be a separate and distinct number from the Contractor's regional crisis toll free telephone number(s). The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8:00 a.m. to 5:00 p.m. Pacific Time, or alternative hours as agreed to by HCA, Monday through Friday, year round and shall provide customer service on all dates recognized as work days for state employees. The Contractor shall report to HCA by December 1 of each year its scheduled non-business days for the upcoming calendar year.

- 6.4.1 The Contractor must notify HCA five (5) business days in advance of any non-scheduled closure during scheduled business days, except in the case when advance notification is not possible due to emergency conditions.
- 6.4.2 The Contractor and its Individual customer service centers, if any, shall comply with the following performance standards:
 - 6.4.2.1 Telephone abandonment rate – standard is less than five percent (5%).
 - 6.4.2.2 Telephone response time – average speed of answer within thirty (30) seconds.
- 6.4.3 The Contractor shall staff its call center with a sufficient number of trained customer service representatives to answer the phones. Staff shall be able to access information regarding eligibility requirements and benefits; GFS/FBG services; refer for behavioral health services; and resolve Grievances and triage Appeals.
- 6.4.4 The Contractor shall develop and maintain customer service policies and procedures that address the following:
 - 6.4.4.1 Information on Contracted Services including where and how to access them;
 - 6.4.4.2 Authorization requirements; and
 - 6.4.4.3 Requirements for responding promptly to family members and supporting links to other service systems such as Medicaid services administered by the AH-IMC MCO, First Responders, criminal justice system, and social services.
- 6.4.5 Providing Individuals with access to qualified clinicians without placing the Individual on hold. The clinician shall assess the crisis and warm transfer the call to a DCR, call 911, refer the Individual for services or to his or her provider, or resolve the crisis.
- 6.4.6 The Contractor shall train customer service representatives on GFS/FBG policies and procedures.

6.5 **Priority Populations and Waiting Lists**

The Contractor shall comply with the following requirements:

- 6.5.1 For SABG services:

6.5.1.1 SABG services shall be provided in the following priority order to:

6.5.1.1.1 Pregnant injecting drug users.

6.5.1.1.2 Pregnant substance abusers.

6.5.1.1.3 Women with dependent children.

6.5.1.1.4 Injecting drug users.

6.5.1.2 The following are additional priority populations for SABG services, in no particular order:

6.5.1.2.1 Postpartum women up to one (1) year, regardless of pregnancy outcome).

6.5.1.2.2 Patients transitioning from residential care to outpatient care.

6.5.1.2.3 Youth.

6.5.1.2.4 Offenders.

6.5.2 For non-crisis behavioral health services funded by GFS:

6.5.2.1 The Contractor shall provide non-crisis Behavioral Health services funded by GFS, within Available Resources, to Individuals who meet financial eligibility standards in this Contract and meet one of the following criteria:

6.5.2.1.1 Are uninsured;

6.5.2.1.2 Have insurance, but are unable to pay the co-pay or deductible for services;

6.5.2.1.3 Are using excessive Crisis Services due to inability to access non-crisis behavioral health services; and

6.5.2.1.4 Have more than five (5) visits over six (6) months to the emergency department, detox facility, or a sobering center due to a SUD.

6.5.3 The Contractor will implement protocols for maintaining Waiting Lists and providing Interim Services for members of SABG priority populations, who are eligible but for whom SUD treatment services are not available due to limitations in provider capacity or Available Resources.

6.6 Access to SABG Services

6.6.1 The Contractor shall, within Available Resources, ensure that SABG services are not denied to any eligible Individuals regardless of:

6.6.1.1 The Individual's drug(s) of choice.

- 6.6.1.2 The fact that an Individual is taking medically-prescribed medications.
- 6.6.1.3 The fact that an Individual is using over the counter nicotine cessation medications or actively participating in a nicotine replacement therapy regimen.
- 6.6.2 The Contractor shall, as required by the SABG Block Grant, ensure Interim Services are provided for Pregnant and Post-partum Women and Individuals Using Intravenous Drugs.
 - 6.6.2.1 Interim Services shall be made available within forty-eight (48) hours of seeking treatment. The Contractor shall document the provision of Interim Services. Interim Services shall include, at a minimum:
 - 6.6.2.1.1 Counseling on the effects of alcohol and drug use on the fetus for pregnant women.
 - 6.6.2.1.2 Referral for prenatal care.
 - 6.6.2.1.3 Human immunodeficiency virus (HIV) and tuberculosis (TB) education.
 - 6.6.2.2 TB treatment services if necessary IUID.
 - 6.6.2.3 Admission to treatment services for the intravenous drug user shall be provided within fourteen (14) days after the Individual makes the request, regardless of funding source.
 - 6.6.2.4 If there is no treatment capacity within fourteen (14) days of the initial Individual request, the Contractor shall have up to one hundred twenty (120) days after the date of such request to admit the Individual into treatment. The Contractor shall offer or refer the Individual to Interim Services within forty-eight (48) hours of the initial request for treatment services.
- 6.6.3 A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of detoxification, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within twenty-four hours.
- 6.6.4 **Capacity Management** (42 U.S.C. 300-23 and 42 U.S.C. 300X 27)
 - 6.6.4.1 The Contractor must notify HCA, in writing, when its network of SABG providers is at ninety (90) percent capacity.
 - 6.6.4.2 On a quarterly basis, submit Exhibit D, SABG Capacity Management Form on the last day of the month following the close of the quarter.
 - 6.6.4.3 The Capacity Management Form must identify PPW and IUID providers receiving SABG funds, who are at ninety percent (90%) capacity, and what action was taken to address capacity.

- 6.6.5 Tuberculosis Screening, Testing and Referral (42 U.S.C. 300x-24(a) and 45 CFR 96.127)
 - 6.6.5.1 The Contractor must directly or through arrangement with other public entities, make tuberculosis services available to each Individual receiving SABG-funded SUD treatment. The services must include tuberculosis counseling, testing, and provide for or refer Individuals with tuberculosis for appropriate medical evaluation and treatment.
 - 6.6.5.2 When an Individual is denied admission to the tuberculosis program because of the lack of capacity, the Contractor will refer the Individual to another provider of tuberculosis services.
 - 6.6.5.3 The Contractor must conduct case management activities to ensure the Individual receives tuberculosis services.
- 6.6.6 Outreach to Individuals Using Intravenous Drugs (IUID)
 - 6.6.6.1 The Contractor shall ensure that Opiate Dependency Outreach is provided to IUID. (45 C.F.R. 96.126)(e)).

7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1 Quality Management Program

- 7.1.1 The Contractor shall ensure its Quality Management (QM) program addresses GFS/FBG requirements according to this Contract and meets Crisis Services Performance Measures, described in this Contract and Exhibit F, Federal Block Grant Annual Progress Report. It shall be the obligation of the Contractor to remain current with all GFS/FBG requirements.
- 7.1.2 The Contractor shall participate in a Community BHAB and attend meetings as required by established bylaws.

7.2 Quality Review Activities

- 7.2.1 The HCA, Office of the State Auditor, or any of their duly-authorized representatives, may conduct announced and unannounced:
 - 7.2.1.1 Surveys, audits, and reviews of compliance with licensing and certification requirements and the terms of this Contract.
 - 7.2.1.2 Audits regarding the quality, appropriateness, and timeliness of behavioral health services provided under this Contract.
 - 7.2.1.3 Audits and inspections of financial records.
- 7.2.2 The Contractor shall participate with HCA in Quality Review activities. Participation will include at a minimum:
 - 7.2.2.1 The submission of requested materials necessary for an HCA initiated review within thirty (30) calendar days of the request.
 - 7.2.2.2 The completion of site visit protocols provided by HCA.
 - 7.2.2.3 Assistance in scheduling interviews and agency visits required for the completion of the review.
- 7.2.3 The Contractor shall notify HCA immediately when any entity other than the State Auditor gives notice of an audit related to any activity contained in this Contract.

7.3 Performance-Measurement Reporting

- 7.3.1 At HCA's discretion, individual performance measures will be linked to potential payment adjustments.
- 7.3.2 The Contractor shall comply with the reporting and data submissions requirements as directed by HCA.
- 7.3.3 For each RSA, the Contractor shall provide all relevant crisis response system and service reports as directed by HCA.

7.4 Critical Incident Reporting

The Contractor shall establish a Critical Incident Management System consistent with all applicable laws and shall include policies and procedures for identification of incidents, reporting protocols and oversight responsibilities. The Contractor shall increase intervention for an Individual when incident behavior escalates in severity or frequency.

The Contractor shall communicate with the appropriate MCO when the Contractor becomes aware of an incident for a Medicaid Enrollee.

- 7.4.1 The Contractor shall submit an individual Critical Incident report for non-Medicaid Individuals for the following incidents:
 - 7.4.1.1 Homicide or attempted homicide by an Individual.
 - 7.4.1.2 A major injury or trauma that has the potential to cause prolonged disability or death, or the unexpected death of an Individual that occurs in a facility licensed by the state of Washington to provide publicly funded Behavioral Health services.
 - 7.4.1.3 An unexpected death of an Individual that occurs in a facility licensed by the state of Washington to provide publicly funded BH services.
 - 7.4.1.4 Abuse, neglect or exploitation of an Individual (not to include child abuse).
 - 7.4.1.5 Violent acts allegedly committed by an Individual to include:
 - 7.4.1.5.1 Arson.
 - 7.4.1.5.2 Assault resulting in serious bodily harm.
 - 7.4.1.5.3 Homicide or attempted homicide by abuse.
 - 7.4.1.5.4 Drive-by shooting.
 - 7.4.1.5.5 Extortion.
 - 7.4.1.5.6 Kidnapping.
 - 7.4.1.5.7 Rape, sexual assault or indecent liberties.
 - 7.4.1.5.8 Robbery.
 - 7.4.1.5.9 Vehicular homicide.
 - 7.4.1.6 Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e. Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions.

- 7.4.1.7 Any event involving an Individual that has attracted or is likely to attract media attention.
- 7.4.2 The Contractor shall report Critical Incidents within one business day in which the Contractor becomes aware of the event. The report shall include:
 - 7.4.2.1 The date the Contractor becomes aware of the incident;
 - 7.4.2.2 The date and time of the incident;
 - 7.4.2.3 A description of the incident;
 - 7.4.2.4 The name of the facility where the incident occurred, or a description of the incident location;
 - 7.4.2.5 The name(s) and age(s) of Individuals involved in the incident;
 - 7.4.2.6 The name(s) and title(s) of facility personnel or other staff involved;
 - 7.4.2.7 The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement;
 - 7.4.2.8 The Individual's location at the time of the report if known (i.e. home, jail, hospital, unknown, etc.) or actions taken by the Contractor to locate the Individual;
 - 7.4.2.9 Actions planned or taken by the Contractor to minimize harm resulting from the incident; and
 - 7.4.2.10 Any legally required notifications made by the Contractor.
- 7.4.3 The Contractor shall report Critical Incidents using the HCA Incident Reporting System at <https://fortress.wa.gov/hca/ics/> if the system is unavailable the Contractor shall report Critical Incidents to HCABHASO@hca.wa.gov.
- 7.4.4 The Contractor shall submit follow-up reports using the Incident Reporting System and close the case within forty-five (45) calendar days after the Critical Incident was initially reported. A case cannot be closed until the following information is provided:
 - 7.4.4.1 A summary of any debriefings;
 - 7.4.4.2 Whether the Individual is in custody (jail), in the hospital or in the community;
 - 7.4.4.3 Whether the Individual is receiving services and include the types of services provided;
 - 7.4.4.4 If the Individual cannot be located, the steps the Contractor has taken to locate the Individual using available, local resources; and

7.4.4.5 In the case of the death of an Individual, verification from official sources that includes the date, name and title of the sources. When official verification cannot be made, the Contractor shall document all attempts to retrieve it.

7.4.5 The Contractor shall submit a semiannual report of all Critical Incidents tracked by the Contractor. At minimum, the report shall include an analysis of the following incidents:

7.4.5.1 Incidents identified through the Individual Critical Incidents process;

7.4.5.2 A credible threat to an Individual's safety;

7.4.5.3 Any allegation of financial exploitation of an enrollee;

7.4.5.4 Suicide and attempted suicide; and

7.4.5.5 Other incidents as defined in the Contractor's Policies and Procedures.

The following elements shall be included in the analysis: The number and types of Critical Incidents and comparison of changes over time; analysis of Critical Incidents that repeat; trends found in the population (i.e. regional differences, demographic groups, vulnerable populations); analysis of the effectiveness of the Critical Incident Management System; and action taken by the Contractor to reduce incidents.

The report is due no later than the last business day of January and July for the prior six (6) month period.

The Contractor shall also include a data file of all Critical Incidents from which the analysis is made using a template provided by HCA.

7.5 Practice Guidelines

7.5.1 The Contractor shall adopt behavioral health practice guidelines known to be effective in improving outcomes. Practice guidelines shall be based on the following:

7.5.1.1 Valid and reliable clinical scientific evidence;

7.5.1.2 In the absence of scientific evidence, professional standards; or

7.5.1.3 In the absence of scientific evidence and professional standards, a consensus of Health Care Professionals in the particular field.

7.5.2 The Contractor shall adopt guidelines from recognized sources that develop or promote evidence-based clinical practice guidelines such as voluntary health organizations, National Institute of Health Centers, or SAMHSA. If the Contractor does not adopt guidelines from recognized sources, board-certified BH Providers must participate in the development of the guidelines. The guidelines shall:

7.5.2.1 Consider the needs of Individuals and support Individual and family involvement in care plans.

- 7.5.2.2 Be adopted in consultation with contracting Behavioral Health Professionals within the state of Washington.
 - 7.5.2.3 Be reviewed and updated at least every two (2) years and more often if national guidelines change during that time.
 - 7.5.2.4 Be disseminated to all affected providers and, upon request, to HCA and Individuals.
- 7.5.3 The Contractor shall include its Behavioral Health Medical Director in the evaluation of emerging technologies for the treatment of behavioral health conditions and related decisions. The Contractor shall also have a Child or Adolescent Psychiatrist available for consultation related to other emerging technologies for the treatment of behavioral health conditions in children and youth.

7.6 Health Information Systems

The Contractor shall establish and maintain, and shall require Subcontractors to maintain, a health information system that complies with the requirements of OCIO Security Standard 141.10, and the Data, Security and Confidentiality Exhibit, and provides the information necessary to meet the Contractor's obligations under this Contract. OCIO Security Standards are available at: <https://ocio.wa.gov>.

The Contractor shall have in place mechanisms to verify the health information received from Subcontractors. The Contractor shall:

- 7.6.1 Collect, analyze, integrate, and report data. The system must provide information on areas including, but not limited to utilization, and fund availability by service type and fund source.
- 7.6.2 Ensure data received from providers is accurate and complete by:
 - 7.6.2.1 Verifying the accuracy and timeliness of reported data;
 - 7.6.2.2 Screening the data for completeness, logic and consistency; and
 - 7.6.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.
- 7.6.3 Make all collected data available to HCA upon request, to the extent permitted by the HIPAA Privacy Rule (45 C.F.R. Part 160 and Subparts A and E of Part 164 and RCW 70.02.005).
- 7.6.4 Establish and maintain protocols to support timely and accurate data exchange with any Subcontractor that will perform any delegated functions under the Contract. Adding information to the portal shall not be a barrier to providing a necessary Crisis Service.
- 7.6.5 Establish and maintain web-based portals with appropriate security features that allow referrals, requests for prior authorizations, claims/encounters submission, and claims/encounters status updates.

- 7.6.6 Have information systems that enable paperless submission, automated processing, and status updates for prior authorization and other utilization management related requests.
- 7.6.7 Maintain behavioral health content on a website that meets the following minimum requirements.
 - 7.6.7.1 Public and secure access via multi-level portals for providing web-based training, standard reporting, and data access for the effective management and evaluation of the performance of the Contract and the service delivery system as described under this Contract.
 - 7.6.7.2 The Contractor shall organize the website to allow for easy access of information by Individuals, family members, network providers, stakeholders and the public in compliance with the Americans with Disabilities Act. The Contractor shall include on its website, at a minimum, the following information or links:
 - 7.6.7.2.1 Hours of operations;
 - 7.6.7.2.2 How to access information on Contracted Services and toll-free crisis telephone numbers;
 - 7.6.7.2.3 Telecommunications device for the deaf/text telephone numbers;
 - 7.6.7.2.4 Information on the right to choose a qualified behavioral health service provider, when available and medically necessary; and
 - 7.6.7.2.5 An overview of the range of behavioral health services being provided.

7.7 Required Reporting for Behavioral Health Services

- 7.7.1 The Contractor will comply with required reporting for behavioral health services in this Contract. The Contractor’s disclosure of PII is authorized by law, including 42 C.F.R. § 2.53, authorizing disclosure of patient records for purposes of Medicaid evaluation. Data dictionary collection shall continue however, reporting shall be suspended, until notified by HCA.
- 7.7.2 The Contractor shall continue to report to HCA data related to ITA investigations and detentions under Chapter 71.05 and 71.34 RCW within twenty four (24) hours.

7.8 Technical Assistance

The Contractor may request technical assistance for any matter pertaining to this Contract by contacting HCA.

8 POLICIES AND PROCEDURES

The Contractor shall develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of this Contract. The Contractor shall submit policies and procedures to the HCA for review upon request by HCA and any time there is a new policy and procedure or there is a substantive change to an existing policy and procedure. The Contractor shall provide all relevant policies and procedures to its providers and Subcontractors, including but not limited to: billing, critical incidents, and other reporting requirements.

8.1 The Contractor's policies and procedures shall:

- 8.1.1 Direct and guide the Contractor's employees, Subcontractors, and any non-contracted providers' compliance with all applicable federal, state, and contractual requirements.
- 8.1.2 Fully articulate the requirements.
- 8.1.3 Have an effective training plan related to the requirements and maintain records of the number of staff participating in training, including evidence of assessment of participant knowledge and satisfaction with the training.
- 8.1.4 Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.

9 SUBCONTRACTS

9.1 Contractor Remains Legally Responsible

Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract, except as limited in this Section. However, no Subcontract shall terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions or responsibilities it delegates to any Subcontractor.

9.2 Provider Nondiscrimination

9.2.1 The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold, however, the Contractor is free to establish criteria and/or standards for providers' inclusion in a network of providers based on their specialties.

9.2.2 If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

9.2.3 The Contractor's policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

9.2.4 Consistent with the Contractor's responsibilities to Individuals, this section does not:

9.2.4.1 Require the Contractor to contract with providers beyond the number necessary to meet the behavioral health requirements under the Contract.

9.2.4.2 Preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty.

9.2.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs.

9.3 Required Provisions

9.3.1 Subcontracts shall be in writing, and available to HCA upon request. All Subcontracts shall contain the following provisions in addition to applicable provisions contained in this Contract:

9.3.1.1 Identification of the parties of the Subcontract and their legal basis for operation in the state of Washington.

9.3.1.2 The process for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

9.3.1.3 Procedures and specific criteria for terminating the Subcontract.

- 9.3.1.4 Identification of the services to be performed by the Subcontractor and which of those services may be subcontracted by the Subcontractor. If the Contractor allows the Subcontractor to further subcontract, all Subcontractor requirements contained in this Contract must be propagated downward into any other lower tiered Subcontracts (45 C.F.R. 92.35).
 - 9.3.1.5 Reimbursement rates and procedures for services provided under the Subcontract.
 - 9.3.1.6 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.
 - 9.3.1.7 Reasonable access to facilities, and financial and medical records for duly authorized representatives of HCA or DOH for audit purposes and immediate access for Medicaid fraud investigators.
 - 9.3.1.8 The requirement to submit complete and accurate reports and data required under the Contract, including encounter data that complies with HCA Service Encounter Reporting Instructions (SERI) Guide, to the Contractor. The Contractor shall ensure that all Subcontractors required to report encounter data have the capacity to submit all HCA required data to enable the Contractor to meet the requirements under the Contract.
 - 9.3.1.9 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved Program Integrity policies and procedures.
 - 9.3.1.10 A requirement to comply with the applicable state and federal statutes, rules and Regulations as set forth in this Contract.
 - 9.3.1.11 A requirement to comply with any term or condition of this Contract that is applicable to the services to be performed under the Subcontract.
- 9.3.2 The Contractor shall provide the following information regarding the Grievance system for GFS/FBG funded Contracted Services to all Subcontractors:
- 9.3.2.1 The toll-free numbers to file oral Grievances and Appeals.
 - 9.3.2.2 The availability of assistance in filing a Grievance or Appeal.
 - 9.3.2.3 The Individual's right to file Grievances and Appeals and their requirements and timeframes for filing.
 - 9.3.2.4 The Individual's right to an Administrative Hearing, how to obtain an Administrative Hearing and representation rules at an Administrative Hearing.

- 9.3.3 The Contractor may not delegate its responsibility to contract with a provider network. This does not prohibit a contracted, licensed provider from subcontracting with other appropriately licensed providers so long as the subcontracting provisions of this Contract are met.
- 9.3.4 The responsibilities found in the Quality Management Section in this Contract may not be delegated to a contracted network Behavioral Health Agency.
- 9.3.5 HCA may place limits on delegating financial risk to any Subcontractor in any amount, and is subject to review and approval by HCA.

9.4 **Management of Subcontracts**

- 9.4.1 The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject to formal review according to HCA, consistent with industry standards or state law and Regulation.
 - 9.4.1.1 The review shall be based on the specific delegation agreement with each Subcontractor, and shall address compliance with Contract requirements for each delegated function including, but not limited to:
 - 9.4.1.1.1 Documentation and appropriateness of medical necessity determinations.
 - 9.4.1.1.2 Patient record reviews to ensure services are appropriate based on diagnosis, and the treatment plan is based on the patient's needs and progress notes support the use of each service.
 - 9.4.1.1.3 Timeliness of service.
 - 9.4.1.1.4 Cultural, ethnic, linguistic, disability or age related needs are addressed.
 - 9.4.1.1.5 Coordination with other service providers.
 - 9.4.1.1.6 Provider adherence to relevant practice guidelines.
 - 9.4.1.1.7 Provider processes for reporting, tracking, and resolving grievances.
 - 9.4.1.1.8 Provider compliance with reporting and managing critical incidents.
 - 9.4.1.1.9 Information security.
 - 9.4.1.1.10 Disaster recovery plans.

9.4.1.1.11 Fiscal management, including documenting the provider's cost allocations, revenues, and expenditures in order to ensure that funds under this Contract are being spent. A fiscal review shall be conducted at least annually of Subcontractors receiving FBG funds, regardless of reimbursement methodology, to ensure expenditures are accounted for by revenue source, no expenditures were made for items identified as prohibited in the Payment and Sanctions Section of this Contract, expenditures are made only for the purposes stated in this Contract and that services were actually provided.

9.4.1.1.12 Oversight of any issues noted during licensing and/or certification reviews conducted by DOH and communicated to the Contractor.

9.4.2 The Contractor shall evaluate any prospective Subcontractor's ability to perform the activities for which that Subcontractor is contracting, including the Subcontractor's ability to perform delegated activities described in the Subcontracting document.

9.4.3 FBG funds may not be used to pay for services provided prior to the execution of Subcontracts, or to pay in advance of service delivery.

9.4.4 The Contractor shall not provide GFS or FBG funds to a county, unless a county is a licensed service provider and is providing direct services.

9.5 **Provider Subcontracts**

The Contractor's Subcontracts shall contain the following provisions:

9.5.1 A statement that Subcontractors receiving GFS or FBG funds shall cooperate with the Contractor or HCA-sponsored Quality Improvement (QI) activities.

9.5.2 A means to keep records necessary to adequately document services provided to Individuals for all delegated activities including QI, Utilization Management, and Individual Rights and Protections.

9.5.3 For providers, a requirement to provide discharge planning services which shall, at a minimum:

9.5.3.1 Coordinate a community-based discharge plan for each Individual served under this Contract beginning at intake. Discharge planning shall apply to all Individuals regardless of length of stay or whether they complete treatment.

9.5.3.2 Coordinate exchange of assessment, admission, treatment progress, and continuing care information with the referring entity. Contact with the referral agency shall be made within the first week of residential treatment.

- 9.5.3.3 Establish referral relationships with assessment entities, outpatient providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of entities making referrals in treatment activities;
- 9.5.3.4 Coordinate, as needed, with DBHR prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including the DCYF, and the DSHS Economic Services Administration including Community Service Offices (CSOs).
- 9.5.3.5 Coordinate services to financially-eligible Individuals who are in need of medical services.
- 9.5.4 A requirement that residential treatment providers ensure that priority admission is given to the populations identified in this contract.
- 9.5.5 Requirements for information and data sharing to support Care Coordination consistent with this Contract.
- 9.5.6 A requirement to implement a Grievance process that complies with WAC 182-538C-110 and as described in the Grievance System Section of this Contract.
- 9.5.7 A requirement that termination of a Subcontract shall not be grounds for an appeal, Administrative Hearing, or a Grievance for the Individual if similar services are immediately available in the service area.
- 9.5.8 Requirements for how Individuals will be informed of their right to a Grievance or Appeal in the case of:
 - 9.5.8.1 Denial or termination of service related to medical necessity determinations.
 - 9.5.8.2 Failure to act upon a request for services with reasonable promptness.
- 9.5.9 A requirement that the Subcontractor shall comply with Chapter 71.32 RCW (Mental Health Advance Directives).
- 9.5.10 A requirement to provide Individuals access to translated information and interpreter services as described in the Materials and Information Section of this Contract.
- 9.5.11 A requirement for adherence to established protocols for determining eligibility for services consistent with this Contract.
- 9.5.12 A requirement to use the Integrated Co-Occurring Disorder Screening Tool (GAIN-SS found at <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/gain-ss>). The Contractor shall include requirements for training staff that will be using the tool(s) to address the screening and assessment process, the tool and quadrant placement as well as requirements for corrective action if the process is not implemented and maintained throughout the Contract's period of performance.

- 9.5.13 A requirement for subcontracted staff to participate in training when requested by HCA. Exceptions must be in writing and include a plan for how the required information shall be provided to them.
- 9.5.14 A requirement to conduct criminal background checks and maintain related policies and procedures and personnel files consistent with requirements in Chapter 43.43 RCW and, Chapter 246-341 WAC.
- 9.5.15 Requirements for nondiscrimination in employment and Individual services.
- 9.5.16 Protocols for screening for debarment and suspension of certification.
- 9.5.17 Requirements to identify funding sources consistent with the Payments and Sanctions Section of this Contract, FBG reporting requirements and the rules for payer responsibility found in the table "How do providers identify the correct payer" within the Apple Health Mental Health Services Billing Guide.
- 9.5.18 A requirement to participate in the peer review process when requested by HCA. (42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136). The MHBG and SABG Block Grant requires an annual peer review by individuals with expertise in the field of drug abuse treatment (for SABG) and individuals with expertise in the field of mental health treatment consisting (for MHBG). At least five percent (5%) of treatment providers will be reviewed.
- 9.5.19 The Contractor shall ensure that the Charitable Choice Requirements of 42 CFR Part 54 are followed and that Faith-Based Organizations (FBO) are provided opportunities to compete with traditional alcohol/drug abuse treatment providers for funding.
- 9.5.20 If the Contractor Subcontracts with FBOs, the Contractor shall require the FBO to meet the requirements of 42 C.F.R. Part 54 as follows:
 - 9.5.20.1 Individuals requesting or receiving SUD services shall be provided with a choice of SUD treatment providers.
 - 9.5.20.2 The FBO shall facilitate a referral to an alternative provider within a reasonable time frame when requested by the recipient of services.
 - 9.5.20.3 The FBO shall report to the Contractor all referrals made to alternative providers.
 - 9.5.20.4 The FBO shall provide Individuals with a notice of their rights.
 - 9.5.20.5 The FBO provides Individuals with a summary of services that includes any religious activities.
 - 9.5.20.6 Funds received from the FBO must be segregated in a manner consistent with federal Regulations.
 - 9.5.20.7 No funds may be expended for religious activities.

- 9.5.21 A requirement that the Subcontractor shall respond in a full and timely manner to law enforcement inquiries regarding an individual's eligibility to possess a firearm under RCW 9.41.040(2)(a)(ii).
 - 9.5.21.1 The Contractor shall report new commitment data within twenty-four (24) hours. Commitment information under this section does not need to be re-sent if it is already in the possession of HCA. The Contractor and HCA shall be immune from liability related to the sharing of commitment information under this section (RCW 71.05.740).
- 9.5.22 Delegated activities are documented and agreed upon between Contractor and Subcontractor. The document must include:
 - 9.5.22.1 Assigned responsibilities.
 - 9.5.22.2 Delegated activities.
 - 9.5.22.3 A mechanism for evaluation.
 - 9.5.22.4 Corrective action policy and procedure.
- 9.5.23 A requirement that information about Individuals, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and Regulations.
- 9.5.24 The Subcontractor agrees to hold harmless HCA and its employees, and all Individuals served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors.
- 9.5.25 A ninety (90) day termination notice provision.
- 9.5.26 A specific provision for termination with short notice when a Subcontractor is excluded from participation in the Medicaid program.
- 9.5.27 The Subcontractor agrees to comply with the appointment wait time standards of this Contract. The Subcontract must provide for regular monitoring of timely access and corrective action if the Subcontractor fails to comply with the appointment wait time standards.
- 9.5.28 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards. Formal review must be completed no less than once every three (3) years, except as noted below, and must identify deficiencies or areas for improvement and provide for corrective action.

- 9.5.28.1 The Contractor shall conduct a Subcontractor review which shall include at least one (1) onsite visit every two (2) years to each Subcontractor site providing state funded or FBG funded treatment services during the period of performance of this Contract in order to monitor and document compliance with requirements of the Subcontract.
- 9.5.28.2 The Contractor shall ensure that Subcontractors have complied with data submission requirements established by HCA for all services funded under the Contract.
- 9.5.28.3 The Contractor shall ensure that the Subcontractor updates patient funding information when the funding source changes.
- 9.5.28.4 The Contractor shall maintain written or electronic records of all Subcontractor monitoring activities and make them available to HCA upon request.
- 9.5.28.5 The Contractor shall monitor SUD and Mental Health residential providers.
- 9.5.29 A statement that Subcontractors shall comply with all applicable required audits including authority to conduct a facility inspection, and the federal Office of Management and Budget (OMB) Super Circular 2 C.F.R. 200.501 and 45 C.F.R. 75.501 audits.
 - 9.5.29.1 The Contractor shall submit a copy of the OMB audit performed by the State Auditor to the HCA Contact identified on page one of the Contract within ninety (90) days of receipt by the Contractor of the completed audit.
 - 9.5.29.1.1 If a Subcontractor is subject to OMB Super Circular audit, the Contractor shall require a copy of the completed Single Audit and ensure corrective action is taken for any audit finding, per OMB Super Circular requirements.
 - 9.5.29.1.2 If a Subcontractor is not subject to OMB Super Circular, the Contractor shall perform sub-recipient monitoring in compliance with federal requirements.
- 9.5.30 The Contractor shall document and confirm in writing all single-case agreements with providers. The agreement shall include:
 - 9.5.30.1 The description of the services;
 - 9.5.30.2 The authorization period for the services, including the begin date and the end date for approved services;
 - 9.5.30.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other documents that define payment; and
 - 9.5.30.4 Any other specifics of the negotiated rate.

- 9.5.31 The Contractor must supply documentation to the Subcontractor no later than five (5) business days following the signing of the agreement. Updates to the unique contract, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).
- 9.5.32 The Contractor shall maintain a record of the single-case agreements for a period of six (6) years.

9.6 **Federal Block Grant (FBG) Subcontracts and Subcontract Monitoring**

- 9.6.1 All activities and services performed in accordance with this Contract, which are not performed directly by the Contractor, must be subcontracted according to the terms set forth by the Community BHAB-approved MHBG project plan or SABG project plan.
- 9.6.2 FBG funds may not be used to pay for services provided prior to the execution of Subcontracts, or to pay in advance of service delivery. All Subcontracts and amendments must be in writing and executed by both parties prior to any services being provided.
- 9.6.3 FBG fee-for-service, set rate, performance-based, Cost Reimbursement, and lump sum Subcontracts shall be based on reasonable costs.
- 9.6.4 The Contractor shall retain, on site, all Subcontracts. Upon request by HCA, the Contractor will immediately make available any and all copies, versions, and amendments of Subcontracts.
- 9.6.5 The Contractor shall submit to HCA Certification in writing that the Subcontractor meets all requirements under the Contract and that the Subcontract contains all required language under the contract, including any data security, confidentiality and/or Business Associate language as appropriate.
- 9.6.6 The Contractor shall ensure that its Subcontractors receive an independent audit if the Subcontractor expends a total of \$750,000 or more in federal awards from any and/or all sources in any state fiscal year. The Contractor shall require all Subcontractors submit to the Contractor the data collection form and reporting package specified in 2 C.F.R. Part 200, Subpart F, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor within ten (10) days of audit reports being completed and received by Subcontractors. The Contractor shall follow up with any corrective actions for all Subcontractor audit findings in accordance with 2 C.F.R. Part 200, Subpart F. The Contractor shall retain documentation of all Subcontractor monitoring activities; and, upon request by HCA, shall immediately make all audits and/or monitoring documentation available to HCA.

9.6.7 The Contractor shall conduct and/or make arrangements for an annual fiscal review of each Subcontractor receiving FBG funds through fee-for-service, set rate, performance-based or cost reimbursement Subcontracts, and shall provide HCA with documentation of these annual fiscal reviews upon request. The annual fiscal review shall ensure that:

9.6.7.1 Expenditures are accounted for by revenue source.

9.6.7.2 No expenditures were made for items identified in the Payment and Sanctions Section of this Contract.

9.6.7.3 Expenditures are made only for the purposes stated in this Contract, and for services that were actually provided.

9.7 Health Care Provider Subcontracts Delegating Administrative Functions

9.7.1 Subcontracts that delegate Administrative Functions under the terms of this Contract shall include the following additional provisions:

9.7.1.1 Clear descriptions of any Administrative Functions delegated by the Contractor in the Subcontract.

9.7.1.2 Provisions for revoking delegation or imposing sanctions if the Subcontractor's performance is inadequate.

9.7.2 The Contractor shall submit a list of all current delegated entities, activities delegated, and the number of Individuals assigned or served by the delegated entity annually by March 31.

9.7.3 A Subcontractor providing Administrative Functions has established a conflict of interest policy that:

9.7.3.1 Requires screening of employees upon hire and board members at the time of initial appointment, and annually thereafter, for conflicts of interests related to performance of services under the Subcontract.

9.7.3.2 Prohibits employees and/or board members from participating in actions which could impact or give the appearance of impacting a personal interest or the interest of any corporate, partnership or association in which the employee or board member is directly or indirectly involved.

9.7.3.3 Prohibits access to information regarding proprietary information for other providers including, but not limited to: reimbursement rates, for any Subcontractor that provides behavioral health services and administrative services under the Contract.

9.8 Provider Education

9.8.1 The Contractor shall inform GFS and FBG providers in writing regarding these requirements:

9.8.1.1 Contracted services for Individuals served under this Contract.

- 9.8.1.2 Coordination of care requirements.
- 9.8.1.3 HCA and the Contractor's policies and procedures as related to this Contract.
- 9.8.1.4 Data interpretation.
- 9.8.1.5 Practice guidelines as described in the provisions of this Contract.
- 9.8.1.6 Requirements for Utilization Management (UM) decision making, procedure coding, and submitting claims for GFS and FBG funded services.
- 9.8.1.7 Care management staff who can assist in care transitions and care management activity.
- 9.8.1.8 Program Integrity requirements.

9.9 **Provider Payment Standards**

- 9.9.1 The Contractor shall meet the timeliness of payment standards as specified in this section. To be compliant with payment standards the Contractor shall pay or deny, and shall require Subcontractors to pay or deny, ninety-five percent (95%) of clean claims and encounters within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) calendar days of receipt and ninety-nine percent (99%) of claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.
 - 9.9.1.1 A claim is a bill for services, a line item of service, or all services for one (1) Individual within a bill.
 - 9.9.1.2 A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.
 - 9.9.1.3 The date of receipt is the date the Contractor receives the claim or encounter from the provider.
 - 9.9.1.4 The date of payment is the date of the check or other form of payment.
- 9.9.2 The Contractor shall update its claims and encounter system to support hardcopy and electronic submission of claims, adjustment claims, encounters, payments and bills for all Contracted Services types for which claims submission is required.

9.10 **Coordination of Benefits (COB) and Subrogation of Rights of Third Party Liability**

- 9.10.1 Coordination of Benefits:
 - 9.10.1.1 The services and benefits available under this Contract shall be secondary to any other coverage.

- 9.10.1.2 Nothing in this section negates any of the Contractor's responsibilities under this Contract. The Contractor shall:
- 9.10.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable COB rules in WAC 284-51.
 - 9.10.1.2.2 Attempt to recover any third-party resources available to Individuals and make all records pertaining to COB collections for Individuals available for audit and review.
 - 9.10.1.2.3 Pay claims for contracted services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed
 - 9.10.1.2.4 Coordinate with out-of-network providers with respect to payment to ensure the cost to Individuals is no greater than it would be if the services were furnished within the network.
 - 9.10.1.2.5 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.
 - 9.10.1.2.6 Ensure subcontracts require the pursuit and reporting of all third party revenue related to services provided under this agreement, including pursuit of Fee-for-Service Medicaid funds provided for AI/AN Individuals who did not opt into managed care.

9.11 **Provider Credentialing**

The Contractor's policies and procedures shall follow the State's requirements related to the credentialing and re-credentialing of Health Care Professionals who have signed contracts or participation agreements with the Contractor (Chapter 246-12 WAC).

- 9.11.1 The Contractor's policies and procedures shall ensure compliance with requirements described in this section.
- 9.11.1.1 The Contractor shall verify that all Subcontractors meet the licensure and certification requirements as established by state and federal statute, administrative code, or as directed in this contract.
 - 9.11.1.2 The Contractor shall recognize providers operating under the license of a licensed or certified agency.
 - 9.11.1.3 The Contract shall verify that DCRs are authorized as such by the county authorities.

10 INDIVIDUAL RIGHTS AND PROTECTIONS

10.1 General Requirements

- 10.1.1 The Contractor shall comply with any applicable federal and state laws that pertain to Individual rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to Individuals.
- 10.1.2 The Contractor and its Subcontractors shall guarantee that each Individual has the following rights:
 - 10.1.2.1 To information regarding the Individual's behavioral health status.
 - 10.1.2.2 To receive all information regarding behavioral health treatment options including any alternative or self-administered treatment, in a culturally-competent manner.
 - 10.1.2.3 To receive information about the risks, benefits, and consequences of behavioral health treatment (including the option of no treatment).
 - 10.1.2.4 To participate in decisions regarding his or her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions.
 - 10.1.2.5 To be treated with respect and with due consideration for his or her dignity and privacy.
 - 10.1.2.6 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - 10.1.2.7 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 C.F.R. Part 164.
 - 10.1.2.8 To be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the Contractor treats the Individual.
- 10.1.3 The Contractor shall require a criminal history background check through 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, in accordance with Chapter 388-06 WAC.

10.2 Ombuds

- 10.2.1 The Contractor shall provide a regional behavioral health Ombuds as described in Chapter 71.24 RCW. Contracting for Ombuds services shall include the following provisions:
 - 10.2.1.1 Separation of personnel functions (e.g., hiring, salary and benefits determination, supervision, accountability and performance evaluations).

- 10.2.1.2 Independent decision making to include all activities, findings, recommendations and reports.
- 10.2.1.3 Is responsive to the age and demographic character of the region and assists and advocates for Individuals with resolving grievances at the lowest possible level.
- 10.2.1.4 Independent from Contracted Services providers.
- 10.2.1.5 Receives Individual, family member, and other interested party Grievances.
- 10.2.1.6 Is accessible to Individuals, including a toll-free, independent phone line for access.
- 10.2.1.7 Is able to access service sites and records relating to the Individual with appropriate releases so that it can reach out to Individuals, and provide assistance with the grievance process.
- 10.2.1.8 Receive training and adheres to confidentiality consistent with this Contract and Chapters 71.05, 71.24, and 70.02 RCW.
- 10.2.1.9 Continue to be available to advocate and assist the Individual through the Grievance System and Administrative Hearing processes.
- 10.2.1.10 Involve other persons, at the Individual's request.
- 10.2.1.11 Coordinates and collaborates with allied systems' advocacy and Ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared Individuals.
- 10.2.1.12 Prepare reports and formalized recommendations at least biennially to the Community BHAB.

10.3 Cultural Considerations

- 10.3.1 The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- 10.3.2 At a minimum, the Contractor shall:
 - 10.3.2.1 Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing bases. (CLAS Standard 4);
 - 10.3.2.2 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. (CLAS Standard 5);

- 10.3.2.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally, and in writing. (CLAS Standard 6);
- 10.3.2.4 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. (CLAS Standard 7);
- 10.3.2.5 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. (CLAS Standard 8);
- 10.3.2.6 Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations. (CLAS Standard 9);
- 10.3.2.7 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (CLAS Standard 11); and
- 10.3.2.8 Create conflict and Grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints. (CLAS Standard 14).

10.4 Mental Health Advance Directive (MHAD)

- 10.4.1 The Contractor shall maintain a written Mental Health Advance Directive (MHAD) policy and procedure that respects an Individual's Advance Directive. Policy and procedures must comply with Chapter 71.32 RCW.
- 10.4.2 The Contractor shall inform all Individuals seeking mental health services and individuals with a history of frequent crisis system utilization of their right to a MHAD and shall provide technical assistance to those who express an interest in developing and maintaining a MHAD.
- 10.4.3 The Contractor shall maintain current copies of any MHAD in the Individual's records.
- 10.4.4 The Contractor shall inform Individuals that complaints concerning noncompliance with a MHAD should be referred to the Department of Health.

10.5 Individual Choice of Behavioral Health Provider

- 10.5.1 An Individual may maintain existing behavioral health provider relationships when funding is available and when the Contracted Services are medically necessary. Individuals are not guaranteed a choice of Behavioral Health providers for Contracted Services.

10.6 Individual Charges for Contracted Services

- 10.6.1 Under no circumstances shall the Contractor deny the provision of Crisis Services, E&T services, ITA services, or SUD involuntary commitment services, to an Individual due to the Individual's ability to pay.
- 10.6.2 Providers must develop and implement a sliding fee schedule for Individuals that takes into consideration an individual's circumstances and ability to pay. The fee schedule must be reviewed and approved by the Contractor.
- 10.6.3 In developing sliding fee schedules, providers must comply with the following:
 - 10.6.3.1 Put the sliding fee schedule in writing that is non-discriminatory;
 - 10.6.3.2 Include language in the sliding fee schedule that no individual shall be denied services due to inability to pay;
 - 10.6.3.3 Provide signage and information to Individuals to educate them on the sliding fee schedule;
 - 10.6.3.4 Protect Individual's privacy in assessing fees;
 - 10.6.3.5 Maintain records to account for each Individual's visit and any charges incurred;
 - 10.6.3.6 Charge Individuals at or below one hundred percent (100%) of Federal Poverty Level (FPL) a nominal fee or no fee at all;
 - 10.6.3.7 Develop at least three (3) incremental amounts on the sliding fee scale for Individuals between one hundred one to two hundred and twenty percent (101-220%) FPL.

10.7 **Cost Sharing Assistance**

- 10.7.1 The Contractor may use block grant funds to help individuals satisfy cost-sharing requirements for SABG-authorized SUD services or MHBG-authorized mental health services. The Contractor must ensure that:
 - 10.7.1.1 The provider is a recipient of block grant funds;
 - 10.7.1.2 Cost-sharing is for a block grant authorized service;
 - 10.7.1.3 Payments are in accordance with SABG or MHBG laws and regulations;
 - 10.7.1.4 Cost-sharing payments are made directly to the provider of the service; and
 - 10.7.1.5 A report is provided to HCA upon request that identifies:
 - 10.7.1.5.1 The number of individuals provided cost-sharing assistance;
 - 10.7.1.5.2 The total dollars paid out for cost-sharing; and
 - 10.7.1.5.3 Providers who received cost-sharing funds.

10.8 Individual Self-Determination

The Contractor shall ensure that all providers:

- 10.8.1 Obtain informed consent prior to treatment from Individuals, or persons authorized to consent on behalf of an Individual, as described in RCW 7.70.065;
- 10.8.2 Comply with the provisions of the Natural Death Act (Chapter 70.122 RCW) and state rules concerning Advance Directives (WAC 182-501-0125); and,
- 10.8.3 When appropriate, inform Individuals of their right to make anatomical gifts (Chapter 68.64 RCW).

11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 Utilization Management Requirements

- 11.1.1 The Contractor's Behavioral Health Medical Director will provide guidance, leadership and oversight of the Contractor's Utilization Management (UM) program for Contracted Services used by Individuals. The following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the Behavioral Health Medical Director to oversee:
- 11.1.1.1 Processes for evaluation and referral to services.
 - 11.1.1.2 Review of consistent application of criteria for provision of services within Available Resources and review of related Grievances.
 - 11.1.1.3 Review of assessment and treatment services against clinical practice standards. Clinical practice standards include, but are not limited to evidenced-based practice guidelines, culturally appropriate services, discharge planning guidelines, and activities such as coordination of care.
 - 11.1.1.4 Monitor for over-utilization and under-utilization of services, including Crisis Services.
 - 11.1.1.5 Ensure that resource management and UM activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary behavioral health services.
- 11.1.2 The Contractor shall develop and implement UM protocols for all services and supports funded solely or in part through GFS or FBG funds. The UM protocols shall comply with the following provisions:
- 11.1.2.1 The Contractor must have policies and procedures that establish a standardized methodology for determining when GFS and FBG resources are available for the provision of behavioral health services. The processes and methodology shall include the following components:
 - 11.1.2.1.1 An aggregate of spending across GFS and FBG fund sources under the Contract.
 - 11.1.2.1.2 For any case-specific review decisions, the Contractor shall maintain Level of Care Guidelines for making authorization, continued stay and discharge determinations. The Level of Care Guidelines shall address GFS and SABG priority population requirements. The Contractor shall use ASAM Criteria to make placement decisions for all SUD services.
 - 11.1.2.1.3 A plan to address under- or over-utilization patterns with providers to avoid unspent funds or gaps in service at the end of a contract period due to limits in Available Resources.

- 11.1.2.1.4 Education and technical assistance to address issues related to quality of care, medical necessity, timely and accurate claims submission or aligning service utilization with allocated funds to avoid disruption in service or unspent funds at the end of a contract year.
 - 11.1.2.1.5 Corrective action with providers, as necessary, to address issues with compliance with state and federal Regulations or ongoing issues with patterns of service utilization.
 - 11.1.2.1.6 A process to make payment denials and adjustments when patterns of utilization deviate from state, federal or Contract requirements (e.g., single source funding).
- 11.1.2.2 The Contractor shall monitor provider discharge planning to ensure providers meet requirements for discharge planning defined in this Contract.
- 11.1.3 The Contractor shall educate UM staff in the application of UM protocols including the criteria used in making UM decisions. UM protocols shall address the cultural needs of diverse populations.
- 11.1.4 The Contractor shall ensure that all UM staff making service authorization decisions have been trained in working with the specific area of service which they are authorizing and managing.
- 11.1.5 The Contractor's policies and procedures related to UM shall comply with, and require the compliance of Subcontractors with delegated authority for UM requirements described in this section.
- 11.1.6 Authorization reviews shall be conducted by state licensed Behavioral Health Professionals with experience working with the populations and/or settings under review.
- 11.1.6.1 The Contractor shall have UM staff with experience and expertise in working with individuals of all ages with a SUD and who are receiving medication-assisted treatment.
- 11.1.7 Adverse utilization review determinations based on medical necessity including any decision to authorize a service in an amount, duration or scope that is less than requested shall be conducted by:
- 11.1.7.1 A physician board-certified or board-eligible in Psychiatry or Child and Adolescent Psychiatry;
 - 11.1.7.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry; or
 - 11.1.7.3 A licensed, doctoral level clinical psychologist.

- 11.1.8 The Contractor shall ensure that any behavioral health clinical peer reviewer who is subcontracted or works in a service center other than the Contractor's Washington State service center shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center. This includes participation in initial orientation and at least annual training on Washington State specific benefits, protocols and initiatives.
- 11.1.9 The Contractor shall ensure that any behavioral health actions must be peer-to-peer, that is, the credential of the licensed clinician making the decision to authorize service in an amount, duration or scope that is less than requested must be at least equal to that of the recommending clinician. In addition:
 - 11.1.9.1 A physician board-certified or board-eligible in Psychiatry must review all inpatient level of care actions for psychiatric treatment.
 - 11.1.9.2 A physician board-certified or board-eligible in Addiction Medicine, or a subspecialty in Addiction Psychiatry, must review all inpatient level of care actions (denials) for SUD treatment.
- 11.1.10 The Contractor shall ensure that Appeals are evaluated by providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the person's condition or disease.
- 11.1.11 The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Individual.

11.2 **Medical Necessity Determination**

The Contractor shall collect all information necessary to make medical necessity determinations. The Contractor shall determine which services are medically necessary according to the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity shall be final, except as specifically provided in Section 13 of this Contract.

11.3 **Authorization of Services**

- 11.3.1 The Contractor shall provide education and ongoing guidance and training to Individuals and providers about its UM protocols and Level of Care Guidelines, including admission, continued stay, and discharge criteria.
- 11.3.2 The Contractor shall have in effect mechanisms to ensure consistent application of UMP review criteria for authorization decisions.
- 11.3.3 The Contractor shall consult with the requesting provider when appropriate.

11.4 **Timeframes for Authorization Decisions**

- 11.4.1 The Contractor must provide a written Notice of Determination to the Individual, or their legal representative, if a denial, reduction, termination or suspension occurs based on the Level of Care Guidelines. The Contractor shall adhere to the requirements set forth in the Notification of Coverage and Authorization Determination subsection of this Contract.
- 11.4.2 The Contractor is required to acknowledge receipt of a standard authorization request for behavioral health inpatient services within two (2) hours and provide a decision within twelve (12) hours of receipt of the request.
- 11.4.3 The Contractor shall provide for the following timeframes for authorization decisions and notices:
 - 11.4.3.1 For denial of payment that may result in payment liability for the Individual, at the time of any action affecting the claim.
 - 11.4.3.2 For termination, suspension, or reduction of previously contracted services, ten (10) calendar days prior to such termination, suspension, or reduction, unless the criteria stated in 42 C.F.R. §§ 431.213 and 431.214 are met.
 - 11.4.3.3 Standard authorizations for planned or elective service determinations: The authorization decisions are to be made and notices are to be provided as expeditiously as the Individual's condition requires. The Contractor must make a decision to approve, deny, or request additional information from the provider within five (5) calendar days of the original receipt of the request. If additional information is required and requested, the Contractor must give the provider five (5) calendar days to submit the information and then approve or deny the request within four (4) calendar days of the receipt of the additional information.
 - 11.4.3.3.1 An extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances:
 - 11.4.3.3.1.1 The Individual or the provider requests the extension; or
 - 11.4.3.3.1.2 The Contractor justifies and documents a need for additional information and how the extension is in the Individual's interest.
 - 11.4.3.3.2 If the Contractor extends the timeframe past fourteen (14) calendar days of the receipt of the request for service:

11.4.3.3.2.1 The Contractor shall provide the Individual written notice within three (3) business days of the Contractor's decision to extend the timeframe. The notice shall include the reason for the decision to extend the timeframe and inform the Individual of the right to file a grievance if he or she disagrees with that decision.

11.4.3.3.2.2 The Contractor shall issue and carry out its determination as expeditiously as the Individual's condition requires, and no later than the date the extension expires.

11.4.3.4 Expedited Authorization Decisions: For timeframes for authorization decisions not described in inpatient authorizations or standard authorizations, or cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the Individual's life or health, or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Individual's condition requires.

11.4.3.4.1 The Contractor will make the decision within two (2) calendar days if the information provided is sufficient; or request additional information within one (1) calendar day, if the information provided is not sufficient to approve or deny the request. The Contractor must give the provider two (2) calendar days to submit the requested information and then approve or deny the request within two (2) calendar days.

11.4.3.4.2 The Contractor may extend the expedited time period by up to ten (10) calendar days under the following circumstances:

11.4.3.4.2.1 The Individual requests the extension; or

11.4.3.4.2.2 The Contractor justifies and documents a need for additional information and how the extension is in the Individual's interest.

11.4.3.5 Concurrent Review Authorizations: The Contractor must make its determination within one (1) business day of receipt of the request for authorization.

11.4.3.5.1 Requests to extend concurrent care review authorization determinations may be extended to within three (3) business days of the request of the authorization, if the Contractor has made at least one (1) attempt to obtain needed clinical information within the initial one (1) business day after the request for authorization of additional days or services.

- 11.4.3.5.2 Notification of the Concurrent Review determination shall be made within one (1) business day of the Contractor's decision.
- 11.4.3.5.3 Expedited appeal timeframes apply to Concurrent Review requests.
- 11.4.3.6 For post-service authorizations, the Contractor shall make its determination within thirty (30) calendar days of receipt of the authorization request.
 - 11.4.3.6.1 The Contractor shall notify the Individual and the requesting provider within two (2) business days of the Contractor's determination.
 - 11.4.3.6.2 Standard Appeal timeframes apply to post-service denials.
 - 11.4.3.6.3 When post-service authorizations are approved they become effective the date the service was first administered.

11.5 Notification of Coverage and Authorization Determinations

- 11.5.1 For all Actions the Contractor shall notify the individual in writing and the requesting provider or facility orally or in writing. The Contractor must notify all parties, other than the Individual, in advance whether notification will be provided by phone, mail, fax, or other means.
 - 11.5.1.1 For an adverse authorization decision involving an expedited authorization request, the Contractor may initially provide notice orally within seventy-two (72) hours of the request. The Contractor shall provide written notification of the decision within seventy-two (72) hours after receipt of the request for service.
 - 11.5.1.2 Provide notice at least ten (10) calendar days before the date of action when the action is a termination, suspension or reduction of previously authorized services.
 - 11.5.1.2.1 The notice to the Individual and provider shall explain the following:
 - 11.5.1.2.1.1 The action the Contractor has taken or intends to take.
 - 11.5.1.2.1.2 The reasons for the action, in easily understood language including citation to any Contractor guidelines, protocols, or other criteria that were used to make the decision, and how to access the guidelines, protocols or other criteria.
 - 11.5.1.2.1.3 A statement of whether the Individual has any liability for payment.

11.5.1.2.1.4 Information regarding whether and how the Individual may Appeal the decision.

11.5.1.2.1.5 The Individual's right to receive the Contractor's assistance in filing an Appeal and how to request it, including access to services for Individuals with communication barriers or disabilities.

11.5.2 The Contractor shall provide notification in accordance with the timeframes described in this section except in the following circumstances:

11.5.2.1 The Individual dies;

11.5.2.2 The Contractor has a signed statement from the Individual requesting service termination or giving information that makes the Individual ineligible and requiring termination or reduction of services (where the Individual understands that termination, reduction, or suspension of services is the result of supplying this information);

11.5.2.3 The Individual is admitted to a facility where he or she is ineligible for services.

11.5.2.4 The Individual's address is unknown and there is no forwarding address.

11.5.2.5 The Individual has moved out of the Contractor's service area.

11.5.2.6 The Individual requests a change in the level of care.

11.5.3 Untimely Service Authorization Decisions: When the Contractor does not reach service authorization decisions within the timeframes for either standard or expedited service authorizations it is considered a denial and thus, an Action.

12 PROGRAM INTEGRITY

12.1 General Requirements

- 12.1.1 The Contractor shall have and comply with policies and procedures that guide and require the Contractor and the Contractor's officers, employees, agents, and Subcontractors to comply with Program Integrity requirements.
- 12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts.

12.2 Information on Persons Convicted of Crimes

- 12.2.1 The Contractor must include in its written agreements with all Subcontractors and providers requirements that the Subcontractor/provider investigate and disclose to HCA immediately upon becoming aware of any person in their employment who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act since the inception of those programs.

12.3 Fraud, Waste and Abuse

- 12.3.1 The Contractor's Fraud, Waste and Abuse program shall have:
 - 12.3.1.1 A process to inform officers, employees, agents and Subcontractors about the False Claims Act.
 - 12.3.1.2 Administrative procedures to detect and prevent fraud, waste and abuse, and a mandatory compliance plan.
 - 12.3.1.3 Standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards.
 - 12.3.1.4 The designation of a compliance officer and a compliance committee that is accountable to senior management.
 - 12.3.1.5 Training for all affected parties.
 - 12.3.1.6 Effective lines of communication between the compliance officer and the Contractor's staff and Subcontractors.
 - 12.3.1.7 Enforcement of standards through well-publicized disciplinary policies.
 - 12.3.1.8 Provision for internal monitoring and auditing of the Contractor and providers.
 - 12.3.1.9 Provision for prompt response to detected violations, and for development of corrective action initiatives.
 - 12.3.1.10 Provision of detailed information to employees and Subcontractors regarding fraud and abuse policies and procedures and the False Claims Act and the Washington false claims statutes, Chapter 74.66 RCW and RCW 74.09.210.

12.4 Reporting

- 12.4.1 All Program Integrity reporting to HCA shall be in accordance with the Notices provisions of the General Terms and Conditions of this Contract unless otherwise specified herein.
- 12.4.2 The Contractor shall submit to HCA a report of any recoveries made or overpayments identified by the Contractor during the course of their claims review/analysis.
- 12.4.3 The Contractor shall notify and submit all associated information of any alleged or investigated cases in which the Contractor believes there is a serious likelihood of fraud by an Individual to the HCA Office of Medicaid Eligibility and Policy (OMEP) by any of the following:
- 12.4.3.1 Sending an email to WAHeligibilityfraud@hca.wa.gov;
 - 12.4.3.2 Calling OMEP at 360-725-0934 and leaving a detailed message;
 - 12.4.3.3 Mailing a written referral to:
 - Health Care Authority
 - Attn: OMEP
 - P.O. Box 45534
 - Olympia, WA 98504-5534
 - 12.4.3.4 Faxing the written complaint to Washington Apple Health Eligibility Fraud at 360-725-1158.
- 12.4.4 The Contractor shall submit to HCA on occurrence a list of terminations report including providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related Program Integrity termination. The Contractor shall send the report electronically to HCA at hcabhaso@hca.wa.gov with subject "Program Integrity list of Terminations Report." The report must include all of the following:
- 12.4.4.1 Individual provider/entities' name;
 - 12.4.4.2 Individual provider/entities' NPI number;
 - 12.4.4.3 Source of termination;
 - 12.4.4.4 Nature of the termination; and
 - 12.4.4.5 Legal action against the individual/entities.

12.5 Records Requests

12.5.1 Upon request, the Contractor and the Contractor's Subcontractors shall allow HCA or any authorized state or federal agency or authorized representative, access to all records pertaining to this Contract, including computerized data stored by the Contractor or Subcontractor. The Contractor and its Subcontractors shall provide and furnish the records at no cost to the requesting agency.

12.6 On-Site Inspections

12.6.1 The Contractor and its Subcontractors must provide any record or data pertaining to this Contract including, but not limited to:

12.6.1.1 Medical records;

12.6.1.2 Billing records;

12.6.1.3 Financial records;

12.6.1.4 Any record related to services rendered, quality, appropriateness, and timeliness of service; and

12.6.1.5 Any record relevant to an administrative, civil or criminal investigation or prosecution.

12.6.2 Upon request, the Contractor or Subcontractor shall assist in such review, including the provision of complete copies of records.

12.6.3 The Contractor must provide access to its premises and the records requested to any state or federal agency or entity, including, but not limited to: HCA, OIG, MFCD, Office of the Comptroller of the Treasury, whether the visitation is announced or unannounced.

13 GRIEVANCE SYSTEM

13.1 General Requirements

The Contractor shall have a Grievance system that includes a Grievance process, an Appeal process, and access to the Administrative Hearing process for Contracted Services (WAC 182-538C-110). NOTE: Provider claim disputes initiated by the provider are not subject to this section.

- 13.1.1 The Contractor shall have policies and procedures addressing the Grievance system, which comply with the requirements of this Contract. HCA must approve, in writing, all Grievance system policies and procedures and related notices to Individuals regarding the Grievance system.
- 13.1.2 The Contractor shall give Individuals any reasonable assistance necessary in completing forms and other procedural steps for Grievances and Appeals.
- 13.1.3 The Contractor shall acknowledge receipt of each Grievance, either orally or in writing, within two (2) business days.
- 13.1.4 The Contractor shall acknowledge in writing, the receipt of each Appeal. The Contractor shall provide the written notice to both the Individual and requesting provider within three (3) calendar days of receipt of the Appeal.
- 13.1.5 The Contractor shall ensure that decision makers on Grievances and Appeals were not involved in previous levels of review or decision-making.
- 13.1.6 Decisions regarding Grievances and Appeals shall be made by Health Care Professionals with clinical expertise in treating the Individual's condition or disease if any of the following apply:
 - 13.1.6.1 The Individual is appealing an action.
 - 13.1.6.2 The Grievance or Appeal involves any clinical issues.
- 13.1.7 With respect to any decisions described in subsection 13.1.6, the Contractor shall ensure that the Health Care Professional making such decisions:
 - 13.1.7.1 Has clinical expertise in treating the Individual's condition or disease that is age appropriate (e.g., a board certified Child and Adolescent Psychiatrist for a child Individual).
 - 13.1.7.2 A physician board-certified or board-eligible in Psychiatry or Child or Adolescent Psychiatry if the grievance or appeal is related to inpatient level of care denials for psychiatric treatment.
 - 13.1.7.3 A physician board-certified or board-eligible in Addiction Medicine or a Sub-specialty in Addiction Psychiatry if the Grievance or Appeal is related to inpatient level of care denials for SUD treatment.

- 13.1.7.4 Are one or more of the following, as appropriate, if a clinical Grievance or Appeal is not related to inpatient level of care denials for psychiatric or SUD treatment:
 - 13.1.7.4.1 Physicians board-certified or board-eligible in Psychiatry, Addiction Medicine or Addiction Psychiatry;
 - 13.1.7.4.2 Licensed, doctoral level clinical psychologists; or
 - 13.1.7.4.3 Pharmacists.

13.2 Grievance Process

The following requirements are specific to the Grievance process:

- 13.2.1 Only an Individual or the Individual's authorized representative may file a grievance with the Contractor. A provider may not file a Grievance on behalf of an Individual unless the provider is acting on behalf of the Individual and with the Individual's written consent.
 - 13.2.1.1 The Contractor shall request the Individual's written consent should a provider Appeal on behalf of an Individual without the Individual's written consent.
- 13.2.2 The Contractor shall accept, document, record, and process Grievances forwarded by HCA.
- 13.2.3 The Contractor shall provide a written response to HCA within three (3) business days to any constituent Grievance. For the purpose of this subsection, "constituent Grievance" means a complaint or request for information from any elected official or agency director or designee.
- 13.2.4 The Contractor shall assist the Individual with all Grievance and Appeal processes, and provide information about the availability of Ombuds services to assist the individual.
- 13.2.5 The Contractor shall cooperate with any representative authorized in writing by the Individual.
- 13.2.6 The Contractor shall consider all information submitted by the Individual or his/her authorized representative.
- 13.2.7 The Contractor shall investigate and resolve all Grievances whether received orally or in writing. The Contractor shall not require an Individual or his/her authorized representative to provide written follow up for a Grievance or Appeal the Contractor received orally.
- 13.2.8 The Contractor shall complete the disposition of a Grievance and notice to the affected parties as expeditiously as the Individual's health condition requires, but no later than forty-five (45) calendar days from receipt of the Grievance.

- 13.2.9 The notification may be made orally or in writing for Grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.
- 13.2.10 Individuals do not have the right to an Administrative Hearing in regard to the disposition of a Grievance.

13.3 Appeal Process

The following requirements are specific to the Appeal process:

- 13.3.1 An Individual, the Individual's authorized representative, or a provider acting on behalf of the Individual and with the Individual's written consent, may Appeal a Contractor action.
 - 13.3.1.1 If a provider has requested an Appeal on behalf of an Individual, but without the Individual's written consent, the Contractor shall not dismiss the Appeal without first attempting to contact the Individual within five (5) calendar days of the provider's request, informing the Individual that an appeal has been made on the Individual's behalf, and then asking if the Individual would like to continue the Appeal.

If the Individual wants to continue the Appeal, the Contractor shall obtain from the Individual a written consent for the Appeal. If the Individual does not wish to continue the Appeal, the Contractor shall formally dismiss the Appeal, in writing, with appropriate Appeal rights and by delivering a copy of the dismissal to the provider as well as the Individual.
 - 13.3.1.2 For expedited Appeals, the Contractor may bypass the requirement for the Individual's written consent and obtain the Individual's oral consent. The Individual's oral consent shall be documented in the Contractor's records.
- 13.3.2 If HCA receives a request to Appeal an Action of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the Individual with information that a provider filed an appeal.
- 13.3.3 For Appeals of standard service authorization decisions, an Individual, or a provider acting on behalf of the Individual, must file an Appeal, either orally or in writing, within sixty (60) calendar days of the date on the Contractor's Notice of Action. This also applies to an Individual's request for an expedited Appeal.
- 13.3.4 Oral inquiries seeking to Appeal an Action shall be treated as Appeals and be confirmed in writing, unless the Individual or provider requests an expedited resolution. The appeal acknowledgement letter sent by the Contractor to an Individual shall serve as written confirmation of an Appeal filed orally by an Individual.
- 13.3.5 The Appeal process shall provide the Individual a reasonable opportunity to present evidence, and allegations of fact or law in writing. The Contractor shall inform the Individual of the limited time available for this in the case of expedited resolution.

- 13.3.6 The Appeal process shall provide the Individual and the Individual's representative opportunity, before and during the Appeals process, to examine the Individual's case file, including medical records, and any other documents and records considered during the Appeal process.
- 13.3.7 The Appeal process shall include as parties to the Appeal, the Individual and the Individual's authorized representative, or the legal representative of the deceased Individual's estate.
- 13.3.8 In any Appeal of an Action by a Subcontractor, the Contractor or its Subcontractor shall apply the Contractor's own clinical practice guidelines, standards, protocols, or other criteria that pertain to authorizing specific services.
- 13.3.9 The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Individual's health condition requires, within the following timeframes:
 - 13.3.9.1 For standard resolution of Appeals and for Appeals for termination, suspension or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the Appeal, unless the Contractor notifies the Individual that an extension is necessary to complete the Appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for Appeal.
 - 13.3.9.2 For any extension not requested by an Individual, the Contractor must give the Individual written notice of the reason for the delay.
 - 13.3.9.3 For expedited resolution of Appeals or Appeals of behavioral health drug authorization decisions, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the Appeal.
- 13.3.10 The Contractor shall provide notice of resolution of the Appeal in a language and format which is easily understood by the Individual. The notice of the resolution of the Appeal shall:
 - 13.3.10.1 Be in writing and sent to the Individual and the requesting provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.
 - 13.3.10.2 Include the date completed and reasons for the determination.
 - 13.3.10.3 Include a written statement of the reasons for the decision, including how the requesting provider or Individual may obtain the review or decision-making criteria.
 - 13.3.10.4 For Appeals not resolved wholly in favor of the Individual:
 - 13.3.10.4.1 Include information on the Individual's right to request an Administrative Hearing and how to do so.

13.4 Expedited Appeals Process

- 13.4.1 The Contractor shall establish and maintain an expedited Appeal review process for Appeals when the Contractor determines or a provider indicates that taking the time for a standard resolution could seriously jeopardize the Individual's life or health or ability to attain, maintain, or regain maximum function.
- 13.4.2 The Individual may submit an expedited Appeal either orally or in writing. No additional Individual follow-up is required.
- 13.4.3 The Contractor shall make a decision on the Individual's request for expedited Appeal and provide written notice, as expeditiously as the Individual's health condition requires, within three (3) calendar days after the Contractor receives the Appeal. The Contractor shall also make reasonable efforts to provide oral notice.
- 13.4.4 The Contractor may extend the timeframes by up to fourteen (14) calendar days if the Individual requests the extension; or the Contractor shows there is a need for additional information and how the delay is in the Individual's interest.
- 13.4.5 For any extension not requested by an Individual, the Contractor must give the Individual written notice of the reason for the extension.
- 13.4.6 The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an Individual's Appeal.
- 13.4.7 If the Contractor denies a request for expedited resolution of an Appeal, it shall transfer the Appeal to the timeframe for standard resolution and make reasonable efforts to give the Individual prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of denial.

13.5 **Administrative Hearing**

- 13.5.1 Only the Individual or the Individual's authorized representative may request an Administrative Hearing. A provider may not request an Administrative Hearing on behalf of an Individual.
- 13.5.2 If an Individual does not agree with the Contractor's resolution of an Appeal, the Individual may file a request for an Administrative Hearing within one hundred and twenty (120) calendar days of the date of notice of the resolution of the Appeal. The Contractor will not be obligated to continue services pending the results of the Administrative Hearing.
- 13.5.3 If the Individual requests an Administrative Hearing, the Contractor shall provide to HCA and the Individual, upon request, and within three (3) business days, all Contractor-held documentation related to the Appeal, including, but not limited to: transcript(s), records, or written decision(s) from participating providers or delegated entities.
- 13.5.4 The Contractor is an independent party and is responsible for its own representation in any Administrative Hearing, Board of Appeals, and subsequent judicial proceedings.

- 13.5.5 The Contractor's Behavioral Health Medical Director or designee shall review all cases where an Administrative Hearing is requested and any related Appeals.
- 13.5.6 The Individual must exhaust all levels of resolution and Appeal within the Contractor's grievance system prior to filing a request for an Administrative Hearing with HCA.
- 13.5.7 The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision.
- 13.5.8 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.
- 13.5.9 The Administrative Hearings process shall include as parties to the Administrative Hearing, the Contractor, the Individual and the Individual's authorized representative, or the legal representative of the deceased Individual's estate and HCA.

13.6 **Petition for Review**

Any party may Appeal the initial order from the Administrative Hearing to HCA Board of Appeals in accordance with Chapter 182-526 WAC. Notice of this right shall be included in the Initial Order from the Administrative Hearing.

13.7 **Effect of Reversed Resolutions of Appeals and Administrative Hearings**

If the Contractor's decision not to provide Contracted Services is reversed, either through a final order of the Washington State Office of Administrative Hearings or the HCA Board of Appeals, the Contractor shall provide the disputed services promptly, and as expeditiously as the Individual's health condition requires.

13.8 **Recording and Reporting Actions, Grievances, Appeals**

The Contractor shall maintain records of all Actions, Grievances, and Appeals.

- 13.8.1 The records shall include Actions, Grievances and Appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of responding to such Actions, Grievances, and Appeals.
- 13.8.2 The Contractor shall provide separate reports of all Actions, Grievances, and Appeals related to Contracted Services to HCA, quarterly due the 15th of the month following the quarter.
- 13.8.3 The Contractor is responsible for maintenance of records for and reporting of any Actions, Grievances, and Appeals handled by delegated entities.
- 13.8.4 Delegated Actions, Grievances, and Appeals are to be integrated into the Contractor's report.

- 13.8.5 Data shall be reported in HCA and Contractor agreed upon format. Reports that do not meet the Grievance System Reporting Requirements shall be returned to the Contractor for correction. Corrected reports will be resubmitted to HCA within thirty (30) calendar days.
- 13.8.6 The report medium shall be specified by HCA.
- 13.8.7 Reporting of actions shall include all medical necessity determinations but will not include denials of payment to providers unless the Individual is liable for payment in accord with WAC 182-502-0160 and the provisions of this Contract.
- 13.8.8 The Contractor shall provide information to HCA regarding denial of payment to providers upon request.
- 13.8.9 Reporting of Grievances shall include all expressions of Individual dissatisfaction not related to an Action. All Grievances are to be recorded and counted whether the Grievance is remedied by the Contractor immediately or through its Grievance and quality of care service procedures.

13.9 **Grievance System Terminations**

When Available Resources are exhausted, any Appeals or Administrative Hearings related to a request for authorization of a non-Crisis Contracted Service will be terminated since non-Crisis Services cannot be authorized without funding regardless of medical necessity.

14 CARE MANAGEMENT AND COORDINATION

14.1 Care Coordination Requirements

- 14.1.1 The Contractor shall develop and implement protocols that promote coordination, continuity, and quality of care that address the following:
 - 14.1.1.1 Use of GFS/FBG funds to care for Individuals in alternative settings such as homeless shelters, permanent supported housing, nursing homes or group homes.
 - 14.1.1.2 Strategies to reduce unnecessary crisis system utilization as defined in the Crisis System Section of this Contract.
 - 14.1.1.3 Care transitions and sharing of information among jails, prisons, hospitals, residential treatment centers, detoxification and sobering centers, homeless shelters and service providers for Individuals with complex behavioral health and medical needs.
 - 14.1.1.4 Continuity of Care for Individuals in an active course of treatment for an acute or chronic behavioral health condition, including preserving Individual-provider relationships through transitions.

14.2 Coordination with External Entities

- 14.2.1 The Contractor shall coordinate with External Entities including, but not limited to:
 - 14.2.1.1 BH-ASOs and BHOs for transfers between regions;
 - 14.2.1.2 Family Youth System Partner Roundtable (FYSPRT);
 - 14.2.1.3 Apple Health Managed Care Organizations to facilitate enrollment of Individuals who are eligible for Medicaid;
 - 14.2.1.4 Tribal entities regarding tribal members who access the crisis system;
 - 14.2.1.5 Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHC);
 - 14.2.1.6 The Criminal Justice system (courts, jails, law enforcement, public defenders, Department of Corrections, juvenile justice system);
 - 14.2.1.7 DSHS and other state agencies;
 - 14.2.1.8 State and federal agencies and local partners that manage access to housing;
 - 14.2.1.9 Education systems, to assist in planning for local school district threat assessment process;
 - 14.2.1.10 Accountable Community of Health; and
 - 14.2.1.11 First Responders.

- 14.2.2 The Contractor shall coordinate the transfer of Individual information, including initial assessments and care plans, with other Contractors, BH-ASOs and BHOs as needed when an Individual moves between regions or gains or loses Medicaid eligibility, to reduce duplication of services and unnecessary delays in service provision.
- 14.2.3 The Contractor shall participate in disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by HCA, county, or local public health jurisdiction. The Contractor shall attend state-sponsored training and participate in emergency/disaster preparedness planning when requested by HCA, the county or local public health jurisdiction in the region and provide Disaster Outreach and post-Disaster Outreach in the event of a disaster/emergency.

14.3 Care Coordination and Continuity of Care: Children and Youth in the Behavioral Health System

- 14.3.1 The Contractor shall collaborate with child/TAY serving systems, as follows:
 - 14.3.1.1 Convene the regional Children's Long Term Inpatient Program (CLIP) Committee unless an alternative organization is approved by HCA using the guidelines provided by HCA.
 - 14.3.1.2 If requested by a WISe provider, CLIP facility or other program in the behavioral health system served by the Contractor.
 - 14.3.1.3 Refer potentially CLIP-eligible children to the regional CLIP Committee and CLIP Administration.

14.4 Care Coordination and Continuity of Care: State Hospitals

- 14.4.1 The Contractor shall work with the discharge team to identify potential placement options and resolve barriers to placement, to assure that individuals will be discharged back to the community after the physician/treatment team determines the individual is ready for discharge, per the timeline guidelines in the Ready to Discharge Behavioral Health Administration policy.
- 14.4.2 The Contractor shall be responsible for coordinating discharge for the assigned Individuals and, until discharged, these Individuals will count against the Contractor's target allocation of State Hospital beds.
- 14.4.3 The Contractor shall provide the following services for American Indian/Alaska Native Individuals in fee for service who have opted out of managed care:
 - 14.4.3.1 Crisis services and related coordination of care;
 - 14.4.3.2 Involuntary commitment evaluation services; and
 - 14.4.3.3 Services related to inpatient discharge and transitions of care.
- 14.4.4 The Contractor shall ensure Individuals are medically cleared prior to admission to a State Hospital.

- 14.4.5 The Contractor shall respond to State Hospital census alerts to divert admissions and expedite discharges by using alternative community resources and mental health services, within Available Resources.
- 14.4.6 The Contractor or Subcontractor shall monitor Individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 to ensure compliance with LRA requirements.
- 14.4.7 The Contractor shall offer mental health services to Individuals who are ineligible for Medicaid to ensure compliance with LRA requirements.
- 14.4.8 The Contractor shall respond to requests for participation, implementation, and monitoring of Individuals receiving services on conditional release consistent with RCW 71.05.340. The Contractor or Subcontractor shall provide mental health services to Individuals who are ineligible for Medicaid to ensure compliance with conditional release requirements (RCW 10.77.150 and RCW 71.05.340).
- 14.4.9 Non-Medicaid Conditional Release Individuals in transitional status in Pierce or Spokane County will transfer back to the region they resided prior to entering the State Hospital upon completion of transitional care. Individuals residing in the Contractor's RSA prior to admission, and discharging to another RSA, will do so according to the RSA Transfer agreement established between the receiving RSA and the Contractor. The Agreements shall include:
 - 14.4.9.1 Specific roles and responsibilities of the parties related to transitions between the community and the State Hospital.
 - 14.4.9.2 Collaborative discharge planning and coordination with cross-system partners such as residential facilities, community MH or SUD providers, etc.
 - 14.4.9.3 Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's Service Area.
 - 14.4.9.4 When Individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the Contractor shall:
 - 14.4.9.4.1 Coordinate with DSHS Aging and Long Term Services Administration (ALTSA) Home and Community Services (HCS) and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the HCA website.
 - 14.4.9.4.2 Coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement when the Individual meets access to care criteria.

- 14.4.10 The Contractor shall implement a program staffed by at least one (1) or more Peer Bridger(s) based on FTE allocation table in Exhibit A in each region to facilitate and increase the number of State Hospital discharges and promote continuity of services when an Individual returns to the community. The program shall follow program standards found in the Peer Bridger Exhibit.
- 14.4.11 For each region, the Contractor shall submit the Peer Bridger monthly report to HCA, using a current version of the DBHR report template provided to the Contractor. The monthly report shall include: discharges and community placements, efforts to discharge and place Individuals, and service encounters using the Rehabilitation Case Management Services, until a new service encounter code is in place that is specific to the program. The report is due by the fifteenth (15th) of the month following the month being reported.
- 14.4.12 The Contractor will negotiate and execute an Inter-Regional Service Area Transfer Agreement with a BH-ASO or BHO, when:
 - 14.4.12.1 Requested by a BH-ASO or BHO.
 - 14.4.12.2 A state hospital patient who is assigned to the Contractor is being discharged to a RSA that is not an integrated managed care region.
 - 14.4.12.3 A patient who is assigned to a BH-ASO or BHO is discharging from a state hospital to an Integrated Managed Care Region, and will be covered by the Contractor.

14.5 No Beds Available for Persons Meeting Mental Health Detention Criteria - Report.

- 14.5.1 The Contractor shall ensure its DCRs report to HCA when it is determined a Individual meets detention criteria under RCW 71.05.150, 71.05.153, 71.34.700 or 71.34.710 and there are no beds available at the evaluation and treatment facility, the Individual has not been provisionally accepted for admission by a facility, and cannot be served on a single bed certification or LRA.
- 14.5.2 When the DCR determines an Individual meets detention criteria, the investigation has been completed and when no bed is available, the DCR shall submit an Unavailable Detention Facilities report to HCA within twenty-four (24) hours.

The report shall include the following:

- 14.5.2.1 The date and time the investigation was completed;
- 14.5.2.2 A list of facilities that refused to admit the Individual;
- 14.5.2.3 Information sufficient to identify the Individual, including name and age or date of birth; and;
- 14.5.2.4 Other reporting elements deemed necessary or supportive by HCA.

- 14.5.3 The Contractor receiving notification of the report must attempt to engage the Individual in appropriate services for which the Individual is eligible and report back within seven (7) days to HCA. The Contractor may contact the Individual's MCO to ensure services are provided.
- 14.5.4 The Contractor shall implement a plan to provide evaluation and treatment services to the Individual, which may include the development of LRAs to involuntary treatment, or relapse prevention programs reasonably calculated to reduce demand for evaluation and treatment.
- 14.5.5 HCA may initiate corrective action to ensure an adequate plan is implemented. An adequate plan may include development of LRAs to Involuntary Commitment, such as crisis triage, crisis diversion, voluntary treatment, or relapse prevention programs reasonably calculated to reduce demand for evaluation and treatment.

14.6 Care Coordination and Continuity of Care: Evaluation and Treatment (E&T) Facilities

- 14.6.1 E&T Discharge Planners shall be provided within the identified resources in Exhibit A. HCA shall pay the Contractor upon receipt and acceptance by HCA of verification that an E&T Discharge Planner position has been fully staffed by an individual whose sole function is the E&T Discharge Planner role, as described in this Contract.
- 14.6.2 Each E&T location shall have a designated E&T Discharge Planner. The E&T Discharge Planner shall develop and coordinate discharge plans that are: complex, multi system, mixed funding, and specific to Individuals that would otherwise be transferred to a state hospital. The plan shall track the Individual's progress upon discharge for no less than thirty (30) days after discharge from the E&T facility.
- 14.6.3 The Contractor shall submit to HCA the E&T Discharge Planner's reports that track the total number of all discharges from their E&T location and differentiate between those that were deemed complex and those that were deemed standard. The report is due the fifteenth (15th) of the month following the month being reported using the template provided by HCA.

15 GENERAL REQUIREMENTS AND BENEFITS

15.1 Special Provisions Regarding Behavioral Health Benefits

For each RSA, the Contractor's administration of behavioral health benefits shall comply with the following:

- 15.1.1 The location of the telephone crisis intervention and triage services (call center staff) is within Washington or within two hundred (200) miles of the Contractor's Service Area unless approved by HCA.
- 15.1.2 Call center staff located in another state must receive sufficient training to ensure adequate knowledge of the Contractor's operating policies and procedures and Washington's behavioral health service delivery system including, but not limited to, regional network and community resources, practice patterns, culture, and other relevant factors (e.g. state and federal laws).
- 15.1.3 A Behavioral Health Professional shall be available on-call twenty-four (24) hours a day, seven (7) days a week, to provide training and consultation to telephone crisis intervention and triage service providers located in another state.
- 15.1.4 The same staffing requirements as defined in this Contract and the same performance metrics apply regardless of the location of call center operations.
- 15.1.5 Data management and reporting, claims and financial management may be located out of Washington State. If claims are administered in another location, provider relations staff shall have access to the claims payment and reporting platform during Pacific Time Business Hours.
- 15.1.6 Unless otherwise noted, utilization review and Crisis Services shall be available twenty-four (24) hours a day, seven (7) days a week.
- 15.1.7 The Contractor shall designate employees who fulfill the following Behavioral Health roles:
 - 15.1.7.1 A Medical Director. Upon approval from HCA, the Medical Director may be a subcontracted position.
 - 15.1.7.2 A Clinical Director.
 - 15.1.7.3 A Crisis Triage Administrator.
 - 15.1.7.4 A Utilization/Care Management Administrator.
 - 15.1.7.5 A Network Development Administrator.
 - 15.1.7.6 A Provider Relations Administrator.
 - 15.1.7.7 A Children's Specialist.
 - 15.1.7.8 An Addictions Specialist.

- 15.1.8 In addition to the managerial staff, the Contractor shall have a sufficient number of qualified operational staff to meet its responsibilities under the Contract.
 - 15.1.8.1 The Contractor shall have a sufficient number of staff available twenty-four (24) hours a day, seven (7) days a week, and sufficient DCRs to respond to requests for SUD Involuntary Commitment services and Mental Health ITA services. Crisis triage staff shall have training in crisis triage and management for individuals of all ages and behavioral health conditions, including SMI, SUDs, and co-occurring disorders.
 - 15.1.8.2 The Contractor shall have access to a physician, psychiatrist, physician assistant or ARNP with prescriptive authority twenty-four (24) hours a day, seven (7) days a week, to address specialized needs of callers experiencing crisis, and to provide assistance with crisis triage, referral, and resolution.
 - 15.1.8.3 The Contractor shall have a sufficient number of behavioral health clinical peer reviewers available to conduct Appeal reviews or to provide clinical consultation on complex cases, treatment plan issues, and other treatment needs.
 - 15.1.8.3.1 Clinical peer reviewers may be subcontracted and can be located outside of Washington State but shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center, to include participation in initial orientation and at least annual training on Washington State-specific benefits, protocols, and initiatives.
 - 15.1.8.4 The Contractor shall ensure that staffing is sufficient to support behavioral health data analytics and behavioral health data systems, including FBG reporting requirements, to oversee all data interfaces and support the behavioral health specific reporting requirements under the Contract.
 - 15.1.8.5 The Contractor shall ensure adequate staffing to perform the following functions: administrative services, member services, Grievances and Appeals, claims, encounter data processing, data analysts, and financial reporting analysts.
- 15.1.9 The Contractor shall develop and maintain a human resources and staffing plan that describe how the Contractor will maintain adequate staffing. The Contractor shall:
 - 15.1.9.1 Develop and implement staff training plans that address how all staff will be trained on the requirements of this Contract.
 - 15.1.9.2 Locate a sufficient number of Provider Relations staff within the State to meet requirements under this Contract for provider education, training and performance management, including SABG outreach requirements related to pregnant women with intravenous drug use, pregnant women with a SUD, and other individuals with intravenous drug use.

15.1.10 The Contractor shall ensure development and implementation of training programs for network providers that deliver, coordinate, or oversee behavioral health services to Individuals.

15.2 Scope of Services

15.2.1 The Contractor may limit the provision of contracted services to Participating Providers except Crisis Services specifically provided in this Contract.

15.2.2 Outside the Service Areas:

15.2.2.1 The Contractor is only responsible for telephone crisis intervention and triage services for Individuals who are temporarily outside the Service Area.

15.2.2.2 The Contractor is not responsible for coverage of any services when an Individual is outside the United States of America and its territories and possessions.

15.3 General Description of Contracted Services

15.3.1 The Contractor shall prioritize state funds for Crisis Services, evaluation and treatment services for individuals ineligible for Medicaid, and services related to the administration of Chapters 71.05 and 71.34 RCW. Available Resources shall then be used to cover the services listed in this subsection for the priority populations defined in this Contract (refer to Scope of Services-Crisis System for additional Crisis and ITA services requirements).

15.3.2 The Contractor must expend SABG funds in accordance with the optional and required service details as specified in Exhibit J, SABG Project Plan Template.

15.3.3 The Contractor shall establish and apply medical necessity criteria for the provision or denial of the following services:

15.3.3.1 Assessment.

15.3.3.2 Brief Intervention.

15.3.3.3 Brief Outpatient Treatment.

15.3.3.4 Case Management.

15.3.3.5 Day Support.

15.3.3.6 Engagement and Referral.

15.3.3.7 Evidenced Based/Wraparound Services.

15.3.3.8 Interim Services.

15.3.3.9 Opiate Dependency/HIV Services Outreach.

- 15.3.3.10 E&T Services provided at Community Hospitals or E&T facilities.
- 15.3.3.11 Family Treatment.
- 15.3.3.12 Group Therapy.
- 15.3.3.13 High Intensity Treatment.
- 15.3.3.14 Individual Therapy.
- 15.3.3.15 Inpatient Psychiatric Services.
- 15.3.3.16 Intake Evaluation.
- 15.3.3.17 Intensive Outpatient Treatment – SUD.
- 15.3.3.18 Intensive Inpatient Residential Treatment Services – SUD.
- 15.3.3.19 Long Term Care Residential – SUD.
- 15.3.3.20 Medication Management.
- 15.3.3.21 Medication Monitoring.
- 15.3.3.22 Mental Health Residential.
- 15.3.3.23 Opioid Treatment Programs (OTPs)/Medication Assisted Treatment (MAT)
- 15.3.3.24 Outpatient Treatment.
- 15.3.3.25 Peer Support.
- 15.3.3.26 Psychological Assessment.
- 15.3.3.27 Recovery House Residential Treatment – SUD.
- 15.3.3.28 Rehabilitation Case Management.
- 15.3.3.29 Special Population Evaluation.
- 15.3.3.30 TB Counseling, Screening, Testing and Referral.
- 15.3.3.31 Therapeutic Psychoeducation.
- 15.3.3.32 Urinalysis/Screening Test.
- 15.3.3.33 TB Screening/Skin Test.
- 15.3.3.34 Withdrawal Management – Acute.
- 15.3.3.35 Withdrawal Management – Sub-Acute.

- 15.3.4 The Contractor shall develop and apply criteria and to determine the provision for or denial of following services to which medical necessity does not apply:
 - 15.3.4.1 Alcohol/Drug Information School.
 - 15.3.4.2 Childcare.
 - 15.3.4.3 Community Outreach – SABG priority populations PPW and IUID.
 - 15.3.4.4 Continuing Education and Training.
 - 15.3.4.5 PPW Housing Support Services.
 - 15.3.4.6 Recovery Support Services.
 - 15.3.4.7 Sobering Services.
 - 15.3.4.8 Therapeutic Interventions for Children.
 - 15.3.4.9 Transportation.
- 15.3.5 Pharmaceutical Products:
 - 15.3.5.1 Prescription drug products may be provided within Available Resources based on medical necessity. Coverage to be determined by HCA Fee for Service (FFS) formulary.

16 Scope of Services- Crisis System

16.1 Crisis System General Requirements

- 16.1.1 The Contractor shall develop and maintain a regional behavioral health crisis system and provide services that meet the following requirements:
 - 16.1.1.1 Crisis Services will be available to all individuals who present with a need for Crisis Services in the Contractor's Service Area, as defined in this Contract.
 - 16.1.1.2 Crisis Services shall be provided in accordance with Chapters 71.05 RCW and 71.34 RCW.
 - 16.1.1.3 ITA services include all services and Administrative Functions required for the evaluation of involuntary detention or involuntary treatment of Individuals in accordance with Chapter 71.05 RCW, RCW 71.24.300 and Chapter 71.34 RCW. Requirements include payment for all services ordered by the court for individuals ineligible for Medicaid, and costs related to court processes and Transportation. Crisis Services become ITA Services when a DCR determines an individual must be evaluated for involuntary treatment. ITA services continue until the end of the Involuntary Commitment.
- 16.1.2 Crisis Services shall be delivered as follows:
 - 16.1.2.1 Stabilize individuals as quickly as possible and assist them in returning to a level of functioning that no longer qualifies them for Crisis Services. Stabilization Services will be provided in accordance with WAC 246-341-0915.
 - 16.1.2.2 Provide solution-focused, person-centered and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, institutionalization or out of home placement.
 - 16.1.2.3 Coordinate closely with the regional MCOs, community court system, First Responders, criminal justice system, inpatient/residential service providers, and outpatient behavioral health providers to operate a seamless crisis system and acute care system that is connected to the full continuum of health services.
 - 16.1.2.4 Engage the Individual in the development and implementation of crisis prevention plans to reduce unnecessary crisis system utilization and maintain the Individual's stability.
 - 16.1.2.5 Develop and implement strategies to assess and improve the crisis system over time.

16.2 Crisis System Staffing Requirements

- 16.2.1 The Contractor shall comply with staffing requirements in accordance with Chapter 246-341 WAC. Each staff member working with an Individual receiving crisis services must:
 - 16.2.1.1 Be supervised by a Mental Health Professional or licensed by DOH.
 - 16.2.1.2 Receive annual violence prevention training on the safety and violence prevention topics described in RCW 49.19.030. The staff member's personnel record must document the training.
 - 16.2.1.3 Have the ability to consult with one of the following (who has at least one (1) years' experience in the direct treatment of individuals who have a mental or emotional disorder):
 - 16.2.1.3.1 A psychiatrist;
 - 16.2.1.3.2 A physician;
 - 16.2.1.3.3 Physician assistant; or
 - 16.2.1.3.4 An ARNP.
- 16.2.2 The Contractor shall comply with DCR qualification requirements in accordance with Chapters 71.05 and 71.34 RCW and shall incorporate the statewide DCR Protocols, listed on the HCA website, into the practice of their DCRs.
- 16.2.3 The Contractor shall have clinicians available twenty-four (24) hours a day, seven (7) days a week who have expertise in Behavioral Health issues pertaining to children and families.
- 16.2.4 The Contractor shall make available at least one (1) Certified CDP with experience conducting Behavioral Health crisis support for consultation by phone or on site during regular Business Hours.
- 16.2.5 The Contractor shall make available at least one (1) Certified CPC with experience conducting behavioral health crisis support for consultation by phone or on site during regular Business Hours.
- 16.2.6 The Contractor shall establish policies and procedures for crisis and ITA services that implement the following requirements:
 - 16.2.6.1 No DCR or crisis worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's ITA, unless a second trained individual accompanies them.
 - 16.2.6.2 The clinical team supervisor, on-call supervisor, or the individual professional, shall determine the need for a second individual to accompany them based on a risk assessment for potential violence.

- 16.2.6.3 The second individual who responds may be a First Responder, a Mental Health Professional, a Chemical Dependency professional, or a mental health provider who has received training required in RCW 49.19.030.
- 16.2.6.4 No retaliation shall be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.
- 16.2.6.5 The Contractor shall have a plan to provide training, mental health staff back-up, information sharing, and communication for crisis staff who respond to private homes or other private locations.
- 16.2.6.6 Every DCR dispatched on a crisis visit shall have prompt access to information about a Individual's history of dangerousness or potential dangerousness documented in crisis plans or commitment records and is available without unduly delaying a crisis response.
- 16.2.6.7 The Contractor or Subcontractor shall provide a wireless telephone or comparable device to every DCR or crisis worker, who participates in home visits to provide Crisis Services.

16.3 Crisis System Operational Requirements

- 16.3.1 Crisis Services shall be available twenty-four hours a day, seven days a week.
 - 16.3.1.1 Mobile crisis outreach shall respond within two (2) hours of the referral to an emergent crisis and within twenty-four (24) hours for referral to an urgent crisis.
- 16.3.2 The Contractor shall provide a toll free line that is available twenty-four hours a day, seven days a week, to provide crisis intervention and triage services, including screening and referral to a network of providers and community resources.
 - 16.3.2.1 The toll-free crisis line shall be a separate number from the Contractor's customer service line.
- 16.3.3 Individuals shall be able to access crisis services without full completion of Intake Evaluations and/or other screening and assessment processes. Telephone crisis support services will be provided in accordance with WAC 246-341-0905 and crisis outreach services will be provided in accordance with WAC 246-341-0910.
- 16.3.4 The Contractor shall establish registration processes for non-Medicaid Individuals utilizing crisis services to maintain demographic and clinical information, and establish a medical record/tracking system to manage their crisis care, referrals, and utilization.
- 16.3.5 The Contractor shall establish protocols for providing information about and referral to other available services and resources for individuals who do not meet criteria for Medicaid or GFS/FBG services (e.g., homeless shelters, domestic violence programs, Alcoholics Anonymous).

- 16.3.6 The Contractor shall ensure that Crisis Service providers document calls, services, and outcomes. The Contractor shall comply with record content and documentation requirements in accordance with WAC 246-341-0900.

16.4 Crisis System Services

- 16.4.1 The Contractor shall make the following services available to all individuals in the Contractor's Service Area:
- 16.4.1.1 Crisis Triage and Intervention to determine the urgency of the needs and identify the supports and services necessary to meet those needs. Dispatch mobile crisis or connect the individual to services. For individuals enrolled with a MCO, assist in connecting the individual with current or prior service providers. Crisis Services may be provided prior to completion of an Intake Evaluation. Services shall be provided by or under the supervision of a Mental Health Professional. The Contractor must provide twenty-four (24) hour a day, seven (7) day a week crisis mental health services to individuals who are within the Contractor's Service Area and report they are experiencing a crisis. There must be sufficient staff available, including a DCR, to respond to requests for Crisis Services.
 - 16.4.1.2 SUD ITA Services to identify and evaluate alcohol and drug involved Individuals requiring protective custody, detention, or Involuntary Commitment services. Services include investigation and assessment activities, management of the court case findings, and legal proceedings.
- 16.4.2 The Contractor shall provide the following services to Individuals who meet eligibility requirements defined in this Contract but who do not qualify for Medicaid, when medically necessary, and based on Available Resources:
- 16.4.2.1 Crisis Stabilization Services, includes short-term (up to fourteen (14) days per episode) face-to-face assistance with life skills training and understanding of medication effects and follow up services. Services are provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual experiencing a behavioral health crisis. Crisis stabilization is often referred to as hospital diversion, typically managed by specific programs, apart from initial/emergent Stabilization Services, and available twenty-four (24) hours a day, seven (7) days a week.
 - 16.4.2.2 SUD Crisis Services including short term stabilization, a general assessment of the individual's condition, an interview for therapeutic purposes, and arranging transportation home or to an approved facility for intoxicated or incapacitated individuals on the streets or in other public places. Services may be provided by telephone, in person, in a facility or in the field. Services may or may not lead to ongoing treatment.

- 16.4.2.3 Secure Detoxification Services provided in a facility licensed and certified by DOH to provide evaluation and treatment services to Individuals detained by the DCR for SUD ITA. Appropriate care for Individuals with a history of SUD who have been found to meet criteria for involuntary treatment includes: evaluation and assessment, provided by a CDP; acute or subacute detoxification services; SUD treatment; and discharge assistance provided by CDPs, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to LRA as appropriate for the Individual in accordance with WAC 246-341-1104.
- 16.4.2.4 Peer-to-Peer Warm Line Services are available to callers with routine concerns who could benefit from or who request to speak to a peer for support and help de-escalating emerging crises. Warm line staff may be peer volunteers who provide emotional support, comfort, and information to callers living with a mental illness.

16.5 Coordination with External Entities

- 16.5.1 The Contractor shall collaborate with HCA and MCOs operating in the RSA to develop and implement strategies to coordinate care with community behavioral health providers for Individuals with a history of frequent crisis system utilization. Coordination of care strategies will seek to reduce utilization of Crisis Services.
- 16.5.2 The Contractor shall contract with HCA MCOs operating in the RSA to establish protocols related to the provision of behavioral health Crisis Services and Ombuds services by the Contractor to the MCOs' Medicaid enrollees. The protocols shall, at a minimum, address the following:
 - 16.5.2.1 Payment by the MCOs to the Contractor for crisis services arranged for or delivered by the Contractor or the Contractor's provider network to individuals enrolled in the MCOs' plan.
 - 16.5.2.1.1 If the Contractor is paid on a fee-for-service basis and delivers Crisis Services through a network of crisis providers, it shall reimburse its providers within fourteen (14) calendar days of receipt of reimbursement from the MCO.
 - 16.5.2.1.2 Any sub-capitation arrangement with HCA MCOs or the Contractor's providers shall be reviewed and approved by HCA.
 - 16.5.2.2 The Contractor and MCOs operating in the RSA shall participate in a semi-annual financial reconciliation process, as directed by HCA, related to anticipated versus actual crisis services utilization.
 - 16.5.2.3 The Contractor shall submit claims and/or encounters for crisis services consistent with the provisions of this Contract. Claims and encounter submission timeliness requirements apply regardless of whether the Contractor directly provides services, acts as a third party administrator for a network of crisis providers, or is paid on a capitation or a fee-for-service basis.

- 16.5.2.4 The Contractor shall establish information systems to support data exchange consistent with the requirements in this Contract including, but not limited to: eligibility interfaces, exchange of claims and encounter data, administrative data such as PRISM, and sharing of care plans and MHAD necessary to coordinate service delivery in accordance with applicable privacy laws, HIPAA Regulations and 42 C.F.R. Part 2.
- 16.5.2.5 The Contractor shall notify an MCO within 1 business day when a MCO's Enrollee interacts with the crisis system.
- 16.5.3 The Contractor shall, in partnership with the MCOs operating in the RSA, develop protocols to engage and collaborate with First Responders and other partners within the criminal justice system to coordinate the discharge and transition of incarcerated adults and TAY with SMI for the continuation of prescribed medications and other Behavioral Health services prior to re-entry to the community.

16.6 Tribal Coordination for Crisis and Involuntary Commitment Evaluation Services:

- 16.6.1 The Contractor shall submit to HCA's Tribal Liaison an annual plan for providing crisis and ITA evaluation on Tribal Lands within each RSA. The plan is due no later than July 1.
- 16.6.2 The plan shall be developed in partnership with the affected Tribal entities within the RSA.
- 16.6.3 The plan shall identify a procedure and timeframe for evaluating the plan's efficacy and a procedure and timeframe for reviewing or modifying the plan to the satisfaction of all parties.
- 16.6.4 If the Contractor and Tribal entity are not able to develop a plan or the tribe does not respond to the request, HCA will work with both the Tribes and Contractor to reach an understanding.
- 16.6.5 Meetings shall be conducted in accordance with the HCA government-to-government relationship with Washington Tribes.
- 16.6.6 The Tribes whose Tribal lands lie within multiple regions may develop joint plans with those regions. If the Contractor has multiple Tribal lands within their RSA one plan may be developed for all Tribes if all parties agree.
- 16.6.7 The plan shall include a procedure for crisis responders and non-Tribal DCRs to access Tribal lands to provide services including crisis response and ITA evaluations. The plan shall also include the following:
 - 16.6.7.1 Any notifications and authority needed to provide services for evening, holiday, and weekend access to Tribal lands if different than business hours.
 - 16.6.7.2 A process to notify Tribal authorities when Crisis Services are provided on Tribal land, especially on weekends, holidays, and after business hours and must identify who is notified and timeframe for the notification.

- 16.6.7.3 A description of how crisis responders will coordinate with Tribal Mental Health providers and others identified in the plan and how service coordination and debriefing with any Tribal mental health providers will occur after a Crisis Service has been provided.
- 16.6.7.4 The process when a DCR and Tribal mental health providers determine whether to detain or not for Involuntary Commitment.
- 16.6.7.5 If ITA evaluations cannot be conducted on Tribal land, the plan shall specify how and by whom individuals will be transported to non-Tribal lands for ITA evaluations and detentions, and to a licensed evaluation and treatment facility.
- 16.6.7.6 Specify where individuals will be held and under what authority if no E&T or secure withdrawal management and stabilization beds are available.

17 Juvenile Drug Court and Criminal Justice Treatment Account

17.1 Juvenile Drug Court

- 17.1.1 In RSAs where funding is provided, the Contractor shall support Individuals involved with a region's Juvenile Drug Court (JDC) and provide the following services:
- 17.1.1.1 A drug and alcohol assessment (HCA prefers the GAIN-I tool).
 - 17.1.1.2 Substance abuse and mental health treatment and counseling as appropriate which may include Evidence-Based Practices such as Functional Family Therapy and Aggression Replacement Training.
 - 17.1.1.3 A comprehensive case management plan which is individually tailored, culturally competent, developmentally and gender appropriate, and which includes educational goals that draw on the strengths and address the needs of the Individual.
 - 17.1.1.4 Drug testing, scheduled and at random, to support the treatment plan and monitor compliance.
 - 17.1.1.5 Track attendance and completion of activities, offer incentives for compliance and impose sanctions for lack of compliance.
 - 17.1.1.6 Engagement of the community to broaden the support structure and better ensure success such as referrals to mentors, support groups, pro-social activities, etc.

17.2 Criminal Justice Treatment Account (CJTA)

In RSAs where funding is provided, the Contractor shall be responsible for treatment and recovery support services using specific eligibility and funding requirements for CJTA in accordance with RCW 71.24.580 and RCW 2.30.030. CJTA funds must be clearly document and reported in accordance with section 9.3.1.8.

- 17.2.1 The Contractor shall implement any local CJTA plans developed by the CJTA panel and approved by HCA.
- 17.2.2 CJTA Funding Guidelines:
- 17.2.2.1 In accordance with RCW 2.30.040, if CJTA funds are managed by a Drug Court, then it is required to provide a dollar-for-dollar participation match for services to Individuals who are receiving services under the supervision of a drug court.
 - 17.2.2.2 No more than ten percent (10%) of the total CJTA funds can be used for the following support services combined:
 - 17.2.2.2.1 Transportation; and
 - 17.2.2.2.2 Child Care Services.

- 17.2.3 The Contractor shall provide a minimum thirty percent (30%) of the CJTA funds for special projects that meet any or all of the following conditions:
 - 17.2.3.1 An acknowledged best practice (or treatment strategy) that can be documented in published research, or
 - 17.2.3.2 An approach utilizing either traditional or best practices to treat significantly underserved population(s), or
 - 17.2.3.3 A regional project conducted in partnership with at least 1 other entity serving the RSA service area such as, the AH-IMC MCOs operating in the RSA or the ACH.

- 17.2.4 Services that can be provided using CJTA funds are:
 - 17.2.4.1 Brief Intervention (any level, assessment not required);
 - 17.2.4.2 Acute Withdrawal Management (ASAM Level 3.2WM);
 - 17.2.4.3 Sub-Acute Withdrawal Management (ASAM Level 3.2WM);
 - 17.2.4.4 Outpatient Treatment (ASAM Level 1);
 - 17.2.4.5 Intensive Outpatient Treatment (ASAM Level 2.1);
 - 17.2.4.6 Opiate Treatment Program (ASAM Level 1);
 - 17.2.4.7 Case Management (ASAM Level 1.2);
 - 17.2.4.8 Intensive Inpatient Residential Treatment (ASAM Level 3.5);
 - 17.2.4.9 Long-term Care Residential Treatment (ASAM Level 3.3);
 - 17.2.4.10 Recovery House Residential Treatment (ASAM Level 3.1);
 - 17.2.4.11 Assessment (to include Assessments done while in jail);
 - 17.2.4.12 Interim Services;
 - 17.2.4.13 Community Outreach;
 - 17.2.4.14 Involuntary Commitment Investigations and Treatment;
 - 17.2.4.15 Room and Board (Residential Treatment Only);
 - 17.2.4.16 Transportation;
 - 17.2.4.17 Childcare Services;
 - 17.2.4.18 Urinalysis;
 - 17.2.4.19 Treatment in the jail, limited to 8 sessions that may include:

- 17.2.4.19.1 Engaging individuals in SUD treatment;
- 17.2.4.19.2 Referral to SUD services;
- 17.2.4.19.3 Coordinating care;
- 17.2.4.19.4 Continuity of care; and
- 17.2.4.19.5 Transition planning.
- 17.2.4.20 Employment services and job training;
- 17.2.4.21 Relapse prevention;
- 17.2.4.22 Family/marriage education;
- 17.2.4.23 Peer-to-peer services, mentoring and coaching;
- 17.2.4.24 Self-help and support groups;
- 17.2.4.25 Housing support services (rent and/or deposits);
- 17.2.4.26 Life skills;
- 17.2.4.27 Spiritual and faith-based support;
- 17.2.4.28 Education; and
- 17.2.4.29 Parent education and child development.
- 17.2.5 CJTA Annual Plan –Due October 1, for the biennium.
 - 17.2.5.1 The BH-ASO or BHO must coordinate with the local legislative authority for the county or counties in its regional service area in order to facilitate the planning requirement as described in RCW 71.24.580(6). The Plan shall:
 - 17.2.5.1.1 Describe in detail how substance use disorder treatment and support services will be delivered within the region;
 - 17.2.5.1.2 Address the CJTA Account Match Requirement by providing a local participation match of all HCA-provided criminal justice awards;
 - 17.2.5.1.3 Include details on special projects such as best practices/treatment strategies, significant underserved population(s), or regional endeavors, including the following:
 - 17.2.5.1.3.1 Describe the project and how it will be consistent with the strategic plan;

17.2.5.1.3.2 Describe how the project will enhance treatment services for offenders;

17.2.5.1.3.3 Indicate the number of offenders who were served using innovative funds;

17.2.5.1.3.4 Detail the original goals and objectives of the project.

17.2.6 Completed plans must be submitted to HCA for review and approval. Once approved, the Contractor must implement its plan as written.

18 Federal Block Grants (FBG)

- 18.1 In each RSA, the Contractor shall collect information from key stakeholders and community partners to develop the regional MHBG and SABG Project Plans. The plans shall be submitted to and approved by the regional BHAB. The Contractor shall send its board-approved Project Plans to HCA annually by January 31 for approval prior to submitting the first A-19 invoice. Plans shall be on the most recent templates. The current MHBG plan template is identified in Exhibit I, and the SABG Project Plan template is in Exhibit J. HCA shall review the proposed plans and notify the Contractor of the date of approval, or if not approved, the date revisions are due. HCA shall not process payment for FBG services until HCA has approved the project plans. Any changes to the Project Plans must be submitted to HCA for review and approval prior to implementation.
- 18.2 The Contractor shall provide, or subcontract for services, according to the approved regional MHBG and the regional SABG project plans.
- 18.3 The Contractor shall provide MHBG services to promote recovery for an adult with a SMI and resiliency for SED children in accordance with federal and state requirements. SABG funds shall be used to provide services to priority populations.
- 18.4 The Contractor shall ensure that FBG funds are used only for services to individuals who are not enrolled in Medicaid or for services that are not covered by Medicaid as described below:

Benefits	Services	Use MHBG or SABG Funds	Use Medicaid
Individual is not a Medicaid recipient	Any Allowable Type	Yes	No
Individual is a Medicaid recipient	Allowed under Medicaid	No	Yes
Individual is a Medicaid recipient	Not Allowed under Medicaid	Yes	No

- 18.5 Upon request by HCA, the Contractor shall attend or send a representative to the Washington State Behavioral Health Advisory Committee meetings to discuss priorities for future FBG supported services.
- 18.6 FBG requires annual peer reviews by individuals with expertise in the field of mental health treatment (for MHBG) and by individuals with expertise in the field of drug abuse treatment (for SABG) consisting of at least five percent (5%) of treatment providers. The Contractor and Subcontractors shall participate in a peer review process when requested by HCA (42 U.S.C. 300x-53 (a) and 45 C.F.R. 96.136, MHBG Service Provisions).
- 18.7 The Contractor shall submit regional MHBG and SABG Final Reports, annually, by August 1 of each year, for services provided in the prior state fiscal year. Reports must be provided on the current templates. See Exhibit F, Federal Block Grant Annual Progress Report.

19 Jail Transition Services

- 19.1 Jail Transition Services are to be provided within the identified resources in Exhibit A.
- 19.2 The Contractor shall coordinate with local law enforcement and jail personnel.
- 19.3 The Contractor must identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.
- 19.4 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 Chapter 71.24 RCW. The Contractor must conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.
- 19.5 The Contractor shall assist Individuals with mental illness in completing and submitting an application for medical assistance prior to release from jail.
- 19.6 Pre-release services shall include:
 - 19.6.1 Mental health screening for Individuals who display behavior consistent with a need for such screening or who have been referred by jail staff, or officers of the court.
 - 19.6.2 Mental health intake assessments for persons identified during the mental health screening as a member of a priority population.
 - 19.6.3 Facilitation of expedited medical and financial eligibility determination with the goal of immediate access to benefits upon release from incarceration.
 - 19.6.4 Other prudent pre-release and pre-trial case management and transition planning.
 - 19.6.5 Direct mental health services to Individuals who are in jails that have no mental health staff.
 - 19.6.6 Post-release outreach to ensure follow-up for mental health and other services (e.g. substance abuse) to stabilize Individuals in the community.
 - 19.6.7 If the Contractor has provided the jail services in this section the Contractor may also use the Jail Coordination Services funds, if sufficient, to facilitate any of the following:
 - 19.6.7.1 Daily cross-reference between new booking and the Data Store to identify newly booked persons.
 - 19.6.7.2 Develop individual alternative service plans (alternative to the jail) for submission to the courts.
 - 19.6.7.3 Inter-local Agreements with juvenile detention facilities.
 - 19.6.7.4 Provide up to a seven (7) day supply of medications for the treatment of mental health symptoms following the release from jail.
 - 19.6.7.5 Training to local law enforcement and jail services personnel.

20 DEDICATED MARIJUANA ACCOUNT (DMA)

- 20.1 Dedicated Marijuana Account (DMA) funds are to be provided within the identified resources in Exhibit A.
- 20.2 DMA funds shall be used to fund SUD treatment services for youth living at or below two hundred and twenty percent (220%) of the federal poverty level, without insurance coverage or who are seeking services independent of their parent/guardian;
- 20.3 DMA funds may be used for development, implementation, maintenance, and evaluation of programs that support intervention, treatment, and recovery support services for middle school and high school aged students.
- 20.4 All new programs and services must direct at least eighty-five percent (85%) of funding to evidence-based or research-based programs and practices that produce objectively measurable results, and are expected to be cost beneficial.
- 20.5 Up to fifteen percent (15%) of the funds appropriated for new programs and new services may be used to provide support to proven and tested practices, emerging best practices, or promising practices.

21 FAMILY YOUTH SYSTEM PARTNER ROUNDTABLE (FYSPRT)

- 21.1 FYSPRT support shall be provided within the identified resources in Exhibit A and reported in accordance with this Section.
- 21.2 Consistent with the FYSPRT Manual and Resource Guide, the Contractor will develop, promote and support each Regional FYSPRT, by providing administrative and staff support for the performance of work as defined in this section, including but not limited to: community Outreach and Engagement efforts to publicize the work of the FYSPRTs and recruit members; fiscal management; arranging meeting space; and other administrative supports necessary for the operation of the Regional FYSPRT.
- 21.3 The Contractor shall:
 - 21.3.1 Include youth, family, and system partner representation in all aspects of the development, promotion, and support of the Regional FYSPRT;
 - 21.3.2 Engage Federally Recognized Tribes and Recognized American Indian Organizations to promote, participate in, and aid in the continued development of the Regional FYSPRT and show dates and type of outreach in progress reports;
 - 21.3.3 Expand recruitment and engagement of families and youth with diverse perspectives and document efforts to implement the Contractor's Regional FYSPRT outreach strategy;
 - 21.3.4 Engage with youth, families, and system partners to build and maintain a Regional FYSPRT membership that will include:
 - 21.3.4.1 At least fifty-one percent (51%) Youth and family membership (if not at 51%, note this in the quarterly report and identify strategies being utilized to become compliant);
 - 21.3.4.2 Representatives from Family and Youth Run Organizations and other relevant stakeholder groups within the region;
 - 21.3.4.3 Key administrators connected to the WISE implementation;
 - 21.3.4.4 Community System Partners and Community Members, such as:
 - 21.3.4.4.1 Suggested Participants listed in the FYSPRT Manual;
 - 21.3.4.4.2 Behavioral Health Provider(s);
 - 21.3.4.4.3 The Department of Children, Youth and Families;
 - 21.3.4.4.4 Developmental Disabilities Administration;
 - 21.3.4.4.5 Education/Local Education Agency, Educational Service Districts;
 - 21.3.4.4.6 Faith Community Leaders;

- 21.3.4.4.7 Federally Recognized Tribes or Tribal Governments;
 - 21.3.4.4.8 Foster Care Provider(s);
 - 21.3.4.4.9 Juvenile Justice;
 - 21.3.4.4.10 Law enforcement;
 - 21.3.4.4.11 Regional Advocacy Groups;
 - 21.3.4.4.12 Physical health care/public health;
 - 21.3.4.4.13 Recognized American Indian Organizations; and
 - 21.3.4.4.14 Other interested community stakeholders.
- 21.3.5 Ensure all members of the Regional FYSPRT are engaged as full partners and are included in all aspects of the development, implementation, and evaluation of the Regional FYSPRT.
- 21.3.6 Follow the current version of the FYSPRT Manual.
- 21.3.7 Convene Regional FYSPRT meetings at a minimum of once per month. Meeting materials must be made publicly available on the Contractor's website prior to the meeting. The meetings shall:
- 21.3.7.1 Follow the Regional FYSPRT Meeting protocol found in the FYSPRT Manual;
 - 21.3.7.2 Be open to the public and publicized;
 - 21.3.7.3 Provide for and publicize a process for obtaining travel and support (such as childcare assistance/reimbursement) to attend meetings; and
 - 21.3.7.4 Be planned and facilitated by the Regional Tri-Leads, with input from all Tri-Leads, in the development of meeting agendas, identification of issues for follow up and other items.
 - 21.3.7.5 Include a review of the WISe Quarterly Behavioral Health Assessment Solutions (BHAS) at one meeting per quarter to identify the strengths and needs of the RSA. Include in the progress report a plan to address the need(s) as a meeting agenda item, annual work plan goal or other method. If applicable to the RSA, other regional data reports can be reviewed to fulfill this requirement for two of the four quarters.
- 21.3.8 Continue to implement the five (5) year strategic plan created by the Regional FYSPRT and update as needed based on the results of the following:
- 21.3.8.1 The annual needs assessment completed between July 1 and September 30 using the FYSPRT's tool of choice;
 - 21.3.8.2 FYSPRT meetings and evaluation;

- 21.3.8.3 Between October 1 and December 31 develop and begin implementing a Work Plan using the Strategic Plan and the results of the annual needs assessment. The Work Plan shall be submitted by January 1. As part of the Work Plan, identify at least three (3) priority areas of focus and include for each priority:
 - 21.3.8.3.1 Goals;
 - 21.3.8.3.2 Action steps;
 - 21.3.8.3.3 Those assigned; and
 - 21.3.8.3.4 Timeline for completion.
- 21.3.8.4 No later than June 30, complete goals and action steps as outlined in the Work Plan. Submit quarterly reports that identifies progress on goals and action steps, including barriers found and plans to address barriers.
- 21.3.9 Maintain Regional FYSPRT webpages that include:
 - 21.3.9.1 Point of contact, name, email, phone number, and mailing address;
 - 21.3.9.2 Regional agendas and meeting notes;
 - 21.3.9.3 Dates, locations, and times of past and upcoming Regional meetings (including information on travel reimbursement, child care, and other meeting supports);
 - 21.3.9.4 A Regional Charter;
 - 21.3.9.5 Policies and procedures;
 - 21.3.9.6 Results of the needs assessment and a strategic plan framework;
 - 21.3.9.7 The Strategic Plan;
 - 21.3.9.8 The Work Plan, when developed; and
 - 21.3.9.9 Links to relevant regional/statewide resources and information.
- 21.3.10 Participate in State-level activities, that:
 - 21.3.10.1 Identifies Regional Tri-Leads to participate as members of the Statewide FYSPRT;
 - 21.3.10.2 Offers support for all Regional Tri-Leads to attend the Statewide FYSPRT meetings in-person with the requirement that at least two of the three Tri-Leads attend each Statewide FYSPRT meeting, and ensures that no Tri-Lead attends fewer than one Statewide meeting each year;
 - 21.3.10.3 Supports Regional FYSPRT members to attend FYSPRT-related training and technical assistance meetings or events, as requested by DBHR;

- 21.3.10.4 Supports Regional FYSPRT Youth Tri-Lead(s) to attend youth run organization or program events and activities as determined by regional needs or as requested by DBHR;
- 21.3.10.5 Supports Regional FYSPRT Family Tri-Lead(s) to participate as members of the Washington Behavioral Statewide Family Network a minimum of once per quarter and attend other family run organization or program events and activities as determined by regional needs or requested by DBHR to the maximum amount allocated under this contract; and
- 21.3.10.6 Identify Regional Tri-Leads and FYSPRT members to participate on subgroups of the Statewide FYSPRT.
- 21.3.11 At a minimum utilize the FYSPRT Evaluation Tool and FYSPRT Evaluation – Narrative Team Effectiveness Questionnaire, (found in the FYSPRT Manual) to evaluate the effectiveness of the Regional meetings on at least a quarterly basis and submit a summary to HCA. Identify how the information gathered from the evaluation tools have informed future meetings.
- 21.3.12 The Contractor shall not be obligated to reimburse costs in excess of the difference between its reasonable costs to administer this program and the total available payments.
- 21.3.13 Reporting. On a quarterly basis, the Contractor shall submit the following:
 - 21.3.13.1 A report summarizing the progress or completion of Performance Work Statement items, identifying any barriers and plans for next steps.
 - 21.3.13.2 Submit the Strategic Plan in any quarter in which updates have been made.
 - 21.3.13.3 Sign-in sheets, showing percentage of youth and family in attendance, and meeting notes.
 - 21.3.13.4 Updated membership roster.
 - 21.3.13.5 A link to the required Regional FYSPRT webpage materials in accordance with the Performance Work Statement item found in this contract.
 - 21.3.13.6 Tri-Lead attendance at statewide meetings.
 - 21.3.13.7 Member travel and meeting support. Documentation shall be submitted with the invoice in alignment with Contractor policies and shall be billed quarterly on the A-19.
 - 21.3.13.8 Reports and A-19s are due by the 10th of the months of July, October, January and April.

22 BEHAVIORAL HEALTH ADVISORY BOARD (Advisory Board)

22.1 The Contractor shall maintain a Community BHAB in each RSA that is broadly representative of the demographic character of the region. The composition of the Advisory Board and length of terms shall be provided to HCA upon request and meet the requirement in this section.

22.1.1 Advisory Board Requirements:

- 22.1.1.1 Be representative of the geographic and demographic mix of service population;
- 22.1.1.2 Have at least fifty one percent (51%) of the membership be persons with lived experience, parents or legal guardians of persons with lived experience and/or self-identified as a person in recovery from a behavioral health disorder;
- 22.1.1.3 Law Enforcement representation;
- 22.1.1.4 County representation;
- 22.1.1.5 No more than four elected officials;
- 22.1.1.6 No employees, managers or other decision makers of subcontracted agencies who have the authority to make policy or fiscal decisions on behalf of the subcontractor; and
- 22.1.1.7 Three year term limit, multiple terms may be served, based on rules set by the Advisory Board.

22.1.2 The Advisory Board will:

- 22.1.2.1 Solicit and use the input of Individuals with mental health and/or SUD to improve behavioral health services delivery in the region;
- 22.1.2.2 Provide quality improvement feedback to key stakeholders and other interested parties defined by HCA. The Contractor shall document the activities and provide to HCA upon request; and
- 22.1.2.3 Upon request by HCA, approve and submit the annual SABG and MHBG expenditure plan for the region. The expenditure plan format will be provided by HCA.

23 CRISIS TRIAGE/STABILIZATION CENTERS AND INCREASING PSYCHIATRIC RESIDENTIAL TREATMENT BEDS

- 23.1 In the RSAs where there is an increase in treatment beds the Contractor shall submit an implementation plan update prior to receipt of a one-time payment. Release of funds is contingent upon implementation start date and may be delayed if there is a significant delay in the facility being fully operational.
- 23.2 The Contractor shall receive a one-time payment in state fiscal year 2019 for the start-up of either a Crisis Triage/Stabilization Center, or for increasing psychiatric residential treatment beds for individuals transitioning from psychiatric inpatient settings. Funding must be used for start-up costs, which could include staffing, training, facility rental fees, furniture and/or required equipment. Funding may not be used for capital costs, such as remodeling an existing facility or building a new facility.
- 23.3 Status updates on the implementation plan shall be submitted to HCA monthly until the facility is fully operational. The plan update must include:
 - 23.3.1 An implementation timeline update;
 - 23.3.2 Any update or change in how the funding will be used for start-up costs; and
 - 23.3.3 Any new barriers or challenges to implementation.
- 23.4 The Contractor shall begin submitting quarterly reports to HCA, using the template provided by HCA, when the facility is operational. Reports are due thirty days after the end of the state FY quarter.

24 BUSINESS CONTINUITY AND DISASTER RECOVERY

- 24.1 The Contractor shall have a primary and back-up system for electronic submission of data requested by HCA. The system shall 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 HCA approval.

- 24.2 The Contractor shall create and maintain a business continuity and disaster recovery plan that insures timely reinstatement of the Individual information system following total loss of the primary system or a substantial loss of functionality. The plan shall include the following:
 - 24.2.1 A mission or scope statement.
 - 24.2.2 Information services disaster recovery person (s).
 - 24.2.3 Provisions for back up of key personnel, emergency procedures, and emergency telephone numbers.
 - 24.2.4 Procedures for effective communication, applications inventory and business recovery priorities, and hardware and software vendor lists.
 - 24.2.5 Documentation of updated system and operations and a process for frequent back up of systems and data.
 - 24.2.6 Off-site storage of system and data backups and ability to recover data and systems from back-up files.
 - 24.2.7 Designated recovery options.
 - 24.2.8 Evidence that disaster recovery tests or drills have been performed.

- 24.3 The Contractor must submit an annual certification statement indicating there is a business continuity disaster plan in place for both the Contractor and Subcontractors. The certification must be submitted by January 1 of each Contract year. The certification must indicate the plan is up to date, the system and data backup and recovery procedures have been tested, and copies of the Contractor and Subcontractor plans are available for HCA to review and audit.

**Exhibit A: Non-Medicaid Funding Allocation
North Sound BH-ASO**

Non-Medicaid funding comes from the following sources:

- General Fund State (GF-S)
- Dedicated Marijuana Account (DMA) Funds
- Legislative Provisos
- Mental Health Block Grant (MHBG)
- Substance Abuse Block Grant (SABG)

This Exhibit addresses Non-Medicaid funds in the North Sound RSA for the provision of crisis services and non-crisis behavioral health services for July 1, 2019, through December 31, 2019, of state fiscal year (SFY) 2020.

BH-ASO reserves funds are provided for start-up costs occurring before and after July 1, 2019, and continuing reserves.

Block grant and FYSPRT funding is shown for the full SFY 2020 covering July 2019 - June 2020. The MHBG and the SABG block grant will be administered BH-ASO in accordance with the plans developed locally for each grant. Additional funding for FYSPRT will be provided to the BH-ASO.

Line items such as Dedicated Marijuana Account (DMA), Jail Services, 5480 – ITA Non-Medicaid, Detention Decision Review, Ombuds, and the Behavioral Health Advisory Board are allocated to the BH-ASO. GF-S, Program for Assertive Community Treatment (PACT), and Assisted Outpatient Treatment (AOT) provisos are allocated between the BH-ASO and MCOs on a 70/30 basis, except in the Southwest RSA where funds are split on a 55/45 basis.

Tables 1, 2, and 3 depict the allocations to the North Sound BH-ASO.

Table 1: North Sound RSA July-Dec 2019 GF-S Funding

Fund Source	Monthly	Total 6 Months
Non-Medicaid	\$929,118	\$5,574,708
Prog for Assertive Community Tx (PACT)	\$20,271	\$121,626
Assisted Outpatient Treatment	\$17,270	\$103,620
Jail Services	\$29,992	\$179,952
5480 - ITA Non-Medicaid	\$22,865	\$137,190
Detention Decision Review	\$8,958	\$53,748
Behavioral Health Advisory Board	\$3,333	\$19,998
Ombuds	\$3,750	\$22,500
Juvenile Drug Court	\$11,650	\$69,900
Dedicated Marijuana Account	\$48,441	\$290,646
Criminal Justice Treatment Account	\$3,493	\$20,958
Behavioral Health Enhancements	n/a	\$496,044
Discharge Planners	n/a	\$71,529
Total	\$1,099,141	\$7,162,419

Table 2: North Sound RSA FY 2020 FYSPRT and Grant Funding

Fund Source	Total FY 2020
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FYSPRT	\$75,000
MHBG	\$1,105,480
Peer Bridger	\$240,000
SABG	\$3,289,438
Total	\$4,709,918

Table 3: North Sound BH-ASO Reserves

Fund Source	Total
BH-ASO Reserves	\$3,065,156

Explanations

All proviso dollars are GF-S funds. Outlined below, are explanations of the provisos and the Dedicated Marijuana account applicable **to all regions that receive the specific proviso:**

- **Juvenile Drug Court:** Funding to provide alcohol and drug treatment services to juvenile offenders who are under the supervision of a juvenile drug court.
- **State Drug Court:** Funding to provide alcohol and drug treatment services to offenders who are under the supervision of a drug court.
- **Jail Services:** Funding to provide mental health services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate access to programs that offer mental health service upon mentally ill offenders' release from confinement. This includes efforts to expedite applications for new or re- instated Medicaid benefits.
- **WA - Program for Assertive Community Treatment (WA - PACT)/Additional PACT:** Funds received per the budget proviso for development and initial operation of high-intensity programs for active community treatment WA- PACT teams.
- **Detention Decision Review:** Funds that support the cost of reviewing a DCR's decision whether to detain or not detain an individual under the State's involuntary commitment statutes.
- **Assisted Outpatient Treatment:** Funds received to support Assisted Outpatient Treatment (AOT). AOT is an order for Less Restrictive Alternative Treatment for up to ninety days from the date of judgment and does not include inpatient treatment.
- **Dedicated Marijuana Account (DMA):** Funding to provide a) outpatient and residential SUD treatment for youth and children; b) PPW case management, housing supports and residential treatment program; c) contracts for specialized fetal alcohol services; d) youth drug courts; and e) programs that support intervention, treatment, and recovery support services for middle school and high school aged students. All new program services must direct at least eighty-five percent of funding to evidence-based on research-based programs and practices.
- **ITA Non-Medicaid – Mobile Crisis (5480 Proviso):** Funding that began in 2013, to provide additional local mental health services to reduce the need for hospitalization under the Involuntary Treatment Act in accordance with regional plans approved by DBHR.
- **Secure Detoxification:** Funding for implementation of new requirements of RCW 71.05, RCW 71.34 and RCW 71.24 effective April 1, 2018, such as evaluation and treatment by a

CDP, acute and subacute detoxification services, and discharge assistance provided by a CDP in accordance with this Contract.

- **Crisis Triage/Stabilization and Step-Down Transitional Residential:** Funding originally allocated under SSB 5883 2017, Section 204(e) and Section 204(r) for operational costs and services provided within these facilities.
- **Behavioral Health Enhancements:** Funding for the implementation of regional enhancement plans originally funded under ESSB 6032 and continued in ESHB 1109.SL Section 215(23).
- **BH-ASO Reserves:** Funding for a designated reserve account in accordance with this Contract.

Outlined below are explanation for provisos **applicable to specific regions:**

- **ITA 180 Day Commitment Hearings:** Funding to conduct 180 day commitment hearings.
- **Assisted Outpatient Treatment (AOT) Pilot:** Funding for pilot programs in Pierce and Yakima counties to implement AOT.
- **Spokane: Acute Care Diversion:** Funding to implement services to reduce the utilization and census at Eastern State Hospital.
- **MH Enhancement – Mt Carmel (Alliance):** Funding for the Alliance E&T in Stevens County.
- **MH Enhancement-Telecare:** Funding for the Telecare E&T in King County.

Exhibit B

Non Medicaid Expenditure Report

Attached as a separate document to this Contract.

Exhibit C

Reporting Requirements

For each RSA, the Contractor must collect and report to HCA all applicable transactions described in the most recent BHDC Data Dictionary. The document describes not only the content of the transactions, but also the requirements for frequency and timeliness of reporting. All reporting must be done via a flat file in the format and with the acceptable data values prescribed in the document.

Throughout this document, the term BH-ASO means the same as the Contractor.

The two transactions identified in the HCA document as “DCR Investigation 160.03” and “ITA Hearing 162.03” must be submitted by the Behavioral Health – Administrative Service Organization in accordance with RCW 71.05.740. The BH-ASO is also responsible for making any needed correction of this data within five (5) business days form the date of notification of the error.

Exhibit D
Substance Abuse Block Grant (SABG) Capacity Management Form

Capacity Management is a continually updated system to identify capacity and match Pregnant and Postpartum Women and Women with Dependent Children (PPW), and Individuals Using Intravenous Drugs (IUID) with an available treatment program.

For each region, the Contractor must submit the Capacity Management Form quarterly to HCA. The Contractor shall manage a system that offers real time identification and response to treatment providers who are at 90% capacity to ensure Individuals have access to services in a timely manner. The Contractor shall notify HCA in writing, within two (2) business days, when their network is at 90% capacity.

RSA: _____ **Submission Date/Quarter:** _____

RSA Contact Person:	Phone Number	Email:
----------------------------	--------------	--------

Individuals Using Intravenous Drugs (IUID)				
Unique Client Identifier	Date of first contact	# of days on waitlist	Service Type Individual is waiting for	When/what Interim Services Began
Total Number of Individuals:				
Number of Individuals removed from waitlist and why				
Document weekly contact (why and how individuals are removed from waiting list for any purpose other than admission to treatment)				

PPW				
Unique Client Identifier	Date of first contact	# of days on waitlist	Service Type Individual is waiting for	When/what Interim Services Began
Total Number of Individuals:				

Additional Questions
What are barriers encountered when trying to help an individual receive services?
How can we help to address barriers to increase access to services?
Mechanism for matching and facilitating admission to treatment programs with sufficient capacity for PPW and IUID
Capacity percentage for each county

Exhibit E
Crisis Reporting Metrics and Reporting

RSA: _____

1. Crisis System Call Center Performance Metrics
 - A. Ninety percent of crisis calls are answered live within thirty seconds.
 - B. Call abandonment rate of less than three percent for the crisis line.
 - C. Provide direct line access to all mobile crisis outreach teams for necessary support and information assistance after dispatch so no caller waits more than thirty seconds for a live answer.
2. Crisis Reporting
 - A. Call Center Reports
 - i. Caller demographics.
 - ii. Analysis of calls, callers, dispositions, origin of call (e.g., home, emergency room, community, provider), referral sources, and other relevant information to make recommendations and assist in improving the crisis response system.
 - B. Mobile Crisis Team
 - i. The number and percentage of persons referred to the program for mobile outreach, monitored monthly.
 - ii. The number and percentage of persons successfully diverted from Emergency Rooms and/or ITA commitments, monitored quarterly.
 - C. Other
 - i. Mobile crisis outreach dispatch, time of arrival, and disposition of response.
 - ii. The number of unique individuals served in the crisis system by fund source and service type on a monthly and year to date basis.
 - iii. Number of individuals who are repeat utilizers of the crisis system, monitored quarterly and year to date and compared to prior year, and reported by frequency of utilization.

Exhibit F

Federal Block Grant Annual Progress Reports

Regional Block Grant reports must be submitted annually to HCA with the following information no later than August 1 of each year.

SABG Block Grant Reports must include:

- a) How have the needs of the population identified in the local Needs Assessment, conducted by the Community BHAB, and used for the development of the regional SABG plan, been met?
- b) What strategies were used to improve existing programs, create new programs, or actions taken to remove barriers, to include age, race/ethnicity, gender, and language barriers?
- c) What policies or initiatives were implemented to ensure Cultural Competence?
- d) What efforts have been made to ensure that continuing education or training was made available to treatment staff?
- e) Provide a description of how faith-based organizations were provided opportunities to compete with traditional SUD treatment providers for funding, to include:
 - i. Describe how faith-based organizations were incorporated into the existing referral system, including number of referrals made
 - ii. What training was provided to local governments and/or faith-based and/or community organizations regarding Charitable Choice?
- f) Describe your process to gather public comment from behavioral health association, individuals in recovery, families and local boards in the development of your SABG Plan.
- g) What compliance monitoring strategies are in place to ensure adequacy of efforts to meet all the block grant requirements?
- h) Describe the types of Recovery Support Services made available, including:
 - i. Description of any memorandums of understanding between various service providers and the purpose for each?
 - ii. What were the outcomes?
 - iii. What have been the barriers/challenges and strategies to address such issues?
- i) What activities have been implemented to coordinate service, including:
 - i. Describe the purpose of any memorandums of understanding between various service providers and the purpose for each.
 - ii. What were the outcomes?
 - iii. What have been the barriers/challenges and strategies to address such issues?

- j) What services have been provided for the PPW population including:
 - i. Specialized treatment services designed for PPW.
 - ii. Subcontractors process to make available or make referrals for prenatal care and child care.
- k) What outreach models were used to encourage PPW and IUID to enter treatment?

Mental Health Block Grant reports must include:

Instructions:
 Provide a summary of actions taken during the contract term to increase meaningful Individual involvement (commonly referred to as Consumer Voice) in the development and/or provision of services. If applicable, please be sure to include short notations about Peer-run or influenced projects.

Describe efforts undertaken to incorporate cultural competency (“Cultural Competence,” as defined in this contract) into the delivery of services, especially during subcontractor reviews. Include actions taken that demonstrate efforts to effectively work with Tribes within the BHO’s service area:

Provide a short summary of progress made towards achievement of Contractor’s Project Plan, including barriers encountered and steps taken to remove barriers:

Progress Made:

<u>Barriers Encountered:</u>	<u>Steps Taken to Remove Barriers:</u>
<ul style="list-style-type: none"> • • • 	<ul style="list-style-type: none"> • • •

Provide a short Summary/List of “Lessons Learned,” including any comments or recommendations that will improve future service outcomes:

Exhibit G
Behavioral Health Services

Status	Service	Medicaid	MHBG	SABG	GFS	Drug Court
Required for Medicaid Enrollees	Brief Intervention (Any Level, Assessment not Required)	x	X	x	x	x
Required for Medicaid Enrollees	Acute Withdrawal Management (ASAM Level 3.2WM)	x		x	x	x
Required for Medicaid Enrollees	Sub-Acute Withdrawal Management (ASAM Level 3.2WM)	x		x	x	x
Required	Secure Withdrawal Management	x		x	x	x
Required for Medicaid Enrollees	Intensive Home-Based Services (SMI/SED)	X	X		X	
Required for Medicaid Enrollees	Outpatient Treatment (ASAM Level 1) or SMI/SED	x	X	x	x	x
Required for Medicaid Enrollees	Intensive Outpatient Treatment (ASAM Level 2.1) or SMI/SED	x	X	x	x	x
Required for Medicaid Enrollees	Brief Outpatient Treatment (ASAM Level 1) or SMI/SED	x	X	x	x	x
May be provided or arranged for Medicaid Enrollees when available as a treatment option	Opiate Treatment Program (ASAM Level 1)	x		x	x	x
Required for Medicaid Enrollees	Case Management (ASAM Level 1, 2) or SMI/SED	x	X	x	x	x
Required for Medicaid Enrollees	Intensive Inpatient Residential Treatment (ASAM Level 3.5)	x		x	x	x
Required for Medicaid Enrollees	Long-term Care Residential Treatment (ASAM Level 3.3)	x		x	x	x
Required for Medicaid Enrollees	Residential Treatment (Recovery House ASAM Level 3.1) or for SMI/SED	x	X	x	x	x
Required for Medicaid Enrollees	Assessment	x	X	x	x	x

Optional	Engagement and Referral		X	x	x	
Optional	Alcohol/Drug Information School				x	
Required if delivering SABG Services	Opiate Dependency Outreach			x	x	
Required if delivering SABG Services to PPW/IUID	Interim Services		X	x	x	x
Optional	Community Outreach			x	x	x
Optional	Crisis Services		X	x	x	
Optional	Sobering Services			x	x	
Required	Involuntary Commitment Investigations and Treatment	*	X	x	x	x
Required for Medicaid Enrollees	Room and Board		X	x	x	x
Priority to meet SABG 5% PPW Set-Aside	Therapeutic Interventions for Children		X	x	x	
Optional	Transportation		X	x	x	x
Optional	Childcare Services		X	x	x	x
Priority to meet SABG 5% PPW Set-Aside	PPW Housing Support Services			x	x	
Optional	Family Hardship				x	
Optional	Recovery Support Services			x	x	
Required if receiving SABG or MHBG funds	Continuing Education/ Workforce Development		X	x	x	
Optional	Medication Services not covered by insurance or Medicaid (SMI/SED)		X		X	
Optional	Assisted Living Services (SMI/SED)		X		X	
Optional	Assertive Community Treatment	X	X		X	

*Involuntary Residential Treatment may be paid for with Medicaid funds if service is delivered in a Non-IMD Setting.

Exhibit H Peer Bridger Program

1. Peer Bridger Program Overview

The Peer Bridger Program is intended to serve those who are currently at Western State Hospital (WSH), Eastern State Hospital (ESH) or community hospitals with inpatient mental health beds, and have had a lengthy hospitalization or a history of frequent, multiple hospitalizations. Participation in the program is voluntary. The Peer Bridgers will attempt to engage individuals in planning their discharge. Hospital staff and the BHO/IMC/BH-ASO Hospital Liaisons will help the Peer Bridgers identify potential participants.

The Peer Bridger will transition from spending time on social support and begin offering assistance with independent living skills, coping skills and community adjustment skills. The hand-off between the Peer Bridger and the community behavioral health provider who is providing mental health services will be gradual and based on the participant's needs and their person-centered plan. The anticipated duration of in-community Peer Bridger services is one hundred twenty days with extensions granted by the BH-ASO on a case-by-case basis.

The Peer Bridger is not a case manager, discharge planner or a crisis worker. However, the Peer Bridger can bring the participant's perspective into the provision of those services.

2. The Contractor shall develop and implement the Peer Bridger program in collaboration with the MCOs in the region. Services shall be delivered equitably to Individuals assigned to the MCOs and the Contractor
3. The Contractor shall ensure that the Peer Bridger is allowed to attend treatment activities with the Individual during the one hundred twenty (120) day period following discharge if requested by the Individual. Examples of activities include but are not limited to: intake evaluations, prescriber appointments, treatment planning, etc.

4. Peer Bridger Program Duties

- a. The Peer Bridger will work with six to twelve (6-12) program participants. Prior to hospital discharge the majority of the work will be inside the state hospitals. Post-discharge activities will be in the community. Peer Bridgers shall routinely engage and interact with potential program participants.
 - 1) The Contractor shall contract with an agency licensed as a Community Behavioral Agency by DOH to provide recovery support services.
 - 2) After being recruited, and prior to beginning hospital related activities, the Peer Bridger or Peer Bridger team will:
 - a) Participate in statewide Peer Bridger Orientation and training.
 - b) Participate in a 32-hour orientation at WSH or ESH.
 - c) Participate in ESH or WSH Specialized Orientation.

- b. The Peer Bridger shall work directly with participants and potential participants at least two days per week. After discharge, the time spent between the community and the state hospital shall be adjusted to respond to participants in the hospital and participants in the community. In conjunction with the BHO/FIMC/BH-ASO Hospital Liaisons and State Hospital Peer Bridger Liaison (identified during orientation), the Peer Bridger will work to engage potential participants. The potential participants may:
 - 1) Have been on the hospital “ready to discharge list” for more than one year;
 - 2) Be individuals with multiple state hospitalizations or involuntary hospitalizations;
 - 3) Be individuals with hospital stays of over one year;
 - 4) Be individuals whom hospital staff and/or the Hospital Liaison have been unable to engage in their own discharge planning.
 - 5) Be individuals who require additional assistance to discharge and/or need support in the community.

- c. Examples of Peer Bridger engagement activities may include:
 - 1) Interacting with potential participants.
 - 2) Developing a trusting relationship with participants.
 - 3) Promoting a sense of self-direction and self-advocacy.
 - 4) Sharing their experiences in recovery.
 - 5) Helping motivate through sharing the strengths and challenges of their own illness.
 - 6) Considering the participants’ medical issues and helping plan wellness habits they can pursue.
 - 7) Helping the participant plan how they will successfully manage their life in the community.
 - 8) Educating participants about resources in their home community.
 - 9) Join with the participant (when possible) in treatment team meetings. Help to convey the participant’s perspectives and assist the participant with understanding the process.

- d. The Peer Bridger shall support the participant in discharge planning to include the following:
 - 1) Function as a member of the participant’s hospital discharge team if asked.

- 2) Identify participant-perceived barriers to discharge, assist the participant with working through barriers and assure the participant that they will be supported throughout the process.
- 3) Facilitating transportation for the participant to travel back to his or her community.
- 4) The Peer Bridgers shall conduct routine weekly hospital-based engagement groups for any individual willing to participate.

5. Peer Bridger team duties

- a. Participate in monthly statewide Peer Bridger Program administrative support conference calls.
- b. Participate in biannual Peer Bridger Training events scheduled by HCA.
- c. Ensure that Peer Bridgers Complete Tracking logs on a monthly basis and submit logs to HCA via secured email
- d. Coordinate and communicate Peer Bridger team schedules for participation at the hospital with designated hospital Peer Bridger coordinator.

6. Community-based post-discharge activities will include:

- a. The frequency and duration of community based Peer Bridger services will be determined by the participant's needs, the service level required to help the individual stay safely in the community and caseload prioritization. Peer Bridger services will be decreased when the participant is receiving behavioral health treatment and peer services from a behavioral health agency or when the participant no longer wants the Peer Bridger's support. The Peer Bridger shall facilitate a "warm hand-off" to the behavioral health agency chosen by the participant. Activities the warm hand-off could include are:
 - 1) Being present and supportive during the participant's first appointment and during the intake evaluation, primary provider or prescriber appointments, etc.
 - 2) Helping the participant complete any necessary paperwork for receiving BH services.
 - 3) Participating in developing the treatment plan and treatment activities if requested by the participant.
- b. The Peer Bridger shall assist the participant in developing a crisis plan with the participant's behavioral health service agency. The Peer Bridger may be identified as a non-crisis resource in the plan.
- c. The Peer Bridger shall:
 - 1) Attempt to connect the participant with natural support resources and the local recovery community and attend meetings as allowed.

- 2) Help the participant develop skills to facilitate trust-based relationships, develop strategies for maintaining wellness and develop skills to support relationships.
 - 3) Assist the participant in developing a life structure, including skills for daily living such as visits to coffee shops, use of local transportation, opening a bank account, work effectively with a payee if needed, understand benefits, budget planning, shopping and meal preparation, access leisure activities, find a church or faith home, attain and maintain housing, etc.
 - 4) Help the participant develop skills to schedule, track and attend appointments with providers.
 - 5) Help the participant develop skills for self-advocacy so that the participant can better define his or her treatment plan and communicate clearly with professionals such as psychiatric prescribers, primary care doctors, etc. The Peer Bridger should also help participants prepare for appointments and identify questions or comments the participant might have for the provider.
 - 6) Explore supported employment that addresses the following:
 - a) Employment goals and how they relate to recovery.
 - b) The availability of additional training and education to help the participant become employable.
 - c) The array of employment programs and supported employment opportunities available within the region.
7. Peer Bridgers should demonstrate that recovery is possible and model the ten components of recovery as defined in the SAMHSA Consensus Statement on Mental Health Recovery (<http://store.samhsa.gov/shin/content/SMA05-4129/SMA05-4129.pdf>). Peer Bridgers shall:
- a. Participate in hospital and BHO/FIMC/BH-ASO Peer Bridger trainings.
 - b. Coordinate activities with the BHO/FIMC/BH-ASO Hospital liaison.
 - c. Participate in monthly, statewide Peer Bridger Program support conference calls.
 - d. Attend and participate in quarterly Peer Bridger team coordination meetings at both ESH and WSH and trainings or conferences as directed by HCA.
 - e. Complete Tracking logs on a monthly basis and submit logs to The Contractor.
 - f. Meet the documentation requirements of the state hospital and their employer.
8. **The Peer Bridger team, including Peer Bridger Supervisor will:**
- a. Participate in monthly, statewide Peer Bridger Program administrative support conference calls.

- b. Participate in bi-annual Peer Bridger Training events scheduled by DBHR.
- c. Ensure that Peer Bridgers Complete tracking logs on a monthly basis and submit logs to DBHR via secured or encrypted emails.
- d. Coordinate and communicate Peer Bridger team schedules for participating at the hospital with Peer Bridger coordinator.

9. The Peer Bridger Job Description must contain the following elements:

a. Required Qualifications

- 1) Lived experience of mental health recovery and the willingness to share his/her own experiences.
- 2) Ability to work flexible hours.
- 3) Valid Washington Driver's license or the ability to travel via public transportation.
- 4) Ability to meet timely documentation requirements.
- 5) Ability to work in a cooperative and collaborative manner as a team member with Hospital staff, BHO/FIMC/BH-ASO staff, and program participants.
- 6) Strong written and verbal communication skills.
- 7) General office and computer experience.
- 8) Washington Certified Peer Specialist with at least two years' experience working as a peer.
- 9) Dress professionally and appropriately.

b. Desired Qualifications

- 1) Ability and experience working with people from diverse cultures.
- 2) Experience with state hospital system.
- 3) Ability to form trusting and reciprocal relationships.

Exhibit I – RSA MHBG Project Plan

Introduction

Washington State provides Combined Federal Block Grant service through BH-ASO and BHOs. Contracts with BH-ASOs and BHOs support flexibility to meet the needs of populations based on local planning efforts and goals as identified in this Project Plan. The goal of the MHBG Project Plan is to ensure effective services are provided across populations with measurable outcomes..

Region:	Current Date:	Total MHBG Allocation:
Contact Person:	Phone Number:	Email:

This Plan is for July 1, 2019 – June 30, 2020. All Mental Health Block Grant funds contractually allocated for services provided, but not expended for services actually provided by June 30, 2019, may not be used or carried forward.

Please complete both sections (Section 1- Proposed Plan Narratives and Section 2 – Proposed Project Summaries and Expenditures) in this document and submit electronically to HCA for approval prior to submitting your first A-19 invoice. Contact the person identified above if there are any questions.

DO NOT MODIFY OR DELETE ANY PARTS OF THIS TEMPLATE.

Instructions:

- Provide a detailed description for each anticipated range of services. There is no word limit. Each cell will automatically expand.
- Only complete Categories/Subcategories that align with local plans. There is no requirement to provide services in each Category.
- Insert Planned Expenditure Amounts for each category under the column heading “Proposed Total Expenditure Amount.” The Grand Total at bottom of that column must equal total MHBG Allocation.
- Insert the number of Adults with SMI** and Children with SED** projected to be served.
- “Outcomes and Performance Indicators” – Provide planned outcomes that are measurable and define what indicators will be used to support progress towards outcomes.

**SMI/SED Definitions - For MHBG planning and reporting, SAMHSA has clarified the definitions of SED and SMI: Children with SED refers to persons from birth to age 18 and adults with SMI refers to persons age 18 and over: (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g. most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person’s role or functioning in family, school, employment, relationships, or community activities.

Section 1 Proposed Plan Narratives

Needs Assessment	Describe what strengths, needs, and gaps were identified through a needs assessment of the geographic area of the region. To the extent available, include age, race/ethnicity, gender, and language barriers. <i>Begin writing here:</i>
Cultural Competence*	Provide a narrative summarizing how cultural competence overall, is incorporated within proposed projects. Identify what anticipated efforts will be taken to measure progress. <i>Begin writing here:</i>
Children’s Services	Describe how integrated system of care will be provided for children with SED with multiple needs, including: social services, educational services, juvenile services, and substance use disorder services. <i>Begin writing here:</i>
Public Comment/Local/ BH Advisory Board Involvement	Describe how you facilitated public comment from any person, behavioral health association, individuals in recovery, families, and local boards in the development of this MHBG Plan. <i>Begin writing here:</i>
Outreach Services	Provide a description of how outreach services will target individuals who are homeless and how community-based services will be provided to individuals residing in rural areas. <i>Begin writing here:</i>
Staff Training	Describe the plan to ensure training is available for mental health providers and to providers of emergency mental health services and how this plan will be implemented. <i>Begin writing here:</i>
Program Compliance	Provide a description of the strategies that will be used for monitoring program compliance with all MHBG requirements. <i>Begin writing here:</i>
Cost Sharing (optional)	Provide a description of the policies and procedures established for cost-sharing, to include how individuals will be identified as eligible, how cost-sharing will be calculated, and how funding for cost-sharing will managed and monitored. <i>Begin writing here:</i>

Section 2 Proposed Project Summaries and Expenditures

Category/Sub Category	Provide a plan of action for each supported activity	Proposed #Children with SED	Proposed #Adults with SMI	Proposed Total Expenditure Amount
Prevention & Wellness – Activities that enhance the ability of persons diagnosed with SMI or SED, including their families, to effectively decrease their need for intensive mental health services:				0
Screening, Brief Intervention and Referral to Treatment				0
Brief Motivational Interviews				0
Parent Training				0
Facilitated Referrals				0
Relapse Prevention/ Wellness Recovery Support				0
Warm Line: Please note that ALL costs that directly serve persons with SMI/SED and their families <u>must</u> be tracked.				0
Outcomes and Performance Indicators				0
Engagement Services – Activities associated with providing evaluations, assessments, and outreach to assist persons diagnosed with SMI or SED, including their families, to engage in mental health services:				0
Assessment				0
Specialized Evaluations (Psychological and Neurological)				0
Service Planning (including crisis planning)				0
Educational Programs				0
Outreach				0
Outcomes and Performance Indicators				0
Outpatient Services – Outpatient therapy services for persons diagnosed with SMI or SED, including services to help their families to appropriately support them.				0
Individual Evidenced-Based Therapies				0
Group Therapy				0
Family Therapy				0

Multi-Family Counseling Therapy				0
Consultation to Caregivers				0
Outcomes and Performance Indicators				0
Medication Services – Necessary healthcare medications, and related laboratory services, not covered by insurance or Medicaid for persons diagnosed with SMI or SED to increase their ability to remain stable in the community.				0
Medication Management				0
Pharmacotherapy				0
Laboratory Services				0
Outcomes and Performance Indicators				0
Community Support (Rehabilitative) – Community-based programs that enhance independent functioning for persons diagnosed with SMI or SED, including services to assist their families to care for them.				0
Parent/Caregiver Support				0
Skill Building (social, daily living, cognitive)				0
Case Management				0
Continuing Care				0
Behavior Management				0
Supported Employment				0
Permanent Supported Housing				0
Recovery Housing				0
Therapeutic Mentoring				0
Traditional Healing Services				0
Outcomes and Performance Indicators				0
Recovery Support Services – Support services that focus on improving the ability of persons diagnosed with SMI or SED to live a self-directed life, and strive to reach their full potential.				0
Peer Support				0
Recovery Support Coaching				0
Recovery Support Center Services				0
Supports for Self-Directed Care				0
Outcomes and Performance Indicators				0
Other Supports (Habilitative) – Unique direct services for persons diagnosed with SMI or SED, including services to assist their families to continue caring for them.				0
Personal Care				0

Respite				0
Support Education				0
Transportation				0
Assisted Living Services				0
Trained Behavioral Health Interpreters				0
Interactive communication Technology Devices				0
Outcomes and Performance Indicators				0
Intensive Support Services – Intensive therapeutic coordinated and structured support services to help stabilize and support persons diagnosed with SMI or SED.				0
Assertive Community Treatment				0
Intensive Home-Based Services				0
Multi-Systemic Therapy				0
Intensive Case Management				0
Outcomes and Performance Indicators				0
Out of Home Residential Services – Out of home stabilization and/or residential services in a safe and stable environment for persons diagnosed with SMI or SED.				0
Crisis Residential/Stabilization				0
Adult Mental Health Residential				0
Children’s Residential Mental Health Services				0
Therapeutic Foster Care				0
Outcomes and Performance Indicators				0
Acute Intensive Services – Acute intensive services requiring immediate intervention for persons diagnosed with SMI or SED.				0
Mobile Crisis				0
Peer-Based Crisis Services				0
Urgent Care				0
23 Hour Observation Bed				0
24/7 Crisis Hotline Services				0
Outcomes and Performance Indicators				0

Non-Direct Activities – any activity necessary to plan, carry out, and evaluate this MHBG plan, including Staff/provider training, travel and per diem for peer reviewers, logistics cost for conferences regarding MHBG services and requirements, and conducting needs assessments.				0
Workforce Development/Conferences				–
Grand Total				0

Exhibit J - RSA SABG Project Plan

Introduction

Washington State's Substance Use Disorder strategies to further the goals of the Combined Federal Block Grant will rely on service delivery through BH-ASOs and BHOs. Contracts with BH-ASOs and BHOs continue to support flexibility to meet the needs of populations based on local planning efforts and goals as identified in this Project Plan. Our collective overarching "Goal" is to ensure effective services are provided across populations with measurable outcomes and performance indicators.

This Plan is for July 1, 2019 – June 30, 2020. All Substance Abuse Block Grant funds contractually allocated for services provided, but not expended for services actually provided by June 30, 2018, may not be used or carried forward.

Please complete both sections (Section 1- Proposed Plan Narratives and Section 2 – Proposed Project Summaries and Expenditures) in this document and submit electronically to HCA for approval prior to submitting your first A-19 invoice. Contact the Person identified below if there are any questions.

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- Provide a detailed description for each anticipated range of services. There is no word limit. Each cell will automatically expand.
- Only complete Categories/Subcategories that align with local plans. There is no requirement to provide services in each Category.
- Insert Planned Expenditure Amounts for each category under column heading "Proposed Expenditure Amount." The "Grand Total" at bottom of that column must equal total contract amount. The "Grand Total" will automatically calculate off of the amounts entered into each "Proposed Total Expenditure Amount" text box.
- Federal Requirement – A minimum of 10% of funding must be expended to maintain, develop or enhance services for Pregnant, Postpartum Women and Women with Dependent Children (PPW). Provide the number of PPW expected to be served.
- "Outcomes and Performance Indicators" – Provide planned outcomes that are measurable and define what indicators will be used to support progress towards outcomes.
- Tab or use your cursor to enter into each text box.
- Use your cursor to enter amounts into "Proposed Total Expenditure Amount." You do not need to enter a "\$" – it will automatically add the symbol when you move to the next text box.

Region:	Current Date:	Total SABG Allocation:
Contact Person:	Phone Number: - -	Email:

**Section 1
Proposed Plan Narratives**

Needs Assessment (required)	Describe what strengths, needs, and gaps were identified through a needs assessment of the geographic area of the region. Include age, race/ethnicity, gender, and language barriers. <i>Begin writing here:</i>
Cultural Competence (required)	Provide a narrative summarizing how cultural competence overall, is incorporated within proposed projects. Identify what anticipated efforts will be taken to measure progress. <i>Begin writing here:</i>
Continuing Education for Staff (required)	Describe of how continuing education for employees of treatment facilities is expected to be implemented. <i>Begin writing here:</i>
Charitable Choice (required)	Provide a description of how faith-based organizations will be incorporated into your network and how referrals will be tracked. <i>Begin writing here:</i>
Coordination of Services (required)	Provide a description of how faith-based organizations will be incorporated into your network and how referrals will be tracked. <i>Begin writing here:</i>
Public Comment/Local Board /BH Advisory Board Involvement (required)	Describe how you facilitated public comment from any person, behavioral health association, individuals in recovery, families, and local boards in the development of this SABG Plan. <i>Begin writing here:</i>
Program Compliance (required)	Provide a description of the strategies that will be used for monitoring program compliance with all SABG requirements. <i>Begin writing here:</i>
Recovery Support Services (optional)	Provide a description of how and what recovery support services will be made available to individuals in SUD treatment and their families. <i>Begin writing here:</i>
Cost Sharing (optional)	Provide a description of the policies and procedures established for cost-sharing, to include how individuals will be identified as eligible, how cost-sharing will be calculated, and how funding for cost-sharing will managed and monitored. <i>Begin writing here:</i>

**Section 2
Proposed Project Summaries and Expenditures**

*The * indicates a required component of the Proposed Project Summary*

Category/Sub Category	Provide a plan of action for each supported activity	Proposed # PPW to be served	Outcomes and Performance Indicators	Proposed Total Expenditure Amount
Prevention & Wellness – Preventive services, such as drug use prevention and early intervention, are critical components of wellness.				
*PPW Outreach				0
Outreach to Individuals Using Intravenous Drugs (IUID)				0
Brief Intervention				0
Drug Screening				0
*Tuberculosis Screening				0
Engagement Services – Assessment/admission screening related to SUD to determine appropriateness of admission and levels of care.				
Education Services may include information and referral services regarding available resources, information and training concerning availability of services and other supports. Educational programs can include parent training, impact of alcohol and drug problems, anxiety symptoms and management, and stress management and reduction. Education services may be made available to individuals, groups, organizations, and the community in general. This is different than staff training. Treatment services must meet the criteria as set forth in Chapter 246-341 WAC.				
Assessment				0
*Engagement and Referral				0
*Interim Services				0
Educational Programs				0
Outpatient Services – Services provided in a non-residential SUD treatment facility. Outpatient treatment services must meet the criteria as set forth in Chapter 246-341 WAC.				
Individual Therapy				0
Group Therapy				0

Family Therapy				0
Multi-Family Counseling Therapy				0
Medication Assisted Therapy (MAT)				0
Community Support (Rehabilitative) – Consist of support and treatment services focused on enhancing independent functioning.				
Case Management				0
Recovery Housing				0
Supported Employment				0
Other Support (Habilitative) – Structured services provided in segments of less than 24 hours using a multi -disciplinary team approach to develop treatment plans that vary in intensity of services and the frequency and duration of services based on the needs of the client.				
PPW Housing Support Services				0
Supported Education				0
Housing Assistance				0
Spiritual/Faith-Based Support				0
Intensive Support Services – Services that are therapeutically intensive coordinated and structured group-oriented. Services stabilize acute crisis and clinical conditions, utilizing recovery principles to help return individuals to less intensive outpatient, case management, and/or other recovery based services.				
*Therapeutic Intervention Services for Children				0
Sobering Services				0
Out of Home Residential Services – 24 hour a day, live-in setting that is either housed in or affiliated with a permanent facility. A defining characteristic is that they serve individuals who need safe and stable living environments in order to develop their recovery skills. Treatment services must meet the criteria as set forth in Chapter 246-341 WAC.				
Sub-acute Withdrawal Management				0
Crisis Services Residential/ Stabilization				0
Intensive Inpatient Residential Treatment				0

Long Term Residential Treatment				0
Recovery House Residential Treatment				0
Involuntary Commitment				0
Acute Intensive Services -24-hour emergency services that provide access to a clinician. The range of emergency services available may include but are not limited to direct contact with clinician, medication evaluation, and hospitalization. Services must meet the criteria as set forth in Chapter 246-341 WAC.				
Acute Withdrawal Management				0
Recovery Supports –A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery emphasizes the value of health, home, purpose, and community to support recovery.				
*Interim Services				0
*Transportation for PPW				
Transportation				0
*Childcare Services				0
*Other SABG activities – any activity necessary to plan, carry out, and evaluate this SABG plan, including Continued Education/training, logistics cost for conferences regarding SABG services and requirements, capacity management infrastructure, and conducting needs assessments.				
Grand Totals				\$0.00

Exhibit K RSA Spenddown

Overview

Spenddown for qualifying medical expenses (voluntary and involuntary inpatient, crisis stabilization and crisis residential stays) with State Funds for incurred costs. HCA designates and approves the Contractor as a public program as described in WAC 182-519-0110(9). Qualified expenses paid by the Contractor shall be used to reduce an individual's spenddown liability.

Procedure

Individuals must meet financial eligibility, must incur medical expenses in the amount of spenddown liability determined by DSHS staff before coverage is made active in Provider One, and must not have insurance coverage for services used to meet the spenddown liability. DSHS staff enter medical expenses into ACES when documentation for them is received. Once the expenses equal or exceed the spenddown amount, ACES sends notice to Provider One to open the eligibility segment for the appropriate base period.

Responsible Department	ACTIVITY
Facility and BH-ASO UM clinician	1. Identification and authorization (a) Facility representative seeks authorization for services within required timeframes and identifies spenddown amount. (b) UM clinician confirms eligibility criteria for fund and service, provides authorization for service and confirms payment of spenddown amount to facility representative (units or dollar amount). (c) UM clinician updates BH-ASO director.
Facility	2. Report of spenddown, confirmation and payment (a) Facility reports the Individual's incurred costs that count toward the spenddown amount and confirm submission with UM Clinician and Director. (b) Facility confirms Medicaid assignment after spenddown processing. (c) Facility submits invoices for payment of the agreed spenddown amount to the BH-ASO Director monthly. *Fax documentation of incurred medical expenses to the statewide fax number 1-888-338-7410. Providers with authorization from the client may call 1-877-501-2233 to inquire about status and/or request urgent processing. If urgent medical need is required, processing occurs within two business days or less. Regular processing is completed with 2 business days.
BH-ASO Director	3. Review invoice and submit for payment.
BH-ASO Finance	4. Tracking and Reporting (a) Track spenddown amounts by individual and facility (b) Report expenses on the R&E with a note stating the total amount spent.

**Exhibit L
Service Area Matrix
effective July 1, 2019**

County	BH-ASO	Behavioral Health Organization (BHO)
ADAMS	Spokane	
ASOTIN	Greater Columbia	
BENTON	Greater Columbia	
CHELAN	NCWA - Beacon Health Options	
CLALLAM		Salish
CLARK	SWWA - Beacon Health Options	
COLUMBIA	Greater Columbia	
COWLITZ		Great Rivers
DOUGLAS	NCWA - Beacon Health Options	
FERRY	Spokane	
FRANKLIN	Greater Columbia	
GARFIELD	Greater Columbia	
GRANT	NCWA - Beacon Health Options	
GRAYS HARBOR		Great Rivers
ISLAND	North Sound	
JEFFERSON		Salish
KING	King	
KITSAP		Salish
KITTITAS	Greater Columbia	
KLICKITAT	SWWA – Beacon Health Options	
LEWIS		Great Rivers
LINCOLN	Spokane	
MASON		Thurston-Mason
OKANOGAN	NCWA – Beacon Health Options	
PACIFIC		Great Rivers
PEND OREILLE	Spokane	
PIERCE	Pierce – Beacon Health Options	
SAN JUAN	North Sound	
SKAGIT	North Sound	
SKAMANIA	SWWA – Beacon Health Options	
SNOHOMISH	North Sound	
SPOKANE	Spokane	
STEVENS	Spokane	
THURSTON		Thurston-Mason
WAHKIAKUM		Great Rivers
WALLA WALLA	Greater Columbia	
WHATCOM	North Sound	
WHITMAN	Greater Columbia	
YAKIMA	Greater Columbia	

Exhibit M
State Hospital Beds
 Effective July 1, 2019

Regional State Hospital Bed Allocations and Targets

Western State Hospital Regional Allocations and Bed Targets

The Southwest Washington, Pierce County, North Sound, and King County RSAs were each allocated beds at Western State Hospital. The methodology for determining the regional allocations considers regional prevalence and utilization data and is calculated by Research and Data Analysis (RDA) at DSHS.

The regional allocations are further divided for each MCO and BH-ASO. BH-ASO beds are allocated based on historical utilization patterns for the non-Medicaid population. For the remaining State Hospital beds, targets are set for the MCOs based on current enrollment.

Effective July 1, 2019

RSA	BH-ASO	AMG	CHPW	CCW	MHW	UHC	Total Regional Allocation
King	29	20	31	17	77	34	208
Pierce	9	10	0	10	46	18	93
SWWA	7	1	6	0	21	0	35
North Sound	20	7	16	7	35	16	101

Eastern State Hospital Regional Allocations and Bed Targets

The North Central, Spokane and Greater Columbia RSAs were each allocated beds at Eastern State Hospital. The methodology for determining the regional allocations considers regional prevalence and utilization data calculated by RDA.

The regional allocations are further divided for each MCO and BH-ASO. BH-ASO beds are allocated based on historical utilization patterns for the non-Medicaid population. For the remaining State Hospital beds, targets are set for the MCOS based on current enrollment.

Effective July 1, 2019

RSA	BH-ASO	AMG	CHPW	CCW	Molina	Total Regional Allocation
North Central	3	3	0	4	10	20
Greater Columbia	14	7	13	15	19	68
Spokane	21	18	17	0	48	104

Exhibit N
Triage/Stabilization and Increasing Inpatient Reporting

Attached as a separate excel document.

Exhibit O
DATA USE, SECURITY AND CONFIDENTIALITY

1. Definitions

The definitions below apply to this Exhibit:

- a. **“Authorized User”** means an individual or individuals with an authorized business need to access HCA’s Confidential Information under this Contract.
- b. **“Breach”** means the unauthorized acquisition, access, use, or disclosure of Data shared under this Contract that compromises the security, confidentiality or integrity of the Data.
- c. **“Data”** means the information that is disclosed or exchanged as described by this Contract. For purposes of this Exhibit, Data means the same as “Confidential Information.”
- d. **“Disclosure”** means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.
- e. **“Hardened Password”** after July 1, 2019 means a string of characters containing at least three of the following character classes: upper case letters; lower case letters; numerals; and special characters, such as an asterisk, ampersand or exclamation point.
 - i) Passwords for external authentication must be a minimum of 10 characters long.
 - i. Passwords for internal authentication must be a minimum of 8 characters long.
 - ii) Passwords used for system service or service accounts must be a minimum of 20 characters long.
- f. **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as modified by the American Recovery and Reinvestment Act of 2009 (“ARRA”), Sec. 13400 – 13424, H.R. 1 (2009) (HITECH Act).
- g. **“HIPAA Rules”** means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and Part 164.
- h. **“Portable/Removable Media”** means any Data storage device that can be detached or removed from a computer and transported, including but not limited to: optical media (e.g. CDs, DVDs); USB drives; or flash media (e.g. CompactFlash, SD, MMC).
- i. **“Portable/Removable Devices”** means any small computing device that can be transported, including but not limited to: handhelds/PDAs/Smartphones; Ultramobile PC’s, flash memory devices (e.g. USB flash drives, personal media players); and laptops/notebook/tablet computers. If used to store Confidential Information, devices should be Federal Information Processing Standards (FIPS) Level 2 compliant.
- j. **“Protected Health Information” or “PHI”** means information that relates to the provision of health care to an individual; the past, present, or future physical or mental health or condition of an individual; or past, present or future payment for provision of health care to an individual. 45 C.F.R. §160 and 164. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe, can be used to identify the individual. 45 C.F.R. § 160.103. PHI is information transmitted, maintained, or stored in any form or medium. 45 C.F.R. § 164.501. PHI

does not include education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. § 1232g(a)(4)(b)(iv).

- k. **“ProviderOne”** means the Medicaid Management Information System, which is the State’s Medicaid payment system managed by HCA.
- l. **“Transmitting”** means the transferring of data electronically, such as via email, SFTP, web-services, AWS Snowball, etc.
- m. **“Trusted System(s)”** means the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; (2) United States Postal Service (“USPS”) first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail; (3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.
- n. **“U.S.C.”** means the United States Code. All references in this Exhibit to U.S.C. chapters or sections will include any successor, amended, or replacement statute. The U.S.C. may be accessed at <http://uscode.house.gov/>
- o. **“Use”** includes the sharing, employment, application, utilization, examination, or analysis, of Data.

2. Data Classification

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

The Data that is the subject of this Contract is classified as Category 4 – Confidential Information Requiring Special Handling. Category 4 Data is information that is specifically protected from disclosure and for which:

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

3. Constraints on Use of Data

- a. This Contract does not constitute a release of the Data for the Contractor’s discretionary use. Contractor must use the Data received or accessed under this Contract only to carry out the purpose of this Contract. Any ad hoc analyses or other use or reporting of the Data is not permitted without HCA’s prior written consent.
- b. Any disclosure of Data contrary to this Contract is unauthorized and is subject to penalties identified in law.
- c. The Contractor must comply with the *Minimum Necessary Standard*, which means that Contractor will use the least amount of PHI necessary to accomplish the Purpose of this Contract.

- i) Contractor must identify:
 - 1. Those persons or classes of persons in its workforce who need access to PHI to carry out their duties; and
 - 2. For each such person or class of persons, the category or categories of PHI to which access is needed and any conditions appropriate to such access.
- ii) Contractor must implement policies and procedures that limit the PHI disclosed to such persons or classes of persons to the amount reasonably necessary to achieve the purpose of the disclosure, in accordance with this Contract.

4. Security of Data

a. Data Protection

- i) The Contractor must protect and maintain all Confidential Information gained by reason of this Contract, information that is defined as confidential under state or federal law or regulation, or Data that HCA has identified as confidential, against unauthorized use, access, disclosure, modification or loss. This duty requires the Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:
 - 1. Allowing access only to staff that have an authorized business requirement to view the Confidential Information.
 - 2. Physically securing any computers, documents, or other media containing the Confidential Information.

b. Data Security Standards

- i. Contractor must comply with the Data Security Requirements set out in this section and the Washington OCIO Security Standard, 141.10, which will include any successor, amended, or replacement regulation (<https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets>.) The Security Standard 141.10 is hereby incorporated by reference into this Contract.

ii. Data Transmitting

- 1. When transmitting Data electronically, including via email, the Data must be encrypted using NIST 800-series approved algorithms (<http://csrc.nist.gov/publications/PubsSPs.html>). This includes transmission over the public internet.
- 2. When transmitting Data via paper documents, the Contractor must use a Trusted System.

iii. Protection of Data. The Contractor agrees to store and protect Data as described.

1. Data at Rest:

- a. Data will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data. Access to the

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

2. Data stored on Portable/Removable Media or Devices

- a. Confidential Information provided by HCA on Removable Media will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the Data.
- b. HCA's Data must not be stored by the Contractor on Portable Devices or Media unless specifically authorized within the Contract. If so authorized, the Contractor must protect the Data by:
 - i. Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;
 - ii. Controlling access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics;
 - iii. Keeping devices in locked storage when not in use;
 - iv. Using check-in/check-out procedures when devices are shared;
 - v. Maintaining an inventory of devices; and
 - vi. Ensuring that when being transported outside of a Secured Area, all devices containing Data are under the physical control of an Authorized User.

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

iv. Data Segregation

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

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

- a. On media (e.g. hard disk, optical disc, tape, etc.) which contains only HCA Data;

- b. In a logical container on electronic media, such as a partition or folder dedicated to HCA's Data;
 - c. In a database that contains only HCA Data;
 - d. Within a database – HCA data must be distinguishable from non-HCA Data by the value of a specific field or fields within database records;
 - e. Physically segregated from non-HCA Data in a drawer, folder, or other container when stored as physical paper documents.
2. When it is not feasible or practical to segregate HCA's Data from non-HCA data, both HCA's Data and the non-HCA data with which it is commingled must be protected as described in this Exhibit.

c. Data Disposition

- i) Upon request by HCA, at the end of the Contract term, or when no longer needed, Confidential Information/Data must be returned to HCA or disposed of as set out below, except as required to be maintained for compliance or accounting purposes.

Media are to be destroyed using a method documented within NIST 800-88 (<http://csrc.nist.gov/publications/PubsSPs.html>).

- i. For Data stored on network disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in Section 4.b.iii, above. Destruction of the Data as outlined in this section of this Exhibit may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

5. Data Confidentiality and Non-Disclosure

a. Data Confidentiality.

- i) The Contractor will not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Contract for any purpose that is not directly connected with the purpose of this Contract, except:
 - 1. as provided by law; or
 - 2. with the prior written consent of the person or personal representative of the person who is the subject of the Confidential Information.

b. Non-Disclosure of Data

- i) The Contractor will ensure that all employees or Subcontractors who will have access to the Data described in this Contract (including both employees who will use the Data and IT support staff) are instructed and aware of the use restrictions and protection requirements of this Exhibit before gaining access to the Data identified herein. The Contractor will ensure that any new employee is made aware of the use restrictions and protection requirements of this Exhibit before they gain access to the Data.
- ii) The Contractor will ensure that each employee or Subcontractor who will access the Data signs a non-disclosure of confidential information agreement regarding confidentiality and

non-disclosure requirements of Data under this Contract. The Contractor must retain the signed copy of employee non-disclosure agreement in each employee's personnel file for a minimum of six years from the date the employee's access to the Data ends. The Contractor will make this documentation available to HCA upon request.

c. Penalties for Unauthorized Disclosure of Data

- i) The Contractor must comply with all applicable federal and state laws and regulations concerning collection, use, and disclosure of Personal Information and PHI. Violation of these laws may result in criminal or civil penalties or fines.
- ii) The Contractor accepts full responsibility and liability for any noncompliance with applicable laws or this Contract by itself, its employees, and its Subcontractors.

6. Data Shared with Subcontractors

If Data access is to be provided to a Subcontractor under this Contract, the Contractor must include all of the Data security terms, conditions and requirements set forth in this Exhibit in any such Subcontract. However, no subcontract will terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any subcontractor.

7. Data Breach Notification

- a. The Breach or potential compromise of Data must be reported to the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov and to the BH-ASO Contract Manager at hcabhaso@hca.wa.gov within five (5) business days of discovery. If the Contractor does not have full details, it will report what information it has, and provide full details within fifteen (15) business days of discovery. To the extent possible, these reports must include the following:
 - i) The identification of each non-Medicaid Individual whose PHI has been or may have been improperly accessed, acquired, used, or disclosed;
 - ii) The nature of the unauthorized use or disclosure, including a brief description of what happened, the date of the event(s), and the date of discovery;
 - iii) A description of the types of PHI involved;
 - iv) The investigative and remedial actions the Contractor or its Subcontractor took or will take to prevent and mitigate harmful effects, and protect against recurrence;
 - v) Any details necessary for a determination of the potential harm to Individuals whose PHI is believed to have been used or disclosed and the steps those Individuals should take to protect themselves; and
 - vi) Any other information HCA reasonably requests.
- b. The Contractor must take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or HCA including but not limited to 45 C.F.R. Part 164, Subpart D; RCW 42.56.590; RCW 19.255.010; or WAC 284-04-625.
- c. The Contractor must notify HCA in writing, as described in 7.a of this exhibit, within two (2) business days of determining notification must be sent to non-Medicaid Individuals.

- d. At HCA's request, the Contractor will provide draft Individual notification to HCA at least five (5) business days prior to notification, and allow HCA an opportunity to review and comment on the notifications.
- e. At HCA's request, the Contractor will coordinate its investigation and notifications with HCA and the Office of the state of Washington Chief Information Officer (OCIO), as applicable.

8. HIPAA Compliance

- a. The Contractor must perform all of its duties, activities, and tasks under this Contract in compliance with HIPAA, the HIPAA Rules, and all applicable regulations as promulgated by the U.S. Department of Health and Human Services, Office for Civil Rights, as applicable. The Contractor and Contractor's subcontracts must fully cooperate with HCA efforts to implement HIPAA requirements.
- b. Within ten business days, Contractor must notify the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov, with a copy to the BH-ASO Contract Manager at hcabhaso@hca.wa.gov, of any complaint, enforcement, or compliance action initiated by the Office for Civil Rights based on an allegation of violation of HIPAA or the HIPAA Rules and must inform HCA of the outcome of that action. Contractor bears all responsibility for any penalties, fines, or sanctions imposed against Contractor for violations of HIPAA or the HIPAA Rules and for any sanction imposed against its Subcontractors or agents for which it is found liable.

9. Inspection

HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Individuals collected, used, or acquired by Contractor during the terms of this Contract. All HCA representatives conducting onsite audits of Contractor agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

10. Material Breach

The Contractor must indemnify and hold HCA and its employees harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Individuals.

Exhibit P
Federal Award Identification for Subrecipients

Federal Award Identification for Subrecipients (reference 2 CFR 200.331)
WA-STR addresses the Opiate Epidemic by increasing treatment and prevention activities

(i) Subrecipient name (which must match the name associated with its unique entity identifier);	
(ii) Subrecipient's unique entity identifier; (DUNS)	
(iii) Federal Award Identification Number (FAIN);	TI080249
(iv) Federal Award Date (see §200.39 Federal award date);	
(v) Subaward Period of Performance Start and End Date;	
(vi) Amount of Federal Funds Obligated by this action;	
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	
(viii) Total Amount of the Federal Award;	\$
(ix) Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);	WA-STR addresses the Opiate Epidemic by increasing treatment and prevention activities
(x) Name of Federal awarding agency, pass-through entity, and contact information for awarding official,	SAMHSA Washington State HCA Michael Langer, Assistant Director DBHR PO Box 45330 Olympia, WA 98504-5330 Michael.langer@hca.wa.gov
(xi) CFDA Number and Name; the pass-through entity must identify the dollar amount made available under each Federal award and the CFDA number at time of disbursement;	93.788
(xii) Identification of whether the award is R&D; and	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
(xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per §200.414 Indirect (F&A) costs).	de minimis (10%)

**Federal Award Identification for Subrecipients (reference 2 CFR 200.331)
Mental Health Block Grant**

(i) Subrecipient name (which must match the name associated with its unique entity identifier);	
(ii) Subrecipient's unique entity identifier; (DUNS)	
(iii) Federal Award Identification Number (FAIN);	SM010056
(iv) Federal Award Date (see §200.39 Federal award date);	
(v) Subaward Period of Performance Start and End Date;	
(vi) Amount of Federal Funds Obligated by this action;	
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	
(viii) Total Amount of the Federal Award;	
(ix) Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);	Community Mental Health Services Block Grant
(x) Name of Federal awarding agency, pass-through entity, and contact information for awarding official,	SAMHSA Washington State HCA Michael Langer, Assistant Director DBHR PO Box 45330 Olympia, WA 98504-5330 Michael.langer@hca.wa.gov
(xi) CFDA Number and Name; the pass-through entity must identify the dollar amount made available under each Federal award and the CFDA number at time of disbursement;	93.958
(xii) Identification of whether the award is R&D; and	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
(xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per §200.414 Indirect (F&A) costs).	5%

**Federal Award Identification for Subrecipients (reference 2 CFR 200.331)
Substance Abuse Block Grant**

(i) Subrecipient name (which must match the name associated with its unique entity identifier);	
(ii) Subrecipient's unique entity identifier; (DUNS)	
(iii) Federal Award Identification Number (FAIN);	TI010056-18
(iv) Federal Award Date (see §200.39 Federal award date);	
(v) Subaward Period of Performance Start and End Date;	
(vi) Amount of Federal Funds Obligated by this action;	
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	
(xiii) Total Amount of the Federal Award;	\$
(ix) Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);	Substance Abuse Prevention and Treatment Block Grant
(x) Name of Federal awarding agency, pass-through entity, and contact information for awarding official,	SAMHSA Washington State HCA Michael Langer, Assistant Director DBHR PO Box 45330 Olympia, WA 98504-5330 Michael.langer@hca.wa.gov
(xi) CFDA Number and Name; the pass-through entity must identify the dollar amount made available under each Federal award and the CFDA number at time of disbursement;	93.959
(xii) Identification of whether the award is R&D; and	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
(xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per §200.414 Indirect (F&A) costs).	5%