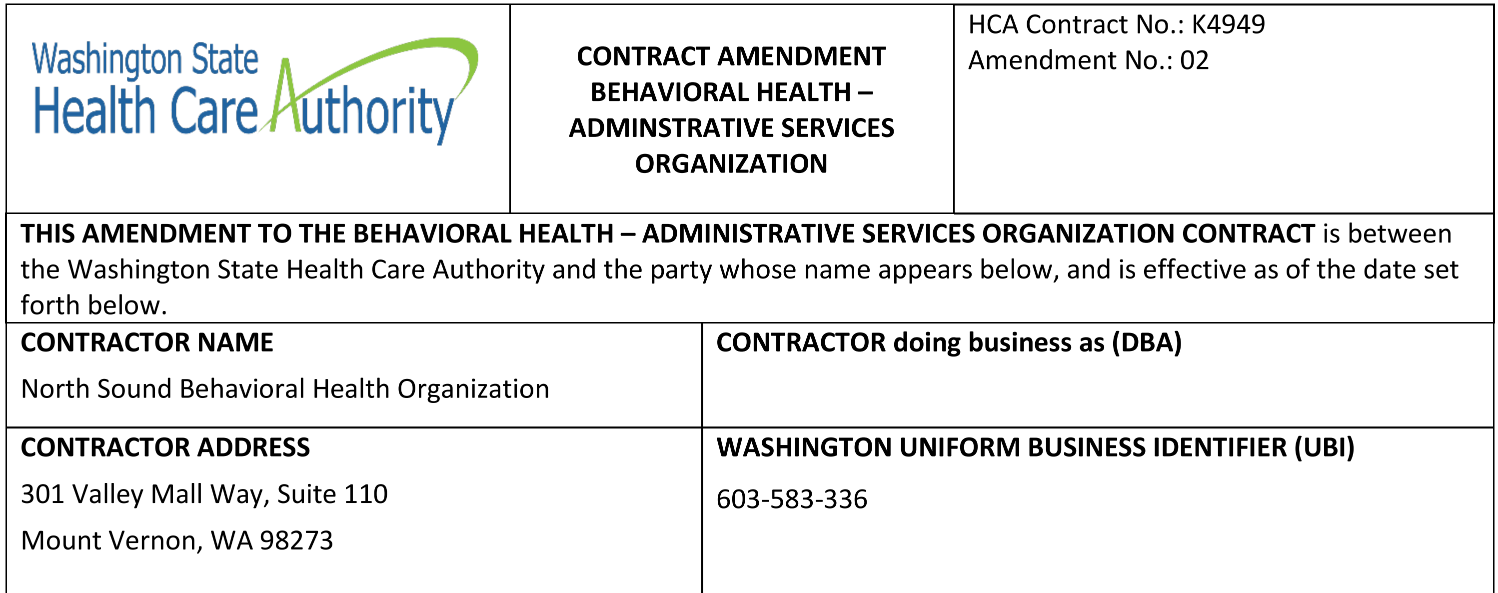

Washington State Health Care Authority	CONTRACT AMENDMENT BEHAVIORAL HEALTH – ADMINSTRATIVE SERVICES ORGANIZATION	HCA Contract No.: K4949 Amendment No.: 02

THIS AMENDMENT TO THE BEHAVIORAL HEALTH – ADMINISTRATIVE SERVICES ORGANIZATION CONTRACT is between the Washington State Health Care Authority and the party whose name appears below, and is effective as of the date set forth below.

CONTRACTOR NAME	**CONTRACTOR doing business as (DBA)**
North Sound Behavioral Health Organization	
CONTRACTOR ADDRESS	**WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)**
301 Valley Mall Way, Suite 110 Mount Vernon, WA 98273	603-583-336

WHEREAS, HCA and Contractor previously entered into a Contract for behavioral health services, and;

WHEREAS, HCA and Contractor wish to amend the Contract to: 1) update requirements and provide editorial changes to the BH-ASO Contract to ensure clarity of contract expectations; 2) revisions to C.F.R., RCW, and WAC references; 3) update Exhibit A, Non-Medicaid Funding Allocation; 4) revise Exhibit F, Federal Award Identification for Subrecipients; 5) revise Exhibit G, Behavioral Health Services.

NOW THEREFORE, the parties agree the Contract is amended as follows:

1. The total maximum consideration for this Contract is increased by $17,370,046.00 from $13,660,109.00 to $31,030,155.00.

2. Section 1, Definitions, 1.17 Auxiliary Aids and Services, is amended to read as follows:

1.17 Auxiliary Aids and Services

"Auxiliary Aids and Services" means services or devices that enable Individuals with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the benefits, programs or activities conducted by the Contractor. Auxiliary Aids and Services includes:

1.17.1 Qualified interpreters onsite or through video remote interpreting (VRI), note takers, real-time computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons, videotext displays, or other effective methods of making aurally delivered materials available to Individuals with hearing impairments;

1.17.2 Qualified readers, taped texts, audio recordings, Brailed materials, large print materials, or other effective methods of making visually delivered materials available to Individuals with visual impairments;

1.17.3 Acquisition or modification of equipment or devices; and

1.17.4 Other similar services and actions.

3. Section 1, Definitions, 1.27 Business Associates Agreement (BAA), is amended to read as follows:

   1.27 Business Associates Agreement (BAA)

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

4. Section 1, Definitions, 1.58 Designated Crisis Responder (DCR), is amended to read as follows:

   1.58 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.

5. Section 1, Definitions, 1.62 Division of Behavioral Health and Recovery (DBHR), is amended to read as follows:

   1.62 Division of Behavioral Health and Recovery (DBHR)

   "Division of Behavioral Health and Recovery (DBHR)" means the HCA behavioral health division.

6. Section 1, Definitions, a new subsection 1.77 Forensic Housing and Recovery through Peer Services (FHARPS), is added as follows:

   1.77 Forensic Housing and Recovery through Peer Services (FHARPS)

   "Forensic Housing and Recovery through Peer Services (FHARPS)" means a program specifically for Individuals who are identified as being involved or at risk of being involved in the criminal justice system. The goal of FHARPS is to help Individuals overcome barriers in order to find and maintain housing.

   All remaining subsections are subsequently renumbered and internal references updated accordingly.

7. Section 1, Definitions, a new subsection 1.78 Forensic Navigators, is added as follows:

   1.78 Forensic Navigators

   "Forensic Navigators" means agents of the court who assist Individuals in accessing services related to diversion and community outpatient competency restoration.

   All remaining subsections are subsequently renumbered and internal references updated accordingly.

8. Section 1, Definitions, a new subsection 1.88 Health Care Authority (HCA) Provided Referral List, is added as follows:

   1.88 Health Care Authority (HCA) Provided Referral List

   "Health Care Authority (HCA) Provided Referral List" means confidential information that will be provided by HCA, on a need-to-know basis, that identifies which Individuals are eligible for Forensic Projects for Assistance in Transition from Homelessness (PATH) services.

   All remaining subsections are subsequently renumbered and internal references updated accordingly.

9. Section 1, Definitions, a new subsection 1.92 Housing and Recovery through Peers Services (HARPS), is added as follows:

   1.92 Housing and Recovery through Peers Services (HARPS)

   "Housing and Recovery through Peer Services (HARPS)" means a program to help Individuals overcome barriers in order to find and maintain housing by providing a supportive housing program that includes a bridge subsidy. The supportive housing services are delivered by peers (persons with lived experience).

   All remaining subsections are subsequently renumbered and internal references updated accordingly.

10. Section 1, Definitions, a new subsection 1.131 Outpatient Competency Restoration Program (OCRP), is added as follows:

    1.131 Outpatient Competency Restoration Program (OCRP)

    "Outpatient Competency Restoration Program (OCRP)" means a program that helps defendants in a criminal case achieve the ability to participate in his or her own defense in a community-based setting.

    All remaining subsections are subsequently renumbered and internal references updated accordingly.

11. Section 1, Definitions, 1.143 Protocols for Coordination with Tribes and non-Tribal IHCPs, is amended to read as follows:

    1.143 Protocols for Coordination with Tribes and non-Tribal IHCPs

    "Protocols for Coordination with Tribes and non-Tribal IHCPs" means the protocols that HCA and a Tribe or non-Tribal IHCP develop and agree on, with input from the Contractor, for the coordination of crisis services (including involuntary commitment assessment), care coordination, and discharge and transition planning. See Subsection 16.7, Protocols for Coordination with Tribes and non-Tribal IHCPs.

12. Section 1, Definitions, a new subsection 1.166 Stabilization/Triage Services, is added as follows:

    1.166 Stabilization/Triage Services

    "Stabilization/Triage Services" means services provided in a facility licensed by DOH and certified by DBHR as either Crisis Stabilization Units or Crisis Triage Facilities.

    All remaining subsections are subsequently renumbered and internal references updated accordingly.

13. Section 1, Definitions, a new subsection 1.183 Trueblood, is added as follows:

    1.183 Trueblood

    "Trueblood" refers to the court case of Trueblood, et al., v Department of Social and Health Services that challenges unconstitutional delays in competency evaluations and restoration services.

    All remaining subsections are subsequently renumbered and internal references updated accordingly.

14. Section 2, General Terms and Conditions, Subsection 2.3 Report Deliverable Templates, is amended to read as follows:

    2.3 Report Deliverable Templates

2.3.1 Templates for all reports that the Contractor is required to submit to HCA are hereby incorporated by reference into this Contract. HCA may update the templates from time to time, and any such updated templates will also be incorporated by reference into this Contract. The report templates are located at: https://www.hca.wa.gov/billers-providers-partners/programs-and-services/model-managed-care-contracts.The Contractor may email HCA at any time to confirm the most recent version of any template to HCABHASO@hca.wa.gov.

2.3.1.1 Report templates include:

2.3.1.1.1 Community Behavioral Health Enhancement (CBHE) Funds Quarterly Report

2.3.1.1.2 Criminal Justice Treatment Account (CJTA) Quarterly Progress Report

2.3.1.1.3 Crisis Housing Voucher Log (King only)

2.3.1.1.4 Crisis System Metrics Report

2.3.1.1.5 Crisis Triage/Stabilization and Increasing Psychiatric Bed Capacity report

2.3.1.1.6 Data Shared with External Entities Report

2.3.1.1.7 Enhanced Mobile Crisis Response Report (quarterly) (Beacon and Spokane only)

2.3.1.1.8 E&T Discharge Planner Report

2.3.1.1.9 Federal Block Grant Annual Progress Report

2.3.1.1.10 Grievance, Adverse Authorization Determination, and Appeals

2.3.1.1.11 Juvenile Court Treatment Program Reporting

2.3.1.1.12 Mental Health Block Grant (MHBG) Project Plan

2.3.1.1.13 Non-Medicaid Expenditure Report

2.3.1.1.14 Peer Bridger Program

2.3.1.1.15 Semi-Annual Trueblood Misdemeanor Diversion Fund Report

2.3.1.1.16 Substance Abuse Block Grant (SABG) Capacity Management Form

2.3.1.1.17 Substance Abuse Block Grant (SABG) Project Plan

2.3.1.1.18 Trueblood Lifeline Connections Transportation log (Beacon only)

2.3.1.1.19 Trueblood Quarterly Enhanced Crisis Stabilization/Crisis Triage Report (Beacon, Spokane and King only)

15. Section 2, General Terms and Conditions, Subsection 2.15 Insolvency, is amended to read as follows:

2.15.2 The Contractor shall, in accordance with RCW 48.44.055, provide for the Continuity of Care for Individuals and shall provide Crisis Services and ITA services in accordance with Chapters 71.05 and 71.34 RCW.

16. Section 2, General Terms and Conditions, Subsection 2.17 Insurance, is amended to read as follows:

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

2.17.1 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.

2.17.2 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.

2.17.3 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.

2.17.4 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.

2.17.5 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.

2.17.5.1 Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the Indian Self Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 et seq, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Contractor will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq, are covered by the Federal Tort Claims Act (FTCA), which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Contractor's agreement (including any addendum) with a tribe or tribal organization shall be interpreted to authorize or obligate such provider, any

employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

2.17.5.2 Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Contractor will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Contractor's agreement (or any addendum thereto) with an urban Indian organization shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

2.17.6 Separation of Insured's: All insurance Commercial General Liability policies shall contain a "separation of insured's" provision.

2.17.7 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.

2.17.8 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.

2.17.9 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.

2.17.10 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.

2.17.11 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.

2.17.12 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:

2.17.12.1 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).

12.17.12.2 Notification and call center services for Individuals affected by a Security Incident or privacy Breach.

2.17.12.3 Breach resolution and mitigation services for Individuals affected by a Security Incident or privacy Breach including fraud prevention, credit monitoring and identity theft assistance.

2.17.12.4 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).

All remaining subsections are subsequently renumbered and internal references updated accordingly.

17. Section 2, General Terms and Conditions, Subsection 2.30 Notices, is amended to read as follows:

2.30 Notices

Whenever one party is required to give notice to the other under this Contract, it shall be deemed given if either (a) emailed or (b) mailed by the United States Postal Services, registered or certified mail, return receipt requested, postage prepaid, and addressed as below.

2.30.1 In the case of notice from HCA to the Contractor, notice will be sent to:

Margaret Rojas, Contracts Manager
North South Behavioral Health Organization
301 Valley Mall Way, Suite 110
Mount Vernon, WA 98273
Margaret.rojas@nsbhaso.org

2.30.2 In the case of notice from the Contractor to HCA, notice will be sent to:

HCA Contract Administrator
Division of Legal Services/Contracts Office
P.O. Box 42702
Olympia, WA 98504-2702

OR

contracts@hca.wa.gov

2.30.3 Notices delivered through the United States Postal Service will be effective on the date delivered as evidenced by the return receipt. Notices delivered by email to contracts@hca.wa.gov, will be deemed to have been received when the recipient acknowledges, by email reply, having received that email.

2.30.4 Either party may, at any time, change its mailing address or email address for notification purposes by sending a notice in accord with this Section, stating the change and setting for the

new address, which shall be effective on the tenth (10th) Business Day following the effective date of such notice unless a later date is specified.

18. Section 2, General Terms and Conditions, subsection 2.36 Reserves, subsection 2.36.1 is amended to read as follows:

2.36.1 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 allocated amount 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.

BH-ASO	Residents	Percent	Allocation
Greater Columbia	750,910	10.5%	$1,796,298
Great Rivers	291,520	4.1%	$697,363
King	2,260,800	31.7%	$5,408,199
Thurston-Mason	356,650	5.0%	$853,164
North Central	266,670	3.7%	$637,918
North Sound	1,291,820	18.1%	$3,090,242
Pierce	900,700	12.6%	$2,154,620
Salish	381,160	5.4%	$911,796
Spokane	621,780	8.7%	$1,487,398

19. Section 3, Material and Information Requirements, Subsection 3.1 Media Materials and Publications, subsection 3.1.4 is deleted in its entirety. The contract language was moved to subsection 16.2.1. All remaining subsections are subsequently renumbered and internal referenced updated accordingly.

20. Section 3, Material and Information Requirements, Subsection 3.2 Information Requirements for Individuals, is amended to read as follows:

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.

3.2.1.1 Pursuant to 25 USC 1621t and 1647a, Contractor shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the state or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the Contractor shall not require the licensure of a health professional employed by such an entity under the state or local law where the entity is located, if the professional is licensed in another state.

21. Section 5, Payment and Sanctions, Subsection 5.1 Funding, is amended to read as follows:

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. HCA will provide the Contractor with its Federal Award Identification for Subrecipients prior to the beginning of the state fiscal year as identified in Exhibit F. 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 subsection 5.1.7.

5.1.3 A maximum of 10 percent of available funds paid to the Contractor may be used for administrative costs, taxes and other fees per RCW 71.24.330 including costs incurred for the planning, development and implementation of the MHBG and SABG annual project plans. A maximum of 5 percent of state-only and proviso funds paid to the Contractor may be used for direct service support costs. Administrative and direct service support costs must be reported on the 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 on a monthly cost reimbursement basis upon receipt and approval of an A-19 invoice.

5.1.6 The Contractor shall send the Non-Medicaid Expenditure Report to the Finance Department (hcarevenue&expenditures@hca.wa.gov) no later than forty-five (45) 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 10 percent administrative load identified in this Section will be included on the report.

5.1.7 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 within twelve (12) months from the calendar month in which the services were provided to the eligible Individual.

5.1.8.2 If a claim was incorrectly billed Contractor has an additional year to correct the claim WAC 182-502-0150.

5.1.8.3 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.

5.1.8.4 Both GFS and FBG funds may be used to spenddown qualifying medical expenses incurred such as but not limited to, voluntary and involuntary inpatient, crisis stabilization and crisis residential stays. HCA designates and approves the Contractor as a Public Program as described in WAC 182-509-0110(9). Qualified expenses paid by the Contractor shall be used to reduce an Individual's spenddown liability as outlined in Exhibit C, RSA Spenddown Liability.

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 1911-1935 and 1941-1957 of the Public Health Services Act (42 U.S.C. §§ 300x-1 – 300x-9; 300x-21 – 300x-35; and 300x-51 – 300x-67, as amended). The Contractor shall not use FBG funds for the following:

5.1.9.1 Construction and/or renovation.

5.1.9.2 Capital assets or the accumulation of operating reserve accounts.

5.1.9.3 Equipment costs over $5,000.

5.1.9.4 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 10 percent allowed for administration and 5 percent for direct service supports and up to 1.75 percent for B&O tax for actual expenditures paid directly to government entities specifically for B&O taxes) including interest earned, are to be used to provide services as described in this Contract. Direct service supports and B&O tax expense allowances are up to the percentage indicated and not a percentage of GFS funding as is calculated for administrative costs.

22. Section 6, Access to Care and Provider Network, Subsection 6.1 Network Capacity, subsection 6.1.1 is amended to read as follows:

6.1.1 The Contractor shall maintain and monitor an appropriate and adequate provider network, supported by written agreements, sufficient to comply with timely access standards, as identified in subsection 16.4.1.1 through 16.4.3, and provide all Contracted Services under this Contract and services outlined in Exhibit B, Behavioral Health Services, within available resources.

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.

23. Section 6, Access to Care and Provider Network, Subsection 6.1 Network Capacity, subsection 6.1.6 is amended to read as follows:

6.1.6 The Contractor shall meet the following requirements when developing its network:

6.1.6.1 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, IHCPs, licensed agencies or clinics, or professionals operating under an agency affiliated license.

6.1.6.2 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.

6.1.6.3 Assist the state in expanding community-based alternatives for crisis stabilization, such as mobile crisis outreach or crisis residential and respite beds.

6.1.6.4 Assist the state in expanding community-based, Recovery-oriented services, use of Certified Peer Counselors and Research- and Evidence-Based Practices.

24. Section 6, Access to Care and Provider Network, Subsection 6.4 Customer Service, is amended to read as follows:

6.4 Customer Service

The Contractor shall have a customer service line, with 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 workdays 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 shall staff its Customer Services Line 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.

6.4.3 The Contractor shall develop and maintain customer service policies and procedures that address the following:

6.4.3.1 Information on Contracted Services including where and how to access them;

6.4.3.2 Authorization requirements; and

6.4.3.3 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, Tribal governments, IHCPs, and social services.

6.4.4 The Contractor shall staff its customer services line and provide Individuals in crisis with access to qualified clinicians without placing the Individual on hold. The clinician shall assess the crisis and warm transfer the call to the regional crisis call center, a DCR, call 911, refer the Individual for services or to his or her provider, or resolve the crisis.

6.4.5 The Contractor shall train customer service representatives on GFS/FBG policies and procedures.

25. Section 7, Quality Assessment and Performance Improvement, Subsection 7.3 Performance-Measurement, is amended to read as follows:

7.3 Performance-Measurement

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.

26. Section 8, Policies and Procedures, Subsection 8.1 Policies and Procedures Requirements, subsection 8.1.4 is amended to read as follows:

8.1.4 The Contractor's policies and procedures shall:

8.1.4.1 Direct and guide the Contractor's employees, Subcontractors, and any non-contracted providers' compliance with all applicable federal, state, and contractual requirements.

8.1.4.2 Comply with the Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's RSA.

8.1.4.3 Fully articulate the requirements.

8.1.4.4 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.

8.1.4.5 Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.

27. Section 9, Subcontracts, Subsection 9.3 Required Provisions, subsection 9.3.1 is amended to read as follows:

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, including the use of the Contractor's own fee schedule for all services provided, other than for psychiatric inpatient services provided in a community hospital.

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 SERI Guide, HCA Encounter Data Reporting Guide (EDRG), and Behavioral Health Supplemental Transactions that complies with the BHDS Guide, to the Contractor. The Contractor shall ensure that all Subcontractors required to report encounter and Behavioral Health Supplemental Transactions data have the capacity to submit all HCA required data to enable the Contractor to meet the requirements under the Contract. Behavioral Health Supplemental Transactions related to services provided to Individuals must be submitted within thirty (30) calendar days from the date of service or event.

9.3.1.8.1 Contractor shall work with IHCPs to develop a mechanism to collect reports and data that will minimize duplication of reporting for IHCPs that submit reports and data to HCA without using the Contractor's processes or systems.

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 The requirement to refer potential allegations of Fraud to HCA and as described in Section 12 of this Contract.

9.3.1.11 A requirement to comply with the applicable state and federal statutes, rules and Regulations as set forth in this Contract.

9.3.1.12 A requirement to comply with any term or condition of this Contract that is applicable to the services to be performed under the Subcontract.

28. Section 9, Subcontracts, Subsection 9.5 Provider Subcontracts, subsection 9.5.27 is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

29. Section 9, Subcontracts, Subsection 9.6 Federal Block Grant (FBG) Subcontracts and Subcontract Monitoring, subsection 9.6.7 is amended to read as follows:

    9.6.7 The Contractor shall conduct and/or make arrangements for an annual fiscal review of each Subcontractor receiving FBG funds regardless of reimbursement methodology (e.g., through FFS, 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.

    9.6.7.4 As negotiated through consultation between HCA and Tribes, the Contractor shall not request on-site inspections of Tribes, including facilities and programs operated by Tribes or Tribal Organizations.

30. Section 9, Subcontracts, Subsection 9.7 Subcontracts with Indian Health Care Providers, subsection 9.7.5 is amended to read as follows:

    9.7.5 The Contractor will include reference in any contract between the Contractor and the IHCP to the Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's RSA.

31. Section 9, Subcontracts, Subsection 9.9 Provider Education, is amended to read as follows:

    9.9 Provider Education

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

    9.9.1.1 Contracted Services for Individuals served under this Contract.

    9.9.1.2 Coordination of care requirements.

    9.9.1.3 HCA and the Contractor's policies and procedures as related to this Contract.

    9.9.1.4 Data interpretation.

    9.9.1.5 Requirements for Utilization Management (UM) decision making, procedure coding, and submitting claims for GFS and FBG funded services.

    9.9.1.6 Care management staff who can assist in care transitions and care management activity.

    9.9.1.7 Program Integrity requirements.

    9.9.1.8 Ensure Contractor sponsored Certified Peer Counselor trainings are offered in accordance with DBHR policies. Policy requirements include the use of DBHR approved curriculum, trainers, testers and applicants.

9.9.1.9 The Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's RSA.

32. Section 9, Subcontracts, Subsection 9.14 Provider Credentialing, a new subsections 9.14.2.5 is added as follows:

9.14.2.5 The Contractor is not responsible for credentialing providers or facilities that are part of the Indian Health System.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

33. Section 10, Individual Rights and Protections, Subsection 10.3 Cultural Considerations, subsection 10.3.2 is amended to read as follows:

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 basis. (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).

34. Section 11, Utilization Management Program and Authorization of Services, Subsection 11.1 Utilization Management Requirements, subsection 11.1.2 is amended to read as follows:

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 UM criteria when making authorization, continued stay and discharge determinations. The UM criteria shall address GFS and SABG priority population requirements.

11.1.2.1.3 The Contractor shall use the six dimensions of the ASAM criteria to make medical necessity decisions for SUD services.

11.1.2.1.4 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.

11.1.2.1.5 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.

11.1.2.1.6 Corrective action with providers, as necessary, to address issues with compliance with state and federal Regulations or ongoing issues with patterns of service utilization.

11.1.2.1.7 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.

35. Section 11, Utilization Management Program and Authorization of Services, Subsection 11.5 Notification of Coverage and Authorization Determinations, subsection 11.5.2, is amended to read as follows:

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

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 requests a change in the level of care.

36. Section 13, Grievance and Appeal System, Subsection 13.3 Appeal Process, subsection 13.3.4 is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

37. Section 13, Grievance and Appeal System, Subsection 13.4 Expedited Appeals Process, subsection 13.4.2 is amended to read as follows:

13.4.2 The Individual may submit an expedited Appeal either orally or in writing.

38. Section 14, Care Management and Coordination, Subsection 14.2 Coordination with External Entities, subsection 14.2.1 is amended to read as follows:

14.2.1 The Contractor shall coordinate with External Entities including, but not limited to:

14.2.1.1 BH-ASOs for transfers between regions;

14.2.1.2 Family Youth System Partner Roundtable (FYSPRT);

14.2.1.3 Apple Health MCOs 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;

14.2.1.10 Accountable Community of Health (ACH); and

14.2.1.11 First Responders.

39. Section 14, Care Management and Coordination, Subsection 14.5 Care Coordination: Filing of an Unavailable Detention Facilities Report, subsection 14.5.3 is amended to read as follows:

14.5.3 When a DCR submits a No Bed Report due to the lack of an involuntary treatment bed, a face-to-face re-assessment is conducted each day by the DCR or Mental Health Professional (MHP) employed by the crisis provider to verify that the person continues to require involuntary treatment. If a bed is still not available, the DCR sends a new Unavailable Detention Facilities Report (No Bed Report) to HCA and the DCR or MHP works to develop a safety plan to help the person meet their health and safety needs, which includes the DCR or MHP continuing to search for an involuntary treatment bed or appropriate less restrictive alternative to meet the Individual’s current crisis.

40. Section 14, Care Management and Coordination, Subsection 14.6 Care Coordination and Continuity of Care: Evaluation and Treatment (E&T) Facilities, subsection 14.6.3 is amended to read as follows:

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 last Business Day of the month following the month being reported using the template provided by HCA.

41. Section 15, General Requirements and Benefits, Subsection 15.1 Special Provisions Regarding Behavioral Health Benefits, is renamed and amended to read as follows:

15 GENEERAL REQUIREMENTS FOR SERVICE DELIVERY

15.1 Special Provisions Regarding Behavioral Health Crisis Services

For each RSA, the Contractor's administration of behavioral health services 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 200 miles of the Contractor's Service Area unless approved by HCA.

15.1.2 Call center staff located in another state must receive training to ensure sufficient knowledge of the Contractor's operating policies and procedures and Washington's behavioral health service delivery system including regional network and community resources, relevant state and federal laws, and other relevant factors.

15.1.3 A Behavioral Health Professional licensed in Washington shall be available on-call 24 hours a day, seven (7) days a week, to provide training and consultation to BH-ASO contracted crisis call center providers located in another state.

15.1.4 The same staffing requirements as defined in this Contract and the same performance standards apply regardless of the location of call center operations.

15.1.5 Data management and reporting, claims administration and financial management may be located out of Washington State. If claims are administered in another location, the Contractor shall have access to the claims payment and reporting platform during Pacific Time Business Hours.

15.1.6 The Contractor shall have sufficient staff to ensure effective provider relations, network development, utilization management, quality management and performance of Grievances and Appeals.

15.1.7 The Contractor shall have sufficient staff with clinical expertise, to include:

15.1.7.1 A Behavioral Health Medical Director. Upon approval from HCA, the Behavioral Health Medical Director may be a subcontracted position.

15.1.7.2 A Children's Specialist.

15.1.7.3 An Addictions Specialist.

15.1.8 In addition, the Contractor shall have a sufficient number of staff to support data analytics and data systems, claims administration, encounter and Behavioral Health Supplemental Transactions data processing and all reporting requirements under the Contract.

15.1.9 The Contractor shall maintain current organizational charts and upon request will provide organizational charts to HCA that identifies what positions are responsible for the requirements under the contract.

15.1.10 The Contractor shall develop and implement staff training plans that address how the Contractor's applicable staff will be trained on the requirements of this Contract.

15.1.11 The Contractor shall ensure development and implementation of training programs for network providers that deliver, coordinate, or oversee behavioral health services to Individuals, to include contract requirements, Contractor policies and SABG outreach requirements related to pregnant Individuals with intravenous drug use, pregnant Individuals with a SUD, and other Individuals with intravenous drug use.

15.1.11.1 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.

42. Section 15, General Requirements for Service Delivery, Subsection 15.2 Scope of Services, is renamed and amended to read as follows:

15.2 Scope of Allowable Limitations

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

15.2.2 Outside the RSAs:

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

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.

43. Section 15, General Requirements for Service Delivery, Subsection 15.3 General Description of Contracted Services, is renamed and amended to read as follows:

15.3 Prioritization of Contracted Services

15.3.1 The Contractor shall provide services in accordance with RCW 71.24.045. 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 for voluntary inpatient services, crisis stabilization services and services for the priority populations defined in this Contract.

15.3.2 The Contractor must expend FBG funds in accordance with the optional and required services as specified in the Block Grant Project Plan Templates.

15.3.3 The Contractor shall establish and apply medical necessity criteria for the provision or denial of behavioral health services provided for the population served within this Contract as outlined in Exhibit B, Behavioral Health Services.

15.3.4 The Contractor shall develop and apply criteria to determine the approval or denial of services and supports when medical necessity does not apply.

15.3.5 Prescription drug products may be provided within Available Resources based on medical necessity. Coverage to be determined by HCA FFS formulary.

44. Section 16, Scope of Services- Crisis System, is amended to read as follows:

16.1 Crisis System General Requirements

16.1.1 The Contractor must provide 24-hour a day, seven (7) day a week crisis behavioral health services to Individuals who are within the Contractor's RSAs and report they are experiencing a crisis.

16.1.2 Under no circumstance shall the Contractor deny the provision of Crisis Services, Behavioral Health ITA Services, E&T, or Secure Withdrawal Management and Stabilization services to an Individual due to the Individual's ability to pay.

16.1.3 Crisis Services shall be provided in accordance with WAC 246-341-0900 to -0915.

16.1.4 ITA services shall 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.

16.1.4.1 Requirements include payment for all services ordered by the court for Individuals ineligible for Medicaid, and costs related to court processes and Transportation for court hearings.

16.1.4.2 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 and may be outpatient or inpatient.

16.1.5 Crisis Services shall be delivered as follows:

16.1.5.1 Stabilize Individuals as quickly as possible and assist Individuals in returning to a level of functioning that no longer requires Crisis Services.

16.1.5.2 Provide solution-focused, person-centered, and Recovery-oriented services designed to avoid unnecessary hospitalization, incarceration, institutionalization or out of home placement.

16.1.5.3 Engage the Individual in the development and implementation of crisis prevention plans to reduce unnecessary crisis system utilization and maintain the Individual's stability.

16.1.6 The Contractor shall develop and implement strategies to continuously evaluate and improve the crisis system.

16.2 Community Information and Education

16.2.1 The Contractor shall develop and implement a Community Information and Education Plan (CIEP) that educates and informs community stakeholders about the crisis system. Community stakeholders shall include residents of the RSA, health care providers, First Responders, the criminal justice system, educational systems, Tribes, and faith-based organizations.

16.2.1.1 The CIEP shall be provided to HCA by January 31, 2022. An updated CIEP shall be provided to HCA by January 31 of each year, thereafter.

16.2.1.1 The CIEP and any plan updates shall be submitted to HCA at hcabhaso@hca.wa.gov.

16.3 Crisis System Staffing Requirements

16.3.1 The Contractor shall ensure Provider compliance with applicable staffing requirements of Chapter 246-341 WAC.

16.3.2 The Contractor shall ensure Providers have sufficient staff available, including DCRs, to respond to requests for Crisis Services and ITA services.

16.3.3 The Contractor shall ensure Provider compliance with DCR qualification requirements in accordance with Chapters 71.05 and 71.34 RCW and WAC 246-341-0900 to -0915. The Contractor shall ensure providers incorporate the statewide DCR Protocols, listed on the HCA website, into the practice of DCRs.

16.3.4 The Contractor shall ensure Providers have clinicians available for consultation 24 hours a day, seven (7) days a week who have expertise in Behavioral Health conditions pertaining to children and families.

16.3.5 The Contractor shall ensure Providers have at least one SUDP and one CPC with experience providing Behavioral Health crisis support available for consultation by phone or on site during regular Business Hours.

16.3.6 The Contractor shall ensure Providers of crisis and ITA services establish policies and procedures that implement WAC 246-341-0810 and the following requirements:

16.3.6.1 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.

16.3.6.2 The team supervisor, on-call supervisor, or the individual, shall determine the need for a second individual to accompany them based on a risk assessment for potential violence.

16.3.6.3 The second individual who responds may be a First Responder, a Mental Health Professional, a SUDP, or a mental health provider who has received training required in RCW 49.19.030.

16.3.6.4 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.

16.3.6.5 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.

16.3.6.6 Every DCR dispatched on a crisis visit shall have prompt access to information about an Individual's history of dangerousness or potential dangerousness documented in crisis plans or commitment records and is available without unduly delaying a crisis response.

16.3.6.7 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.

16.4 Crisis System Operational Requirements

16.4.1 Crisis Services shall be available 24 hours a day, seven (7) days a week.

16.4.1.1 Mobile crisis outreach shall respond within two (2) hours of the referral to an emergent crisis and within 24 hours for referral to an urgent crisis.

16.4.2 The Contractor shall provide a toll-free line that is available 24 hours a day, seven (7) days a week, to provide crisis intervention and triage services, including screening and referral to a network of providers and community resources. The toll-free crisis line shall be a separate number from the Contractor's customer service line.

16.4.3 The Contractor shall ensure crisis call centers comply with the following crisis line performance standards.

16.4.3.1 Telephone abandonment rate – performance standard is 5 percent or less.

16.4.3.2 Telephone response time – performance standard is at least 90 percent of calls are answered within thirty (30) seconds.

16.4.4 Individuals shall be able to access Crisis Services without full completion of Intake Evaluations and/or other screening and assessment processes.

16.4.5 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.

16.4.6 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). Protocols shall align with the Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's RSA.

16.4.7 The Contractor shall ensure that Crisis Service providers document calls, services, and outcomes.

16.5 Crisis System Services

16.5.1 The Contractor shall make the following services available to all Individuals in the Contractor's RSAs, in accordance with the specified requirements:

16.5.1.1 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. For Individuals who are AI/AN, assist in connecting the Individual to services available from a Tribal government or IHCP.

16.5.1.2 Behavioral Health ITA Services shall be provided in accordance with WAC 246-341-0810. Services shall include investigation and evaluation activities, management of the court case findings and legal proceedings in order to ensure the due process rights of the Individuals who are detained for involuntary treatment. The Contractor shall reimburse the county for court costs associated with ITA and shall provide for evaluation and treatment services as ordered by the court for Individuals who are not eligible for Medicaid, including Individuals detained by a DCR.

16.5.1.3 Services provided in Involuntary Treatment facilities such as Evaluation and Treatment Facilities and Secure Withdrawal Management and Stabilization facility, must be licensed and certified by DOH. These facilities must have adequate staff to provide a safe and secure environment for the staff, patients and the community. The facilities will provide evaluation and treatment services to limit the duration of involuntary treatment until the person can be discharged back to their home community to continue their treatment without the loss of their civil liberties. The treatment shall be evidence-based practices to include Pharmacological services, psycho-social classes, withdrawal management as needed, discharge planning, and warm handoff to follow-up treatment including any less restrictive alternative care ordered by the court.

16.5.2 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:

16.5.2.1 Crisis Stabilization Services, includes short-term 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.

16.5.2.2 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.

16.5.2.3 Secure Withdrawal Management and Stabilization Services provided in a Facility licensed and certified by DOH to provide involuntary 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 SUDP; acute or subacute withdrawal management services; SUD treatment; and discharge assistance provided by SUDPs, 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. This is an involuntary treatment which does not require authorization.

16.5.2.4 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.

16.6 Coordination with External Entities

16.6.1 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.

16.6.2 The Contractor shall coordinate with the regional MCOs, community court system, First Responders, criminal justice system, inpatient/residential service providers, Tribal governments, IHCPs, and outpatient behavioral health providers, to include processes to improve access to timely and appropriate treatment for Individuals with current or prior criminal justice involvement.

16.6.3 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 Transitional Age Youth (TAY) with SMI for the continuation of prescribed medications and other Behavioral Health services prior to re-entry to the community.

16.6.4 The Contractor shall collaborate 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:

16.6.4.1 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.

16.6.4.1.1 If the Contractor is paid on a FFS 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.

16.6.4.1.2 Any sub-capitation arrangement with HCA MCOs or the Contractor's providers shall be reviewed and approved by HCA.

16.6.5 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 FFS basis.

16.6.6 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, critical incidents, sharing of care and crisis plans, and MHAD necessary to coordinate service delivery in accordance with applicable privacy laws, HIPAA Regulations and 42 C.F.R. Part 2.

16.6.7 The Contractor shall notify an MCO within one Business Day when a MCO's Enrollee interacts with the crisis system.

16.6.8 The Contractor shall require that Mobile Crisis Services coordinate with co-responders within their region.

16.7 Protocols for Coordination with Tribes and non-Tribal IHCPs

16.7.1 The Contractor shall participate in meetings with Tribes and non-Tribal IHCPs, facilitated by HCA, to develop the Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's RSA.

16.7.2 The Contractor will comply with the Protocols for Coordination with Tribes and Non-Tribal IHCPs applicable to the Contractor's Regional Service Area(s) when they are completed and agreed upon for each Tribe or non-Tribal IHCP. Until these protocols are completed and agreed upon, the Contractor shall use the most recent annual plan for providing crisis and ITA evaluation on Tribal Lands that was agreed upon by the Contractor and the Tribe.

16.7.3 The Contractor, in partnership with HCA, will participate in HCA convened meetings to develop and revise protocols for the coordination of crisis services (including involuntary commitment assessment), care coordination, and discharge and transition planning as part of HCA's government-to-government relationship with each of the Tribes under chapter 43.376 RCW and various federal requirements and as part of HCA's meet-and-confer relationship with each non-Tribal IHCP under HCA policy. These protocols will include a procedure and timeframe for evaluating the protocols' efficacy and reviewing or modifying the protocols to the satisfaction of all parties. These protocols may be jointly developed with more than one Tribe and/or non-Tribal IHCPs in an RSA. With respect to crisis and involuntary commitment assessment services, these protocols will include at a minimum a description of the procedures or processes for:

16.7.3.1 DCRs access to Tribal lands to provide services, including crisis response and involuntary commitment assessment;

16.7.3.2 Providing services on Tribal lands in the evening, holidays, or weekends if different than during business hours;

16.7.3.3 Notifying Tribal authorities when crisis services are provided on Tribal land, especially on weekends or holidays or after business hours, including who is notified and timeframes for the notification;

16.7.3.4 How DCRs will coordinate with Tribal mental health and/or SUD providers and others identified in the protocols, including coordination and debriefing with any Tribal mental health or SUD providers after a crisis service has been provided;

16.7.3.5 When a DCR determines whether to detain or not for involuntary commitment; and

16.7.3.6 If ITA evaluations cannot be conducted on Tribal land, how and by whom Individuals will be transported to non-Tribal lands for involuntary commitment assessment and detention and/or to a licensed Evaluation and Treatment Facility.

16.7.4 HCA will provide the Contractor a copy of each set of Protocols applicable to the Contractor's RSA as soon as they are agreed upon by the Tribe or non-Tribal IHCP.

16.8 Tribal Designated Crisis Responders

16.8.1 Upon the Contractors authority to designate DCR's, and upon request, the Contractor must assist and designate at least one person from each Tribe within the Contractor's RSA as a Tribal DCR, subject to the following requirements:

16.8.1.1 The potential Tribal DCR must meet all the requirements as a DCR in accordance with RCW 71.05.020, 71.24.025 and 71.34.020.

16.8.1.2 The request for designation of a potential Tribal DCR person must be made in writing to the Contractor from the Tribal Authority.

16.8.1.3 If the Contractor's RSA includes multiple Tribes, and upon written request from all the affected Tribes, Tribes may elect to share Tribal DCRs.

16.8.1.4 The decision-making authority of the DCR must be independent of the Contractor's administration and the Tribal Authority.

16.8.2 In the event the Contractor and Tribal Authority are unable to reach agreement on a methodology to designate a Tribal DCRs, including hiring, funding and operational processes, written documentation must be provided to HCA's office of Tribal Affairs and must be submitted to HCABHASO@hca.wa.gov.

16.8.2.1 Documentation must include names of those participating in the planning discussions from both parties and barriers or issues that remain unresolved.

16.8.2.2 HCA will work with both parties to attempt to resolve issues and provide technical assistance where needed. This may include a facilitated executive level meeting between both parties.

16.8.3 The Contractor will enable any Tribal DCR, whether appointed by the Contractor, by the courts within the region, or by HCA, to shadow with and receive on-the-job training and technical assistance from a DCR employed by a DCR provider agency that is contracted with the Contractor.

16.8.4 The Contractor must actively engage and include Tribal DCRs whether appointed by the Contractor, by the courts within the region, or by HCA, in the regional work on Crisis Services collaborative groups, trainings, and policy impacts within their RSA and as provided to other crisis and DCR service providers.

16.8.5 The Contractor must pay for non-Medicaid DCR evaluations provided by Tribal DCRs.

16.9 Crisis System Reporting

16.9.1 For each RSA, the Contractor shall provide crisis system reports to include quarterly and annual reports. Reports must be submitted to HCA at hcabhaso@hca.wa.gov.

16.9.1.1 The quarterly report is due by the last day of the month following each quarter. The Contractor must use the HCA provided Crisis System Metrics Report template.

16.9.1.2 The annual report is due by the last day of February for the previous calendar year. The report must include:

16.9.1.2.1 A summary and analysis about each region's crisis system, to include information from the quarterly Crisis System Metrics Report, callers funding sources (Medicaid, non-Medicaid, other) and caller demographics including age, gender, and ethnicity.

16.9.1.2.2 A summary of crisis system coordination activities with external entities, including successes and challenges. External entities addressed in the summary must include but are not limited to regional MCOs, community behavioral health providers, First Responders, partners within the criminal justice system, and Tribal entities.

16.9.1.2.3 A summary of how Individuals' crisis prevention plans are used to inform DCRs dispatched on crisis visits, reduce unnecessary crisis system utilization and maintain the Individual's stability. Include in the summary an analysis of the consistency of use and effectiveness of the crisis prevention plans.

16.9.1.2.4 Provide a summary of the development, implementation, and outcomes of activities and strategies used to improve the crisis system. To include:

16.9.1.2.4.1 An overview and analysis of available information and data about the disposition of crisis calls.

16.9.1.2.4.2 Coordination of referrals to provider agencies or MCOs for case management, awareness of frequent crisis line callers and reduction of law enforcement involvement with the crisis system.

16.9.1.2.4.3 A description of how crisis system data is used throughout the year, including the use of information from community partners about the crisis system effectiveness.

16.9.1.2.4.4 Any systemic changes to the crisis system planned in the upcoming year as a result of the information and data.

45. Section 17, Juvenile Court Treatment Program, Subsection 17.1 Juvenile Court Treatment Program Requirements, is amended to read as follows:

17.1 Juvenile Court Treatment Program Requirements

17.1.1 In RSAs where funding is provided, the Contractor shall support Individuals involved with a region's Juvenile Drug Court (JDC), or other juvenile court treatment program, to provide the following services:

17.1.1.1 A SUD assessment.

17.1.1.2 SUD 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 appropriate, 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 Track attendance, completion of activities, and offer incentives for compliance.

17.1.1.5 Engagement of the community to broaden the support structure and better ensure success such as referrals to mentors, support groups, pro-social activities, etc.

46. Section 18, Criminal Justice Treatment Account (CJTA), is amended to read as follows:

18.1 CJTA Funding Guidelines

18.1.1 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 per RCW 71.24.580. Services provided through CJTA appropriation must be clearly documented and reported in accordance with subsection 9.3.1.8.

18.1.2 The Contractor shall implement any CJTA plans developed by the local CJTA panel established under RCW 71.24.580(6) and approved by the CJTA Panel in accordance with RCW 71.24.580(5)(b).

18.1.3 In accordance with RCW 2.30.040, counties are required to provide a dollar-for-dollar participation match for CJTA funded services for Individuals who are under the supervision of a therapeutic court.

18.1.4 No more than 10 percent of the total CJTA funds can be used for the following treatment support services combined:

18.1.4.1 Transportation; and

18.1.4.2 Child Care Services.

18.1.5 Moneys allocated under this Section shall be used to supplement, not supplant, other federal, state, and local funds used for SUD treatment per RCW 71.24.580(8).

18.1.6 The Contractor shall dedicate a minimum 30 percent of the CJTA funds for innovative projects that meet any or all of the following conditions:

18.1.6.1 An acknowledged evidence or research based best practice (or treatment strategy) that can be documented in published research, or

18.1.6.2 An approach utilizing either traditional or best practices to treat significantly underserved and marginalized population(s) and populations who are disproportionately affected by involvement in the criminal justice system, or

18.1.6.3 A regional project conducted in partnership with at least one other entity serving the RSA such as, the AH-IMC MCOs operating in the RSA or the ACH.

18.1.7 HCA retains the right to request progress reports or updates on innovative projects funded under this subsection.

18.2 Allowable Expenditures under CJTA

18.2.1 Services that can be provided using CJTA funds are:

18.2.1.1 Brief Intervention (any level, assessment not required);

18.2.1.2 Acute Withdrawal Management (ASAM Level 3.2WM);

18.2.1.3 Sub-Acute Withdrawal Management (ASAM Level 3.2WM);

18.2.1.4 Outpatient Treatment (ASAM Level 1);

18.2.1.5 Intensive Outpatient Treatment (ASAM Level 2.1);

18.2.1.6 Opioid Treatment Program (ASAM Level 1);

18.2.1.7 Case Management (ASAM Level 1.2);

18.2.1.8 Intensive Inpatient Residential Treatment (ASAM Level 3.5);

18.2.1.9 Long-term Care Residential Treatment (ASAM Level 3.3);

18.2.1.10 Recovery House Residential Treatment (ASAM Level 3.1);

18.2.1.11 Assessment (to include Assessments done while in jail);

18.2.1.12 Interim Services;

18.2.1.13 Community Outreach;

18.2.1.14 Involuntary Commitment Investigations and Treatment;

18.2.1.15 Room and Board (Residential Treatment Only);

18.2.1.16 Transportation;

18.2.1.17 Childcare Services;

18.2.1.18 Urinalysis;

18.2.1.19 Treatment in the jail:

18.2.1.19.1 The Contractor may not use more than 30 percent of their total annual allocation for providing treatment services in jail.

18.2.1.19.1.1 The Contractor may request an exception to this funding limit within their strategic plan submitted per subsection 18.3.1 of this Contract.

18.2.1.19.2 SUD treatment services provided in jail may include, but are not limited to the following:

18.2.1.19.2.1 Engaging Individuals in SUD treatment;

18.2.1.19.2.2 Referral to SUD services;

18.2.1.19.2.3 Administration of medications for the treatment of SUDs, including Opioid Use Disorder, to include the following:

18.2.1.19.2.3.1 Screening for medications for SUDs;

18.2.1.19.2.3.2 Cost of medications for SUDs; and

18.2.1.19.2.3.3 Administration of medications for SUDs.

18.2.1.19.3 Coordinating care;

18.2.1.19.4 Continuity of Care; and

18.2.1.19.5 Transition planning.

18.2.1.20 Employment services and job training;

18.2.1.21 Relapse prevention;

18.2.1.22 Family/marriage education;

18.2.1.23 Peer-to-peer services, mentoring and coaching;

18.2.1.24 Self-help and support groups;

18.2.1.25 Housing support services (rent and/or deposits);

18.2.1.26 Life skills;

18.2.1.27 Education; and

18.2.1.28 Parent education and child development.

18.3 CJTA Strategic Plan

18.3.1 Beginning October 1, 2021, the CJTA Biennial Plan is due every two years on October 1.

18.3.1.1 The BH-ASO must coordinate with the local legislative authority for the county or counties in its RSA in order to facilitate the planning requirement as described in RCW 71.24.580(6). The CJTA Biennial Plan shall:

18.3.1.1.1 Describe in detail how SUD treatment and support services will be delivered within the region;

18.3.1.1.2 Address the CJTA Account Match Requirement from subsection 18.1.3 of this Contract;

18.3.1.1.3 Include details on innovative projects as referenced in subsection 18.1.6, including the following:

18.3.1.1.3.1 Describe the project and how it will be consistent with the strategic plan;

18.3.1.1.3.2 Describe how the project will enhance treatment services for eligible Individuals identified in RCW 71.24.580(1)(a) - (b);

18.3.1.1.3.3 Describe how the project will incorporate best practices and treatment strategies while addressing underserved populations;

18.3.1.1.3.4 Indicate the number of Individuals who were served using innovative funds; and

18.3.1.1.3.5 Detail the original goals and objectives of the project.

18.3.1.2 If applicable, the CJTA Biennial Plan will indicate a plan of action for meeting the requirements in subsection 18.5 of this Contract.

18.3.1.3 Completed plans must be submitted to HCA and the CJTA Panel established in RCW 71.24.580(5)(b), for review and approval. Once approved, the Contractor must implement its plan as written.

18.4 State Appropriation Recoupment

18.4.1 In accordance with RCW 71.24.580(11), HCA shall monitor and review, on an annual basis, expenditures related to CJTA appropriations.

18.4.2 HCA will help recoup and redistribute underspent or overspent funds on an annual basis to ensure accordance with RCW 71.24.580(11), any remaining unspent CJTA appropriations will be returned to HCA at the end of the state fiscal biennium.

18.5 Medications for Opioid Use Disorder in Therapeutic Courts

18.5.1 The Contractor, under the provisions of this Contract and in accordance with RCW 71.24.580(9), will abide by the following guidelines related to CJTA funding that supports therapeutic courts.

18.5.1.1 The Contractor will only subcontract with behavioral health providers and therapeutic courts that have policy and procedures in place that:

18.5.1.1.1 Allow Individuals at any point in their course of treatment to be prescribed any medication approved by the FDA for the treatment of SUD.

18.5.1.1.2 Do not deny admission into therapeutic court programs and related services for Individuals who are prescribed any medication approved by the FDA for the treatment of SUD; and

18.5.1.1.3 Do not mandate titration of any medication approved by the FDA for the treatment of SUD, as a condition of Individuals being admitted into the program, continuing in the program, or graduating from the program; with the understanding that decisions concerning medication adjustment are made solely between the Individual and their prescribing provider.

18.5.1.2 The Contractor will ensure the subcontractor coordinates care with agencies that are able to provide or facilitate the induction of any medication approved by the FDA for the treatment of SUD.

18.5.1.3 The Contractor must notify the HCA if it discovers that a behavioral health provider or therapeutic court program that receive CJTA funding are practicing any of the following:

18.5.1.3.1 Requiring discontinuation, titration, or alteration of their medication regimen as a precluding factor in admittance into a therapeutic court program;

18.5.1.3.2 Requiring Individuals already in the program to discontinue medication regimen to comply with program requirements; and

18.5.1.3.3 Requiring discontinuation, titration, or alteration of their medication regimen as a necessary component of meeting program requirements for graduation from a therapeutic court program.

18.5.1.4 All decisions regarding an Individual's amenability and appropriateness for medications will be made by the Individual in concert with a prescribing provider.

18.6 CJTA Quarterly Progress Report

18.6.1 The Contractor will submit a CJTA Quarterly Progress Report within forty-five (45) calendar days of the state fiscal quarter end using the reporting template, CJTA Quarterly Progress Report. CJTA Quarterly Progress Report must include the following program elements:

18.6.1.1 Number of Individuals served under CJTA funding for that time period;

18.6.1.2 Barriers to providing services to the criminal justice population;

18.6.1.3 Strategies to overcome the identified barriers;

18.6.1.4 Training and technical assistance needs;

18.6.1.5 Success stories or narratives from Individuals receiving CJTA services; and

18.6.1.6 If a therapeutic court provides CJTA funded services: the number of admissions of Individuals into the program who were either already on medications for SUD, referred to a prescriber of medications for SUD, or were provided information regarding medications for SUD.

18.6.2 CJTA quarterly reports are due forty-five calendar days following the end of the quarter. Reporting periods: Quarter 1, July through September; Quarter2, October through December; Quarter 3, January through March; and Quarter 4, April through June.

47. Section 20, Jail Transition Services, is amended to read as follows:

20.1 Jail Transition Services Requirements

20.1.1 Jail Transition Services are to be provided within the identified resources in Exhibit A.

20.1.2 The Contractor shall coordinate with local and Tribal law enforcement, courts and jail personnel to meet the needs of Individuals detained in city, county, tribal, and regional jails.

20.1.3 The Contractor must identify and provide transition services to Individuals with mental illness and/or co-occurring disorders to expedite and facilitate their return to the community.

20.1.4 The Contractor shall accept referrals for intake of Individuals 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 Individuals and when appropriate provide transition services prior to their release from jail.

20.1.5 The Contractor shall assist Individuals with mental illness in completing and submitting an application for medical assistance prior to release from jail.

20.1.6 The Contractor shall assist Individuals with mental illness and/or co-occurring disorders with the coordination of the re-activation of Medicaid benefits if those benefits were suspended while the Individual was incarcerated, which may involve coordinating the submission of Prior Authorization with the MCOs, or the FFS Medicaid Program.

20.1.7 Pre-release services shall include:

20.1.7.1 Mental health and SUD screening for Individuals who display behavior consistent with a need for such screening who submit a Health Kite requesting services, or have been referred by jail staff, or officers of the court.

20.1.7.2 Mental health intake assessments for Individuals identified during the mental health screening as a member of a priority population.

20.1.7.3 Facilitation of expedited medical and financial eligibility determination with the goal of immediate access to benefits upon release from incarceration.

20.1.7.4 Other prudent pre-release and pre-trial case management and transition planning.

20.1.7.5 Direct mental health or SUD services to Individuals who are in jails that have no mental health staff working in the jail providing services.

20.1.7.6 Post-release outreach to ensure follow-up for mental health and other services (e.g., SUD) to stabilize Individuals in the community.

20.1.8 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:

20.1.8.1 Identify recently booked Individuals that are eligible for Medicaid or had their Medicaid benefits suspended for purposes of establishing Continuity of Care upon release.

20.1.8.2 Develop individual alternative service plans (alternative to the jail) for submission to the courts. Plans will incorporate evidence-based risk assessment screening tools.

20.1.8.3 Interlocal agreements with juvenile detention facilities.

20.1.8.4 Provide up to a seven (7) day supply of medications for the treatment of mental health symptoms following the release from jail.

20.1.8.5 Training to local law enforcement and jail services personnel regarding de-escalation, crisis intervention, and similar training topics.

48. Section 22, Family Youth System Partner Roundtable (FYSPRT), is amended to read as follows:

22.1 General Requirements

22.1.1 FYSPRT support shall be provided within the identified resources in Exhibit A and reported in accordance with this Section.

22.1.2 Work completed under this Section of the Contract will be in alignment with the FYSPRT manual.

22.1.3 Include Youth, family and system partner representation in all aspects of the development, promotion, support, implementation and evaluation of the Regional FYSPRT.

22.1.4 Consistent with the FYSPRT manual, the Contractor will continue to develop, promote and support each Regional FYSPRT by providing administrative and staff support for FYSPRT deliverables as outlined 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.

22.1.5 Engage with Youth, families, and system partners to build and maintain Regional FYSPRT participation as identified in the FYSPRT manual.

22.1.6 Convene a minimum of ten Regional FYSPRT meetings, in person or virtually, in the calendar year. Meeting materials must be made publicly available on the Contractor's or FYSPRT's website prior to the meeting. The meetings shall:

22.1.6.1 Follow the Regional FYSPRT Meeting protocol found in the FYSPRT manual; and

22.1.6.2 Include a review of WISe data or WISe reports at two meetings per calendar year to identify the strengths and needs of the RSA. Include in the quarterly report a plan to address the need(s) as a meeting agenda item, Work Plan goal or other method.

22.1.7 Complete a needs assessment due October 31 of every even calendar year.

22.1.8 Create and submit a Work Plan for a two-year period based on the results of the following:

22.1.8.1 Completed needs assessment submitted to HCA October 31 of every even calendar year; and

22.1.8.2 FYSPRT meetings and evaluations.

22.1.8.3 The Work Plan shall be submitted to HCA by January 31 of odd years and must identify at least four priority areas of focus. One of the four priority areas must be connected to the research, identification, and outreach to diverse communities in your RSA, including but not limited to tribal, minority, and underserved communities, to engage in the Regional FYSPRT. All four priority areas of focus shall include for each priority:

22.1.8.3.1 Goals;

22.1.8.3.2 Action steps;

22.1.8.3.3 Those assigned; and

22.1.8.3.4 Timeline for completion.

22.1.8.4 Submit progress on goals and action steps as outlined in the Work Plan as part of quarterly reports, including barriers identified and plans to address barriers; and

22.1.8.5 Funding identified in Exhibit A is to support FYSPRT deliverables outlined in this contract including travel, meeting support, and projects outlined in the Work Plan.

22.1.9 Maintain Regional FYSPRT webpages that include:

22.1.9.1 Point of contact, name, email, and phone number;

22.1.9.2 Regional agendas and meeting notes;

22.1.9.3 Dates, locations, and times of past and upcoming Regional meetings, including information on travel reimbursement, child care, and other meeting supports. If the meeting is online, include information about how to join;

22.1.9.4 A Regional Charter;

22.1.9.5 Policies and procedures (may also be addressed in the Regional FYSPRT Charter);

22.1.9.6 Results of the needs assessment;

22.1.9.7 The Work Plan; and

22.1.9.8 Links to relevant regional/statewide resources and information.

22.1.10 Participation in state-level activities, to include:

22.1.10.1 Identification of Regional Tri-Leads to participate as members of the Statewide FYSPRT, including attending meetings and responding to surveys and emails;

22.1.10.2 Provision of travel support for all Regional Tri-Leads to attend the Statewide FYSPRT meetings, if in-person with the requirement that at least two of the three Tri-Leads attend each Statewide FYSPRT meeting on a rotating schedule to prioritize each Tri-Lead attending once per calendar year within available resources;

22.1.10.3 Provide supports for Regional FYSPRT Youth Tri-Lead(s) to participate as members of the Statewide Youth Leadership Network activities, trainings, or meetings a minimum of once per quarter and attend other youth run organization or program events and activities as determined by regional needs or as requested by HCA within available resources; and

22.1.10.4 Provide supports for Regional FYSPRT Family Tri-Lead(s) to participate as members of the Washington Behavioral Health Statewide Family Network activities, trainings, or meetings 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 HCA and within available resources.

22.1.11 Utilize a meeting evaluation tool, such as the FYSPRT Evaluation Tool and FYSPRT Evaluation – Narrative Team Effectiveness Questionnaire, (found in the FYSPRT manual) to evaluate the effectiveness of the Regional FYSPRT meetings at least one time per quarter. Include in quarterly reports how the information gathered from the evaluation tools have informed future meetings.

22.1.12 Reporting. On a quarterly basis, the Contractor shall submit the following:

22.1.12.1 A quarterly report summarizing the progress or completion of FYSPRT deliverables outlined in the FYSPRT section of this Contract, identifying any barriers and plans to address barriers;

22.1.12.2 Submit the Work Plan, with progress updates included in the document;

22.1.12.3 Sign-in sheets, showing percentage of youth and family in attendance; if below the benchmark of 51 percent, note the percentage in the quarterly report and identify three strategies to increase youth and family participation to 51 percent in the next quarter;

22.1.12.4 Meeting notes;

22.1.12.5 Updated membership roster;

22.1.12.6 A link to the required Regional FYSPRT webpage materials;

22.1.12.7 Tri-Lead attendance at Statewide FYSPRT meetings;

22.1.12.8 Member travel, participation and meeting support shall include documentation of the date of travel/meeting support, name of participant, the purpose of the expense, amount paid and must be billed in the quarter in which the expense occurred. Documentation shall be submitted with the invoice in alignment with Contractor policies and shall be billed quarterly on the A-19; and

22.1.12.9 Reports and A-19s are due by the last day of the month of January, April, July and October and must be submitted to HCA at HCABHASO@hca.wa.gov.

49. Section 25, Crisis Triage/Stabilization Centers and Increasing Psychiatric Residential Treatment Beds, Subsection 25.1 General Requirements, is amended to read as follows:

25.1.1 For Contractors that received a one-time start-up cost payment for either a Crisis Triage/Stabilization Center or to increase psychiatric residential treatment beds for Individuals transitioning from psychiatric inpatient settings the Contractor shall continue submitting quarterly reports to HCA at HCABHASO@hca.wa.gov, using the Crisis Triage/Stabilization and Increasing Psychiatric Bed Capacity reporting template provided by HCA. Reports are due thirty (30) calendar days after the end of the SFY quarter.

50. A new Section 26, Recovery Navigator Program, is added as follows:

26 RECOVERY NAVIGATOR PROGRAM

26.1 Substance Use Disorder Regional Recovery Navigator Administrator

26.1.1 The Contractor must have a SUD regional administrator for the recovery navigator program in place by July 31, 2021. The regional administrator shall be responsible for assuring compliance with program standards, including staffing standards.

26.1.2 The SUD Regional Recovery Navigator Administrator will develop a Regional Resource Assessment for their region which captures existing local, state, and federally funded community-based access points. This resource assessment will map out existing agencies and funding source which provide the following programs:

26.1.2.1 Designated Crisis Responders;

26.1.2.2 Pre-arrest diversion programs (e.g., Co-responder, Mental Health Field Response team, Law Enforcement Assisted Diversion (LEAD) National Support Bureau) which currently are funded and operational within their region.

26.1.2.3 Community-based harm reduction and outreach services;

26.1.2.4 Low-barrier Medications for Opioid Use Disorder programs;

26.1.2.5 Crisis Stabilization Facilities;

26.1.2.6 Safe Station Models;

26.1.2.7 Opioid Treatment Networks or Hub and Spoke Medication for Opioid Use Disorder (MOUD) programs; and

26.1.2.8 Any peer-based program which embeds peer support specialists in community-based programming.

26.1.2.9 The Regional Resource Assessment will consider areas such as transportation and telehealth while identifying geographical areas where there are service gaps.

26.1.3 The SUD Regional Recovery Navigator Administrator will work with local law enforcement organizations to determine which city, county, and tribal law enforcement departments are operating within their regions.

26.1.4 The SUD Regional Recovery Navigator Administrator will work closely with the Accountable Communities of Health, local health jurisdiction, local behavioral advisory committee, local and tribal law enforcement, and any other community-driven stakeholder group while executing the requirements of the position.

26.2 Recovery Navigators Plan

26.2.1 Each navigator program must maintain enough appropriately trained personnel which must include individuals with lived experience with SUD to the extent possible. The SUD Regional Recovery Navigator Administrator must assure that staff conducting intake and referral services and field assessments are paid a livable and competitive wage and have appropriate training and receive continuing education.

26.2.2 The Recovery Navigator Program shall provide services to youth and adults with behavioral health conditions who are referred to the program from diverse sources including:

26.2.2.1 Community-based outreach;

26.2.2.2 Intake and referral services;

26.2.2.3 Comprehensive assessment;

26.2.2.4 Connection to services; and

26.2.2.5 Warm handoffs to treatment and recovery support services along the continuum of care.

26.2.3 Additional services to be provided as appropriate include but not limited to:

26.2.3.1 Long-term intensive case management.

26.2.3.2 Recovery coaching.

26.2.3.3 Recovery support services.

26.2.3.4 Treatment.

26.2.4 The Contractor shall begin implementation planning to establish a recovery navigator program based on uniform program standards modeled upon the components of LEAD program to be implemented by November 1, 2021.

26.2.5 The Contractor must submit a progress report on development of the Contractor's plan demonstrating the ability to fully comply with the statewide program standards to HCA by September 1, 2021. The final plan must be submitted to hcabhaso@hca.wa.gov by October 1, 2022 for approval. If the BH-ASO plan is not approved HCA will provide technical assistance working toward approval. Once the Contractor's plan is approved funding for program implementation will be released.

26.2.6 Each recovery navigator program must submit quarterly reports to hcabhaso@hca.wa.gov using the Recovery Navigator Program report template beginning January 31, 2022 for the quarter ending December 31, 2021. The quarterly reports are due thirty (30) calendar days after the end of each quarter to hcabhaso@hca.wa.gov. Reports are due: January 31 (October through December); April 30 (January through March); July 31 (April through June); and October 31 (July through September).

26.2.7 The Contractor shall participate in technical assistance provided by the LEAD in developing their Regional Navigator Program.

26.2.8 The Contractor must participate in scheduled reviews of the recovery navigator program.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

51. Section 27, Business Continuity and Disaster Recovery, Subsection 26.1 General Requirements, subsection 27.1.2 is amended to read as follows:

27.1.2 The Contractor shall create and maintain a business continuity and disaster recovery plan that ensures timely reinstitution of the Individual information system following total loss of the primary system or a substantial loss of functionality. The plan shall include the following:

27.1.2.1 A mission or scope statement.

27.1.2.2 Information services disaster recovery person (s).

27.1.2.3 Provisions for back up of key personnel, emergency procedures, and emergency telephone numbers.

27.1.2.4 Procedures for effective communication, applications inventory and business recovery priorities, and hardware and software vendor lists.

27.1.2.5 Documentation of updated system and operations and a process for frequent back up of systems and data.

27.1.2.6 Off-site storage of system and data backups and ability to recover data and systems from back-up files.

27.1.2.7 Designated recovery options.

27.1.2.8 Evidence that disaster recovery tests or drills have been performed.

52. Exhibit A-2 Non-Medicaid Funding Allocation, is effective July 1, 2021 through December 31, 2021 and supersedes and replaces Exhibit A-1 Non-Medicaid Funding Allocation and is attached hereto and incorporated herein.

53. Exhibit F-1, Federal Award Identification for Subrecipients, replaces Exhibit F in its entirety, and is attached hereto and incorporated herein.

54. Exhibit G-1, Behavioral Health Services replaces Exhibit G in its entirety, and is attached hereto and incorporated herein.

55. This Amendment will be effective July 1, 2021 (“Effective Date”).

56. All capitalized terms not otherwise defined herein have the meaning ascribed to them in the Contract.

57. All other terms and conditions of the Contract remain unchanged and in full force and effect.

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

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE Annette Schuffenhauer, Chief Legal Officer	DATE SIGNED

Exhibit A-2: Non-Medicaid Funding Allocation
North Sound BH-ASO

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, 2021 through December 31, 2021, of state fiscal year (SFY) 2022.

MHBG and SABG funds will be administered by the BH-ASO in accordance with the plans developed locally for each grant. Bock grant funding is shown for the full SFY 2022, and spending in July-December 2021 is also counted out of these totals.

Table 1: North Sound RSA January-June FY 2022 GF-S Funding

Fund Source	Monthly	Total 6 Months
Flexible GF-S	$1,117,711	$6,706,266
PACT	$23,166	$138,996
Assisted Outpatient Tx	$19,737	$118,422
1109 PACT	$19,477	$116,862
Flexible GF-S (ASO)- Begin FY2021- Proviso (7B)	$55,385	$332,310
Jail Services	$30,628	$183,768
ITA - Non-Medicaid funding	$22,865	$137,190
Detention Decision Review	$8,958	$53,748
Long-Term Civil Commitment Court Costs	$402	$2,412
Trueblood Misdemeanor Diversion	$18,662	$111,972
Island County Crisis Stabilization	$0	$0
Juvenile Drug Court	$11,650	$69,900
DMA	$48,441	$290,646
Secure Detox	$28,913	$173,478
Behavioral Health Advisory Board	$3,333	$19,998
Ombuds	$3,750	$22,500
Discharge Planners	One-Time payment (Six months)	$53,647
BH Service Enhancements	One-Time payment (Six months)	$389,594
Whatcom County Crisis Stabliz & Support	One-Time payment (Six months)	$0
Blake 5476 Lead Admin	One-Time payment (Annual)	$140,000
Total	$1,413,078	$9,061,709

Table 2: North Sound RSA FY 2022 Grant Funding (12 months)

Fund Source	Total FY2022
MHBG (Full Year SFY2022)	$1,111,032
Peer Bridger (Full Year SFY2022)	$240,000
FYSPRT (Full Year SFY2022)	$75,000
SABG (Full Year SFY2022)	$3,289,438
Total	**$4,715,470**

Table 3: North Sound RSA Covid Grant Funding (Utilization until March 2023)

Fund Source	Total FY2022
MHBG Covid (BH-ASO) Peer Pathfinders Transition from Incarceration Pilot	$71,000
MHBG Covid (BH-ASO) Treatment -Crisis Services	$227,109
MHBH Covid MH Services non-Medicaid services & individuals	$1,037,744
SABG Covid BH-ASO Treatment Funding	$2,186,014
SABG Covid Peer Pathfinders Transition from Incarceration Pilot	$71,000
Total	**$3,592,867**

Explanations

All proviso dollars are GF-S funds. Outlined below, are explanations of the provisos and dedicated accounts 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.
- **1109 PACT Startup:** Funding to ensure the productive startup of services while maintaining fidelity to the PACT model. These funds are provided for provider startup expenses.
- **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.
- **Criminal Justice Treatment Account (CJTA):** Funds received, through a designated account in the State treasury, for expenditure on: a) SUD treatment and treatment support services for offenders with an addition of 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.
- **CJTA Therapeutic Drug Court:** Funding to set up of new therapeutic courts for cities or counties or for the expansion of services being provided to an already existing therapeutic court that engages in evidence-based practices, to include medication assisted treatment in jail settings pursuant to RCW 71.24.580.
- **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 SUDP, acute and subacute detoxification services, and discharge assistance provided by a SUDP 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 (one-time payment):** Funding for the implementation of regional enhancement plans originally funded under ESSB 6032 and continued in ESHB 1109.SL Section 215(23).

- **Discharge Planners (one-time payment):** These are funds received for a position solely responsible for discharge planning.

- **Trueblood Misdemeanor Diversion Funds:** These are funds for non-Medicaid costs associated with serving individuals in crisis triage, outpatient restoration, Forensic PATH, Forensic HARPS, or other programs that divert individuals with behavioral health disorders from the criminal justice system.

- **Ombuds:** Specific General Fund allocation to support a regional ombuds.

- **Behavioral Health Advisory Board (BHAB):** Specific General Fund allocation to support a regional BHAB.

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.

- **Long-Term Civil Commitment Beds:** This funding is for court costs and transportation costs related to the provision of long-term inpatient care beds as defined in RCW 71.24.025 through community hospitals or freestanding evaluation and treatment centers.

Exhibit F-1

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);	North Sound Behavioral Health Organization
(ii) Subrecipient's unique entity identifier; (DUNS)	958386666
(iii) Federal Award Identification Number (FAIN);	B08TI083486
(iv) Federal Award Date (see §200.39 Federal award date);	10/1/2020
(v) Subaward Period of Performance Start and End Date;	1/1/2021 – 12/31/2022
(vi) Amount of Federal Funds Obligated by this action;	$3,289,438
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	$6,578,876
(viii) Total Amount of the Federal Award;	$37,788,257
(ix) Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);	**Block Grant for Prevention and Treatment of Substance Abuse**
(x) Name of Federal awarding agency, pass-through entity, and contact information for awarding official,	SAMHSA WA State Health Care Authority Keri Waterland, Assistant Director DBHR 626 8th Ave SE; Olympia, WA 98504-5330 Keri.waterland@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	☐ Yes ☒ No
(xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per §200.414 Indirect (F&A) costs).	10%

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

(i) Subrecipient name (which must match the name associated with its unique entity identifier);	North Sound Behavioral Health Organization
(ii) Subrecipient's unique entity identifier; (DUNS)	958386666
(iii) Federal Award Identification Number (FAIN);	B08TI083519
(iv) Federal Award Date (see §200.39 Federal award date);	3/15/21
(v) Subaward Period of Performance Start and End Date;	7/1/2021 – 3/14/2023
(vi) Amount of Federal Funds Obligated by this action;	$2,257,014
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	$2,257,014
(viii) Total Amount of the Federal Award;	$35,415,872
(ix) Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);	**Block Grant for Prevention and Treatment of Substance Abuse (Covid Enhancement)**
(x) Name of Federal awarding agency, pass-through entity, and contact information for awarding official,	SAMHSA WA State Health Care Authority Keri Waterland, Assistant Director DBHR 626 8th Ave SE; Olympia, WA 98504-5330 Keri.waterland@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	☐ Yes ☒ No
(xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per §200.414 Indirect (F&A) costs).	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);	North Sound Behavioral Health Organization
(ii) Subrecipient's unique entity identifier; (DUNS)	958386666
(iii) Federal Award Identification Number (FAIN);	B09SM083998
(iv) Federal Award Date (see §200.39 Federal award date);	10/1/2020
(v) Subaward Period of Performance Start and End Date;	1/1/2020 – 12/31/2022
(vi) Amount of Federal Funds Obligated by this action;	$1,426,032
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	$2,777,064
(viii) Total Amount of the Federal Award;	$ 16,726,128
(ix) Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);	**Block Grant for Community Mental Health Services**
(x) Name of Federal awarding agency, pass-through entity, and contact information for awarding official,	SAMHSA WA State Health Care Authority Keri Waterland, Assistant Director DBHR 626 8th Ave SE; Olympia, WA 98504-5330 Keri.waterland@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	☐ Yes ☒ No
(xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per §200.414 Indirect (F&A) costs).	10%

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

(i) Subrecipient name (which must match the name associated with its unique entity identifier);	North Sound Behavioral Health Organization
(ii) Subrecipient's unique entity identifier; (DUNS)	958386666
(iii) Federal Award Identification Number (FAIN);	B09SM083829
(iv) Federal Award Date (see §200.39 Federal award date);	3/15/2021
(v) Subaward Period of Performance Start and End Date;	7/1/2021 – 3/14/2023
(vi) Amount of Federal Funds Obligated by this action;	$1,335,853
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	$1,335,853
(viii) Total Amount of the Federal Award;	$19,222,372
(ix) Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);	**Block Grant for Community Mental Health Services (Covid Enhancement)**
(x) Name of Federal awarding agency, pass-through entity, and contact information for awarding official,	SAMHSA WA State Health Care Authority Keri Waterland, Assistant Director DBHR 626 8th Ave SE; Olympia, WA 98504-5330 Keri.waterland@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	☐ Yes ☒ No
(xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per §200.414 Indirect (F&A) costs).	10%

Exhibit G-1
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) , Evaluation and Treatment centers 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 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 Individual's needs and their person-centered plan. The anticipated duration of in-community Peer Bridger services is 120 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 Individual's perspective into the provision of those services.

2) Peer Bridger Program Duties

a) Each Behavioral Health Service Organization is allocated a certain number of Peer Bridger FTEs by HCA/DBHR. If the regions' Peer Bridger team(s) are not fully staffed, monthly invoices will be prorated. The Peer Bridger will work with an average of six to twelve (6-12) program Individuals. Prior to hospital discharge the majority of the work will be inside the state or local psychiatric hospitals or Evaluation and Treatment facilities. Post-discharge activities will be in the community. Peer Bridgers shall routinely engage and interact with potential program participants.

b) Current allocation of Peer Bridger FTEs are detailed as follows in the outline below:

Region	Number of Peer Bridgers
Great Rivers BHASO	2
Greater Columbia BHASO	2
King BHASO	3
Pierce BHASO	3
North Central BHASO	1
North Sound BHASO	3
Salish BHASO	2
Spokane BHASO	3
Thurston/Mason BHASO	2
Southwest BHASO	3

i) The Contractor shall contract with an agency licensed as a Community Behavioral Agency by DOH to provide recovery support services.

ii) After being recruited, and prior to beginning hospital related activities, the Peer Bridger or Peer Bridger team will:

(1) Participate in statewide Peer Bridger Orientation and training.

(2) Participate in statewide specialized training as requested by the inpatient settings.

(3) Complete required non-disclosure, Acknowledgement of Health Care Screening for Contractors and other required forms, as requested by the inpatient setting.

c) The same Peer Bridger shall work directly with Individuals and potential Individuals and follow the Individuals into the community setting to ensure consistency with the “bridging” process. After discharge, the time spent between the community and the inpatient setting shall be adjusted to respond to Individuals in the hospital and Individuals in the community. In conjunction with the MCO/BH-ASO Hospital Liaisons and State Hospital Peer Bridger Liaison (identified during orientation), the Peer Bridger will work to engage potential Individuals. These Individuals may:

i) Have been on the hospital “referred for active discharge planning”; or

ii) Be individuals with multiple state hospitalizations or involuntary hospitalizations; or

iii) Be individuals with hospital stays of over one year; or

iv) Be individuals whom hospital staff and/or the Hospital Liaison have been unable to engage in their own discharge planning; or

v) Be individuals who require additional assistance to discharge and/or need support in the community.

d) Examples of Peer Bridger engagement activities may include:

i) Interacting with potential participants.

ii) Developing a trusting relationship with participants.

iii) Promoting a sense of self-direction and self-advocacy.

iv) Sharing their experiences in recovery.

v) Helping motivate through sharing the strengths and challenges of their own illness.

vi) Considering the Individual’s medical issues and helping them develop wellness plans they can pursue in accordance with their physician recommendations.

vii) Helping the Individual plan how they will successfully manage their life in the community.

viii) Educating Individuals about resources in their home community.

ix) Join with the Individual (when requested by the Individual) in treatment team meetings if there are no safety concerns. Help to convey the Individual's perspectives and assist the Individual with understanding the process.

e) The Peer Bridger shall support the Individual in discharge planning to include the following:

i) Function as a member of the Individual's hospital discharge planning efforts.

ii) Identify Individual-perceived barriers to discharge, assist the Individual with working through barriers and assure the Individual that they will be supported throughout the process.

iii) Coordinating in conjunction with discharge planning efforts for the Individual to travel back to his or her community.

iv) The Peer Bridgers may conduct routine weekly hospital-based engagement groups for any individual willing to participate.

f) Peer Bridger team duties:

i) Participate in monthly statewide Peer Bridger Program administrative support conference calls.

ii) Participate in Peer Bridger Training events scheduled by HCA.

iii) Complete the current DBHR Peer Bridger report/log, submit log to HCA via secured email every month, enter program enrollment start and stop dates into Behavioral Health Data System (BHDS), and enter encounters using the rehabilitation case management code.

iv) Participate in hospital and IMC/BH-ASO Peer Bridger training.

v) Coordinate activities with the IMC/BH-ASO hospital liaison.

vi) Attend and participate in Peer Bridger team coordination meetings as directed by HCA.

vii) Meet the documentation requirements of the inpatient setting and their employer.

g) Community-based post-discharge activities will include:

i) The frequency and duration of community-based Peer Bridger services will be determined by the Individual'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 Individual is receiving behavioral health treatment and peer services from a behavioral health agency or when the Individual 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 Individual. Warm hand-off activities may include:

(1) Being present and supportive during the Individual's first appointment and during the intake evaluation, primary provider or prescriber appointments, etc.

(2) Helping the Individual complete any necessary paperwork for receiving Behavioral Health services.

(3) Supporting the Individual's self-advocacy in the development of their own community treatment plan and treatment activities.

ii) The Peer Bridger may assist the Individual in developing a crisis plan with the Individual's behavioral health service agency. The Peer Bridger may be identified as a non-crisis resource in the plan.

iii) The Peer Bridger shall:

(1) Attempt to connect the Individual with natural support resources and the local recovery community and attend meetings as allowed.

(2) Help the Individual develop skills to facilitate trust-based relationships, develop strategies for maintaining wellness and develop skills to support relationships.

(3) Assist the Individual 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 Individual develop skills to schedule, track and attend appointments with providers.

(5) Help the Individual develop skills for self-advocacy so that the Individual 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 Individuals prepare for appointments and identify questions or comments the Individual 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 Individual become employable.

(c) The array of employment programs and supported employment opportunities available within the region.

h) 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).

i) The Peer Bridger team, including Peer Bridger Supervisor will:

   i) Participate in monthly, statewide Peer Bridger Program administrative support conference calls.

   ii) Participate in bi-annual Peer Bridger Training events scheduled by DBHR.

   iii) Ensure that Peer Bridgers Complete tracking logs on a monthly basis and submit logs to DBHR via secured or encrypted emails.

   iv) Coordinate and communicate Peer Bridger team schedules for participating at the inpatient settings with Peer Bridger coordinator.

j) The Peer Bridger Job Description must contain the following elements:

   i) 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, MCO/BH-ASO staff, and program Individuals.

      (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.

   ii) 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.