THIS DOCUMENT IS A RESTATED CONTRACT WITH AN EFFECTIVE DATE OF JULY 1, 2020.

Washington State Health Care Authority	**WASHINGTON BEHAVIORIAL HEALTH SERVICES INTEGRATED MANAGED CARE WRAPAROUND CONTRACT**	HCA Contract Number: Resulting from Solicitation Number (If applicable):

THIS CONTRACT is made by and between the Washington State Health Care Authority ("HCA") and the party whose name appears below ("Contractor").

CONTRACTOR NAME «Organization_Name»		
CONTRACTOR ADDRESS «City», «State» «Zip_Code»	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) «UBI»	
CONTRACTOR CONTACT «Contact_Fname» «Contact_LName»	CONTRACTOR TELEPHONE «PhoneNo»	CONTRACTOR E-MAIL ADDRESS «EmailAddress»

HCA PROGRAM Managed Care Program	HCA DIVISION/SECTION Medicaid Program Operations and Integrity
HCA CONTACT NAME AND TITLE	HCA CONTACT ADDRESS Post Office Box 45502 Olympia, WA 98504-5502
HCA CONTACT TELEPHONE	HCA CONTACT E-MAIL ADDRESS

IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? ☐YES ☒NO	CFDA NUMBER(S) ; ; ;	FFATA Form Required ☐YES ☒NO

CONTRACT START DATE **July 1, 2020**	**CONTRACT END DATE** **December 31, 2020**

PRIOR MAXIMUM CONTRACT AMOUNT	**AMOUNT OF INCREASE OR DECREASE**	**TOTAL MAXIMUM CONTRACT AMOUNT**

PURPOSE OF CONTRACT: Contract for BH Wrap Around Services

ATTACHMENTS/EXHIBITS. When the box below is marked with an X, the following Exhibits/Attachments are attached and are incorporated into this Contract by reference:

☒ Exhibits (specify):

Exhibit A: Non-Medicaid Funding Allocation
Exhibit B: Non-Medicaid Quarterly Expenditure Report
Exhibit C: intentionally left blank
Exhibit D: intentionally left blank
Exhibit E: intentionally left blank
Exhibit F: intentionally left blank

☒ Attachments: Attachment 1, RFP 15-008 Apple Health Fully Integrated Managed Care (incorporated by reference, available upon request); Attachment 2, Contractors Response to RFP 15-008 Apple Health Fully Integrated Managed Care (incorporated by reference, available upon request); Attachment 3, RFP 1812 Integrated Managed Care (incorporated by reference, available upon request); Attachment 4, Contractors Response to RFP 1812 Integrated Managed Care (incorporated by reference, available upon request); Attachment 5, RFP 2567 Integrated Managed Care (incorporated by reference, available upon request); and Attachment 6, Contractors Response to RFP 2567 Integrated Managed Care (incorporated by reference, available upon request)

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

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

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Exhibits:

Exhibit A: Non-Medicaid Funding Allocation
Exhibit B: Non-Medicaid Quarterly Expenditure Report
Exhibit C: State Hospital Bed Allocation [removed, 1/1/20 Amendment]
Exhibit D: Essential Behavioral Health Providers [removed, 7/1/20 Amendment]
Exhibit E: Data Use, Security and Confidentiality [removed, 7/1/20 Amendment]
Exhibit F: Regional Service Areas [removed, 7/1/20 Amendment]

Attachments:

Attachment 1: RFP 15-008 – Apple Health – Fully Integrated Managed Care (incorporated by reference, available upon request)
Attachment 2: Contractor's Response to RFP 15-008 – Apple Health – Fully Integrated Managed Care (incorporated by reference, available upon request)
Attachment 3: RFP 1812 – Integrated Managed Care (incorporated by reference, available upon request)
Attachment 4: Contractor's Response to RFP 1812 Integrated Managed Care (incorporated by reference, available upon request)
Attachment 5: RFP 2567 – Integrated Managed Care (incorporated by reference, available upon request)
Attachment 6: Contractor's Response to RFP 2567 Integrated Managed Care (incorporated by reference, available upon request)

1. DEFINITIONS

In any subcontracts and in any other documents that relate to this Contract, the Contractor shall use the definitions as they appear in this Contract and as incorporated by reference from the Integrated Managed Care contract. If there is a conflict in the definitions between this Contract and the IMC contract, the definitions from this Contract shall prevail in matters related to this Contract.

1.1 Action

"Action" means the denial or limited authorization of a requested Contracted Service for reasons of medical necessity.

1.2 Adverse Authorization Determination

"Adverse authorization determination" means the denial or limited authorization of a requested Contracted Services for reasons of medical necessity (Action) or any other reason such as lack of Available Resources.

1.3 Alcohol/Drug Information School

"Alcohol/Drug Information School" means costs incurred for Alcohol/Drug information schools provide information regarding the use and abuse of alcohol/drugs in a structured educational setting. Alcohol/Drug Information Schools must meet the certification standards. (The service as described satisfies the level of intensity in ASAM Level 0.5).

1.4 Available Resources

"Available Resources" means funds appropriated for the purpose of providing community behavioral health programs. This includes, federal funds, except those provided according to Title XIX of the Social Security Act; and state funds appropriated under RCW 71.24 or RCW 71.05 by the legislature.

1.5 Childcare Services

"Childcare Services" means the provision of child care services, when needed, to children of parents in treatment in order to complete the parent's plan for Substance Use Disorder treatment services. Childcare services must be provided by licensed childcare providers.

1.6 Continuing Education and Training

"Continuing Education/Training" means costs incurred for activities to support educational programs, training projects, and/or other professional development programs directed toward: 1) improving the professional and clinical expertise of prevention and treatment facility staff; 2) the knowledge base of county employees who oversee the program agreement; and 3) to meet minimum standards and Contract requirements.

1.7 Contracted Services

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

1.8 Enrollee

"Enrollee" means an individual enrolled in Managed Care through a Managed Care Organization (MCO) having a contract with HCA (42 C.F.R. § 438.2. For purposes of this Contract, an Enrollee may receive General Funds-State (GFS) Contracted Services if he/she meets the eligibility requirements for such services.

1.9 Family Hardship Services

"Family Hardship Services" means the provision of transportation and lodging for family members traveling more than fifty (50) miles from home to a treatment facility to support a Youth receiving services in a facility to allow the family to participate in treatment.

1.10 General Fund State (GFS)

"General Fund State (GFS)" means the payment source for services provided by the Contractor under this Contract.

1.11 Intensive Residential Treatment (IRT) team

"Intensive Residential Treatment (IRT) team" means a team based mental health service delivery model. IRT is a pilot project model that packages existing Medicaid State plan services provided by treatment teams. These teams also provide some non-Medicaid treatment activities, which are funded through GFS. IRT teams work with Enrollees being discharged or diverted from state hospitals by referral from ALTSA to an ALTSA licensed adult family home or assisted living facility. Teams provide a wraparound service for both the Enrollee and the facility they are living in.

1.12 Interim Services

"Interim Services" means services to Enrollees who are currently waiting to enter a treatment program to reduce the adverse health effects of substance abuse, promote the health of the Enrollee, and reduce the risk of transmission of disease. Such services are provided until the Enrollee is admitted to a treatment program. Services include referral for prenatal care for a pregnant patient, brief screening activities, the development of a service plan, Enrollee or group contacts to assist the person either directly or by way of referral in meeting his/her basic needs, updates to advise him/her of treatment availability, and information to prepare him/her for treatment, medications to treat opioid use disorder, counseling, education, and referral regarding HIV and tuberculosis (TB) education, if necessary referral to treatment for HIV and TB.

1.13 Notice of Action

"Notice of Action" means a written notice that must be provided to Enrollees to inform them that GFS Contracted Services have not been authorized based on medical necessity criteria.

1.14 Opioid Dependency/HIV Services Outreach

"Opioid Dependency/HIV Services Outreach" means costs incurred to provide Outreach and referral services to special populations such as Opioid use disorder, injecting drug users (IDU), HIV or Hepatitis C-positive Enrollees. Opioid Dependency/HIV and Hepatitis C Outreach is specifically designed to encourage injecting drug users (IDUs) and other high-risk groups such as opioid use disorder and HIV or Hepatitis C-positive Enrollees to undergo treatment and to reduce transmission of HIV and Hepatitis C disease. Costs include providing information and skills training to non-injecting, drug using sex partners of IDUs and other high-risk groups such as street youths. Programs may employ street outreach activities, as well as more formal education and risk-reduction counseling. Referral services include referral to assessment, treatment, interim services, and other appropriate support services. Costs do not include ongoing therapeutic or rehabilitative services.

1.15 Outreach and Engagement

"Outreach and Engagement" means identification of hard-to-reach Enrollees with a possible SUD and engagement of these Enrollees in assessment and ongoing treatment services as necessary. This includes: providing critical information and referral regarding Behavioral Health services to people who might not otherwise have access to that information, providing information on SUD and the impact of SUD on families, providing information on treatment options or resources, re-engaging Enrollees in the treatment process. This does not include ongoing therapeutic or rehabilitative services.

1.16 Pregnant and Post-Partum Women and Parenting Persons (PPW)

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

1.17 Pregnant, Post-Partum or Parenting Women's (PPW) Housing Support Services

"PPW Housing Support Services" means the costs incurred to provide support services to PPW Enrollees with children under the age of six (6) in a transitional residential housing program designed exclusively for this population.

1.18 Program of Assertive Community Treatment (PACT)

"Program of Assertive Community Treatment (PACT)" means a team-based, evidence-based mental health service delivery model that incorporates the values of Recovery and Resiliency. PACT is a package of already existing Medicaid State plan services provided by treatment teams, employed by a licensed BHA acting within the scope of its License. These teams also provide some non-Medicaid treatment activities, which are funded through GFS. PACT is client-centered, recovery-oriented, mental health service delivery model that utilizes a team approach providing services to Enrollees with severe and persistent mental illnesses and co-occurring disorders.

1.19 Recovery Support Services

"Recovery Support Services" means a broad range of non-clinical services that assist Enrollees and families to initiate, stabilize, and maintain long-term Recovery from Substance Use Disorders. Recovery Support Services may include: peer delivered motivational interviewing; peer wellness coaching; peer-run respite services; person-center planning; self-care and wellness approaches; WRAP; supported employment; peer health navigators; supportive housing; promotors; Recovery community centers; whole health action management; wellness-based community campaign; mutual aid groups for Enrollees with co-occurring disorders; peer specialists; Recovery coaching; shared decision-making; telephone Recovery checkups; warm lines; peer-run crisis diversion services.

1.20 Room and Board

"Room and Board" means costs incurred for services in a twenty-four (24) hour-a-day setting, including the provision of accessible, clean and well-maintained sleeping quarters with sufficient space, light and comfortable furnishings for sleeping and personal activities along with nutritionally adequate meals provided three times a day at regular intervals. Room and Board must be provided consistent with the requirements for Residential Treatment Facility Licensing through the Department of Health WAC 246-337.

1.21 Sobering Services

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

1.22 State Hospitals

"State Hospitals" means a State Hospital operated and maintained by the state of Washington for handling the most complicated long-term care needs of patients with a primary diagnosis of mental disorder.

1.23 Therapeutic Interventions for Children

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

1.24 Washington Apple Health Integrated Managed Care (AH-IMC)

"Washington Apple Health Integrated Managed Care (AH-IMC)" means the program under which a Managed Care MCO provides GFS services and, under separate contract, Medicaid funded physical and Behavioral Health services.

2. GENERAL TERMS AND CONDITIONS

2.1 Incorporation by Reference

2.1.1 All of the terms and conditions of the Washington Apple Health Integrated Managed Care Contract between HCA and the Contractor (HCA Contract No. xxxx, with a start date of July 1, 2020 and an end date of December 31, 2020) ("IMC contract") shall apply with equal force and effect to this Contract, unless otherwise explicitly stated in this Contract. If there is a conflict between this Contract and the IMC contract, the provisions of this Contract shall prevail in matters related to this Contract.

3. MARKETING AND INFORMATION REQUIREMENTS

3.1 Information Requirements for Enrollees and Potential Enrollees

3.1.1 The Contractor shall submit branding materials developed by the Contractor that specifically mention GFS services for review and approval. No such materials shall be disseminated to Enrollees, providers or other members of the public without HCA's approval.

3.1.2 The Contractor shall submit Enrollee information developed by the Contractor that specifically mentions GFS services provided under this Contract at least thirty (30) calendar days prior to distribution for review and approval. All other Enrollee materials shall be submitted as informational. HCA may waive the thirty (30) day requirement if, in HCA's sole judgment, it is in the best interest of HCA and its clients to do so.

4. ENROLLMENT

4.1 Eligibility and Enrollment

4.1.1 To be eligible for GFS services under this Contract, an individual must: (i) be eligible for Medicaid and an Enrollee in the Contractor's plan; and (ii) meet the clinical or program eligibility criteria for the GFS service.

4.1.2 Meeting the eligibility requirements under this Contract does not guarantee the Enrollee will receive the GFS service.

4.1.3 HCA shall determine Medicaid eligibility for enrollment over the term of this Contract. Individuals eligible for Medicaid and enrolled with the Contractor will be presumed to meet financial eligibility requirements for GFS services.

4.1.4 At HCA's direction, the Contractor shall participate in a regional initiative to develop and implement consistent protocols to determine clinical or program eligibility for the limited-benefit GFS services.

4.1.5 At HCA's discretion, the Contractor shall participate in developing protocols for Enrollees with frequent Medicaid eligibility changes (including those Enrollees who are eligible through spend-down). The protocols will address, at a minimum, coordination with the BH-ASO, referrals, reconciliations and potential transfer of GFS funds to promote Continuity of Care for the Enrollees. Any reconciliations will occur at a frequency determined by HCA but no less than quarterly with potential for up to monthly reconciliations in the last quarter of the allocation year.

4.2 Termination of Enrollment

4.2.1 The Enrollee remains eligible for GFS services until HCA has notified the Contractor in writing that enrollment in the AH-IMC plan is terminated.

4.2.2 An Enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month remains eligible as a Medicaid Enrollee to receive Contracted Services through the end of that month as long as the Enrollee meets the clinical eligibility requirements for the GFS services.

5. PAYMENT AND SANCTIONS

5.1 Funding

5.1.1 The funds under this Contract are dependent upon HCA's receipt of continued state and federal funding awards. If HCA does not receive continued state and federal funding awards, HCA may terminate this Contract in accordance with the General Terms and Conditions in the IMC Contract.

5.1.2 HCA will provide the Contractor with their budget of GFS and proviso funds annually, identified in Exhibit A. The Contractor's budget is based upon available funding for the regional service area as a whole and the Contractor's share of the eligible enrollment in the region.

5.1.3 A maximum of 10 percent of the GFS and proviso funds expended by the Contractor may be used for administrative costs, taxes and other fees per RCW 71.24.330 and must be reported on the quarterly expenditure report, as identified in Exhibit B.

5.1.4 HCA will pay the Contractor GFS and proviso funds, including the administrative portion, in equal monthly amounts, or as identified in Exhibit A, based upon the budget identified in Exhibit A.

5.1.5 The Contractor shall maintain financial records that track the funding received and the expenditures for services provided under this Contract by category of service, funding source and state fiscal year.

5.1.6 The Contractor shall send a quarterly expenditure report to the HCAmcprograms@hca.wa.gov. The expenditure report format is identified in Exhibit B. The expenditure report is due to HCA no later than thirty (30) calendar days after the last day of the quarter. The expenditures reported shall represent the payments made for services under this Contract during the quarter being reported. The 10 percent administrative load, as identified in subsection 5.1.3 will be included on this expenditure report.

5.1.7 If the expenditures reported by the Contractor on the expenditure report, exceed the Contractor's budget identified in Exhibit A, HCA will not pay the Contractor for the amount that exceeds the budget.

5.1.8 HCA will perform a reconciliation of the Contractor's expenditure reports to their budget at least annually. Based upon the results of the reconciliation, at HCA's discretion, the allocation and distribution of GFS and proviso funds may be reevaluated and unspent funds may be reallocated retrospectively.

5.1.9 Funds paid under this Contract that are not expended by the end of the applicable fiscal year may be used or carried forward to the subsequent applicable 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 next fiscal year, the Contractor shall submit a plan to HCA for approval by September 15.

5.1.10 The Contractor shall ensure that all funds provided pursuant to this Contract,

including interest earned, are used to provide services as described in this Contract.

5.1.11 HCA shall not be obligated to provide funding to the Contractor for any services or activities performed prior to the effective date of this Contract.

5.1.12 The Contractor shall administer services provided under this Contract in a manner that best maintains Available Resources throughout the Contract period.

5.1.13 Upon completing the PMPM recoupment reconciliation for Enrollees who have stayed in an Institute for Mental Disease (IMD) for sixteen (16) calendar days or more, within a single calendar month, as outlined in the Apple Health Integrated Managed Care Medicaid contract, the Contractor shall invoice HCA for all physical health claims for Enrollees that have had a PMPM recouped by HCA. The Contract shall use the state of Washington A-19 invoice form and provide claim transaction control numbers (TCN) as back up for the invoiced amount. The TCNs must have an "Accepted" business status in HCAs ProviderOne Medicaid Management Information System. The Contractor will upload the invoice and a file with claim TCNs thirty (30) calendar days after completion of IMD PMPM recoupment reconciliation. If claims are processed by the Contractor after the initial amount is reported, but within the limitations described in the Billing Limitations section of the IMC contract, the Contractor shall submit the claims to HCA within thirty (30) calendar days of payment.

5.1.13.1 The Contractor shall report the total physical health claims paid on behalf of each IMD Enrollee to HCA within thirty (30) calendar days of notification from HCA of the Enrollee's IMD status. Within thirty (30) calendar days of notification, HCA will reimburse the Contractor for the physical health cost of claims paid on behalf of an IMD Enrollee during the calendar month for which the premium was recouped.

5.2 Encounter Data Reporting

5.2.1 The Contractor shall ensure that final reporting of encounters for services provided under this Contract shall occur no more than ninety (90) days after the end of each fiscal year of this Contract.

5.3 Non-Compliance

5.3.1 Failure to Maintain Reporting Requirements

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

5.3.2 Recovery of Costs Claimed in Error

5.3.2.1 If the Contractor claims and HCA reimburses for expenditures under this Contract which HCA later finds were (1) claimed in error or (2)

not allowable costs under the terms of the Contract, HCA shall recover those costs and the Contractor shall fully cooperate with the Recovery.

5.3.3 Stop Placement

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

5.3.4 Additional Remuneration Prohibited

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

5.4 Prospective and Retrospective Premium Adjustments

5.4.1 If, at HCA's sole discretion, HCA determines as a result of data errors or inadequacies, policy changes beyond the control of the Contractors, or other causes there are material errors or omissions in the allocation of GFS funds, HCA may make prospective and/or retrospective modifications to the allocations, as necessary. At the explicit written approval of HCA, the Contractor can elect to make a lump sum or similar arrangement for payment.

5.5 Remedial Actions

5.5.1 HCA may initiate remedial action if it is determined that any of the following situations exist:

5.5.1.1 A problem exists that negatively impacts Enrollees receiving services.

5.5.1.2 The Contractor has failed to perform any of the GFS services required in this Contract.

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

5.5.1.4 The Contractor has failed to perform any administrative function required under this Contract. For the purposes of this section,

"administrative function" is defined as any obligation other than the actual provision of Behavioral Health services.

5.5.1.5 The Contractor has failed to implement corrective action required by the state and within HCA prescribed timeframes.

5.5.2 HCA may impose any of the following remedial actions:

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

5.5.2.1.1 Corrective action plans must include:

5.5.2.1.1.1 A brief description of the situation requiring corrective action.

5.5.2.1.1.2 The specific actions to be taken to remedy the situation.

5.5.2.1.1.3 A timetable for completion of the actions.

5.5.2.1.1.4 Identification of individuals responsible for implementation of the plan.

5.5.2.1.2 Corrective action plans are subject to approval by HCA, which may:

5.5.2.1.2.1 Accept the plan as submitted.

5.5.2.1.2.2 Accept the plan with specified modifications.

5.5.2.1.2.3 Request a modified plan.

5.5.2.1.2.4 Reject the plan.

5.5.3 HCA will withhold up to 5 percent of the next payment and each payment thereafter until the corrective action has achieved resolution. The amount of withhold will be based on the severity of the situation as detailed in this section. HCA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

5.5.4 Increase withholdings identified above by up to an additional 3 percent for each successive month during which the remedial situation has not been resolved.

5.5.5 Deny any incentive payment to which the Contractor might otherwise have

been entitled under this Contract.

5.5.6 Terminate for Default as described in the General Terms and Conditions of the AH-IMC Contract.

6. ACCESS TO CARE AND PROVIDER NETWORK

6.1 Network Capacity

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

6.1.2 The Contractor shall incorporate the following requirements when developing its network:

6.1.2.1 The Contractor shall, in partnership with the BH-ASO, assist the state to expand community-based alternatives for crisis stabilization, such as mobile crisis or crisis residential and respite beds.

6.1.2.2 The Contractor shall assist the state to expand community-based, recovery-oriented services and research- and evidence-based practices.

6.1.2.3 The Contractor shall implement an adequate plan to provide Evaluation and Treatment services to Enrollees, which may include the development of less restrictive alternative to involuntary treatment or prevention programs reasonably calculated to reduce the demand for Evaluation and Treatment services.

6.1.2.4 Regional Behavioral Health entities must develop and implement plans for improving access to timely and appropriate treatment for Enrollees with Behavioral Health needs and current or prior criminal justice involvement.

6.1.3 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network of GFS Behavioral Health providers in any contracted service area for two (2) consecutive quarters, and after notification following the first quarter, HCA reserves the right to immediately terminate the Contractor's services for that service area. The network established under the Contract must complement and support the network of Medicaid providers established by the AH-IMC Medicaid Contract.

6.1.4 The Contractor shall update and maintain the Contractor's existing provider manual to include all relevant information regarding GFS services and requirements.

6.1.5 The Contractor shall have, maintain, and provide to HCA upon request an up-to-date database of its provider network. The Contractor shall update its existing database to meet the following requirements:

6.1.5.1 A network inventory, including licensure, to quantify the number of providers offering GFS services, including a list of all GFS providers.

6.1.5.2 Includes the providers' names, locations, telephone numbers, GFS services offered, clinical specialty and areas of expertise.

6.1.5.3 Includes a description of each provider's language(s) spoken and if appropriate, a brief description of the provider's skills or experiences that would support the cultural or linguistic needs of its Enrollees when provided by a provider.

6.1.5.4 Indicates whether each provider has capacity to serve new patients and the limits on capacity for each provider.

6.1.5.5 Updates to the provider database shall be made: no less than quarterly or whenever there is a change in the Contractor's network that would affect adequate capacity in a service area.

6.1.5.6 Contractor program staff shall be available to conduct provider searches based on office or facility location, clinical specialty, provider discipline, provider capacity, available languages and allowable fund sources (e.g., Medicaid, GFS).

6.2 Customer Service

6.2.1 The Contractor shall submit its customer service policies and procedures to HCA for review. Customer service policies and procedures shall address the following:

6.2.1.1 Information on the GFS services including where and how to access them;

6.2.2 The Contractor shall train customer service representatives on revised GFS-related policies and procedures.

7. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1 Quality Management Program

7.1.1 The Contractor shall ensure its Quality Management (QM) program addresses GFS requirements.

7.2 Quality Review Activities

7.2.1 The HCA, Office of the State Auditor, or any of their duly-authorized representatives, may conduct announced and unannounced:

7.2.1.1 Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Contract;

7.2.1.2 Audits regarding the quality, appropriateness, and timeliness of Behavioral Health services provided under this Contract; and

7.2.1.3 Audits and inspections of financial records, related to GFS services.

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

7.2.2.1 The submission of requested materials necessary for an HCA initiated review within thirty (30) days of the request.

7.2.2.2 The completion of site visit protocols provided by HCA.

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

7.2.3 The Contractor shall notify HCA when an entity other than the State Auditor performs any audit described above related to any activity contained in this Contract.

7.3 Performance-Based Goals and Other Reporting Requirements

7.3.1 At HCA's discretion, performance will be linked to payment.

7.3.2 HCA defined reporting and data submission methods for Performance Measurement and Reporting:

7.3.2.1 The Contractor shall comply with the reporting and data submissions requirements as directed by HCA and shall make reports available to HCA at least annually through the HCA monitoring process or more frequently, as requested by HCA. Should HCA adopt a subsequent set of requirements during the term of this Contract, HCA shall update the performance requirements as necessary.

7.3.3 All performance measures are subject to an audit.

7.4 Health Information Systems

7.4.1 The Contractor shall establish and maintain web-based portals with appropriate security features that allow referrals, requests for prior authorizations, and encounter submission, for GFS services. The Contractor may use its Medicaid website as long as the website includes information on GFS services. The Contractor shall include information on how to access GFS services, including crisis contact information and toll-free crisis telephone numbers.

8. SUBCONTRACTS

8.1 Required Provisions

8.1.1 The Contractor shall provide the following information regarding the Grievance system for GFS funded services to all Subcontractors:

8.1.1.1 The Enrollees do not have a right to continuation of benefits during an Appeal Process or the Administrative Hearing process.

8.2 Management of Subcontracts

8.2.1 The Contractor must monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the HCA, consistent with industry standards or state law and regulation.

8.2.1.1 This review may be combined with a formal review of services performed pursuant to the Contractor's Medicaid Contract between the Contractor and HCA.

8.2.1.2 The review must be based on the specific delegation agreement with each Subcontractor, and must address compliance with Contract requirements for each delegated function, which may include but is not limited to:

8.2.1.2.1 Documentation and appropriateness of medical necessity determinations.

8.2.1.2.2 Enrollee record reviews to ensure services are appropriate based on diagnosis, the treatment plan is based on the Enrollee's needs and progress notes support the use of each service.

8.2.1.2.3 Enrollee record reviews to ensure the treatment plans are consistent with WAC 246-341-0620 and 246-341-0640.

8.2.1.2.4 Timeliness of service.

8.2.1.2.5 Network adequacy.

8.2.1.2.6 Cultural, ethnic, linguistic, disability or age related needs are addressed.

8.2.1.2.7 Coordination with primary care.

8.2.1.2.8 Provider adherence to practice guidelines, as relevant.

8.2.1.2.9 Provider compliance with reporting and managing critical incidents.

8.2.1.2.10 Information security.

8.2.1.2.11 Disaster recovery plans.

8.2.1.2.12 Fiscal management, including documenting the provider's cost allocations, revenues, expenditures and reserves in order to ensure that funds under this Contract are being spent appropriately.

8.2.1.2.13 Licensing and certification reviews, including oversight of any issues noted during licensing and/or certification reviews conducted by the Department of Health and communicated to the Contractor.

8.2.2 Unless a county is a licensed service provider and the Contractor is contracting with the county for direct services, the Contractor shall not provide GFS funds to a county without a contract or single-case agreement.

8.3 Health Care Provider Subcontracts

The Contractor's Subcontracts shall also contain the following provisions:

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

8.3.2 For providers in twenty-four (24) hour settings, a requirement to provide discharge planning services which shall, at a minimum:

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

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

8.3.2.3 Establish referral relationships with assessment entities, outpatient providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of entities making referrals in treatment activities;

8.3.2.4 Coordinate, as needed, with HCA/DBHR prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, such as DCYF services for children and families, including, DCYF-contracted home visiting, Early Support for Infants and Toddlers (ESIT), Early Childhood Intervention and Prevention Services (ECLIPSE), Early Childhood Education and Assistance Program (ECEAP) and Head Start programs using the informational letter template jointly developed by the DCYF and HCA; and

8.3.2.5 Coordinate services to financially-eligible Enrollees who are in need of medical services.

8.3.3 A requirement that termination of a subcontract shall not be grounds for a fair hearing or a Grievance for the Enrollee if similar services are immediately available in the service area.

8.3.4 How Enrollees will be informed of their right to a Grievance in the case of:

8.3.4.1 Denial or termination of service related to medical necessity determinations.

8.3.4.2 Denial or termination of service related to Available Resources.

8.3.4.3 Failure to act upon a request for services with reasonable promptness.

8.3.5 A requirement to provide Enrollees access to translated information and interpreter services as described in the Marketing and Information Requirements section of the IMC contract.

8.3.6 Adherence to established protocols for determining eligibility for services consistent with the Enrollment section of the IMC contract.

8.3.7 A requirement to use HCA/DBHR approved Integrated Co-Occurring Disorder Screening and Assessment Tool(s); this shall include requirements for training staff that will be using the tool(s) to address the screening and assessment process, the tool and quadrant placement as well as requirements for corrective action if the process is not implemented and maintained throughout the Contract's period of performance.

8.3.8 A requirement to conduct criminal background checks and maintain related policies and procedures and personnel files consistent with requirements in Chapter 43.43 RCW and Chapter 388-06 WAC.

8.3.9 Requirements for nondiscrimination in employment and Enrollee services.

8.3.10 Protocols for screening for debarment and suspension of certification.

8.3.11 Requirements to identify funding sources consistent with the Payment and Sanctions Section and Federal Block Grant reporting requirements.

8.3.12 A requirement that the Subcontractor shall respond with all available records in a timely manner to law enforcement inquiries regarding an Enrollee's eligibility to possess a firearm under RCW 9.41.040(2)(C)(iv).

8.3.12.1 The Contractor shall conduct a Subcontractor review which shall include at least one onsite visit every two (2) years to each Subcontractor site providing state funded treatment services during the period of performance of this Contract in order to monitor and document compliance with requirements of the subcontract.

8.3.12.2 The Contractor shall ensure that Subcontractors have complied with data submission requirements established by HCA for all services funded under the Contract.

8.3.12.3 The Contractor shall ensure that the Subcontractor updates Enrollee funding information when the funding source changes.

8.3.12.4 The Contractor shall maintain written or electronic records of all Subcontractor monitoring activities and make them available to HCA upon request.

8.3.13 A statement that Subcontractors shall comply with required audits, including authority to conduct a facility inspection and Office of Management and Budget (OMB) Circular and 2 C.F.R. Part 200, Subpart F – Audit Requirements audits, as applicable to the Subcontractor.

8.3.13.1 The Contractor shall submit a copy of the 2 C.F.R. Part 200, Subpart F – Audit Requirements audit performed by the State Auditor to the HCA Contact identified on page one (1) of the Contract within ninety (90) days of receipt by the Contractor of the completed audit.

8.3.13.1.1 If a Subcontractor is subject to OMB Circular and 2 C.F.R. Part 200, Subpart F – Audit Requirements, the Contractor shall require a copy of the completed Single Audit and ensure corrective action is taken for any audit finding, per 2 C.F.R. Part 200, Subpart F – Audit Requirements.

8.3.13.1.2 If a Subcontractor is not subject to OMB Circular 2 C.F.R. Part 200, Subpart F – Audit Requirements, the Contractor shall perform subrecipient monitoring in compliance with federal requirements.

8.4 Provider Education

8.4.1 The Contractor shall develop and deliver ongoing training, technical assistance and support tools for GFS providers regarding GFS protocols and requirements. The training materials and documents shall be pre-approved by HCA. The training program shall meet the following minimum requirements:

8.4.1.1 Training shall be accessible to GFS providers at alternate times and days of the week. A schedule of training shall be available on the Contractor's website and updated as needed but at least annually. The Contractor shall make reasonable efforts to ensure that:

8.4.1.1.1 Training is developed in collaboration with peer MCOs.

8.4.1.1.2 Training is made available to treatment staff.

8.4.1.1.3 Subcontractors provide opportunities for staff to attend trainings.

8.4.1.2 Training for GFS providers address the following requirements:

8.4.1.2.1 Screening and assessment tools and protocols, including the GAINS-SS.

8.4.1.2.2 Referral protocols.

8.4.1.2.3 Claims and encounter submission.

8.4.1.2.4 Other data submission and reporting required under the Contract.

8.4.1.2.5 Evidence-Based Practices, as relevant to the service(s) provided.

8.4.1.2.6 Transition protocols for Enrollees moving between funding sources or with frequent Medicaid eligibility status changes.

8.4.1.2.7 Training includes the application of Evidence-Based, research-based, Promising Practices related to the assessment and treatment of Behavioral Health conditions.

8.4.1.2.8 Recovery and Resilience principles are incorporated in service provision as well as policies and procedures.

8.4.1.3 Enrollees, family members and other caregivers are involved in the planning, development and delivery of trainings specific to delivery of GFS services.

8.4.1.4 Cultural competency is incorporated into provider training specific to delivery of GFS services.

8.5 Provider Payment Standards

8.5.1 The Contractor must support both hardcopy and electronic submission of claims, encounters and bills for all GFS services types.

8.5.2 The Contractor shall update its claims and encounter system to support processing of payments for the GFS services.

8.5.2.1 The Contractor shall ensure prompt payment to the BH providers, including developing a contingency plan that will ensure payment for services delivered to Enrollees in the event that a mental health or substance use disorder provider cannot submit HIPAA-compliant encounters or electronic claims.

8.5.2.2 The Contractor shall produce reports for contracted BH providers that assist them with claims management, such as monthly reports with numbers of accepted claims or encounters vs. those that are not accepted on initial submission, and error rates by types of errors.

9. ENROLLEE RIGHTS AND PROTECTIONS

9.1 Enrollee Choice of Behavioral Health Provider

9.1.1 An Enrollee may maintain existing Behavioral Health provider relationships when funding is available and when the GFS services are medically necessary for GFS services. However, Enrollees are not guaranteed choice of Behavioral Health providers for GFS services.

10. UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

10.1 Utilization Management Requirements

10.1.1 The Contractor's BH Medical Director will provide guidance, leadership and oversight of the Contractor's UM program for Contracted Services. The following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the BH Medical Director to oversee:

10.1.1.1 Processes for evaluation and referral to Contracted Services.

10.1.1.2 Review of consistent application of criteria for provision of services within Available Resources and related Grievances.

10.1.1.3 Review of assessment and treatment services against clinical practice standards. Clinical practice standards include, but are not limited to evidenced-based practice guidelines, culturally appropriate services, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals. This review must include a review of the coordination with Indian Health Service, Indian Tribal Organizations, and Indian Health Care Providers (IHCP) and other Enrollee serving agencies.

10.1.1.4 Monitoring for over-utilization and under-utilization of services and ensuring that resource management and UM activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue Medically Necessary mental health services inconsistent with the Contractors policy and procedures for determining eligibility for services within Available Resource.

10.1.2 The Contractor shall develop and implement UM protocols for all services and supports funded solely or in part through GFS funds. The UM protocols shall comply with the following provisions:

10.1.2.1 The Contractor must have policies and procedures that establish a standardized methodology for determining when GFS resources are available for the provision of Behavioral Health services. The methodology shall include the following components:

10.1.2.1.1 A plan to address under- or over-utilization patterns with any provider to avoid unspent funds or gaps in service at the end of a contract period due to limits in Available Resources;

10.1.2.1.2 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;

10.1.2.1.3 Corrective action with providers, as necessary, to address issues with compliance with state and federal regulations or ongoing issues with patterns of service utilization; and

10.1.2.1.4 A process to make payment denials and adjustments when patterns of utilization deviate from state, federal or contract requirements (e.g., single source funding).

10.1.2.2 The Contractor shall monitor provider discharge planning to ensure GFS providers meet contractual requirements for discharge planning defined in this Contract.

10.1.3 The Contractor's Care Management system must include a periodic review of Enrollees that have an Individual Service Plan to ensure the requirements are being met. The Contractor must establish criteria for, document and monitor:

10.1.3.1 Consistent application of Medical Necessity criteria; and

10.1.3.2 Over- and under-utilization of services.

10.2 Notification of Coverage and Authorization Determinations

10.2.1 For all authorization determinations, the Contractor must notify the ordering provider, requesting facility, and the Enrollee in writing.

10.2.1.1 The Contractor must follow all timeframes outlined in the Timeframes for Authorization Decisions and Notification of Coverage and Authorization Determinations sections of the IMC contract.

10.2.1.1.1 The notice shall explain the following:

10.2.1.1.1.1 The decision the Contractor has taken or intends to take.

10.2.1.1.1.2 The reasons for the decision, in easily understood language including citation to any Contractor guidelines, protocols, or other criteria that were used to make the decision, and how to access the guidelines, protocols or other criteria.

10.2.1.1.1.3 A statement of whether the Enrollee has any liability for payment.

10.2.1.1.1.4 Information regarding whether and how the Enrollee may Appeal the decision.

10.2.1.1.1.5 The Enrollee's right to receive the Contractor's assistance in filing an Appeal and how to request it, including access to

services for Enrollees with communication barriers or disabilities.

11. GRIEVANCE AND APPEAL SYSTEM

11.1 Available Resources Exhausted

When GFS funding for a requested Contracted Service is exhausted, any Appeals process, independent review, or agency Administrative Hearing process will be terminated, since Contracted Services cannot be authorized without funding regardless of medical necessity.

12. CARE COORDINATION

The Contractor shall develop policies that promote quality and efficient healthcare for the Enrollee. The Contractor's Care Coordination policies shall include integration of GFS funded services into the AH-IMC program. Considerations shall include use of GFS funds to care for Enrollees in alternative settings such as homeless shelters, permanent supported housing, nursing homes or group homes.

The Care Coordinator shall provide or oversee interventions that address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices.

12.1 **Care Coordination and Continuity of Care: State Hospitals and Community Hospital and Evaluation and Treatment 90/180 Civil Commitment Facilities**

12.1.1 Utilization of State Hospital Beds

12.1.1.1 The Contractor will be assigned Enrollees for discharge planning purposes in accordance with agency assignment process within each RSA in which the Contractor operates. Assignment process considers Enrollee choice, Enrollee history with an MCO, and direct agency assignment proportionally for the overall enrolled population.

12.1.1.1.1 If the Contractor disagrees with the Enrollee assignment, it must request a reassignment within thirty (30) days of admission. If a request to change the assignment is made within thirty (30) days of admission and the request is granted, the reassignment will be retroactive to the date of admission.

12.1.1.1.2 If the Contractor's request is received by HCA after the thirtieth (30) day of admission and is granted, the effective date of the reassignment will be based on the date HCA receives the reassignment request form.

12.1.1.1.3 The Contractor will be responsible for coordinating discharge for the Enrollees assigned and, until discharged.

12.1.1.1.4 The Contractor may not enter into any agreement or make other arrangements for use of State Hospital beds outside of this Contract.

12.1.1.1.5 The Contractor will be notified of changes to the allocation targets on an annual basis. If allocation targets are updated during an annual period, the allocation shall require an amendment to this Contract.

12.1.2 Admission and Discharge Planning for State Hospital and Community 90/180 Civil Commitment Facilities.

12.1.2.1 The Contractor shall meet the requirements of the State Hospital

MOU or working Agreement.

12.1.2.2 The Contractor shall ensure Enrollees are medically cleared, if possible, prior to admission to a State Psychiatric Hospital or 90/180 Community Civil Commitment facility.

12.1.2.3 The Contractor shall use best efforts to divert admissions and expedite discharges by utilizing alternative community resources and mental health services.

12.1.2.4 The Contractor shall work with the discharge team to identify potential placement options and resolve barriers to placement, to assure that Enrollees will be discharged back to the community after the physician/treatment team determines the individual is ready for discharge.

12.1.2.5 The Contractor or its subcontractor shall monitor Enrollees discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 to ensure compliance with LRA requirements.

12.1.2.6 The Contractor shall provide behavioral health services to assure compliance with LRA requirements.

12.1.2.7 The Contractor shall respond to requests for participation, implementation, and monitoring of Enrollees receiving services on Conditional Release consistent with RCW 71.05.340. The Contractor or Subcontractor shall provide behavioral health services to assist with compliance with Conditional Release requirements.

12.1.2.8 The Contractor shall ensure provision of behavioral health services to Enrollees on a Conditional Release under RCW 10.77.150 and RCW 71.05.340.

12.1.2.9 Enrollees on a Conditional Release in transitional status either in Pierce or Spokane County will transfer back to the MCO they were enrolled in prior to entering the State Hospital, upon completion of transitional care.

12.1.2.10 The Contractor shall coordinate with the DSHS, Aging and Long Term Support Administration (ALTSA)-Home and Community Services (HCS) regional office or its designee to support the placement of persons discharged or diverted from state hospitals or Community 90/180 Community Civil Commitment facilities into HCS placements. In order to accomplish this, the Contractor shall:

12.1.2.10.1 Ensure that a request for a Comprehensive Assessment Report and Evaluation (CARE) is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all persons who might be eligible for long-term care services. HCS will

prioritize requests for CARE assessments for Enrollees who have been detained to an E&T or in another setting.

12.1.2.10.2 If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to determine individualized Enrollee-centered service needs and attempt a community placement prior to referral to the state hospital whenever it supports individualized Enrollee need.

12.1.2.10.3 Ensure that a request for a Comprehensive Assessment Report and Evaluation (CARE) is made as soon as possible after it is determined that a Enrollee is ready for discharge from the State Hospital in order to initiate placement activities for persons who might be eligible for long-term care services.

12.1.2.10.4 When Enrollees being discharged or diverted from state hospitals or Community 90/180 Civil Detention facilities are placed in a long-term care setting, the Contractor shall:

12.1.2.10.4.1 Coordinate with HCS and any residential provider to develop a crisis plan to support the placement.

12.1.2.11 Uniform Discharge Tool and Aggregate Reporting

12.1.2.11.1 The Contractor shall complete the Uniform Discharge Tool for every Enrollee discharging from Western or Eastern State Hospital to ensure all components of a successful discharge are utilized. The tool was developed collaboratively with the contracted MCOs and provided to the MCOs by HCA.

12.1.2.11.1.1 HCA may request a copy of the Uniform Discharge Tool for an Enrollee, and the Contractor must provide the completed tool within one (1) business day of the request.

12.1.2.11.2 On a semi-annual basis, the Contractor must compile and submit a summary of aggregate scores derived from the Uniform Discharge Tool using the Uniform Aggregate Scoring Tool template provided by HCA. The report is due on July 15 for the reporting period of January 1 through June 30 and January 15 for the reporting period of July 1 through December 31. The report should be sent through the HCA MC Programs Mailbox, hcamcprograms@hca.wa.gov.

12.2 Behavioral Health Personal Care (BHPC) and Related Services Funding

Behavioral Health Personal Care is the sharing of funding between the behavioral health system (contractor) and Home and Community Services (HCS) for personal care and related services provided to Enrollees whose need for personal care is primarily related to a psychiatric diagnosis and the Enrollee meets established criteria.

12.2.1 The Contractor shall approve Behavioral Health Personal Care funding using the following criteria:

12.2.1.1 The psychiatric diagnosis is the primary need for personal care and at least one of the following apply:

12.2.1.1.1 The Enrollee has a primary diagnosis of a serious mental illness (schizophrenia, bi-polar disorder, major depressive disorder).

12.2.1.1.2 Behaviors/symptoms of a mental illness that cause impairment and functional limitations in self-care/self-management activities.

12.2.1.2 Excluded primary diagnoses are: intellectual disabilities, Alzheimer's/dementia, traumatic brain injury or, a primary diagnosis of Substance Use Disorder. Considerations will be made for these diagnoses when a co-occurring serious mental illness diagnosis is present.

12.2.1.3 The Enrollee is currently receiving mental health services or, there is a plan to engage Enrollee in needed mental health services or, Enrollee's needs are met by Residential Services Waiver (RSW) services through HCS (e.g. ECS, SBS, ESF, other).

12.2.2 The Contractor shall abide by the following funding request process:

12.2.2.1 HCS or its designee will use the CARE tool to determine personal care needs.

12.2.2.2 HCS will send a funding request to the Contractor at the initial assessment and annually thereafter, if the Enrollee appears to meet criteria, for either new or ongoing personal care services. HCS will provide the following:

12.2.2.2.1 Funding Request Form (13-712); and

12.2.2.2.2 A copy of the CARE assessment including a Service Summary.

12.2.3 To support completion of an accurate assessment, the Contractor shall provide the following information when it is missing from the request:

12.2.3.1 Information to connect HCS or its designee with the Enrollee's outpatient behavioral health providers.

12.2.3.2 Historical information relating to emergency department visits, inpatient stays, medications, and/or medical and behavioral health providers.

12.2.4 Personal care and related services authorized by HCS must not duplicate services the Contractor is required to provide.

12.2.5 The Contractor shall provide HCS Headquarters with updates to internal contacts for funding requests, care coordination escalation and billing within five (5) business days of a change or when requested.

12.2.6 BHPC Funding decisions must be based on the following:

12.2.6.1 A review of the request to determine if the Enrollee is currently residing in and eligible to receive Behavioral Health services in the Contractor's Service Area.

12.2.6.2 Verification that the need for personal care and related services is related to a psychiatric disability. Services shall not be denied should the CARE assessment include other diagnosis unrelated to the need for personal care.

12.2.6.3 The Contractor may request additional information from HCS or its designee if questions arise regarding services, providers or if there are questions about the assessment.

12.2.6.3.1 If changes are made to the assessment or funding request, HCS or its designee will provide a corrected 13-712 for signature.

12.2.6.4 A review of the requested services to determine if the Enrollee's personal care and related services or other needs could be met through provision of other available Behavioral Health services.

12.2.6.5 Additional information, as necessary in making a decision about whether the above criteria are met, including contractor care management information systems, PRISM, conversation with the HCS/AAA worker, conversation with the Enrollee's Mental Health Provider and others involved providers.

12.2.7 For funding requests that exceed the CARE generated rate:

12.2.7.1 The Contractor agrees to fund BHPC in line with the Contractor guideline created and agreed to by all Contractors for funding level alignment.

12.2.8 The Contractor must adhere to the following funding timeframe requirements:

12.2.8.1 Funding timelines should align with the CARE plan period.

12.2.8.2 The start date can be adjusted to the date received by MCO at the MCO's discretion if the requested state date is more than thirty (30)

days before date of request.

12.2.8.3 If the requested start date is less than thirty (30) days before the date of the request, the MCO will back date to the requested start date.

12.2.8.4 Without the exceptions listed above, the time period of authorization cannot be shortened by the MCO after the agreement to fund the services has been provided.

12.2.8.5 The Contract may not have policies that inhibit Enrollees from obtaining medically necessary personal care or related services. Funding for personal care and related services is needed on an ongoing basis. Authorization shall not be required any more frequently than for the care plan period, unless there is a significant change in condition that changes the level of need for personal care or related services.

12.2.9 The Contractor must respond within the following timeframes for funding requests:

12.2.9.1 The Contractor or its designee must acknowledge the receipt of a funding request from HCS or its designee with two (2) business days.

12.2.9.2 If the request is marked urgent the acknowledgement will be within one (1) business day.

12.2.9.3 The Contractor or its designee must make a decision on complete requests from HCS within five (5) business days of receipt of a complete request.

12.2.9.4 The Contractor and the local HCS office or its designee may mutually agree in writing to extend the five (5) business day requirement.

12.2.9.5 If the Contractor does not approve the funding, the Contractor shall provide clear rationale for why the request did not meet the criteria, and/or what services will be provided to the Enrollee.

12.2.10 When the Contractor denies authorization based on the provision of other services, a plan (e.g., Individual Service Plan) must be developed by the Contractor and implemented to meet the service needs identified in the CARE assessment.

12.2.11 If a dispute arises amongst parties regarding a funding request or relating to services, the following process will be followed:

12.2.11.1 All parties agree to participate in discussions when circumstances arise regarding disagreements pertaining to eligibility, effectiveness and appropriateness of BHPC and related services. This may include: changes in psychiatric symptoms, environment and related

risk factors.

12.2.11.2 Disagreements regarding the need for BHPC and assignment of financial responsibility shall be worked out between the escalation contacts identified in the contact list for HCS/AAA or their designees and the Contractor.

12.2.11.3 The Contractor agrees to participate in discussions and case staffing, as needed, to resolve differences.

12.2.12 When an Enrollee is approved for BHPC funding for the plan period (typically one year) by the Contractor, but transitions to another Contractor during the same plan period, the receiving Contractor will honor the funding approval of the previous Contractor for a period no less than 180 days and up to the rest of the plan period to ensure continuity of care.

12.2.13 The Contractor shall provide ALTSA fiscal staff on the last day of each month, a spreadsheet of all Enrollees authorized for BHPC by emailing to MCOBHOforms@dshs.wa.gov.

12.2.14 The Contractor will adhere to the following billing and payment process:

12.2.14.1 HCS or its designee will authorize services in ProviderOne, upon receipt of the Contractor's approval of DSHS Personal Care Transmittal form (13-712).

12.2.14.2 ALTSA financial will bill the Contractor for monthly GFS cost of services billed each month by the 25th of the following month.

12.2.14.3 The Contractor shall review the invoice provided by ALTSA for accuracy. If the Contractor does not agree with any billed costs, it must provide a written dispute to ALTSA within fifteen (15) days of each monthly billing.

12.2.14.3.1 ALTSA will respond to the Contractor's dispute within fifteen (15) calendar days.

12.2.14.4 The Contractor shall provide a copy of the final ALTSA invoice to HCA, with a copy to ALTSA at MCOBHObilling@dshs.wa.gov, within fifteen (15) calendar days of agreement between ALTSA and the Contractor on the billed cost.

12.2.14.5 HCA will deduct the amount on the invoice from the Contractor's next monthly GFS payment.

12.2.15 The Contractor must provide the following documentation to DSHS, HCS or its designee on request:

12.2.15.1 the original funding request from HCS or its designee;

12.2.15.2 any information provided by HCS or its designee including the CARE assessment;

12.2.15.3 a copy of the Contractor's determination and written response provided to HCS or its designee; and

12.2.15.4 a copy of the plan developed and implemented to meet the Enrollee's needs through provision of other services when a BHPC funding request has been denied based on the Contractor's determination.

13. BENEFITS

13.1 Scope of Services

13.1.1 This Contract does not in any manner delegate coverage decisions to the Contractor. The Contractor makes the decision whether or not a contracted non-Medicaid service is medically necessary. Medical necessity decisions are to be made based on an individual Enrollee's healthcare needs by a Health Care Professional with expertise appropriate to the Enrollee's condition. The Contractor is allowed to have guidelines, developed and overseen by appropriate Health Care Professionals, for approving services. All retrospective denials of Contracted Services are to be individual medical necessity decisions made by a Health Care Professional.

13.1.2 Except as specifically provided in the provisions of the Authorization of Services Section of the IMC Contract, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary Contracted Services to Enrollees nor unduly burden providers or Enrollees. For specific Contracted Services, the requirements of this Section shall also not be construed as requiring the Contractor to provide the specific items provided by the Health Care Authority under its fee-for-service program, but shall rather be construed to require the Contractor, at a minimum, to provide the same scope of services.

13.2 General Description of Contracted Services

13.2.1 The Contractor shall ensure services are paid through Medicaid when the service is a covered Medicaid service. GFS funding shall be used for Medicaid Enrollees only when the service is not covered by Medicaid. GFS funds shall be used to cover the following services within Available Resources. The Contractor must utilize GFS funds in accordance with funding allowances provided in Exhibit A.

13.2.2 The Contractor shall establish criteria, and policies and procedures to determine the provision or denial of the following services:

13.2.2.1 Room and board: With funds provided under this Agreement the Contractor is expected to prioritize payment for expenditures associated with providing medically necessary residential services to Medicaid Enrollees that are not included in the Medicaid State Plan or 1915(b) Waiver, this includes, but is not limited to, Room and Board in hospital diversion settings, SUD and mental health residential settings or freestanding Evaluation and Treatment facilities.

13.2.2.2 Urinalysis Testing.

13.2.2.3 Therapeutic Interventions for Children

13.2.2.4 High Intensity Treatment, including non-Medicaid PACT or IRT

services and supports.

13.2.2.5 Sobering Services.

13.2.2.6 Rehabilitation Case Management.

13.2.3 Within available resources, the Contractor may also provide other appropriate services to Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver, such as, but not limited to the following. The Contractor shall establish policies and procedures to determine the provision or denial of these and other services provided.

13.2.3.1 Interim Services

13.2.3.2 Opioid Dependency/HIV Services Outreach

13.2.3.3 Childcare Services.

13.2.3.4 Expanded Community Services.

13.2.3.5 Recovery support services.

13.2.3.6 Outreach and Engagement.

13.2.3.7 Assistance with transportation that would not otherwise be covered by Medicaid.

13.2.3.8 Family Hardship services.

13.2.3.9 Continuing Education and Training.

13.2.3.10 Assistance with application for entitlement programs.

13.2.3.11 Alcohol/Drug Information School.

13.2.3.12 PPW Housing Support Services.

13.2.3.13 Supported Employment.

13.2.3.14 Jail Transition Services.

Exhibit A: Non-Medicaid Funding Allocation
[Name of MCO goes here]

This Exhibit addresses Non-Medicaid funds for services in IMC regions for the provision of behavioral health services for July 1, 2020, through December 31, 2020, of state fiscal year (SFY) 2020.

Tables 1 depicts July 1, 2020 to December 31, 2020 allocations.

Table 1: [Name of MCO] July-December 2020 Monthly and Total Funding

Region	Monthly				Total (six months)
	Non-Medicaid State	PACT	AOT	Total	
Greater Columbia	**$**	**$**	**$**	**$**	**$**
King	**$**	**$**	**$**	**$**	**$**
North Central	**$**	**$**	**$**	**$**	**$**
Pierce	**$**	**$**	**$**	**$**	**$**
Southwest Washington	**$**	**$**	**$**	**$**	**$**
Spokane	**$**	**$**	**$**	**$**	**$**
Total	**$**	**$**	**$**	**$**	**$**

Proviso Explanations

All proviso dollars are GF-S funds. Outlined below are explanations of the provisos applicable to all regions that receive the specific proviso:

- WA-Program for Assertive Community Treatment (WA-PACT): Funds received per the budget proviso for development and initial operation of high-intensity programs for active community treatment WA- PACT teams.

- 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.

- **Intensive Residential Treatment teams (IRT)**: Funds received per the budget proviso for development and initial operation of high-intensity programs for IRT teams.

Exhibit B
Non-Medicaid Quarterly Expenditure Report

Attached as a separate document and incorporated by reference.

Exhibit C

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Exhibit D

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Exhibit E

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Exhibit F

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