Attachment 1 – Draft Sample BH-ASO Contract

Washington State Health Care Authority	**WASHINGTON BEHAVIORAL HEALTH – ADMINISTRATIVE SERVICES ORGANIZATION CONTRACT**	HCA Contract Number: Awarded from -

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

CONTRACTOR NAME .		CONTRACTOR doing business as (DBA)
CONTRACTOR ADDRESS		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS

HCA CONTACT NAME AND TITLE	HCA CONTACT ADDRESS	
HCA CONTACT TELEPHONE	HCA CONTACT FAX N/A	HCA CONTACT E-MAIL ADDRESS
IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF THIS CONTRACT? No	CFDA NUMBER(S) N/A	
CONTRACT START DATE	CONTRACT END DATE	MAXIMUM CONTRACT AMOUNT

EXHIBITS. The following Exhibits are attached and are incorporated into this Contract by reference:
☒ Exhibits:
☒ Attachment.

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

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

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1 DEFINITIONS

1.1 Accountable Community of Health (ACH)

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

1.2 Action

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

1.3 Administrative Hearing

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

1.4 Advance Directive

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to the provision of health care when an individual is incapacitated (WAC 182-501-0125, 42 C.F.R. § 438.6, 438.10, 422.128, and 489.100).

1.5 Alcohol/Drug Information School

"Alcohol/Drug Information School" means a program that provides information regarding the use and abuse of alcohol/drugs in a structured educational setting. Alcohol/Drug Information Schools must meet the certification standards in WAC 388-877B (The service as described satisfies the level of intensity in ASAM Level 0.5).

1.6 Allegation of Fraud

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

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

1.6.1 Fraud hotline complaints;

1.6.2 Claims data mining; and

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

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1.7 **American Society of Addiction Medicine Level of Care Guidelines (ASAM)**

"American Society of Addiction Medicine Level of Care Guidelines (ASAM" means a professional society dedicated to increasing access and improving the quality of Substance Use Disorder (SUD) treatment. ASAM Guidelines are a set of criteria promulgated by ASAM used for determining SUD treatment placement, continued stay and transfer/discharge of Consumers with SUD and co-occurring disorders.

1.8 **Appeal**

"Appeal" means a request for review of an action.

1.9 **Appeal Process**

"Appeal Process" means the Contractor's procedures for reviewing an action.

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

"Assessment (SUD)" means the activities conducted to evaluate an individual to determine if the individual has a Substance Use Disorder and determine placement in accordance with the ASAM patient placement criteria.

1.11 **Available Resources**

"Available Resources" means funds appropriated for the purpose of providing community MH and SUD programs; federal funds, except those provided according to Title XIX of the Social Security Act; and state funds appropriated by the Legislature during any biennium for the purpose of providing residential services resource management services, community support services, and other MH/SUD services.

1.12 **Behavioral Health**

"Behavioral Health" means mental health and/or SUD conditions and related benefits.

1.13 **Behavioral Health Organization (BHO)**

"Behavioral Health Organization (BHO)" means a county authority or a group of county authorities or other entity recognized by the Secretary of DSHS in contract in a defined Regional Service Area (RSA).

1.14 **Brief Intervention for SUD**

"Brief Intervention for SUD" means a time limited, structured behavioral intervention using SUD brief intervention techniques, such as evidence-based motivational interviewing, and referral to treatment services when indicated. Services may be provided at, but not limited to, sites exterior to treatment facilities such as hospitals, medical clinics, schools or other non-traditional settings.

1.15 **Brief Outpatient Treatment for SUD**

"Brief Outpatient Treatment for SUD" means a program of care and treatment that provides a systematic, focused process that relies on assessment, client engagement, and rapid

implementation of change strategies (The services as described satisfy the level of intensity in ASAM Level 1).

1.16 **Business Associate Agreement**

"Business Associate Agreement" means an agreement under the U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996 between a HIPAA covered entity and HIPAA business associate. The agreement protects Personal Health Information (PHI) in accordance with HIPAA guidelines.

1.17 **Business Hours**

"Business Hours" means 8:00 am to 6:00 pm Pacific Time, Monday through Friday.

1.18 **Care Coordination**

"Care Coordination" means an approach to healthcare in which all of a Consumer's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the Consumer and the Consumer's caregivers, and works with the Consumer to make sure that the Consumer gets the most appropriate treatment, while ensuring that care is not duplicated.

1.19 **Case Management Services (SUD)**

"Case Management Services" means services provided by a Chemical Dependency Professional (CDP), CDP Trainee, or person under the clinical supervision of a CDP who will assist Consumers in gaining access to needed medical, social, education, and other services. This covers costs associated with case planning, case consultation, referral services, and other support services for the purpose of engaging and retaining clients in treatment or maintaining clients in treatment. This does not include treatment planning activities required in WAC 388-887B.

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

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

1.21 **Certified Peer Counselor (CPC)**

"Certified Peer Counselor (CPC)" means individuals that have met the requirements in WAC 388-864-0107 to help consumers and families identify goals that promote recovery and resiliency and help to identify services and activities to reach these goals.

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1.22 **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 treatment services. Childcare services must be provided by licensed childcare providers or by providers operating in accordance with the provisions set forth in WAC's published by the Department of Health and Department of Early Learning for the provision of child care services.

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

"Child and Family Team (CFT)" means a group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family's plan, address unmet needs, and work toward the family's vision and team mission, monitoring progress regularly and using this information to revise and refine the plan of care.

1.24 **Code of Federal Regulations (CFR)**

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

1.25 **Community Behavioral Health Advisory (CBHA) Board**

"Community Behavioral Health Advisory (CBHA) Board" means an advisory board representative of the demographic characteristics of the Region. Representatives to the board shall include, but are not limited to: representatives of the Consumer and families, clinical and community service resources, including law enforcement. Membership shall be comprised of at least fifty-one percent (51%) Consumer or Consumer family members as defined in WAC 388-865-0222. Composition of the CBHA Board and the length of terms shall be submitted to HCA upon request.

1.26 **Community Health Workers (CHW)**

"Community Health Workers (CHW)" means individuals who serve as a liaison/link/intermediary/advocate between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHW includes Community Health Representatives (CHR) in the Indian Health Service funded, Tribally contracted/granted and directed program.

1.27 **Community Mental Health Agency (CMHA)**

"Community Mental Health Agency (CMHA)" means a local mental health entity that is licensed by the state of Washington to provide mental health services.

1.28 **Confidential Information**

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

1.29 **Consumer**

For purposes of mental health Crisis Services, “Consumer” means any individual in the Regional Service Area regardless of income, ability to pay, insurance status or county of residence. With respect to non-Crisis Services, “Consumer” means per WAC 388.865.0150, a person who has applied for, is eligible for, or who has received GFS/SAPT services through this contract.

1.30 **Continuity of Care**

“Continuity of Care” means the provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one (1) setting as the Consumer transitions between: facility to home; facility to facility; providers or service areas; managed care Contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of Care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include but are not limited to: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings or emergency departments, to home or other health care settings such as outpatient settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; from one primary care practice to another; and from substance use care to primary and/or mental health care.

1.31 **Contract**

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

1.32 **Contractor**

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

1.33 **Continuing Education and Training**

“Continuing Education and Training” means 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.

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1.34 **Contracted Services**

"Contracted Services" means services that are to be provided by the Contractor under the terms of this Contract within Available Resources. When Available Resources are exhausted, non-Crisis Services and services not related to the administration of the Involuntary Treatment Act (ITA for SUD or Mental Health) are no longer covered and cannot be authorized regardless of medical necessity.

1.35 **Cost Reimbursement**

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

1.36 **Criminal Justice Treatment Account (CJTA)**

"Criminal Justice Treatment Account" means, pursuant to RCW 70.96.A.400, an account created in the State treasury for expenditure on: a) SUD treatment and treatment support services for offenders with an addiction 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.

1.37 **Crisis Services (Mental Health)**

"Crisis Services" means evaluation and treatment of mental health crisis to all individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis Services shall be available on a twenty-four (24) hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration, and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available.

1.38 **Crisis Services (SUD)**

"Crisis Services (SUD)" means services provided on a very short term basis to intoxicated or incapacitated individuals on the streets or in other public places and may include general assessments of the patient's condition, an interview for diagnostic or therapeutic purposes, and transportation home or to an approved treatment facility. Services may be provided by telephone or in person, in a facility or in the field, and may or may not lead to ongoing treatment. This does not include the costs of ongoing therapeutic services.

1.39 **Day Support**

"Day Support" means an intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Consumers to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. This modality may be provided as an adjunctive treatment or as a primary intervention, is provided by or under the supervision of a Mental Health Professional in a location easily accessible to the Consumer, and is available five (5) hours per day, five (5) days per week.

1.40 **Debarment**

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

1.41 **Department of Social and Health Services (DSHS)**

"Department of Social and Health Services (DSHS)" means the Washington State agency responsible for providing a broad array of health care and social services. DSHS administrations with which the Contractor may interface include, but are not limited to:

1.41.1 Behavioral Health Administration (BHA) is responsible for providing mental health services in State psychiatric hospitals and community settings and SUD inpatient and outpatient treatment, recovery and prevention services.

1.41.2 Aging and Long-Term Support Administration (ALTSA) is responsible for providing a safe home, community and nursing facility array of long-term supports for Washington citizens.

1.41.3 Children's Administration (CA) is responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.

1.41.4 Developmental Disabilities Administration (DDA) is responsible for providing a safe, high-quality, array of home, community and facility-based residential services and employment support for Washington citizens with disabilities.

1.41.5 Division of Behavioral Health and Recovery (DBHR) is means the DSHS- designated state behavioral health authority to administer state only, federal block grant, and Medicaid funded behavioral health programs.

1.42 **Designated Mental Health Professional (DMHP)**

"Designated Mental Health Professional (DMHP)" means a mental health professional appointed by the county or other authority authorized in rule, to perform the commitment duties described in Chapter 71.05 RCW.

1.43 **Designated Chemical Dependency Specialist (DCDS)**

"Designated Chemical Dependency Specialist (DCDS)" means a person designated by the county alcoholism and other drug addiction program under RCW 70.76A.310 to perform the commitment duties described in Chapters 70.96A and 70.96B RCW.

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1.44 **Disaster Outreach**

"Disaster Outreach" means contacting persons in their place of residence or in non-traditional settings to provide support, as well as education, information and referral to resources to assist with recovery efforts.

1.45 **Director**

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

1.46 **Emergency Medical Condition**

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

1.47 **Emergency Services**

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

1.48 **Encrypt**

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

1.49 **Evidence-Based Practices (Physical Health [PH] and Behavioral Health [BH] Practices)**

"Evidence-Based Practices (PH and BH Practices)" means a program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial per the Washington State Institute for Public Policy (WSIPP).

1.50 **External Entities (EE)**

"External Entities (EE)" means organizations that serve eligible Medicaid clients and include DSHS, Department of Health (DOH), Local Health Jurisdictions (LHJ), community-based service providers and HCA services/programs as defined in this Contract.

1.51 **Facility**

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

1.52 **Family Treatment**

"Family Treatment" means behavioral health counseling provided for the direct benefit of a Consumer. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and his/her family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment shall provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the client. Family treatment may take place without the client present in the room, but service must be for the benefit of attaining the goals identified for the individual in his/her Individual Service Plan (ISP). This service is provided by or under the supervision of a Mental Health Professional.

1.53 **Federally Qualified Health Center (FQHC)**

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

1.54 **First Responders**

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

1.55 **Fraud**

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

1.56 **Freestanding Evaluation and Treatment**

"Freestanding Evaluation and Treatment" means services provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self-due to the onset or exacerbation of a psychiatric disorder. Services are provided in freestanding inpatient residential (non-hospital/non-Institution for Mental Disease (IMD) facilities) licensed by DOH and certified by DSHS to provide medically necessary evaluation and treatment to the Consumer who would otherwise meet hospital admission criteria.

At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses, and other Mental Health Professionals, and discharge planning involving the individual, family, significant others, so as to ensure continuity of mental health care. Nursing care includes, but is not limited to; performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self-due to the onset or exacerbation of a psychiatric disorder. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow him/her to be managed at a lesser level of care.

This service does not include cost for Room and Board. The HCA shall authorize exceptions for involuntary length of stay beyond a fourteen (14) day commitment.

1.57 **General Fund State/Substance Abuse Prevention and Treatment Services (GFS/SAPT)**

"General Fund State/Substance Abuse Prevention and Treatment (GFS/SAPT)" means the services provided by the Contractor under this Contract and funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant and General Fund State (GFS).

1.58 **Grievance**

"Grievance" means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Consumer's rights.

1.59 **Grievance Process**

"Grievance Process" means the procedure for addressing Consumers' grievances.

1.60 **Grievance System**

"Grievance System" means the overall system that includes Grievances and Appeals handled by the Contractor and access to the hearing system.

1.61 **Guideline**

"Guideline" means a set of statements used to determine a course of action. A guideline streamlines utilization management decision-making processes according to a set routine or sound evidence-based clinical practice. By definition, following a guideline is never mandatory. Guidelines are not binding and are not enforced.

1.62 **Hardened Password**

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

1.63 **Health Care Authority (HCA)**

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

1.64 **Health Care Professional**

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

1.65 **Health Care Provider (HCP)**

"Health Care Provider (HCP)" for purposes of this Contract, means a Primary Care Provider, Mental Health Professional or Chemical Dependency Professional.

1.66 **High Intensity Treatment**

"High Intensity Treatment" means intensive levels of service provided to Consumers who require a multi-disciplinary treatment team in the community that is available upon demand twenty-four (24) hours per day, seven (7) days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or SUD residential placement.

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

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1.67 **Institute for Mental Disease (IMD)**

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

1.68 **Indian/Tribal/Urban (I/T/U) Provider**

"Indian/Tribal/Urban (I/T/U) Provider" means the Indian Health Service and/or any Tribe, Tribal organization, or Urban Indian Organization which provides Medicaid-reimbursable services.

1.69 **Individuals with Intellectual or Developmental Disability (I/DD)**

"Individuals with Intellectual or Developmental Disability (I/DD)" means people with a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of eighteen (18).

1.70 **Intake Evaluation**

"Intake Evaluation" means an evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except Crisis Services, Stabilization Services, and free-standing evaluation and treatment. The Intake Evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment, and be completed within thirty (30) working days. Routine services such as Rehabilitation Case Management may begin before the completion of the intake once medical necessity is established. This service must be provided by a Mental Health Professional.

1.71 **Interim Services**

"Interim Services" means services to individuals who are currently waiting to enter a treatment program to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease. Such services are provided until the individual 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, individual 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, counseling, education, and referral regarding HIV and tuberculosis (TB) education, if necessary referral to treatment for HIV and TB.

1.72 **Intensive Inpatient Residential Services**

"Intensive Inpatient Residential Services" means a concentrated program of SUD treatment, individual and group counseling, education, and related activities for alcoholics and addicts including room and board in a twenty-four (24)hour-a-day supervised facility in accordance with Chapter 388-877B WAC (The service as described satisfies the level of intensity in ASAM Level 3.5).

1.73 **Intensive Outpatient SUD Treatment**

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

1.74 **Involuntary Commitment (SUD)**

"Involuntary Commitment" means services employed to identify and evaluate alcohol and drug involved individuals requiring protective custody, detention, or Involuntary Commitment services in accordance with RCW 70.96A.120-140. Activities include case finding, investigation activities, assessment activities, and legal proceedings associated with these cases.

1.75 **Involuntary Treatment Act (ITA – Mental Health)**

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

1.76 **Involuntary Treatment Act Services (Mental Health)**

"Involuntary Treatment Act Services (Mental Health)" includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with Chapters 71.05, and 71.34 RCW and RCW 71.24.300.

1.77 **Juvenile Drug Court**

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

1.78 **Level of Care Guidelines**

"Level of Care Guidelines" means the criteria the Contractor uses in determining which individuals within the target groups identified in the Contractor's policy and procedures will receive services.

1.79 **List of Excluded Individuals/Entities (LEIE)**

"List of Excluded Individuals/Entities (LEIE)" means an Office of Inspector General's List of Excluded Individuals/Entities and provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.

1.80 **Long-Term Care Residential SUD Services**

"Long-Term Care Residential SUD Services" means the care and treatment of chronically impaired individuals diagnosed with SUD who also have impaired self-maintenance capabilities who reside in a twenty-four (24) hour-a-day, supervised facility in accordance with Chapter 388-877B WAC (The service as described satisfies the level of intensity in ASAM Level 3.3).

1.81 **Lump Sum**

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

1.82 **Managed Care**

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

1.83 **Managed Care Organization (MCO)**

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

1.84 **Marketing**

"Marketing" means any promotional activity or communication with Enrollee that is intended to increase a Contractor's membership or to "brand" a Contractor's name or organization.

The activities are directed from the Contractor to a Potential Consumer or Consumer who is enrolled with another HCA-Contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or to either not enroll or to end their enrollment with another HCA-contracted MCO. Marketing communications include written, oral, in-person (telephonic or face-to-face) or electronic methods of communication, including email, text messaging, and social media (i.e. Facebook, Instagram, and Twitter).

1.85 **Medically Necessary Services**

"Medically Necessary Services" means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Consumer that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Consumer requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

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1.86 **Medication Assisted Treatment (MAT)**

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

1.87 **Medication Management**

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

1.88 **Medication Monitoring**

"Medication Monitoring" means face-to-face, one-on-one cueing, observing, and encouraging a Consumer to take medications as prescribed. Also includes reporting back to persons licensed to perform Medication Management services for the direct benefit of the Consumer. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes.

Consumers with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a Mental Health Professional. Time spent with the Consumer is the only direct service billable component of this modality.

1.89 **Mental Health Advance Directive or Directive**

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

1.90 **Mental Health Block Grant or MHBG**

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

1.91 **Mental Health Parity**

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

1.92 **Mental Health Professional**

"Mental Health Professional" means:

1.92.1 A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in Chapters 71.05 and 71.34 RCW;

1.92.2 A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such persons shall have, in addition, at least two (2) years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional;

1.92.3 A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;

1.92.4 A person who is licensed by the Department of Health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate.

1.92.5 A person who has an approved exception to perform the duties of a Mental Health Professional by the DSHS Behavioral Health Administration before July 1, 2001; or

1.92.6 A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional by the DSHS Behavioral Health Administration consistent with WAC 388-865-0265 before April 1, 2016.

1.93 **National Correct Coding Initiative (NCCI)**

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

1.94 **Network Adequacy**

"Network Adequacy" means a network of providers for the Contractor that is sufficient in numbers and types of providers/facilities to ensure that all services are accessible to Consumers within the access standards outlined in the Contract and within Available Resources.

1.95 **Non-Participating Provider**

"Non-Participating Provider" means a person, Health Care Provider, practitioner, facility, or entity acting within their scope of practice and licensure that does not have a written agreement with the Contractor to participate in the provider network, but provides health care services to Consumers.

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1.96 **Notice of Action**

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

1.97 **Office of Inspector General (OIG)**

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

1.98 **Opiate Dependency/HIV Services Outreach**

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

1.99 **Opiate Substitution Treatment**

"Opiate Substitution Treatment" means assessment and treatment to opiate dependent patients. Services include prescribing and dispensing of an approved medication, as specified in 212 C.F.R. Part 291, for opiate substitution services in accordance with WAC 388-877B (The service as described satisfies the level of intensity in ASAM Level 1).

1.100 **Outreach and Engagement**

"Outreach and Engagement" means identification of hard-to-reach individuals with a possible SUD and engagement of these individuals 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 Substance Use Disorders and the impact of Substance Use Disorders on families, providing information on treatment options or resources, re-engaging individuals in the treatment process. This does not include ongoing therapeutic or rehabilitative services.

1.101 **Overpayment**

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

1.102 **Participating Provider**

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

1.103 **Peer Bridger**

"Peer Bridger" means a trained Peer Support specialist who offers Peer Support services to participants in state hospitals prior to discharge and after their return to their communities. The Peer Bridger must be an employee of an agency licensed by DSHS that provides recovery services.

1.104 **Peer Support**

"Peer Support" means services provided by peer counselors to individuals under the consultation, facilitation, or supervision of a Mental Health Professional who understands rehabilitation and recovery.

1.105 **Personal Information**

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

1.106 **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) men or women who are parenting children under the age of six (6), including those attempting to gain custody of children supervised by the Department of Social and Health Services, Children's Administration.

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

"PPW Housing Support Services" means the costs incurred to provide support services provided to PPW individuals in a transitional residential housing program designed exclusively for this population.

1.108 **Provider**

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

1.109 **ProviderOne**

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

1.110 **Psychological Assessment**

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

1.111 **Recovery**

"Recovery" means the process by which people are able to live, work, learn, and participate fully in their communities.

1.112 **Recovery House Residential Treatment**

"Recovery House Residential Treatment" means costs incurred for a program of care and treatment with social, vocational, and recreational activities designed to aid individuals diagnosed with SUD in the adjustment to abstinence and to aid in job training, reentry to employment, or other types of community activities, excluding Room and Board in a twenty-four (24) hour-a-day supervised facility in accordance with WAC 388-877B (The service as described satisfies the level of intensity in ASAM Level 3.1).

1.113 **Recovery Support Services**

"Recovery Support Services" means a broad range of non-clinical services that assist individuals and families to initiate, stabilize, and maintain long-term Recovery from 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 individuals with co-occurring disorders; peer specialists; recovery coaching; shared decision-making; telephone recovery checkups; warm lines; and peer-run crisis diversion services.

1.114 **Regional Service Area (RSA)**

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

1.115 **Regulation**

"Regulation" means any federal, State, or local Regulation, rule, or ordinance.

1.116 **Rehabilitation Case Management**

"Rehabilitation Case Management" means a range of activities by the outpatient CMHA's liaison conducted in or with a facility for the direct benefit of a Consumer in the public mental health system. To be eligible, the individual must be in need of Case Management in order to ensure timely and appropriate treatment and Care Coordination.

Activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, maximize the benefits of the placement, minimize the risk of unplanned re-admission, and to increase the community tenure for the Individual. Services are provided by or under the supervision of a Mental Health Professional.

1.117 **Resilience**

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

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

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

1.119 **Room and Board**

"Room and Board" means 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 (3) 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.

1.120 **Substance Abuse Prevention and Treatment (SAPT) Block Grant**

"Substance Abuse Prevention and Treatment (SAPT) Block Grant" means the Federal Substance Abuse Prevention and Treatment Block Grant (also known as the SABG Program) authorized by Section 1921 of Title XIX, Part B, Subpart II and III of the Public Health Service Act.

1.121 **Secured Area**

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

1.122 **Serious Emotionally Disturbed (SED)**

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

1.123 **Serious Mental Illness (SMI)**

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

1.124 **Sobering Services**

"Sobering Services" means short-term (twelve (12) hours or less) emergency shelter, screening, and referral services to persons who need to recover from the effects of alcohol.

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1.125 **Special Population Evaluation**

"Special Population Evaluation" means an evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods.

1.126 **Stabilization Services**

"Stabilization Services" means services provided to Consumers who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the Mental Health Professional. Stabilization Services shall include short-term (less than two (2) weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to Crisis Services; and b) other individuals determined by a Mental Health Professional to need additional Stabilization Services. Stabilization Services may be provided prior to an Intake Evaluation for mental health services.

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

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

1.128 **Subcontract**

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

1.129 **Substance Use Disorder (SUD)**

"Substance Use Disorder (SUD)" means a condition in which the use of one (1) or more substances leads to a clinically significant impairment or distress.

1.130 **Substance Use Disorder Outpatient Treatment**

"Substance Use Disorder Outpatient Treatment" means services provided in a non-residential SUD treatment facility. Outpatient treatment services must meet the criteria in the specific modality provisions set forth in WAC 388-877B (The service as described satisfies the level of intensity in ASAM Level 1).

1.131 **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.

1.132 **Therapeutic Psychoeducation**

"Therapeutic Psychoeducation" means informational and experiential services designed to aid Consumers, their family members (e.g., spouse, parents, siblings) and other individuals identified by the Consumer as a primary natural support in the management of psychiatric conditions.

1.133 **Tracking**

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

1.134 **Transitional Age Youth (TAY)**

"Transition Age Youth (TAY)" means an individual between the ages of sixteen (16) and twenty-five (25) years who present unique service challenges because they are too old for pediatric services but are often not ready or eligible for adult services.

1.135 **Transport**

"Transport" means the movement of Confidential Information from one entity to another or within an entity that:

1.135.1 Places the Confidential Information outside of a Secured Area or system (such as a local area network), and

1.135.2 Is accomplished other than via a Trusted System.

1.136 **Transportation**

"Transportation" means the transport of individuals to and from SUD treatment facilities.

1.137 **Tribal Land**

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

1.138 **Trusted Systems**

"Trusted Systems" means methods of delivering Confidential Information in such a manner that confidentiality is not compromised. Trusted Systems include only the following methods of physical delivery:

1.138.1 Hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt, and

1.138.2 United States Postal Service (USPS) delivery services that include Tracking, such as Certified Mail, Express Mail, or Registered Mail.

Any other method of physical delivery will be deemed not be a Trusted System.

1.139 **Unique User ID**

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

1.140 **Validation**

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

1.141 **Waiting List**

"Waiting List" means a list of clients who qualify for SAPT-funded services for whom a date for service has not been scheduled due to lack of capacity.

1.142 **Washington Administrative Code (WAC)**

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

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

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

1.144 **Wraparound with Intensive Services (WISe)**

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

1.145 **Youth**

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

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2 GENERAL TERMS AND CONDITIONS

2.1 Amendment

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

2.1.1 Any amendment shall be in writing and shall be signed by a Contractor's authorized officer and an authorized representative of HCA. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

2.1.2 HCA reserves the right to issue unilateral amendments which provide corrective or clarifying information.

2.1.3 The Contractor shall submit all feedback or questions to HCA at contracts@hca.wa.gov or other email address as expressly stated.

2.1.4 The Contractor shall submit written feedback within the expressed deadline provided to the Contractor upon receipt of any amendments. HCA is not obligated to accept Contractor feedback after the written deadline provided by HCA.

2.1.5 The Contractor shall return all signed amendments within the written deadline provided by HCA contracts administration.

2.2 Assignment

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

2.3 Billing Limitations

2.3.1 HCA shall pay the Contractor only for services provided in accordance with this Contract.

2.3.2 HCA shall not pay any claims for payment for services submitted more than one hundred and twenty (120) days after the end of the Fiscal Year (FY) in which the services were performed unless otherwise specified in this Contract.

2.4 Compliance with Applicable Law

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

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

2.4.1 Title XIX and Title XXI of the Social Security Act.

2.4.2 Title VI of the Civil Rights Act of 1964.

2.4.3 Title IX of the Education Amendments of 1972, regarding any education programs and activities.

2.4.4 The Age Discrimination Act of 1975.

2.4.5 The Rehabilitation Act of 1973.

2.4.6 The Budget Deficit Reduction Act of 2005.

2.4.7 The Washington Medicaid False Claims Act and Federal False Claims Act (FCA).

2.4.8 The Health Insurance Portability and Accountability Act (HIPAA).

2.4.9 The American Recovery and Reinvestment Act (ARRA).

2.4.10 The Patient Protection and Affordable Care Act (PPACA or ACA).

2.4.11 The Health Care and Education Reconciliation Act.

2.4.12 The Mental Health Parity and Addiction Equity Act (MHPAEA) and final rule.

2.4.13 21 C.F.R. Food and Drugs, Chapter 1 Subchapter C – Drugs – General.

2.4.14 42 C.F.R. Subchapter A, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.

2.4.15 42 C.F.R. Subchapter A, Part 8 – Certification of Opioid Treatment Programs.

2.4.16 45 C.F.R. 96 Block Grants.

2.4.17 45 C.F.R. 96.126 Capacity of Treatment for Intravenous Substance Abusers who Receive Services under Block Grant funding.

2.4.18 Chapter 70.96A RCW Treatment for Alcoholism, Intoxication, and Drug Addiction.

2.4.19 Chapter 70.02 RCW Medical Records – Health Care Information Access and Disclosure.

2.4.20 Chapter 71.05 RCW Mental Illness.

2.4.21 Chapter 71.24 RCW Community Mental Health Services Act.

2.4.22 Chapter 71.34 RCW Mental Health Services for Minors.

2.4.23 WAC 388-865 Community Mental Health and Involuntary Treatment Programs.

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2.4.24 WAC 388-810 Administration of County Chemical Dependency Prevention Treatment and Support Programs.

2.4.25 RCW 43.20A Department of Social and Health Services.

2.4.26 Senate Bill 6312 (Chapter 225. Laws of 2014) State Purchasing of Mental Health and Chemical Dependency Treatment Services.

2.4.27 All federal and State professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including but not limited to:

2.4.27.1 All applicable standards, orders, or requirements issued under Section 306 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) Regulations (40 C.F.R. Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to HCA, Department of Health and Human Services (DHHS), and the EPA.

2.4.27.2 Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.

2.4.27.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

2.4.27.4 Those specified in Title 18 RCW for professional licensing.

2.4.27.5 Industrial Insurance – Title 51 RCW.

2.4.27.6 Reporting of abuse as required by RCW 26.44.030.

2.4.27.7 Federal Drug and Alcohol Confidentiality Laws in 42 C.F.R. Part 2.

2.4.27.8 EEO Provisions.

2.4.27.9 Copeland Anti-Kickback Act.

2.4.27.10 Davis-Bacon Act.

2.4.27.11 Byrd Anti-Lobbying Amendment.

2.4.27.12 All federal and State nondiscrimination laws and Regulations.

2.4.27.13 Americans with Disabilities Act: The Contractor shall make reasonable accommodation for Consumers with disabilities, in accord with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit Consumers with disabilities from obtaining contracted services.

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2.4.28 Any other requirements associated with the receipt of federal funds.

2.4.29 Any services provided to an individual enrolled in Medicaid are subject to applicable Medicaid rules.

2.5 **Confidentiality**

2.5.1 The Contractor shall protect and preserve the confidentiality of HCA's data or information that is defined as confidential under State or federal law or Regulation or data that HCA has identified as confidential.

2.5.2 The Contractor shall comply with all applicable federal and state laws and Regulations concerning collection, use, and disclosure of Personal Information set forth in Governor Locke's Executive Order 00-03 and Protected Health Information (PHI), defined at 45 C.F.R. § 160.103, as may be amended from time to time. The Contractor shall not release, divulge, publish, transfer, sell, or otherwise make known to unauthorized third parties Personal Information or PHI without the advance express written consent of the individual who is the subject matter of the Personal Information or PHI or as otherwise required in this Contract or as permitted or required by state or federal law or Regulation. The Contractor shall implement appropriate physical, electronic and managerial safeguards to prevent unauthorized access to Personal Information and PHI. The Contractor shall require the same standards of confidentiality of all its Subcontractors.

2.5.3 The Contractor agrees to share Personal Information regarding Consumers in a manner that complies with applicable state and federal law protecting confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 U.S.C. § 1320(d) et. seq. and 45 C.F.R. parts 160, 162, and 164., the HIPAA Regulations, 42 C.F.R. § 431 Subpart F, RCW 5.60.060(4), and Chapter 70.02 RCW). The Contractor and the Contractor's Subcontractors shall fully cooperate with HCA efforts to implement HIPAA requirements.

2.5.4 The Contractor shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss.

2.5.4.1 This duty requires that Contractor employ reasonable security measures, which include restricting access to the Confidential Information by:

2.5.4.1.1 Encrypting electronic Confidential Information during Transport;

2.5.4.1.2 Physically securing and tracking media containing Confidential Information during Transport;

2.5.4.1.3 Limiting access to staff that have an authorized business requirement to view the Confidential Information;

2.5.4.1.4 Using access lists, Unique User ID and Hardened Password authentication to protect Confidential Information;

2.5.4.1.5 Physically securing any computers, documents or other media containing the Confidential Information; and

2.5.4.1.6 Encrypting all Confidential Information that is stored on portable devices including but not limited to laptop computers and flash memory devices.

2.5.4.2 Upon request by HCA the Contractor shall return the Confidential Information or certify in writing that the Contractor employed a HCA approved method to destroy the information. Contractor may obtain information regarding approved destruction methods from the HCA contact identified in this Contract.

2.5.5 In the event of a breach, meaning an acquisition, access, use, or disclosure of PHI in a manner not permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule which compromises the security or privacy of a Consumer's PHI, the Contractor shall notify HCA in writing, as described in the Notices section of the General Terms and Conditions, within two (2) business days after determining notification must be sent to Consumers. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirement imposed by law (45 C.F.R. Part 164, Subpart D, WAC 284-04-625, RCW 19.255.010).

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

2.5.7 Any material breach of this confidentiality provision may result in termination of this Contract. The Contractor shall indemnify and hold HCA harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Consumers.

2.6 Covenant Against Contingent Fees

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

2.7 Debarment Certification

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

2.8 **Defense of Legal Actions**

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

2.9 **Disputes**

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

2.9.1 The Contractor shall request a dispute resolution conference with the Agency Director. The request for a dispute resolution conference must be in writing and shall clearly state all of the following:

2.9.1.1 The disputed issue(s).

2.9.1.2 An explanation of the positions of the parties.

2.9.1.3 Any additional facts necessary to explain completely and accurately the nature of the dispute.

2.9.2 Requests for a dispute resolution conference must be mailed to the Director, Washington State HCA, P.O. Box 45502, Olympia, WA 98504-5502. Any such requests must be received by the Director within thirty (30) calendar days after the Contractor receives notice of the disputed issue(s).

2.9.2.1 The Director, in his or her sole discretion, shall determine a time for the parties to present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's discretion. The Director shall provide written notice of the time, format, and location of the conference. The conference is informal in nature and is not governed in any way by the Administrative Procedure Act, chapter 34.05 RCW.

2.9.2.2 The Director shall consider all of the information provided at the conference and shall issue a written decision on the disputed issue(s) within thirty (30) calendar days after the conclusion of the conference. However, the Director retains the option of taking up to an additional sixty (60) calendar days to consider the disputed issue(s) or taking additional steps to attempt to resolve them. If the Director determines, in his or her sole discretion, that an additional period of up to sixty (60) calendar days is needed for review, he or she shall notify the Contractor, in writing, of the delay and the anticipated completion date before the initial thirty-day period expires.

2.9.2.3 The Director, at his or her sole discretion, may appoint a designee to represent him or her at the dispute conference. If the Director does appoint a designee to represent him or her at the dispute conference, the Director shall retain all final decision-making authority regarding the disputed issue(s). Under no circumstances shall the Director's designee have any authority to issue a final decision on the disputed issue(s).

2.9.3 The parties hereby agree that this dispute process shall precede any judicial or quasi-judicial proceeding and is the sole administrative remedy under this Contract.

2.9.4 Disputes regarding overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Section.

2.10 **Force Majeure**

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

2.11 **Governing Law and Venue**

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

2.12 **Independent Contractor**

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

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

2.13 Insolvency

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

2.13.1 The state of Washington and Consumers shall not be, in any manner, liable for the debts and obligations of the Contractor.

2.13.2 The Contractor shall, in accordance with RCW 48.44.055, provide for the continuity of care for Consumers and shall provide Crisis Services and Involuntary Treatment Act services in accordance with Chapters 71.05, 71.34 and 70.96A RCW.

2.13.3 The Contractor shall cover continuation of services to Consumers for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

2.13.4 The above obligations shall survive the termination of this contract.

2.14 Inspection

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

2.15 Insurance

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

2.15.1 Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. The state of Washington, HCA, its elected and appointed officials, agents, and employees shall be named as additional insured's expressly for, and limited to, Contractor's services provided under this Contract.

2.15.2 Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000.

2.15.3 Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and Regulations. The state of Washington and HCA shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and Regulations.

2.15.4 Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.

2.15.5 Subcontractors: The Contractor shall ensure that all Subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for Subcontractors, to HCA if requested.

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

2.15.7 Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the state of Washington, with a "Best's Reports'' rating of A-, Class VII or better. Any exception must be approved by HCA. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.

2.15.8 Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accord with the Notices section of the General Terms and Conditions, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

2.15.9 Material Changes: The Contractor shall give HCA, in accord with the Notices section of the General Terms and Conditions, forty-five (45) calendar days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give HCA ten (10) calendar days advance notice of cancellation.

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

2.15.11 The Contractor may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers and Evidence of Coverage Provisions of this section if self-insured. In the event the Contractor is self-insured, the Contractor must send to HCA by the third Wednesday of January in each Contract year, a signed written document, which certifies that the Contractor is self-insured, carries coverage adequate to meet the requirements of this section, shall treat HCA as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA.

2.16 Records

2.16.1 The Contractor and its Subcontractors shall maintain all financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.

2.16.2 All records and reports relating to this Contract shall be retained by the Contractor and its Subcontractors for a minimum of six (6) years after final payment is made under this Contract. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action (RCW 40.14.060).

2.16.3 The Contractor acknowledges the HCA is subject to the Public Records Act (Chapter 42.56 RCW). This Contract shall be a "public record" as defined in Chapter 42.56 RCW. Any documents submitted to HCA by the Contractor may also be construed as "public records" and therefore subject to public disclosure.

2.17 Mergers and Acquisitions

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

2.18 Notification of Organizational Changes

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

2.19 Order of Precedence

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

2.19.1 Federal statutes and Regulations applicable to the services provided under this Contract.

2.19.2 State of Washington statutes and Regulations concerning the operation of HCA programs participating in this Contract.

2.19.3 Applicable state of Washington statutes and Regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers.

2.19.4 General Terms and Conditions of this Contract.

2.19.5 Attachment 1 – RFP 15-026 (incorporated by reference).

2.19.6 Attachment 2 – Contractor's response to RFP 15-026 (incorporated by reference).

2.19.7 Any other term and condition of this Contract and exhibits.

2.19.8 Any other material incorporated herein by reference.

2.20 **Severability**

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

2.21 **Survivability**

The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: Billing Limitations, Defense of Legal Actions, Grievance System, Disputes, Payment and Sanctions, Confidentiality, Program Integrity, Notice of Overpayment, Indemnification and Hold Harmless, Inspection and Records. After termination of this Contract, the Contractor remains obligated to:

2.21.1 Submit reports required in this Contract.

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

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

2.21.4 Repay any overpayments that:

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

2.21.4.2 Are identified through an HCA audit or other HCA administrative review at any time on or before six (6) years from the date of the termination of this Contract; or

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

2.22 Waiver

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

2.23 Contractor Certification Regarding Ethics

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

2.24 Health and Safety

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

2.25 Indemnification and Hold Harmless

HCA and the Contractor shall each be responsible for their own acts and omissions, and the acts and omissions of their agents and employees. Each party to this Contract shall defend, protect and hold harmless the other party, or any of the other party's agents, from and against any loss and all claims, settlements, judgments, costs, penalties, and expenses, including attorney fees, arising from any willful misconduct, or dishonest, fraudulent, reckless, unlawful, or negligent act or omission of the first party, or agents of the first party, while performing under the terms of this Contract except to the extent that such losses result from the willful misconduct, or dishonest, fraudulent, reckless, unlawful or negligent act or omission on the part of the second party. The Contractor shall indemnify and hold harmless HCA from any claims by Participating or Non-Participating Providers related to the provision of services to Consumers according to the terms of this Contract; this obligation shall not apply to any services that were unpaid due to non-payment of installment moneys by HCA. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees.

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2.26 **Industrial Insurance Coverage**

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

2.27 **No Federal or State Endorsement**

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

2.28 **Notices**

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

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

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

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

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

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

2.29 **Notice of Overpayment**

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

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

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

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

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

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

2.29.2.5 Include a copy of the Notice of Overpayment.

2.29.3 If the Contractor submits a timely and complete request for an adjudicative proceeding, then the Office of Administrative Hearings will schedule the proceeding. The Contractor may be offered a pre-hearing or alternative dispute resolution conference in an attempt to resolve the dispute prior to the adjudicative proceeding. The adjudicative proceeding will be governed by the administrative procedure act, Chapter 34.05 RCW, and Chapter 182-526 WAC.

2.29.4 If HCA does not receive a request for an adjudicative proceeding within twenty-eight (28) calendar days of service of a Notice of Overpayment, then the Contractor will be responsible for repaying the amount specified in the Notice of Overpayment. This amount will be considered a final debt to HCA from the Contractor. HCA may charge the Contractor interest and any costs associated with the collection of the debt. HCA may collect an overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; withholding the amount of the debt from any future payment to the Contractor under this contract; or any other collection action available to HCA to satisfy the overpayment debt.

2.29.5 Nothing in this Agreement limits HCA's ability to recover overpayments under applicable law.

2.30 **Proprietary Data or Trade Secrets**

2.30.1 Except as required by law, Regulation, or court order, data identified by the Contractor as proprietary trade secret information shall be kept strictly confidential, unless the Contractor provides prior written consent of disclosure to specific parties. Any release or disclosure of data shall include the Contractor's interpretation.

2.30.2 The Contractor shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. If HCA anticipates releasing data that is identified as proprietary or trade secrets, HCA will notify the Contractor upon receipt of any request under the Public Records Act (Chapter 42.56 RCW) or otherwise for data or Claims Data identified by the Contractor as proprietary trade secret information and will not release any such information until five (5) business days after it has notified the Contractor of the receipt of such request. If the Contractor files legal proceedings within the aforementioned five (5) business day period in an attempt to prevent disclosure of the data, HCA agrees not to disclose the information unless it is ordered to do so by a court, the Contractor dismisses its lawsuit, or the Contractor agrees that the data may be released.

2.30.3 Nothing in this section shall prevent HCA from filing its own lawsuit or joining any other lawsuit in an attempt to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will promptly notify the Contractor of the filing of any such lawsuit.

2.31 Ownership of Material

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

2.32 Solvency

2.32.1 The Contractor understands and agrees that it is required to make some advance payments under this contract prior to reimbursement from the state, and that the amount of such payments may vary on a month to month basis.

2.32.2 The Contractor understands and agrees that it must remain solvent at all times during the term of this contract, including any extensions to the term, and that the failure to remain solvent at all times is grounds for immediate termination by default.

2.32.3 The Contractor agrees that HCA at any time may access any information related to the Contractor's financial condition, and upon HCA's request, the Contractor shall furnish to HCA all such financial information and documentation they have concerning their current financial condition. This shall also include the production of financial information that may be held by a third party agent of the contractor; the Contractor hereby agrees to sign any necessary to allow for the distribution of such information to HCA.

2.32.4 The Contractor shall notify HCA within ten (10) business days after the end of any month in which the Contractor's net worth (capital and/or surplus) reaches a level representing two (2) or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Contract or which may otherwise materially affect the relationship of the parties under this Contract.

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2.33 **Surety Bond**

At Contractor's cost, and as a condition precedent to HCA executing the contract, Contractor is required to furnish HCA with a surety bond in an amount of one million dollars ($1,000,000.00) through the Initial Term and all Renewal Terms within thirty (30) days of the Effective Date. Such surety bond shall be in a form and substance satisfactory to HCA. Contractor shall maintain the surety bond in full force and effect until expiration or termination of the Contract. Any change or extension of time of this Contract shall in no way release Contractor or any of its sureties from any of their obligations under the bond. Such bond shall contain a waiver of notice of any changes to this Contract. Notwithstanding, Contractor shall notify its sureties and any bonding organizations of changes to this Contract.

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

2.33.1 The surety bond shall ensure that the Contractor, and every officer, director, contractor or employee thereof who is authorized to act on behalf of Contractor for the purpose of receiving, processing and depositing funds pursuant to this Contract shall be bonded to provide protection against loss. Surety bonding secured must name the state of Washington, Health Care Authority, as beneficiary. In the event of any default of such obligations regarding funds pursuant to this Contract, the surety bond shall become payable to HCA. An amount up to the full amount of the surety bond may also be applied to Contractor's liability for any administrative costs and/or excess costs incurred by HCA in obtaining similar products and services to replace those terminated as a result of Contractor's default. HCA may seek other remedies in addition to this stated liability.

2.34 **Conflict of Interest Safeguards**

The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public Contracting (42 U.S.C. § 423).

2.35 **Reservation of Rights and Remedies**

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

Contract during or as a result of any threatened or actual breach.

2.36 **Termination by Default**

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

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

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

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

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

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

2.36.2.5 One of the Contractor's owners did not cooperate with any screening methods as required by the HCA.

2.36.2.6 One of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years.

2.36.2.7 The Contractor has been terminated under title XVIII of the Social Security Act, or under any states' Medicaid or CHIP program.

2.36.2.8 One of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by HCA within thirty (30) days of a HCA request.

2.36.2.9 The Contractor failed to permit access to one of the Contractor's locations for site visits.

2.36.2.10 The Contractor has falsified any information provided on its application.

2.37 Termination for Convenience

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

2.38 Terminations: Pre-termination Processes

2.38.1 Either party to the Contract shall give the other party to the Contract written notice, as described in the Notices section of the General Terms and Conditions of this Contract, of its intent to terminate this Contract and the reason for termination.

2.38.2 HCA shall provide written notice to the Contractor's Consumers of the decision to terminate the Contract and indicate whether the Contractor may Appeal the decision.

2.38.3 If either party disagrees with the other party's decision to terminate this Contract, that party will have the right to a dispute resolution as described in the Disputes section of this Contract.

2.39 Termination Due to Funding

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

2.40 Termination - Information on Outstanding Claims

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

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2.41 **Administrative Simplification**

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

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

2.41.1.1 Current Procedural Terminology (CPT).

2.41.1.2 International Classification of Diseases (ICD).

2.41.1.3 Healthcare Common Procedure Coding System (HCPCS).

2.41.1.4 The Diagnostic and Statistical Manual of Mental Disorders.

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

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

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

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

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

3 MARKETING AND INFORMATION REQUIREMENTS

3.1 **Media Materials and Publications**

3.1.1 Media materials and publications developed with state funds shall be submitted to the HCA for written approval prior to publication. HCA must be cited as the funding source in news releases, publications, and advertising messages created with or about HCA funding. The funding source shall be cited as: The state of Washington Health Care Authority. The HCA logo may also be used in place of the above citation.

3.1.2 Marketing materials related under 3.1.1. but not paid for by funds provided under this contract must be submitted to HCA for prior approval as noted in 3.1.1.

3.1.3 The Contractor is encouraged but is not required to submit the following items to HCA for approval:

3.1.3.1 News coverage resulting from interviews with reporters including online news coverage;

3.1.3.2 Pre-scheduled posts on electronic / social media sites;

3.1.3.3 When a statewide media message developed by HCA is localized; and

3.1.3.4 When the current SAMHSA-sponsored media campaign is localized (As of August 2013, this is the "Talk They Hear You" campaign) http://www.samhsa.gov/underagedrinking.

3.1.4 Marketing for Crisis Services

3.1.4.1 The Contractor shall develop and implement a targeted Marketing plan that educates and informs community stakeholders to include: residents of the Regional Service Area (RSA), health care providers, First Responders, the criminal justice community, educational systems, faith-based organizations.

3.1.4.2 The plan is due by July 1 of each contract year to the Contract Manager and shall:

3.1.4.2.1 Address specific Marketing strategies to target the following individuals: those whose primary language is not English, those who reside in rural areas, individuals with Serious Mental Illness, persons with SUD, and otherwise underserved populations in the Contractor's RSA who may not have adequate exposure to advertising/Marketing mediums; and

3.1.4.2.2 Publicize the regional crisis system services and facilitate awareness of the existence of the mental health Crisis Services for all stakeholders.

3.2 **Information Requirements for Consumers**

3.2.1 Upon a Consumer's request, the Contractor shall provide:

3.2.1.1 All relevant licensure, certification and accreditation status and information.

3.2.1.2 Upon a Consumer's request, the Contractor shall provide any and all information included in the database in 6.1.4 of this contract, this information shall include but is not limited to, licensure, certification and accreditation status for any contracted provider.

3.3 **Equal Access for Consumers with Communication Barriers**

The Contractor shall assure equal access for all Consumers when oral or written language creates a barrier to such access for Consumers with communication barriers.

3.3.1 Oral Information:

3.3.1.1 The Contractor shall assure that interpreter services are provided for Consumers with a primary language other than English, free of charge. Interpreter services shall be provided for all interactions between such Consumers and the Contractor or any of its providers including, but not limited to:

3.3.1.1.1 Customer service;

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

3.3.1.1.3 All steps necessary to file grievances and Appeals.

3.3.1.2 Interpreter services include the provision of interpreters for Consumers who are deaf or hearing impaired at no cost to the Consumer.

3.3.2 Written Information:

3.3.2.1 The Contractor shall provide all generally available and Consumer-specific written materials in a language and format which may be understood by each individual Consumer in each of the prevalent languages that are spoken by five percent (5%) or more of the population of the RSA based on the most recent US census.

3.3.2.2 For Consumers whose primary language has not been translated as required in 3.3.2.1, the Contractor may meet the requirement of this section by doing any one of the following:

3.3.2.2.1 Translating the material into the Consumer's primary reading language;

3.3.2.2.2 Providing the material in an audio format in the Consumer's primary language;

3.3.2.2.3 Having an interpreter read the material to the Consumer in the Consumer's primary language;

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

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

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

3.3.4 HCA may make exceptions to the sixth (6th) grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth (6th) grade reading level or the Consumers' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth (6th) grade reading level must be in writing.

3.3.5 Educational materials about topics or other information used by the Contractor for health promotion efforts must be submitted to HCA, but do not require HCA approval as long as they do not specifically mention the Contracted Services.

3.3.6 Educational materials that are not developed by the Contractor or by the Contractor's Subcontractors are not required to meet the sixth (6th) grade reading level requirement and do not require HCA approval.

3.3.7 All other written materials must have the written approval of HCA prior to use. For Consumer-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved materials in final form.

4 SERVICE AREA AND CONSUMER ELIGIBILITY

4.1 Service Areas

The Contractor's policies and procedures related to eligibility shall ensure compliance with the requirements described in this section.

4.1.1 The Contractor's RSA is Southwest Washington (SWWA), comprised of Clark and Skamania counties.

4.2 Service Area Changes

4.2.1 The Contractor must offer services to all Consumers within the boundaries of the RSA covered by this Contract.

4.2.2 The Contractor may not decrease its service areas or its level of participation in any service area except during Contract renewal.

4.2.3 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's RSA, HCA shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected Contractors.

4.2.4 HCA shall determine, in its sole judgment, which zip codes fall within each service area.

4.2.5 HCA will use the Consumer's residential zip code to determine whether a Consumer resides within a service area.

4.3 Eligibility

4.3.1 All individuals in the Contractor's RSA regardless of insurance status, ability to pay, county of residence, or level of income are eligible to receive medically necessary Mental Health Crisis Services, SUD crisis services, and services related to the administration of the Involuntary Treatment Act and Involuntary Commitment Act (Chapters 71.05 and 71.34 RCW and RCW 70.96A.140).

4.3.2 The Contractor has discretion on the use of funds for the provision of other non-crisis behavioral health services including crisis stabilization and voluntary behavioral health admissions for Consumers in the Contractor's RSA who are not eligible for Medicaid and/or do not have third party insurance.

4.3.3 To be eligible for any non-crisis behavioral health service under this Contract, an individual must meet: (i) the financial eligibility criteria; and (ii) the clinical or program eligibility criteria for the GFS/SAPT service:

4.3.3.1 Individuals who do not qualify for Medicaid and have income up to two hundred twenty percent (220%) of the federal poverty level meet the financial eligibility for all of the GFS/SAPT services.

4.3.3.2 For services in which medical necessity criteria applies, all services must be medically necessary.

4.3.3.3 As defined in Section 6 of the Contract, certain populations have priority to receive GFS/SAPT services.

4.3.4 Meeting the eligibility requirements under this Contract does not guarantee the Consumer will receive a non-crisis behavioral health service. Services other than mental health Crisis Service and ITA-related services are contingent upon Available Resources as managed by the Contractor.

4.3.5 The Contractor shall develop protocols to determine eligibility for non-crisis behavioral health services and submit to HCA for review and approval. At a minimum, protocols shall address data collection, income verification, frequency of financial eligibility review, and identification of priority populations. Eligibility functions may be done by the Contractor or delegated to providers. If delegated to providers, the Contractor shall monitor the providers' use of such protocols and ensure appropriate compliance in determining eligibility.

4.3.5.1 The Contractor shall develop eligibility data collection protocols for providers to follow to ensure that: (i) the provider checks the individual's Medicaid eligibility; and (ii) the provider captures sufficient demographic, financial, and other information to support eligibility decisions and reporting requirements.

4.3.5.2 At HCA's direction, the Contractor shall participate with the regional Accountable Community of Health and AH-FIMC MCO's providing fully integrated services in a regional initiative to develop and implement consistent protocols to determine clinical or program eligibility for the non-crisis behavioral health services.

4.3.5.3 The Contractor shall participate in developing protocols for individuals with frequent eligibility changes. The protocols will address, at a minimum, coordination with the AH-FIMC MCOs, referrals, reconciliations, and potential transfer of GFS/SAPT funds to promote Continuity of Care for the individual. Any reconciliation will occur at a frequency determined by HCA, but no less than semiannually, with potential for up to monthly reconciliations in the last quarter of the allocation year.

5 PAYMENT AND SANCTIONS

5.1 Funding

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

5.1.2 HCA will provide the Contractor with their budget of State-Only, proviso, and Federal Block Grant (FBG) funds for the first quarter of the Contract, and on an annual basis thereafter, identified in Exhibit A-2.

5.1.3 A maximum of ten percent (10%) of the State-Only and proviso funds paid to the Contractor may be used for administrative costs, taxes and other fees per RCW 71.24.330 and must be reported on the monthly expenditure report, as identified in Exhibit B-1.

5.1.4 HCA will pay the quarterly 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 Block Grant funds monthly based upon receipt of a monthly expenditure report as identified in Exhibit B-1. The Contractor shall not use Block Grant funds for administrative costs.

5.1.6 The Contractor shall send a monthly expenditure report to the HCA Contract Manager. The monthly expenditure report format is identified in Exhibit B-1. The monthly expenditure report is due to the HCA no later than fourteen (14) calendar days after the last day of the month. The expenditures reported shall represent the payments made for services under this contract during the calendar month being reported. The ten percent (10%) administrative load, as identified in section 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-2, HCA will not pay the Contractor for the amount that exceeds the budget.

5.1.8 At the end of each quarter, HCA will perform a reconciliation of the Contractor's expenditure reports to their budget. If the Contractor has expended less than the Contractor's quarterly budget, or if the Contractor has expended more than the Contractor's quarterly budget, HCA may adjust Contractor's budget effective the next available quarter within the fiscal year.

5.1.9 For all services, the Contractor must determine whether the Consumer receiving services is eligible for Medicaid or has other insurance coverage.

5.1.9.1 For individuals eligible for Medicaid or other insurance, the Contractor must submit the claim for services to the appropriate party, in accordance with related timely filing requirements.

5.1.9.1.1 At HCA's direction, the Contractor shall participate in a regional initiative to develop and implement claims submission protocols for Crisis Services.

5.1.9.2 For those individuals who do not have other insurance coverage and are not eligible for Medicaid coverage, the Contractor may develop a sliding fee schedule in accordance with Section 10.6.2.

5.1.10 For Mental Health Block Grant (MHBG) services, the Contractor shall comply with the utilization funding agreement guidelines within the State's most recent MHBG plan. The Contractor agrees to comply with Title V, Section 1913 of the Public Health Services Act [42 U.S.C. 300x-1 et seq.]. The Contractor shall not use MHBG funds for the following:

5.1.10.1 The Contractor's administrative costs associated with salaries and benefits at the Contractor's organization level.

5.1.10.2 Inpatient mental health services.

5.1.10.3 Constructions and/or renovation.

5.1.10.4 Capital assets or the accumulation of operating reserve accounts.

5.1.10.5 Equipment costs over $5,000.

5.1.10.6 Cash payments to Consumers.

5.1.11 The Contractor shall administer services provided under this Contract in a manner that best maintains Available Resources throughout the Contract period. 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 (i.e., GFS and FBG), State fiscal or block grant year, and whether the expenditure was for a Medicaid or Non-Medicaid eligible individual. The Contractor shall provide a detailed report of their expenditures for services provided under this Contract to HCA at the close of each calendar month in a format to be determined by HCA and identified in Exhibit B-1.

5.1.12 All funds under this Contract are subject to reconciliation by HCA no less than quarterly. The reconciliation process will compare the funds allocated to the funds expended by the Contractor for eligible services provided to eligible Consumers. HCA may, based on the results of such reconciliations, adjust the Contractor's future allocations as deemed appropriate.

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5.1.13 Funds allocated under this Contract that are not expended by the end of the applicable fiscal year may not be used or carried forward to the subsequent applicable Fiscal Year (FY) or to any other Contract. Unspent allocations will be collected by HCA at the end of the applicable FY.

5.1.14 The Contractor shall ensure that all funds provided pursuant to this Contract, (other than the ten percent (10%) allowed for administration) including interest earned, are to be used to provide services as described in Sections 15 and 16 of this contract.

5.2 State Hospital Beds

5.2.1 The Contractor is allocated seven (7) beds at WSH. This allocation shall be used by the Contractor as a ceiling for the State Hospital Bed utilization by the Consumers they serve under this Contract.

5.2.2 The Contractor may be required to pay a reimbursement for each State Hospital Patient Day of Care that exceeds the Contractor's daily allocation of State Hospital beds based on a quarterly calculation of the bed usage by the Contractor.

5.2.2.1 The Contractor may not enter into any agreement or make other arrangements for use of State Hospital beds outside of the agreed-upon allocation.

5.2.2.2 HCA may bill the Contractor quarterly for State Hospital Patient Days of Care exceeding the Contractor's daily allocation of State Hospital beds. The amount due will be based on the quarterly net census overage. HCA will bill the Contractor within thirty (30) days of notification by DSHS that the Contractor exceeded the allocation. The Contractor shall pay HCA within 30 days of the date on the reimbursement bill. The Contractor shall only use the GFS for the potential State Hospital Bed Allocation overage fee.

5.2.2.2.1 The rate of payment for reimbursement for Eastern State Hospital is $611.00 per day/per bed.

5.2.2.2.2 The rate of payment for reimbursement for Western State Hospital is $541.00 per day/per bed.

5.2.2.3 If the region as a whole has exceeded the quarterly bed allocation, HCA will combine the amount paid by the Contractor with the amounts paid by the other Contractors and will pay DSHS on the Contractor's behalf.

5.2.2.4 If HCA requests for a reimbursement pursuant to 5.1.11 or 5.1.11.3, contractor shall be entitled to waive all or part of its obligation to pay by verifying that the over-allocation of bed usage was solely and completely outside of the contractor's control. This waiver shall be liberally interpreted in the contractor's favor for the first three months of the contact. If the contractor had a prior opportunity to provide for crisis intervention services to an individual who ends up allocating a bed, then the contractor will not be allowed a full waiver of payment for such incident. The amount of any waived portion of the penalty shall be up to the sole discretion of HCA on an incident by incident analysis

5.2.3 If at the end of a Quarter, the Contractor has utilized less than the Contractor's allocation of State Hospital beds and the region as a whole has utilized less than the regional allocated share, the Contractor shall receive a payment from HCA proportional to their share of the bonus payment received from DSHS for the entire region. HCA will pay the bonus payment within thirty (30) days after the payment for the region for the applicable quarter has been received by DSHS.

5.2.4 If at the end of a Quarter, the Contractor has utilized less than the Contractor's allocation of State Hospital beds and the region as a whole has exceeded the regional allocation, the Contractor will receive a portion of the reimbursement collected from the other Contractors proportional to its share of the total number of Patient Days of Care that were not used at the appropriate State Hospital. HCA will pay the bonus payment within thirty (30) days after the payments from the other Contractors in the region or the applicable quarter has been received.

5.2.5 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.

5.3 Inpatient Psychiatric Stays Outside the State Hospital System

HCA will pay professional fees on a fee-for-service basis directly to the hospital for inpatient psychiatric stays that are authorized by the Contractor The inpatient hospital claim(s) will be paid by the Contractor.

5.4 Non-Compliance

5.4.1 Failure to Maintain Reporting Requirements

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.

5.4.2 Recovery of Costs Claimed in Error

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.

5.4.3 Stop Placement:

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

5.4.4 Additional Remuneration Prohibited

5.4.4.1 The Contractor shall not charge or accept additional fees from any patient, relative, or any other person, for FBG services provided under this Contract other than those specifically authorized by HCA. 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.

5.4.4.2 The Contractor shall reduce the amount paid to providers by any sliding fee schedule amounts collected from Consumers in accordance with Section 10.6.2.

5.5 **Overpayments or Underpayments**

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

5.6 **Sanctions**

HCA may:

5.6.1 Initiate remedial action if it is determined that any of the following situations exist:

5.6.1.1 A problem exists that negatively impacts Consumers receiving services.

5.6.1.2 The Contractor has failed to perform any of the Contracted Services.

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

5.6.1.4 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.

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

5.6.2 Impose any of the following remedial actions:

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5.6.2.1 Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to HCA within thirty (30) calendar days of notification. 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.

5.6.2.2 Corrective action plans must include:

5.6.2.2.1 A brief description of the situation requiring corrective action.

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

5.6.2.2.3 A timetable for completion of the actions.

5.6.2.2.4 Identification of individuals responsible for implementation of the plan.

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

5.6.2.3.1 Accept the plan as submitted.

5.6.2.3.2 Accept the plan with specified modifications.

5.6.2.3.3 Request a modified plan.

5.6.2.3.4 Reject the plan.

5.6.3 Withhold up to five percent (5%) of the next payment and each payment thereafter if the Contractor fails to submit or implement the requested corrective action plan within agreed upon timeframes. The amount of withhold will be based on the severity of the situation as detailed in section 5.6. HCA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

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

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

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

6 ACCESS TO CARE AND PROVIDER NETWORK

6.1 **Network Capacity**

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6.1.1 The Contractor shall maintain and monitor an appropriate and adequate provider network, supported by written agreements, sufficient to provide all Contracted Services under this Contract. 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. This provision shall not be construed to require the Contractor to cover such services without authorization. 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. The Contractor may not Contract for Crisis Services (SUD or mental health) or ITA-related services out of Washington State.

6.1.1.1 The Contractor shall submit a network of its Crisis Services to the HCA prior to the start of this contract and at any subsequent time requested by the HCA. The network must have the capacity to serve the RSA and include, at a minimum:

6.1.1.1.1 Designated Mental Health Professional (DMHP);

6.1.1.1.2 Designated Chemical Dependency Specialist (DCDS);

6.1.1.1.3 Evaluation and treatment (E&T) capacity to serve the RSA non-Medicaid population;

6.1.1.1.4 SUD inpatient beds to serve the RSA non-Medicaid population;

6.1.1.1.5 Sufficient staff for mobile crisis outreach in the RSA.

6.1.1.2 The Contractor shall provide quarterly status reports to HCA on its contracting activities in bordering states and RSAs. Quarterly reports are due no later than the 15th of the month following the quarter

6.1.1.3 The Contractor shall notify HCA ninety (90) calendar days prior to terminating any of its Subcontracts or entering into new Subcontracts with entities that provide direct services, including mental health Crisis Services providers. This notification shall occur prior to any public announcement of this change.

6.1.1.3.1 If a Subcontract is terminated in less than the ninety (90) calendar days or a site closure occurs in less than the ninety (90) calendar days, the Contractor shall notify HCA as soon as possible and prior to a public announcement.

6.1.1.3.2 If a Subcontract is terminated or a site closes unexpectedly, the Contractor shall submit a plan within seven (7) calendar days to HCA that includes:

6.1.1.3.2.1 Notification to Ombuds services and Consumers;

6.1.1.3.2.2 A provision for uninterrupted services; and

6.1.1.3.2.3 Any information released to the media.

6.1.1.3.3 HCA reserves the right to impose sanctions, in accordance with the sanctions subsection of this Contract, if the Contractor was notified by the terminating provider in a timely manner and does not comply with the notification requirements of this section.

6.1.1.3.3.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor shall provide documentation of the date of notification along with the notice of loss of a terminating provider.

6.1.1.4 The updated provider network information will be reviewed by HCA for:

6.1.1.4.1 Completeness and accuracy;

6.1.1.4.2 The need for HCA provision of technical assistance;

6.1.1.4.3 Removal of providers who no longer contract with the Contractor; and

6.1.1.4.4 The effect that the change(s) in the provider network will have on the network's compliance with the requirements of this section.

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

6.1.2.1 Only licensed or certified behavioral health providers shall provide behavioral health services. Licensed or certified behavioral health providers include, but are not limited to, Health Care Professionals, licensed agencies or clinics, or non-licensed professionals operating under an agency affiliated license.

6.1.2.2 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.

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

6.1.2.4 Assist the State in expanding community-based, recovery-oriented services, use of Certified Peer Counselors and research- and Evidence-Based Practices.

6.1.3 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network for mental health Crisis Services for two (2) consecutive quarters, and after notification following the first quarter, HCA reserves the right to immediately terminate the Contractor's services.

6.2 **Priority Population Considerations**

6.2.1 In establishing, maintaining, monitoring and reporting of its network, the Contractor must consider the following:

6.2.1.1 The expected utilization of services, characteristics and health care needs of the population, the number and types of providers (training, experience and specialization) able to furnish services, and the geographic location of providers and individuals (including distance, travel time, means of Transportation ordinarily used by Consumers, and whether the location is ADA accessible) for all Contractor funded behavioral health programs and services based on Available Resources.

6.2.1.2 The anticipated needs of priority populations as identified in Section 6.5.

6.2.2 The Contractor and its Subcontractors shall:

6.2.2.1 Ensure that all services and activities provided under this Contract shall be designed and delivered in a manner sensitive to the needs of the diverse population;

6.2.2.2 Initiate actions to ensure or improve access, retention, and cultural relevance of treatment, prevention or other appropriate services, for ethnic minorities and other diverse populations in need of services under this Contract as identified in their needs assessment.

6.3 Hours of Operation for Network Providers

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

6.4 Customer Service

The Contractor shall have a single toll-free number for Consumers to call regarding services, at its expense, which shall be a separate and distinct number from the Contractor's regional crisis toll free telephone line. 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 that are recognized as work days for state employees. HCA may authorize exceptions to this requirement if the Contractor provides HCA with written assurance that its providers will accept enrollment information from HCA. The Contractor shall report by December 1st 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 advanced notification is not possible due to emergency conditions.

6.4.2 The Contractor and its provider help desks, and Consumer customer service centers, if any, shall comply with the following customer service performance standards:

6.4.2.1 Telephone abandonment rate – standard is less than five percent (5%).

6.4.2.2 Telephone response time – average speed of answer within thirty (30) seconds.

6.4.3 The Contractor shall staff its call center with a sufficient number of trained customer service representatives to answer the phones. Staff shall be able to access information regarding eligibility requirements and benefits; GFS/SAPT services; refer for behavioral health services; and resolve and triage Grievances and Appeals.

6.4.4 The Contractor shall submit its customer service policies and procedures to the HCA no later than twenty (20) calendar days before implementation. Customer services policies and procedures shall address the following:

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

6.4.4.2 Authorization requirements;

6.4.4.3 Requirements for responding promptly to family members and supporting links to other service systems such as, Medicaid services administered by the AH-FIMC managed care organizations, law enforcement, criminal justice system, and social services.

6.4.4.4 Assisting and triaging Consumers with access to qualified clinicians without placing the Consumer on hold. The qualified clinician shall assess the crisis and warm transfer the call to the designated crisis provider(s), call 911, refer the Consumer for services or to his or her provider, or resolve the crisis as appropriate.

6.4.5 The Contractor shall train customer services representatives on GFS/SAPT policies and procedures.

6.5 **Priority Populations and Waiting Lists**

The Contractor shall comply with the following requirements:

6.5.1 For SAPT services:

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

6.5.1.1.1 Pregnant injecting drug users.

6.5.1.1.2 Pregnant substance abusers.

6.5.1.1.3 Women with dependent children.

6.5.1.1.4 Injecting drug users.

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

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

6.5.1.2.2 Patients transition from residential care to outpatient care.

6.5.1.2.3 Youth.

6.5.1.2.4 Offenders as defined in RCW 70.96.350.

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

6.5.2.1 The Contractor shall provide non-crisis behavioral health services funded by GFS Consumers who meet financial eligibility standards in Section 4.3.3 and meet one of the following criteria:

6.5.2.1.1 Are uninsured;

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

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

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

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

6.6 **Access to Services**

6.6.1 The Contractor shall, subject to Available Resources, ensure that SAPT services are not denied to any eligible Consumer regardless of:

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

6.6.1.2 The fact that a Consumer is taking medically-prescribed medications.

6.6.1.3 The fact that a person is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.

6.6.2 The Contractor shall, as required by the SAPT Block Grant, ensure Interim Services are provided for pregnant and parenting women and intravenous drug users.

6.6.2.1 Interim Services shall be made available within forty-eight (48) hours of seeking treatment for pregnant and parenting women and intravenous drug users.

6.6.2.2 Admission to treatment services for the intravenous drug user shall be provided within fourteen (14) days after the patient makes the request, regardless of funding source.

6.6.2.3 If there is no treatment capacity within fourteen (14) days of the initial patient request, the Contractor shall have up to one hundred twenty (120) days, after the date of such request, to admit the patient into treatment, while offering or referring to Interim Services within forty-eight (48) hours of the initial request for treatment services

6.6.3 A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of detoxification, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within twenty-four (24) hours.

6.7 **Capacity to Deliver SAPT Services**

The Contractor shall comply with the following requirements for SAPT services:

6.7.1 Data Collection

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6.7.1.1 The Contractor shall collect and report on patient information as specified by the DSHS Reporting Requirements in Exhibit C. 6.7.1.2 Except for the requirement that the Contractor provide timely and accurate data related to the Involuntary Treatment Act pursuant to ITA investigations and detentions under Chapter 71.05 RCW, the above provision under 6.7.1.1 shall be suspended until such time that the Contractor receives additional funding from HCA in the amount appropriated by the 2016 Legislature for Early Adopter implementation. The purpose of these funds is to allow the Contractor to fully develop or purchase the necessary computer programing or services to complete such reporting. Such funds shall only be paid to the contractor, if the Legislature in its 2016 session specifically appropriates the funds to HCA for Early Adopter implementation purposes, and HCA agrees in writing that the funding amount for the technological solution requested by the Contractor is appropriate, and not to exceed $1,100,000.00. Within one-hundred eighty (180) days of such funding being provided, the suspension of the reporting requirement in this Section expires.

6.7.2 **Capacity Management** (42 U.S.C. 300-23 and 42 U.S.C. 300X 27)

6.7.2.1 The Contractor must notify HCA, in writing, when their network of SAPT providers is at ninety (90) percent capacity.

6.7.2.2 On a quarterly basis, submit Exhibit D, SAPT Capacity Management Form on the last day of the month following the close of the quarter. For example the first report is due July 31, 2016, for April 1, 2016, through June 30, 2016.

6.7.2.3 The Capacity Management Form must identify PPW and Individuals Using Intravenous Drugs (IUID) providers receiving SAPT funds, who are at (90) percent capacity, and what was or is being done to address capacity.

6.7.2.4 Per Section 9.5.5, PPW/IUID providers receiving SAPT funds must notify the Contractor when they have reached (90) percent capacity and must maintain records using the Capacity Management Form.

6.7.3 **Tuberculosis Screening, Testing and Referral (42 USC 300x-24(a) and 45 CFR 96.127)**

6.7.3.1 The Contractor must directly or through arrangement with other public entities, make tuberculosis services available to each Individual receiving SAPT-funded SUD treatment. The services must include tuberculosis counseling, testing, and provide for or refer Consumers with tuberculosis for appropriate medical evaluation and treatment.

6.7.3.2 When a Consumer is denied admission to the tuberculosis program because of the lack of capacity, the Contractor will refer the Individual to another provider of tuberculosis services.

6.7.3.3 The Contractor must conduct case management activities to ensure the Consumer receives tuberculosis services.

6.8 **Outreach to Individuals Using Intravenous Drugs**

6.8.1 The Contractor shall ensure that Opiate Dependency Outreach is conducted to IUID. (45 C.F.R. 96.126)(e).

7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1 **Quality Management Program**

7.1.1 The Contractor shall ensure its Quality Management (QM) program addresses GFS/SAPT requirements and meets Crisis Services standards. It shall be the independent obligation of the Contractor to remain current with all GFS/SAPT requirements.

7.1.2 The Contractor shall participate in a Community Behavioral Health Advisory Board and attend meetings as required by established bylaws.

7.2 **Quality Review Activities**

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

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

7.2.1.2 Audits regarding the quality, appropriateness, and timeliness of behavioral health services provided under this Contract.

7.2.1.3 Audits and inspections of financial records.

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

7.3 Performance-Measurement Reporting

7.3.1 At HCA's discretion, individual performance measures will be linked to potential payment adjustments.

7.3.2 HCA Defined Reporting and Data Submission Methods for Performance Measurement:

7.3.2.1 The Contractor shall comply with the reporting and data submissions requirements as directed by HCA. Should HCA adopt a subsequent set of requirements during the course of this Contract, HCA shall update the performance requirements as necessary.

7.3.2.2 Prior to the implementation of a new program of service, the Contractor and HCA shall agree upon a program guidance/instruction document that will specify the process for reporting the service activity under that program.

7.3.3 The Contractor shall report on the performance measures and metrics in Exhibit E.

7.3.4 The Contractor shall provide all relevant crisis response system and service reports as directed by HCA. The reports shall include at a minimum, the information included in Exhibit E.

7.4 Critical Incident Reporting

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The Contractor shall report critical incidents through the DSHS *Behavioral Health & Recovery Incident Reporting System* database, notify the HCA critical incident manager through the HCA MC Programs mailbox, and if appropriate, notify the MCO of any critical incident of which it becomes aware as described in this subsection and in accordance with WAC 388-877-0200, 388-877-0365, 388-877-0410, and 388-877-0420.

7.4.1 Report shall include a description of the event, including the date and time of the incident, the incident location, incident type, names, and ages if known of all individuals involved and the nature of their involvement, service history with the Contractor, steps taken by the Contractor to minimize harm, and any legally required notification made by the Contractor.

7.4.2 The Contractor must report and follow up on the incidents listed below. In addition, the Contractor shall use professional judgment in reporting incidents not listed herein.

7.4.2.1 Category One Incidents. Report shall be made during the business day in which the Contractor becomes aware of such an event:

7.4.2.1.1 Death or serious injury of, a Consumer, staff, or public citizen, at a state licensed or certified healthcare facility that HCA or DSHS licenses, contracts with, or

7.4.2.1.2 Unauthorized leave of a mentally ill offender or a sexually violent offender from a mental health facility or a Secure Community Transition Facility to include Evaluation and Treatment centers (E&T), Crises Stabilization Units (CSU), and Triage Facilities that accept involuntary Consumers.

7.4.2.1.3 Any violent act to include rape or sexual assault, as defined in RCW 71.05.020 and RCW 9.94A.030, or any homicide or attempted homicide committed by a Consumer.

7.4.2.1.4 Any event involving an individual or staff that has attracted or is likely to attract media attention.

7.4.2.2 Category Two Incidents. Report shall be made within one business day in which the Contractor becomes aware of such an event:

7.4.2.2.1 Alleged abuse or neglect of a Consumer that is serious or emergent in nature by an employee, volunteer, licensee, Contractor or another individual.

7.4.2.2.2 A substantial threat to facility operation or Consumer safety resulting from a natural disaster, to include but not limited to: an earthquake, volcanic eruption, tsunami, fire, flood, or an outbreak of communicable disease, etc.

7.4.2.2.3 Any allegation of financial exploitation as defined in RCW 74.34.020.

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7.4.2.2.4 Any attempted suicide that requires medical care that occurs at a facility that HCA or DSHS licenses, contracts with, and/or certifies.

7.4.2.2.5 Any event involving: a credible threat towards a staff member that occurs at a licensed or certified healthcare facility; or a similar event that occurs within the community. A credible threat in this subsection means either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family, which resulted in a report to Law Enforcement, a restraining/protection order, or a workplace safety/personal protection plan.

7.4.2.3 The Contractor shall also report all instances of suspected patient abuse or neglect in accordance with all state and federal law.

7.4.2.4 The Contractor must ensure that subcontracted providers follow requirements for reporting to the Contractor and managing critical incidents. The Contractor must track and monitor the incidents within its provider network and determine if the incidents are responded to in an appropriate and timely manner. If a pattern suggesting a systematic issue is identified, the Contractor must monitor the provider's actions towards resolving the issue.

7.4.2.5 Comprehensive Review: HCA or DSHS may require the Contractor initiate a comprehensive review of an incident.

7.4.2.5.1 The Contractor shall fully cooperate with any investigation initiated by HCA or DSHS and provide any information requested by HCA or DSHS in the timeframe specified within the request.

7.4.2.5.2 If the Contractor does not respond in the timeframe allowed HCA or DSHS may obtain information directly from any involved party and request their assistance in the investigation.

7.4.2.6 Incident Review and Follow Up: The Contractor shall review and follow up on all incidents within two (2) weeks. An incident shall not be categorized as complete until the following information is provided:

7.4.2.6.1 A summary of any incident debriefings or review process dispositions.

7.4.2.6.2 Whether the person is in custody (jail), in the hospital, or in the community, and if in the community whether the person is receiving services. If the Consumer cannot be located, the Contractor shall document in the Incident Reporting System the steps taken to locate the Consumer using available local resources.

7.4.2.6.3 Documentation of whether the Consumer is or is not receiving behavioral health services from the Contractor at the time the incident is closed.

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7.4.2.6.4 In the case of the death of the Consumer either a telephonic verification from an official source or a death certificate.

7.4.2.6.5 In the case of a telephonic verification, the Contractor shall document the date of the contact and both the name and official duty title of the person verifying the information.

7.4.2.6.6 If this information is unavailable, the Contractor shall document the attempt to retrieve it.

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7.5 **Practice Guidelines**

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

7.5.1.1 Valid and reliable clinical scientific evidence;

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

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

7.5.2 The Contractor may adopt guidelines developed by recognized sources that develop or promote evidence-based clinical practice guidelines such as voluntary health organizations, National Institute of Health Centers, or the Substance Abuse and Mental Health Services Administration (SAMHSA). If the Contractor does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines. The guidelines shall:

7.5.2.1 Consider the needs of Consumers and support client and family involvement in care plans.

7.5.2.2 Be adopted in consultation with contracting Behavioral Health Professionals within the state of Washington.

7.5.2.3 Be reviewed and updated at least every two (2) years and more often if national guidelines change during that time.

7.5.2.4 Be disseminated to all affected providers and, upon request, to HCA and Consumers.

7.5.3 The Contractor shall include the Behavioral Health Medical Director in the evaluation of emerging technologies for the treatment of behavioral health conditions and related decisions. The Contractor shall also have a child psychiatrist available for consultation related to other emerging technologies for the treatment of behavioral health conditions in children and adolescents.

7.6 **Health Information Systems**

The Contractor shall establish and maintain, and shall require Subcontractors to maintain, a health information system that complies with the requirements of HCA Security Policies and standards 6-05 through 6-15-01, and OCIO Security Standard 141.10, and provides the information necessary to meet the Contractor's obligations under this Contract. HCA Security Policies and Standards are available at: https://shared.sp.wa.gov/sites/InsideHCA/policies_and_procedures/Pages/Agency-Policies-and-Procedures.aspx. OCIO Security Standards are available at: https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets. The Contractor shall have in place mechanisms to verify the health information received from Subcontractors. The Contractor shall:

7.6.1 Collect, analyze, integrate, and report data. The system must provide information on areas including, but not limited to: utilization, and fund availability by service type and fund source.

7.6.2 Ensure data received from providers is accurate and complete by:

7.6.2.1 Verifying the accuracy and timeliness of reported data;

7.6.2.2 Screening the data for completeness, logic and consistency; and

7.6.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.

7.6.3 Make all collected data available to HCA upon request, to the extent permitted by the HIPAA Privacy Rule (45 C.F.R. Part 160 and Subparts A and E of Part 164 and RCW 70.02.005 et seq.).

7.6.4 Establish and maintain protocols to support timely and accurate data exchange with any Subcontractor that will perform any delegated functions under the Contract.

7.6.5 Establish and maintain web-based portals with appropriate security features that allow referrals, requests for prior authorizations, claims/encounters submission, and claims/encounters status updates.

7.6.5.1 In addition, the web-based portal should allow for contracted providers to determine whether or not an individual is enrolled in Medicaid. Inputting information in the portal shall not be a barrier to providing a necessary Crisis Service.

7.6.6 Have information systems that enable paperless submission, automated processing, and status updates for prior authorization and other utilization management related requests.

7.6.7 Maintain behavioral health content on a website that meets the following minimum requirements.

7.6.7.1 Public and secure access via multi-level portals for providing web-based training, standard reporting, and data access for the effective management and evaluation of the performance of the Contract and the service delivery system as described under this Contract.

7.6.7.2 The Contractor shall organize the website to allow for easy access of information by Consumers, family members, network providers, stakeholders and the general public in compliance with the Americans with Disabilities Act. The Contractor shall include on its website, at a minimum, the following information or links:

7.6.7.2.1 Hours of operations;

7.6.7.2.2 How to access information on Contracted Services and toll-free crisis telephone numbers;

7.6.7.2.3 Telecommunications device for the deaf/text telephone numbers;

7.6.7.2.4 Information on the right to choose a qualified behavioral health service provider, when available and medically necessary; and

7.6.7.2.5 An overview of the range of behavioral health services being provided.

7.6.8 Data Security Requirements

7.6.8.1 The Contractor shall comply with applicable provisions of the (HIPAA of 1996, codified in 42 USC §1320(d) et. seq. and 45 CFR Parts 160, 162 and 164l, and HCA Security Policies and Standards 6-05 through 6-15-01 and OCIO Security Standard 141.10. The Contractor will implement physical, administrative, and technical safeguards to assure the confidentiality, integrity, and accessibility of the data. The Contactor will require all Subcontractors to implement those safeguards.

7.6.8.2 The Contractor shall ensure that confidential information provided through or obtained by way of this Contract or services provided, is protected in accordance with the Data Security Requirements described in this section.

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

7.6.8.4 The Contractor shall take appropriate action if a Subcontractor or Contractor employee wrongly releases confidential information.

7.6.8.5 Data Transport. When transporting HCA Confidential Information electronically, including via email, the data will be protected by:

7.6.8.5.1 Transporting the data within the (State Governmental Network) SGN or, if it is secure, Contractor's internal network, or;

7.6.8.5.2 Encrypting any data that will be in transit outside the SGN or, if it is secure, Contractor's internal network. This includes transit over the public Internet.

7.6.8.6 Protection of Data. The Contractor agrees to store data in a manner that follows HIPAA security measures.

7.6.8.7 Data Segregation.

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7.6.8.7.1 HCA data on Contracted Services must be segregated or otherwise distinguishable from non-HCA data. This is to ensure that when no longer needed by the Contractor, all HCA data can be identified for return or destruction. It also aids in determining whether HCA data has or may have been compromised in the event of a security breach.

7.6.8.7.2 The Contractor shall store HCA data:

7.6.8.7.2.1 On media (e.g., hard disk, optical disc, tape, etc.) which will contain no non-HCA data; or

7.6.8.7.2.2 In a logical container on electronic media, such as a partition or folder dedicated to HCA data; or

7.6.8.7.2.3 In a database which will contain no non-HCA data; or

7.6.8.7.2.4 Within a database and will be distinguishable from non-HCA data by the value of a specific field or fields within database records; or

7.6.8.7.2.5 Physically segregated from non-HCA data in a locked container, when stored as physical paper documents.

7.6.8.7.3 When it is not feasible or practical to segregate HCA data from non-HCA data, then both the HCA data and the non-HCA data must be protected as described in this subsection.

7.6.8.8 Data Disposition. When the contracted work has been completed or no longer needed, data shall be returned to HCA or destroyed. When the Contractor destroys data, the Contractor will keep no copies. Media on which data may be stored and associated acceptable methods of destruction are as follows:

Data stored on:	**Will be destroyed by:**
Server or workstation hard disks, or Removable media (e.g. floppies, USB flash drives, portable hard disks, Zip or similar disks).	Using a "wipe" utility which will overwrite the data at least three (3) times using either random or single character data, or Degaussing sufficiently to ensure that the data cannot be reconstructed, or Physically destroying the disk.
Paper documents with sensitive or confidential data.	Recycling through a contracted firm provided the contract with the recycler assures that the confidentiality of data will be protected.
Paper documents containing confidential information requiring special handling (e.g., protected health information).	On-site shredding, pulping, or incineration.

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Optical discs (e.g. CDs or DVDs).	Incineration, shredding, or completely defacing the readable surface with a coarse abrasive.
Magnetic tape.	Degaussing, incinerating or crosscut shredding.

7.6.8.9 The Contractor shall report the compromise or potential compromise of HCA shared data to the HCA within one (1) business day of discovery. The report will include at least the following: any omitted information will be added, and any information found to have been incomplete or inaccurate will be supplemented or corrected, within fifteen (15) days of the discovery:

7.6.8.9.1 A description of the incident;

7.6.8.9.2 A description of the types of PHI or Personally Identifiable Information (PII) involved;

7.6.8.9.3 An estimate of the number of individuals whose information were or may have been compromised; and

7.6.8.9.4 A description of what the Contractor is doing to investigate the matter, mitigate harm to individuals, and avoid further compromise.

7.6.8.10 If the Contractor notifies individuals, the federal Department of Health and Human Services, or the Washington State Attorney General of the compromise or possible compromise, pursuant to 45 C.F.R. §164.400 et seq., RCW 19.255.010, or otherwise, Contractor will give HCA a copy of the notice no later than the day the notice is sent.

7.6.8.11 Data Shared with Subcontractors. If HCA's data provided under this Contract is shared with a Subcontractor, the Contract with the Subcontractor must include all of the data security provisions within this Contract. If the Contractor cannot protect the data as articulated within this Contract, then the Contract with the Subcontractor must be submitted to the HCA for review and approval.

7.7 **Required Reporting for Behavioral Health Services**

7.7.1 The Contractor will comply with required reporting for behavioral health services in Exhibit C and elsewhere in this Contract. The Contractor's disclosure of PII is authorized by law, including 42 C.F.R. § 2.53, authorizing disclosure of patient records for purposes of Medicaid evaluation.

7.7.2 Except for the requirement that the Contractor provide timely and accurate data related to the Involuntary Treatment Act (ITA) pursuant to ITA investigations and detentions under Chapter 71.05 RCW, the above provision under subsection 7.7.1 shall be suspended as it relates to the reporting of behavioral health services in Exhibit C, until such time that the Contractor receives additional funding from HCA in the amount appropriated by the legislature for Early Adopter implementation, The purpose of such funds is to allow the Contractor to develop or purchase the necessary computer programing or services to complete such reporting. Such funds shall only be paid to the Contractor, if the Legislature in its 2016 session specifically appropriates the funds to HCA for Early Adopter implementation purposes and HCA agrees in writing that the funding amount for the technological solution requested by the Contractor is appropriate, and not to exceed $1,100,000.00. Within one-hundred eighty (180) days of such funding being provided, the suspension of the reporting requirement in this section expires.

7.8 Technical Assistance

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

8 POLICIES AND PROCEDURES

The Contractor shall develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of this Contract. The Contractor shall submit policies and procedures to the HCA for review and approval in accordance with Section 8.2, Assessment of Policies and Procedures.

8.1 The Contractor's policies and procedures shall:

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

8.1.2 Fully articulate the Contractor's understanding of the requirements.

8.1.3 Have an effective training plan related to the requirements and maintain records of the number of staff participating in training, including evidence of assessment of participant knowledge and satisfaction with the training.

8.1.4 Have an effective training plan related to the requirements and maintain records of the number of providers who participate in training, including satisfaction with the training.

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

8.2 Assessment of Policies and Procedures

8.2.1 The Contractor shall complete a self-assessment of its policies and procedures related to this Contract to HCA for review and approval. The self-assessment will be provided by HCA. The Contractor shall complete and submit the self-assessment no later than June 30th of each year starting in 2017 and; thereafter, in response to corrective action and any time there is a new policy and procedure or a change to an existing policy and procedure. The Contractor shall also submit copies of policies and procedures upon request by HCA.

9 SUBCONTRACTS

9.1 Contractor Remains Legally Responsible

Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract, except as limited in Section 9.5. However, no Subcontractor may terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any Subcontractor.

9.2 Provider Nondiscrimination

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

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

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

9.2.4 Consistent with the Contractor's responsibilities to Consumers, this section may not be construed to:

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

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

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

9.3 **Required Provisions**

9.3.1 Subcontracts shall be in writing, and available to HCA upon request. All Subcontracts shall contain the following provisions, in addition to applicable provisions contained in Subsections 9.5 and 9.6 of this Contract:

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

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

9.3.1.3 Procedures and specific criteria for terminating the Subcontract.

9.3.1.4 Identification of the services to be performed by the Subcontractor and which of those services may be subcontracted by the Subcontractor. If the Contractor allows the Subcontractor to further subcontract, all Subcontractor requirements contained in this Contract must be propagated downward into any other lower tiered Subcontracts (45 C.F.R. 92.35).

9.3.1.5 Reimbursement rates and procedures for services provided under the Subcontract.

9.3.1.6 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.

9.3.1.7 Reasonable access to facilities, and financial and medical records for duly authorized representatives of HCA or DHHS 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, to the Contractor. The Contractor shall ensure that all Subcontractors required to report encounter data have the capacity to submit all HCA required data to enable the Contractor to meet the requirements under the Contract.

9.3.1.9 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved Program Integrity policies and procedures.

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

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

9.3.2 The Contractor shall provide the following information regarding the Grievance system for GFS/SAPT funded Contracted Services to all Subcontractors:

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9.3.2.1 The toll-free numbers to file oral Grievances and Appeals.

9.3.2.2 The availability of assistance in filing a Grievance or Appeal.

9.3.2.3 The Consumer's right to file Grievances and Appeals and their requirements and timeframes for filing.

9.3.2.4 The Consumer's right to a hearing, how to obtain a hearing and representation rules at a hearing.

9.3.3 The Contractor may not delegate its responsibility to contract with a provider network. This does not prohibit a contracted, licensed provider from subcontracting with other appropriately licensed providers so long as the subcontracting provisions of this Contract are met.

9.3.4 The responsibilities Section 7.8 Quality Management, may not be delegated to a Contracted Network CMHA.

9.3.5 HCA may place limits on delegating financial risk to any Subcontractor in any amount, and is subject to review and approval by HCA.

9.4 **Management of Subcontracts**

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

9.4.1.1 The review must be based on the specific delegation agreement with each Subcontractor, and must address compliance with Contract requirements for each delegated function including, but not limited to:

9.4.1.1.1 Documentation and appropriateness of medical necessity determinations.

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

9.4.1.1.3 Client record reviews to the treatment plans.

9.4.1.1.4 Timeliness of service.

9.4.1.1.5 Network adequacy.

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

9.4.1.1.7 Coordination with other service providers.

9.4.1.1.8 Provider adherence to practice guidelines, as relevant.

9.4.1.1.9 Provider processes for reporting, tracking, and resolving complaints/grievances.

9.4.1.1.10 Provider compliance with reporting and managing critical incidents.

9.4.1.1.11 Information security.

9.4.1.1.12 Disaster recovery plans.

9.4.1.1.13 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 under WAC 388-865-0270. A fiscal review shall be conducted at least annually of Subcontractors receiving FBG funds, regardless of reimbursement methodology, to ensure: a) expenditures are accounted for by revenue source; b) no expenditures were made for items identified as prohibited in Section 5 of this Contract; c) expenditures are made only for the purposes stated in this Contract; and d) that services were actually provided.

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

9.4.2 No assignment of a Subcontract shall take effect without HCA's written agreement.

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

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

9.4.5 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 and/or FBG funds to a county without a contract or single-case agreement.

9.5 **Provider Subcontracts**

The Contractor's Subcontracts shall contain the following provisions:

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

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

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

9.5.3.1 Coordinate a community-based discharge plan for each Consumer served under this Contract beginning at intake in order to procure the best available recovery plan and environment for the patient. Discharge planning shall apply to all Consumers regardless of length of stay or whether they complete treatment;

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

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

9.5.3.4 Coordinate, as needed, with DBHR prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including the DSHS Children's Administration, and the DSHS Economic Services Administration including Community Service Offices (CSOs); and

9.5.3.5 Coordinate services to financially-eligible Consumers who are in need of medical services.

9.5.4 A requirement that residential treatment providers ensure that priority admission is given to the populations identified by HCA in Section 6.

9.5.5 Requirements for information and data sharing to support Care Coordination consistent with Section 14 of this Contract.

9.5.6 A requirement to implement a Grievance process that complies with WAC 182-538C-110 and as described in the Grievance Section of this Contract.

9.5.7 A requirement that termination of a Subcontract shall not be grounds for an appeal, Administrative Hearing, or a Grievance for the Consumer if similar services are immediately available in the service area.

9.5.8 Requirements for how Consumers will be informed of their right to a Grievance or Appeal in the case of:

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

9.5.8.2 Denial or termination of service related to Available Resources.

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

9.5.9 A requirement that the Subcontractor shall comply with Chapter 71.32 RCW (Mental Health Advance Directives).

9.5.10 A requirement to provide Consumers access to translated information and interpreter services as described in Section 3.3 of this Contract.

9.5.11 A requirement for adherence to established protocols for determining eligibility for services consistent with Section 4 and Section 6 of this Contract.

9.5.12 A requirement to use DSHS 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.

9.5.13 A requirement to participate in training when requested by HCA. Exceptions must be in writing and include a plan for how the required information shall be provided to targeted Subcontracted staff.

9.5.14 A requirement to conduct criminal background checks and maintain related policies and procedures and personnel files consistent with requirements in Chapter 43.43 RCW, Chapters 388-877 and 388-877B WAC and Chapter 388-06A WAC.

9.5.15 Requirements for nondiscrimination in employment and patient services.

9.5.16 Protocols for screening for debarment and suspension of certification.

9.5.17 Requirements to identify funding sources consistent with Section 5 and Federal Block Grant reporting requirements.

9.5.18 A requirement to participate in the peer review process when requested by HCA. (42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136). The SAPT Block Grant requires an annual peer review by individuals with expertise in the field of drug abuse treatment. At least five percent (5%) of treatment providers will be reviewed.

9.5.19 The Contractor shall ensure that the Charitable Choice Requirements of 42 CFR Part 54 are followed and that Faith-Based Organizations (FBO) are provided opportunities to compete with traditional alcohol/drug abuse treatment providers for funding.

9.5.20 If the Contractor Subcontracts with FBOs, the Contractor shall require the FBO to meet the requirements of 42 C.F.R. Part 54 as follows:

9.5.20.1 Consumers requesting or receiving SUD services shall be provided with a choice of SUD treatment providers.

9.5.20.2 The FBO shall facilitate a referral to an alternative provider within a reasonable time frame when requested by the recipient of services.

9.5.20.3 The FBO shall report to the Contractor all referrals made to alternative providers.

9.5.20.4 The FBO shall provide Consumers with a notice of their rights.

9.5.20.5 The FBO provides Consumers with a summary of services that includes any inherently religious activities.

9.5.20.6 Funds received from the FBO must be segregated in a manner consistent with federal Regulations.

9.5.20.7 No funds may be expended for religious activities.

9.5.21 A requirement that the Subcontractor shall respond in a full and timely manner to law enforcement inquiries regarding an individual's eligibility to possess a firearm under RCW 9.41.040(2)(a)(ii).

9.5.21.1 As of August 1, 2013, all behavioral health organizations in the state of Washington are required to forward historical mental health Involuntary Commitment information retained by the organization including identifying information and dates of commitment to DSHS. As soon as feasible, the Contractor must arrange to report new commitment data to the DSHS within twenty-four (24) hours. Commitment information under this section does not need to be re-sent if it is already in the possession of DSHS. The Contractor and DSHS shall be immune from liability related to the sharing of commitment information under this section (RCW 71.05.740).

9.5.22 Delegated activities are documented and agreed upon between Contractor and Subcontractor. The document must include:

9.5.22.1 Assigned responsibilities.

9.5.22.2 Delegated activities.

9.5.22.3 A mechanism for evaluation.

9.5.22.4 Corrective action policy and procedure.

9.5.23 A requirement that information about Consumers, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and Regulations.

9.5.24 The Subcontractor agrees to hold harmless HCA and its employees, and all Consumers served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors.

9.5.25 A ninety (90) day termination notice provision.

9.5.26 A specific provision for termination with short notice when a Subcontractor is excluded from participation in the Medicaid program.

9.5.27 The Subcontractor agrees to comply with the appointment wait time standards of this Contract. The Subcontract must provide for regular monitoring of timely access and corrective action if the Subcontractor fails to comply with the appointment wait time standards.

9.5.28 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards. Formal review must be completed no less than once every three (3) years, except as noted below, and must identify deficiencies or areas for improvement and provide for corrective action.

9.5.28.1 The Contractor shall conduct a Subcontractor review which shall include at least one (1) onsite visit every two (2) years to each Subcontractor site providing state funded or FBG funded treatment services during the period of performance of this Contract in order to monitor and document compliance with requirements of the Subcontract.

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

9.5.28.3 The Contractor shall ensure that the Subcontractor updates patient funding information when the funding source changes.

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

9.5.28.5 The Contractor shall monitor SUD and Mental Health residential providers.

9.5.29 A statement that Subcontractors shall comply with required audits, including authority to conduct a facility inspection and the federal Office of Management and Budget (OMB) Super Circular 2 C.F.R. 200.501 and 45 C.F.R. 75.501 audits, as applicable to the Subcontractor.

9.5.29.1 The Contractor shall submit a copy of the OMB audit performed by the State Auditor to the HCA Contact identified on page one of the Contract within ninety (90) days of receipt by the Contractor of the completed audit.

9.5.29.1.1 If a Subcontractor is subject to OMB Super Circular audit, the Contractor shall require a copy of the completed Single Audit and ensure corrective action is taken for any audit finding, per OMB Super Circular requirements.

9.5.29.1.2 If a Subcontractor is not subject to OMB Super Circular, the Contractor shall perform sub-recipient monitoring in compliance with federal requirements.

9.5.30 The Contractor shall document and confirm in writing all single-case agreements with providers. The agreement shall include:

9.5.30.1 The description of the services;

9.5.30.2 The authorization period for the services, including the begin date and the end date for approved services;

9.5.30.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other plan documents that define payment; and

9.5.30.4 Any other specifics of the negotiated rate.

9.5.31 The Contractor must supply documentation to the Subcontractor no later than five (5) business days following the signing of the agreement. Updates to the unique contract, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).

9.5.32 The Contractor shall maintain a record of the single-case agreements for a period of six (6) years.

9.6 **Federal Block Grant Subcontracts and Subcontract Monitoring**

9.6.1 All activities and services performed in accordance with this Contract, which are not performed directly by the Contractor, must be subcontracted according to the terms set forth by the Community Behavioral Health Advisory Board approved MHBG or SAPT project plan.

9.6.2 FBG funds may not be used to pay for services provided prior to the execution of Subcontracts, or to pay in advance of service delivery. All Subcontracts and amendments must be in writing and executed by both parties prior to any services being provided.

9.6.3 FBG fee-for-service, set rate, performance-based, Cost Reimbursement, and lump sum Subcontracts shall be based on reasonable costs.

9.6.4 The Contractor shall retain, on site, all Subcontracts. Upon request by HCA, the Contractor will immediately make available any and all copies, versions, and amendments of Subcontracts.

9.6.5 The Contractor must obtain prior approval before entering into any subcontracting arrangement. In addition, the Contractor shall submit to the HCA Contract Manager at least one (1) of the following for review and approval:

9.6.5.1 A copy of the proposed Subcontract to ensure it meets all HCA requirements; or

9.6.5.2 A copy of the Contractor's standard contract template to ensure it meets all requirements and approve only Subcontracts entered into using that template; or

9.6.5.3 Certification in writing that the Subcontractor meets all requirements under the Contract and that the Subcontract contains all required language under the contract, including any data security, confidentiality and/or Business Associate language as appropriate.

9.6.6 The Contractor shall ensure that its Subcontractors receive an independent audit if the Subcontractor expends a total of $750,000 or more in federal awards from any and/or all sources in any fiscal year. The Contractor shall require all Subcontractors submit to the Contractor the data collection form and reporting package specified in 2 C.F.R. Part 200, Subpart F, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor within ten (10) days of audit reports being completed and received by Subcontractors. The Contractor shall follow up with any corrective actions for all Subcontractor audit findings in accordance with 2 C.F.R. Part 200, Subpart F. The Contractor shall retain documentation of all Subcontractor monitoring activities; and, upon request by HCA, shall immediately make all audits and/or monitoring documentation available to HCA.

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

9.6.7.1 Expenditures are accounted for by revenue source.

9.6.7.2 No expenditures were made for items identified in Section 5.1.6 of this Contract.

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

9.7 **Health Care Provider Subcontracts Delegating Administrative Functions**

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

9.7.1.1 Clear descriptions of any administrative functions delegated by the Contractor in the Subcontract. Administrative functions are any obligations of the Contractor under this Contract other than the direct provision of services to Consumers and include, but are not limited to: utilization/medical management, claims processing, Consumer Grievances and Appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.

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

9.7.2 Prior to delegation, an evaluation of the Subcontractor’s ability to successfully perform and meet the requirements of this Contract for any delegated administrative function.

9.7.3 The Contractor shall submit a report of all current delegated entities, activities delegated, and the number of Consumers assigned or serviced by the delegated entity to the HCA as part of the annual monitoring review, or as required by the HCA.

9.7.4 A Subcontractor that is a provider of behavioral health services and providing behavioral health administrative functions has established a conflict of interest policy that:

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

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

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

9.8 **Provider Education**

9.8.1 The Contractor shall maintain a system for keeping providers informed about:

9.8.1.1 Contracted services for Consumers served under this Contract.

9.8.1.2 Coordination of care requirements.

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

9.8.1.4 Data interpretation.

9.8.1.5 Practice guidelines as described in the provisions of this Contract.

9.8.1.6 The information requirements for Utilization Management (UM) decision making, procedure coding, and submitting claims for GFS and FBG funded services. The Contractor shall inform GFS and FBG providers in writing regarding these requirements.

9.8.1.7 Contractor care management staff for assistance in care transitions and care management activity.

9.8.1.8 Program Integrity requirements.

9.9 **Provider Payment Standards**

9.9.1 The Contractor shall meet the timeliness of payment standards as specified in this section. To be compliant with payment standards the Contractor shall pay or deny, and shall require Subcontractors to pay or deny, ninety-five percent (95%) of clean claims and encounters within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) calendar days of receipt and ninety-nine percent (99%) of claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

9.9.1.1 A claim is a bill for services, a line item of service, or all services for one (1) Consumer within a bill.

9.9.1.2 A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

9.9.1.3 The date of receipt is the date the Contractor receives the claim or encounter from the provider.

9.9.1.4 The date of payment is the date of the check or other form of payment.

9.9.2 The Contractor shall support both hardcopy and electronic submission of claims, encounters and bills for all Contracted Services types for which claims submission is required.

9.9.3 The Contractor must support hardcopy and electronic submission of claim, encounter or bill inquiry forms, and adjustment claims, encounters and bills.

9.9.4 The Contractor shall update its claims and encounter system to support processing of payments for the Contracted Services.

9.10 Coordination of Benefits and Subrogation of Rights of Third Party Liability

9.10.1 Coordination of Benefits:

9.10.1.1 The services and benefits available under this Contract shall be secondary to any other coverage.

9.10.1.2 Nothing in this section negates any of the Contractor's responsibilities under this Contract. The Contractor shall:

9.10.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in WAC 284-51.

9.10.1.2.2 Attempt to recover any third-party resources available to Consumers and make all records pertaining to coordination of benefits collections for Consumers available for audit and review.

9.10.1.2.3 Pay claims for contracted services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed

9.10.1.2.4 Coordinate with out-of-network providers with respect to payment to ensure the cost to Consumers is no greater than it would be if the services were furnished within the network.

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9.10.1.2.5 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

9.11 **Provider Credentialing**

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

9.11.1 The Contractor's policies and procedures shall ensure compliance with requirements described in this section.

9.11.1.1 The Contractor shall verify that all Subcontractors meet the licensure and certification requirements as established by state and federal statute, administrative code, or as directed in this contract.

9.11.1.2 The Contractor shall recognize providers operating under the license of a licensed or certified agency.

9.11.1.3 The Contract shall verify that all Designated Mental Health Professionals and Designated Chemical Dependency Specialists are authorized as such by the county authorities.

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10 CONSUMER RIGHTS AND PROTECTIONS

10.1 General Requirements

10.1.1 The Contractor shall comply with any applicable federal and state laws that pertain to Consumer rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to Consumers.

10.1.2 The Contractor and its Subcontractors shall guarantee that each Consumer has the following rights:

10.1.2.1 The Consumer's behavioral health status.

10.1.2.2 To receive all information regarding mental health and/or SUD treatment options including any alternative or self-administered treatment, in a culturally-competent manner.

10.1.2.3 To receive the risks, benefits, and consequences of mental health and/or SUD treatment (including the option of no treatment).

10.1.2.4 To participate in decisions regarding his or her behavioral health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions.

10.1.2.5 To be treated with respect and with due consideration for his or her dignity and privacy.

10.1.2.6 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

10.1.2.7 To request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.

10.1.2.8 To be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the Contractor treats the Consumer.

10.1.3 The Contractor shall require a criminal history background check through the Washington State Patrol for employees and volunteers of the Contractor who may have unsupervised access to children, people with developmental disabilities or vulnerable adults, consistent with Chapter 388-06 WAC.

10.2 Ombuds

10.2.1 The Contractor shall provide a regional behavioral health ombuds as described in WAC 388-865-0262 and Chapter 71.24 RCW. Considerations for contracting for ombuds services shall provide for the following:

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

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

10.2.1.3 Is responsive to the age and demographic character of the region and assists and advocates for Consumers with resolving complaints and grievances at the lowest possible level.

10.2.1.4 Is independent of Contracted Services providers.

10.2.1.5 Receives and investigates Consumer, family member, and other interested party complaints and Grievances.

10.2.1.6 Is accessible to Consumers, including a toll-free, independent phone line for access.

10.2.1.7 Is able to access service sites and records relating to the Consumer with appropriate releases so that it can reach out to Consumers, and resolve complaints and/or Grievances.

10.2.1.8 Receives training and adheres to confidentiality consistent with this Contract and Chapters 71.05, 71.24, and 70.02 RCW.

10.2.1.9 Continues to be available to investigate, advocate and assist the Consumer through the Grievance and Administrative Hearing processes.

10.2.1.10 Involves other persons, at the Consumer's request.

10.2.1.11 Assists Consumers in the pursuit of formal resolution of Grievance.

10.2.1.12 If necessary, continues to assist the Consumer through the Administrative Hearing processes.

10.2.1.13 Coordinates and collaborates with allied systems' advocacy and ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared Consumers.

10.2.1.14 Provides reports and formalized recommendations at least biennially to the Consumer Behavioral Health Advisory Board.

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10.3 **Cultural Considerations**

10.3.1 The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

10.3.2 At a minimum, the Contractor shall:

10.3.2.1 Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each Consumer with limited English. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing bases. (CLAS Standard 4);

10.3.2.2 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. (CLAS Standard 5);

10.3.2.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally, and in writing. (CLAS Standard 6);

10.3.2.4 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. (CLAS Standard 7);

10.3.2.5 Provide easy–to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. (CLAS 8);

10.3.2.6 Establish culturally and linguistically appropriate goals. (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 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 14).

10.4 **Mental Health Advance Directive**

10.4.1 The Contractor shall maintain a written Mental Health Advance Directive policy and procedure that respects individuals' Advance Directive for behavioral health care. Policy and procedures must comply with Chapter 71.32 RCW.

10.4.2 The Contractor shall inform all Consumers and individuals with a history of frequent crisis system utilization of their right to a Mental Health Advance Directive and shall provide technical assistance to those who express an interest in developing and maintaining a Mental Health Advance Directive.

10.4.3 The Contractor shall maintain current copies of any Mental Health Advance Directive in the Consumer's and individuals' with a history of frequent crisis system utilization records.

10.4.4 The Contractor shall inform Consumers and individuals with a history of frequent crisis system utilization that complaints concerning noncompliance with a Mental Health Advance Directive should be referred to the Department of Health by calling 1-360-236-2620.

10.5 **Consumer Choice of Behavioral Health Provider**

10.5.1 A Consumer may maintain existing behavioral health provider relationships when funding is available and when the Contracted Services are medically necessary. However, Consumers are not guaranteed choice of behavioral health providers for Contracted Services.

10.6 **Consumer Charges for Contracted Services**

10.6.1 Under no circumstances shall the Contractor deny the provision of mental health Crisis Services, evaluation and treatment services, Involuntary Treatment Act services, or SUD involuntary commitment services, to a Consumer due to the Consumer's ability to pay.

10.6.2 Providers may develop a sliding fee schedule for Consumers to pay for services that is reviewed and approved by the Contractor.

10.6.3 In developing sliding fee schedules, providers shall comply with the following:

10.6.3.1 Put the sliding fee schedule in writing that is non-discriminatory;

10.6.3.2 Include language in the sliding fee schedule that no individual shall be denied services due to inability to pay;

10.6.3.3 Provide signage and information to Consumers to educate them on the sliding fee schedule;

10.6.3.4 Protect Consumers' privacy in assessing Consumer fees;

10.6.3.5 Maintain records to account for each Consumer's visit and any charges incurred;

10.6.3.6 Charge Consumers at or below one hundred percent (100%) of Federal Poverty Level (FPL) a nominal fee or no fee at all;

10.6.3.7 Develop at least three (3) incremental amounts on the sliding fee scale for Consumers between one hundred one to two hundred and twenty percent (101-220%) FPL.

10.7 **Cost Sharing Assistance**

10.7.1 The Contractor may use SAPT block grant funds to help individuals satisfy cost-sharing requirements for SAPT-authorized SUD services. The Contractor must ensure that:

10.7.1.1 The provider is a recipient of SAPT block grant funds;

10.7.1.2 Cost-sharing is for a SAPT block grant authorized service;

10.7.1.3 Payments are in accordance with SAPT block grant laws and Regulations;

10.7.1.4 Cost-sharing payments are made directly to the provider of the service; and

10.7.1.5 A report is provided to HCA upon request that identifies:

10.7.1.5.1 The number of individuals provided cost-sharing assistance;

10.7.1.5.2 The total dollars paid out for cost-sharing; and

10.7.1.5.3 Providers who received cost-sharing funds.

10.8 Consumer Self-Determination

The Contractor shall ensure that all providers:

10.8.1 Obtain informed consent prior to treatment from Consumers, or persons authorized to consent on behalf of a Consumer as described in RCW 7.70.065;

10.8.2 Comply with the provisions of the Natural Death Act (Chapter 70.122 RCW) and state rules concerning Advance Directives (WAC 182-501-0125); and,

10.8.3 When appropriate, inform Consumers of their right to make anatomical gifts (Chapter 68.64 RCW).

11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 Utilization Management Requirements

11.1.1 The Contractor's Behavioral Health Medical Director will provide guidance, leadership and oversight of the Contractor's Utilization Management (UM) program for Contracted Services used by Consumers. The following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the Behavioral Health Medical Director to oversee:

11.1.1.1 Processes for evaluation and referral to services.

11.1.1.2 Review of consistent application of criteria for provision of services within Available Resources and related complaints and grievances.

11.1.1.3 Review of assessment and treatment services against clinical practice standards. Clinical practice standards include, but are not limited to evidenced-based practice guidelines, culturally appropriate services, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals.

11.1.1.4 Monitoring for over-utilization and under-utilization of services, including Crisis Services.

11.1.1.5 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 behavioral health services inconsistent with the Contractors policy and procedure for determining eligibility for services within Available Resources.

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 methodology shall include the following components:

11.1.2.1.1 The review may be an aggregate review of spending across GFS and SAPT fund sources under the Contract.

11.1.2.1.2 For any case specific review decisions, the Contractor shall maintain Level of Care Guidelines for making authorization, continued stay and discharge determinations. The Level of Care Guidelines shall address GFS and SAPT priority population requirements. The Contractor shall ensure use of ASAM Level of Care Guidelines to make placement decisions for all SUD services.

11.1.2.1.3 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.

11.1.2.1.4 Education and technical assistance to address issues related to quality of care, medical necessity, timely and accurate claims submission or aligning service utilization with allocated funds to avoid disruption in service or unspent funds at the end of a contract year.

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

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

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

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11.1.3 The Contractor shall educate UM staff in the application of UM protocols, communicating the criteria used in making UM decisions. UM protocols shall recognize and respect the cultural needs of diverse populations.

11.1.4 The Contractor shall demonstrate that all UM staff making service authorization decisions have been trained and are competent in working with the specific area of service which they are authorizing and managing including, but not limited to, co-occurring mental health and SUDs, co-occurring behavioral health and medical diagnoses, and co-occurring behavioral health and I/DD.

11.1.5 The Contractor's policies and procedures related to UM shall comply with, and require the compliance of Subcontractors with delegated authority for UM requirements described in this section.

11.1.6 The Contractor shall develop and maintain a Utilization Management Program (UMP) description and policies and procedures that include the following components:

11.1.6.1 Monthly and annual utilization reports. The following minimum measure set shall be included, with monthly and year to date performance for each metric. Monthly reports are due the 15th of the month following the month being reported. Annual reports are due April 30th of each year:

11.1.6.2 Number of unduplicated individuals served by fund source (i.e., GFS SAPT block grant).

11.1.6.3 Service dollars expended as a percent of grant allocation by service type, by provider, and in aggregate by fund source.

11.1.6.4 Number of FBG providers at or above capacity by service type.

11.1.6.5 Number of providers identified as outliers by service type and by fund source.

11.1.6.6 Number of provider interventions by type of intervention (e.g., education, technical assistance, corrective action).

11.1.6.7 Other GFS and FBG reporting requirements as determined by HCA and DSHS.

11.1.7 The Contractor must submit to HCA the Federal Block Grant Progress Report as specified in Exhibit G within thirty (30) days after the end of each state fiscal year. This report shall be submitted annually beginning in calendar year 2018.

11.1.8 Authorization reviews shall be conducted by state licensed Behavioral Health Professionals with experience working with the populations and/or settings under review.

11.1.8.1 The Contractor shall have UM staff with experience and expertise in working with TAY, adults, and older adults with a SUD and are receiving medication-assisted treatment.

11.1.9 Adverse utilization review determinations based on medical necessity including any decision to authorize a service in an amount, duration or scope that is less than requested shall be conducted by:

11.1.9.1 A physician board-certified or board-eligible in General Psychiatry or Child Psychiatry;

11.1.9.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry; or

11.1.9.3 A licensed, doctoral level psychologist.

11.1.10 The Contractor shall ensure that any behavioral health clinical peer reviewer who is subcontracted or works in a service center other than the Contractor's Washington State service center shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center, to include participation in initial orientation and at least annual training on Washington State specific benefits, protocols and initiatives.

11.1.11 The Contractor shall ensure that any behavioral health actions must be peer-to-peer, that is, the credential of the licensed clinician making the decision to authorize service in an amount, duration or scope that is less than requested must be at least equal to that of the recommending clinician. In addition:

11.1.11.1 A physician board-certified or board-eligible in General Psychiatry must review all inpatient level of care actions for psychiatric treatment.

11.1.11.2 A physician board-certified or board-eligible in Addiction Medicine, or a subspecialty in Addiction Psychiatry; must review all inpatient level of care actions (denials) for SUD treatment.

11.1.12 The Contractor shall ensure that Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the person's condition or disease.

11.1.12.1 The Contractor shall ensure documentation of timelines for Appeals shall be in accordance with the Appeal Process provisions of the Grievance System Section of this Contract.

11.1.13 The Contractor shall not penalize or threaten a provider or facility with a reduction in future payment or termination of Participating Provider or participating facility status because the provider or facility disputes the Contractor's determination with respect to coverage or payment for health care service.

11.2 **Medical Necessity Determination**

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The Contractor shall collect all information necessary to make Medical Necessity determinations. The Contractor shall determine which services are Medically Necessary according to the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding Appeals and hearings.

11.3 Authorization of Services

11.3.1 The Contractor shall provide education and ongoing guidance and training to Consumers and providers about its UM protocols and Level of Care Guidelines, including admission, continued stay, and discharge criteria.

11.3.2 The Contractor shall have in effect mechanisms to ensure consistent application of UMP review criteria for authorization decisions.

11.3.3 The Contractor shall consult with the requesting provider when appropriate.

11.4 Timeframes for Authorization Decisions

11.4.1 The Contractor must provide a written Notice of Determination to the Consumer, or their legal representative, if a denial, reduction, termination or suspension occurs based on the Level of Care Guidelines. The Contractor shall adhere to the requirements set forth in Section 11.5, Notification of Coverage and Authorization Determination.

11.4.2 The Contractor is required to acknowledge receipt of a standard authorization request for psychiatric inpatient services within two (2) hours, with a decision within twelve (12) hours of receipt of the request

11.4.3 The Contractor shall provide for the following timeframes for authorization decisions and notices:

11.4.3.1 For denial of payment that may result in payment liability for the Consumer, at the time of any action affecting the claim.

11.4.3.2 For termination, suspension, or reduction of previously contracted services, ten (10) calendar days prior to such termination, suspension, or reduction, except if the criteria stated in 42 C.F.R. § 431.213 and 431.214 are met.

11.4.3.3 For post-service authorizations, the Contractor must make its determination within thirty (30) calendar days of receipt of the authorization request.

11.4.3.3.1 The Contractor shall notify the Consumer and the requesting provider within two (2) business days of the Contractor’s determination.

11.4.3.3.2 Standard Appeal timeframes apply to post-service denials.

11.4.3.3.3 When post-service authorizations are approved they become effective the date the service was first administered.

11.5 **Notification of Coverage and Authorization Determinations**

11.5.1 For all Actions the Contractor shall:

11.5.1.1 The Contractor must notify the Consumer in writing of the decision. For an adverse authorization decision involving an expedited authorization request the Contractor may initially provide notice orally. For all actions, the Contractor shall provide written notification within seventy-two (72) hours of the decision (WAC 182-538C-110).

11.5.1.2 Notify parties, other than the Consumer, in advance, whether it will provide notification by phone, mail, fax, or other means.

11.5.1.3 The Contractor shall give notice at least five (5) calendar days before the date of action when the action is a termination, suspension or reduction of previously authorized services. Such notice shall explain the following:

11.5.1.3.1 The action the Contractor has taken or intends to take.

11.5.1.3.2 The reasons for the action, in easily understood language and citation to any Contractor guidelines, protocols, or other criteria, on which the decision was based in whole or in part, and how to access the guidelines.

11.5.1.3.3 A statement of whether the Consumer has any liability for payment

11.5.1.3.4 Information regarding whether and how the Consumer may Appeal the decision.

11.5.1.3.5 Assistance in filing an Appeal and how to request it, including access to services for Consumers with communication barriers or disabilities.

11.5.2 The Contractor shall provide notification in accordance with the timeframes described in subsection 11.5.1 in the following circumstances:

11.5.2.1 The Consumer dies;

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

11.5.2.3 The Consumer is admitted to an institution where he or she is ineligible for services;

11.5.2.4 The Consumer's address is unknown and mail directed to him or her has no forwarding address;

11.5.2.5 The Consumer has moved out of the Contractor's service area;

11.5.2.6 The Consumer prescribes the change in the level of medical care;

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

12 PROGRAM INTEGRITY

12.1 General Requirements

12.1.1 The Contractor shall have and comply with policies and procedures that guide and require the Contractor and the Contractor's officers, employees, agents, and Subcontractors to comply with the requirements of this section.

12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts.

12.2 Information on Persons Convicted of Crimes

12.2.1 The Contractor shall include the following provisions in its written agreements with all Subcontractors and providers who are not individual practitioners or a group of practitioners:

12.2.1.1 Requiring the Subcontractor/provider to investigate and disclose to HCA, at contract execution or renewal, and upon request of HCA, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

12.3 Fraud and Abuse

12.3.1 The Contractor's Fraud and Abuse program shall have:

12.3.1.1 A process to inform officers, employees, agents and Subcontractors regarding the False Claims Act.

12.3.1.2 Administrative and management arrangements or procedures, and a mandatory compliance plan.

12.3.1.3 Standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards.

12.3.1.4 The designation of a compliance officer and a compliance committee that is accountable to senior management.

12.3.1.5 Effective training for all affected parties.

12.3.1.6 Effective lines of communication between the compliance officer and the Contractor's staff and Subcontractors.

12.3.1.7 Enforcement of standards through well-publicized disciplinary guidelines.

12.3.1.8 Provision for internal monitoring and auditing.

12.3.1.9 Provision for prompt response to detected offenses, and for development of corrective action initiatives.

12.3.1.10 Provision of detailed information to employees and Subcontractors regarding fraud and abuse policies and procedures and the False Claims Act and the Washington false claims statutes, Chapter 74.66 RCW and RCW 74.09.210.

12.4 **Reporting**

12.4.1 All Program Integrity reporting to HCA shall be in accordance with the Notices provisions of the General Terms and Conditions of this Contract unless otherwise specified herein.

12.4.2 On a quarterly basis, the Contractor shall submit to HCA, on a HCA generated reporting format, a report of any recoveries made, or overpayments identified by the Contractor during the course of their claims review/analysis.

12.4.3 The Contractor shall notify the DSHS Office of Fraud and Accountability (OFA) of any cases in which the Contractor believes there is a serious likelihood of Consumer fraud by:

12.4.3.1 Calling the Welfare Fraud Hotline at 1-800-562-6906 and pressing option "1" to report Welfare Fraud by leaving a detailed voice mail message;

12.4.3.2 Mailing a written complaint to:

Welfare Fraud Hotline
P.O. Box 45817
Olympia, WA 98504-5817

12.4.3.3 Entering the complaint online at:
https://fortress.wa.gov/dshs/dshsroot/fraud/index.asp;

12.4.3.4 Faxing the written complaint to Attention Hotline at 360-664-0032; or

12.4.3.5 Emailing the compliant electronically to the DSHS OFA Hotline at Hotline@dshs.wa.gov.

12.4.4 The Contractor shall submit to HCA monthly a list of involuntary terminations report including providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related Program Integrity involuntary termination. The Contractor shall send the report electronically to HCA at hcamcprograms@hca.wa.gov with subject "Program Integrity Monthly list of Involuntary Terminations Report." The report must include all of the following:

12.4.4.1 Individual provider/entities' name;

12.4.4.2 Individual provider/entities' NPI number;

12.4.4.3 Source of involuntary termination;

12.4.4.4 Nature of the involuntary termination; and

12.4.4.5 Legal action against the individual/entities.

12.5 **Records Requests**

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

12.6 **On-Site Inspections**

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

12.6.1.1 Medical records;

12.6.1.2 Billing records;

12.6.1.3 Financial records;

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

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

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

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

13 GRIEVANCE SYSTEM

13.1 **General Requirements**

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The Contractor shall have a Grievance system. The Grievance system shall include a Grievance process, an Appeal process, and access to the hearing process for Contracted Services. NOTE: Provider claim disputes initiated by the provider are not subject to this section.

13.1.1 The Contractor shall have policies and procedures addressing the Grievance system, which comply with the requirements of this Contract. HCA must approve, in writing, all Grievance system policies and procedures and related notices to Consumers regarding the Grievance system.

13.1.2 The Contractor shall give Consumers any reasonable assistance necessary in completing forms and other procedural steps for Grievances and Appeals.

13.1.3 The Contractor shall acknowledge receipt of each Grievance, either orally or in writing, within two (2) business days.

13.1.4 The Contractor shall acknowledge in writing, the receipt of each Appeal. The Contractor shall provide the written notice to both the Consumer and requesting provider within seventy-two (72) hours of receipt of the Appeal.

13.1.5 The Contractor shall ensure that decision makers on Grievances and Appeals were not involved in previous levels of review or decision-making.

13.1.6 Decisions regarding Grievances and Appeals shall be made by Health Care Professionals with clinical expertise in treating the Consumer's condition or disease if any of the following apply:

13.1.6.1 If the Consumer is Appealing an action.

13.1.6.2 If the Grievance or Appeal involves any clinical issues.

13.1.7 With respect to any decisions described in subsection13.1.6, the Contractor shall ensure that the Health Care Professional making such decisions:

13.1.7.1 Has clinical expertise in treating the Consumer's condition or disease that is age appropriate (e.g., a pediatric psychiatrist for a child Consumer).

13.1.7.2 A physician board-certified or board-eligible in General Psychiatry or Child Psychiatry if the grievance or appeal is related to inpatient level of care denials for psychiatric treatment.

13.1.7.3 A physician board-certified or board-eligible in Addiction Medicine or a Sub-specialty in Addiction Psychiatry, if the Grievance or Appeal is related to inpatient level of care denials for SUD treatment.

13.1.7.4 Are one or more of the following, as appropriate, if a clinical Grievance or Appeal is not related to inpatient level of care denials for psychiatric or SUD treatment:

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13.1.7.4.1 Physicians board-certified or board-eligible in Psychiatry, Addiction Medicine or a sub-specialty in Addiction Psychiatry;

13.1.7.4.2 Licensed, doctoral level psychologists; or

13.1.7.4.3 Pharmacists.

13.2 **Grievance Process**

The following requirements are specific to the Grievance process:

13.2.1 Only a Consumer or the Consumer's authorized representative may file a grievance with the Contractor. A provider may not file a Grievance on behalf of a Consumer unless the provider is acting on behalf of the Consumer and with the Consumer's written consent.

13.2.1.1 The Contractor shall request the Consumer's written consent should a provider request an Appeal on behalf of a Consumer without the Consumer's written consent.

13.2.2 The Contractor shall accept, document, record, and process Grievances forwarded by HCA or DSHS.

13.2.3 The Contractor shall provide a written response to HCA within three (3) business days to any constituent Grievance. For the purpose of this subsection, "constituent Grievance" means a complaint or request for information from any elected official or agency director or designee.

13.2.4 The Contractor shall assist the Consumer with all Grievance and Appeal processes.

13.2.5 The Contractor shall cooperate with any representative authorized in writing by the covered Consumer.

13.2.6 The Contractor shall consider all information submitted by the covered person or representative.

13.2.7 The Contractor shall investigate and resolve all Grievances whether received orally or in writing. The Contractor shall not require a Consumer or his/her authorized representative to provide written follow up for a Grievance or Appeal the Contractor received orally.

13.2.8 The Contractor shall complete the disposition of a Grievance and notice to the affected parties as expeditiously as the Consumer's health condition requires, but no later than forty-five (45) calendar days from receipt of the Grievance.

13.2.9 The Contractor must notify Consumers of the disposition of Grievances within five (5) business days of determination. The notification may be orally or in writing for Grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

13.2.10 Consumers do not have the right to a hearing in regard to the disposition of a Grievance.

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13.3 **Appeal Process**

The following requirements are specific to the Appeal process:

13.3.1 A Consumer, the Consumer's authorized representative, or a provider acting on behalf of the Consumer and with the Consumer's written consent, may Appeal a Contractor action.

13.3.1.1 If a provider has requested an Appeal on behalf of a Consumer, but without the Consumer's written consent, the Contractor shall not dismiss the Appeal without first contacting the Consumer, informing the Consumer that an appeal has been made on the Consumer's behalf, and then asking if the Consumer would like to continue the Appeal.

If the Consumer does wish to continue the Appeal, the Contractor shall obtain from the Consumer a written consent for the Appeal. If the Consumer does not wish to continue the Appeal, the Contractor shall formally dismiss the Appeal, in writing, with appropriate Consumer Appeal rights and by delivering a copy of the dismissal to the provider as well as the Consumer.

13.3.1.2 For expedited Appeals, the Contractor may bypass the requirement for the Consumer's written consent and obtain the Consumer's oral consent. The Consumer's oral consent shall be documented in the Contractor's UMP records.

13.3.2 If HCA receives a request to Appeal an action of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the Consumer.

13.3.3 For Appeals of standard service authorization decisions, a Consumer, or a provider acting on behalf of the Consumer, must file an Appeal, either orally or in writing, within ninety (90) calendar days of the date on the Contractor's Notice of Action. This also applies to a Consumer's request for an expedited Appeal.

13.3.4 Oral inquiries seeking to Appeal an action shall be treated as Appeals and be confirmed in writing, unless the Consumer or provider requests an expedited resolution. The appeal acknowledgement letter sent by the Contractor to a Consumer shall serve as written confirmation of an Appeal filed orally by a Consumer.

13.3.5 The Appeal process shall provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law in writing. The Contractor shall inform the Consumer of the limited time available for this in the case of expedited resolution.

13.3.6 The Appeal process shall provide the Consumer and the Consumer's representative opportunity, before and during the Appeals process, to examine the Consumer's case file, including medical records, and any other documents and records considered during the Appeal process.

13.3.7 The Appeal process shall include as parties to the Appeal, the Consumer and the Consumer's representative, or the legal representative of the deceased Consumer's estate.

13.3.8 In any Appeal of an action by a Subcontractor, the Contractor or its Subcontractor shall apply the Contractor's own clinical practice guidelines, standards, protocols, or other criteria that pertain to authorizing specific services.

13.3.9 The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Consumer's health condition requires, within the following timeframes:

13.3.9.1 For standard resolution of Appeals and for Appeals for termination, suspension or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the Appeal, unless the Contractor notifies the Consumer that an extension is necessary to complete the Appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for Appeal, without the informed written consent of the Consumer. In all circumstances, the Appeal determination must not be extended beyond forty-five (45) calendar days from the day the Contractor receives the Appeal request.

13.3.9.2 For any extension not requested by a Consumer, the Contractor must give the Consumer written notice of the reason for the delay.

13.3.9.3 For expedited resolution of Appeals or Appeals of behavioral health drug authorization decisions, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the Appeal.

13.3.10 The Contractor shall provide notice of resolution of the Appeal in a language and format which may be easily understood by the Consumer. The notice of the resolution of the Appeal shall:

13.3.10.1 Be in writing and sent to the Consumer and the requesting provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

13.3.10.2 Include the date completed and reasons for the determination.

13.3.10.3 Include a written statement of the clinical rationale for the decision, including how the requesting provider or Consumer may obtain the UMP clinical review or decision-making criteria.

13.3.10.4 For Appeals not resolved wholly in favor of the Consumer:

13.3.10.4.1 Include information on the Consumer's right to request a hearing and how to do so.

13.4 **Expedited Appeals Process**

13.4.1 The Contractor shall establish and maintain an expedited Appeal review process for Appeals when the Contractor determines or a provider indicates that taking the time for a standard resolution could seriously jeopardize the Consumer's life or health or ability to attain, maintain, or regain maximum function.

13.4.2 The Consumer may file an expedited Appeal either orally or in writing. No additional Consumer follow-up is required.

13.4.3 The Contractor shall make a decision on the Consumer's request for expedited Appeal and provide written notice, as expeditiously as the Consumer's health condition requires, within three (3) calendar days after the Contractor receives the Appeal. The Contractor shall also make reasonable efforts to provide oral notice.

13.4.4 The Contractor may extend the timeframes by up to fourteen (14) calendar days if the Consumer requests the extension; or the Contractor shows there is a need for additional information and how the delay is in the Consumer's interest.

13.4.5 For any extension not requested by a Consumer, the Contractor must give the Consumer written notice of the reason for the delay.

13.4.6 The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a Consumer's Appeal.

13.4.7 If the Contractor denies a request for expedited resolution of an Appeal, it shall transfer the Appeal to the timeframe for standard resolution and make reasonable efforts to give the Consumer prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of denial.

13.5 **Administrative Hearing**

13.5.1 Only the Consumer or the Consumer's authorized representative may request a hearing. A provider may not request a hearing on behalf of a Consumer.

13.5.2 If a Consumer does not agree with the Contractor's resolution of the Appeal, the Consumer may file a request for a hearing within ninety (90) calendar days of the date of notice of the resolution of the Appeal (See WAC 182-526-0200). The Contractor will not be obligated to continue services pending the results of the hearing.

13.5.3 If the Consumer requests a hearing, the Contractor shall provide to HCA and the Consumer, upon request, and within three (3) working days, all Contractor-held documentation related to the Appeal, including, but not limited to: any transcript(s), records, or written decision(s) from participating providers or delegated entities.

13.5.4 The Contractor is an independent party and is responsible for its own representation in any hearing, Board of Appeals, and subsequent judicial proceedings.

13.5.5 The Contractor's Behavioral Health Medical Director or designee shall review all cases where a hearing is requested and any related Appeals.

13.5.6 The Consumer must exhaust all levels of resolution and Appeal within the Contractor's grievance system prior to filing a request for a hearing with HCA.

13.5.7 The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision.

13.5.8 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.

13.5.9 The hearings process shall include as parties to the hearing, the Contractor, the Consumer and the Consumer's representative, or the legal representative of the deceased Consumer's estate and HCA.

13.6 **Petition for Review**

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

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

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

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

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

13.8.1 The records shall include Actions, Grievances and Appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of responding to such Actions, Grievances, and Appeals.

13.8.2 The Contractor shall provide separate reports of all Actions, Grievances, and Appeals related to Contracted Services to HCA in accord with the Grievance System Reporting Requirements published by HCA.

13.8.3 The Contractor is responsible for maintenance of records for and reporting of any Actions, Grievances, and Appeals handled by delegated entities.

13.8.4 Delegated Actions, Grievances, and Appeals are to be integrated into the Contractor's report.

13.8.5 Data shall be reported in HCA and Contractor agreed upon format. Reports that do not meet the Grievance System Reporting Requirements shall be returned to the Contractor for correction. Corrected reports will be resubmitted to HCA within thirty (30) calendar days.

13.8.6 The report medium shall be specified by HCA and shall be in accord with the Grievance System Reporting Requirements published by HCA.

13.8.7 Reporting of actions shall include all medical necessity determinations but will not include denials of payment to providers unless the Consumer is liable for payment in accord with WAC 182-502-0160 and the provisions of this Contract.

13.8.8 The Contractor shall provide information to HCA regarding denial of payment to providers upon request.

13.8.9 Reporting of Grievances shall include all expressions of Consumer dissatisfaction not related to an Action. All Grievances are to be recorded and counted whether the Grievance is remedied by the Contractor immediately or through its Grievance and quality of care service procedures.

13.9 Grievance System Terminations

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

14 CARE MANAGEMENT AND COORDINATION

14.1 General Requirements

14.1.1 The Contractor shall develop policies that promote quality and efficient care for Consumers.

14.2 Care Coordination Requirements

14.2.1 The Contractor shall develop and implement protocols that promote coordination, continuity, and quality of care that address the following:

14.2.1.1 Considerations shall include use of GFS/SAPT fund to care for Consumers in alternative settings such as homeless shelters, permanent supported housing, nursing homes or group homes.

14.2.1.2 Strategies to reduce unnecessary crisis system utilization as defined in Section 16, Crisis System.

14.2.1.3 Facilitate sharing of information, and care transitions among jails, prisons, hospitals and residential treatment centers, detoxification and sobering centers, and homeless shelters and between service providers for Consumers with complex behavioral health and medical needs.

14.2.1.4 Facilitate Continuity of Care, within Available Resources, for Consumers in an active course of treatment for an acute or chronic behavioral health condition, including preserving Consumer-provider relationships through transitions.

14.3 Coordination with External Entities

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

14.3.1.1 BHOs for transfers between regions;

14.3.1.2 Family Youth Systems Partnership Roundtable (FYSPRT);

14.3.1.3 Apple Health Managed Care Organizations to facilitate enrollment of individuals who are potentially eligible for Medicaid;

14.3.1.4 Tribal entities regarding tribal members who access the crisis system;

14.3.1.5 Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHC);

14.3.1.6 The Criminal Justice system (courts, jails, law enforcement, public defenders, Department of Corrections, juvenile justice system);

14.3.1.7 Department of Social and Health Services;

14.3.1.8 State and federal agencies and local partners that manage access to housing;

14.3.1.9 Education systems, to assist in planning for local ESD threat assessment process;

14.3.1.10 Accountable Community of Health; and

14.3.1.11 First responders as identified in Section 16, Crisis System.

14.3.2 The Contractor shall coordinate the transfer of Consumer information, including initial assessments and care plans, with other Contractors and BHOs as needed when a Consumer moves between regions or gains or loses Medicaid eligibility, to reduce duplication of services and unnecessary delays in service provision.

14.3.3 The Contractor shall participate in disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by HCA, county, or local public health jurisdiction. The Contractor shall attend state-sponsored training and participate in emergency/disaster preparedness planning when requested by the county or local public health jurisdiction in the region and provide Disaster Outreach and post-Disaster Outreach in the event of a disaster/emergency.

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

14.4.1 The Contractor shall collaborate with child serving systems, as follows:

14.4.1.1 Participate in Child and Family Teams (CFTs) for children who are enrolled in WISe and also served by the Contractor, or when requested by the regional WISe provider.

14.4.1.2 If requested by a WISe provider, Children's Long Term Inpatient Program (CLIP) facility or other program serving Transitional Age Youth (TAY) in the behavioral health system ,and ~~participate~~ in the development of a plan of care for TAY ages sixteen through twenty-five (16 – 2~~1~~5).

14.4.1.3 Refer potentially CLIP eligible children to the CLIP Administration.

14.5 **Care Coordination and Continuity of Care: State Hospitals**

14.5.1 The Contractor shall abide by HCA's daily allocation of State Hospital beds and patient assignments.

14.5.2 The Contractor shall be responsible for coordinating discharge for the individuals assigned and, until discharged, these individuals will count against the Contractor's allocation of State Hospital Beds.

14.5.3 The Contractor shall ensure Consumers are medically cleared prior to admission to a State Hospital.

14.5.4 The Contractor shall respond to State Hospital census alerts to divert admissions and expedite discharges by using alternative community resources and mental health services, within Available Resources.

14.5.5 The Contractor or Subcontractor shall monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 to ensure compliance with LRA requirements.

14.5.6 The Contractor shall offer mental health services to individuals who are ineligible for Medicaid to ensure compliance with LRA requirements.

14.5.7 The Contractor shall respond to requests for participation, implementation, and monitoring of individuals receiving services on Conditional Release (CR) consistent with RCW 71.05.340. The Contractor or Subcontractor shall provide mental health services to individuals who are ineligible for Medicaid, to ensure compliance with CR requirements.

14.5.8 The Contractor shall ensure provision of mental health services to Consumers that are ineligible for Medicaid on a Conditional Release (CR) under RCW 10.77.150 and RCW 71.05.340.

14.5.9 CR Consumers in transitional status 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. Consumers residing in the Contractor's RSA prior to admission and discharging to another RSA will do so according to ~~the~~ RSA Transfer agreement established between the BHO and the Contractor. The ~~A~~greements shall include:

14.5.9.1 Specific roles and responsibilities of the parties related to transitions between the community and the hospital.

14.5.9.2 Collaborative discharge planning and coordination with cross-system partners.

14.5.9.3 Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's Service Area.

14.5.9.4 When individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the Contractor shall:

14.5.9.4.1 Coordinate with Home and Community Services (HCS) and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the DBHR website.

14.5.9.4.2 When the individual meets access to care criteria, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement.

14.5.10 The Contractor shall implement a program staffed by one (1) Peer Bridger to facilitate and increase the number of state hospital discharges and promote continuity of services when a Consumer returns to the community. The program shall follow program standards found Exhibit I, Peer Bridger.

14.5.11 The Contractor shall develop the WSH Peer Bridger program in collaboration with the FIMC plans in the region. Services will be delivered equitably to individuals assigned to the FIMC plans and the BH-ASO.

14.5.12 The Contractor shall submit a monthly report to HCA that shows discharges and community placements or efforts to discharge and place Consumers. The report is due by the fifteenth (15th) of the month following the month being reported.

14.5.13 The Contractor shall inform its mental health providers that they must allow the Peer Bridger to attend treatment activities with the Consumer during the one hundred twenty (120) day period following discharge if requested by the Consumer. Examples of activities include but are not limited to: intakes, prescriber appointments, treatment planning, etc.

14.5.14 Inter-Regional Service Area Transfer Agreements

14.5.14.1 When requested by a BHO, the Contractor shall coordinate with the requesting BHO to negotiate and execute an Inter-RSA Transfer Agreement.

14.5.14.2 When a WSH patient who is assigned to the Contractor is being discharged to a Regional Service Area that is not Southwest Washington, the Contractor will execute an Inter-RSA Transfer Agreement with the Receiving BHO.

14.5.14.3 At any juncture in which a patient assigned to a BHO in a Regional Service Area other than SWWA is discharging from WSH to Clark or Skamania Counties and will be enrolled with the Contractor, the Contractor will execute an Inter-RSA Transfer Agreement with the Referring BHO.

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

14.6.1 The Contractor shall ensure their DMHPs report to DSHS when it is determined a Consumer meets detention criteria under RCW 71.05.150, 71.05.153, 71.34.700 or 71.34.710, and there are no beds available at the evaluation and treatment facility, the Consumer has not been provisionally accepted for admission by a facility, and cannot be served on a single bed certification or less restrictive alternative.

14.6.2 When the DMHP determines a Consumer meets detention criteria, the investigation has been completed and when no bed is available, the DMHP shall submit a completed report to DSHS

within twenty-four (24) hours.

14.6.3 The report shall include the following:

14.6.3.1 The date and time the investigation was completed;

14.6.3.2 A list of facilities that refused to admit the Consumer;

14.6.3.3 Information sufficient to identify the Consumer, including name and age or date of birth; and;

14.6.3.4 Other reporting elements deemed necessary or supportive by DSHS.

14.6.4 The Contractor receiving notification of the report must attempt to engage the Consumer in appropriate services for which the Consumer is eligible and report back within seven (7) days to HCA. The Contractor may contact the Consumers AH-FIMC MCO to ensure services are provided.

14.6.5 The Contractor shall implement a plan to provide evaluation and treatment services to the Consumer, which may include the development of less restrictive alternatives to involuntary treatment, or prevention programs reasonably calculated to reduce demand for evaluation and treatment.

14.6.6 HCA may initiate corrective action when appropriate to ensure an adequate plan is implemented. An adequate plan may include development of less restrictive alternatives to Involuntary Commitment, such as crisis triage, crisis diversion, voluntary treatment, or prevention programs reasonably calculated to reduce demand for evaluation and treatment.

15 GENERAL REQUIREMENTS AND BENEFITS

15.1 Special Provisions Regarding Behavioral Health Benefits

The Contractor's administration of behavioral health benefits shall comply with the following provisions:

15.1.1 The location of the telephone crisis intervention and triage services is within two hundred (200) miles of the Contractor's Service Area.

15.1.2 Call center staff located in a border state must receive sufficient training to ensure adequate knowledge of the Contractor's operating policies and procedures and Washington's behavioral health service delivery system including, but not limited to regional network and community resources, practice patterns, culture, and other relevant factors.

15.1.3 A behavioral health professional (BHP) shall be available on-call to provide training and consultation to telephone crisis intervention and triage service providers located in a border state.

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

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

15.1.6 Unless otherwise noted, utilization review and mental health Crisis Services shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.

15.1.7 The Contractor shall designate employees who fulfill the following behavioral health key functions:

15.1.7.1 A Behavioral Health Medical Director.

15.1.7.2 A Behavioral Health Clinical Director.

15.1.8 The Contractor will designate employees who fulfill following behavioral health managerial functions:

15.1.8.1 A Behavioral Health Crisis Triage Administrator.

15.1.8.2 A Behavioral Health Utilization/Care Management Administrator.

15.1.8.3 A Behavioral Health Network Development Administrator.

15.1.8.4 A Behavioral Health Provider Relations Administrator.

15.1.8.5 A Behavioral Health Children's Specialist.

15.1.8.6 An Addictions Specialist.

15.1.9 In addition to the key and managerial staff, the Contractor shall have a sufficient number of qualified operational staff to meet its responsibilities under the Contract.

15.1.9.1 The Contractor shall have a sufficient number of staff available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year to handle crisis calls, warm-line transfers and triage, and sufficient Designated Mental Health Professionals and Designated Chemical Dependency Specialists to respond to requests for SUD Involuntary Commitment services and Mental Health ITA services. Crisis triage staff shall have training in crisis triage and management for individuals of all ages and behavioral health conditions, including SMI, SUDs, and co-occurring disorders.

15.1.9.2 The Contractor shall have access to a physician or mental health nurse practitioner to address specialized needs of callers experiencing crisis, and to provide assistance with crisis triage, referral, and resolution.

15.1.9.3 The Contractor shall have a sufficient number of behavioral health clinical peer reviewers available to conduct Appeal reviews or to provide clinical consultation on complex cases, treatment plan issues, and other treatment needs.

15.1.9.3.1 Clinical peer reviewers may be subcontracted and can be located outside of Washington State but shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center, to include participation in initial orientation and at least annual training on Washington State-specific benefits, protocols, and initiatives.

15.1.9.4 The Contractor shall ensure that staffing is sufficient to support behavioral health data analytics and behavioral health data systems, including FBG reporting requirements, to oversee all data interfaces and support the behavioral health specific reporting requirements under the Contract.

15.1.9.5 The Contractor shall ensure adequate staffing to perform the following functions: administrative services, member services, Grievances and Appeals, claims, encounter data processing, data analysts, and financial reporting analysts.

15.1.10 The Contractor shall develop and maintain a human resources and staffing plan that describe how the Contractor will maintain adequate staffing. The Contractor shall:

15.1.10.1 Hire employees for the key and required behavioral health functions specified in the Contract.

15.1.10.2 Develop and implement staff training plans that address how all staff will be trained on the requirements of this Contract.

15.1.10.3 Locate a sufficient number of Provider Relations staff within the State to meet requirements under this Contract for provider education, training and performance management, including FBG requirements related to pregnant women with intravenous drug use, pregnant women with a SUD, and other individuals with intravenous drug use and scientifically sound outreach models for intravenous drug users.

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 Consumers. The individual(s) responsible for behavioral health training must have at least two (2) years' experience and expertise in developing training programs related to behavioral health systems comparable to those under the Contract.

15.2 **Scope of Services**

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

15.2.2 Outside the Service Areas

15.2.2.1 The Contractor is only responsible for telephone crisis intervention and triage services for Consumers who are temporarily outside the service area.

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

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15.3 General Description of Contracted Services

15.3.1 After prioritizing state funds for mental health Crisis Services, evaluation and treatment services for individuals ineligible for Medicaid, and services related to the administration of Chapters 71.05, 71.34 and 70.96A RCW, Available Resources shall be used to cover the services listed in subsection 15.3.3 for the priority populations defined in this Contract (Refer to Section 16 for additional Crisis and ITA services requirements).

15.3.2 The Contractor must expend SAPT block grant funds in accordance with the optional and required service details as specified in Exhibit I.

15.3.3 The Contractor shall establish and apply medical necessity criteria for the provision or denial of all clinical services offered below:

15.3.3.1 Assessment – SUD Adult, PPW and Youth (GFS and SAPT).

15.3.3.2 Brief Intervention (GFS and SAPT).

15.3.3.3 Brief Outpatient Treatment (GFS and SAPT).

15.3.3.4 Case Management – SUD Adult, PPW and Youth (GFS and SAPT).

15.3.3.5 Day Support (GFS only).

15.3.3.6 Engagement and Referral (GFS and SAPT).

15.3.3.7 Evidenced Based/Wraparound Services (GFS only).

15.3.3.8 Interim Services (GFS and SAPT).

15.3.3.9 Opiate Dependency/HIV Services Outreach (GFS and SAPT).

15.3.3.10 Evaluation and Treatment (E&T) Services provided at Community Hospitals or Freestanding Evaluation and Treatment facilities (GFS only).

15.3.3.11 Family Treatment (GFS only).

15.3.3.12 Group Therapy – SUD Adult, PPW and Youth (GFS and SAPT).

15.3.3.13 High Intensity Treatment (GFS only).

15.3.3.14 Individual Therapy – SUD Adult, PPW and Youth (GFS and SAPT).

15.3.3.15 Inpatient Psychiatric Services (GFS only).

15.3.3.16 Intake Evaluation (GFS only).

15.3.3.17 Intensive Outpatient Treatment – SUD (GFS and SAPT).

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15.3.3.18 Intensive Inpatient Residential Treatment Services – SUD (GFS and SAPT).

15.3.3.19 Long Term Care Residential – SUD (GFS and SAPT).

15.3.3.20 Medication Management (GFS only).

15.3.3.21 Medication Monitoring (GFS only).

15.3.3.22 Mental Health Residential (GFS only).

15.3.3.23 Opiate Substitution Treatment (GFS and SAPT).

15.3.3.24 Outpatient Treatment – SUD (GFS and SAPT).

15.3.3.25 Peer Support (GFS only).

15.3.3.26 Psychological Assessment (GFS only).

15.3.3.27 Recovery House Residential Treatment – SUD (GFS and SAPT).

15.3.3.28 Rehabilitation Case Management (GFS Only).

15.3.3.29 Special Population Evaluation (GFS only).

15.3.3.30 TB Counseling, Screening, Testing and Referral (GFS only).

15.3.3.31 Therapeutic Psychoeducation (GFS only).

15.3.3.32 Urinalysis/Screening Test (GFS and SAPT).

15.3.3.33 TB Screening/Skin Test (GFS only).

15.3.3.34 Withdrawal Management – Acute (GFS and SAPT).

15.3.3.35 Withdrawal Management – Sub-Acute (GFS and SAPT).

15.3.4 The Contractor shall develop and apply criteria, and policies and procedures to determine the provision or denial of non-clinical services to which medical necessity does not apply, such as the following services:

15.3.4.1 Alcohol/Drug Information School (GFS only).

15.3.4.2 Childcare (GFS and SAPT).

15.3.4.3 Community Outreach – SAPT priority populations PPW and IVDU (GFS and SAPT).

15.3.4.4 Continuing Education and Training (GFS and SAPT).

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15.3.4.5 PPW Housing Support Services (GFS and SAPT).

15.3.4.6 Recovery Support Services.

15.3.4.7 Sobering Services (GFS and SAPT).

15.3.4.8 Therapeutic Interventions for Children (GFS and SAPT).

15.3.4.9 Transportation (GFS only).

15.3.5 Pharmaceutical Products:

15.3.5.1 Prescription drug products may be provided within Available Resources based on medical necessity. Coverage to be determined by HCA Fee for Service (FFS) formulary.

16 Crisis System

16.1 Crisis System General Requirements

16.1.1 The Contractor shall develop and maintain a regional behavioral health crisis system that meets the following requirements:

16.1.1.1 Mental Health Crisis Services will be available to all individuals who present with a need for Crisis Services in the Contractor's Service Area, as defined in this Contract.

16.1.1.2 Mental Health Crisis Services shall be provided in accordance with 388-865 WAC, Chapters 71.05 RCW and 71.34 RCW and WAC 388-877A-0200.

16.1.1.3 ITA services will 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 RCW 71.34.700. Requirements under the Contract include payment for all clinical services ordered by the court for individuals who are not eligible for Medicaid and costs related to court processes and Transportation. Crisis Services become ITA Services when a DMHP determines an individual must be evaluated for involuntary treatment. The decision making authority of the DMHP must be independent of the Contractor's administration. ITA services continue until the end of the Involuntary Commitment.

16.1.1.4 Chemical Dependency ITA services will be administered in accordance with RCW 70.96A.120 and 140.

16.1.2 Mental Health Crisis Services shall be delivered in a manner that is consistent with the following:

16.1.2.1 Stabilize individuals as quickly as possible and assist them in returning to a level of functioning that no longer qualifies them for Crisis Services. Stabilization Services will be provided in accordance with WAC 388-877A-0260.

16.1.2.2 Provide solution-focused, person-centered and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, institutionalization or out of home placement.

16.1.2.3 Coordinate closely with the regional MCOs, community court system, First Responders, criminal justice system, inpatient/residential service providers, and outpatient behavioral health providers to operate a seamless crisis system and acute care system that is connected to the full continuum of health services.

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

16.1.2.5 Develop and implement strategies to assess and improve the crisis system over time.

16.2 **Crisis System Staffing Requirements**

16.2.1 The Contractor shall comply with staffing requirements in accordance with WAC 388-877A-0210. Each staff member working with a Consumer receiving crisis mental health services must:

16.2.1.1 Be clinically supervised by a mental health professional or an independent practitioner licensed by the Department of Health.

16.2.1.2 Receive annual violence prevention training on the safety and violence prevention topics described in RCW 49.19.030. The staff member's personnel record must document the training.

16.2.1.3 Have the ability to consult with one of the following professionals (who has at least one (1) years' experience in the direct treatment of individuals who have a mental or emotional disorder):

16.2.1.3.1 A psychiatrist;

16.2.1.3.2 A physician; or

16.2.1.3.3 An advanced registered nurse practitioner who has prescriptive authority.

16.2.2 The Contractor shall comply with DMHP qualification requirements in accordance with RCW 71.05.020(11) and RCW 71.34.020(5).

16.2.3 The Contractor shall have clinicians available twenty-four (24) hours a day, seven (7) days a week who have expertise in mental health issues pertaining to children and families.

16.2.4 The Contractor shall make available at least one (1) Chemical Dependency Specialist (CDP) with experience conducting behavioral health crisis support for consultation by phone or on site during regular Business Hours.

16.2.5 The Contractor shall make available at least one (1) Certified Peer Specialist (CPS) with experience conducting behavioral health crisis support for consultation by phone or on site during regular Business Hours.

16.2.6 The Contractor shall establish policies and procedures for crisis and ITA services that implement the following requirements:

16.2.6.1 No DMHP, DCDS or crisis intervention worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's ITA, unless a second trained individual accompanies them.

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

16.2.6.3 The second individual may be a law enforcement officer, a Mental Health Professional, a mental health paraprofessional who has received training required in RCW 49.19.030, or other first responder, such as fire or ambulance personnel.

16.2.6.4 No retaliation may be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.

16.2.6.5 The Contractor must have a plan to provide training, mental health staff back-up, information sharing, and communication for crisis outreach staff who respond to private homes or other private locations.

16.2.6.6 Every Mental Health Professional dispatched on a crisis visit, shall have prompt access to information about a Consumer’s history of dangerousness or potential dangerousness documented in crisis plans or commitment records and is available without unduly delaying a crisis response.

16.2.6.7 The Contractor or Subcontractor shall provide to every Mental Health Professional, who engages in home visits to Consumers or potential Consumers for the provision of Crisis Services, a wireless telephone or comparable device for the purpose of emergency communication.

16.3 **Crisis System Operational Requirements**

16.3.1 Crisis Services shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.

16.3.1.1 Mobile crisis outreach shall be able to respond within two (2) hours of the referral to an emergent crisis and within twenty-four (24) hours for referral to an urgent crisis.

16.3.2 The Contractor shall provide a toll free line that is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year to provide crisis intervention and triage services, including screening and referral to a network of providers and community resources.

16.3.2.1 The toll-free crisis line will be a separate number from the Contractor's customer service line.

16.3.3 Individuals will be able to access crisis services without full completion of Intake Evaluations and/or other screening and assessment processes. Telephone crisis support services will be provided in accordance with WAC 388-877A-0230 and crisis outreach services will be provided in accordance with WAC 388-877A-0240.

16.3.4 The Contractor shall establish registration processes for non-Medicaid individuals utilizing crisis services to maintain demographic and clinical information, and establish a medical record/tracking system to manage their crisis care, referrals, and utilization.

16.3.5 The Contractor shall establish protocols for providing information about and referral to other available services and resources for individuals who do not meet criteria for Medicaid or GFS/SAPT services (e.g., homeless shelters, domestic violence programs, Alcoholics Anonymous).

16.3.6 The Contractor shall ensure that Crisis Service providers document calls, services, and outcomes. The Contractor shall comply with record content and documentation requirements in accordance with WAC 388-877A-0220.

16.4 **Crisis System Services**

16.4.1 The Contractor shall make the following services available to all individuals in the Contractor's Service Area:

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16.4.1.1 Crisis Triage and Intervention to determine the severity and urgency of the needs and identify the supports and services necessary to meet those needs. Dispatch mobile crisis, as appropriate, or connect the individual to services. For individuals enrolled with a MCO, assist in connecting the individual with current or prior service providers. Crisis Services may be provided prior to completion of an Intake Evaluation. Services must be provided by or under the supervision of a Mental Health Professional. The Contractor must provide twenty-four (24) hour a day, seven (7) day a week crisis mental health services to individuals who are within the Contractor's RSA and report they are experiencing a mental health crisis. There must be sufficient staff available, including a DMHP, to respond to requests for Crisis Services. Crisis Services must be provided regardless of a Consumer's ability to pay.

16.4.1.2 Administration of the ITA services, including making DMHPs available twenty-four (24) hours a day, seven (7) day a week to conduct evaluations. Emergency involuntary detention services shall be provided in accordance with WAC 388-877A-0282. DMHPs file petitions for detentions and provide testimony for ITA services. The Contractor also 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. Individuals who are not eligible for Medicaid may be billed directly for services, in accordance with Section 10.6.2 of the contract.

16.4.1.3 CD ITA Services to identify and evaluate alcohol and drug involved individuals requiring protective custody, detention, or Involuntary Commitment services. Services include investigation activities, assessment activities, management of the court case findings, and legal proceedings.

16.4.2 The Contractor shall provide the following services to individuals who meet Eligibility requirements as defined in Section 4, Service Area and Consumer Eligibility and who do not qualify for Medicaid when medically necessary and based on Available Resources:

16.4.2.1 Crisis Stabilization Services, includes short-term (up to fourteen (14) days per episode) face-to-face assistance with life skills training and understanding of medication effects. Services are provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the Mental Health Professional to individuals experiencing a mental health crisis. This service also includes follow up. Crisis stabilization is often referred to as hospital diversion, typically managed by specific programs, apart from initial/emergent Stabilization Services, and available twenty-four (24) hours a day, seven (7) days a week.

16.4.2.2 SUD Crisis Services: Short term stabilization to include a general assessment of the individual's condition, an interview for therapeutic purposes, and arranging transportation home or to an approved facility for intoxicated or incapacitated individuals on the streets or in other public places. Services may be provided by telephone, in person, in a facility or in the field. Services may or may not lead to ongoing treatment.

16.4.2.3 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 use principles of recovery and empowerment, to provide emotional support, comfort, and information to callers living with a mental illness. All calls to the warm line are confidential.

16.5 **Coordination with External Entities**

16.5.1 The Contractor shall collaborate with HCA and AH-FIMC MCOs operating in the RSA to develop and implement strategies to coordinate care with community behavioral health providers for Consumers with a history of frequent crisis system utilization. Coordination of care strategies will seek to reduce utilization of Crisis Services.

16.5.2 The Contractor shall Contract with HCA selected AH-FIMC MCOs operating in the RSA to establish protocols related to the provision of behavioral health Crisis Services by the Contractor to the MCOs' Medicaid enrollees. The protocols shall, at a minimum, address the following:

16.5.2.1 Payment by the MCOs to the Contractor for crisis services arranged for or delivered by the Contractor or the Contractor's provider network to individuals enrolled in the MCOs' AH-FIMC plan.

16.5.2.1.1 If the Contractor is paid on a fee-for-service basis and delivers Crisis Services through a network of crisis providers, it shall reimburse its providers within fourteen (14) calendar days of receipt of reimbursement from the Contractor.

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

16.5.2.2 The Contractor and MCOs operating in the RSA shall participate in a semi-annual financial reconciliation process, as directed by HCA, related to predicted versus actual crisis services utilization.

16.5.2.3 The Contractor shall submit claims and/or encounters for crisis services consistent with the provisions of this Contract including, but not limited to Section 2.3, Billing Limitations. 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, is paid a capitation or on a fee-for-service basis.

16.5.2.4 The Contractor shall establish information systems to support data exchange consistent with the requirements under this Contract including, but not limited to eligibility interfaces, exchange of claims and encounter data and sharing of care plans and Mental Health Advance Directive necessary to coordinate service delivery in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.

16.5.2.5 Requirements for the parties to collaborate in the development and implementation of strategies to coordinate care for individuals with a history of frequent crisis system utilization consistent with Section 16.5.1 of this Contract.

16.5.3 The Contractor shall, in partnership with the AH-FIMC MCOs operating in the RSA, develop protocols to engage and collaborate with First Responders to coordinate the discharge and transition of incarcerated adults and TAY with SMI for the continuation of prescribed medications and other BH services prior to re-entry to the community.

16.6 **Tribal Coordination for Crisis and Involuntary Commitment Evaluation Services:**

16.6.1 The Contractor shall submit to HCA's Tribal Liaison a plan for providing crisis and ITA evaluation on Tribal Lands within the SWWA region.

16.6.2 The plan shall be developed in partnership with the affected Tribal entities within the SWWA region and must be co-signed by the appropriate Tribal representative for each affected Tribe.

16.6.3 The plan shall identify a procedure and timeframe for evaluating the plan's efficacy and a procedure and timeframe for modifying the plan to the satisfaction of all parties at least once per year.

16.6.4 If the Contractor and Tribal entity are not able develop a plan or the tribe does not respond to the request, HCA will work with both the Tribes and Contractor to reach an understanding.

16.6.5 Meetings will be conducted in accordance with the HCA government-to-government relationship with Washington Tribes.

16.6.6 The Tribes, whose Tribal lands lie within multiple regions, may develop joint plans with those regions. If the Contractor has multiple Tribal lands within their service region, one plan may be developed for all Tribes if all parties agree.

16.6.7 The plan must include a procedure for crisis responders and DHMPs (non-Tribal) to access Tribal lands to provide requested services, including crisis response, and ITA evaluations. The plan must also include the following:

16.6.7.1 Any notifications and authority needed to provide services including a plan for evening, holiday, and weekend access to Tribal lands if different than business hours.

16.6.7.2 A process for notification of Tribal authorities when Crisis Services are provided on Tribal land, especially on weekends, holidays, and after

Business Hours. This must identify the essential elements included in this notification, who is notified, and timeframe for the notification.

16.6.7.3 A description of how crisis responders will coordinate with Tribal Mental Health providers and/or others identified in the plan for, including a description of how service coordination and debriefing with Tribal mental health providers will occur after a Crisis Service has been provided.

16.6.7.4 The process for determining when a DMHP is requested and a timeframe for consulting with Tribal mental health providers regarding the determination to detain or not for Involuntary Commitment.

16.6.7.5 If ITA evaluations cannot be conducted on Tribal land, the plan shall specify how and by whom individuals will be transported to non-Tribal lands for ITA evaluations and detentions.

16.6.7.6 If DMHP evaluations cannot be conducted on Tribal Land, the plan shall specify how and by whom individuals will be transported from Tribal Land to the licensed Evaluation and Treatment facility.

16.6.7.7 Specify where individuals will be held and under what authority if no E&T beds are available.

17 Criminal Justice Treatment Account and Juvenile Drug Court

17.1 Criminal Justice Treatment Account Services (CJTA)

The Contractor shall be responsible for providing services concerning the specific eligibility and funding requirements for Criminal Justice Treatment Account Services (CJTA) (Chapter 70.96A RCW,).

17.1.1 Each county has an established local CJTA panel that creates the CJTA plan to describe how CJTA funds will be used. After the plan is approved by the state CJTA panel, it is provided to the Contractor. The Contractor shall implement the plan as approved by the state panel. The plan will address the priorities for use of funds for:

17.1.1.1 The treatment of individuals with an addiction or SUD that if not treated may result in addiction or in subsequent actions from which charges may be filed by a prosecuting attorney in Washington State.

17.1.1.2 Drug and alcohol treatment services and treatment support services for non-violent individuals within a drug court program.

17.1.1.3 Adult or juvenile offenders within a drug court program as defined in RCW 70.96A.055: Drug courts and RCW 2.28.170: Drug courts.

17.1.2 CJTA Funding Guidelines

17.1.2.1 No more than ten percent (10%) of the total CJTA funds can be used for the following support services combined:

17.1.2.2 Transportation; and

17.1.2.3 Child Care Services.

17.1.3 The Contractor shall provide a minimum thirty percent (30%) of the CJTA funds for special projects that meet any or all of the following conditions:

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

17.1.3.2 An approach utilizing either traditional or best practices to treat significantly underserved population(s), or

17.1.3.3 A regional project conducted in partnership with at least one (1) other entity serving the SWWA service area such as, the AH-FIMC MCOs operating in the RSA or the ACH).

17.1.4 Services that can be provided through CJTA funds are:

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

17.1.4.2 Acute Withdrawal Management (ASAM Level 3.2WM);

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

17.1.4.4 Outpatient Treatment (ASAM Level 1);

17.1.4.5 Intensive Outpatient Treatment (ASAM Level 2.1);

17.1.4.6 . Brief Outpatient Treatment (ASAM Level 1);

17.1.4.7 Opiate Substitution Treatment (ASAM Level 1);

17.1.4.8 Case Management (ASAM Level 1.2);

17.1.4.9 Intensive Inpatient Residential Treatment (ASAM Level 3.5);

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

17.1.4.11 Recovery House Residential Treatment (ASAM Level 3.1);

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

17.1.4.13 Interim Services;

17.1.4.14 Community Outreach;

17.1.4.15 Involuntary Commitment Investigations and Treatment;

17.1.4.16 Room and Board (Residential Treatment Only);

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17.1.4.17 Transportation;

17.1.4.18 Childcare Services; and

17.1.4.19 Urinalysis.

17.1.5 CJTA Special Projects Report - The Contractor shall submit a progress report to HCA on a timeline provided by HCA prior to the Contract execution date that summarizes the status of the project and includes the following required information:

17.1.5.1 Type of project (acknowledge best practice/treatment strategy, significant underserved population(s), or regional endeavor).

17.1.5.2 Current Status:

17.1.5.2.1 Describe the project and how it is consistent with your strategic plan.

17.1.5.2.2 Describe how the project has enhanced treatment services for offenders.

17.1.5.2.3 Indicate the number of offenders who were served using innovative funds.

17.1.5.2.4 Indicate the cost of service per participant.

17.2 **Juvenile Drug Court**

17.2.1 The Contractor shall provide the services and staff to support Consumers involved with a Juvenile Drug Court (JDC) and provide the following:

17.2.1.1 A drug and alcohol assessment (HCA prefers the GAIN-I assessment tool).

17.2.1.2 Substance abuse and mental health treatment and counseling as appropriate.

17.2.1.3 A comprehensive case management plan which is individually tailored, culturally competent, developmentally and gender appropriate, and which includes educational goals that draw on the strengths and address the needs of the Consumer.

17.2.1.4 Drug testing, scheduled and at random, to support the treatment plan and monitor compliance.

17.2.1.5 Track attendance and completion of activities, and impose appropriate incentives for compliance and sanctions for lack of compliance.

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

17.3 **Juvenile Drug Court Reporting Requirements**

17.3.1 The contractor shall submit to HCA, a quarterly report that details the following:

17.3.1.1 Consumer levels, including: number of Consumers; number of Consumers terminated for drug use, for new charges, for other reasons; and number of graduates/completions.

17.3.1.2 Drug test information, including: number of Urinary Analysis (UAs), and number of positive UAs.

17.3.1.3 Number of sanctions and incentives imposed by a judge.

17.3.1.4 Percentage of Consumers and their families involved in programs such as Functional Family Therapy, Aggression Replacement Therapy, etc.

17.3.1.5 Percentage of Consumers working on education and/or employment goals.

17.3.1.6 Recidivism rate (conviction-free at six (6) months and at one (1) year following graduation).

17.3.1.7 Percentage of graduates who continue with optional aftercare services.

The quarterly reports are due to HCA by the fifteenth (15th) of the month following the end of the quarter.

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18 Federal Block Grants (FBG)

18.1 FBG Provision

18.1.1 The Contractor shall collect information from key stakeholders and community partners to provide input into the development of the MHBG and SAPT Project Plans. The plans shall be submitted to and approved by the regional Behavioral Health Advisory Board. The Contractor shall send its board-approved proposed SAPT Project Plan to HCA by January 31, 2017. Updated plans are due annually by July 31st for the prior fiscal year. The MHBG plan format is identified in Exhibit J, and the format for SAPT is in Exhibit K. HCA shall review the proposed project plans and notify the Contractor of the date of approval, or if not approved, the date revisions are due. HCA shall not process payment for FBG services until HCA has approved the project plans.

18.1.2 The Contractor shall provide or subcontract for services according to the local MHBG and the local SAPT project plans, as approved by the SWWA RSA Community BHAB, and the State BHAC.

18.1.3 Upon request by HCA, the Contractor shall attend or send a representative to the Washington State Behavioral Health Advisory Council meeting to discuss priorities for future FBG supported services.

18.2 FBG requires annual peer reviews by individuals with expertise in the field of mental health treatment consisting of at least five percent (5%) of treatment providers. The Contractor and Subcontractors shall participate in a peer review process when requested by HCA (42 U.S.C. 300x-53 (a) and 45 C.F.R. 96.136) MHBG Service Provisions

18.2.1 The contractor shall provide MHBG services to promote recovery for an adult with a Serious Mental Illness (SMI) and resiliency for Seriously Emotionally Disturbed (SED) children, in accordance with federal and state requirements.

18.2.2 The Contractor shall submit a MHBG Final Report by June 1, 2017, for services provided April, 1 2016, through March 31, 2017. The report must include the following:

18.2.2.1 Actions taken to increase Consumer involvement in services, commonly referred to as Consumer Voice.

18.2.2.2 Progress towards achievement of the SWWA RSA's MHBG project plan including barriers encountered and steps taken to remove barriers.

18.2.2.3 Lessons learned with recommendations to improve future service delivery outcomes.

18.2.3 The Contractor shall ensure that MHBG funds are used only for services to individuals who are not enrolled in Medicaid or for services that are not covered by Medicaid, as described below:

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

19 Jail Transition Services

19.1 Jail Coordination Services are to be provided within the identified resources in Exhibit A-2, Funding Allocation.

19.1.1 The Contractor must coordinate with local law enforcement and jail personnel.

19.1.1.1 The Contractor must identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.

19.1.1.2 The Contractor must accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in Chapter 71.24 RCW. The Contractor must conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.

19.1.1.3 The Contractor must develop and execute a memorandum of understanding agreement with local DSHS Community Services Offices (CSOs) for expedited application or reinstatement of medical assistance for Individuals in jails, prisons, or IMDs. The Contractor must assist Individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.

19.1.2 Pre-release services must provide:

19.1.2.1.1 Mental health screening for Individuals who display behavior consistent with a need for such screening or who have been referred by jail staff, or officers of the court.

19.1.2.1.2 Mental health intake assessments for persons identified during the mental health screening as a member of the priority populations.

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

19.1.2.1.4 Other prudent pre-release (including pre-trial) case management and transition planning.

19.1.2.1.5 Direct mental health services to Individuals who are in jails that have no mental health staff.

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

19.1.3 If the Contractor has provided the jail services in this section, the Contractor may use the Jail Coordination Services funds, if sufficient, to facilitate any of the following:

19.1.3.1 Daily cross-reference between new booking and the DSHS Data Store to identify newly booked persons.

19.1.3.2 Develop individual alternative service plans (alternative to the jail) for submission to the courts.

19.1.3.3 Inter-local Agreements with juvenile detentions facilities.

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

19.1.3.5 Training to local law enforcement and jail services personnel.

20 BUSINESS CONTINUITY AND DISASTER RECOVERY

20.1 Business Continuity and Disaster Recovery

20.1.1 The Contractor shall demonstrate a primary and back-up system for electronic submission of data requested by HCA. This must include the use of the Inter-Governmental Network (IGN) Information Systems Services Division (ISSD) approved secured virtual private network (VPN) or other ISSD-approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on HCA approval.

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

20.1.1.1.1 A mission or scope statement.

20.1.1.1.2 An information services disaster recovery person(s).

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

20.1.1.1.4 Procedures for allowing effective communication, applications inventory and business recovery priority, and hardware and software vendor list.

20.1.1.1.5 Confirmation of updated system and operations documentation and process for frequent back up of systems and data.

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

20.1.1.1.7 Designated recovery options.

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

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

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