



WASHINGTON
BEHAVIORAL HEALTH SERVICES
WRAPAROUND CONTRACT

HCA Contract Number:
«Contract»

Contractor Contract Number:

Competition Exempt

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, chapter 74.09 RCW and Title 182 WAC.

CONTRACTOR NAME «Organization_Name»		CONTRACTOR doing business as (DBA)	
«Mailing_AddressSt_Address» «City», «State» «Zip_Code»		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) «UBI»	HCA INDEX NUMBER
CONTRACTOR CONTACT «Contact_Fname» «Contact_LName»	CONTRACTOR TELEPHONE «PhoneNo»	CONTRACTOR E-MAIL ADDRESS «EmailAddress»	
HCA CONTACT NAME AND TITLE		HCA CONTACT ADDRESS Post Office Box 45502 Olympia, WA 98504-5502	
HCA CONTACT TELEPHONE	HCA CONTACT FAX N/A	HCA CONTACT E-MAIL ADDRESS @hca.wa.gov	
IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF THIS CONTRACT? No		CFDA NUMBER(S)	
CONTRACT START DATE	CONTRACT END DATE	MAXIMUM CONTRACT AMOUNT	
<p>EXHIBITS. The following Exhibits are attached and are incorporated into this Contract by reference:</p> <p><input checked="" type="checkbox"/> Exhibits (specify): Exhibit A, List of Essential Behavioral Health Providers, Exhibit B SUD/MH Services by Funding, Exhibit C, Combined BG FFY 2016.</p> <p><input checked="" type="checkbox"/> Attachments. Attachment 1 – Encounter Data/Financial Summary Reconciliation, Form C, Attachment 2 – Apple Health Quarterly Encounter/General Ledger Reconciliation, Form D</p> <p><input type="checkbox"/> No Exhibits.</p>			
<p>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.</p>			
CONTRACTOR SIGNATURE		PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE		PRINTED NAME AND TITLE	DATE SIGNED

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Exhibits

Exhibit A – List of Essential Behavioral Health Providers
Exhibit B – SUD and Mental Health Services by Funding Source
Exhibit C – Combined Block Grant Application Federal Fiscal Year 2016

Attachments

Attachment 1 – Encounter Data/Financial Summary Reconciliation, Form C
Attachment 2 – Apple Health Quarterly Encounter/General Ledger Reconciliation, Form D

SAMPLE

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 requested State Only/Federal Block Grant Service(s) for reasons of medical necessity.

1.3 Acute Withdrawal Management Services

“Acute Withdrawal Management Services” means detoxification services provided to an individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner. Acute detoxification provides medical care and physician supervision for withdrawal from alcohol or other drugs. Limited to three to five (3-5) days for Medicaid State Plan Services.

1.4 Administrative Hearing

“Administrative Hearing” means an adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by Chapter 34.05 RCW, the agency’s hearings rules found in chapter 182-526 WAC.

1.5 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).

1.6 Alcohol/Drug Information School

“Alcohol/Drug Information School” means costs incurred for Alcohol/Drug information schools provide information regarding the use and abuse of alcohol/drugs in a structured educational setting. Alcohol/Drug Information Schools must meet the certification standards in WAC 388-877B. (The service as described satisfies the level of intensity in ASAM Level 0.5)

1.7 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:

1.7.1 Fraud hotline complaints;

1.7.2 Claims data mining; and

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

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

“American Society of Addiction Medicine (ASAM) Criteria” means criteria that allows a clinician to systematically evaluate the severity and diagnosis of a patient’s need for treatment along six (6) dimensions, and then utilize a fixed combination rule to determine which of four levels of care a substance using patient will respond to with the greatest success. ASAM also includes the recommended duration of substance use disorder (SUD) treatment.

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

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

1.10 **Appeal**

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

1.11 **Appeal Process**

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

1.12 **Available Resources**

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

1.13 **Behavioral Health**

“Behavioral Health” means mental health and/or substance use disorders and/or conditions and related benefits.

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

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

1.15 **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.

1.16 **Behavioral Health Services Only (BHSO)**

“Behavioral Health Services Only” means those enrollees who receive only behavioral health benefits through this Contract and the companion AH-FIMC Medicaid Contract.

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 an enrollee’s needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the enrollee and the enrollee’s caregivers, and works with the enrollee to make sure that the enrollee gets the most appropriate treatment, while ensuring that care is not accidentally duplicated.

1.19 Care Management

“Care Management” means a set of services, delivered by Care Coordinators, designed to improve the health of Enrollees. Care management includes a health assessment, development of a care plan and monitoring of Enrollee status, care coordination, ongoing reassessment and consultation and crisis intervention and case conferencing as needed to facilitate improved outcomes and appropriate use of health services, including moving the Enrollee to a less intensive level of care management as warranted by Enrollee improvement and stabilization. Effective care management includes the following:

- 1.19.1 Actively assisting Enrollees to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- 1.19.2 Utilization of evidence-based clinical practices in screening and intervention;
- 1.19.3 Ready access to behavioral health services that are, to the extent possible, integrated with primary care; and
- 1.19.4 Use of appropriate community resources to support individual Enrollees, families and caregivers in managing care.

1.20 Care Plan or Individual Service Plan (ISP)

“Care Plan or Individual Service Plan (ISP)” means a written agreement between the Enrollee and his or her healthcare team to help guide and manage the delivery of diagnostic and therapeutic services and the Enrollee’s engagement in self-management of his or her health (may also be called treatment plan).

1.21 Centers for Medicare and Medicaid Services (CMS)

“Centers for Medicare and Medicaid Services (CMS)” means the federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children’s Health Insurance Program (CHIP), and health insurance portability standards.

1.22 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 chemical dependency counseling (Substance Use Disorder [SUD] services).

1.23 Certified Chemical Dependency Professional Trainee (CDPT)

“Certified Chemical Dependency Professional Trainee (CDPT)” means an individual working toward the education and experience requirements for certification as a CDP according to RCW 18.205.020 and the certification requirements of WAC 246.811-030.

1.24 **Certified Peer Counselor (CPC)**

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

- a. Help individuals and families take specific steps to achieve goals, such as building social support networks, managing internal and external stress, and navigating service delivery systems;
- b. Share their own experiences in recovery to encourage consumers and families to regain hope and control over their own lives;
- c. Promote personal responsibility for recovery and assist consumers and families in learning to advocate for themselves;
- d. Model competency in ongoing coping skills; and
- e. Work with consumers in groups or individually. Many work for licensed community mental health agencies or their Subcontractors. For more information: <https://www.dshs.wa.gov/node/8976>.

1.25 **Childcare Services**

“Childcare Services” means cost incurred in the provision of child care services, when needed, to children of parents in treatment in order to complete the parent's plan for substance use disorder treatment services. Childcare services must be provided by licensed childcare providers 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.

1.26 **Children with Special Health Care Needs**

“Children with Special Health Care Needs” means children under nineteen (19) years of age who are any one of the following:

- 1.26.1 Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act;
- 1.26.2 Eligible for Medicaid under section 1902(e) (3) of the Act;
- 1.26.3 In foster care or other out-of-home placement;
- 1.26.4 Receiving foster care or adoption assistance; and/or
- 1.26.5 Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a) (1) (D) of Title V of the Social Security Act.

1.27 **Child Study and Treatment Center (CSTC)**

“Child Study and Treatment Center (CSTC)” means the Department of Social and Health Services' child psychiatric hospital.

1.28 **Chronic Disease Self-Management Education (CDSME)**

“Chronic Disease Self-Management Education (CDSME)” means programs that enable individuals with multiple chronic conditions to learn how to manage their overall health, symptoms, and risk factors. An example is the Stanford University Chronic Disease Self-Management Program which has been shown in randomized trials to improve symptoms such as pain, shortness of breath and fatigue, improve ability to engage in everyday activities, reduce depression and decrease costly health care such as emergency department visits.

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

“Code of Federal Regulations (C.F.R.)” 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.

1.30 **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 Enrollee and families, clinical and community service resources, including law enforcement. Membership shall be comprised of at least fifty-one percent (51%) Enrollee or Enrollee family members as defined in WAC 388-865-0222. Composition of the Advisory Board and the length of terms shall be submitted to HCA upon request.

1.31 **Community Health Workers (CHW)**

“Community Health Workers (CHW)” means individuals who serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. They include Community Health Representatives (CHR) in the Indian Health Service funded, Tribally contracted/granted and directed program. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. For more information: <http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/CommunityHealthWorkerTrainingSystem>.

1.32 **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.

1.33 **Community Outreach**

“Community Outreach” means an activity of providing critical information and referral regarding behavioral health services to people who might not otherwise have access to that information. This may include assisting individuals to navigate through different systems including health care enrollment, scheduling appointments for a substance use disorder assessment and ongoing treatment, or providing transportation to appointments. Outreach tasks may include educating communities, family members, significant others, or partners about services and to support access to services where care coordination may be necessary. Costs to be covered may also include responding to requests for information to be presented both in and out of the treatment facility by individuals, the general public and community organizations.

1.34 **Comparable Coverage**

“Comparable Coverage” means an Enrollee has other insurance that HCA has determined provides a full scope of health care benefits.

1.35 **Comprehensive Assessment Report and Evaluation (CARE)**

“Comprehensive Assessment Report and Evaluation (CARE)” means a person centered, automated assessment tool used for determining Medicaid functional eligibility, level of care for budget and comprehensive care planning, as defined in chapter 388-106 WAC.

1.36 **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.

1.37 **Continuing Education and Training**

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

1.38 **Continuity of Care**

“Continuity of Care” means the provision of continuous care for chronic or acute medical and behavioral health conditions through enrollee 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.

1.39 **Contract**

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

1.40 **Contractor**

“Contractor” means the individual or entity performing services pursuant to this Contract and includes the Contractor’s owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, “Contractor” includes any Subcontractor and its owners, officers, directors, partners, employees, and/or agents. In this Contract “Contractor” may also refer to any other Managed Care Organization (MCO) contracting with HCA for State-Only and Substance Abuse Prevention and Treatment (SAPT) Block Grant services.

1.41 **Contracted Services**

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

1.42 **Covered Services**

“Covered Services” means health care services that HCA determines are covered for Enrollees within Available Resources. When State Only/Federal Block Grant Services (GFS/SAPT) funding is exhausted, services are no longer covered and cannot be authorized regardless of medical necessity.

1.43 **Credible Allegation of Fraud**

“Credible Allegation of Fraud” means the Contractor has investigated an allegation of fraud and concluded that the existence of fraud is more probable than not. (42 C.F.R. § 455.2).

1.44 **Day**

“Day” for purposes of this Contract means calendar days unless otherwise indicated in the Contract.

1.45 **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, or debarment under chapter 39.26 RCW.

1.46 **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:

- 1.46.1 Behavioral Health and Services Integration Administration (BHSIA) is responsible for providing mental health services in State psychiatric hospitals and community settings and SUD inpatient and outpatient treatment, recovery and prevention services.
- 1.46.2 Aging and Long-Term Support Administration (ALSA) is responsible for providing a safe home, community and nursing facility array of long-term supports for Washington citizens.
- 1.46.3 Children’s Administration (CA) is responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.
- 1.46.4 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.

1.47 **Division of Behavioral Health and Recovery (DBHR)**

“Division of Behavioral Health and Recovery (DBHR)” means the DSHS-designated single state agency for mental health and substance use disorder treatment, authorized by RCW chapters 71.05, 71.24, 71.34, 70.96a and 70.96b.

1.48 **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.

1.49 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.

1.50 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.

1.51 Encrypt

“Encrypt” means to encipher or encode electronic data using software that generates a minimum key length of 128 bits.

1.52 Engagement and Referral

“Engagement and Referral” means cost incurred to identify hard-to-reach individuals with possible substance use disorder and to engage these individuals in an assessment and ongoing treatment services as deemed necessary. Costs can be reimbursed for activities associated with providing information on substance use disorders, the impact of substance use disorders on families, treatment of substance use disorders, and treatment resources that may be available as well as re-engaging individuals in the treatment process. This does not include ongoing therapeutic or rehabilitative services.

1.53 Enrollee

“Enrollee” means an individual enrolled in Fully Integrated Managed Care or a behavioral health services only managed care plan through a MCO having a Contract with HCA. For purposes of this Contract, an Enrollee may receive State-Only and/or SAPT block grant services if he/she meets the eligibility requirements for such services.

1.54 Essential Behavioral Health Administrative Functions

“Essential Behavioral Health Administrative Functions” means utilization management, grievance and appeals, network development and management, provider relations, quality management, data management and reporting, claims and financial management.

1.55 Evaluation and Treatment (E&T)

“Evaluation and Treatment” means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is certified as such by the Department. A physically separate and separately operated portion of a State Hospital may be designated as an evaluation and treatment facility. A facility which is part of, or operated by, the Department or any federal agency will not require certification. No correctional institution of facility, or jail, shall be an evaluation and treatment facility within the meaning of RCW Chapter 71.05.020. State only funds shall be used to cover the cost of room and board in an E&T.

1.56 **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. (Washington State Institute for Public Policy (WSIPP) 3/2015).

1.57 **External Entities (EE)**

“External Entities (EE)” means organizations that serve eligible Medicaid clients and include the Department of Social and Health Services, Department of Health, local health jurisdictions, community-based service providers and HCA services/programs as defined in this Contract.

1.58 **Family Hardship**

“Family Hardship” means the provision of transportation and lodging for family members traveling from their home to the treatment facility for distances over 50 miles within Washington State in support of Medicaid funded youth who are receiving services in a Residential facility in order to allow them to participate in treatment with the youth.

1.59 **Facility**

“Facility” means but is not limited to, a hospital, an inpatient rehabilitation center, long-term and acute care (LTAC), skilled nursing facility, and nursing home.

1.60 **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.

1.61 **Fiscal/Program Requirements**

“Fiscal/Program Requirements” formerly titled “BARS Manual” including the DSHS BHSIA/Division of Behavioral Health and Recovery/Chemical Dependency Supplementary Instructions and Fiscal Policy Standards for Reimbursable Costs as used by DBHR and HCA located at:
<https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Substance%20Use/FY14%20Fiscal%20Program%20Requirements%20for%20SUD.pdf>.

1.62 **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 (42 C.F.R § 455.2).

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

“Global Appraisal of Individual Needs Shorter Screener (GAIN-SS)” means the integrated, comprehensive screening for behavioral health conditions as required by 70.96C RCW.

1.64 **Grievance**

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

1.65 **Grievance Process**

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

1.66 **Grievance System**

“Grievance System” means the overall system that includes grievances and appeals handled by the Contractor and access to the hearing system.

1.67 **Guideline**

“Guideline” means a set of statements by which 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.

1.68 **Hardened Password**

“Hardened Password” means a string of at least eight characters containing at least one alphabetic character, at least one number and at least one special character such as an asterisk, ampersand or exclamation point.

1.69 **Health Care Authority (HCA)**

“Health Care Authority (HCA)” means the State of Washington Health Care Authority and its employees and authorized agents.

1.70 **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, 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.

1.71 **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.

1.72 **Health Care Settings (HCS)**

“Health Care Settings (HCS)” for the purpose of this Contract, means health care settings shall include: health care clinics where primary care services are delivered, community mental health agencies or SUD agencies.

1.73 **High Intensity Treatment**

“High Intensity Treatment” means intensive levels of service provided to Medicaid-enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual’s needs. 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 members’ work together to provide intensive coordinated and integrated treatment as described in the Individual Service Plan. The team’s intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning shall be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the Individual Service Plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to client ratio for this service is no more than 1:15.

1.74 **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.

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

“ITA or Involuntary Treatment Act” 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 71.05.240 and 71.05.920).

Involuntary Treatment Act (ITA Substance Use Disorder) allows for Individuals to be committed by court order to an approved treatment program for a limited period of time. Involuntary civil commitments are meant to provide for the treatment of Individuals with a substance use 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. Individuals can be committed for a period of sixty (60) days unless sooner discharged if it has been determined that the likelihood of harm no longer exists or treatment is no longer adequate or appropriate, or incapacity no longer exists. A petition for recommitment can be filed for an additional period of up to ninety (90) days. (RCW 70.96A.140)

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

“Individuals with Intellectual or Developmental Disability (I/DD)” means a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition of an individual found by the secretary to be closely related to an intellectual disability or to require treatment similar to that required for individuals with intellectual disabilities, which disability originates before the individual attains age eighteen (18), which has continued or can be expected to continue indefinitely, and which constitutes a substantial limitation to the individual. (RCW 71a.10.020 (5)).

1.77 Intensive Inpatient Residential Services

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

1.78 Institute for Mental Disease (IMD)

“IMD or Institute for Mental Disease” means, per P.L. 100-360, an institution for mental diseases as 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. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of Individuals with mental diseases.

1.79 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.

1.80 Interim Services

“Interim Services” means services to individuals who are currently waiting for an appointment 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.

1.81 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.

1.82 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.

1.83 Long Term Care Residential Services

“Long Term Care Residential Services” means the care and treatment of chronically impaired alcoholics and addicts with impaired self-maintenance capabilities including personal care services and a concentrated program of substance use disorder treatment, individual and group counseling, education, vocational guidance counseling and related activities for alcoholics and addicts including room and board in a twenty-four-hour-a-day, supervised facility accordance with WAC 388-877B. (The service as described satisfies the level of intensity in ASAM Level 3.3).

1.84 Managed Care

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

1.85 Managed Care Organization (MCO)

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

1.86 Marketing

“Marketing” means any communication, whether written, oral, in-person (telephonic or face-to-face), or electronic, and includes promotional activities intended to increase a Contractor’s membership or to “brand” a Contractor’s name or organization. Marketing is communication from the Contractor to a potential Enrollee or Enrollee 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 end enrollment with another HCA-contracted MCO.

1.87 Material Provider

“Material Provider” means a Participating Provider whose loss would negatively affect access to care in the service area in such a way that a significant percentage of Enrollees would have to change their Provider or Contractor, receive services from a non-participating Provider, or consistently receive services outside the service area.

1.88 Medicaid Fraud Control Unit (MFCU)

“Medicaid Fraud Control Unit (MFCU)” means the Washington State Medicaid Fraud Control Unit which investigates and prosecutes fraud by health care providers. The MFCU is part of the Washington State Office of the Attorney General.

1.89 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 Enrollee 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 Enrollee 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).

1.90 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 substance use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful. Medication assisted treatment (MAT) is clinically driven with a focus on individualized patient care.

1.91 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.

1.92 Mental Health Parity

"Mental Health Parity" means for purposes of this Contract and until which time CMS release final parity rules, inclusive of mental health and substance use disorder benefits shall apply to this contract. (WAC 284-43-990- through 284-43-995).

1.93 Mental Health Professional

"Mental Health Professional" means:

- 1.93.1 A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in Chapter 71.34 RCW;
- 1.93.2 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 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;
- 1.93.3 A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;
- 1.93.4 A person who has an approved exception to perform the duties of a Mental Health Professional by the DSHS Division of Behavioral Health and Recovery before July 1, 2001; or
- 1.93.5 A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional by the DSHS Division of Behavioral Health and Recovery consistent with WAC 388-865-0265 before April 1, 2016.

1.94 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 CPT manual, national and local policies and edits.

1.95 Network Adequacy

“Network Adequacy” means a network of providers for the Contractor that is sufficient in numbers and types of providers/facilities (as required by the Contract) to ensure that all services are accessible to Enrollees within the access standards outlined in the Contract.

1.96 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 a managed care organization’s provider network, but provides health care services to Enrollees.

1.97 Notice of Action

“Notice of Action” means a written notice that must be provided to Enrollees to inform them that State-Only and SAPT block grant services, available per the Contractor’s policy and procedures have not been authorized based on medical necessity criteria.

1.98 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.

1.99 Opiate Dependency/HIV Services Outreach

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

1.100 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.

1.101 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 Enrollees under the terms of this Contract.

1.102 **Peer Support**

“Peer Support” means services provided by peer counselors to Medicaid-enrolled individuals under the consultation, facilitation, or supervision of a Mental Health Professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Clients actively participate in decision-making and the operation of the programmatic supports.

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

1.103 **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.

1.104 **Physician Group**

“Physician Group” means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

1.105 **Physician Incentive Plan**

“Physician Incentive Plan” means any compensation arrangement between the Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to Enrollees under the terms of this Contract.

1.106 **Physician’s Orders for Life Sustaining Treatment (POLST)**

“Physician’s Orders for Life Sustaining Treatment (POLST)” means a set of guidelines and protocols for how emergency medical personnel shall respond when summoned to the site of an injury or illness for the treatment of a person who has signed a written directive or durable power of attorney requesting that he or she not receive futile emergency medical treatment (RCW 43.70.480).

1.107 **Potential Enrollee**

“Potential Enrollee” means any individual who HCA determines is eligible for enrollment in Apple Health - Fully Integrated Managed Care or BHSO and who, at the time of HCA’s determination, is not enrolled with any Apple Health - Fully Integrated Managed Care Contractor.

1.108 **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, including those attempting to gain custody of children supervised by the Department of Social and Health Services, Division of Children and Family Services (DCFS).

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

“PPW Housing Support Services” means the costs incurred to provide support services to PPW individuals in a transitional residential housing program designed exclusively for this population. Activities include facilitating contacts and appointments for community resources for medical care, financial assistance, social services, vocational, childcare needs, outpatient treatment services, and permanent housing services. This includes services to family or significant others of an individual currently in transitional housing.

1.110 **Promising Practice**

“Promising Practice (BHPractices)” means a practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the evidence-based or research-based criteria that may include the use of a program that is evidence-based for outcomes. (WSIPP 3/2015).

1.111 **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.

1.112 **ProviderOne**

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

1.113 **Quality**

“Quality” means the degree to which a Contractor increases the likelihood of desired health outcomes of its Enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

1.114 **Recovery**

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

1.115 **Recovery House Residential Services**

“Recovery House Residential Services” means the costs incurred for a program of care and treatment with social, vocational and recreational activities designed to aid alcoholics and addicts in the adjustment to abstinence and to aid in job training, reentry to employment, or other types of community activities, including room and board in a twenty-four-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).

1.116 **Recovery Support Services**

“Recovery Support Services” means the costs incurred to provide activities that help individuals enter and navigate systems of care, remove barriers to recovery; stay engaged in the recovery process and live full lives in the communities of their choice. Includes SAPT-funded Recovery Support Services as identified in Exhibit C.

1.117 Regional Service Area (RSA)

“Regional Service Area (RSA)” means a single county or multi-county grouping formed for the purpose of health care purchasing and designated by the Health Care Authority and the Department of Social and Health Services.

1.118 Regulation

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

1.119 Rehabilitation Case Management

“Rehabilitation Case Management” means a range of activities conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities (which can be provided prior to an intake evaluation) 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. General State Funds may be used for the cost of providing rehabilitation case management services for Medicaid-enrolled individuals who are receiving treatment in a non-Medicaid facility (e.g. IMD or State Hospital). 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.

1.120 Research-Based Practice

“Research-Based Practice (BHPractices)” means a program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes but does not meet the full criteria for evidence-based. (Washington State Institute for Public Policy (WSIPP) 3/2015).

1.121 Residential Mental Health Services

“Residential Mental Health Services” means a specialized form of rehabilitation service (non-hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, Single Room Occupancy (SRO) apartments) for extended hours to provide direct mental health care to a Medicaid Enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. General Fund State funds may be used for the costs for room and board.

1.122 **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.

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

“Revised Code of Washington (RCW)” means the laws of the State of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended or replacement statute. Pertinent RCW chapters can be accessed at <http://www.leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx>.

1.124 **Room and Board**

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

1.125 **SAPT Block Grant**

“SAPT Block Grant” means the Federal Substance Abuse Prevention and Treatment (SAPT) 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. The program’s objective is to help plan, implement and evaluate activities that prevent and treat substance abuse.

1.126 **The System for Communicating Outcomes, Performance & Evaluation (SCOPE)**

“The System for Communicating Outcomes, Performance & Evaluation SCOPE” means a web-based query and reporting service for substance and mental health professionals across Washington State.

1.127 **Secured Area**

“Secured Area” means an area to which only authorized representatives of the entity possessing the Confidential Information have access. Secured Areas may include buildings, rooms or locked storage containers such as a filing cabinet within a room, as long as access to the Confidential Information is not available to unauthorized personnel.

1.128 **Single Case Agreement**

“Single Case Agreement” means a written agreement between the Contractor and a nonparticipating provider to deliver services to an Enrollee.

1.129 **Sobering Services**

“Sobering Services” means costs incurred to provide short-term (12 hours or less) emergency shelter, screening, and referral services to persons who need to recover from the effects of alcohol. Services include medical screening, observation and referral to continued treatment and other services as appropriate.

1.130 State Only/Federal Block Grant Services (GFS/SAPT)

“State Only/Federal Block Grant Services (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).

1.131 Sub-Acute Withdrawal Management

“Sub-Acute Withdrawal Management” means costs incurred for detoxification services provided to an individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner. Sub-Acute is a nonmedical detoxification or patient self-administration of withdrawal medications ordered by a physician, provided in a home-like environment. Limited to three to five (3-5) days for Medicaid State Plan Services.

1.132 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.

1.133 Subcontractor

“Subcontractor” means one who takes a portion of a Contract from the principle Contractor or from another Subcontractor.

1.134 Substance Use Disorder (SUD)

“Substance Use Disorder (SUD)” means a problematic pattern of substance use leading to clinically significant impairment or distress ranging in severity from mild, moderate to severe.

1.135 System for Award Management (SAM)

“System for Award Management (SAM)” means the official U.S. Government system that consolidated the capabilities of CCR/FedReg, ORCA and EPLS. Providers listed in the SAM should not be awarded a Contract with the Contractor.

1.136 Therapeutic Interventions for Children

“Therapeutic Interventions for Children” means services promoting the health and welfare of children accompanying parents to or who are participating in a substance abuse program. Services 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.

1.137 Transitional Age Youth (TAY)

“Transition age youth” are commonly defined as individuals between the ages of sixteen (16) and twenty five (25) years. They have unique service challenges because they are too old for child services but are often not ready or eligible for adult services

1.138 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.

1.139 **Transitional Healthcare Services (THS)**

“Transitional Healthcare Services (THS)” means the mechanisms to ensure coordination and continuity of care as Enrollees transfer between different locations or different levels of care within the same location. Transitional Healthcare Services are intended to prevent secondary health conditions or complications, re-institutionalization or re-hospitalization, including recidivism following SUD treatment.

1.140 **Transport**

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

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

1.140.2 Is accomplished other than via a Trusted System.

1.141 **Treatment and Assessment Report Generation Tool (Target)**

“TARGET” means the Treatment and Assessment Report Generation Tool, the management information system maintained by DSHS that retains demographic, treatment, and ancillary service data on each individual receiving publicly-funded outpatient and residential chemical dependency treatment services in Washington State, as well as data on other general services provided.

1.142 **Trusted System**

“Trusted System” 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:

1.142.1 Hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt.

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

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

1.143 **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.

1.144 **United States Code (USC)**

“United States Code” means the USC chapters or sections shall include any successor, amended, or replacement statute. The USC may be accessed at <http://www.gpoaccess.gov/uscode/>.

1.145 **Urgent Medical Condition**

“Urgent Medical Condition” means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity such that if services are not received within twenty four (24) hours of the request, the person’s situation is likely to deteriorate to the point that Emergent Services are necessary.

1.146 **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.

1.147 **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.

1.148 **Washington Administrative Code (WAC)**

“Washington Administrative Code (WAC)” means the rules adopted by agencies to implement legislation and RCWs. All references in this Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation. Pertinent WAC chapters or sections can be accessed at <http://www.leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx>.

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

“Washington Apple Health – Fully Integrated Managed Care (AH-FIMC)” means the program under which a managed care organization provides GFS/SAPT services and, under separate companion Contract, Medicaid funded physical and behavioral health services.

1.150 **Washington Healthplanfinder (HPF)**

“Washington Healthplanfinder (HPF)” means an online marketplace for individuals, families, and small businesses to compare and enroll in qualified health insurance plans.

1.151 **Washington State Institute for Public Policy (WSIPP)**

“Washington State Institute for Public Policy (WSIPP)” means the entity that carries out non-partisan research at the direction of the legislature or Board of Directors. WSIPP works closely with legislators, legislative and State agency staff, and experts in the field to ensure that studies answer relevant policy questions. Fiscal and administrative services for WSIPP are provided by a state college.

1.152 **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.

1.153 **Young Adult**

“Young Adult” means a person from age eighteen (18) through age twenty (20).

1.154 **Youth**

“Youth” means an enrollee from age ten (10) through age seventeen (17).

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.
- 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. HCA may withhold its consent at its sole discretion.

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 ninety (90) days after the end of the fiscal year in which the services were performed unless otherwise specified in this Contract.

2.4 Compliance with Applicable Law

In the provision of services under this Contract, the Contractor and its Subcontractors shall comply with all applicable federal, State and local laws and regulations, and all amendments thereto, that are in effect when the Contract is signed or that come into effect during the term of this Contract. The provisions of this Contract that are in conflict with applicable State or federal laws or regulations are hereby amended to conform to the minimum requirements of such laws or regulations. A provision of this Contract that is stricter than such laws or regulations will not be deemed a conflict. Applicable laws and regulations include, but are not limited to:

- 2.4.1 Title XIX and Title XXI of the Social Security Act.
- 2.4.2 Title VI of the Civil Rights Act of 1964.
- 2.4.3 Title IX of the Education Amendments of 1972, regarding any education programs and activities.
- 2.4.4 The Age Discrimination Act of 1975.
- 2.4.5 The Rehabilitation Act of 1973.
- 2.4.6 The Budget Deficit Reduction Act of 2005.

- 2.4.7 The Washington Medicaid False Claims Act and Federal False Claims Act (FCA).
- 2.4.8 The Health Insurance Portability and Accountability Act (HIPAA).
- 2.4.9 The American Recovery and Reinvestment Act (ARRA).
- 2.4.10 The Patient Protection and Affordable Care Act (PPACA or ACA).
- 2.4.11 The Health Care and Education Reconciliation Act.
- 2.4.12 The Mental Health Parity and Addiction Equity Act (MHPAEA) and final rule.
- 2.4.13 21 CFR Food and Drugs, Chapter 1 Subchapter C – Drugs – General.
- 2.4.14 42 CFR Subchapter A, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.
- 2.4.15 42 CFR Subchapter A – Part 8 – Certification of Opioid Treatment Programs.
- 2.4.16 45CFR 96 Block Grants.
- 2.4.17 45 CFR 96.126 Capacity of Treatment for Intravenous Substance Abusers who Receive Services under Block Grant funding.
- 2.4.18 Chapter 70.02 RCW and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews.
- 2.4.19 Chapter 70.96A RCW Treatment for Alcoholism, Intoxication, and Drug Addiction.
- 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.
- 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, 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 Enrollees with disabilities, in accord with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit Enrollees with disabilities from obtaining contracted services.
- 2.4.28 All applicable Office of Insurance Commissioner's (OIC) statutes and regulations.
- 2.4.29 Any other requirements associated with the receipt of federal funds for the GFS/SAPT services.

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 Enrollees 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 an Enrollee'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 Enrollees. 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 Enrollees collected, used, or acquired by Contractor during the term of this Agreement. 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 Enrollees.

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, 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 2.37 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 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 42700, Olympia, WA 98504-2700. Any such requests must be received by the Director within fifteen (15) 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 2.9

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.

Nothing in this Contract shall be construed as a waiver by HCA of the State's immunity under the 11th Amendment to the United States Constitution.

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 Enrollees shall not be, in any manner, liable for the debts and obligations of the Contractor.
- 2.13.2 In accord with the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge Enrollees for Contracted services.
- 2.13.3 The Contractor shall, in accord with RCW 48.44.055 or 48.46.245, provide for the continuity of care for Enrollees.
- 2.13.4 The Contractor shall cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

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, including HCA and MFCU, and the Washington State Auditor's Office, as well as the federal Department of Health and Human Services, 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 under chapter 42.56 RCW.

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 key personnel within seven (7) days including, but not limited to, the Contractor’s Chief Executive Officer, the Contractor’s Chief Financial Officer, HCA government relations contact, HCA Account Executive, Medical Director, behavioral health Medical Director, and behavioral health Clinical Director. The Contractor shall provide HCA with an interim contact person that will be performing the key personnel member’s duties and a written plan for replacing key personnel, including expected timelines. If key personnel will not be available for work under the Contract for a continuous period exceeding thirty (30) days, or are no longer working full-time in the key position, the Contractor shall notify the HCA within seven (7) days after the date of notification of the change.

2.19 Order of Precedence

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

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

2.20 Severability

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

2.21 **Survivability**

The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: 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, Enrollee appeals) provided to Enrollees 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.
- 2.21.5 Reimburse providers for claims erroneously billed to and paid by HCA within the twenty-four (24) months before the expiration or termination of this Contract.

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**

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. The Contractor shall require participating hospitals, ambulatory care surgery centers, and office-based surgery sites to endorse and adopt procedures for verifying the correct patient, the correct procedure, and the correct surgical site that meets or exceeds those set forth in the Universal Protocol™ developed by the Joint Commission or other similar standards.

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 Enrollees according to the terms of this Contract. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees.

2.26 Industrial Insurance Coverage

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

2.27 No Federal or State Endorsement

The award of this Contract does not indicate an endorsement of the Contractor by the Centers for Medicare and Medicaid Services (CMS), the federal government, or the State of Washington. No federal funds have been used for lobbying purposes in connection with this Contract or managed care program.

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:

«CEO»

«Organization_Name»

«Mailing_Address»

«City», «State» «Zip_Code»

- 2.28.2 In the case of notice to HCA, send notice to:
Contract Administrator
HCA
Legal and Administrative 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 If HCA determines it has made an overpayment to the Contractor, then HCA will issue a Notice of Overpayment to the Contractor.
- 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, in accordance with RCW 41.05A.170(1);
 - 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, in accordance with RCW 41.05A.170(3);
 - 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 shall have a Certificate of Registration as a Health Maintenance Organization (HMO), Health Care Service Contractor (HCSC) or Life and Disability Insurance Carrier, from the Washington State Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of chapters 48.21, 48.21a, 48.44 or 48.46 RCW, as amended.

2.32.2 The Contractor agrees that HCA may at any time access any information related to the Contractor's financial condition, or compliance with the Office of the Insurance Commissioner (OIC) requirements, from OIC and consult with OIC concerning such information.

2.32.3 The Contractor shall deliver to HCA copies of any financial reports prepared at the request of the OIC or National Association of Insurance Commissioners (NAIC) per the HCSC required filing checklist for financial reports. The Contractor's routine quarterly and annual statements submitted to the OIC are exempt from this requirement. The Contractor shall also deliver copies of related documents and correspondence (including, but not limited to, Risk-Based Capital [RBC] calculations and Management's Discussion and Analysis), at the same time the Contractor submits them to the OIC or NAIC.

- 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 or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Contract or which may otherwise materially affect the relationship of the parties under this Contract.
- 2.32.5 The Contractor shall notify HCA within 24 hours after any action by the OIC which may affect the relationship of the parties under this Contract.
- 2.32.6 The Contractor shall notify HCA if the OIC requires enhanced reporting requirements within fourteen (14) calendar days after the Contractor's notification by the OIC. The Contractor agrees that HCA may, at any time, access any financial reports submitted to the OIC in accordance with any enhanced reporting requirements and consult with OIC staff concerning information contained therein.

2.33 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 (41 U.S.C. § 423).

2.34 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.

2.35 Termination by Default

- 2.35.1 **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 receipt from the Contractor of a written notice, as described in the Notices section of the General Terms and Conditions, specifying 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.
- 2.35.2 **Termination by HCA.** HCA may terminate this Contract if HCA determines:
 - 2.35.2.1 The Contractor did not fully and accurately make any disclosure required under 42 C.F.R. 455.116(a).

- 2.35.2.2 The Contractor failed to timely submit accurate information required under 42 C.F.R. 455, Subpart E. (42 C.F.R. 455.416(d)).
- 2.35.2.3 One of the Contractor's owners failed to timely submit accurate information required under 42 C.F.R. 455, Subpart E. (42 C.F.R. 455.416(d)).
- 2.35.2.4 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 required under 42 C.F.R. 455, Subpart E. (42 C.F.R. 455.416(d)).
- 2.35.2.5 One of the Contractor's owners did not cooperate with any screening methods required under 42 C.F.R. 455, Subpart E. (42 C.F.R. 455.416(a)).
- 2.35.2.6 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 10 years. (42 C.F.R. 455.416(b)).
- 2.35.2.7 The Contractor has been terminated under title XVIII of the Social Security Act, or under any states' Medicaid or CHIP program. (42 C.F.R. 455.416(c)).
- 2.35.2.8 One of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by HCA within 30 days of a CMS or HCA request. (42 C.F.R. 455.416(e); 42 C.F.R. 455.450(d)).
- 2.35.2.9 The Contractor failed to permit access to one of the Contractor's locations for site visits under 42 C.F.R. 455.432. (42 C.F.R. 455.416(f)).
- 2.35.2.10 The Contractor has falsified any information provided on its application. (42 C.F.R. 455.416(g)).

2.36 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 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.

2.37 Terminations: Pre-termination Processes

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 the intent to terminate this Contract and the reason for termination.

HCA shall provide written notice to the Contractor's Enrollees of the decision to terminate the Contract and indicate whether the Contractor may appeal the decision.

- 2.37.1 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.

2.38 Savings

In the event funding from any state, federal, or other sources 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.

2.39 Post Termination Responsibilities

The following requirements survive termination of this Contract. Contractor shall:

- 2.39.1 Submit all data and reports required in the Contract;
- 2.39.2 Provide access to records, related to audits and performance reviews; and
- 2.39.3 Provide administrative services associated with services (e.g., claims processing and Enrollee appeals) to be provided to Enrollees under the terms of this Contract.

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 GFS/SAPT services to Enrollees. Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions Section of this Contract.

2.41 Treatment of Client Property

Unless otherwise provided, the Contractor shall ensure that any adult Enrollee receiving services from the Contractor has unrestricted access to the Enrollee's personal property. The Contractor shall not interfere with any adult Enrollee's ownership, possession, or use of the Enrollee's property. The Contractor shall provide Enrollees under age eighteen (18) with reasonable access to their personal property that is appropriate to the Enrollee's age, development, and needs. Upon termination of the Contract, the Contractor shall immediately release to the Enrollee and/or the Enrollee's guardian or custodian all of the Enrollee's personal property.

2.42 Administrative Simplification

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

- 2.42.1 To maximize understanding, communication, and administrative economy among all managed care Contractors, their Subcontractors, governmental entities, and Enrollees, Contractor shall use and follow the most recent updated versions of:
 - Current Procedural Terminology (CPT).
 - International Classification of Diseases (ICD).
 - Healthcare Common Procedure Coding System (HCPCS).
 - The Diagnostic and Statistical Manual of Mental Disorders.
 - NCPDP Telecommunication Standard D.O.
 - Medi-Span® Master Drug Data Base or other nationally recognized drug data base with approval by HCA.

- 2.42.2 The Contractor must follow National Correct Coding Initiative (NCCI) policies to control improper coding that leads to inappropriate payments. The Contractor must incorporate compatible NCCI methodologies in its payment systems for processing claims. The NCCI editing should occur in addition to current procedure code review and editing by the Contractor's claims payment systems.
- 2.42.3 In lieu of the most recent versions, Contractor may request an exception. HCA's consent thereto will not be unreasonably withheld.
- 2.42.4 Contractor may set its own conversion factor(s), including special code-specific or group-specific conversion factors, as it deems appropriate.

3 MARKETING AND INFORMATION REQUIREMENTS

3.1 Marketing

The marketing requirements contained the companion Apple Health Fully-Integrated Medicaid Contract apply to this Contract.

3.2 Information Requirements for Enrollees and Potential Enrollees

- 3.2.1 The Contractor shall provide to new Enrollees the information needed to understand benefit coverage and obtain care in accord with the provisions of this Section. Specifically, the Contractor shall provide information to Enrollees on the GFS/SAPT services, including how to access them. The information shall be provided at least once a year upon request and within fifteen (15) working days of enrollment. In providing this information to the Enrollees, the Contractor may use an existing member handbook that is otherwise provided to Enrollees; however, such handbook must be prior approved in writing by the HCA.
- 3.2.2 The Contractor shall submit branding materials developed by the Contractor that specifically mention GFS/SAPT services for review and approval. No such materials shall be disseminated to Enrollees, providers or other members of the public without HCA's approval.
- 3.2.3 The Contractor shall submit Enrollee information developed by the Contractor that specifically mentions GFS/SAPT services provided under this Contract at least thirty (30) calendar days prior to distribution for review and approval. All other Enrollee materials shall be submitted as informational. HCA may waive the thirty (30) day requirement if, in HCA's sole judgment, it is in the best interest of HCA and its clients to do so.

3.3 Equal Access for Enrollees with Communication Barriers

The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access for enrollees and potential enrollees with communication barriers (42 C.F.R. § 438.10).

3.3.1 Oral Information

- 3.3.1.1 The Contractor shall assure that interpreter services are provided for Enrollees and potential Enrollees with a primary language other than English, free of charge. Interpreter services shall be provided for all interactions between such Enrollees or potential Enrollees 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;

- 3.3.1.1.3 Emergency services, and
- 3.3.1.1.4 All steps necessary to file grievances and appeals including requests for Independent Review of Contractor decisions (RCW 48.43.535; WAC 246-305, 284-43).
- 3.3.1.2 The Contractor is responsible for payment for interpreter services for Contractor administrative matters including, but not limited to handling Enrollee grievances and appeals.
- 3.3.1.1 Services must be requested in accordance with the HCA Interpreter Service (IS) program rules. If an Interpreter is unavailable through the State Interpreter Services contractor, the contractor shall ensure interpreter services are provided through their providers to enrollees or potential enrollees at no charge (Section 601 of Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act.
- 3.3.1.2 Hospitals are responsible for payment for interpreter services during inpatient stays.
- 3.3.1.3 Public entities, such as Public Health Departments, are responsible for payment for interpreter services provided at their facilities or affiliated sites.
- 3.3.1.4 Interpreter services include the provision of interpreters for Enrollees and potential Enrollees who are deaf or hearing impaired at no cost to the Enrollee or potential Enrollee.
- 3.3.2 Written Information
 - 3.3.2.1 The Contractor shall provide all generally available and Enrollee-specific written materials in a language and format which may be understood by each individual Enrollee and potential Enrollee. If five percent (5%) or more of the Contractor's Enrollees speak a specific language other than English.
 - 3.3.2.2 For Enrollees whose primary language is not translated or whose need cannot be addressed by translation under the preceding subsection as required by the provisions of this Section, the Contractor may meet the requirement of this Section by doing any one of the following:
 - 3.3.2.2.1 Translating the material into the Enrollee's or potential Enrollee's primary reading language.
 - 3.3.2.2.2 Providing the material in an audio format in the Enrollee's or potential Enrollee's primary language.
 - 3.3.2.2.3 Having an interpreter read the material to the Enrollee or potential Enrollee in the Enrollee's primary language.
 - 3.3.2.2.4 Providing the material in another alternative medium or format acceptable to the Enrollee or potential Enrollee. The Contractor shall document the Enrollee's or potential Enrollee's acceptance of the material in an alternative medium or format in the Enrollee's record.
 - 3.3.2.2.5 Providing the material in English, if the Contractor documents the Enrollee's or potential Enrollee's preference for receiving material in English.

- 3.3.3 The Contractor shall ensure that all written information provided to Enrollees or potential Enrollees is accurate, is not misleading, is comprehensible to its intended audience, designed to provide the greatest degree of understanding, is written at the sixth 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 grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth grade reading level or the Enrollees' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth 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 GFS/SAPT services provided under this Contract.
- 3.3.6 Educational materials that are not developed by the Contractor or developed under Contract with the Contractor are not required to meet the sixth 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 Enrollee-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 ENROLLMENT

4.1 Service Areas

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

4.2 Eligibility and Enrollment

- 4.2.1 To be eligible for GFS/SAPT services under this Contract, an individual must: (i) be eligible for Medicaid and an Enrollee in the Contractor's plan; and (ii) meet the clinical or program eligibility criteria for the GFS/SAPT service.
- 4.2.2 Meeting the eligibility requirements under this Contract does not guarantee the Enrollee will receive the GFS/SAPT service.
- 4.2.3 HCA shall determine Medicaid eligibility for enrollment over the term of the Contract. Individuals eligible for Medicaid and enrolled with the Contractor will be presumed to meet financial eligibility requirements for GFS/SAPT services.
- 4.2.4 At HCA's direction, the Contractor shall participate in a regional initiative to develop and implement consistent protocols to determine clinical or program eligibility for the limited-benefit GFS/SAPT services.
- 4.2.5 At HCA's discretion, the Contractor shall participate in developing protocols for individuals with frequent Medicaid eligibility changes (including those individuals who are eligible through spend-down). The protocols will address, at a minimum, coordination with the BH-ASO, referrals, reconciliations and potential transfer of GFS/SAPT funds to promote continuity of care for the individual. Any reconciliations will occur at a frequency determined by HCA but no less than quarterly with potential for up to monthly reconciliations in the last quarter of the allocation year.

4.3 Termination of Enrollment

- 4.3.1.1 The Enrollee remains eligible for GFS/SAPT services until HCA has notified the Contractor in writing that enrollment in the AH-FIMC plan is terminated, or the Enrollee no longer meets clinical/program eligibility requirements, contingent on Available Resources.
- 4.3.2 An Enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month remains eligible as a Medicaid Enrollee to receive contracted services through the end of that month as long as the Enrollee meets the clinical eligibility requirements for the GFS/SAPT services.

5 PAYMENT AND SANCTIONS

5.1 Funding

- 5.1.1 The funds under this Contract are dependent upon HCA's receipt of continued State and federal funding awards. If HCA does not receive continued State and federal funding awards, HCA may terminate this Contract in accordance with this Contract's General Terms and Conditions.
- 5.1.2 HCA will allocate State-Only and Federal Substance Abuse Prevention and Treatment Block Grant (SAPT) funds to the Contractor on a quarterly basis, identified in Exhibit X, based upon available funding for the regional service area as a whole and the Contractor's share of the eligible enrollment in the region.
- 5.1.3 A maximum of ten percent of the State-Only funds allocated to the Contractor may be used for administrative costs, taxes and other fees per RCW 71.24.330. The Contractor shall not use SAPT funds for administrative costs.
- 5.1.4 HCA will pay the Contractor State-only funds and SAPT funds on a monthly basis based upon receipt of accepted encounters for services provided under this Contract. A ten percent administrative load will be added to the State-only funds and paid to the Contractor with the monthly payment. If the expenditures reported by the Contractor on the encounters, exceed the Contractor's quarterly allocation, HCA will not pay the Contractor for the amount that exceeds the allocation.
- 5.1.5 HCA will provide a quarterly State Hospital Bed Allocation to the Contractor as described in section 14.2. This allocation shall be used by the Contractor as a ceiling for the State Hospital Bed utilization by the clients they serve under this Contract.
- 5.1.6 The Contractor shall pay a reimbursement for each State Hospital Patient Day of Care that exceeds the Contractor's daily allocation of State Hospital beds identified in Exhibit X based on a quarterly calculation of the bed usage by the Contractor.
 - 5.1.6.1 The Contractor may not enter into any agreement or make other arrangements for use of State Hospital beds outside of the agreed-upon allocation in Exhibit X.
 - 5.1.6.2 Any changes to the allocation shall require an amendment to the Agreement, and will become effective the 1st day of the quarter following the effective date of this Amendment.

- 5.1.6.3 HCA will 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 two months after the last day of each quarter the Contractor exceeded the allocation. The Contractor shall pay HCA within 30 days of the date on the reimbursement bill.
- 5.1.6.4 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.
- 5.1.7 The rate of payment for reimbursement for Eastern State Hospital is \$611.00.
- 5.1.8 The rate of payment for reimbursement for Western State Hospital is \$541.00.
- 5.1.9 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 payments approximately five (5) months after the end of the applicable quarter.
- 5.1.10 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 approximately five (5) months after the end of the applicable quarter.
- 5.1.11 The Contractor shall only use the administrative portion of the State-Only funds for the potential State Hospital Bed Allocation overage fee.
- 5.1.12 Funds allocated under this Contract that are not expended by the end of the applicable FY may not be used or carried forward to the subsequent applicable FY or to any other Contract. Unspent allocations will be collected by HCA at the end of the applicable FY as specified in section 2.29 of this Contract.
- 5.1.13 The Contractor shall ensure that all funds provided pursuant to this Contract, including interest earned, are used to provide services as described in Section 16 of this Contract.
- 5.1.14 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.

5.2 **Encounter Data**

- 5.2.1 For purposes of this Subsection:
 - 5.2.1.1 "Encounter" means a single health care service or a period of examination or treatment.
 - 5.2.1.2 "Encounter data" means records of health care services submitted as electronic data files created by the Contractor's system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format.

- 5.2.1.3 “Encounter record” means the number of service lines or products submitted as line items in the standard 837 format or the National Council for Prescription Drug Programs (NCPDP) Batch format.
- 5.2.1.4 “Duplicate Encounter” means multiple encounters where all fields are alike except for the ProviderOne Transaction Control Numbers (TCNs) and the Contractors Claim Submitter’s Identifier or Transaction Reference Number.
- 5.2.2 The Contractor shall comply with the all of the following:
 - 5.2.2.1 Designate a person dedicated to work collaboratively with HCA on quality control and review of encounter data submitted to HCA.
 - 5.2.2.2 Submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards:
 - 5.2.2.2.1 Encounter data must be submitted to HCA at a minimum monthly, and no later than thirty (30) calendar days from the end of the month in which the Contractor paid the financial liability;
 - 5.2.2.2.2 Submitted encounters and encounter records must pass all HCA ProviderOne system edits with a disposition of accept and listed in the Encounter Data Reporting Guide or sent out in communications from HCA to the Contractor; and
 - 5.2.2.2.3 Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.
 - 5.2.2.3 These data quality standards are listed within this Contract and incorporated by reference into this Contract. The Contractor shall make changes or corrections to encounter data and/or any systems, processes or data transmission formats as needed to comply with HCA’s data quality standards as defined and subsequently amended.
- 5.2.3 The Contractor must report the paid date and amount paid for each encounter. The “amount paid” data is considered the Contractor’s proprietary information and is protected from public disclosure under RCW 42.56.270(11). Amount paid shall not be utilized in the consideration of a Contractor’s assignment percentage or in the evaluation of a Contractor’s performance.
- 5.2.4 HCA shall perform encounter data quality reviews to ensure receipt of complete and accurate encounter data for program administration.
- 5.2.5 The Contractor must certify the accuracy and completeness of all encounter data concurrently with each file upload (42 C.F.R. § 438.606). The certification must affirm that:
 - 5.2.5.1 The Contractor has reported to HCA for the month of (indicate month and year) all paid claims for all claim types; and
 - 5.2.5.2 The Contractor has reviewed the claims data for the month of submission.

- 5.2.6 The Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer attest that based on best knowledge, information, and belief as of the date indicated, all information submitted to HCA in the submission is accurate, complete, truthful, and they hereby certify that no material fact has been omitted from the certification and submission.
- 5.2.7 HCA collects and uses this data for many reasons such as: Audits, investigations, identifications of improper payments and other program integrity activities, federal reporting (42 C.F.R. § 438.242(b)(1)), rate setting and risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care; HCA hospital rate setting; pharmacy rebates and research studies.
- 5.2.8 Additional detail can be found in the Encounter Data Reporting Guide published by HCA and incorporated by reference into this Contract:
 - 5.2.8.1 HCA may change the Encounter Data Reporting Guide with ninety (90) calendar days' written notice to the Contractor.
 - 5.2.8.2 The Encounter Data Reporting Guide may be changed with less than ninety (90) calendar days' notice by mutual agreement of the Contractor and HCA.
 - 5.2.8.3 The Contractor shall, upon receipt of such notice from HCA, provide notice of changes to subcontractors.
- 5.2.9 HCA may also require additional reporting of client utilization to adhere to Federal Reporting Standards for SAPT funded services. The format and frequency of the additional reports will be provided to the Contractor by December, 2015.
- 5.2.10 The Contractor shall ensure that final reporting of encounters for services provided under this Contract shall occur no more than ninety (90) days after the end of each fiscal year of this Contract.

5.3 Non-Compliance

- 5.3.1 Failure to Maintain Reporting Requirements
 - 5.3.1.1 In the event the Contractor or a Subcontractor fails to maintain its reporting obligations under this Contract, HCA reserves the right to withhold reimbursements to the Contractor until the obligations are met.
- 5.3.2 Recovery of Costs Claimed in Error
 - 5.3.2.1 If the Contractor claims and HCA reimburses for expenditures under this Contract which HCA later finds were (1) claimed in error or (2) not allowable costs under the terms of the Contract, HCA shall recover those costs and the Contractor shall fully cooperate with the recovery.
- 5.3.3 Stop Placement
 - 5.3.3.1 HCA may stop the placement of Enrollee in a treatment facility immediately upon finding that the Contractor or a Subcontractor is not in substantial compliance, as determined by HCA, with provisions of the Contractor any WAC related to chemical dependency treatment. The treatment facility will be notified by HCA of this decision in writing.

5.3.4 Additional Remuneration Prohibited

5.3.4.1 The Contractor shall not charge or accept additional fees from any patient, relative, or any other person, for SAPT 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 Overpayments or Underpayments

5.4.1 If, at HCA's the 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 SO/FGB funds, HCA may make prospective and/or retrospective modifications to the allocations, as necessary. At the explicit written approval of HCA, the Contractor can elect to make a lump sum or similar arrangement for payment.

5.5 Sanctions

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

5.5.1.1 A problem exists that negatively impacts Enrollees receiving services.

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

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

5.5.1.4 The Contractor has failed to perform any administrative function required under this Contract. For the purposes of this section, "administrative function" is defined as any obligation other than the actual provision of behavioral health services.

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

5.5.2 HCA may impose any of the following remedial actions:

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

5.5.2.2 Corrective action plans must include:

5.5.2.2.1 A brief description of the situation requiring corrective action.

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

5.5.2.2.3 A timetable for completion of the actions.

- 5.5.2.2.4 Identification of individuals responsible for implementation of the plan.
- 5.5.2.3 Corrective action plans are subject to approval by HCA, which may:
 - 5.5.2.3.1 Accept the plan as submitted.
 - 5.5.2.3.2 Accept the plan with specified modifications.
 - 5.5.2.3.3 Request a modified plan.
 - 5.5.2.3.4 Reject the plan.
- 5.5.3 Withhold up to five percent (5%) of the next payment and each payment thereafter until the corrective action has achieved resolution. The amount of the withhold will be based on the severity of the situation as detailed in section 5.5. HCA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.
- 5.5.4 Increase withholdings identified above by up to an additional three percent (3%) for each successive month during which the remedial situation has not been resolved.
- 5.5.5 Deny any incentive payment to which the Contractor might otherwise have been entitled under this Contract.
- 5.5.6 Terminate for Default as described in the General Terms and Conditions.

5.6 Medicaid Personal Care

- 5.6.1 The Contractor shall provide DSHS Aging and Disabilities Services program funds equal to the general-fund state cost of Medicaid Personal Care Services used by the Contractor for Individuals who are determined to have personal care needs, as per the CARE assessment, and the need is due solely to a psychiatric disability when such payments have been authorized by the Contractor.

6 ACCESS TO CARE AND PROVIDER NETWORK

6.1 Network Capacity

- 6.1.1 The Contractor shall maintain and monitor an appropriate and adequate provider network, supported by written agreements, sufficient to provide GFS/SAPT services under this Contract to its Enrollees. The Contractor may provide contracted services through non-participating providers, at a cost to the Enrollee 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 medical needs of Enrollees in a manner consistent with this Contract. To the extent necessary to comply with the provider network adequacy and distance standards required under this Contract, the Contractor may offer contracts to providers in bordering states. The Contractor's provider contracts with providers in bordering states must ensure access to necessary care, including inpatient and outpatient services and must coordinate with Oregon and Idaho providers to explore opportunities for reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective.
 - 6.1.1.1 The Contractor shall provide quarterly status reports to HCA on its contracting activities in border communities and services area. HCA will provide a template for the report.

- 6.1.2 The Contractor must submit documentation quarterly assuring adequate capacity and services, including information regarding its maintenance, monitoring and analysis of the network to include full provider network submissions to determine compliance with the requirements of this Section, at any time upon HCA request or when there has been a change in the Contractor's network or operations that, in the sole judgment of HCA, would affect adequate capacity and/or the Contractor's ability to provide services.
 - 6.1.2.1 The Contractor shall submit updated provider network information as requested by HCA:
 - 6.1.2.1.1 At the time it enters into a Contract with HCA and within ten (10) business days of HCA's request.
 - 6.1.2.1.2 At any time there has been a significant change in the Contractor's operations that would affect adequate capacity and services, including:
 - 6.1.2.1.2.1 Changes in GFS/SAPT services, geographic service area;
 - 6.1.2.1.2.2 The termination or addition of a subcontract with an entity that provides behavioral health services, the closing of a Subcontractor site that is providing services under this Contract or temporary inability of a subcontracted provider to deliver services such as strike or other work stoppage;
 - 6.1.2.1.2.3 Enrollment of a new population in the Contractor;
 - 6.1.2.1.2.4 The closing of a Subcontractor, agency or provider that is providing services under this Contract;
 - 6.1.2.1.2.5 Any other changes that result in the Contractor being unable to meet access including a decrease in the number or frequency of a required service, employee strike or other work stoppage related to union activities, or any changes that results in the Contractor being unable to provide timely services.
 - 6.1.2.2 The Contractor shall notify HCA ninety (90) days prior to terminating any of its subcontracts with entities that provide direct services or entering into new subcontracts with entities that provide direct services. This notification shall occur prior to any public announcement of this change.
 - 6.1.2.2.1 If a subcontract is terminated in less than ninety (90) days or a site closure occurs in less than ninety (90) days, the Contractor shall notify HCA as soon as possible and prior to a public announcement.
 - 6.1.2.2.2 If a subcontract is terminated or a site closes, the Contractor shall submit a plan to HCA that includes at a minimum:
 - 6.1.2.2.2.1 Notification to Ombuds services;
 - 6.1.2.2.2.2 Individual notification plan;
 - 6.1.2.2.2.3 Plan for provision of uninterrupted services; and
 - 6.1.2.2.2.4 Any information released to the media.

- 6.1.2.2.3 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.
 - 6.1.2.2.3.1 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 material provider.
- 6.1.2.3 The updated provider network information will be reviewed by HCA for:
 - 6.1.2.3.1 Completeness and accuracy;
 - 6.1.2.3.2 The need for HCA provision of technical assistance;
 - 6.1.2.3.3 Removal of providers who no longer contract with the Contractor; and
 - 6.1.2.3.4 The effect that the change(s) in the provider network will have on the network's compliance with the requirements of this section.
- 6.1.3 The Contractor's network capacity analysis required in Section 6.1. shall be updated to address the impact of GFS/SAPT funded service on network capacity, with specific attention to SAPT funded SUD treatment services.
- 6.1.4 A work plan to address any materials gaps in the behavioral health network, as identified by HCA, with priorities for network development and goals, action steps, timelines, performance targets, and measurement methodologies for addressing the gaps and priorities.
- 6.1.5 The Contractor shall incorporate the following requirements when developing its network:
 - 6.1.5.1 Only licensed behavioral health providers shall provide behavioral health services to Enrollees. Licensed 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.
 - 6.1.5.2 The Contractor shall establish and maintain contracts with Washington State determined Essential Behavioral Health Providers. The current list of Essential Behavioral Health Providers can be found in Exhibit A.
 - 6.1.5.3 The Contractor shall, in partnership with the BH-ASO, assist the State to expand community-based alternatives for crisis stabilization, such as mobile crisis or crisis residential and respite beds.
 - 6.1.5.4 The Contractor shall assist the State to expand community-based, recovery-oriented services and research- and evidence-based practices.
 - 6.1.5.5 The Contractor shall implement an adequate plan to provide evaluation and treatment services to Enrollees, which may include the development of less restrictive alternative to involuntary treatment or prevention programs reasonably calculated to reduce the demand for evaluation and treatment services.

- 6.1.6 If the Contractor, in HCA's sole opinion, and in conjunction with recommendations provided by the ACH, fails to maintain an adequate network of behavioral health providers in any contracted service area for two (2) consecutive quarters, and after notification following the first quarter, HCA reserves the right to immediately terminate the Contractor's services for that service area. The network established under the Contract must complement and support the network of Medicaid providers established by the companion AH-FIMC Medicaid Contract.
- 6.1.7 The Contractor shall update and maintain the Contractor's existing provider manual to include all relevant information regarding GFS/SAPT services and requirements.
- 6.1.8 The Contractor shall update its existing database to meet the following requirements:
 - 6.1.8.1 Includes a list of all GFS/SAPT providers.
 - 6.1.8.2 Includes the providers' names, locations, telephone numbers, GFS/SAPT services offered, clinical specialty and areas of expertise.
 - 6.1.8.3 Includes a description of each provider's language(s) spoken and if appropriate, a brief description of the provider's skills or experiences that would support the cultural or linguistic needs of its Enrollees when provided by a provider.
 - 6.1.8.4 Indicates whether each provider has capacity to serve new patients and the limits on capacity for each provider.
 - 6.1.8.5 Updates to the provider database shall be made: no less than quarterly or whenever there is a change in the Contractor's network that would affect adequate capacity in a service area.
 - 6.1.8.6 Contractor program staff shall be available to conduct provider searches based on office or facility location, clinical specialty, provider discipline, provider capacity, available languages and allowable fund sources (e.g., Medicaid, SAPT, GFS).

6.2 Service Delivery Network

- 6.2.1 In establishing, maintaining, monitoring and reporting of its network, the Contractor must consider the following:
 - 6.2.1.1 The impact of anticipated enrollment levels, 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 clients, and whether the location is ADA accessible) for all Contractor funded behavioral health programs and services on the availability of GFS/SAPT services.
 - 6.2.1.2 The anticipated needs of priority populations, in priority order below with 6.2.1.2.1 being the first priority, as identified in the SAPT block grant or by HCA but not limited to:
 - 6.2.1.2.1 Pregnant injecting drug users.
 - 6.2.1.2.2 Pregnant substance users.
 - 6.2.1.2.3 Women with dependent children.
 - 6.2.1.2.4 Injecting drug users.

- 6.2.1.3 The following additional priority populations, in no particular order:
 - 6.2.1.3.1 Postpartum women (up to one year, regardless of pregnancy outcome).
 - 6.2.1.3.2 Patients transition from residential care to outpatient care.
 - 6.2.1.3.3 Youth.
 - 6.2.1.3.4 Offenders (as defined in RCW 70.96.350).
- 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 all diverse populations;
 - 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; and
 - 6.2.2.3 Take the initiative to strengthen working relationships with other agencies serving these populations.

6.3 Hours of Operation for Network Providers

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

6.4 24/7 Availability

The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week, 365 days a year basis by a toll free telephone number. These services may be provided directly by the Contractor or may be delegated to subcontractors. The Contractor shall have a single toll-free number for Enrollees to call regarding Medicaid and GFS/SAPT services at its expense. The Contractor shall not have a separate toll-free number for GFS/SAPT services.

- 6.4.1 Medical and behavioral health advice for enrollees from licensed Health Care Professionals.
- 6.4.2 Authorization of urgent and emergency services, including emergency care and services provided outside the Contractor's service area.
- 6.4.3 The toll-free line staff must be able to make a warm handoff to the regional crisis line.
- 6.4.4 Information, triage and referral for GFS/SAPT funded services with access to licensed Health Care Professionals and, licensed agencies or clinics to address emergent or urgent needs.

6.5 Customer Service

The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8:00 a.m. to 6:00 p.m., Pacific Standard Time or Daylight Savings Time (depending on the season), 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. Call center operations must be located in Washington State. The Contractor shall have a single toll-free number for Enrollees to call regarding Medicaid and GFS/SAPT services at its expense. The Contractor shall not have a separate toll-free number for GFS/SAPT services.

- 6.5.1 The Contractor shall report by December 1st of each year its scheduled non-business days for the upcoming calendar year.
- 6.5.2 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.
- 6.5.3 The Contractor and its provider help desks, and Enrollee customer service centers, if any, shall comply with the following customer service performance standards:
 - 6.5.3.1 Telephone abandonment rate – standard is less than three percent (3%).
 - 6.5.3.2 Telephone response time – average speed of answer within thirty (30) seconds.
- 6.5.4 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 GFS/SAPT service eligibility requirements and benefits; navigation of the eligibility systems to access Medicaid benefits and GFS/SAPT services; refer for needed behavioral health services; distinguish between a benefit inquiry, third party insurance issue, Appeal or Grievance; and resolve and triage grievances and appeals.
- 6.5.5 The Contractor shall submit its customer services policies and procedures to the HCA for review at least ninety (90) days before implementation. Customer services policies and procedures shall be updated to address the following:
 - 6.5.5.1 Information on the GFS/SAPT services including where and how to access them.
 - 6.5.5.2 Authorization requirements.
 - 6.5.5.3 Requirements for responding promptly to family members and other service systems including, but not limited to GFS/SAPT regional BH-ASO, law enforcement, criminal justice system and social services.
 - 6.5.5.4 Assisting and triaging Enrollees who may be in crisis with access to appropriately qualified clinicians to assist with triaging callers who may be in crisis without placing the Enrollee on hold. The qualified clinician shall assess the crisis and warm transfer the call to the BH-ASO or its designated crisis provider(s), call 911, refer the individual for services, refer the individual to his or her provider, or resolve the crisis over the telephone as appropriate.
- 6.5.6 The Contractor shall train customer services representatives on revised GFS/SAPT policies and procedures. The training shall incorporate the State's vision, mission, system goals, and operating principals for behavioral health managed care programs and services.

6.6 **Waiting List and Appointment Requirements**

The Contractor shall have contracts in place with all Subcontractors that meet State standards for access, taking into account the urgency of the need for services. The Contractor shall comply with the following requirements:

- 6.6.1 For SAPT services:
 - 6.6.1.1 The Contractor shall collect patient information as required by the HCA using the HCA designated data reporting system.
- 6.6.2 The Contractor shall ensure that Enrollees receive services in a timely manner. Contingent on Available Resources, the following appointment standards would apply:
- 6.6.3 Transitional healthcare services by a home care nurse, a home care Mental Health Professional, or another behavioral health care professional within seven (7) calendar days of discharge from inpatient or institutional care for behavioral health care, if ordered by the Enrollee's primary care provider or as part of the discharge plan.
- 6.6.4 Care for a non-life-threatening emergency within six (6) hours.
- 6.6.5 Urgent care within forty-eight (48) hours
- 6.6.6 An appointment for a routine office visit within ten (10) business days.
- 6.6.7 Failure to meet appointment standards may, at the HCA's sole discretion, result in withholding of payments, assignments and/or re-enrollments as described in the Sanctions subsection of this Contract.

6.7 **Provider Database**

The Contractor shall have, maintain and provide to HCA upon request an up-to-date database of its provider network. In populating its database, the Contractor shall obtain the following information: the identity, location, languages spoken (when this information is supplied by the provider), qualifications, practice restrictions, and availability of all current contracted providers, including specialty providers.

- 6.7.1 The Contractor shall prepare a network inventory, including licensure, to quantify the number of providers offering GFS/SAPT services.

6.8 **Assignment of Enrollees**

- 6.8.1 HCA has the sole and exclusive right to determine the methodology and procedures by which Enrollees are assigned to the Contractor or reassigned to any other Apple Health - Fully Integrated Managed Care Contractors.
- 6.8.2 HCA may adjust the methodology or procedures at any time during the term of this Contract if, in its sole discretion, it determines that any such adjustment would be in the best interests of HCA or the Enrollees.
 - 6.8.2.1 HCA, in its sole discretion, shall determine whether the Contractor's provider network meets the required capacity.
- 6.8.3 HCA shall enroll all eligible clients with the Contractor of their choice except as provided herein, unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.

- 6.8.4 HCA may suspend voluntary enrollment and/or assignments in any service area if, in its sole judgment, the Contractor's network is not adequate to meet the requirements of Section 6.10. The Contractor shall submit any information HCA requires to make a final decision on the suspension within thirty (30) calendar days of the Contractor's receipt of the request for information.
- 6.8.5 No eligible client shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, the existence of a pre-existing physical or mental condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care.

6.9 Medicaid Enrollment, Non-Billing Providers

The Contractor shall ensure that all of its contracted providers have a signed Core Provider Agreement with HCA within one hundred twenty (120) calendar days of contracting with the Contractor. A provider may enroll with HCA as a "non-billing" provider if he or she does not wish to serve fee-for-service Medicaid clients, but the provider must have an active NPI number with HCA.

6.10 Access to Services

- 6.10.1 The Contractor shall, subject to allocated and available funds, ensure that SAPT Block Grant services to eligible Enrollees are not denied to any Enrollee regardless of:
 - 6.10.1.1 The Enrollee's drug(s) of choice.
 - 6.10.1.2 The fact that an Enrollee is taking medically-prescribed medications.
 - 6.10.1.3 The fact that a person is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.
- 6.10.2 The Contractor shall, as required by the SAPT Block Grant, ensure interim services are provided for pregnant and parenting women and intravenous drug users.
 - 6.10.2.1 Interim services shall be made available within forty-eight (48) hours of seeking treatment for pregnant and parenting women and intravenous drug users.
 - 6.10.2.2 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.
 - 6.10.2.3 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. Interim services must be documented in the system platform designated by the HCA and include, at a minimum:
 - 6.10.2.3.1 Counseling on the effects of alcohol and drug use on the fetus for the pregnant patient.
 - 6.10.2.3.2 Prenatal care for the pregnant patient.
 - 6.10.2.3.3 Human immunodeficiency virus (HIV) and tuberculosis (TB) education.
 - 6.10.2.3.4 HIV or TB treatment services if necessary for an intravenous drug user.

- 6.10.2.4 The interim service documentation requirement is specifically for the admission of priority populations with any funding source; and any patient being served with SAPT Block Grant funds.
- 6.10.3 Enrollees cannot be required to relinquish custody of minor children in order to access residential SUD treatment services.
- 6.10.4 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.

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.
- 7.1.2 The Contractor shall comply with the following QM requirements:
 - 7.1.2.1 The Contractor shall participate in the single RSA Community Behavioral Health Advisory Board (CBHA). The Contractor may have one (1) CBHA to advise the Contractor on both Medicaid services and GFS/SAPT services.
 - 7.1.2.2 The CBHA shall at minimum advise on the need for establishing a health QM subcommittee, in keeping with Section 7.1. in the AH -FIMC Medicaid Contract.

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 an entity other than the State Auditor performs any audit described above related to any activity contained in this Contract.

7.3 Performance-Based Goals and Other Reporting Requirements

- 7.3.1 At HCA's discretion, performance will be linked to payment.
- 7.3.2 HCA defined reporting and data submission methods for Performance Measurement and Reporting:
 - 7.3.2.1 The Contractor shall comply with the reporting and data submissions requirements as directed by HCA and shall make reports available to HCA at least annually through the HCA monitoring process or more frequently, as requested by HCA. Should the HCA adopt a subsequent set of requirements during the course of this Contract, the HCA shall update the performance requirements as necessary.
 - 7.3.2.2 The Contractor may be required to submit additional data to satisfy Federal SAPT block grant reporting requirements in a format to be provided to the Contractor by HCA by December, 2015.
- 7.3.3 The Contractor shall submit raw de-identified data to HCA electronically for all measures, quarterly of each year according to specifications provided by HCA.
- 7.3.4 All performance measures are subject to an audit; HCA will fund the audit.
- 7.3.5 The Contractor shall report all instances of suspected patient abuse to HCA in accordance with State law and HCA policy; including the Guidelines for Reporting Child Abuse and Neglect Occurring in Chemical Dependency Treatment Agencies Serving Youth. In addition, the Contractor shall notify the HCA and Treatment Manager within forty-eight (48) hours of critical incidents including serious injury requiring medical attention, alleged sexual, and serious physical assaults between patients, and alleged abuse of, youth patient by a staff member.

7.4 Critical Incident Reporting

Refer and adhere to Section 7.8 in the AH-FIMC Medicaid Contract.

7.5 Practice Guidelines

Refer to adhere to Section 7.10 in the AH-FIMC Medicaid Contract.

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 42 C.F.R. § 438.242, 42 CFR 164, 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, grievance and appeals, and fund availability by service.

- 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 and the Washington State Uniform Health Care Information Act.
- 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, encounter submission, for GFS/SAPT services.
- 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. The Contractor may use its Medicaid website as long as the website includes information on GFS/SAPT services.
 - 7.6.7.1 Public and secure access via multi-level portals (such as providers and Enrollees) for providing web-based training, standard reporting, and data access as needed 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 Enrollees, 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 for the Contractor.
 - 7.6.7.2.2 How to access GFS/SAPT services, including crisis contact information 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.
 - 7.6.7.2.5 An overview of the range of behavioral health services being provided.
 - 7.6.7.2.6 Access to behavioral health-medical integration tools and supports to support provider integration initiatives.
 - 7.6.7.2.7 Access to information for Transition Age Youth (TAY).
 - 7.6.7.2.8 A library, for providers and Enrollees, that provides comprehensive information and practical recommendations related to mental illness, addiction and recovery, life events and daily living skills.

- 7.6.7.2.9 Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for Enrollees, family members, providers and stakeholders to become involved.
 - 7.6.7.2.10 Information regarding advocacy organizations, including how Enrollees and other family members may access advocacy services.
 - 7.6.7.2.11 Opportunities, including surveys, for Enrollees, family members, network providers, and other stakeholders to provide satisfaction/complaint feedback.
- 7.6.8 Data Security Requirements
- 7.6.8.1 The Contractor shall comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified in 42 USC §1320(d) et. seq. and 45 CFR Parts 160, 162 and 164l, and HCA Security Policies and Standards 6-05 through 6-15-01 and OCIO Security Standard 141.10. Contractor will implement physical, administrative, and technical safeguards to assure the confidentiality, integrity, and accessibility of the data. Contractor 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 mental health information system that is signed by the provider and attested to by a witness's signature, acknowledging that the provider understands and agrees to follow all regulations on confidentiality.
 - 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.**
 - 7.6.8.7.1 HCA data 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 with which it is co-mingled must be protected as described in this section.

7.6.8.8 **Data Disposition.** When the contracted work has been completed or when no longer needed, data shall be returned to HCA or destroyed. When contractor destroys data, it 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
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 **Notification of Compromise or Potential Compromise.** Contractor shall report the compromise or potential compromise of HCA shared data to the HCA within one (1) business day of discovery. That report will include at least the following, to the extent known, and 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 Description of the incident.
 - 7.6.8.9.2 Description of the types of PHI or PII involved.
 - 7.6.8.9.3 Estimate of the number of individuals whose information were or may have been compromised.
 - 7.6.8.9.4 Description of what Contractor is doing to investigate the matter, to mitigate harm to individuals, and to avoid further compromise.
- 7.6.8.10 If Contractor notifies individuals, the Department of Health and Human Services, or the Washington Attorney General of the compromise or possible compromise, pursuant to 45 CFR §§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 data provided under this Contract is to be shared with a Subcontractor, the Contract with the Subcontractor must include all of the data security provisions within this Contract and within any amendments, attachments, or exhibits 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 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 8.2 of this Section, Assessment of Policies and Procedures. The Contractor may use policies and procedures it has developed under other contracts with the HCA to the extent the policies and procedures meet the requirements of this Contract. However, the Contractor shall re-submit such policies and procedures and note that such policy/procedure was previously approved by the HCA under another contract.

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 developed by HCA. The Contractor shall complete and submit the self-assessment no later than June 30 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 9.7. However, the Contractor is legally responsible to HCA for any work performed under this Contract and 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.
- 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 the Enrollees, 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 needs of its Enrollees within Available Resources.
 - 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

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 Sections 9.5 and 9.6 of this Contract:

- 9.3.1 Identification of the parties of the Subcontract and their legal basis for operation in the State of Washington.
- 9.3.2 The process for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.
- 9.3.3 The responsibilities of the Quality Management section of this Contract may not be delegated to a Contracted Network CMHA.
- 9.3.4 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.
- 9.3.5 Procedures and specific criteria for terminating the Subcontract.
- 9.3.6 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).
- 9.3.7 Reimbursement rates and procedures for services provided under the Subcontract.
- 9.3.8 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.
- 9.3.9 Reasonable access to facilities and financial and medical records for duly authorized representatives of HCA or DSHS for audit purposes, and immediate access for Medicaid fraud investigators.
- 9.3.10 The requirement to submit complete and accurate reports and data required under the Contract, including encounter data, to the Contractor. 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 reporting requirements under the Contract, including reporting requirements developed by HCA and agreed upon by HCA and the Contractor as described in Section 7.3.
- 9.3.11 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved program integrity policies and procedures.
- 9.3.12 The Subcontractor shall comply with the applicable State and federal statutes, rules and regulations as set forth in this Contract.
- 9.3.13 Subcontracts shall set forth and require the Subcontractor to comply with any term or condition of this Contract that is applicable to the services to be performed under the Subcontract.
- 9.3.14 The Contractor shall provide the following information regarding the Grievance system for GFS/SAPT funded services to all Subcontractors:
 - 9.3.14.1 The toll-free numbers to file oral grievances and appeals.
 - 9.3.14.2 The availability of assistance in filing a grievance or appeal.

- 9.3.14.3 The Enrollees do not have a right to continuation of benefits during an appeal process or the administrative hearing process.
- 9.3.14.4 The Enrollee's right to file grievances and appeals and their requirements and timeframes for filing.
- 9.3.14.5 The Enrollee's right to a hearing, how to obtain a hearing and representation rules at a hearing.

9.4 Management of Subcontracts

- 9.4.1 The Contractor must monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the HCA, consistent with industry standards or State law and regulation.
 - 9.4.1.1 This review may be combined with a formal review of services performed pursuant to the Contractor's Medicaid Contract between the Contractor and HCA.
 - 9.4.1.2 The review must be based on the specific delegation agreement with each Subcontractor, and must address compliance with Contract requirements for each delegated function, which may include but is not limited to:
 - 9.4.1.2.1 Documentation and appropriateness of medical necessity determinations.
 - 9.4.1.2.2 Patient record reviews to ensure services are appropriate based on diagnosis, the treatment plan is based on the patient's needs and progress notes support the use of each service.
 - 9.4.1.2.3 Client record reviews to ensure 180 day reviews are completed to update diagnostic information and the treatment plan and provide justification for level of continued treatment, consistent with WAC 388-865-0425.
 - 9.4.1.2.4 Timeliness of service.
 - 9.4.1.2.5 Network adequacy.
 - 9.4.1.2.6 Cultural, ethnic, linguistic, disability or age related needs are addressed.
 - 9.4.1.2.7 Coordination with primary care.
 - 9.4.1.2.8 Provider adherence to practice guidelines, as relevant.
 - 9.4.1.2.9 Provider processes for reporting, tracking and resolving complaints/grievances.
 - 9.4.1.2.10 Provider compliance with reporting and managing critical incidents.
 - 9.4.1.2.11 Information security.
 - 9.4.1.2.12 Disaster recovery plans.
 - 9.4.1.2.13 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.

- 9.4.1.2.14 Licensing and certification reviews, including oversight of any issues any issues noted during licensing and/or certification reviews conducted by DSHS and communicated to the Contractor.
- 9.4.1.2.15 No assignment of a Subcontract shall take effect without HCA's written agreement.
- 9.4.2 The Contractor shall evaluate any prospective Subcontractor's ability to perform the activities for which that Subcontractor is contracting, including the Subcontractor's ability to perform delegated activities described in the subcontracting document.
- 9.4.3 Unless a county is a licensed service provider and the Contractor is contracting for direct services, the Contractor shall not provide GFS/SAPT funds to a county that is a participant in a DSHS or BHO sponsored Interlocal agreement without a delegation of duties agreement. The agreement must identify the specific duties from this Contract that are being delegated. The requirements for delegation in Section 9 must be met.

9.5 Health Care Provider Subcontracts

The Contractor's Subcontracts for the provision of GFS and/or SAPT services shall also contain the following provisions:

- 9.5.1 A statement that Subcontractors receiving GFS and SAPT funds shall cooperate with Contractor or HCA-sponsored Quality Improvement (QI) activities.
- 9.5.2 A means to keep records necessary to adequately document services provided to Enrollees for all delegated activities including Quality Improvement, Utilization Management, Enrollee Rights and Responsibilities, and Credentialing and Recredentialing.
- 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 Enrollee 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 Enrollees 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 Division of Children and Family Services, the Community Services Division including Community Service Offices (CSOs).
 - 9.5.3.5 Coordinate services to financially-eligible Enrollees who are in need of medical services.
- 9.5.4 A requirement to ensure that SAPT-funded SUD residential treatment providers shall ensure that priority to admission is given to the populations identified by the HCA in Section 6.2.

- 9.5.5 A requirement that SUD outpatient and inpatient providers notify the Contractor when they have reached ninety (90) percent capacity, and inform the Contractor of their procedures to implement a waiting list system and/or provide interim services.
- 9.5.6 Requirements for information and data sharing to support care coordination consistent with Section 14 of this Contract.
- 9.5.7 A requirement to implement a Grievance process that complies with WAC 388-865 or any successors as described in the Grievance Section of this Contract.
- 9.5.8 A requirement that termination of a subcontract shall not be grounds for a fair hearing or a grievance for the Enrollee if similar services are immediately available in the service area.
- 9.5.9 How Enrollees will be informed of their right to a grievance in the case of:
 - 9.5.9.1 Denial or termination of service related to medical necessity determinations.
 - 9.5.9.2 Denial or termination of service related to Available Resources.
 - 9.5.9.3 Failure to act upon a request for services with reasonable promptness.
- 9.5.10 A requirement that the Subcontractor shall comply with Chapter 71.32 RCW (Mental Health Advance directives).
- 9.5.11 A requirement to provide Enrollees access to translated information and interpreter services as described in Section 3.3 of this Contract.
- 9.5.12 Adherence to established protocols for determining eligibility for services consistent with Section 4 of this Contract.
- 9.5.13 A requirement to use HCA specified 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.
- 9.5.14 A requirement to participate in training when requested by the HCA; exceptions must be in writing and include a plan for how the required information shall be provided to targeted Subcontracted staff.
- 9.5.15 A requirement to conduct criminal background checks and maintain related policies and procedures and personnel files consistent with requirements in RCW43.43, WAC 388-877 and 388-877b and WAC 388-06-0170.
- 9.5.16 Requirements for nondiscrimination in employment and patient services.
- 9.5.17 Protocols for screening for debarment and suspension of certification.
- 9.5.18 Requirements to identify funding sources consistent with Section 5 and Federal Block Grant reporting requirements.
- 9.5.19 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. The Contractor and Subcontractor shall participate in the peer review process when requested by HCA. (42 USC 300x-53(a) and 45 CFR 96.136).
- 9.5.20 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.

- 9.5.21 If the Contractor Subcontracts with FBOs, the Contractor shall require the FBO to meet the requirements of 42 CFR Part 54 as follows:
 - 9.5.21.1 Enrollees requesting or receiving SUD services shall be provided with a choice of SUD treatment providers.
 - 9.5.21.2 The FBO shall facilitate a referral to an alternative provider within a reasonable time frame when requested by the recipient of services.
 - 9.5.21.3 The FBO shall report to the Contractor all referrals made to alternative providers.
 - 9.5.21.4 The FBO shall provide recipients with a notice of their rights.
 - 9.5.21.5 The FBO provides recipients with a summary of services that includes any inherently religious activities.
 - 9.5.21.6 Funds received from the SAPT block grant must be segregated in a manner consistent with federal regulations.
 - 9.5.21.7 No funds may be expended for religious activities.
- 9.5.22 In accordance with RCW 71.05.390(17), 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).
- 9.5.23 Delegated activities are documented and agreed upon between Contractor and Subcontractor. The document must include:
 - 9.5.23.1 Assigned responsibilities.
 - 9.5.23.2 Delegated activities.
 - 9.5.23.3 A mechanism for evaluation.
 - 9.5.23.4 Corrective action policy and procedure.
- 9.5.24 Information about Enrollees, including their medical records, shall be kept confidential in a manner consistent with State and federal laws and regulations.
- 9.5.25 The Subcontractor accepts payment from the Contractor as payment in full; shall not request payment from HCA or any Enrollee for contracted services performed under the subcontract, and shall comply with WAC 182-502-160 requirements applicable to providers.
- 9.5.26 The Subcontractor agrees to hold harmless HCA and its employees, and all Enrollees 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.
- 9.5.27 A ninety (90) day termination notice provision.
- 9.5.28 A specific termination provision for termination with short notice when a subcontractor is excluded from participation in the Medicaid program.

- 9.5.29 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.
- 9.5.30 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. 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.
 - 9.5.30.1 The Contractor shall conduct a Subcontractor review which shall include at least one onsite visit every two (2) years to each Subcontractor site providing State funded or SAPT funded treatment services during the period of performance of this Contract in order to monitor and document compliance with requirements of the subcontract.
 - 9.5.30.2 The Contractor shall ensure that Subcontractors have complied with data submission requirements established by HCA for all services funded under the Contract.
 - 9.5.30.3 The Contractor shall ensure that the Subcontractor updates patient funding information when the funding source changes.
 - 9.5.30.4 The Contractor shall maintain written or electronic records of all Subcontractor monitoring activities and make them available to HCA upon request.
 - 9.5.30.5 The Contractor shall monitor SUD residential providers on HCA selected performance-measures.
- 9.5.31 A statement that Subcontractors shall comply with required audits, including authority to conduct a facility inspection and OMB Circular A-133 audits, as applicable to the Subcontractor.
 - 9.5.31.1 The Contractor shall submit a copy of the A-133 audit performed by the State Auditor to the HCA Contact identified on page one (1) of the Contract within ninety (90) days of receipt by the Contractor of the completed audit.
 - 9.5.31.1.1 If a Subcontractor is subject to OMB Circular A-133, the Contractor shall require a copy of the completed Single Audit and ensure corrective action is taken for any audit finding, per A-133 requirements.
 - 9.5.31.1.2 If a Subcontractor is not subject to OMB Circular A-133, the Contractor shall perform subrecipient monitoring in compliance with federal requirements.
- 9.5.32 The Contractor shall document and confirm in writing all single-case agreements with providers. The agreement shall include:
 - 9.5.32.1 The description of the services;
 - 9.5.32.2 The authorization period for the services, including the begin date and the end date for approved services;
 - 9.5.32.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other plan documents that define payment; and
 - 9.5.32.4 Any other specifics of the negotiated rate.

- 9.5.33 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).
- 9.5.34 The Contractor shall maintain a record of the single-case agreements for a period of six (6) years.

9.6 Health Care Provider Subcontracts Delegating Administrative Functions

- 9.6.1 Subcontracts that delegate administrative functions under the terms of this Contract shall include the following additional provisions:
- 9.6.1.1 For those Subcontractors at financial risk, the Subcontractor shall maintain the Contractor's solvency requirements throughout the term of the Contract.
- 9.6.1.2 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 Enrollees and include, but are not limited to: utilization/medical management, claims processing, Enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.
- 9.6.1.3 If complaints and Grievances are delegated, the Contractor must ensure that network providers have a process in place for reporting, tracking, and resolving customer expressions of dissatisfaction. The Contractor must monitor and report grievances/complaints documented at the provider level.
- 9.6.1.4 How frequently and by what means the Contractor will monitor compliance with solvency requirements and Subcontractor performance related to any administrative function delegated in the subcontract.
- 9.6.1.5 Provisions for revoking delegation or imposing sanctions if the Subcontractor's performance is inadequate.
- 9.6.1.6 Whether referrals for Enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.
- 9.6.1.7 Prior to delegation, an evaluation of the Subcontractors ability to successfully perform and meet the requirements of this Contract for any delegated administrative function.
- 9.6.2 The Contractor shall submit a report of all current delegated entities, activities delegated and the number of Enrollees 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 Behavioral Benefit Administration with Subcontractors and Subsidiaries

- 9.7.1 Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract, except Essential Behavioral Health Administrative Functions. Essential Behavioral Health Administrative Functions may be subcontracted for a period of time as determine by HCA and the Contractor. The Contractor shall achieve full integration of Essential Behavioral Health Administrative Functions according to a timeline agreed upon with HCA. No subcontractor shall 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.

9.8 Provider Education

- 9.8.1 The Contractor shall maintain a system for keeping participating providers informed about:
 - 9.8.1.1 Covered services for Enrollees 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 Interpretation of data from the QI program.
 - 9.8.1.5 Practice guidelines as described in the provisions of this Contract.
 - 9.8.1.6 Behavioral health services through the Contractor.
 - 9.8.1.7 The information requirements for utilization management (UM) decision making, procedure coding and submitting claims for GFS and SAPT funded services. The Contractor shall inform GFS and SAPT providers in writing regarding these requirements.
 - 9.8.1.8 Contractor care management staff for assistance in care transitions and care management activity.
 - 9.8.1.9 Program Integrity requirements.
- 9.8.2 The Contractor shall develop and deliver ongoing training, technical assistance and support tools for GFS and SAPT providers regarding GFS and SAPT protocols and requirements. The training materials and documents shall be pre-approved by HCA. The training program shall meet the following minimum requirements:
 - 9.8.2.1 Training shall be accessible to GFS/SAPT providers at alternate times and days of the week. A schedule of training shall be available on the Contractor's website and updated as needed but at least annually. The Contractor shall make reasonable efforts to ensure that:
 - 9.8.2.1.1 Training is developed in collaboration with peer MCO's.
 - 9.8.2.1.2 Training is made available to treatment staff.
 - 9.8.2.1.3 Subcontractors provide opportunities for staff to attend trainings.
 - 9.8.2.2 Training for GFS/SAPT providers address the following requirements:
 - 9.8.2.2.1 Screening and assessment tools and protocols, including the GAINS-SS.
 - 9.8.2.2.2 Referral protocols.
 - 9.8.2.2.3 SAPT Block Grant requirements, including information on priority SAPT block grant populations as identified in Section 6.2 and services allowable with the use of SAPT block grant funds as identified in Section 16 of this Contract.
 - 9.8.2.2.4 Claims and/or encounter submission.
 - 9.8.2.2.5 Other data submission and reporting required under the Contract.
 - 9.8.2.2.6 Evidence-based practices, as relevant to the service(s) provided.
 - 9.8.2.2.7 Transition protocols for individuals moving between funding sources or with frequent Medicaid eligibility status changes.

- 9.8.2.2.8 Training includes the application of evidence-based, research-based, promising practices related to the assessment and treatment of behavioral health conditions, including those from the Bree Collaborative.
- 9.8.2.2.9 Recovery and resilience principles are incorporated in service provision as well as policies and procedures.
- 9.8.2.3 Enrollees, family members and other caregivers are involved in the planning, development and delivery of trainings specific to delivery of GFS/SAPT services.
- 9.8.2.4 Cultural competency is incorporated into provider training specific to delivery of GFS/SAPT services.
 - 9.8.2.5 Continuing education is provided for employees of any entity providing treatment services. (42 USC 300x-28(b) and 45 CFR 96.132(b)).
- 9.8.3 The Contractor shall maintain records of the number and type of providers and support staff participating in provider education, including evidence of assessment of participant satisfaction from the training process.

9.9 Provider Payment Standards

- 9.9.1 The Contractor shall meet the same timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a) (37) (A) of the Social Security Act, 42 C.F.R. § 447.46 and specified for health carriers in WAC 284-43-321 for paying providers who submit claims and encounters for GFS/SAPT services. 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) 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 Enrollee 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 must support both hardcopy and electronic submission of claims, encounters and bills for all GFS/SAPT services types.
- 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 GFS/SAPT services.

- 9.9.5 The Contractor shall conduct and submit to HCA a quarterly claims denial analysis report. The first report shall be due October 1, 2016, reflecting the April 1, 2016 through June 30, 2016 contract period and each successive quarter of the Contract. The report shall include the following data:
 - 9.9.5.1 Total number of claims denied by claim line.
 - 9.9.5.2 Total number of claims approved by claim line.
 - 9.9.5.3 Summary by reason type for claims denied.
 - 9.9.5.4 The proportion of aggregated top five (5) reasons for claims denied by claim line divided by total denied claim lines.
 - 9.9.5.5 The proportion of claim lines denied in error and subsequently adjusted to total claims denied.
 - 9.9.5.6 The total number of denied claims divided by the total number of claims.
 - 9.9.5.7 The five (5) Subcontractors with the highest aggregated denied claim lines expressed as a ratio.
- 9.9.6 The report shall include a narrative, including the action steps planned to address:
 - 9.9.6.1 The top five (5) reasons for denial, including steps taken with the top five (5) Subcontractors to educate the Subcontractors on actions to address root causes of denied claims.
 - 9.9.6.2 Claims denied in error by the Contractor.

9.10 Provider Credentialing

The Contractor's policies and procedures shall follow the State's requirements related to the credentialing and recredentialing of Health Care Professionals who have signed contracts or participation agreements with the Contractor (Chapter 246-12 WAC). The Contractor shall ensure and demonstrate compliance with the requirements described in this Contract.

- 9.10.1 The Contractor's policies and procedures shall ensure compliance with the following requirements described in this section.
 - 9.10.1.1 The Contractor's BH Medical Director or other designated physician who is a board certified psychiatrist or physician certified in addiction medicine shall have direct responsibility for and participation in the credentialing program.
 - 9.10.1.2 The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.
- 9.10.2 The Contractor's credentialing and recredentialing program shall include:
 - 9.10.2.1 Identification of the type of providers credentialed and recredentialed.
 - 9.10.2.2 Specification of the verification sources used to make credentialing and recredentialing decisions, including any evidence of provider sanctions.
 - 9.10.2.3 A process for provisional credentialing that affirms that:
 - 9.10.2.3.1 The practitioner may not be held in a provisional status for more than sixty (60) calendar days; and
 - 9.10.2.3.2 The provisional status will only be granted one time and only for providers applying for credentialing the first time.

- 9.10.2.3.3 Provisional credentialing shall include an assessment of:
 - 9.10.2.3.3.1 Primary source verification of a current, valid license to practice;
 - 9.10.2.3.3.2 Primary source verification of the past five (5) years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Databank query; and
 - 9.10.2.3.3.3 A current signed application with attestation.
- 9.10.2.4 Prohibition against employment or contracting with providers excluded from participation in federal health care programs under federal law and as described in the Excluded Individuals and Entities provisions of this Contract.
- 9.10.2.5 A detailed description of the Contractor's process for delegation of credentialing and recredentialing.
- 9.10.2.6 Verification of provider compliance with all Program Integrity requirements in this Contract.
- 9.10.3 The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials shall include communication of the provider's rights to:
 - 9.10.3.1 Review materials.
 - 9.10.3.2 Correct incorrect or erroneous information.
 - 9.10.3.3 Be informed of their credentialing status.
- 9.10.4 The Contractor's process for notifying providers within sixty (60) calendar days of the credentialing committee's decision.
- 9.10.5 An appeal process for providers for quality reasons and reporting of quality issues to the appropriate authority and in accord with the Program Integrity requirements of this Contract.
- 9.10.6 The Contractor's process to ensure confidentiality.
- 9.10.7 The Contractor's process to ensure listings in provider directories for Enrollees are consistent with credentialing file content, including education, training, certification and specialty designation.
- 9.10.8 The Contractor's process for recredentialing providers at minimum every thirty-six (36) months through information verified from primary sources, unless otherwise indicated.
- 9.10.9 The Contractor's process to ensure that offices of all Health Care Professionals meet office site standards established by the Contractor.
- 9.10.10 The Contractor's system for monitoring sanctions, limitations on licensure, complaints and quality issues or information from identified adverse events and provide evidence of action, as appropriate based on defined methods or criteria.
- 9.10.11 The Contractor's process and criteria for assessing and reassessing organizational providers.
- 9.10.12 The criteria used by the Contractor to credential and recredential practitioners shall include:
 - 9.10.12.1 Evidence of a current valid license or certification to practice;
 - 9.10.12.2 A valid DEA or CDS certificate if applicable;

- 9.10.12.3 Evidence of appropriate education and training;
- 9.10.12.4 Board certification if applicable;
- 9.10.12.5 Evaluation of work history;
- 9.10.12.6 A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider; and
- 9.10.12.7 A signed, dated attestation statement from the provider that addresses:
 - 9.10.12.7.1 The lack of present illegal drug use;
 - 9.10.12.7.2 A history of loss of license and criminal or felony convictions;
 - 9.10.12.7.3 A history of loss or limitation of privileges or disciplinary activity;
 - 9.10.12.7.4 Current malpractice coverage;
 - 9.10.12.7.5 Any reason(s) for inability to perform the essential functions of the position with or without accommodation; and
 - 9.10.12.7.6 Accuracy and completeness of the application.
- 9.10.12.8 Verification of the: National Provider Identifier, the provider's enrollment as a Washington Medicaid provider, and the Social Security Administration's death master file.
- 9.10.13 The Contractor shall ensure that all subcontracted GFS and SAPT providers have completed a background check consistent with RCW43.43, WAC 388-877, WAC 388-877b and WAC 388-06-0170.
- 9.10.14 The Contractor shall terminate any provider where HCA or Medicare has taken any action to revoke the provider's privileges for cause, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. For cause may include, but is not limited to: fraud, integrity, or quality (42 C.F.R. § 455.101).
- 9.10.15 The Contractor shall notify HCA in accord with the Notices section of this Contract, within three (3) business days of receipt of information relating to disciplinary action against the accreditation, certification, license and/or registration of the Contractor, an employee, Subcontractor or Subcontractor employee.
- 9.10.16 The Contractor's policies and procedures shall be consistent with 42 C.F.R. § 438.12, and the process shall ensure the Contractor does not discriminate against particular Health Care Professionals that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination.

10 ENROLLEE RIGHTS AND PROTECTIONS

10.1 General Requirements

- 10.1.1 The Contractor shall comply with any applicable federal and State laws that pertain to Enrollee rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to Enrollees.

- 10.1.2 The Contractor shall require that Mental Health Professionals, CDPs acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an Enrollee with respect to:
 - 10.1.2.1 The Enrollee's behavioral health status.
 - 10.1.2.2 Receiving 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 Any information the Enrollee needs in order to decide among all relevant behavioral health treatment options.
 - 10.1.2.4 The risks, benefits, and consequences of behavioral health treatment (including the option of no treatment).
 - 10.1.2.5 The Enrollee's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions.
 - 10.1.2.6 The Enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy.
 - 10.1.2.7 The Enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - 10.1.2.8 The Enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.
 - 10.1.2.9 The Enrollee's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the Contractor or CMHA treats the Enrollee.
- 10.1.3 The Contractor shall provide information including but not limited to education, licensure, and board certification or re-certification or registration of Mental Health Professionals and MHCPs upon an Enrollee's request.
- 10.1.4 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 WAC 388-06-0170. If the employee or volunteer has been working in another state within the last twelve (12) months, a background check from that state will be required.

10.2 Cultural Considerations

- 10.2.1 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.
- 10.2.2 At a minimum, the Contractor shall:
 - 10.2.2.1 Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each Enrollee with limited English proficiency at all points of contact, in a timely manner during all hours of operation. (CLAS Standard 4);

- 10.2.2.2 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);
 - 10.2.2.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. (CLAS Standard 6);
 - 10.2.2.4 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);
 - 10.2.2.5 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. (CLAS 8);
 - 10.2.2.6 Establish culturally and linguistically appropriate goals. (CLAS Standard 9);
 - 10.2.2.7 Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. (CLAS Standard 10);
 - 10.2.2.8 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
 - 10.2.2.9 Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints. (CLAS 14).
- 10.2.3 No later than January 31 of each year the Contractor shall provide HCA with an annual report evidencing its compliance with each CLAS standard.

10.3 Advance Directives and Physician Orders for Life Sustaining Treatment (POLST)

- 10.3.1 The Contractor shall meet the requirements of WAC 182-501-0125, 42 C.F.R. § 438.6, 438.10, 422.128, 489.100 and 489 Subpart I as described in this section.
- 10.3.2 The Contractor's advance directive policies and procedures shall be disseminated to all affected providers, Enrollees, HCA, and, upon request, potential Enrollees.
 - 10.3.2.1 The Contractor shall develop policies and procedures to address Physician Orders for Life Sustaining Treatment (POLST) and ensure that they are distributed in the same manner as those governing advance directives.
- 10.3.3 The Contractor's written policies respecting the implementation of advance directive POLST rights shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:
 - 10.3.3.1 Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.
 - 10.3.3.2 Identify the State legal authority permitting such objection.
 - 10.3.3.3 Describe the range of medical conditions or procedures affected by the conscience objection.

- 10.3.4 If an Enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive or received a POLST, the Contractor may give advance directive information to the Enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated Enrollee or to a surrogate or other concerned persons in accord with State law. The Contractor is not relieved of its obligation to provide this information to the Enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.
- 10.3.5 The Contractor must require and ensure, that the Enrollee's medical record documents, in a prominent part, whether or not the individual has executed an advance directive or received a POLST.
- 10.3.6 The Contractor shall not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an advance directive or received a POLST.
- 10.3.7 The Contractor shall ensure compliance with requirements of State and federal law (whether statutory or recognized by the courts of the State) regarding advance directives or POLSTs.
- 10.3.8 The Contractor shall provide for education of staff concerning its policies and procedures on advance directives or POLSTs.
- 10.3.9 The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and federal law concerning advance directives. The Contractor shall document its community education efforts.
- 10.3.10 The Contractor is not required to provide care that conflicts with an advance directive; and is not required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or any Subcontractor providing services under this Contract to conscientiously object.
- 10.3.11 The Contractor shall inform Enrollees that they may file a grievance with the Contractor if the Enrollee is dissatisfied with the Contractor's advance directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform Enrollees that they may file a grievance with the Washington State Department of Health if they believe the Contractor is non-compliant with advance directive and POLST requirements.

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 RCW 71.32.
- 10.4.2 The Contractor shall inform all Enrollees 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 Enrollee's record.
- 10.4.4 The Contractor shall inform Enrollees that complaints concerning noncompliance with a mental health advance directive should be referred to the Department of Health by calling 1-360-236-2620 or by following the written instructions contained in the behavioral health services only benefit booklet.

10.5 Enrollee Choice of Behavioral Health Provider

- 10.5.1 An Enrollee may maintain existing behavioral health provider relationships when funding is available and when the GFS/SAPT services are medically necessary. Enrollees are not guaranteed choice of behavioral health providers for GFS/SAPT services.

10.6 Prohibition on Enrollee Charges for Covered Services

- 10.6.1 Under no circumstances shall the Contractor, or any providers used to deliver services under the terms of this Contract, including non-participating providers, charge Enrollees for covered services (WAC 182-502-0160).
- 10.6.2 The Contractor shall require providers to report when an Enrollee is charged for services. The Contractor shall maintain a central record of the charged amount, Enrollee's agreement to pay, if any, and actions taken regarding the billing by the Contractor. The Contractor shall be prepared at any time to report to HCA any and all instances where an Enrollee is charged for services, whether or not those charges are appropriate.
- 10.6.3 If an Enrollee has paid inappropriate charges, the Contractor will make every effort to have the provider repay the Enrollee the inappropriate amount. If the Contractor's efforts to have the provider repay the Enrollee fail, the Contractor will repay the Enrollee the inappropriately charged amount.
- 10.6.4 The Contractor shall have a separate and specific policy and procedure that fully articulates how the Contractor will protect Enrollees from being billed for contracted services.
- 10.6.5 The Contractor shall coordinate benefits with other insurers in a manner that does not result in any payment by or charges to the Enrollee for covered services including other insurer's copayments and coinsurance.

10.7 Enrollee Self-Determination

The Contractor shall ensure that all providers: obtain informed consent prior to treatment from Enrollees, or persons authorized to consent on behalf of an Enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (Chapter 70.122 RCW) and State rules concerning advance directives (WAC 182-501-0125); and, when appropriate, inform Enrollees of their right to make anatomical gifts (Chapter 68.64 RCW).

10.8 Enrollment Not Discriminatory

- 10.8.1 The Contractor will not discriminate against Enrollees due to an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, diminished mental capacity, uncooperative or disruptive behavior resulting from their special needs or treatable behavioral health condition.

- 10.8.2 No eligible person shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, including the existence of a pre-existing physical or behavioral health condition, functional impairment, pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care.
- 10.8.3 The Contractor will not discriminate against Enrollees or those eligible to enroll on the basis of race, color, or national origin, gender, age, veteran or military status, sexual orientation, or the presence of any sensory, behavioral health or physical disability, or the use of a trained dog guide or service animal by a person with a disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin (42 U.S.C. 18116).

11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 Utilization Management Requirements

- 11.1.1 The Contractor's BH Medical Director will provide guidance, leadership and oversight of the Contractor's UM program for GFS and SAPT funded services. These following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the BH Medical Director to oversee:
 - 11.1.1.1 Processes for evaluation and referral to GFS and SAPT 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. This review must include a review of the coordination with Indian Health Service (IHS), Indian Tribal Organizations, and Urban Indian Organization (I/T/U) Providers and other Consumer serving agencies.
 - 11.1.1.4 Monitoring for over-utilization and under-utilization of services and ensuring that resource management and UM activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue Medically Necessary mental health services inconsistent with the Contractors policy and procedures for determining eligibility for services within Available 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 SAPT 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 SAPT 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 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.
- 11.1.2.1.3 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.
- 11.1.2.1.4 Corrective action with providers, as necessary, to address issues with compliance with State and federal regulations or ongoing issues with patterns of service utilization.
- 11.1.2.1.5 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 GFS/SAPT providers meet contractual requirements for discharge planning defined in Section 9.5. of this Contract.
- 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 for which they are authorizing and managing including, but not limited to co-occurring MH 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 update its Utilization Management Program (UMP) description and policies and procedures (WAC 284-43-410(2)) to address GFS/SAPT funded services.
 - 11.1.6.1 The Contractor shall produce monthly and annual utilization reports. The following minimum measure set shall be included, with monthly and year to date performance for each metric:
 - 11.1.6.1.1 Number of unduplicated individuals served with GFS funds.
 - 11.1.6.1.2 Number of unduplicated individuals served with SAPT funds.
 - 11.1.6.1.3 Service dollars expended as a percent of GFS grant allocation by service type, by provider and in aggregate.
 - 11.1.6.1.4 Service dollars expended as a percent of SAPT grant allocation by service type by provider and in aggregate.
 - 11.1.6.1.5 Number of SAPT providers at or above ninety (90) percent of treatment capacity by service type.
 - 11.1.6.1.6 Number of providers identified as outliers by service type and by fund source.

- 11.1.6.1.7 Number of provider interventions by type of intervention (e.g., education, technical assistance, corrective action).
 - 11.1.6.1.8 Other GFS and SAPT reporting requirements as determined by HCA and the Secretary of DSHS.
- 11.1.7 Authorization reviews shall be conducted by U.S. licensed behavioral health professionals with experience working with the populations and/or settings under review.
 - 11.1.7.1 The Contractor shall have UM staff with experience and expertise in working with TAY, adults and older adults with a SUD and medication-assisted treatment.
- 11.1.8 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:
 - 11.1.8.1 A physician board-certified or board-eligible in General Psychiatry or Child Psychiatry;
 - 11.1.8.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry; or by ASAM, or
 - 11.1.8.3 A licensed, doctoral level psychologist.
- 11.1.9 The Contractor shall have a sufficient number of behavioral health clinical peer reviewers available to conduct denial and appeal reviews or to provide clinical consultation on complex cases, treatment plan issues and other treatment needs.
- 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 a 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 (full or partial denials, terminations and reductions) for psychiatric treatment.
 - 11.1.11.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry; must review all inpatient level of care actions (full or partial denials, termination and reductions) 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 covered person's condition or disease (WAC 284-43-620(4)).
 - 11.1.12.1 The Contractor shall ensure documentation of timelines for appeals shall be in accord with the Appeal Process provisions of the Grievance System Section of this Contract.

11.1.13 The Contractor's care management system must include a periodic review of any consumer having an Individual Service Plan to ensure the requirements of WAC 388-865-0425 are being met. This review additionally can be used by the contracted network CMHA to meet the requirements of the one hundred eighty (180) day review required in WAC 388-865-0425. The Contractor must establish criteria for, document and monitor:

11.1.13.1 Consistent application of Medical Necessity criteria and Level of Care Guidelines;

11.1.13.2 Over and under-utilization of services.

11.1.14 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

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, hearings and independent review.

11.3 Authorization of Services

11.3.1 The Contractor shall provide education and ongoing guidance and training to Enrollees 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.

11.4.2 The Contractor shall adhere to the requirements set forth in the Community Psychiatric Inpatient Instructions and Requirements can be found at <http://www.nsmha.org/policies/sections/1500/1571.01.pdf> or are available upon request from HCA.

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 Enrollee, at the time of any action affecting the claim.

11.4.3.2 For termination, suspension, or reduction of previously covered 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.

- 11.4.3.2.1 Expedited authorization decisions shall be made within twenty-four (24) hours for of a request for emergency services.
- 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 Enrollee 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 adverse determinations, the Contractor must notify the ordering provider, facility, and the Enrollee. The Contractor must inform the parties, other than the Enrollee, in advance whether it will provide notification by phone, mail, fax or other means. The Contractor must notify the Enrollee in writing of the decision. For an adverse authorization decision involving an expedited authorization request the Contractor may initially provide notice orally. For all adverse authorization decisions, the Contractor shall provide written notification within seventy-two (72) hours of the decision (WAC 284-43-410).
 - 11.5.1.1 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 Medicaid-covered services when Enrollee fraud has been verified.

11.6 Compliance with Office of the Insurance Commissioner Regulations

The Contractor shall comply with all Office of the Insurance Commissioner (OIC) regulations regarding utilization management and authorization of services unless those regulations are in direct conflict with federal regulations. Where it is necessary to harmonize federal and State regulations, HCA will direct such harmonization. If an OIC regulation changes during the Period of Performance of this Contract, HCA will determine whether and when to apply the regulation.

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 compliance with the requirements of this section.
- 12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts and provider application, credentialing and recredentialing processes.
- 12.1.3 The following are relevant citations for Program Integrity compliance. The Contractor is expected to be familiar with, comply with, and require compliance with all regulations related to Program Integrity whether or not those regulations are listed.
 - 12.1.3.1 Section 1902(a) (68) of the Social Security Act.

12.2 Program Integrity

The Contractor shall ensure compliance with the program integrity provisions of this Contract, including proper payments to providers or Subcontractors and methods for detection of fraud, waste, and abuse.

- 12.2.1 The Contractor shall have a staff person dedicated to working collaboratively with HCA on program integrity issues. This will include the following:
 - 12.2.1.1 Participation in MCO-specific, quarterly program integrity meetings with HCA following the submission of the quarterly allegation log defined in Section 12.9, Reporting, of this Contract. Discussion at these meetings shall include but not be limited to case development and monitoring.
 - 12.2.1.2 Participation in a bi-annual Contractor-wide forum to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned.
 - 12.2.1.3 Quality control and review of encounter data submitted to HCA.
- 12.2.2 The Contractor shall perform ongoing analysis of its utilization, claims, billing, and/or encounter data to detect overpayments, and shall perform audits and investigations of Subcontractor providers and provider entities. This may include audits against all State-funded claims including Medicaid, CHIP, and Basic Health Plan. For the purposes of this subsection, "Overpayment" means a payment from the Contractor to a Subcontractor, to which the Subcontractor is not entitled to by law, rule, or contract, including amounts in dispute.
 - 12.2.2.1 When the Contractor or the State identifies an overpayment, it will be considered an obligation, as defined at RCW 74.09.220, and the funds must be recovered by and/or returned to the State or the Contractor.
 - 12.2.2.2 To maintain compliance with regulations found in Section 1128J(d) of the Social Security Act, overpayments that are not recovered by or returned to the Contractor within sixty (60) calendar days from the date they were identified and known by the State and/or the Contractor, such overpayments may be recovered by HCA.
 - 12.2.2.3 Consistent with subsection 12.9.3 of this Contract, the Contractor shall submit quarterly reports of any recoveries made by the Contractor during the course of its claims review/analysis.

12.3 Disclosure by Managed Care Organization: Information on Ownership and Control

- 12.3.1 The Contractor must provide to HCA the following disclosures and must require its Subcontractors to provide the same disclosures to the Contractor (42 C.F.R. § 455.104):
 - 12.3.1.1 The name, address, and financial statement(s) of any person (individual or corporation) that has five percent (5%) or more ownership or control interest in the Contractor.
 - 12.3.1.2 The name and address of any person (individual or corporation) that has five percent (5%) or more ownership or control interest in the Contractor's Subcontractor.
 - 12.3.1.3 The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
 - 12.3.1.4 Date of birth and Social Security Number (in the case of an individual).

- 12.3.1.5 Other tax identification number (in the case of a corporation) with an ownership or control interest in the managed care organization or its Subcontractor.
- 12.3.2 Whether the person (individual or corporation) with an ownership or control interest in the managed care organization is related to another person with ownership or control interest in the managed care organization as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the managed care organization has a five percent (5%) or more interest is related to another person with ownership or control interest in the managed care organization as a spouse, parent, child, or sibling.
- 12.3.3 The name of any other managed care organization in which an owner of the managed care organization has an ownership or control interest.
- 12.3.4 The name, address, date of birth, and Social Security Number of any managing employee of the managed care organization. For the purposes of this Subsection “managing employee” means a general manager, business manager, administrator, director (i.e. member of the board of directors), or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
- 12.3.5 The Contractor must terminate or deny enrollment if the provider, or any person with five percent (5%) or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by HCA within thirty (30) calendar days when requested by HCA or any authorized federal agency. (See 42 C.F.R. 455.416(e)).
- 12.3.6 Disclosures from the Contractor are due to HCA at any of the following times:
 - 12.3.6.1 Upon the managed care organization submitting the proposal in accordance with HCA’s procurement process.
 - 12.3.6.2 Upon the managed care entity executing the Contract with HCA.
 - 12.3.6.3 Upon renewal or extension of the Contract.
 - 12.3.6.4 Within thirty-five (35) calendar days after any change in ownership of the managed care entity.
 - 12.3.6.5 Upon request by HCA.

12.4 Disclosure by Managed Care Organization: Information on Ownership and Control, Subcontractors and Providers

- 12.4.1 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:
 - 12.4.1.1 Requiring the Subcontractor or provider to disclose to HCA upon Contract execution [42 C.F.R. 455.104(c)(1)(ii)], upon request during the re-validation of enrollment process under 42 C.F.R. 455.414 [42 C.F.R. 455.104(c)(1)(iii)], and within thirty-five (35) business days after any change in ownership of the Subcontractor or provider 42 C.F.R. 455.104(c)(1)(iv).
 - 12.4.1.2 The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor or provider. 42 C.F.R. 455.104(b) (1) (i).

- 12.4.1.3 If the Subcontractor or provider is a corporate entity, the disclosure must include primary business address, every business location, and P.O. Box address. 42 C.F.R. 455.104(b) (1) (i).
- 12.4.1.4 If the Subcontractor or provider has corporate ownership, the tax identification number of the corporate owner(s). 42 C.F.R. 455.104(b) (1) (iii).
- 12.4.1.5 If the Subcontractor or provider is an individual, date of birth and Social Security Number. 42 C.F.R. 455.104(b) (1) (ii).
- 12.4.1.6 If the Subcontractor or provider has a five percent (5%) ownership interest in any of its Subcontractors, the tax identification number of the Subcontractor(s). 42 C.F.R. 455.104(b) (1) (iii).
- 12.4.1.7 Whether any person with an ownership or control interest in the Subcontractor or provider is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the Subcontractor/provider. 42 C.F.R. 455.104(b) (2).
- 12.4.1.8 If the Subcontractor or provider has a five percent (5%) ownership interest in any of its Subcontractors, whether any person with an ownership or control interest in such Subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the Subcontractor or provider. 42 C.F.R. 455.104(b) (2).
- 12.4.1.9 Whether any person with an ownership or control interest in the Subcontractor/provider also has an ownership or control interest in any other Medicaid provider, in the State's fiscal provider or in any managed care entity. 42 C.F.R. 455.104(b) (4).

12.5 Information on Persons Convicted of Crimes

- 12.5.1 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:
 - 12.5.1.1 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 and who is [42 C.F.R. 455.106(a)]:
 - 12.5.1.1.1 A person who has an ownership or control interest in the Subcontractor or provider. 42 C.F.R. 455.106(a) (1).
 - 12.5.1.1.2 An agent or person who has been delegated the authority to obligate or act on behalf of the Subcontractor or provider. 42 C.F.R. 455.101; 42 C.F.R. 455.106(a) (1).
 - 12.5.1.1.3 An 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 Subcontractor or provider. 42 C.F.R. 455.101; 42 C.F.R. 455.106(a) (2).

12.6 Fraud and Abuse

- 12.6.1 The Contractor's Fraud and Abuse program shall have:
- 12.6.1.1 A process to inform officers, employees, agents and Subcontractors regarding the False Claims Act.
 - 12.6.1.2 Administrative and management arrangements or procedures, and a mandatory compliance plan.
 - 12.6.1.3 Standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards.
 - 12.6.1.4 The designation of a compliance officer and a compliance committee that is accountable to senior management.
 - 12.6.1.5 Effective training for all affected parties.
 - 12.6.1.6 Effective lines of communication between the compliance officer and the Contractor's staff and Subcontractors.
 - 12.6.1.7 Enforcement of standards through well-publicized disciplinary guidelines.
 - 12.6.1.8 Provision for internal monitoring and auditing.
 - 12.6.1.9 Provision for prompt response to detected offenses, and for development of corrective action initiatives.
 - 12.6.1.10 Provision of detailed information to employees and Subcontractors regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(68) of the Social Security Act and the Washington false claims statutes, Chapter 74.66 RCW and RCW 74.09.210.
 - 12.6.1.11 Provision for full cooperation with any federal, HCA or Attorney General Medicaid Fraud Control Unit (MFCU) investigation including promptly supplying all data and information requested for the investigation.
 - 12.6.1.12 Verification that services billed by providers were actually provided to Enrollees. The Contractor may use explanation of benefits (EOB) for such verification only if the Contractor suppresses EOBs that would be a violation of Enrollee confidentiality requirements for women's healthcare, family planning, sexually transmitted diseases, and behavioral health services (42 C.F.R. § 455.20).

12.7 Referrals of Credible Allegations of Fraud and Provider Payment Suspensions

- 12.7.1 The Contractor shall establish policies and procedures for MFCU referrals on credible allegations of fraud and for payment suspension when the Contractor determines there is a credible allegation of fraud. (42 C.F.R § 455.23).
- 12.7.1.1 When the Contractor has concluded that a credible allegation of fraud has occurred, the Contractor shall make a fraud referral to MFCU and HCA within five (5) business days of the determination. The referral must be in writing and sent to MFCUreferrals@atq.wa.gov with copies to HotTips@hca.wa.gov and the managed care mail box (hcamcprograms@hca.wa.gov). The referral must include the following information:
 - 12.7.1.1.1 The reporter's full name, company and contact information, to include, telephone number, electronic mail address and mailing address;

- 12.7.1.1.2 Subject(s) of the complaint by name and either subject/Subcontractor type or employee position;
 - 12.7.1.1.3 Whether the subject is subcontracted with the Contractor;
 - 12.7.1.1.4 Source of complaint by name and subject/Subcontractor type or employee position, if applicable;
 - 12.7.1.1.5 Nature of the complaint;
 - 12.7.1.1.6 Estimate of the amount of funds involved;
 - 12.7.1.1.7 Indicate whether a good cause exception is requested and the grounds for the exception;
 - 12.7.1.1.8 Include a recommendation of whether or not a payment suspension should occur, in whole or in part; and
 - 12.7.1.1.9 Legal and administrative disposition of the case.
- 12.7.1.2 If HCA, the Medicaid Fraud Control Unit (MFCU) or other law enforcement agency accepts the allegation for investigation, HCA shall notify the Contractor's compliance officers within two (2) business days of acceptance notification, along with a directive to suspend payment to the affected provider(s) if it is determined that suspension will not impair MFCU's or law enforcement's investigation. HCA shall notify the Contractor if the referral is declined for investigation. If HCA, MFCU, or other law enforcement agencies decline to investigate the fraud referral, the Contractor may proceed with its own investigation and comply with the reporting requirements contained in this Subsection.
- 12.7.1.3 Upon receipt of notification from HCA, the Contractor shall send notice of the decision to suspend program payments to the provider within the following timeframes:
- 12.7.1.3.1 Within five (5) calendar days of taking such action unless requested in writing by HCA, the Medicaid Fraud Control Unit (MFCU), or law enforcement agency to temporarily withhold such notice.
 - 12.7.1.3.2 Within thirty (30) calendar days if requested by HCA, MFCU, or law enforcement in writing to delay sending such notice. The request for delay may be renewed in writing no more than twice and in no event may the delay exceed ninety (90) calendar days.
- 12.7.1.4 The notice must include or address all of the following (42 C.F.R. § 455.23(2)):
- 12.7.1.4.1 State that payments are being suspended in accordance with this provision;
 - 12.7.1.4.2 Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation;
 - 12.7.1.4.3 State that the suspension is for a temporary period and cite the circumstances under which the suspension will be lifted;
 - 12.7.1.4.4 Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

- 12.7.1.4.5 Where applicable and appropriate, Inform the provider of any appeal rights available to this provider, along with the provider's right to submit written evidence for consideration by the Contractor.
- 12.7.1.5 All suspension of payment actions under this section will be temporary and will not continue after either of the following:
 - 12.7.1.5.1 It is determined by HCA, MFCU, or law enforcement that there is insufficient evidence of fraud by the provider; or
 - 12.7.1.5.2 Legal proceedings related to the provider's alleged fraud are completed and the allegation of fraud was not upheld.
- 12.7.1.6 The Contractor must document in writing the termination of a suspension.
- 12.7.1.7 The Contractor and/or HCA may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:
 - 12.7.1.7.1 MFCU or other law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
 - 12.7.1.7.2 Other available remedies are implemented by the Contractor, after HCA approves remedy, that more effectively or quickly protect GFS/SAPT funds.
 - 12.7.1.7.3 The Contractor determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, there is no longer a credible allegation of fraud and that the suspension should be removed. The Contractor shall review evidence submitted by the provider and submit it with a recommendation to HCA. HCA shall direct the Contractor to continue, reduce or remove the payment suspension within thirty (30) calendar days of having received the evidence.
 - 12.7.1.7.4 Enrollee access to items or services would be jeopardized by a payment suspension because of either of the following:
 - 12.7.1.7.4.1 An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
 - 12.7.1.7.4.2 The individual or entity serves a large number of Enrollees within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.
 - 12.7.1.7.5 MFCU or law enforcement declines to certify that a matter continues to be under investigation.
 - 12.7.1.7.6 HCA determines that payment suspension is not in the best interests of the GFS/SAPT program.

- 12.7.1.8 The Contractor shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:
 - 12.7.1.8.1 Details of payment suspensions that were imposed in whole or in part;
 - 12.7.1.8.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.
- 12.7.1.9 If the Contractor fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of fraud without good cause, and HCA directed the Contractor to suspend payments, HCA may impose sanctions in accord with the Sanctions Subsection of this Contract.
- 12.7.1.10 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity, the entirety of such monetary recovery belongs exclusively to the State of Washington and the Contractor has no claim to any portion of this recovery.
- 12.7.1.11 Furthermore, the Contractor is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the State of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the Contractor or Subcontractor has or may have against any entity that directly or indirectly receives funds under this Contract including, but not limited to, any health care provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products or services.
- 12.7.1.12 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.
- 12.7.1.13 For the purposes of this Section, "subrogation" means the right of any State of Washington government entity or local law enforcement to stand in the place of a Contractor or client in the collection against a third party.

12.8 Excluded Individuals and Entities

- 12.8.1 The Contractor is prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction or on the prescription of an excluded person (Social Security Act (SSA) section 1903(i) (2) of the Act; 42 C.F.R. § 455.104, 42 C.F.R. § 455.106, and 42 C.F.R. § 1001.1901(b)).
 - 12.8.1.1 The Contractor shall monitor for excluded individuals and entities by:
 - 12.8.1.1.1 Screening Contractor and Subcontractor individuals and entities with an ownership or control interest during the initial provider application, credentialing and recredentialing processes and prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract and payable by a federal health care program.

- 12.8.1.1.2 Screening individuals during the initial provider application, credentialing and recredentialing process and before entering into a contractual or other relationship where the individual would benefit directly or indirectly from funds received under this Contract or payable by a federal health care program.
- 12.8.1.1.3 Screen, the LEIE and SAM lists monthly no later than the 15th of each month, all Contractor and Subcontractor individuals and entities with an ownership or control interest, individuals defined as affiliates, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a) (1), and individuals that would benefit from funds received under this Contract for newly added excluded individuals and entities. 42 C.F.R. 438.610(a), 42 C.F.R. 438.610(b), SMD letter 2/20/98).
- 12.8.1.2 The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of exclusion. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.
- 12.8.1.3 The Contractor shall immediately terminate any employment, contractual and control relationships with any excluded individual or entity discovered during its provider screening processes, including the provider application, credentialing and recredentialing, and shall report these individuals and entities within ten (10) business days of discovery.
- 12.8.1.4 Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees. (SSA section 1128A (a) (6) and 42 C.F.R. § 1003.102(a) (2)).
- 12.8.1.5 An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent (5%) or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 C.F.R. § 455.104(a), and 42 C.F.R. § 1001.1001(a) (1)).
- 12.8.1.6 In addition, if HCA notifies the Contractor that an individual or entity is excluded from participation by HCA, the Contractor shall terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately (WAC 182-502-0030).
- 12.8.1.7 The HCA will validate that the Contractor is conducting all screenings required by this Section during its annual monitoring review.

12.9 Reporting

- 12.9.1 All Program Integrity reporting to HCA shall be in accord with the Notices provisions of the General Terms and Conditions of this Contract unless otherwise specified herein.

- 12.9.2 Quarterly Allegation Log: Notwithstanding the obligation to report suspicions of fraud directly to MFCU and HCA as required under 12.9.1 of this Section, on a quarterly basis (the first week of April, July, October, and January) the Contractor shall submit to HCA in a format determined by HCA, a report of all allegations of fraud received and reviewed by the Contractor during the previous quarter. The report shall include:
 - 12.9.2.1 All cases being actively pursued by the Contractor;
 - 12.9.2.2 All cases that did not warrant opening a case for investigation; and
 - 12.9.2.3 All allegations that were reported to the Office of the Attorney General, Medicaid Fraud Control Unit.
 - 12.9.2.4 This report shall contain the following information for each case described above, submitted on a template provided by HCA:
 - 12.9.2.4.1 Date complaint or referral received;
 - 12.9.2.4.2 Date the complaint was opened as a case;
 - 12.9.2.4.3 Last date case was updated with additional information;
 - 12.9.2.4.4 Subject(s) of complaint by name and provider/Subcontractor type, Enrollee or employee position;
 - 12.9.2.4.5 Source of complaint (i.e., provider/Subcontractor type, Enrollee, employee, vendor, hotline call, etc.), if applicable;
 - 12.9.2.4.6 Nature of complaint;
 - 12.9.2.4.7 Estimate of the amount of funds involved;
 - 12.9.2.4.8 Legal and administrative disposition of the case; and
 - 12.9.2.4.9 If actual recoveries were made by the Contractor as the result of the investigation.
- 12.9.3 On a quarterly basis, the Contractor shall submit to HCA, on an HCA generated reporting format, a report of any recoveries made, or overpayments identified by the Contractor during the course of their claims review/analysis.
- 12.9.4 On an annual basis, the Contractor shall report to HCA summary information on each of the following:
 - 12.9.4.1 Suspension of payment, including the nature of the suspected fraud, the basis for suspension, any known progress on the investigation, date the suspension was implemented, the outcome of the suspension, and total amount being withheld, if any, from the provider.
 - 12.9.4.2 Situations in which the Contractor determined good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.
 - 12.9.4.3 The Contractor is responsible for investigating Enrollee fraud, waste and abuse. The Contractor shall provide a report of initial allegations, investigations and resolutions of Enrollee fraud, waste and abuse to HCA during the annual monitoring review.

- 12.9.5 The Contractor shall notify the Washington State Department of Social and Health Services (DSHS) Office of Fraud and Accountability (OFA) of any cases in which the Contractor believes there is a serious likelihood of Enrollee fraud by:
- 12.9.5.1 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;
 - 12.9.5.2 Mailing a written complaint to:
Welfare Fraud Hotline
P.O. Box 45817
Olympia, WA 98504-5817
 - 12.9.5.3 Entering the complaint online at:
<https://fortress.wa.gov/dshs/dshsroot/fraud/index.asp>;
 - 12.9.5.4 Faxing the written complaint to Attention Hotline at 360-664-0032; OR
 - 12.9.5.5 Emailing the complaint electronically to the DSHS OFA Hotline at Hotline@dshs.wa.gov.
- 12.9.6 Any excluded individuals and entities discovered in the screening described in the Fraud and Abuse Subsection of this Contract, including the provider application, credentialing and recredentialing processes, must be reported to HCA within ten (10) business days of discovery. HCA will provide a template for the report by January 30, 2016.
- 12.9.7 The Contractor shall 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 XXI services program since the inception of those programs and who is an agent or person who has been delegated the authority to obligate or act on behalf of the Contractor.
- 12.9.8 The Contractor shall submit to HCA a monthly report on the fifteenth of each month of identified excluded individuals/entities that have been reported on the HHS-OIG LEIE and the SAM.
- 12.9.9 The Contractor shall submit to HCA a monthly 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:
- 12.9.9.1 Individual provider/entities' name;
 - 12.9.9.2 Individual provider/entities' NPI number;
 - 12.9.9.3 Source of involuntary termination;
 - 12.9.9.4 Nature of the involuntary termination; and
 - 12.9.9.5 Legal action against the individual/entities.
- 12.9.10 Upon request, the Contractor and the Contractor's Subcontractors shall furnish to HCA, within thirty-five (35) calendar days of the request, full and complete business transaction information as follows:

- 12.9.10.1 The ownership of any Subcontractor with whom the Contractor or Subcontractor has had business transactions totaling more than \$25,000 during the twelve (12)-month period ending on the date of the request.
- 12.9.10.2 Any significant business transactions between the Contractor or Subcontractor and any wholly owned supplier, or between the provider and any Subcontractor, during the five (5)-year period ending on the date of the request.
- 12.9.11 Upon request the Contractor and the Contractor's Subcontractors shall furnish to the Washington Secretary of State, OIG, the US Comptroller of the Currency, and to HCA a description of the transaction between the Contractor and the other party of interest within thirty-five (35) calendar days of the request, including the following transactions 42 C.F.R. 438.50(c)(1):
 - 12.9.11.1 A description of transactions between the Contractor and a party in interest (as defined in section 1318(b) of the Public Health Service Act), including the following:
 - 12.9.11.1.1 Any sale or exchange, or leasing of any property between the Contractor and such a party.
 - 12.9.11.1.2 Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party but not including salaries paid to employees for services provided in the normal course of their employment.
 - 12.9.11.1.3 Any lending of money or other extension of credit between the Contractor and such a party. (1903(m) (4) (B); 42 C.F.R. 438.50(c) (1)).

12.10 Records Requests

- 12.10.1 Upon request the Contractor and the Contractor's Subcontractors shall give 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 the records at no cost to the requesting agency. (42 C.F.R. 455.21(a) (2); 42 C.F.R. 431.107(b) (2)).
- 12.10.2 The Contractor or Subcontractor shall furnish all records pertaining to this Contract upon request.

12.11 On-Site Inspections

- 12.11.1 The Contractor and its Subcontractors must provide any record or data pertaining to this Contract including, but not limited to:
 - 12.11.1.1 Medical records;
 - 12.11.1.2 Billing records;
 - 12.11.1.3 Financial records;
 - 12.11.1.4 Any record related to services rendered, quality, appropriateness, and timeliness of service; and
 - 12.11.1.5 Any record relevant to an administrative, civil or criminal investigation or prosecution.

- 12.11.2 If these records must be evaluated, inspected, or reviewed, the Contractor or Subcontractor shall immediately provide the records.
- 12.11.3 Upon request, the Contractor or Subcontractor shall assist in such review, including the provision of complete copies of records.
- 12.11.4 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

The Contractor shall have a grievance system. The grievance system shall include a grievance process, an appeal process, access to independent review, and access to the hearing process. 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 Enrollees regarding the grievance system.
- 13.1.2 The Contractor shall give Enrollees 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 Enrollee and requesting provider within seventy-two (72) hours of receipt of the appeal (WAC 284-43-620).
- 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 (WAC 284-43-620(4)).
- 13.1.6 Decisions regarding grievances and appeals shall be made by Health Care Professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:
 - 13.1.6.1 If the Enrollee 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 13.1.6, the Contractor shall ensure that the Health Care Professional making such decisions:
 - 13.1.7.1 Has clinical expertise in treating the Enrollee's condition or disease that is age appropriate and when clinically indicated (e.g., a pediatric psychiatrist for a child Enrollee).
 - 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, a Sub-specialty in Addiction Psychiatry, if the grievance or appeal is related to inpatient level of care denials for SUD treatment.

- 13.1.7.4 Are one or more of the following, as appropriate, if a clinical grievance or appeal is not related to inpatient level of care denials for psychiatric or SUD treatment:
 - 13.1.7.4.1 Physicians board-certified or board-eligible in Psychiatry, Addiction Medicine or 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 an Enrollee or the Enrollee's authorized representative may file a grievance with the Contractor; a provider may not file a grievance on behalf of an Enrollee unless the provider is acting on behalf of the Enrollee and with the Enrollee's written consent.
 - 13.2.1.1 The Contractor shall request the Enrollee's written consent should a provider request an appeal on behalf of an Enrollee without the Enrollee'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 Enrollee with all grievance and appeal processes (WAC 284-43-615(2) (d)).
- 13.2.5 The Contractor shall cooperate with any representative authorized in writing by the covered Enrollee (WAC 284-43-615(2) (e)).
- 13.2.6 The Contractor shall consider all information submitted by the covered person or representative (WAC 284-43-615(2) (f)).
- 13.2.7 The Contractor shall investigate and resolve all grievances whether received orally or in writing (WAC 284-43-615(2) (g)). The Contractor shall not require an Enrollee 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 Enrollee's health condition requires, but no later than forty-five (45) calendar days from receipt of the grievance.
- 13.2.9 The Contractor shall provide information on the covered person's right to obtain a second opinion (WAC 284-43-615(2)(h)).
- 13.2.10 The Contractor must notify Enrollees 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.
- 13.2.11 Enrollees do not have the right to a hearing in regard to the disposition of a grievance.

13.3 Appeal Process

The following requirements are specific to the appeal process:

- 13.3.1 An Enrollee, the Enrollee's authorized representative, or a provider acting on behalf of the Enrollee and with the Enrollee's written consent, may appeal a Contractor action.
- 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 Enrollee.
- 13.3.3
An Enrollee may appeal an action by filing an appeal, either orally or in writing, within ninety (90) calendar days of the date of the Contractor's notice of action. The Contractor will not be obligated to continue services pending the results of the appeal.
- 13.3.4 Oral inquiries seeking to appeal an action shall be treated as appeals and be confirmed in writing. The appeal acknowledgement letter sent by the MCO to an Enrollee shall serve as written confirmation of an appeal filed orally by an Enrollee.
- 13.3.5 The appeal process shall provide the Enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available.
- 13.3.6 The appeal process shall provide the Enrollee and the Enrollee's representative opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the appeal process.
- 13.3.7 The appeal process shall include as parties to the appeal, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee'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 the medical necessity determination.
- 13.3.9 The Contractor shall resolve each appeal and provide notice, as expeditiously as the Enrollee's health condition requires, but no longer than three (3) calendar days.
- 13.3.10 The Contractor may extend the timeframes by up to fourteen (14) calendar days if the Enrollee requests the extension; or the Contractor shows there is a need for additional information and how the delay is in the Enrollee's interest.
- 13.3.11 For any extension not requested by an Enrollee, the Contractor must give the Enrollee written notice of the reason for the delay.
- 13.3.12 The notice of the resolution of the appeal shall:
 - 13.3.12.1 Be in writing and sent to the Enrollee and the requesting provider.
 - 13.3.12.2 Include the date completed and reasons for the determination in easily understood language.
 - 13.3.12.3 Include a written statement of the clinical rationale for the decision, including how the requesting provider or Enrollee may obtain the UMP clinical review or decision-making criteria.
 - 13.3.12.4 For appeals not resolved wholly in favor of the Enrollee, include information on the Enrollee's right to request a hearing and how to do so.

13.4 Administrative Hearing

- 13.4.1 Only the Enrollee or the Enrollee's authorized representative may request a hearing. A provider may not request a hearing on behalf of an Enrollee.
- 13.4.2 If an Enrollee does not agree with the Contractor's resolution of the appeal, the Enrollee 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.
- 13.4.3 If the Enrollee requests a hearing, the Contractor shall provide to HCA and the Enrollee, 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.
- 13.4.4 The Contractor is an independent party and is responsible for its own representation in any hearing, independent review, Board of Appeals and subsequent judicial proceedings.
- 13.4.5 The Contractor's Medical Director or designee shall review all cases where a hearing is requested and any related appeals.
- 13.4.6 The Enrollee must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a hearing with HCA.
- 13.4.7 The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision. Implementation of the final order shall not be the basis for termination of enrollment by the Contractor.
- 13.4.8 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.
- 13.4.9 The hearings process shall include as parties to the hearing, the Contractor, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate and HCA.

13.5 Independent Review

After exhausting both the Contractor's appeal process and the administrative hearing, an Enrollee has a right to request an independent review in accord with RCW 48.43.535, WAC 182-526-0200, and Chapter 284-43 WAC. Independent review is at the option of the Enrollee but is not a prerequisite for filing a Petition for Review at HCA's Board of Appeals.

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 or the written decision of the Independent Review Organization.

If an enrollee or HCA disagrees with the independent review decision, the enrollee or HCA may appeal the independent review decision to the HCA Board of Appeals; The MCO may not appeal the independent review decision to the HCA Board of Appeals. See RCW 48.43.535 and Chapter 182-526 WAC.

13.7 Effect of Reversed Resolutions of Appeals and Hearings

- 13.7.1 If the Contractor's decision not to provide GFS/SAPT services is reversed, either through a final order of the Office of Administrative Hearings or of the HCA Board of Appeals, the Contractor shall provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires.

13.8 Recording and Reporting Actions, Grievances, Appeals and Independent Reviews

The Contractor shall maintain records of all actions, grievances, appeals and independent reviews.

- 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, appeals, and independent reviews.
- 13.8.2 The Contractor shall provide a separate report of all actions, grievances, appeals and independent reviews related to GFS/SAPT 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 grievance, actions, 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 Enrollee 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 Enrollee 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 State-Only/Federal Block Grant Services (GFS/SAPT) funding for a requested service is exhausted, any appeals process, independent review, administrative hearings process will be terminated since services cannot be authorized without funding regardless of medical necessity.

14 CARE COORDINATION

14.1 System of Care Strategic Plan

The Contractor shall develop strategies that promote high quality and efficient healthcare for the whole person. The Contractor's strategic plan, as required in the Washington Apple Health - Fully Integrated Managed Care Medicaid Contract (AH-FIMC) shall include integration of GFS/SAPT funded services into the AH-FIMC program. Considerations shall include use of GFS/SAPT funds to support provision of care to Enrollees in alternative settings (e.g., in homeless shelters, permanent supported housing, nursing homes or group homes).

14.2 Care Coordination and Continuity of Care: State Hospitals

- 14.2.1 The Contractor's daily allocation of State Hospital beds is provided in Exhibit X.
- 14.2.1.1 If the Contractor disagrees with the Fully Integrated Managed Care (FIMC) patient assignment, it must request a reassignment within thirty (30) days of admission. If a request to change the assignment is made within thirty (30) days of admission and the request is granted, the reassignment will be retroactive to the date of admission.
 - 14.2.1.2 If a request comes in after the thirtieth (30th) day of admission and is granted, the effective date of the reassignment will be based on the date HCA receives the reassignment request form.
 - 14.2.1.3 All reassignment requests are to be made using the Hospital Correction Request Form. This process shall be described in the Data Sharing Agreement between the Contractor and the State Hospital (See Exhibit X).
- 14.2.2 The Contractor shall ensure enrollees are medically cleared, if possible, prior to admission to a State Psychiatric Hospital.
- 14.2.3 The Contractor shall respond to State Hospital census alerts by using best efforts to divert admissions and expedite discharges by utilizing alternative community resources and mental health services.
- 14.2.4 The Contractor or its designee shall monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320.
- 14.2.5 The Contractor shall offer mental health services to assist with compliance with LRA requirements.
- 14.2.6 The Contractor shall respond to requests for participation, implementation, and monitoring of individuals receiving services on Conditional Releases (CR) consistent with RCW 71.05.340. The Contractor or designee shall provide mental health services to assist with compliance with CR requirements.
- 14.2.7 The Contractor ensures provision of mental health services to individuals on a Conditional Release under RCW 10.77.150.
- 14.2.8 For conditional releases under RCW 10.77, individuals in transitional status in Pierce or Spokane County will transfer back to the MCO they were enrolled in prior to entering Western State Hospital, upon completion of transitional care. Individuals discharging to a RSA other than the Contractor's RSA will do so according to the RSA transfer agreement described in the State Hospital Working Agreement. The Agreements shall include:
- 14.2.8.1 Specific roles and responsibilities of the parties related to transitions between the community and the hospital.

- 14.2.8.2 A process for the completion and processing of the Inter- BHO Transfer Request Form for individuals requesting placement outside of the Regional Service Area of residence.
- 14.2.8.3 Collaborative discharge planning and coordination with cross-system partners.
- 14.2.8.4 Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's Service Area.
- 14.2.9 The Contractor shall coordinate with the Department of Social and Health Services-Home and Community Services regional office to support the placement of persons discharged or diverted from state hospitals into HCS placements. In order to accomplish this, the Contractor shall:
 - 14.2.9.1 Refer to HCS, whenever possible, prior to referring a person with a diagnosis of dementia for a ninety (90) day commitment to a state hospital:
 - 14.2.9.2 Ensure that a request for a CARE assessment is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all persons who might be eligible for long-term care services. HCS has agreed to prioritize requests for CARE assessments for individuals who have been detained to an E&T or in another setting.
 - 14.2.9.3 Request and coordinate with HCS, a scheduled CARE assessment for such persons. If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to attempt a community placement prior to referral to the state hospital.
 - 14.2.9.4 For individuals (both those being discharged and those being diverted) whose CARE assessments indicate likely functional and financial eligibility for long-term care services:
 - 14.2.9.4.1 The Contractor shall coordinate with HCS placement activities with one entity designated as being responsible for those activities. This designation will be documented in writing and agreed upon by both the Contractor and HCS. Where such designation is not made, the responsibility shall be the Contractor's.
 - 14.2.9.4.2 The responsible entity will establish and coordinate a placement or discharge planning team that includes Contractor staff, HCS assessors, and other community partners, as necessary, to develop a plan of action for finding a safe, sustainable placement.
 - 14.2.9.4.3 The Contractor shall ensure coordination and communication will occur between those participants involved in placement activities as identified by the discharge planning team.
 - 14.2.9.5 If a placement has not been found for an individual referred for long-term care services within thirty (30) days, the designated entity will convene a meeting to review the plan and to make adjustments as necessary. Such review meetings will occur at least every thirty (30) days until a placement is affected.

- 14.2.9.6 When individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the Contractor shall:
 - 14.2.9.6.1 Coordinate with 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.
 - 14.2.9.6.2 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.
- 14.2.10 Uniform Transfer Agreement - Eastern and Western State Hospital Inter-RSA Transfer Protocol
 - 14.2.10.1 This section describes the inter-RSA transfer process for individuals preparing for discharge from a state hospital, and who require specialized non-Medicaid resources.
 - 14.2.10.2 Generally, individuals are discharged back to the Regional Service Area they resided prior to their hospitalization.
 - 14.2.10.3 For all individuals in a state hospital (regardless of risk factors) who intend to discharge to another BHO or MCO, an Inter-RSA-transfer request is required and will be initiated by the BHO or MCO of responsibility (hereinafter referred to as the referring BHO or MCO).
 - 14.2.10.4 The financial benefits section at the state hospital will provide assistance to the enrollee to update the enrollee's residence information for Apple Health Benefits.
 - 14.2.10.5 The placement is to be facilitated through the joint efforts of the state hospital social work staff and the BHO-MCO liaisons of both the referring BHO-MCO and receiving BHO-MCO.
 - 14.2.10.6 A Request for Inter- RSA Transfer form and relevant treatment and discharge information is to be supplied by the Referring BHO or MCO to the Receiving BHO or MCO via the liaisons.
 - 14.2.10.7 The Referring BHO or MCO will remain the primary contact for the state hospital social worker and the individual until the placement is completed.
 - 14.2.10.8 The Receiving BHO or MCO will supply the state hospital social worker with options for community placement at discharge.
 - 14.2.10.9 Other responsible agencies must be involved and approve the transfer plan and placement in the Receiving BHO or MCO when that agency's resources are obligated as part of the plan (e.g., DSHS Home and Community Services or Developmental Disabilities Administration).
 - 14.2.10.10 Should there be disagreement about the discharge and outpatient treatment plan, a conference will occur. Participants will include the individual, state hospital social worker or representative of the state hospital treatment team, liaisons, the mental health care provider from the referring BHO-MCO, and other responsible agencies.

14.2.10.11 Once the discharge plan has been agreed upon, the Request for Inter- RSA transfer will be completed within two weeks. The Receiving BHO or MCO has two weeks to complete and return the form to the Referring BHO or MCO. This process binds both the Referring and Receiving BHO and MCO to the payment obligations as detailed above.

14.3 Medicaid Personal Care

- 14.3.1 DSHS Aging and Disabilities Services (ADS) or its designee uses the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine personal care needs. The Contractor or its designee must respond to requests for Medicaid Personal Care (MPC) from ADS within five (5) business days of the request. The Contractor and the local ADS office may mutually agree in writing to extend the five (5) business day requirement. Authorization decisions must be based on the following:
 - 14.3.2 A review of the request to determine if the Individual is currently authorized to receive services in the Contractor's Service Area.
 - 14.3.3 A verification that need for MPC services is based solely due to a psychiatric disability.
 - 14.3.4 A review of the requested MPC services to determine if the Individual's personal care needs could be met through provision of other available behavioral health services.
 - 14.3.4.1 The Contractor may not limit or restrict authorization for personal care services due to insufficient resources.
 - 14.3.5 If the Contractor denies authorization for MPC, the written response to ADS must include the reason for the determination and other available provided services that will be used to meet the personal care needs identified in the CARE.
 - 14.3.5.1 When the Contractor denies authorization based on provision of other RSN services, a plan (e.g., Individual Service Plan) must be developed and implemented to meet the personal care needs identified in the CARE assessment.
 - 14.3.6 The Contractor must provide the following documentation to DBHR or ADS on request:
 - 14.3.6.1 The original ADS referral and request for authorization.
 - 14.3.6.2 Any information provided by ADS including the CARE assessment.
 - 14.3.6.3 A copy of the Contractor's determination and written response provided to ADS.
 - 14.3.6.4 A copy of the plan developed and implemented to meet the Individual's needs through provision of other services when the MPC request has been denied based on this determination.

15 GENERAL REQUIREMENTS

15.1 Second Opinions

- 15.1.1 The Contractor must authorize a second opinion regarding the Enrollee's health care from a qualified health care professional within the Contractor's network, or provide authorization for the Enrollee to obtain a second opinion outside the Contractor's network, if the Contractor's network is unable to provide for a qualified health care professional. The appointment for a second opinion must occur within thirty (30) days of the request. The Enrollee may request to postpone the second opinion to a date later than thirty (30) days.

15.1.2 This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider.

15.2 Narcotic Review

A Contractor's Medical Director or representative shall participate in the Washington HCA Managed Care Medical Director's meeting to develop a process to identify and manage Enrollees with a diagnosis of chronic, non-cancer pain taking opioids at a combined daily dose of greater than listed as the maximum in the Agency Medical Directors' Group (AMDG) Opioid Guidelines. Contractor activities developed in collaboration with peer managed care organizations to address this health and safety concern may include, but is not limited to: prescriber and Enrollee education about the risk of using high dose opioids, including the provision of opioid dosing guidelines to the prescriber, requesting second opinions from a pain management specialist, preauthorization of all opioid medication, negotiating taper plans with the prescriber resulting in safer dosing levels and referrals to mental health services and/or SUD programs for assessment.

15.3 Special Provisions for Substance Use Disorder Benefits

All Enrollees are entitled to an assessment of need for SUD services. The Contractor shall ensure use of ASAM level of care guidelines to make medical necessity decisions for all SUD services.

15.4 Special Provisions Regarding Behavioral Health Benefits

The Contractor's administration of behavioral health benefits also shall comply with the following provisions:

15.4.1 Unless otherwise noted, Essential Behavioral Health Administrative Functions and required behavioral health personnel shall be located in Washington State and available during business hours.

15.4.2 Outside of business hours, information, crisis triage, referral services and prior authorization may be conducted out-of-state. Any Contractor staff that work outside of Washington State must be trained and have knowledge of Washington State-specific behavioral health covered services, managed care rules, UM protocols and level of care guidelines.

15.4.3 The Contractor must maintain an adequate complement of qualified and trained staff located in Washington State to accomplish AH-FIMC program goals and to meet the needs of individuals with serious emotional disturbance, serious mental illness and SUDs, including services funded through State general funds and SAPTs covered by this Contract. The Contractor shall have behavioral health resources sufficient to meet all Contract requirements and performance standards and shall require that all staff have the required education, experience, credentials, orientation and training to perform assigned job duties.

15.4.4 The Contractor shall designate employees who fulfill the following behavioral health key functions:

15.6.4.1 A Behavioral Health Medical Director.

15.6.4.2 A Behavioral Health Clinical Director.

15.4.5 The Contractor shall designate managerial positions with the following behavioral health responsibilities:

15.6.4.1 A behavioral health Children's System Administrator.

15.6.4.2 An Addictions Administrator.

- 15.6.4.3 A behavioral health Utilization/Care Management Administrator.
- 15.6.4.4 A behavioral health network development manager.
- 15.6.4.5 A behavioral health provider relations manager.
- 15.4.6 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.
 - 15.6.4.6 The Contractor must locate a sufficient number of Provider Relations staff within the State to meet requirements under this Contract for provider education and training, provider profiling, and provider performance improvement or problem resolution.
 - 15.6.4.7 The Contractor shall ensure that one or more Data Management and Reporting Specialists shall have experience and expertise in BH data analytics and behavioral health data systems, to oversee all data interfaces and support the behavioral health specific reporting requirements under the Contract. This position can be located outside of Washington State.
 - 15.6.6.1 The Contractor shall ensure a sufficient number of qualified staff including the following functions: administrative and support, member services, grievance and appeal, claims, encounter processing, data analysts, and financial reporting analysts.
 - 15.6.6.2 The Contractor may administer claims out-of-state. If claims are administered in another location, provider relations staff shall have access to the claims payment and reporting platform during business hours.
- 15.6.7 The Contractor shall develop and maintain a human resources and staffing plan that described how the Contractor will maintain adequate staffing.
 - 15.6.4.8 The Contractor shall hire employees for the key and required behavioral health functions specified in the Contract. Consultants must be prior approved by the State.
 - 15.6.4.9 The Contractor may propose a staffing plan, to be prior approved by the State, that combines positions and functions with other positions.
 - 15.6.4.10 The Contractor shall develop and implement staff training plans that address how all staff will be trained on the requirements of this Contract.
- 15.6.8 The Contractor must ensure development and implementation of training programs for network providers and staff of other State agencies that deliver, coordinate, or oversee behavioral health services to Enrollees. The Contractor must also work closely with ACH to ensure regional provider training priorities are met. 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.

16 BENEFITS

16.1 Scope of Services

- 16.1.1 The Contractor is responsible for covering medically necessary behavioral health services to Enrollees sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor is responsible for meeting the medical necessity needs of all Enrollees, and is responsible for providing clinically appropriate Medicaid services to Enrollees in the event that the Contractor does not have Available Resources to provide GFS/SAPT services under this Contract. The Contractor shall cover services related to the following:
- 16.1.1.1 The prevention, intervention, treatment and after-care of behavioral health conditions.
 - 16.1.1.2 The achievement of age-appropriate growth and development.
 - 16.1.1.3 The attainment, maintenance or regaining of functional capacity.
- 16.1.2 This Contract does not in any manner delegate coverage decisions to the Contractor. The Contractor makes the decision whether or not a contracted service is medically necessary. Medical necessity decisions are to be made based on an individual Enrollee's healthcare needs by a health care professional with expertise appropriate to the Enrollee's condition. The Contractor is allowed to have guidelines, developed and overseen by appropriate Health Care Professionals, for approving services. All retrospective denials of contracted services are to be individual medical necessity decisions made by a health care professional.
- 16.1.3 Except as specifically provided in the provisions of the Authorization of Services Section, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary contracted services to Enrollees nor unduly burden providers or Enrollees. For specific contracted services, the requirements of this Section shall also not be construed as requiring the Contractor to provide the specific items provided by the Health Care Authority under its fee-for-service program, but shall rather be construed to require the Contractor to provide the same scope of services.
- 16.1.4 The Contractor may limit the provision of contracted services to participating providers except as specifically provided in this Contract; and the following provisions of this subsection:
- 16.1.4.1 Emergency services;
 - 16.1.4.2 Outside the service areas as necessary to provide medically necessary services; and
 - 16.1.4.3 Coordination of Benefits, when an Enrollee has other primary comparable behavioral health coverage as necessary to coordinate benefits.
- 16.1.5 Within the Service Areas
- 16.1.5.1 Within the Contractor's service areas, as defined in the service areas provisions of the Enrollment Section of this Contract, the Contractor shall cover Enrollees for all behavioral health medically necessary services included in the scope of services covered by this Contract.

16.1.6 Outside the Service Areas

16.1.6.1 For the Enrollees who are temporarily outside of the service areas or who have moved to a service area not served by the Contractor, the Contractor shall cover the following services:

16.1.6.1.1 Emergency and post-stabilization services.

16.1.6.1.2 Urgent care services associated with the presentation of behavioral health conditions that require immediate attention, but are not life threatening.

16.1.6.1.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until Enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area.

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

16.2 General Description of Contracted Services

16.2.1 **GFS and SAPT High Priority Services:** The Contractor shall ensure services are paid through Medicaid when the service is a covered Medicaid service. GFS/SAPT funding shall be used for Medicaid Enrollees only when the service is not covered by Medicaid. GFS and/or SAPT funds shall be used to cover the following high priority services within Available Resources. Funding must be prioritized for the following services, which must be provided unless the Contractor has fully exhausted all funds provided under this Contract. The Contractor must utilize GFS and/or SAPT funds in accordance with funding allowances provided in Exhibit B, and must prioritize the provision of SAPT services and use of SAPT funds for the SAPT priority populations as identified in Section 6.2 of this Contract.

16.2.1.1 The Contractor shall establish and apply medical necessity criteria to the provision or denial the following high priority GFS/SAPT services:

16.2.1.1.1 Interim Services (GFS and SAPT).

16.2.1.1.2 Therapeutic Interventions for Children (GFS and SAPT).

16.2.1.1.3 Opiate Dependency/HIV Services Outreach (GFS and SAPT).

16.2.1.2 The Contractor shall apply the same medical necessity criteria as applied in the Medicaid program to the provision or denial of the following high priority GFS/SAPT services:

16.2.1.2.1 Drug and Alcohol Withdrawal Management (GFS and SAPT):

16.2.1.2.1.1 Acute withdrawal management (detoxification) that occurs in IMDs, licensed Residential Treatment Facilities (RTF) certified to provide acute detoxification.

16.2.1.2.1.2 Sub-Acute withdrawal management in IMDs, RTFs licensed to provide sub-acute detoxification.

16.2.1.2.1.3 Acute drug withdrawal management in a non-IMD facility after five (5) days of Medicaid State Plan services have been provided.

16.2.1.2.1.4 Sub-Acute drug withdrawal management in a non-IMD facility after five (5) days of Medicaid State Plan services have been provided.

16.2.1.2.1.5 Acute alcohol withdrawal management in a non-IMD facility after three (3) days of Medicaid State Plan services have been provided.

16.2.1.2.1.6 Sub-Acute alcohol withdrawal management in a non-IMD facility after three (3) days of Medicaid State Plan services have been provided treatment has been provided.

16.2.1.2.2 Evaluation and Treatment services provided at Community Hospitals or Evaluation and Treatment Facilities, after thirty (30) inpatient days (GFS only).

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

16.2.1.2.4 High Intensity Treatment such as PACT Teams (GFS only).

16.2.1.2.5 Inpatient Psychiatric Services in IMDs for Medicaid enrollees who voluntarily agree or are involuntarily detained in accordance with RCW 71.05 or RCW 71.34 (GFS only).

16.2.1.2.6 Inpatient Psychiatric Services in IMDs for beneficiaries of Medical Care Services (MCS) admitted involuntarily, in-state only when it is determined to be Medically Necessary (GFS only).

16.2.1.2.7 Intensive Inpatient/Residential Substance Abuse Treatment Services in IMDs: Includes Long-Term Care Residential Services and Recovery House Residential Services (GFS and SAPT).

16.2.1.2.8 Mental Health Residential in IMDs (GFS only) after thirty (30) inpatient days.

16.2.1.2.9 Wraparound with Intensive Services (WISe) (GFS Only).

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

16.2.1.3.1 Childcare Services (GFS and SAPT).

16.2.1.3.2 Continuing Education and Training (GFS and SAPT).

16.2.1.3.3 Rehabilitation Case Management (GFS only).

16.2.1.3.4 Recovery support services, including SAPT-funded services as authorized by the FFY 2016 Washington State Combined Block Grant Application, provided in Exhibit C (GFS and SAPT)).

16.2.1.3.5 Community Outreach (GFS and SAPT).

16.2.1.3.6 Engagement and Referral (GFS and SAPT).

16.2.2 **Ancillary Services in Support of Medicaid Services.** When the Contractor has Available Resources after prioritizing services in Section 1.2 the Contractor shall provide services necessary to the facilitation of providing or preventing Medicaid Services to members of priority populations (RCW 71.24 and 70.96B). The Contractor must have policies and procedures that determine how Available Resources for these services are utilized, or to deny the services due to insufficient resources.

16.2.2.1 Within Available Resources and pursuant to Contractor's policies and procedure, Contractor may use the funds provided under this Agreement to provide any of the following ancillary services:

16.2.2.1.1 Assistance with transportation that would not otherwise be covered by Medicaid (GFS only).

16.2.2.1.2 Family hardship services.

16.2.2.1.3 Assistance with application for entitlement programs (GFS only).

16.2.2.1.4 Sobering Services (GFS and SAPT).

16.2.2.1.5 Alcohol/Drug Information School (GFS only).

16.2.2.1.6 PPW Housing Support Services (GFS and SAPT).

16.2.2.1.7 Clinically appropriate outpatient services to Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver (GFS only).

17 BUSINESS CONTINUITY AND DISASTER RECOVERY

17.1 Business Continuity and Disaster Recovery

17.1.1 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.

- 17.1.2 The Contractor shall create and maintain a business continuity and disaster recovery plan that insures timely reinstatement of the Enrollee information system following total loss of the primary system or a substantial loss of functionality. The plan must be in written format, have an identified update process (at least annually) and a copy must be stored off site.
- 17.1.2.1 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 year of this Contract. The certification must indicate that the plans are 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. The plan must address the following:
- 17.1.2.1.1 A mission or scope statement.
 - 17.1.2.1.2 An appointed information services disaster recovery staff.
 - 17.1.2.1.3 Provisions for back up of key personnel, identified emergency procedures and visibly listed emergency telephone numbers.
 - 17.1.2.1.4 Procedures for allowing effective communication, applications inventory and business recovery priority and hardware and software vendor list.
 - 17.1.2.1.5 Confirmation of updated system and operations documentation and process for frequent back up of systems and data.
 - 17.1.2.1.6 Off-site storage of system and data back-ups and ability to recover data and systems from back up files.
 - 17.1.2.1.7 Designated recovery options which may include use of a hot or cold site.
 - 17.1.2.1.8 Evidence that disaster recovery tests or drills have been performed.

18 SPECIAL PROVISIONS FOR I/T/U PROVIDERS AND AMERICAN INDIAN/ALASKA NATIVE ENROLLEES

18.1 Special Provisions for Subcontracts with I/T/U Providers

- 18.1.1 If at any time during the term of this Contract an I/T/U Provider submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such I/T/U Provider's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the I/T/U Provider.
- 18.1.1.1 Such subcontract must include The Special Terms and Conditions set forth in the I/T/U Provider Addendum to be developed in consultation with the I/T/U Providers and Tribes, based on Model QHP Addendum for Indian Health Care Providers issues by the U.S. Department of Health and Human Services on April 4, 2013. To the extent that any provision set forth in the subcontract between the Contractor and the I/T/U Provider conflicts with the provisions set forth in the I/T/U Provider Addendum, the provisions of the I/T/U Provider Addendum shall prevail.

- 18.1.1.2 Such subcontract may include additional Special Terms and Conditions that are approved by the I/T/U Provider and the Contractor. Each party must provide the HCA Tribal Liaison with a complete copy of such Additional Special Terms and Conditions, in the format specified by the Agency, and a written statement that both parties have agreed to such Additional Special Terms and Conditions.
- 18.1.2 Any subcontracts with I/T/U Providers must be consistent with the laws and regulations that are applicable to the I/T/U Provider. The Contractor must work with each I/T/U Provider to prevent the Contractor's business operations from placing requirements on the I/T/U Provider that are not consistent with applicable law or any of the special terms and conditions in the subcontract between the Contractor and the I/T/U Provider.
- 18.1.3 The Contractor may seek technical assistance from the HCA Tribal Liaison to understand the legal protections applicable to I/T/U Providers and American Indian/Alaska Native Medicaid recipients.
- 18.1.4 In the event that (a) the Contractor and the I/T/U Provider fail to reach an agreement on a subcontract within ninety (90) days from the date of the I/T/U Provider's written request (as described in Section 18.1) and (b) the I/T/U Provider submits a written request to HCA for a consultation with the Contractor, the Contractor and the I/T/U Provider shall meet in person with HCA in Olympia within thirty (30) days from the date of the I/T/U Provider's written consultation request in an effort to resolve differences and come to an agreement. Executive leadership of the Contractor must attend this meeting in person and be permitted to have legal counsel present.

18.2 Special Provisions for American Indian/Alaska Native Enrollees

- 18.2.1 In accord with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating I/T/U Providers for contracted services provided to American Indian/Alaska Native enrollees at a rate equal to the rate negotiated between the Contractor and the I/T/U Provider. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an I/T/U Provider.
- 18.2.2 Care Coordination and Continuity of Care: Tribal Members
 - 18.2.2.1 The Contractor must amend or attempt to amend its Tribal and Recognized American Indian Organization (RAIO) Coordination Implementation Plan with each Tribe and RAIO to address protocols for coordination of care, or transition of care for members losing eligibility, for any tribal member in need of GFS or FBG funded services. The Contractor must provide documentation of attempts to amend its plan if any Tribe or RAIO declines to participate.

Exhibit A: List of Essential Behavioral Health Providers

List of Essential Behavioral Health Providers:

- Certified residential treatment providers¹
- DBHR Licensed Community MH Agencies
- DBHR-certified CD Agencies
- DOH-certified medication assisted treatment (e.g. buprenorphine)
- DBHR-certified opiate substitution providers (Methadone Treatment programs)
- Evaluation and Treatment in DOH-licensed and DBHR-certified free-standing inpatient, hospitals, or psychiatric inpatient facilities
- DOH-licensed and DBHR certified detox facilities (for acute and sub-acute)
- DOH licensed and DBHR certified residential treatment facility to provide crisis stabilization services

¹ Certified residential treatment providers: residential programs must have Department of Health (DOH) Residential Treatment Facility (RTF) license and then can apply for DBHR Certification for a type of service such as, Evaluation and Treatment, Crisis Stabilization, Intensive Inpatient, Recovery House, Long Term and Detoxification.

Exhibit B: SUD/MH Services by Funding Source

Number	Service Asterisk * Indicates a services can only be reimbursed though Medicaid if provided in a setting that meets the IMD exclusion	SAPT	GF-S	Medicaid
1	Brief Intervention	X	X	X
2	Acute Withdrawal Management*	X	X	X
3	Sub-Acute Withdrawal Management*	X	X	X
4	Outpatient Treatment	X	X	X
5	Intensive Outpatient Treatment	X	X	X
6	Brief Outpatient Treatment	X	X	X
7	Opiate Substitution Treatment	X	X	X
8	Intensive Inpatient Residential Services*	X	X	X
9	Long-term Care Residential Services*	X	X	X
10	Recovery House Residential Services*	X	X	X
11	Screening Tests/Urinalysis	X	X	X
12	Case Management	X	X	X
13	Assessment	X	X	X
14	DUI Assessment	X	X	X
15	Engagement and Referral	X	X	
16	Alcohol/Drug Information School		X	
17	Opiate Dependency/HIV Outreach (SAPT only for Opiate)	X	X	
18	Interim Services	X	X	
19	Community Outreach	X	X	
20	Sobering Services	X	X	
21	Therapeutic Interventions for Children	X	X	
22	Transportation	X	X	
23	Childcare Services	X	X	
24	PPW Housing Support Services	X	X	
25	Tuberculosis Screening/Skin Tests	X	X	X
26	Family Hardship		X	
27	Recovery Support Services	X	X	
28	Continuing Education	X	X	
29	Inpatient Psychiatric Services*		X	X
30	High Intensity Treatment (PACT Teams)		X	X
31	Mental Health Residential Services*		X	X
32	Evaluation and Treatment services after 30 days of treatment		X	
33	Evaluation and Treatment services prior to 30 days of treatment			X
34	Room and board in residential settings		X	
35	Rehabilitation Case Management		X	X
36	Wraparound Intensive Service (WISE)		X	X

Substance Abuse Prevention and Treatment Block Grant

Priority Populations

1. Pregnant Women Intravenous Drug User (IVDU)
2. Pregnant Women
3. Intravenous Drug User (IVDU)
4. All others

SAPT Goal Requirements

1. Maintain continuum of SUD Treatment services.
2. No less than 20% for primary prevention programs. (Per 45 CFR Part 96, it should be noted that the definition for primary prevention is for the purposes of the SAPT *only*. This definition does *not* apply to other programs administered by SAMHSA or the CSAP which include intervention activities which go beyond activities authorized by these regulations. Early intervention activities which counted as part of the 20% prevention set aside are allowable activities under the block grant but *do not* count as primary prevention).
3. Expend at least 5% to increase the availability of treatment services designed for pregnant women and women with dependent children (Services should also provide or arrange for Primary medical care including prenatal care and child care; primary pediatric care including immunizations; gender specific SUD treatment; therapeutic intervention for children sufficient case management and transportation services).
4. Provide treatment to intravenous drug abusers within 14 days of request to admission, longer interim services must be provided with 48 hours after request.
5. Make tuberculosis services to each individual receiving treatment services and monitor such delivery.
6. Establish and provide for the ongoing operation of a revolving fund for the purpose of making loans for the costs of establishing housing for individuals in recovery.
7. Pregnant women will be given preference in admission treatment facilities, if not able within 48 hours interim services must be provided.
8. Provide a capacity management system which tracks all open treatment slots. Such system must be continually updated. Also provide documentation describing the results of the system.
9. Establish a waiting list which provides systematic reporting treatment demand.
10. Improve the process for referring individuals to most appropriate treatment modality.
11. Provide continuing education for employees that provide prevention activities or treatment services.

12. Coordinate prevention activities and treatment services with other appropriate services including health, social, correctional and criminal justice, education, vocational rehabilitation, and employment services.
13. Submit a need assessment for both treatment and prevention by locality and by the State in general and must include the incidence and prevalence data which is supported by quantitative studies; a summary describing the weaknesses and bias in the data and description on how the State plans to strengthen the data; barriers and activities to remove barriers; and strategies to improve existing programs.
14. Ensure that BG funds will not be used to support hypodermic needles or syringes.
15. Assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers.
16. Have a system in place to protect patient record from inappropriate disclosure.
17. Ensure those religious organizations that are providers provide notice of client of their right to alternative services (service providers that have no religious objection); Ensure that religious organizations that are providers refer clients to alternative services; Fund alternative services.

Community Mental Health Services Block Grant

Target populations:

- Adults with serious mental illness (SMI)
- Children with serious emotional disturbances (SED)

Requirements

- Submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with SMI and children with SED that describes:
 - Available services and resources in a comprehensive system of care, including services for dually diagnosed individuals.
 - Systems of care to include health and mental health services, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical and dental care, and other support services to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems.
 - Case management services and activities leading to reduction of hospitalization
 - For Children Services, a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services.
 - Outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.
- Distribute funds to local government entities and non-governmental organizations.
- Ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs.
- Form and support a mental health planning council.
- Allocate no less than ten (10) percent of the grant for systems of integrated services for children.
- Allocate no less than five (5) percent of the grant for programs addressing Transitional Age Youth with First Episode Psychosis.

- Provide services through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).
- Provide services through community mental health centers only if the centers meet the criteria specified as follows:
 - Services are provided to individuals residing in a defined geographic area regardless of ability to pay for such services;
 - Outpatient services include specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility;
 - 24-hour-a-day emergency care services;
 - Day treatment or other partial hospitalization services, or psychosocial rehabilitation services;
 - Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission.

NOTE: SAMHSA has clarified a common baseline definition for SMI and SED. States may have additional elements that are included in their specific definition. Children with SED refer to persons from birth to age eighteen (18) and adults with SMI refer to persons age eighteen (18) and over; (1) who currently meets or at any time during the past year has met criteria for a mental disorder-including within developmental and cultural contexts-as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, IDC, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

FFY2016 changes include:

According to NASADAD, there are two (2) rules in using Block Grant funds for co-pays.

- Must be to a not-for-profit only, and
- Can only be co-pay for a service covered by the SABG.

Room and Board

SABG cannot be used for rental subsidy, but

- Can pay for room and board costs as long as client is in treatment.
- Recovery Support Housing can be covered if part of the treatment plan.

The most significant change is related to evidence based practice for early intervention for MHBG (5% Set-Aside), participant directed care, medication assisted treatment for SABG, crisis services, pregnant women and women with dependent children, community living and the implementation of Olmstead, and quality and data readiness collection. And, a PPW services narrative has been added back into the application.

Required: Pregnant women and women with dependent children: Women with dependent children are identified as a priority for specialized treatment (as opposed to treatment as usual).

Expend no less than an amount equal to that spent in prior fiscal years for treatment services designed for pregnant women and women with dependent children.

Required: Quality, Data and Information Technology are now part of the planning section.

The overall format has been streamlined to integrate the environmental factors throughout the behavioral health assessment and plan narrative. States are required to submit a Continuous Quality Improvement Plan that describes the process to identify and track critical outcomes and performance measures. The CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Not Required: Participant-Directed Care - One option that states can consider is the role that vouchers may play in their overall financing strategy. The major goal of a voucher program is to ensure individuals have genuine, free, and independent choice among a network of eligible providers.

Not Required: Medication Assisted Treatment (MAT) – Strongly encouraged to require treatment facilities be required to either have the capacity or staff expertise to utilize MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need.

Not Required: Community living and the Implementation of Olmstead - Ensure BG funds are allocated to support treatment and recovery services in community settings. *States should consider linking their Olmstead planning work in the block grant application, identifying individuals who are needlessly institutionalized or at risk of institutionalization.*

Other Block Grant changes include:

- Strategies for funds should reflect the priorities identified from the needs assessment process.
- Funds can be used to support auxiliary aids and services to allow people with disabilities to benefit from the mental health and substance use services and language assistance services for people who experience communication barriers to access.
- SAPT funding will now be allowed for screening, brief intervention, referral and treatment (SBIRT). However, primary prevention set-aside funds cannot be used to fund SBIRT.

Recover Support Services (RSS) - does not need to be tied to a treatment plan and can now be in the community setting, with the exception of Recovery Support Housing which must be covered as part of the treatment plan.

- RSS can include:

❖ Drop-in Centers	❖ Family Navigators/parent support partners/providers	❖ Mutual aid groups for individuals with MH/SA disorders or CODs.
❖ Peer-Delivered motivational interviewing	❖ Peer health navigators	❖ Peer specialist
❖ Peer Wellness coaching	❖ Promotoras	❖ Recovery Coaching
❖ Peer-run respite services	❖ Self-directed care	❖ Shared decision making
❖ Person-centered planning	❖ Supportive housing models	❖ Telephone recovery checkups
❖ Self-care and wellness approaches	❖ Recovery community centers	❖ Warm lines
❖ WRAP	❖ Whole health action Management	❖ Peer run crisis diversion services
❖ Support employment	❖ Wellness-based community campaign	❖

SAMHSA encourages the use of peer specialist or recovery coaches to provide needed recovery support services, which are already delivered by volunteers and paid staff. Peers are trained, supervised, and regarded as staff and operate out of a community-based or recovery organization.

Application Sections

Needs Assessment: Required

- **Table 1: Priority Area and Annual Performance Indicators**

Planned Expenditure Reports

- Table 2: State Agency Planned Expenditures
- *Table 3: State Agency Planned Block Expenditures by Service*
- Table 4: SABG Planned Expenditures
- Table 5a: SABG Primary Prevention Planned Expenditures
- *Table 5b: Not-Required*
- Table 5c: SABG Planned Primary Prevention Targeted Priorities
- Table 6a: SABG Resource Development Activities Planned Expenditures
- Table 6b: MHBG Non-Direct Service Activities Planned Expenditures

State Narratives regardless of fund source:

- Environmental Factors and Plan
- The Health Care System and Integration
- Health Disparities
- Use of Evidence in Purchasing Decisions
- Prevention for Serious Mental Illness
- Participant Directed Care
- Program Integrity
- **Tribes: Required**
- **Primary Prevention for Substance Abuse: Required**
- **Quality Improvement Plan: Required, A CQI plan for FY2016-2017 must be submitted.**
- Trauma
- Criminal and Juvenile Justice
- State Parity Efforts
- Medication Assisted Treatment
- Crisis Services
- Recovery
- Community Living and the Implementation of Olmstead
- **Pregnant Women and Women with Dependent Children: Required**
- Suicide Prevention
- Support of State Partners
- **Behavioral Health Advisory Council: Required**

Exhibit X:

[Exhibit will be provided when Medicaid rates, non-Medicaid funding allocations, and State hospital bed allocations become available.]