

	<b>WASHINGTON</b>  <b>BEHAVIORAL HEALTH – ADMINISTRATIVE</b>  <b>SERVICES ORGANIZATION CONTRACT</b>	HCA Contract Number: «Contract»  Contractor Contract Number:  <input type="checkbox"/> Competition Exempt
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This Contract is between the State of Washington Health Care Authority (HCA) and the Contractor identified below, and is governed by chapter 41.05 RCW and Title 182 WAC.

<b>CONTRACTOR NAME</b>  «Organization_Name»		<b>CONTRACTOR doing business as (DBA)</b>  	
«Mailing_AddressSt_Address» «City», «State» «Zip_Code»		<b>WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)</b> «UBI»	<b>HCA INDEX NUMBER</b>  
<b>CONTRACTOR CONTACT</b>  «Contact_Fname» «Contact_LName»	<b>CONTRACTOR TELEPHONE</b>  «PhoneNo»	<b>CONTRACTOR E-MAIL ADDRESS</b>  «EmailAddress»	

<b>HCA CONTACT NAME AND TITLE</b>  	<b>HCA CONTACT ADDRESS</b> Post Office Box 45502 Olympia, WA 98504-5502		
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<b>HCA CONTACT TELEPHONE</b>  	<b>HCA CONTACT FAX</b> N/A	<b>HCA CONTACT E-MAIL ADDRESS</b> @hca.wa.gov
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<b>IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF THIS CONTRACT?</b>  No	<b>CFDA NUMBER(S)</b>  
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<b>CONTRACT START DATE</b>  	<b>CONTRACT END DATE</b>  	<b>MAXIMUM CONTRACT AMOUNT</b>  
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**EXHIBITS. The following Exhibits are attached and are incorporated into this Contract by reference:**  
 Exhibits: Exhibit A, State Hospital Beds; Exhibit B, Community Behavioral Health Advisory Board Requirements; Exhibit C, Other Performance Measures or Reporting Requirements; Exhibit D, Crisis Performance Measures and Reporting Requirements; Exhibit E, Combined BG FFY2016; Exhibit F, SUD Service Matrix; Exhibit G, MHBG Sample Service List.  
 Attachment.

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

<b>CONTRACTOR SIGNATURE</b>  	<b>PRINTED NAME AND TITLE</b>  	<b>DATE SIGNED</b>  
<b>HCA SIGNATURE</b>  	<b>PRINTED NAME AND TITLE</b>  	<b>DATE SIGNED</b>  

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**Exhibits**

- Exhibit A - State Hospital Beds *(Not attached yet; to be attached via amendment upon receipt.)*
- Exhibit B - Community Behavioral Health Advisory Board Requirements
- Exhibit C – Other Performance Measures or Reporting Requirements
- Exhibit D – Crisis Performance Measures and Reporting Requirements
- Exhibit E - Combined BG FFY2016
- Exhibit F - SUD Service Matrix
- Exhibit G – MHBG Sample Service List

## 1 DEFINITIONS

### 1.1 Accountable Community of Health (ACH)

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

### 1.2 Action

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

### 1.3 Acute Withdrawal Management Services (Detoxification)

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

### 1.4 Administrative Hearing

“Administrative Hearing” means an adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by Chapter 34.05 RCW, and 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 cost incurred to 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 American Society of Addiction Medicine Level of Care Guidelines [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. Appeal

**1.8 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 Consumers with addiction and co-occurring disorders.

**1.9 Appeal**

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

**1.10 Appeal Process**

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

**1.11 Assessment (SUD)**

“Assessment (SUD)” means the activities conducted to evaluate and individual to determine if the individual has a substance use disorder and determine placement in accordance with the American Society of Addiction Medicine (ASAM) patient placement criteria.

**1.12 Available Resources**

“Available Resources” means funds appropriated for the purpose of providing community behavioral health programs: federal funds, except those provided according to Title XIX of the Social Security Act, and State funds appropriated by the legislature during any biennium for the purpose of providing services in Section 15 and 16 of this Contract. 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 substance use disorder conditions and related benefits.

**1.14 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.

**1.15 Brief Intervention for Substance Use Disorder (SUD)**

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

**1.16 Brief Outpatient Treatment for SUD**

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

#### 1.17 **Business Hours**

“Business Hours” means 8:00 am to 5:00 pm Pacific Time, Monday through Friday, or alternative hours as agreed to by HCA.

#### 1.18 **Care Coordination**

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

#### 1.19 **Case Management Services (SUD)**

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

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

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

#### 1.21 **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>.

### 1.22 **Childcare Services**

“Childcare Services” means the provision of child care services, when needed, to children of parents in treatment in order to complete the parent's plan for 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.

### 1.23 **Child and Family Team (CTF)**

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

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

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

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

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

### 1.26 **Community Health Workers (CHW)**

“Community Health Workers (CHW)” means individuals who serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. 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>.

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

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

### 1.28 **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.

### 1.29 **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.

### 1.30 **Consumer**

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

### 1.31 **Continuity of Care**

“Continuity of Care” means the provision of continuous care for chronic or acute behavioral health conditions through enrollee transitions between: facility to home; facility to facility; providers or service areas; managed care Contractors;. 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 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 disorder treatment to primary and/or mental health care.

### 1.32 **Contract**

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

### 1.33 **Contractor**

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

#### **1.34 Continuing Education and Training**

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

#### **1.35 Contracted Services or Covered Services**

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

#### **1.36 Cost Reimbursement**

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

#### **1.37 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.

#### **1.38 Criminal Justice Treatment Account (CJTA)**

“Criminal Justice Treatment Account” means, pursuant to 70.96.A.400 an account created in the State treasury for expenditure on: a) substance use disorder treatment and treatment support services for offenders with an addiction of a substance use disorder that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; b) the provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program.

#### **1.39 Crisis Services (Mental Health)**

“Crisis Services” means evaluation and treatment of mental health crisis to all individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis Services shall be available on a twenty-four (24) hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration, and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services include but are not limited to the Telephone Crisis Triage and Intervention and Mobile Crisis Outreach. Crisis Services also include referral and coordination with other Medicaid, third party insurance, and GFS/SAPT services for which the member may be eligible and to community resources, as necessary and appropriate to stabilize the crisis.

Crisis Services may be provided prior to completion of an intake evaluation. Services must be provided by or under the supervision of a Mental Health Professional. The Contractor must provide 24-hour, 7 day per week crisis mental health services to individuals who are within the Contractor's Regional Service Area and report they are experiencing a mental health crisis. There must be sufficient staff available, including Designated Mental Health Professionals, to respond to requests for crisis services. Crisis services must be provided regardless of the individuals ability to pay.

#### 1.40 **Crisis Services (SUD)**

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

#### 1.41 **Day**

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

#### 1.42 **Day Support**

"Day Support" means an intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Consumers to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to client ratio is no more than 1:20 and is provided by or under the supervision of a Mental Health Professional in a location easily accessible to the Consumer (e.g., community mental health agencies, community centers). This service is available five (5) hours per day, five (5) days per week.

#### 1.43 **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.

#### 1.44 **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:

- 1.44.1 Behavioral Health and Services Integration Administration is responsible for providing mental health services in State psychiatric hospitals and community settings and SUD inpatient and outpatient treatment, recovery and prevention services.
- 1.44.2 Aging and Long-Term Support Administration is responsible for providing a safe home, community and nursing facility array of long-term supports for Washington citizens.

- 1.44.3 Children's Administration is responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.
- 1.44.4 Developmental Disabilities Administration 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.

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

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

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

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

**1.47 Disaster Outreach**

"Disaster Outreach" means contacting persons in their place of residence or in non-traditional settings for the purpose of assessing their mental health and social functioning following a disaster or increasing the utilization of human services and resources.

**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 services used to identify hard-to-reach individuals with a 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

### **1.53 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).

### **1.54 External Entities (EE)**

“External Entities (EE)” means organizations that serve Consumers and include DSHS, local health jurisdictions, community-based service providers and HCA services/programs as defined in this contract.

### **1.55 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.

### **1.56 Family Treatment**

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

### **1.57 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.

### 1.58 **Fraud**

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

### 1.59 **Freestanding Evaluation and Treatment**

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

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

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

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

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

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

### 1.61 **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 Consumer’s rights.

### 1.62 **Grievance Process**

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

### 1.63 **Grievance System**

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

#### 1.64 **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.

#### 1.65 **Hardened Password**

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

#### 1.66 **Health Care Authority (HCA)**

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

#### 1.67 **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, psychologist, physician assistant, registered nurse (including nurse practitioner or clinical nurse specialist), licensed clinical social worker, licensed mental health counselor, licensed marriage and family therapist, and pharmacist.

#### 1.68 **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.

#### 1.69 **High Intensity Treatment**

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

### **1.70 Institute for Mental Disease (IMD)**

“IMD or Institute for Mental Disease” means, per P.L. 100-360, an institution for mental diseases such 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.

### **1.71 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.

### **1.72 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)).

### **1.73 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.

### **1.74 Interim Services**

“Interim Services” means means services that are provided until and individual is admitted to a substance abuse treatment program. The purposes of the services are to reduce the adverse health effects of such abuse, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim services include counseling and education about Human Immunodeficiency Virus (HIV) and tuberculosis (TB), about the risks of needle-sharing, the risk of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

### **1.75 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 individuals diagnosed with a substance use disorder, excluding 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.)

#### **1.76 Intensive Outpatient SUD Treatment**

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

#### **1.77 Involuntary Commitment (SUD)**

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

#### **1.78 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).

#### **1.79 Involuntary Treatment Act Services (Mental Health)**

“Involuntary Treatment Act Services (Mental Health)” includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05 RCW 71.24. 300 and RCW 71.34. Requirements under the Contract include payment for all clinical services ordered by the court for individuals who are not eligible for Medicaid and costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional (DMHP) determines an individual must be evaluated for involuntary treatment. The decision making authority of the DMHP must be independent of the Contractor’s administration. ITA services continue until the end of the involuntary commitment.

#### **1.80 Juvenile Drug Court**

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

#### **1.81 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 SUD Services**

“Long-Term Care Residential SUD Services” means the care and treatment of chronically impaired individuals diagnosed with substance use disorder 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 individuals diagnosed with substance use disorder, excluding 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 Lump Sum**

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

### **1.85 Managed Care**

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

### **1.86 Managed Care Organization (MCO)**

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

### **1.87 Marketing**

“Marketing” means any communication, whether written, oral, in-person (telephonic or face-to-face), or electronic, and includes promotional activities intended to “brand” a Contractor’s name or organization.

### **1.88 Material Provider**

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

### **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 Consumer that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Consumer requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

### **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 SUDs. Research shows that when treating SUDs, a combination of medication and behavioral therapies is most successful. MAT is clinically driven with a focus on individualized patient care.

### **1.91 Medication Management**

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

### **1.92 Medication Monitoring**

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

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

### **1.93 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.

### **1.94 Mental Health Block Grant or MHBG**

“Mental Health Block Grant” or “MHBG” means those funds granted by the Secretary of the Department of Health and Human Services (HHS), through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), to states to establish or expand an organized community-based system for providing mental health services for adults with serious mentally ill (SMI) and children with serious emotionally disturbed (SED). States must submit an application in accordance with the law for applicable fiscal years for which they seek MHBG funds. Awarded MHBG funds must be used to carry out the State plan contained within the application, to evaluate programs and services set in place under the plan, and to conduct planning, administration, and educational activities related to the provision of services under the plan.

### **1.95 Mental Health Parity**

“Mental Health Parity” means for purposes of this Contract and until which time CMS release parity rules, the Washington Office of the Insurance Commissioner rules for behavioral health parity, inclusive of mental health and substance use disorder benefits shall apply to this Contract. (WAC 284-43-990 through 284-43-995).

### **1.96 Mental Health Professional**

“Mental Health Professional” means:

- 1.96.1 A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in Chapter 71.34 RCW;
- 1.96.2 A person with a master’s degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such persons shall have, in addition, at least two (2) years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional;
- 1.96.3 A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;
- 1.96.4 A person who is licensed by the Department of Health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate.
- 1.96.5 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
- 1.96.6 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.

### **1.97 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.

### **1.98 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 Consumers within the access standards outlined in the Contract.

### **1.99 Non-Participating Provider**

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

### **1.100 Notice of Action**

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

### **1.101 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.

#### 1.102 **Opiate Dependency/HIV Services Outreach**

“Opiate Dependency/HIV Services” means 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.

#### 1.103 **Opiate Substitution Treatment**

“Opiate Substitution Treatment” means assessment and treatment to opiate dependent patients. Services include prescribing and dispensing of an approved medication, as specified in 212 CFR Part 291, for opiate substitution services in accordance with WAC 388-877B. Both withdrawal management and maintenance are included, as well as physical exams, clinical evaluations, individual or group therapy for the primary patient and their family or significant others. Additional services include guidance counseling, family planning and educational and vocational information. (The service as described satisfies the level of intensity in ASAM Level 1).

#### 1.104 **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.

#### 1.105 **Participating Provider**

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

#### 1.106 **Peer Support**

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

#### 1.107 **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.

#### **1.108 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 (6), 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 (PPW) Women’s Housing Support Services**

“PPW Housing Support Services” means support services provided 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 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.

#### **1.111 ProviderOne**

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

#### **1.112 Psychological Assessment**

“Psychological Assessment” means all psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall be culturally relevant; provide information relevant to a client’s continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

#### **1.113 Recovery**

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

#### **1.114 Recovery House Residential Treatment**

“Recovery House Residential Treatment” means costs incurred for a program of care and treatment with social, vocational, and recreational activities designed to aid individuals diagnosed with substance use disorder in the adjustment to abstinence and to aid in job training, reentry to employment, or other types of community activities, excluding room and board in a twenty-four-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).

#### **1.115 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.

#### **1.116 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.

#### **1.117 Regulation**

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

#### **1.118 Rehabilitation Case Management**

“Rehabilitation Case Management” means a range of activities by the outpatient CMHA’s liaison conducted in or with a facility for the direct benefit of a Consumer in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination.

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

#### **1.119 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.

#### **1.120 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>.

#### **1.121 Room and Board**

“Room and Board” means for services in a 24-hour-a-day setting this is 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.

#### **1.122 SAPT Block Grant**

“SAPT Block Grant” means the Federal Substance Abuse Prevention and Treatment Block Grant (also known as the SABG Program) authorized by Section 1921 of Title XIX, Part B, Subpart II and III of the Public Health Service Act. The program’s objective is to help plan, implement, and evaluate activities that prevent and treat substance abuse.

### 1.123 **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.

### 1.124 **Serious Emotionally Disturbed (SED)**

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

### 1.125 **Serious Mentally Ill (SMI)**

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

### 1.126 **Sobering Services**

“Sobering Services” means the provision of 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.

### 1.127 **Special Population Evaluation**

“Special Population Evaluation” means an evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a client’s continuation in appropriate treatment and assist in treatment planning.

This evaluation occurs after intake. Consultation from a non-staff specialist) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

### 1.128 **Stabilization Services**

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

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

“Sub-Acute withdrawal management” means services provided to an individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner. Sub-Acute is nonmedical withdrawal management or patient self-administration of withdrawal medications ordered by a physician.

**1.130 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.

**1.131 Subcontractor**

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

**1.132 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.

**1.133 Substance Use Disorder Outpatient Treatment**

“Substance Use Disorder Outpatient Treatment” means services provided in a non-residential substance use disorder treatment facility. Outpatient treatment services must meet the criteria in the specific modality provisions set forth in WAC 388-877B. Services are specific to client populations and broken out between group and individual therapy. (The service as described satisfies the level of intensity in ASAM Level 1).

**1.134 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.

**1.135 Therapeutic Psychoeducation**

“Therapeutic Psychoeducation” means informational and experiential services designed to aid Consumers, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support in the management of psychiatric conditions, increase knowledge of mental illnesses and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the Consumers and are included in the Care Plan/ ISP.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc. Services are provided at locations convenient to the client, by or under the supervision of a Mental Health Professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

#### **1.136 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.

#### **1.137 Transport**

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

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

1.137.2 Is accomplished other than via a Trusted System.

#### **1.138 Transportation**

"Transportation" means the transport of individuals to and from substance use disorder treatment programs.

#### **1.139 Tribal Land**

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

#### **1.140 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:

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

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

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

#### 1.141 **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.

#### 1.142 **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/>.

#### 1.143 **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.

#### 1.144 **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.

#### 1.145 **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>.

#### 1.146 **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.

#### 1.147 **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.

#### 1.148 **Youth**

“Youth” means a person 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](mailto: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.

### **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 (FY) in which the services were performed unless otherwise specified in this Contract.

### **2.4 Compliance with Applicable Law**

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

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

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

- 2.4.5 The Rehabilitation Act of 1973.
- 2.4.6 The Budget Deficit Reduction Act of 2005.
- 2.4.7 The Washington Medicaid False Claims Act and Federal False Claims Act (FCA).
- 2.4.8 The Health Insurance Portability and Accountability Act (HIPAA).
- 2.4.9 The American Recovery and Reinvestment Act (ARRA).
- 2.4.10 The Patient Protection and Affordable Care Act (PPACA or ACA).
- 2.4.11 The Health Care and Education Reconciliation Act.
- 2.4.12 The Mental Health Parity and Addiction Equity Act (MHPAEA) and final rule.
- 2.4.13 21 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 45 CFR 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 70.96A RCW Treatment for Alcoholism, Intoxication, and Drug Addiction.
- 2.4.19 Chapter 70.02 RCW Medical Records – Health Care Information Access and Disclosure
- 2.4.20 Chapter 71.05 RCW Mental Illness.
- 2.4.21 Chapter 71.24 RCW Community Mental Health Services Act.
- 2.4.22 Chapter 71.34 RCW Mental Health Services for Minors.
- 2.4.23 WAC 388-865 Community Mental Health and Involuntary Treatment Programs.
- 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 Consumers with disabilities, in accord with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit Consumers with disabilities from obtaining contracted services.
- 2.4.28 Any other requirements associated with the receipt of federal funds.
- 2.4.29 Any services provided to an individual enrolled in Medicaid are subject to applicable Medicaid rules.

## 2.5 **Non-Regulation by Office of the Insurance Commissioner (OIC)**

HCA believes the ASO will not be subject to Title 48 RCW and will not be subject to regulation by the Insurance Commissioner.

## 2.6 **Confidentiality**

- 2.6.1 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.
- 2.6.2 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.

- 2.6.3 The Contractor agrees to share Personal Information regarding Consumers in a manner that complies with applicable State and federal law protecting confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 U.S.C. § 1320(d) et. seq. and 45 C.F.R. parts 160, 162, and 164., the HIPAA regulations, 42 C.F.R. § 431 Subpart F, RCW 5.60.060(4), and Chapter 70.02 RCW). The Contractor and the Contractor's Subcontractors shall fully cooperate with HCA efforts to implement HIPAA requirements.
- 2.6.4 The Contractor shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss.
- 2.6.4.1 This duty requires that Contractor employ reasonable security measures, which include restricting access to the Confidential Information by:
- 2.6.4.1.1 Encrypting electronic Confidential Information during Transport;
  - 2.6.4.1.2 Physically Securing and Tracking media containing Confidential Information during Transport;
  - 2.6.4.1.3 Limiting access to staff that have an authorized business requirement to view the Confidential Information;
  - 2.6.4.1.4 Using access lists, Unique User ID and Hardened Password authentication to protect Confidential Information;
  - 2.6.4.1.5 Physically Securing any computers, documents or other media containing the Confidential Information; and
  - 2.6.4.1.6 Encrypting all Confidential Information that is stored on portable devices including but not limited to laptop computers and flash memory devices.
- 2.6.4.2 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.
- 2.6.5 In the event of a breach, meaning an acquisition, access, use, or disclosure of PHI in a manner not permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule which compromises the security or privacy of a Consumer's PHI, the Contractor shall notify HCA in writing, as described in the Notices section of the General Terms and Conditions, within two (2) business days after determining notification must be sent to Consumers. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirement imposed by law (45 C.F.R. Part 164, Subpart D, WAC 284-04-625, RCW 19.255.010).
- 2.6.6 HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Consumers collected, used, or acquired by Contractor during the term of this Agreement. 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.
- 2.6.7 Any material breach of this confidentiality provision may result in termination of this Contract. The Contractor shall indemnify and hold HCA harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Consumers.

## 2.7 **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.

## 2.8 **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 2.38 of this Contract if the Contractor becomes debarred during the term hereof.

## 2.9 **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.

## 2.10 **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:

- 2.10.1 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:
  - 2.10.1.1 The disputed issue(s).
  - 2.10.1.2 An explanation of the positions of the parties.
  - 2.10.1.3 Any additional facts necessary to explain completely and accurately the nature of the dispute.
- 2.10.2 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).

- 2.10.2.1 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.
- 2.10.2.2 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.
- 2.10.2.3 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).
- 2.10.3 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.
- 2.10.4 Disputes regarding overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Subsection 2.9.

## 2.11 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.

## 2.12 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 11<sup>th</sup> Amendment to the United States Constitution.

### 2.13 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.

### 2.14 Insolvency

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

- 2.14.1 The State of Washington and Consumers shall not be, in any manner, liable for the debts and obligations of the Contractor.
- 2.14.2 The Contractor shall, in accord with RCW 48.44.055 or 48.46.245, provide for the continuity of care for Consumers and shall provide crisis services and involuntary treatment act services in accordance with RCW 71.05, RCW 71.34 and RCW 70.96A.
- 2.14.3 The Contractor shall cover continuation of services to Consumers for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.
- 2.14.4 The above obligations shall survive the termination of this contract.

### 2.15 Inspection

The Contractor and its Subcontractors shall cooperate with all audits and investigations performed by duly authorized representatives of the State of Washington, HCA and MFCU, 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.

### 2.16 Insurance

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

- 2.16.1 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.
- 2.16.2 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.
- 2.16.3 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.
- 2.16.4 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.
- 2.16.5 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.
- 2.16.6 Separation of Insured's: All insurance Commercial General Liability policies shall contain a "separation of insured's" provision.
- 2.16.7 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.
- 2.16.8 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.
- 2.16.9 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.
- 2.16.10 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.

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

## 2.17 Records

- 2.17.1 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.
- 2.17.2 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).
- 2.17.3 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.

## 2.18 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.

## 2.19 Notification of Organizational Changes

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

## 2.20 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:

- 2.20.1 Federal statutes and regulations applicable to the services provided under this Contract.

- 2.20.2 State of Washington statutes and regulations concerning the operation of HCA programs participating in this Contract.
- 2.20.3 Applicable State of Washington statutes and regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers.
- 2.20.4 General Terms and Conditions of this Contract.
- 2.20.5 Any other term and condition of this Contract and exhibits.
- 2.20.6 Any other material incorporated herein by reference.

## 2.21 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.

## 2.22 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:

- 2.22.1 Submit reports required in this Contract.
- 2.22.2 Provide access to records required in accord with the Inspection provisions of this section.
- 2.22.3 Provide the administrative services associated with Contracted services (e.g., claims processing, Consumer appeals) provided to Consumers prior to the effective date of termination under the terms of this Contract.
- 2.22.4 Repay any overpayments that:
  - 2.22.4.1 Pertain to services provided at any time during the term of this Contract; and
  - 2.22.4.2 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
  - 2.22.4.3 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.

## 2.23 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.

## 2.24 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.

#### **2.25 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 on Accreditation of Healthcare Organizations (JCAHO) or other similar standards.

#### **2.26 Indemnification and Hold Harmless**

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

#### **2.27 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.

#### **2.28 No Federal or State Endorsement**

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

#### **2.29 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:

- 2.29.1 In the case of notice to the Contractor, notice will be sent to:  
«CEO»  
«Organization\_Name»  
«Mailing\_AddressSt\_Address»  
«City», «State» «Zip\_Code»
- 2.29.2 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
- 2.29.3 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.
- 2.29.4 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.

### **2.30 Notice of Overpayment**

- 2.30.1 If HCA determines it has made an overpayment to the Contractor, then HCA will issue a Notice of Overpayment to the Contractor.
- 2.30.2 The Contractor may contest a Notice of Overpayment by requesting an adjudicative proceeding. The request for an adjudicative proceeding must:
- 2.30.2.1 Comply with all of the instructions contained in the Notice of Overpayment;
  - 2.30.2.2 Be received by HCA within twenty-eight (28) calendar days of service receipt of the Notice of Overpayment by the Contractor;
  - 2.30.2.3 Be sent to HCA by certified mail (return receipt), to the location specified in the Notice of Overpayment;
  - 2.30.2.4 Include a statement and supporting documentation as to why the Contractor thinks the Notice of Overpayment is incorrect; and
  - 2.30.2.5 Include a copy of the Notice of Overpayment.
- 2.30.3 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.

- 2.30.4 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.
- 2.30.5 Nothing in this Agreement limits HCA's ability to recover overpayments under applicable law.

### **2.31 Proprietary Data or Trade Secrets**

- 2.31.1 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.
- 2.31.2 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.
- 2.31.3 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.

### **2.32 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.

### **2.33 Solvency**

- 2.33.1 The Contractor understands and agrees that it is required to make some advance payments under this contract prior to reimbursement from the State, and that the amount of such payments may vary on a month to month basis.
- 2.33.2 The Contractor understands and agrees that it must remain solvent at all times during the term of this contract, including any extensions to the term, and that the failure to remain solvent at all times is grounds for immediate termination by default..

- 2.33.3 The Contractor agrees that HCA at any time may access any information related to the Contractor's financial condition, and upon HCA's request, the Contractor shall furnish to HCA all such financial information and documentation they have concerning their current financial condition. This shall also include the production of financial information that may be held by a third party agent of the contractor; the contractor hereby agrees to sign any necessary to allow for the distribution of such information to HCA.
- 2.33.4 The Contractor shall notify HCA within ten (10) business days after the end of any month in which the Contractor's net worth (capital and/or surplus) reaches a level representing two (2) or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Contract or which may otherwise materially affect the relationship of the parties under this Contract.

#### 2.34 Surety Bond

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

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

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

#### 2.35 Conflict of Interest Safeguards

The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public Contracting (41 U.S.C. § 423).

## 2.36 Reservation of Rights and Remedies

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

## 2.37 Termination by Default

**2.37.1 Termination by Contractor.** The Contractor may terminate this Contract whenever HCA defaults in performance of the Contract and fails to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after 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.

**2.37.2 Termination by HCA.** HCA may terminate this Contract if HCA determines:

2.37.2.1 HCA may terminate this Contract whenever the Contractor defaults in performance of the Contract and fails to cure the default within a reasonable period of as set by HCA, based on the nature of the default and how such default impacts possible consumers.

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

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

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

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

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

- 2.37.2.7 One of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years.
- 2.37.2.8 The Contractor has been terminated under title XVIII of the Social Security Act, or under any states' Medicaid or CHIP program.
- 2.37.2.9 One of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by HCA within thirty (30) days of a HCA request.
- 2.37.2.10 The Contractor failed to permit access to one of the Contractor's locations for site visits.
- 2.37.2.11 The Contractor has falsified any information provided on its application.

### **2.38 Termination for Convenience**

Notwithstanding any other provision of this Contract, the HCA may, by giving thirty (30) calendar days written notice, beginning on the second (2<sup>nd</sup>) 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.

### **2.39 Terminations: Pre-termination Processes**

- 2.39.1 Either party to the Contract shall give the other party to the Contract written notice, as described in the Notices Section of the General Terms and Conditions of this Contract, of the intent to terminate this Contract and the reason for termination.
- 2.39.2 HCA shall provide written notice to the Contractor's Consumers of the decision to terminate the Contract and indicate whether the Contractor may appeal the decision.
- 2.39.3 If either party disagrees with the other party's decision to terminate this Contract, that party will have the right to a dispute resolution as described in the Disputes Section of this Contract.

### **2.40 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.

### **2.41 Post Termination Responsibilities**

- 2.41.1 The following requirements survive termination of this Contract.
- 2.41.2 The Contractor shall:
  - 2.41.2.1 Submit all data and reports required in the Contract;
  - 2.41.2.2 Provide access to records, related to audits and performance reviews; and

- 2.41.2.3 Provide administrative services associated with services (e.g., claims processing and Consumer appeals) to be provided to Consumers under the terms of this Contract.

## 2.42 Termination - Information on Outstanding Claims

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

## 2.43 Treatment of Consumer Property

Unless otherwise provided, the Contractor shall ensure that any adult Consumers receiving services from the Contractor has unrestricted access to the Consumer's personal property, except when deprivation is essential to protect the safety of the Consumer or another person, in accordance with RCW 71.05.217. The Contractor shall not interfere with any adult Consumer's ownership, possession, or use of the Consumer's property. The Contractor shall provide Consumers under age eighteen (18) with reasonable access to their personal property that is appropriate to the Consumer's age, development, and needs. Upon termination of the Contract, the Contractor shall immediately release to the Consumer and/or the Consumer's guardian or custodian all of the Consumer's personal property.

## 2.44 Administrative Simplification

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

- 2.44.1 To maximize understanding, communication, and administrative economy among all Contractors, their Subcontractors, governmental entities, and Consumers, Contractor shall use and follow the most recent updated versions of:
  - 2.44.1.1 Current Procedural Terminology (CPT).
  - 2.44.1.2 International Classification of Diseases (ICD).
  - 2.44.1.3 Healthcare Common Procedure Coding System (HCPCS).
  - 2.44.1.4 The Diagnostic and Statistical Manual of Mental Disorders.
  - 2.44.1.5 NCPDP Telecommunication Standard D.O.
  - 2.44.1.6 Medi-Span® Master Drug Data Base or other nationally recognized drug data base with approval by HCA.
- 2.44.2 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.
- 2.44.3 In lieu of the most recent versions, Contractor may request an exception. HCA's consent thereto will not be unreasonably withheld.
- 2.44.4 Contractor may set its own conversion factor(s), including special code-specific or group-specific conversion factors, as it deems appropriate.

### 3 MARKETING AND INFORMATION REQUIREMENTS

#### 3.1 Media Materials and Publications

- 3.1.1 Media materials and publications developed with federal or State funds shall be submitted to the HCA for written approval prior to publication (the HCA will respond within five (5) working days, but may have up to thirty (30) days to approve). The HCA must be cited as the funding source in news releases, publications, and advertising messages created with or about HCA funding. The funding source shall be cited as: The State of Washington Health Care Authority. The HCA logo may also be used in place of the above citation.
- 3.1.2 Marketing materials related in subject matter to all materials under 3.1.1. but not paid for by funds provided under this contract still must be submitted to HCA for prior approval as noted in 3.1.1.
- 3.1.3 Exceptions: The Contractor is encouraged but is not required to submit the following items to the HCA:
  - 3.1.3.1 News coverage resulting from interviews with reporters including online news coverage;
  - 3.1.3.2 Pre-scheduled posts on electronic / social media sites;
  - 3.1.3.3 When a statewide media message developed by HCA is localized; and
  - 3.1.3.4 When the current SAMHSA-sponsored media campaign is localized (As of August 2013, this is the "Talk They Hear You" campaign)  
<http://www.samhsa.gov/underagedrinking>.
- 3.1.4 Marketing for Crisis Services
  - 3.1.4.1 The Contractor shall develop and implement a targeted marketing plan that educates and informs community stakeholders such as residents of the Regional Service Area , health care providers, first responders, law enforcement personnel, the criminal justice community, educational system, faith-based organizations, and human service organizations about the regional crisis system.
  - 3.1.4.2 The initial plan is due thirty (30) days prior to the start date of this Contract and by July 1 of each subsequent contract year for approval by the HCA. The marketing plan shall:
    - 3.1.4.2.1 Include a detailed timeline for implementation;
    - 3.1.4.2.2 Address specific marketing strategies to target those whose primary language is not English, those in rural areas, individuals with serious mental illness, persons with substance use disorders, and otherwise underserved populations in the Contractor's Regional Service Area who may not have adequate exposure to mainstream advertising/marketing mediums; and
    - 3.1.4.2.3 Publicize the regional crisis system services and facilitate enhanced awareness of the existence of the mental health crisis services for all stakeholders.

## 3.2 Information Requirements for Consumers

- 3.2.1 Upon a Consumer's request, the Contractor shall provide all relevant licensure, certification and accreditation status and information.
- 3.2.2 Upon a Consumer's request, the Contractor shall provide any and all information included in the database in 6.1.4 of this contract, this information shall include but not limited to licensure, certification and accreditation status for CMHAs and education, licensure, and board certification or re-certification or registration of Mental Health Professionals and Designated Mental Health Professionals (DMHPs).

## 3.3 Equal Access for Consumers with Communication Barriers

The Contractor shall assure equal access for all Consumers when oral or written language creates a barrier to such access for Consumers with communication barriers consistent with WAC 388-865-0410.

### 3.3.1 Oral Information

- 3.3.1.1 The Contractor shall assure that interpreter services are provided for Consumers with a primary language other than English, free of charge. Interpreter services shall be provided for all interactions between such Consumer 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 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 Interpreter services include the provision of interpreters for Consumers who are deaf or hearing impaired at no cost to the Consumer.

### 3.3.2 Written Information

- 3.3.2.1 The Contractor shall provide all generally available and Consumer-specific written materials in a language and format which may be understood by each individual Consumer in each of the prevalent languages that are spoken by five percent (5%) or more of the population of the Regional service Area based on the most recent US census.
- 3.3.2.2 For Consumers whose primary language has not been translated as required in 3.3.2.1, the Contractor may meet the requirement of this section by doing any one of the following:
  - 3.3.2.2.1 Translating the material into the Consumer's primary reading language.
  - 3.3.2.2.2 Providing the material in an audio format in the Consumer's primary language.
  - 3.3.2.2.3 Having an interpreter read the material to the Consumer in the Consumer's primary language.

- 3.3.2.2.4 Providing the material in another alternative medium or format acceptable to the Consumer. The Contractor shall document the Consumer's acceptance of the material in an alternative medium or format in the Consumer's record.
      - 3.3.2.2.5 Providing the material in English, if the Contractor documents the Consumer's preference for receiving material in English.
- 3.3.3 The Contractor shall ensure that all written information provided to Consumers is accurate, is not misleading, is comprehensible to its intended audience, is designed to provide the greatest degree of understanding, is written at the sixth (6<sup>th</sup>) 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 (6<sup>th</sup>) grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth (6<sup>th</sup>) grade reading level or the Consumers' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth (6<sup>th</sup>) grade reading level must be in writing.
- 3.3.5 Educational materials about topics or other information used by the Contractor for health promotion efforts must be submitted to HCA, but do not require HCA approval as long as they do not specifically mention the Contracted Services.
- 3.3.6 Educational materials that are not developed by the Contractor or by the Contractor's Subcontractors are not required to meet the sixth (6<sup>th</sup>) grade reading level requirement and do not require HCA approval.
- 3.3.7 All other written materials must have the written approval of HCA prior to use. For Consumer-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved materials in final form.
- 3.3.8 The Contractor shall ensure that providers have an effective mechanism to communicate with Consumers with sensory impairments.

## **4 SERVICE AREA AND CONSUMER ELIGIBILITY**

### **4.1 Service Areas**

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

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

### **4.2 Service Area Changes**

- 4.2.1 The Contractor must offer services to all Consumers within the boundaries of the Regional Service Area covered by this Contract.
- 4.2.2 The Contractor may not decrease its service areas or its level of participation in any service area except during Contract renewal (i.e., when the Contract is extended as provided herein).

- 4.2.3 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's Regional Service Area, HCA shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected Contractors.
- 4.2.4 HCA shall determine, in its sole judgment, which zip codes fall within each service area.
- 4.2.5 HCA will use the Consumer's residential zip code to determine whether a Consumer resides within a service area.

### 4.3 Eligibility

- 4.3.1 All individuals in the Contractor's Regional Service Area regardless of insurance status, ability to pay, county of residence, or level of income are eligible to receive medically necessary Mental Health Crisis Services, SUD crisis services, and services related to the administration of the Involuntary Treatment Act and Involuntary Commitment Act (RCW 71.05, 71.34 and 70.96A.140).
- 4.3.2 The Contractor has discretion on the use of funds for the provision of other non-crisis behavioral health services including crisis stabilization, voluntary behavioral health admissions for Consumers in the Contractor's Regional Service Area who are not eligible for Medicaid and/or do not have third party insurance.
- 4.3.3 To be eligible for any non-crisis behavioral health service under this Contract, an individual must meet: (i) the financial eligibility criteria; and (ii) the clinical or program eligibility criteria for the GFS/SAPT service:
  - 4.3.3.1 Individuals who do not qualify for Medicaid and have income up to two hundred twenty percent (220%) of the federal poverty level meet the financial eligibility for all of the GFS/SAPT services.
  - 4.3.3.2 For services in which medical necessity criteria applies, all services must be medically necessary.
  - 4.3.3.3 As defined in Section 6 of the Contract, certain populations have priority to receive GFS/SAPT services.
- 4.3.4 Meeting the eligibility requirements under this Contract does not guarantee the Consumer will receive a non-crisis behavioral health service. Services other than mental health Crisis Service and ITA-related services are contingent upon Available Resources as managed by Contractor.
- 4.3.5 The Contractor shall develop protocols to determine eligibility for non-crisis behavioral health services and submit to HCA for review and approval. At a minimum, protocols shall address data collection, income verification, frequency of financial eligibility review, and identification of priority populations. Eligibility functions may be done by the Contractor or delegated to providers. If delegated to providers, the Contractor shall monitor the providers' use of such protocols and ensure appropriate compliance in determining eligibility.
  - 4.3.5.1 The Contractor shall develop eligibility data collection protocols for providers to follow to ensure that: (i) the provider checks the individual's Medicaid eligibility; and (ii) the provider captures sufficient demographic, financial, and other information to support eligibility decisions and reporting requirements.

- 4.3.5.2 The Contractor shall participate with the regional Accountable Community of Health and MCO's providing fully integrated services in a regional initiative to develop and implement consistent protocols to determine clinical or program eligibility for the non-crisis behavioral health services.
- 4.3.5.3 The Contractor shall participate in developing protocols for individuals with frequent eligibility changes. The protocols will address, at a minimum, coordination with the AH-FIMC managed care organizations, referrals, reconciliations, and potential transfer of GFS/SAPT funds to promote continuity of care for the individual. Any reconciliation will occur at a frequency determined by HCA, but no less than semiannually, with potential for up to monthly reconciliations in the last quarter of the allocation year.

## **5 PAYMENT AND SANCTIONS**

### **5.1 Funding**

- 5.1.1 HCA will calculate the quarterly allocation of State-Only and Federal Substance Abuse Prevention and Treatment Block Grant (SAPT) funds available to the Contractor, identified in Exhibit A, based upon available funding for the Regional Service Area as a whole and the Contractor's share of the funds in the region.
- 5.1.2 HCA will pay the quarterly allocation of State-Only funds to the contractor in equal monthly installments at the beginning of each calendar month. A maximum of ten percent of the State-Only funds paid 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. (Editorial note: If Exhibit A is not attached to this sample contract at this time; it will be included as soon as fully developed and approved prior to contract execution.)
- 5.1.3 HCA will pay the Contractor SAPT funds on a monthly basis based upon receipt of accepted encounters for services provided under this Contract. 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. The Contractor shall not use SAPT funds for administrative costs.
- 5.1.4 For all services, the Contractor must distinguish whether the individual receiving the services is eligible for Medicaid and/or has any other form of insurance coverage.
  - 5.1.4.1 For those individuals eligible for Medicaid or other insurance, the Contractor must submit the claim for services to the appropriate party, in accordance with related timely filing requirements.
    - 5.1.4.1.1 At HCA's direction, the Contractor shall participate in a regional initiative to develop and implement claims submission protocols for Crisis Services.
  - 5.1.4.2 For those individuals who do not have other insurance coverage and are not eligible for Medicaid coverage, the Contractor may develop a sliding fee schedule in accordance with Section 10.6.2.
- 5.1.5 For Mental Health Block Grant (MHBG) services, the Contractor shall comply with the utilization funding agreement guidelines within the State's most recent MHBG plan. The Contractor agrees to comply with Title V, Section 1913 of the Public Health Services Act [42 U.S.C. 300x-1 et seq.]. The Contractor shall not use MHBG funds for the following:

- 5.1.5.1 The Contractor's administrative costs associated with salaries and benefits at the Contractor's organization level.
- 5.1.5.2 Inpatient mental health services.
- 5.1.5.3 Constructions and/or renovation.
- 5.1.5.4 Capitol assets or the accumulation of operating reserve accounts.
- 5.1.5.5 Equipment costs over \$5,000.
- 5.1.5.6 Cash payments to Consumers.
- 5.1.6 The Contractor shall administer services provided under this Contract in a manner that best maintains Available Resources throughout the Contract period. The Contractor shall maintain financial records that track the funding received and the expenditures for services provided under this Contract by category of service, funding source (i.e., GFS and FBG), State fiscal or block grant year, and whether the expenditure was for a Medicaid or Non-Medicaid eligible individual. The Contractor shall provide a detailed report of their expenditures for services provided under this Contract to HCA at the close of each calendar month in a format to be determined by HCA and identified in Exhibit A.
- 5.1.7 All funds under this Contract are subject to reconciliation by HCA no less than quarterly. The reconciliation process will compare the funds allocated to the funds expended by the Contractor for eligible services provided to eligible Consumers. HCA may, based on the results of such reconciliations, adjust the Contractor's future allocations as deemed appropriate.
- 5.1.8 Funds allocated under this Contract that are not expended by the end of the applicable fiscal year may not be used or carried forward to the subsequent applicable FY or to any other Contract. Unspent allocations will be collected by HCA at the end of the applicable FY.
- 5.1.9 The Contractor shall ensure that all funds provided pursuant to this Contract, (other than the 10% allowed for administration) including interest earned, are to be used to provide services as described in Sections 15 and 16 of this contract.
- 5.1.10 HCA will provide a quarterly State Hospital Bed Allocation to the Contractor as described in section 14.5. This allocation shall be used by the Contractor as a ceiling for the State Hospital Bed utilization by the Consumers they serve under this Contract.
- 5.1.11 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 B based on a quarterly calculation of the bed usage by the Contractor.
  - 5.1.11.1 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 B.
  - 5.1.11.2 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.

5.1.11.3 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.

5.1.11.4 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.

5.1.12 The rate of payment for reimbursement for Eastern State Hospital is \$611.00.

5.1.13 The rate of payment for reimbursement for Western State Hospital is \$541.00.

5.1.14 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.

5.1.15 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.

5.1.16 The Contractor shall only use the administrative portion of the State-Only funds for the potential State Hospital Bed Allocation overage fee.

5.1.17 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 **Non-Compliance**

### 5.2.1 Failure to Maintain Reporting Requirements

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

### 5.2.2 Recovery of Costs Claimed in Error

If the Contractor claims and HCA reimburses for expenditures under this Contract which HCA later finds were: (1) claimed in error; or (2) not allowable costs under the terms of the Contract, HCA shall recover those costs and the Contractor shall fully cooperate with the recovery.

### 5.2.3 Stop Placement

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

#### 5.2.4 Additional Remuneration Prohibited

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

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

### 5.3 Overpayments or Underpayments

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

5.3.2 The Contractor shall have the ability to:

5.3.2.1 Submit encounter data through the HCA's Provider One system or as determined by HCA, within thirty (30) days of the end of the month in which the Contractor paid/processed the claim/encounter.

5.3.2.2 Submit non-encounter data that meets requirements as specified by the HCA as necessary to meet State or federal data and reporting requirements.

Non-encounter data will include, but is not limited to:

5.3.2.2.1 Client-level data to track and report on investigations and detentions under ITA RCW 71.05.

5.3.2.2.2 Client-level data to meet the reporting requirements of the Substance Abuse Mental Health Services Administration (SAMHSA) Block Grant programs.

5.3.2.3 Submit reports that detail service related expenditures that are not supported by encounter data, in a format to be determined by HCA.

### 5.4 Sanctions

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

- 5.4.1.1 A problem exists that negatively impacts Consumers receiving services.
- 5.4.1.2 The Contractor has failed to perform any of the Contracted Services..
- 5.4.1.3 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.
- 5.4.1.4 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.
- 5.4.1.5 The Contractor has failed to implement corrective action required by the State and within HCA prescribed timeframes.
- 5.4.2 HCA may impose any of the following remedial actions:
  - 5.4.2.1 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.
  - 5.4.2.2 Corrective action plans must include:
    - 5.4.2.2.1 A brief description of the situation requiring corrective action.
    - 5.4.2.2.2 The specific actions to be taken to remedy the situation.
    - 5.4.2.2.3 A timetable for completion of the actions.
    - 5.4.2.2.4 Identification of individuals responsible for implementation of the plan.
  - 5.4.2.3 Corrective action plans are subject to approval by HCA, which may:
    - 5.4.2.3.1 Accept the plan as submitted.
    - 5.4.2.3.2 Accept the plan with specified modifications.
    - 5.4.2.3.3 Request a modified plan.
    - 5.4.2.3.4 Reject the plan.
- 5.4.3 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.
- 5.4.4 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.
- 5.4.5 Deny any incentive payment to which the Contractor might otherwise have been entitled under this Contract.
- 5.4.6 Terminate for Default as described in the General Terms and Conditions.

## 6 ACCESS TO CARE AND PROVIDER NETWORK

### 6.1 Network Capacity

- 6.1.1 The Contractor shall maintain and monitor an appropriate and adequate provider network, supported by written agreements, sufficient to provide all Contracted Services under this Contract. The Contractor may provide contracted services through non-participating providers, at a cost to the individual that is no greater than if the contracted services were provided by participating providers, if its network of participating providers is insufficient to meet the behavioral health needs of individuals in a manner consistent with this Contract. This provision shall not be construed to require the Contractor to cover such services without authorization. To the extent necessary to provide non-crisis behavioral health services covered under this Contract, the Contractor may offer contracts to providers in other Regional Service Areas in the state of Washington and to providers in bordering states. The Contractor may not Contract for crisis services (SUD or mental health) or ITA-related services out of Washington State.
- 6.1.1.1 The Contractor shall submit a network of its Crisis Services and submit to the HCA at least thirty (30) days prior to the start of this contract and at any subsequent time requested by the HCA. The network must include at a minimum: (i) Designated Mental Health Professional (DMHP) capacity to serve the Regional Service Area population; (ii) Designated Chemical Dependency Specialist (DCDS) capacity to serve the Regional Service Area population; (iii) evaluation and treatment (E&T) capacity to serve the Regional Service Area non-Medicaid population; (iv) substance use disorder inpatient beds to serve the Regional Service Area non-Medicaid population; (v) sufficient staff for mobile crisis outreach in the Regional Service Area. .
- 6.1.1.2 The Contractor shall provide quarterly status reports to HCA on its contracting activities in border States and bordering Regional Service Area..
- 6.1.1.3 The Contractor shall notify HCA ninety (90) days prior to terminating any of its Subcontracts or entering into new Subcontracts with entities that provide direct services, including mental health crisis services providers. This notification shall occur prior to any public announcement of this change.
- 6.1.1.3.1 If a Subcontract is terminated in less than 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.
- 6.1.1.3.2 If a Subcontract is terminated or a site closes, the Contractor shall submit a plan within seven (7) days to HCA that includes at a minimum:
- 6.1.1.3.2.1 Notification to Ombuds services;
  - 6.1.1.3.2.2 Individual notification plan for Consumers affected by the termination or site closure;
  - 6.1.1.3.2.3 Plan for provision of uninterrupted services; and
  - 6.1.1.3.2.4 Any information released to the media.

- 6.1.1.3.3 HCA reserves the right to impose sanctions, in accordance with the sanctions subsection of this Contract, if the Contractor was notified by the terminating provider in a timely manner and does not comply with the notification requirements of this section.
  - 6.1.1.3.3.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor shall provide documentation of the date of notification along with the notice of loss of a material provider.
- 6.1.1.4 The updated provider network information will be reviewed by HCA for:
  - 6.1.1.4.1 Completeness and accuracy;
  - 6.1.1.4.2 The need for HCA provision of technical assistance;
  - 6.1.1.4.3 Removal of providers who no longer contract with the Contractor; and
  - 6.1.1.4.4 The effect that the change(s) in the provider network will have on the network's compliance with the requirements of this section.
- 6.1.2 The Contractor shall incorporate the following requirements when developing its network:
  - 6.1.2.1 Only licensed or certified behavioral health providers shall provide behavioral health services. Licensed or certified behavioral health providers include, but are not limited to, Health Care Professionals, licensed agencies or clinics, or non-licensed professionals operating under an agency affiliated license.
  - 6.1.2.2 The Contractor shall establish and maintain contracts with office-based opioid treatment qualifying providers in their service area that have obtained a waiver under the Drug Addiction Treatment Act of 2000 to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the Food and Drug Administration.
  - 6.1.2.3 The Contractor shall assist the State to expand community-based alternatives for crisis stabilization, such as mobile crisis outreach or crisis residential and respite beds.
  - 6.1.2.4 The Contractor shall assist the State to expand community-based, recovery-oriented services, use of Certified Peer Counselors and research- and evidence-based practices.
- 6.1.3 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network for mental health crisis services for two consecutive quarters, and after notification following the first quarter, HCA reserves the right to immediately terminate the Contractor's services for that Regional Service Area.

## 6.2 SAPT Priority Populations

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

- 6.2.1.1 The expected utilization of services, characteristics and health care needs of the population, the number and types of providers (training, experience and specialization) able to furnish services, and the geographic location of providers and individuals (including distance, travel time, means of transportation ordinarily used by Consumers, and whether the location is ADA accessible) for all Contractor funded behavioral health programs and services based on Available Resources.
- 6.2.1.2 The anticipated needs of priority populations, in priority order below with 6.2.1.2.1 being the first priority, as identified in the SAPT or by HCA but not limited to:
  - 6.2.1.2.1 Pregnant injecting drug users.
  - 6.2.1.2.2 Pregnant substance abusers.
  - 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 a diverse population;
  - 6.2.2.2 Initiate actions to ensure or improve access, retention, and cultural relevance of treatment, prevention or other appropriate services, for ethnic minorities and other diverse populations in need of services under this Contract as identified in their needs assessment.

### 6.3 Hours of Operation for Network Providers

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

### 6.4 Customer Service

The Contractor shall have a single toll-free number for Consumers to call regarding GFS/SAPT services at its expense, which shall be a separate and distinct number from the Contractor's regional crisis toll free telephone line. The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8:00 a.m. to 5:00 p.m., or alternative hours as agreed to by HCA, 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.

- 6.4.1 The Contractor shall report by December 1<sup>st</sup> of each year its scheduled non-business days for the upcoming calendar year.
- 6.4.2 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.
- 6.4.3 The Contractor and its provider help desks, and Consumer customer service centers, if any, shall comply with the following customer service performance standards:
  - 6.4.3.1 Telephone abandonment rate – standard is less than three percent (3%).
  - 6.4.3.2 Telephone response time – average speed of answer within thirty (30) seconds.
- 6.4.4 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 Contracted Service eligibility requirements and benefits; 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.
- 6.4.5 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:
  - 6.4.5.1 Information on the array of Contracted Services including where and how to access them.
  - 6.4.5.2 Authorization requirements.
  - 6.4.5.3 Requirements for responding promptly to family members and supporting linkages to other service systems including, but not limited to: Medicaid services administered by the AH-FIMC managed care organizations for Consumers with eligibility status changes, law enforcement, criminal justice system, and social services.
  - 6.4.5.4 Assisting and triaging Consumers who may be in crisis with access to appropriately qualified clinicians to assist with triaging callers who may be in crisis without placing the Consumer on hold. The qualified clinician shall assess the crisis and warm transfer the call to the designated crisis provider(s), call 911, refer the individual for services, refer the individual to his or her provider, or resolve the crisis over the telephone as appropriate.
- 6.4.6 The Contractor shall train customer services representatives on GFS/SAPT policies and procedures.

## 6.5 Priority Populations and Waiting Lists

The Contractor shall comply with the following requirements:

- 6.5.1 For SAPT services:
  - 6.5.1.1 SAPT services shall be provided in accordance with the HCA's priority populations as identified in the SAPT block grant or by HCA but not limited to:
    - 6.5.1.1.1 Pregnant injecting drug users.
    - 6.5.1.1.2 Pregnant substance abusers.

- 6.5.1.1.3 Women with dependent children.
- 6.5.1.1.4 Injecting drug users.
- 6.5.1.2 The following are additional priority populations for SAPT services, in no particular order:
  - 6.5.1.2.1 Postpartum women (up to one year, regardless of pregnancy outcome).
  - 6.5.1.2.2 Patients transition from residential care to outpatient care.
  - 6.5.1.2.3 Youth.
  - 6.5.1.2.4 Offenders (as defined in RCW 70.96.350).
- 6.5.2 For non-crisis behavioral health services funded by GFS:
  - 6.5.2.1 The Contractor shall provide non-crisis behavioral health services funded by GFS based on the following priorities:
    - 6.5.2.1.1 Consumers who meet financial eligibility standards in Section 4.3.3 and meet one of the following criteria:
      - 6.5.2.1.1.1 Are uninsured
      - 6.5.2.1.1.2 Have insurance, but are unable to meet the co-pay or deductible for services
      - 6.5.2.1.1.3 Are using excessive SUD or mental health crisis services due to inability to access non-crisis behavioral health services
      - 6.5.2.1.1.4 More than 5 visits over 6 months to the emergency department, detox facility, or the sobering center due to a substance use disorder.
- 6.5.3 The Contractor will implement protocols for maintaining waiting lists and providing interim services for members of SAPT priority populations, as defined in this Contract, who are eligible to receive services but for whom SUD treatment services are not available due to limitations in provider capacity or Available Resources.

## 6.6 Access to Services

- 6.6.1 The Contractor shall, subject to Available Resources, ensure that SAPT Block Grant services to eligible Consumers are not denied to any Consumer regardless of:
  - 6.6.1.1 The Consumer's drug(s) of choice.
  - 6.6.1.2 The fact that a Consumer is taking medically-prescribed medications.
  - 6.6.1.3 The fact that a person is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.
- 6.6.2 The Contractor shall, as required by the SAPT Block Grant, ensure interim services are provided by for pregnant and parenting women and intravenous drug users.
  - 6.6.2.1 Interim services shall be made available within forty-eight (48) hours of seeking treatment for pregnant and parenting women and intravenous drug users.

- 6.6.2.2 Admission to treatment services for the intravenous drug user shall be provided within fourteen (14) days after the patient makes the request, regardless of funding source.
- 6.6.2.3 If there is no treatment capacity within fourteen (14) days of the initial patient request, the Contractor shall have up to one hundred twenty (120) days, after the date of such request, to admit the patient into treatment, while offering or referring to interim services within forty-eight (48) hours of the initial request for treatment services. Interim services must be documented in the system platform designated by the HCA and include, at a minimum:
  - 6.6.2.3.1 Counseling on the effects of alcohol and drug use on the fetus for the pregnant patient.
  - 6.6.2.3.2 Prenatal care for the pregnant patient.
  - 6.6.2.3.3 Human immunodeficiency virus (HIV) and tuberculosis (TB) education.
  - 6.6.2.3.4 HIV or TB treatment services if necessary for an intravenous drug user.
- 6.6.2.4 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.
- 6.6.3 A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of detoxification, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within twenty-four (24) hours.

## **7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT**

### **7.1 Quality Management Program**

- 7.1.1 The Contractor shall ensure its quality management (QM) program addresses GFS/SAPT requirements and meets Crisis Services standards. It shall be the independent obligation of the Contractor to remain current with all GFS/SAPT requirements.
- 7.1.2 The Contractor shall comply with the following QM requirements:
  - 7.1.2.1 The Contractor shall participate in a Community Behavioral Health Advisory Board and attend meetings as required by established bylaws. The Community Behavioral Health Advisory Board must satisfy the requirements in Exhibit C.
  - 7.1.2.2 If requested by the HCA, the Contractor shall attend and send a representative to the Community Behavioral Health Advisory Board meeting to discuss priorities for each State FY of the 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-Measurement Reporting

- 7.3.1 At HCA's discretion, individual performance metrics will be linked to potential payment adjustments.
- 7.3.2 HCA Defined Reporting and Data Submission Methods for Performance Measurement:
  - 7.3.2.1 The Contractor shall comply with the reporting and data submissions requirements as directed by HCA. Should 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 Prior to the implementation of a new program of service, the Contractor and HCA shall agree upon a program guidance/instruction document that will specify the process for reporting the service activity under that program.
- 7.3.3 The Contractor shall 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 on the performance measures and metrics in Exhibit D.
- 7.3.6 Crisis Services
  - 7.3.6.1 The Contractor shall provide all relevant crisis response system and service reports as directed by HCA. The reports shall include, at a minimum, the information included in Exhibit E.

### 7.4 Critical Incident Reporting

The Contractor shall notify HCA of any critical incident of which it becomes aware as described in this subsection:

- 7.4.1 The Contractor must report and follow up on the incidents listed below. In addition, the Contractor shall use professional judgment in reporting incidents not listed herein.
  - 7.4.1.1 Category One Incidents:

- 7.4.1.1.1 Death or serious injury of, Consumer, staff, or public citizens at a HCA facility or a facility that HCA or DSHS licenses, contracts with, or certifies.
- 7.4.1.1.2 Unauthorized leave of a mentally ill offender or a sexual violent offender from a mental health facility or a Secure Community Transition Facility. This includes Evaluation and Treatment centers (E&T) Crises Stabilization Units (CSU) and Triage Facilities that accept involuntary Consumer.
- 7.4.1.1.3 Any violent act to include rape or sexual assault, as defined in RCW 71.05.020 and RCW 9.94A.030, or any homicide or attempted homicide committed by a Consumer.
- 7.4.1.1.4 Any event involving an individual or staff that has attracted, or that in the professional judgment of the Incident Manager, is likely to attract media attention.
- 7.4.1.2 Category Two Incidents:
  - 7.4.1.2.1 Alleged Consumer abuse or Consumer neglect of a serious or emergent nature by an employee, volunteer, licensee, Contractor or another client.
  - 7.4.1.2.2 A substantial threat to facility operation or Consumer safety resulting from a natural disaster (to include earthquake, volcanic eruption, tsunami, fire, flood, an outbreak of communicable disease, etc.).
  - 7.4.1.2.3 Any breach or loss of Consumer data in any form that is considered as reportable in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act and that would allow for the unauthorized use of Consumer personal information. In addition to the standard elements of an incident report, the Contractor shall document and/or attach: 1) the Police report; 2) any equipment that was lost; and 3) specifics of the Consumer information.
  - 7.4.1.2.4 Any allegation of financial exploitation as defined in RCW 74.34.020.
  - 7.4.1.2.5 Any attempted suicide that requires medical care that occurs at a facility that HCA licenses, contracts with, and/or certifies.
  - 7.4.1.2.6 Any event involving a Consumer or staff, likely to attract media attention in the professional judgment of the Incident Manager.

- 7.4.1.2.7 Any event involving: a credible threat towards a staff member that occurs at a HCA facility, a facility that HCA or DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community. A credible threat towards staff as defined in this subsection means a communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family, which resulted in a report to Law Enforcement, a restraining/protection order, or a workplace safety/personal protection plan.
- 7.4.1.2.8 A life safety event that requires an evacuation or that is a substantial disruption to the facility.
- 7.4.1.3 Notification to HCA
  - 7.4.1.3.1 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 or 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.
  - 7.4.1.3.2 The Contractor must report and also notify the HCA-designated Incident Manager by telephone or email immediately upon becoming aware of the occurrence of any Category One Incidents involving any individual that was served within three hundred sixty-five (365) days of the incident. If the Contractor becomes aware of the event after business hours, notice must be given as soon as possible during the next business day.
  - 7.4.1.3.3 The Contractor must report within one (1) working day of becoming aware that any Category Two Incidents has occurred, involving a Consumer.
  - 7.4.1.3.4 Notification must include a description of the event, including the date and time of the incident, the incident location, incident type, names and ages, if known of all individuals involved and the nature of their involvement, service history with the Contractor, steps taken by the Contractor to minimize harm, and any legally required notification made by the Contractor.
- 7.4.1.4 Comprehensive Review: HCA may require the Contractor to initiate a comprehensive review of an incident.
  - 7.4.1.4.1 The Contractor shall fully cooperate with any investigation initiated by HCA and provide any information requested by HCA within the timeframes specified within the request.
  - 7.4.1.4.2 If the Contractor does not respond according to the timeframe in HCAs' request, HCA may obtain information directly from any involved party and request their assistance in the investigation.

- 7.4.1.4.3 HCA may request medication management information.
- 7.4.1.4.4 HCA may also review or may require the Contractor to review incidents that involve Consumer who have received services from the Contractor more than three hundred sixty-five (365) days prior to the incident.
- 7.4.1.5 Incident Review and Follow Up: The Contractor shall review and follow up on all incidents reported. The Contractor shall provide sufficient information, review and follow up to take the process and report to its completion. An incident shall not be categorized as complete until the following information is provided:
  - 7.4.1.5.1 A summary of any incident debriefings or review process dispositions.
  - 7.4.1.5.2 Whether the person is in custody (jail), in the hospital, or in the community, and if in the community whether the person is receiving services. If the Consumer cannot be located, the Contractor shall document in the Incident Reporting System the steps that the Contractor took to attempt to locate the Consumer by using available local resources.
  - 7.4.1.5.3 Documentation of whether the Consumer is receiving or not receiving behavioral health services from the Contractor at the time the incident is being closed.
  - 7.4.1.5.4 In the case of a death of the Consumer, the Contractor must provide either a telephonic verification from an official source or via a death certificate.
  - 7.4.1.5.5 In the case of a telephonic verification, the Contractor shall document the date of the contact and both the name and official duty title of the person verifying the information.
  - 7.4.1.5.6 If this information is unavailable, the Contractor shall document the attempt to retrieve it.
  - 7.4.1.5.7 For individuals served by the Contractor within three hundred sixty-five (365) days of an incident, the Contractor must report and follow up on the incident.
- 7.4.1.6 Unless listed above and when requested by HCA, the Contractor shall submit a written report within two (2) weeks of the original notification to provide information regarding any actions taken in response to the incident, the purpose for which any action was taken, any implications to the service delivery system, and efforts designed to prevent or lessen the possibility of future similar incidents.

## 7.5 Practice Guidelines

- 7.5.1 The Contractor shall adopt behavioral health practice guidelines known to be effective in improving health outcomes. Practice guidelines shall be based on the following:
  - 7.5.1.1 Valid and reliable clinical scientific evidence;
  - 7.5.1.2 In the absence of scientific evidence, on professional standards; or

- 7.5.1.3 In the absence of scientific evidence and professional standards, a consensus of Health Care Professionals in the particular field.
- 7.5.2 The Contractor may adopt guidelines developed by recognized sources that develop or promote evidence-based clinical practice guidelines such as voluntary health organizations, National Institute of Health Centers, or the Substance Abuse and Mental Health Services Administration (SAMHSA). If the Contractor does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines. The guidelines shall:
  - 7.5.2.1 Consider the needs of Consumers and support client and family involvement in care plans.
  - 7.5.2.2 Be adopted in consultation with contracting Behavioral Health Professionals within the State of Washington.
  - 7.5.2.3 Be reviewed and updated at least every two (2) years and more often if national guidelines change during that time.
  - 7.5.2.4 Be disseminated to all affected providers and, upon request, to HCA, and Consumers.
- 7.5.3 The Contractor shall track research and evidence-based practices following guidelines published by the HCA.
- 7.5.4 The Contractor shall include the Behavioral Health Medical Director in the evaluation of emerging technologies for the treatment of behavioral health conditions and related decisions. The Contractor shall also have a child psychiatrist available for consultation related to other emerging technologies for the treatment of behavioral health conditions in children and adolescents.

## 7.6 Health Information Systems

The Contractor shall establish and maintain, and shall require Subcontractors to maintain, a health information system that complies with the requirements of HCA Security Policies and standards 6-05 through 6-15-01, and OCIO Security Standard 141.10, and provides the information necessary to meet the Contractor's obligations under this Contract. HCA Security Policies and Standards are available at:

[https://shared.sp.wa.gov/sites/InsideHCA/policies\\_and\\_procedures/Pages/Agency-Policies-and-Procedures.aspx](https://shared.sp.wa.gov/sites/InsideHCA/policies_and_procedures/Pages/Agency-Policies-and-Procedures.aspx). OCIO Security Standards are available at: <https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets>. The Contractor shall have in place mechanisms to verify the health information received from Subcontractors. The Contractor shall:

- 7.6.1 Collect, analyze, integrate, and report data. The system must provide information on areas including, but not limited to: utilization, and fund availability by service type and fund source.
- 7.6.2 Ensure data received from providers is accurate and complete by:
  - 7.6.2.1 Verifying the accuracy and timeliness of reported data;
  - 7.6.2.2 Screening the data for completeness, logic and consistency; and
  - 7.6.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.

- 7.6.3 Make all collected data available to HCA upon request, to the extent permitted by the HIPAA Privacy Rule 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, claims/encounters submission, and claims/encounters status updates for Contracted Services.
  - 7.6.5.1 In addition, the web-based portal should allow for Contracted Service providers to determine whether or not an individual is enrolled in Medicaid. Inputting information in the portal shall not be a barrier to providing a necessary Crisis Service.
- 7.6.6 Have information systems that enable paperless submission, automated processing, and status updates for prior authorization and other utilization management related requests.
- 7.6.7 Maintain behavioral health content on a website that meets the following minimum requirements.
  - 7.6.7.1 Public and secure access via multi-level portals (such as providers and Consumers) 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 Consumers, family members, network providers, stakeholders and the general public in compliance with the Americans with Disabilities Act. The Contractor shall include on its website, at a minimum, the following information or links:
    - 7.6.7.2.1 Hours of operations for the Contractor.
    - 7.6.7.2.2 How to access information on Contracted Services and toll-free crisis telephone numbers.
    - 7.6.7.2.3 Telecommunications device for the deaf/text telephone numbers.
    - 7.6.7.2.4 Information on the right to choose a qualified behavioral health service provider, when available and medically necessary.
    - 7.6.7.2.5 An overview of the range of behavioral health services being provided.
- 7.6.8 Data Security Requirements
  - 7.6.8.1 The Contractor shall comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified in 42 USC §1320(d) et. seq. and 45 CFR Parts 160, 162 and 164I, 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 behavioral health information system that is signed by the provider and attested to by a witness's signature, acknowledging that the provider understands and agrees to follow all regulations on confidentiality.
- 7.6.8.4 The Contractor shall take appropriate action if a Subcontractor or Contractor employee wrongly releases confidential information.
- 7.6.8.5 Data Transport. When transporting HCA Confidential Information electronically, including via email, the data will be protected by:
  - 7.6.8.5.1 Transporting the data within the (State Governmental Network) SGN or, if it is secure, Contractor's internal network, or;
  - 7.6.8.5.2 Encrypting any data that will be in transit outside the SGN or, if it is secure, Contractor's internal network. This includes transit over the public Internet.
- 7.6.8.6 Protection of Data. The Contractor agrees to store data in a manner that follows HIPAA security measures.
- 7.6.8.7 Data Segregation.
  - 7.6.8.7.1 HCA data on Contracted Services must be segregated or otherwise distinguishable from non-HCA data. This is to ensure that when no longer needed by the Contractor, all HCA data can be identified for return or destruction. It also aids in determining whether HCA data has or may have been compromised in the event of a security breach.
  - 7.6.8.7.2 The Contractor shall store HCA data:
    - 7.6.8.7.2.1 On media (e.g., hard disk, optical disc, tape, etc.) which will contain no non-HCA data; or
    - 7.6.8.7.2.2 In a logical container on electronic media, such as a partition or folder dedicated to HCA data; or
    - 7.6.8.7.2.3 In a database which will contain no non-HCA data; or
    - 7.6.8.7.2.4 Within a database and will be distinguishable from non-HCA data by the value of a specific field or fields within database records; or
    - 7.6.8.7.2.5 Physically segregated from non-HCA data in a locked container, when stored as physical paper documents.
  - 7.6.8.7.3 When it is not feasible or practical to segregate HCA data from non-HCA data, then both the HCA data and the non-HCA data with which it is commingled 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 the Contractor destroys data, the Contractor will keep no copies. Media on which data may be stored and associated acceptable methods of destruction are as follows:

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

### 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 The Contractor 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, no Subcontractor may terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any Subcontractor.

## 9.2 Provider Nondiscrimination

- 9.2.1 The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold.
- 9.2.2 If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.
- 9.2.3 The Contractor's policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- 9.2.4 Consistent with the Contractor's responsibilities to Consumers, this section may not be construed to:
  - 9.2.4.1 Require the Contractor to contract with providers beyond the number necessary to meet the behavioral health requirements under the Contract.
  - 9.2.4.2 Preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty.
  - 9.2.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs.

## 9.3 Required Provisions

- 9.3.1 Subcontracts shall be in writing, and available to HCA upon request. All Subcontracts shall contain the following provisions, in addition to applicable provisions contained in Subsections 9.5 and 9.6 of this Contract:
  - 9.3.1.1 Identification of the parties of the Subcontract and their legal basis for operation in the State of Washington.
  - 9.3.1.2 The process for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.
  - 9.3.1.3 Procedures and specific criteria for terminating the Subcontract.
  - 9.3.1.4 Identification of the services to be performed by the Subcontractor and which of those services may be subcontracted by the Subcontractor. If the Contractor allows the Subcontractor to further subcontract, all Subcontractor requirements contained in this Contract must be propagated downward into any other lower tiered Subcontracts. (45 C.F.R. 92.35).
  - 9.3.1.5 Reimbursement rates and procedures for services provided under the Subcontract.
  - 9.3.1.6 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.

- 9.3.1.7 Reasonable access to facilities and financial and medical records for duly authorized representatives of HCA or DHHS for audit purposes, and immediate access for Medicaid fraud investigators.
- 9.3.1.8 The requirement to submit complete and accurate reports and data required under the Contract, including encounter data, to the Contractor. Contractor shall ensure that all Subcontractors required to report encounter data have the capacity to submit all HCA required data to enable the Contractor to meet the requirements under the Contract.
- 9.3.1.9 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved Program Integrity policies and procedures.
- 9.3.1.10 A requirement to comply with the applicable State and federal statutes, rules and regulations as set forth in this Contract.
- 9.3.1.11 A requirement to comply with any term or condition of this Contract that is applicable to the services to be performed under the Subcontract.
- 9.3.2 The Contractor shall provide the following information regarding the Grievance system for GFS/SAPT funded Contracted Services to all Subcontractors:
  - 9.3.2.1 The toll-free numbers to file oral grievances and appeals.
  - 9.3.2.2 The availability of assistance in filing a grievance or appeal.
  - 9.3.2.3 The Consumer's right to file grievances and appeals and their requirements and timeframes for filing.
  - 9.3.2.4 The Consumer's right to a hearing, how to obtain a hearing and representation rules at a hearing.
- 9.3.3 The Contractor may not delegate its responsibility to contract with a provider network. This does not prohibit a contracted, licensed provider from subcontracting with other appropriately licensed providers so long as the subcontracting provisions of this Contract are met.
- 9.3.4 The responsibilities of the Quality Management Section of this Contract may not be delegated to a Contracted Network CMHA.
- 9.3.5 HCA may place limits on delegating financial risk to any Subcontractor. Delegation of financial risk to a Subcontractor, in any amount, is subject to review and approval by HCA.

#### 9.4 **Management of Subcontracts**

- 9.4.1 The Contractor must monitor the Subcontractor's performance on an ongoing basis and subject 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 The review must be based on the specific delegation agreement with each Subcontractor, and must address compliance with Contract requirements for each delegated function including, but not limited to:
    - 9.4.1.1.1 Documentation and appropriateness of medical necessity determinations.

- 9.4.1.1.2 Patient record reviews to ensure services are appropriate based on diagnosis, the treatment plan is based on the patient's needs and progress notes support the use of each service.
  - 9.4.1.1.3 Client record reviews to ensure one hundred eighty (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.
  - 9.4.1.1.4 Timeliness of service.
  - 9.4.1.1.5 Network adequacy.
  - 9.4.1.1.6 Cultural, ethnic, linguistic, disability or age related needs are addressed.
  - 9.4.1.1.7 Coordination with other service providers.
  - 9.4.1.1.8 Provider adherence to practice guidelines, as relevant.
  - 9.4.1.1.9 Provider processes for reporting, tracking, and resolving complaints/grievances.
  - 9.4.1.1.10 Provider compliance with reporting and managing critical incidents.
  - 9.4.1.1.11 Information security.
  - 9.4.1.1.12 Disaster recovery plans.
  - 9.4.1.1.13 Fiscal management, including documenting the provider's cost allocations, revenues, expenditures, and reserves in order to ensure that funds under this Contract are being spent appropriately under WAC 388-865-0270. A fiscal review shall be conducted at least annually of Subcontractors receiving FBG funds, regardless of reimbursement methodology, to ensure: a) expenditures are accounted for by revenue source; b) no expenditures were made for items identified as prohibited in Section 5 of this Contract; c) expenditures are made only for the purposes stated in this Contract; and d) that services were actually provided.
  - 9.4.1.1.14 Licensing and certification reviews, including oversight of any issues noted during licensing and/or certification reviews conducted by DSHS and communicated to the Contractor.
- 9.4.2 No assignment of a Subcontract shall take effect without HCA's written agreement.
- 9.4.3 The Contractor shall evaluate any prospective Subcontractor's ability to perform the activities for which that Subcontractor is contracting, including the Subcontractor's ability to perform delegated activities described in the Subcontracting document.
- 9.4.4 MHBG funds may not be used to pay for services provided prior to the execution of Subcontracts, or to pay in advance of service delivery.

- 9.4.5 Unless a county is a licensed service provider and the Contractor is contracting for direct services, the Contractor shall not provide GFS and/or FBG 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 Provider Subcontracts

The Contractor's Subcontracts for the provision of Contracted Services shall contain the following provisions:

- 9.5.1 A statement that Subcontractors receiving GFS or FBG 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 Consumers for all delegated activities including QI, Utilization Management, Consumer Rights and Responsibilities.
- 9.5.3 For providers in twenty-four (24) hour settings, a requirement to provide discharge planning services which shall, at a minimum:
- 9.5.3.1 Coordinate a community-based discharge plan for each Consumer served under this Contract beginning at intake in order to procure the best available recovery plan and environment for the patient. Discharge planning shall apply to all Consumers regardless of length of stay or whether they complete treatment.
  - 9.5.3.2 Coordinate exchange of assessment, admission, treatment progress, and continuing care information with the referring entity. Contact with the referral agency shall be made within the first week of residential treatment.
  - 9.5.3.3 Establish referral relationships with assessment entities, outpatient providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of referents in treatment activities.
  - 9.5.3.4 Coordinate, as needed, with DBHR prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including the Division of Children and Family Services, the Community Services Division including Community Service Offices (CSOs).
  - 9.5.3.5 Coordinate services to financially-eligible Consumers who are in need of medical services.
- 9.5.4 A requirement to ensure that residential treatment providers shall ensure that priority to admission is given to the populations identified by the HCA in Section 6.
- 9.5.5 A requirement that SUD outpatient and inpatient providers notify the Contractor when they have reached ninety percent (90%) 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 182-538C-110 or any successors and as described in the Grievance Section of this Contract.

- 9.5.8 A requirement that termination of a Subcontract shall not be grounds for an appeal, administrative hearing or a grievance for the Consumer if similar services are immediately available in the service area.
- 9.5.9 Requirements for how Consumers will be informed of their right to a grievance or appeal 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 Consumers access to translated information and interpreter services as described in Section 3.3 of this Contract.
- 9.5.12 A requirement for adherence to established protocols for determining eligibility for services consistent with Section 4 and Section 6 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 A requirement to participate in the peer review process when requested by HCA. (42 USC 300x-53(a) and 45 CFR 96.136). The SAPT Block Grant requires an annual peer review by individuals with expertise in the field of drug abuse treatment. At least five percent (5%) of treatment providers will be reviewed.
- 9.5.20 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 Consumers 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 Consumers with a notice of their rights.
- 9.5.21.5 The FBO provides Consumers with a summary of services that includes any inherently religious activities.
- 9.5.21.6 Funds received from the BFO 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).
  - 9.5.22.1 As of August 1, 2013, all behavioral health organizations in the state of Washington were required to forward historical mental health involuntary commitment information retained by the organization including identifying information and dates of commitment to DSHS. . As soon as feasible, the Contractor must arrange to report new commitment data to the DSHS within twenty-four hours. Commitment information under this section does not need to be re-sent if it is already in the possession of the department. The Contractor and the DSHS shall be immune from liability related to the sharing of commitment information under this section. (RCW 71.05.740)
- 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 Requirements that information about Consumers, including their medical records, shall be kept confidential in a manner consistent with State and federal laws and regulations.
- 9.5.25 The Subcontractor agrees to hold harmless HCA and its employees, and all Consumers served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors.
- 9.5.26 A ninety (90) day termination notice provision.
- 9.5.27 A specific termination provision for termination with short notice when a Subcontractor is excluded from participation in the Medicaid program.
- 9.5.28 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.

- 9.5.29 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards. Formal review must be completed no less than once every three (3) years, except as noted below, and must identify deficiencies or areas for improvement and provide for corrective action.
- 9.5.29.1 The Contractor shall conduct a Subcontractor review which shall include at least one (1) onsite visit every two (2) years to each Subcontractor site providing State funded or FBG funded treatment services during the period of performance of this Contract in order to monitor and document compliance with requirements of the Subcontract.
  - 9.5.29.2 The Contractor shall ensure that Subcontractors have complied with data submission requirements established by HCA for all services funded under the Contract.
  - 9.5.29.3 The Contractor shall ensure that the Subcontractor updates patient funding information when the funding source changes.
  - 9.5.29.4 The Contractor shall maintain written or electronic records of all Subcontractor monitoring activities and make them available to HCA upon request.
  - 9.5.29.5 The Contractor shall monitor SUD and Mental Health residential providers on HCA selected performance-measures.
- 9.5.30 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.
- 9.5.30.1 The Contractor shall submit a copy of the A-133 audit performed by the State Auditor to the HCA Contact identified on page one of the Contract within ninety (90) days of receipt by the Contractor of the completed audit.
    - 9.5.30.1.1 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.
    - 9.5.30.1.2 If a Subcontractor is not subject to OMB Circular A-133, the Contractor shall perform subrecipient monitoring in compliance with federal requirements.
- 9.5.31 The Contractor shall document and confirm in writing all single-case agreements with providers. The agreement shall include:
- 9.5.31.1 The description of the services;
  - 9.5.31.2 The authorization period for the services, including the begin date and the end date for approved services;
  - 9.5.31.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other plan documents that define payment; and
  - 9.5.31.4 Any other specifics of the negotiated rate.

- 9.5.32 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).
- 9.5.33 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 Clear descriptions of any administrative functions delegated by the Contractor in the Subcontract. Administrative functions are any obligations of the Contractor under this Contract other than the direct provision of services to Consumers and include, but are not limited to: utilization/medical management, claims processing, Consumer grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.
  - 9.6.1.2 Provisions for revoking delegation or imposing sanctions if the Subcontractor's performance is inadequate.
- 9.6.2 Prior to delegation, an evaluation of the Subcontractor's ability to successfully perform and meet the requirements of this Contract for any delegated administrative function.
- 9.6.3 The Contractor shall submit a report of all current delegated entities, activities delegated, and the number of Consumers assigned or serviced by the delegated entity to the HCA as part of the annual monitoring review, or as required by the HCA.
- 9.6.4 A Subcontractor that is a provider of behavioral health services and providing behavioral health administrative functions has established a conflict of interest policy that:
  - 9.6.4.1 Requires screening of employees upon hire and board members at the time of initial appointment, and annually thereafter, for conflicts of interests related to performance of services under the Subcontract.
  - 9.6.4.2 Prohibits employees and/or board members from participating in actions which could impact or give the appearance of impacting a personal interest or the interest of any corporate, partnership or association in which the employee or board member is directly or indirectly involved.
  - 9.6.4.3 Prohibits access to information regarding proprietary information for other providers including, but not limited to: reimbursement rates, for any Subcontractor that provides behavioral health services and administrative services under the Contract.

## 9.7 Provider Education

- 9.7.1 The Contractor shall maintain a system for keeping participating providers informed about:
  - 9.7.1.1 Contracted services for Consumers served under this Contract.
  - 9.7.1.2 Coordination of care requirements.
  - 9.7.1.3 HCA and the Contractor's policies and procedures as related to this Contract.

- 9.7.1.4 Interpretation of data from the QI program.
- 9.7.1.5 Practice guidelines as described in the provisions of this Contract.
- 9.7.1.6 The information requirements for utilization management (UM) decision making, procedure coding, and submitting claims for GFS and FBG funded services. The Contractor shall inform GFS and FBG providers in writing regarding these requirements.
- 9.7.1.7 Contractor care management staff for assistance in care transitions and care management activity.
- 9.7.1.8 Program Integrity requirements.

## 9.8 Provider Payment Standards

- 9.8.1 The Contractor shall meet the timeliness of payment standards as specified in this section. To be compliant with payment standards the Contractor shall pay or deny, and shall require Subcontractors to pay or deny, ninety-five percent (95%) of clean claims and encounters within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) calendar days of receipt and ninety-nine percent (99%) of claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.
  - 9.8.1.1 A claim is a bill for services, a line item of service, or all services for one (1) Consumer within a bill.
  - 9.8.1.2 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.
  - 9.8.1.3 The date of receipt is the date the Contractor receives the claim or encounter from the provider.
  - 9.8.1.4 The date of payment is the date of the check or other form of payment.
- 9.8.2 The Contractor shall support both hardcopy and electronic submission of claims, encounters and bills for all Contracted Services types for which claims submission is required.
- 9.8.3 The Contractor must support hardcopy and electronic submission of claim, encounter or bill inquiry forms, and adjustment claims, encounters and bills.
- 9.8.4 The Contractor shall update its claims and encounter system to support processing of payments for the Contracted Services.
- 9.8.5 The Contractor shall conduct and submit to HCA an annual claims denial analysis report. The first report shall be due July 1, 2017, reflecting the April 1, 2016 through March 31, 2017 contract year and each successive year of the Contract. The report shall include the following data:
  - 9.8.5.1 Total number of claims denied by claim line.
  - 9.8.5.2 Total number of claims approved by claim line.
  - 9.8.5.3 Summary by reason type for claims denied.
  - 9.8.5.4 The proportion of aggregated top five (5) reasons for claims denied by claim line divided by total denied claim lines.

- 9.8.5.5 The proportion of claim lines denied in error and subsequently adjusted to total claims denied.
- 9.8.5.6 The total number of denied claims divided by the total number of claims.
- 9.8.5.7 The five (5) Subcontractors with the highest aggregated denied claim lines expressed as a ratio.
- 9.8.6 The report shall include a narrative, including the action steps planned to address:
  - 9.8.6.1 The top five (5) reasons for denial, including steps taken with the top
  - 9.8.6.2 five (5) Subcontractors to educate the Subcontractors on actions to address root causes of denied claims.
  - 9.8.6.3 Claims denied in error by the Contractor.

**9.9 Coordination of Benefits and Subrogation of Rights of Third Party Liability**

- 9.9.1 Coordination of Benefits:
  - 9.9.1.1 The services and benefits available under this Contract shall be secondary to any other medical coverage.
  - 9.9.1.2 Nothing in this section negates any of the Contractor’s responsibilities under this Contract. The Contractor shall:
    - 9.9.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in WAC 284-51.
    - 9.9.1.2.2 Attempt to recover any third-party resources available to Consumers and shall make all records pertaining to coordination of benefits collections for Consumers available for audit and review.
    - 9.9.1.2.3 Pay claims for contracted services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed
    - 9.9.1.2.4 Coordinate with out-of-network providers with respect to payment to ensure the cost to Consumers is no greater than it would be if the services were furnished within the network.
    - 9.9.1.2.5 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

**9.10 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).

- 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 shall verify that all Subcontractors meet the licensure and certification requirements as established by state and federal statute, administrative code, or as directed in this contract.
- 9.10.1.2 The Contractor shall recognize providers operating under the license of a licensed or certified agency.
- 9.10.1.3 The Contract shall verify that all Designated Mental Health Professionals and Designated Chemical Dependency Specialists are authorized as such by the county authorities.

## **10 CONSUMER RIGHTS AND PROTECTIONS**

### **10.1 General Requirements**

- 10.1.1 The Contractor shall comply with any applicable federal and State laws that pertain to Consumer rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to Consumers.
- 10.1.2 The Contractor shall require that all providers, including licensed agencies and their employees, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of a Consumer with respect to:
  - 10.1.2.1 The Consumer'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 Consumer needs in order to decide among all relevant mental health treatment options.
  - 10.1.2.4 The risks, benefits, and consequences of mental health and/or SUD treatment (including the option of no treatment).
  - 10.1.2.5 The Consumer's right to participate in decisions regarding his or her behavioral health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions.
  - 10.1.2.6 The Consumer's right to be treated with respect and with due consideration for his or her dignity and privacy.
  - 10.1.2.7 The Consumer'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 Consumer'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 Consumer'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 treats the Consumer.

- 10.1.3 The Contractor shall require a criminal history background check through the Washington State Patrol for employees and volunteers of the Contractor who may have unsupervised access to children, people with developmental disabilities or vulnerable adults, consistent with WAC 388-06-0170.

## 10.2 Ombuds

- 10.2.1 The Contractor shall provide a regional behavioral health ombuds as described in WAC 388-865-0250 and RCW 71.24. The ombuds must provide for the following:
- 10.2.1.1 Separation of personnel functions (e.g., hiring, salary and benefits determination, supervision, accountability and performance evaluations).
  - 10.2.1.2 Independent decision making to include all investigation activities, findings, recommendations and reports.
  - 10.2.1.3 Is responsive to the age and demographic character of the region and assists and advocates for consumers with resolving complaints and grievances at the lowest possible level.
  - 10.2.1.4 Is independent of service providers.
  - 10.2.1.5 Receives and investigates consumer, family member, and other interested party complaints and grievances.
  - 10.2.1.6 Is accessible to consumers, including a toll-free, independent phone line for access.
  - 10.2.1.7 Is able to access service sites and records relating to the consumer with appropriate releases so that it can reach out to consumers, and resolve complaints and/or grievances.
  - 10.2.1.8 Receives training and adheres to confidentiality consistent with this chapter and chapters 71.05, 71.24, and 70.02 RCW.
  - 10.2.1.9 Continues to be available to investigate, advocate and assist the consumer through the grievance and administrative hearing processes.
  - 10.2.1.10 Involves other persons, at the consumer's request.
  - 10.2.1.11 Assists consumers in the pursuit of formal resolution of complaints.
  - 10.2.1.12 If necessary, continues to assist the consumer through the fair hearing processes.
  - 10.2.1.13 Coordinates and collaborates with allied systems' advocacy and ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared clients.
  - 10.2.1.14 Provides reports and formalized recommendations at least biennially to the Community Mental Health Advisory Board.

## 10.3 Cultural Considerations

- 10.3.1 The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- 10.3.2 At a minimum, the Contractor shall:
- 10.3.2.1 Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each Consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation. (CLAS Standard 4);
  - 10.3.2.2 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. (CLAS Standard 5);
  - 10.3.2.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally, and in writing. (CLAS Standard 6);
  - 10.3.2.4 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. (CLAS Standard 7);
  - 10.3.2.5 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. (CLAS 8);
  - 10.3.2.6 Establish culturally and linguistically appropriate goals. (CLAS Standard 9);
  - 10.3.2.7 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (CLAS 11); and
  - 10.3.2.8 Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints. (CLAS 14).

#### 10.4 **Mental Health Advance Directive**

- 10.4.1 The Contractor shall maintain a written mental health advance directive policy and procedure that respects individuals' advance directive for behavioral health care. Policy and procedures must comply with RCW 71.32.
- 10.4.2 The Contractor shall inform all Consumers and individuals with a history of frequent crisis system utilization of their right to a mental health advance directive and shall provide technical assistance to those who express an interest in developing and maintaining a mental health advance directive.
- 10.4.3 The Contractor shall maintain current copies of any mental health advance directive in the Consumer's and individuals' with a history of frequent crisis system utilization records.

- 10.4.4 The Contractor shall inform Consumers and individuals with a history of frequent crisis system utilization that complaints concerning noncompliance with a mental health advance directive should be referred to the Department of Health by calling 1-360-236-2620 or by following the written instructions contained in the mental health benefit booklet.

#### **10.5 Consumer Choice of Behavioral Health Provider**

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

#### **10.6 Consumer Charges for Contracted Services**

- 10.6.1 Under no circumstances shall the Contractor deny the provision of mental health crisis services, evaluation and treatment services, involuntary treatment act services, or SUD involuntary commitment services, to a Consumer due to the Consumer's ability to pay.
- 10.6.2 Providers may develop a sliding fee schedule for Consumers to pay for services that is reviewed and approved by the Contractor.
- 10.6.3 In developing sliding fee schedules, providers shall comply with the following:
- 10.6.3.1 Put the sliding fee schedule in writing that is non-discriminatory;
  - 10.6.3.2 Include language in the sliding fee schedule that no individual shall be denied services due to inability to pay;
  - 10.6.3.3 Provide signage and information to Consumers to educate them on the sliding fee schedule;
  - 10.6.3.4 Protect Consumers' privacy in assessing Consumer fees;
  - 10.6.3.5 Maintain records to account for each Consumer's visit and any charges incurred;
  - 10.6.3.6 Charge Consumers at or below one hundred percent (100%) FPL a nominal fee or no charge at all;
  - 10.6.3.7 Develop at least three (3) incremental amounts on the sliding fee scale for Consumers between 101-220% FPL.

#### **10.7 Consumer Self-Determination**

The Contractor shall ensure that all providers:

- 10.7.1 Obtain informed consent prior to treatment from Consumers, or persons authorized to consent on behalf of a Consumer as described in RCW 7.70.065;
- 10.7.2 Comply with the provisions of the Natural Death Act (Chapter 70.122 RCW) and State rules concerning advance directives (WAC 182-501-0125); and,
- 10.7.3 When appropriate, inform Consumers of their right to make anatomical gifts (Chapter 68.64 RCW).

### **11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES**

## 11.1 Utilization Management Requirements

- 11.1.1 The Contractor's Behavioral Health Medical Director will provide guidance, leadership and oversight of the Contractor's utilization management (UM) program for Contracted Services utilized by Consumers. These following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the Behavioral Health Medical Director to oversee:
  - 11.1.1.1 Processes for evaluation and referral to services.
  - 11.1.1.2 Review of consistent application of criteria for provision of services within Available Resources and related Complaints and Grievances.
  - 11.1.1.3 Review of assessment and treatment services against clinical practice standards. Clinical practice standards include, but are not limited to evidenced-based practice guidelines, culturally appropriate services, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals.
  - 11.1.1.4 Monitoring for over-utilization and under-utilization of services, including Crisis Services.
  - 11.1.1.5 Ensuring that resource management and UM activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue Medically Necessary behavioral health services inconsistent with the Contractors policy and 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 FBG funds. The UM protocols shall comply with the following provisions.
  - 11.1.2.1 The Contractor must have policies and procedures that establish a standardized methodology for determining when GFS and FBG resources are available for the provision of behavioral health services. The methodology shall include the following components:
    - 11.1.2.1.1 The review may be an aggregate review of spending across GFS and SAPT fund sources under the Contract.
    - 11.1.2.1.2 For any case specific review decisions, the Contractor shall maintain Level of Care Guidelines for making authorization, continued stay and discharge determinations. The Level of Care Guidelines shall address GFS and SAPT priority populations requirements. The Contractor shall ensure use of ASAM Level of Care Guidelines to make placement decisions for all SUD services.
    - 11.1.2.1.3 A plan to address under- or over-utilization patterns with any provider to avoid unspent funds or gaps in service at the end of a contract period due to limits in Available Resources.
    - 11.1.2.1.4 Education and technical assistance to address issues related to quality of care, medical necessity, timely and accurate claims submission or aligning service utilization with allocated funds to avoid disruption in service or unspent funds at the end of a contract year.

- 11.1.2.1.5 Corrective action with providers, as necessary, to address issues with compliance with State and federal regulations or ongoing issues with patterns of service utilization.
- 11.1.2.1.6 A process to make payment denials and adjustments when patterns of utilization deviate from State, federal or Contract requirements (e.g., single source funding).
- 11.1.2.2 The Contractor shall monitor provider discharge planning to ensure providers meet contractual requirements for discharge planning defined in Section 9.5.3 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 which they are authorizing and managing including, but not limited to co-occurring mental health and SUDs, co-occurring behavioral health and medical diagnoses, and co-occurring behavioral health and I/DD.
- 11.1.5 The Contractor's policies and procedures related to UM shall comply with, and require the compliance of Subcontractors with delegated authority for UM requirements described in this section.
- 11.1.6 The Contractor shall develop and maintain a Utilization Management Program (UMP) description and policies and procedures that include the following components:
  - 11.1.6.1 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 by fund source (i.e., GFS SAPT block grant).
    - 11.1.6.1.2 Service dollars expended as a percent of grant allocation by service type, by provider and in aggregate by fund source.
    - 11.1.6.1.3 Number of FBG providers at or above capacity by service type.
    - 11.1.6.1.4 Number of providers identified as outliers by service type and by fund source.
    - 11.1.6.1.5 Number of provider interventions by type of intervention (e.g., education, technical assistance, corrective action).
    - 11.1.6.1.6 Other GFS and FBG reporting requirements as determined by HCA and the Secretary of DSHS.
- 11.1.7 Authorization reviews shall be conducted by WA 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
  - 11.1.8.3 A licensed, doctoral level psychologist.
- 11.1.9 The Contractor shall ensure that any behavioral health clinical peer reviewer who is subcontracted or works in a service center other than the Contractor's Washington State service center shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center, to include participation in initial orientation and at least annual training on Washington State specific benefits, protocols and initiatives.
- 11.1.10 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:
- 11.1.10.1 A physician board-certified or board-eligible in General Psychiatry must review all inpatient level of care actions (denials) for psychiatric treatment.
  - 11.1.10.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry; must review all inpatient level of care actions (denials) for SUD treatment.
- 11.1.11 The Contractor shall ensure that appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the person's condition or disease.
- 11.1.11.1 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.
- 11.1.12 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 and hearings.

## 11.3 Authorization of Services

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

## 11.4 Timeframes for Authorization Decisions

- 11.4.1 The Contractor must provide a written Notice of Determination to the Consumer, or their legal representative, if a denial, reduction, termination or suspension occurs based on the Level of Care Guidelines. The Contractor shall adhere to the requirements set forth in 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.
- 11.4.2 The Contractor shall provide for the following timeframes for authorization decisions and notices:
  - 11.4.2.1 For denial of payment that may result in payment liability for the Consumer, at the time of any action affecting the claim.
  - 11.4.2.2 For termination, suspension, or reduction of previously contracted services, ten (10) calendar days prior to such termination, suspension, or reduction, except if the criteria stated in 42 C.F.R. § 431.213 and 431.214 are met.
    - 11.4.2.2.1 Expedited authorization decisions shall be made within twenty-four (24) hours for of a request for emergency services.
  - 11.4.2.3 For post-service authorizations, the Contractor must make its determination within thirty (30) calendar days of receipt of the authorization request.
    - 11.4.2.3.1 The Contractor shall notify the Consumer and the requesting provider within two (2) business days of the Contractor's determination.
    - 11.4.2.3.2 Standard appeal timeframes apply to post-service denials.
    - 11.4.2.3.3 When post-service authorizations are approved they become effective the date the service was first administered.

## 11.5 Notification of Coverage and Authorization Determinations

- 11.5.1 For all Actions the Contractor shall:
  - 11.5.1.1 Notify the Consumer in writing, and shall do so within 72 hours of the decision. However, if the action was involving an expedited authorization, the Contractor may provide oral notice in addition to the written notice.
  - 11.5.1.2 Notify parties, other than the Consumer, in advance, but may provide notification by phone, mail, fax, or other means.
  - 11.5.1.3 The Contractor must notify the Consumer in writing of the decision. For an adverse authorization decision involving an expedited authorization request the Contractor may initially provide notice orally. For all actions, the Contractor shall provide written notification within seventy-two (72) hours of the decision (WAC 284-43-410).
  - 11.5.1.4 The Contractor shall give notice at least five (5) calendar days before the date of action when the action is a termination, suspension or reduction of previously authorized services when Consumer fraud has been verified.
  - 11.5.1.5 The notice shall explain the following:
    - 11.5.1.5.1 The action the Contractor has taken or intends to take.
    - 11.5.1.5.2 The reasons for the action, in easily understood language and citation to any Contractor guidelines, protocols, or other criteria, on which the decision was based in whole or in part, and how to access the guidelines.
    - 11.5.1.5.3 A statement of whether the Consumer has any liability for payment
    - 11.5.1.5.4 Information regarding whether and how the Consumer may appeal the decision.
    - 11.5.1.5.5 Assistance in filing an appeal and how to request it, including access to services for Consumers with communication barriers or disabilities.
    - 11.5.1.5.6 The availability of Washington's designated ombuds' office.
- 11.5.2 The Contractor shall provide notification in accord with the timeframes described in Section 11.5.1 in the following circumstances:
  - 11.5.2.1 The Consumer dies;
  - 11.5.2.2 The Contractor has a signed written Consumer statement requesting service termination or giving information requiring termination or reduction of services (where the Consumer understands that termination, reduction, or suspension of services is the result of supplying this information);
  - 11.5.2.3 The Consumer is admitted to an institution where he or she is ineligible for services;
  - 11.5.2.4 The Consumer's address is unknown and mail directed to him or her has no forwarding address;
  - 11.5.2.5 The Consumer has moved out of the Contractor's service area;

- 11.5.2.6 The Consumer prescribes the change in the level of medical care;
- 11.5.2.7 Untimely Service Authorization Decisions: When the Contractor does not reach service authorization decisions within the timeframes for either standard or expedited service authorizations it is considered a denial and thus, an adverse action.

## **12 PROGRAM INTEGRITY**

### **12.1 General Requirements**

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

### **12.2 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 perform ongoing analysis of its claims, billing, and/or encounter data to detect overpayments, and shall perform audits and investigations of Subcontractor providers and provider entities. 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.
  - 12.2.1.1 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.

### **12.3 Information on Persons Convicted of Crimes**

- 12.3.1 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:
  - 12.3.1.1 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)]:

### **12.4 Fraud and Abuse**

- 12.4.1 The Contractor's Fraud and Abuse program shall have:
  - 12.4.1.1 A process to inform officers, employees, agents and subcontractors regarding the False Claims Act.
  - 12.4.1.2 Administrative and management arrangements or procedures, and a mandatory compliance plan.

- 12.4.1.3 Standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards.
- 12.4.1.4 The designation of a compliance officer and a compliance committee that is accountable to senior management.
- 12.4.1.5 Effective training for all affected parties.
- 12.4.1.6 Effective lines of communication between the compliance officer and the Contractor's staff and Subcontractors.
- 12.4.1.7 Enforcement of standards through well-publicized disciplinary guidelines.
- 12.4.1.8 Provision for internal monitoring and auditing.
- 12.4.1.9 Provision for prompt response to detected offenses, and for development of corrective action initiatives.
- 12.4.1.10 Provision of detailed information to employees and Subcontractors regarding fraud and abuse policies and procedures and the False Claims Act and the Washington false claims statutes, Chapter 74.66 RCW and RCW 74.09.210.

## 12.5 Reporting

- 12.5.1 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.
- 12.5.2 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.
- 12.5.3 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 Consumer fraud by:
  - 12.5.3.1 Calling the Welfare Fraud Hotline at 1-800-562-6906 and pressing option "1" to report Welfare Fraud by leaving a detailed voice mail message;
  - 12.5.3.2 Mailing a written complaint to:
    - Welfare Fraud Hotline
    - P.O. Box 45817
    - Olympia, WA 98504-5817
  - 12.5.3.3 Entering the complaint online at: <https://fortress.wa.gov/dshs/dshsroot/fraud/index.asp>;
  - 12.5.3.4 Faxing the written complaint to Attention Hotline at 360-664-0032; OR
  - 12.5.3.5 Emailing the complaint electronically to the DSHS OFA Hotline at [Hotline@dshs.wa.gov](mailto:Hotline@dshs.wa.gov).
- 12.5.4 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](mailto:hcamcprograms@hca.wa.gov) with subject "Program Integrity Monthly list of Involuntary Terminations Report." The report must include all of the following:

- 12.5.4.1 Individual provider/entities' name;
- 12.5.4.2 Individual provider/entities' NPI number;
- 12.5.4.3 Source of involuntary termination;
- 12.5.4.4 Nature of the involuntary termination; and
- 12.5.4.5 Legal action against the individual/entities.

## 12.6 Records Requests

- 12.6.1 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.
- 12.6.2 The Contractor or Subcontractor shall furnish all records pertaining to this Contract upon request.

## 12.7 On-Site Inspections

- 12.7.1 The Contractor and its Subcontractors must provide any record or data pertaining to this Contract including, but not limited to:
  - 12.7.1.1 Medical records;
  - 12.7.1.2 Billing records;
  - 12.7.1.3 Financial records;
  - 12.7.1.4 Any record related to services rendered, quality, appropriateness, and timeliness of service; and
  - 12.7.1.5 Any record relevant to an administrative, civil or criminal investigation or prosecution.
- 12.7.2 If these records must be evaluated, inspected, or reviewed, the Contractor or Subcontractor shall immediately provide the records.
- 12.7.3 Upon request, the Contractor or Subcontractor shall assist in such review, including the provision of complete copies of records.
- 12.7.4 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, and access to the hearing process for Contracted Services. NOTE: Provider claim disputes initiated by the provider are not subject to this section.

- 13.1.1 The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Contract. HCA must approve, in writing, all grievance system policies and procedures and related notices to Consumers regarding the grievance system.
- 13.1.2 The Contractor shall give Consumers any reasonable assistance necessary in completing forms and other procedural steps for grievances and appeals.
- 13.1.3 The Contractor shall acknowledge receipt of each grievance, either orally or in writing, within two (2) business days.
- 13.1.4 The Contractor shall acknowledge in writing, the receipt of each appeal. The Contractor shall provide the written notice to both the Consumer and requesting provider within seventy-two (72) hours of receipt of the appeal.
- 13.1.5 The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making .
- 13.1.6 Decisions regarding grievances and appeals shall be made by Health Care Professionals with clinical expertise in treating the Consumer's condition or disease if any of the following apply:
  - 13.1.6.1 If the Consumer is appealing an action.
  - 13.1.6.2 If the grievance or appeal involves any clinical issues.
- 13.1.7 With respect to any decisions described in 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 Consumer's condition or disease that is age appropriate (e.g., a pediatric psychiatrist for a child Consumer).
  - 13.1.7.2 A physician board-certified or board-eligible in General Psychiatry or Child Psychiatry if the grievance or appeal is related to inpatient level of care denials for psychiatric treatment.
  - 13.1.7.3 A physician board-certified or board-eligible in Addiction Medicine or a Sub-specialty in Addiction Psychiatry, if the grievance or appeal is related to inpatient level of care denials for SUD treatment.
  - 13.1.7.4 Are one or more of the following, as appropriate, if a clinical grievance or appeal is not related to inpatient level of care denials for psychiatric or SUD treatment:
    - 13.1.7.4.1 Physicians board-certified or board-eligible in Psychiatry, Addiction Medicine or a sub-specialty in Addiction Psychiatry;
    - 13.1.7.4.2 Licensed, doctoral level psychologists; or
    - 13.1.7.4.3 Pharmacists.

## 13.2 Grievance Process

The following requirements are specific to the grievance process:

- 13.2.1 Only a Consumer or the Consumer's authorized representative may file a grievance with the Contractor; a provider may not file a grievance on behalf of a Consumer unless the provider is acting on behalf of the Consumer and with the Consumer's written consent.

- 13.2.1.1 The Contractor shall request the Consumer's written consent should a provider request an appeal on behalf of a Consumer without the Consumer's written consent.
- 13.2.2 The Contractor shall accept, document, record, and process grievances forwarded by HCA or DSHS.
- 13.2.3 The Contractor shall provide a written response to HCA within three (3) business days to any constituent grievance. For the purpose of this subsection, "constituent grievance" means a complaint or request for information from any elected official or agency director or designee.
- 13.2.4 The Contractor shall assist the Consumer with all grievance and appeal processes.
- 13.2.5 The Contractor shall cooperate with any representative authorized in writing by the covered Consumer.
- 13.2.6 The Contractor shall consider all information submitted by the covered person or representative.
- 13.2.7 The Contractor shall investigate and resolve all grievances whether received orally or in writing. The Contractor shall not require a Consumer or his/her authorized representative to provide written follow up for a grievance or appeal the Contractor received orally.
- 13.2.8 The Contractor shall complete the disposition of a grievance and notice to the affected parties as expeditiously as the Consumer's health condition requires, but no later than forty-five (45) calendar days from receipt of the grievance.
- 13.2.9 The Contractor must notify Consumers of the disposition of grievances within five (5) business days of determination. The notification may be orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.
- 13.2.10 Consumers do not have the right to a hearing in regard to the disposition of a grievance.

### 13.3 Appeal Process

The following requirements are specific to the appeal process:

- 13.3.1 A Consumer, the Consumer's authorized representative, or a provider acting on behalf of the Consumer and with the Consumer's written consent, may appeal a Contractor action.
- 13.3.2 If HCA receives a request to appeal an action of the Contractor, HCA will forward relevant information to the Contractor, and the Contractor will contact the Consumer.
- 13.3.3 A Consumer 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 Contractor to a Consumer shall serve as written confirmation of an appeal filed orally by a Consumer.
- 13.3.5 The appeal process shall provide the Consumer a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Consumer of the limited time available.

- 13.3.6 The appeal process shall provide the Consumer and the Consumer's representative opportunity, before and during the appeals process, to examine the Consumer's case file, including medical records, and any other documents and records considered during the appeal process.
- 13.3.7 The appeal process shall include as parties to the appeal, the Consumer and the Consumer's representative, or the legal representative of the deceased Consumer's estate.
- 13.3.8 In any appeal of an action by a Subcontractor, the Contractor or its Subcontractor shall apply the Contractor's own clinical practice guidelines, standards, protocols, or other criteria that pertain to the medical necessity determination.
- 13.3.9 The Contractor shall resolve each appeal and provide notice, as expeditiously as the Consumer'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 Consumer requests the extension; or the Contractor shows there is a need for additional information and how the delay is in the Consumer's interest.
- 13.3.11 For any extension not requested by a Consumer, the Contractor must give the Consumer 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 Consumer 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 Consumer may obtain the UMP clinical review or decision-making criteria.
  - 13.3.12.4 For appeals not resolved wholly in favor of the Consumer, include information on the Consumer's right to request a hearing and how to do so.

#### **13.4 Administrative Hearing**

- 13.4.1 Only the Consumer or the Consumer's authorized representative may request a hearing. A provider may not request a hearing on behalf of a Consumer.
- 13.4.2 If a Consumer does not agree with the Contractor's resolution of the appeal, the Consumer may file a request for a hearing within ninety (90) calendar days of the date of notice of the resolution of the appeal (See WAC 182-526-0200). The Contractor will not be obligated to continue services pending the results of the hearing.
- 13.4.3 If the Consumer requests a hearing, the Contractor shall provide to HCA and the Consumer, upon request, and within three (3) working days, all Contractor-held documentation related to the appeal, including, but not limited to: any transcript(s), records, or written decision(s) from participating providers or delegated entities.
- 13.4.4 The Contractor is an independent party and is responsible for its own representation in any hearing, Board of Appeals, and subsequent judicial proceedings.
- 13.4.5 The Contractor's Behavioral Health Medical Director or designee shall review all cases where a hearing is requested and any related appeals.

- 13.4.6 The Consumer must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a hearing with HCA.
- 13.4.7 The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision.
- 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 Consumer and the Consumer's representative, or the legal representative of the deceased Consumer's estate and HCA.

### **13.5 Petition for Review**

Any party may appeal the initial order from the administrative hearing to HCA Board of Appeals in accord with Chapter 182-526 WAC. Notice of this right shall be included in the Initial Order from the administrative hearing.

### **13.6 Effect of Reversed Resolutions of Appeals and Hearings**

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

### **13.7 Recording and Reporting Actions, Grievances, Appeals and Independent Reviews**

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

- 13.7.1 The records shall include actions, grievances and appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of responding to such actions, grievances, and appeals.
- 13.7.2 The Contractor shall provide separate reports of all actions, grievances, and appeals related to Contracted Services to HCA in accord with the Grievance System Reporting Requirements published by HCA.
- 13.7.3 The Contractor is responsible for maintenance of records for and reporting of any grievance, actions, and appeals handled by delegated entities.
- 13.7.4 Delegated actions, grievances, and appeals are to be integrated into the Contractor's report.
- 13.7.5 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.
- 13.7.6 The report medium shall be specified by HCA and shall be in accord with the Grievance System Reporting Requirements published by HCA.
- 13.7.7 Reporting of actions shall include all medical necessity determinations but will not include denials of payment to providers unless the Consumer is liable for payment in accord with WAC 182-502-0160 and the provisions of this Contract.
- 13.7.8 The Contractor shall provide information to HCA regarding denial of payment to providers upon request.

- 13.7.9 Reporting of grievances shall include all expressions of Consumer dissatisfaction not related to an action. All grievances are to be recorded and counted whether the grievance is remedied by the Contractor immediately or through its grievance and quality of care service procedures.

### **13.8 Grievance System Terminations**

When Available Resources are exhausted, any appeals or hearing process related to a request for authorization of a non-crisis Contracted Service will be terminated since non-crisis services cannot be authorized without funding regardless of medical necessity.

## **14 CARE MANAGEMENT AND COORDINATION**

### **14.1 General Requirements**

- 14.1.1 The Contractor shall develop strategies that promote high quality and efficient care for the whole person. Considerations shall include use of GFS/SAPT funds to support provision of care to Consumers in alternative settings (e.g., in homeless shelters, permanent supported housing, nursing homes or group homes).

### **14.2 Care Coordination Requirements**

- 14.2.1 The Contractor shall develop and implement protocols that promote coordination, continuity, and quality of care that address the following:
- 14.2.1.1 Strategies to reduce unnecessary crisis system utilization as defined in Section 17.
  - 14.2.1.2 Facilitate sharing of information, and care transitions among various settings, for example, jails, prisons, hospitals and residential treatment centers, detoxification and sobering centers, and homeless shelters with appropriate Consumer authorizations. Facilitate coordination between service providers for Consumers with complex behavioral health and medical needs.
  - 14.2.1.3 Facilitate Continuity of Care, within Available Resources, for Consumers in an active course of treatment for an acute or chronic behavioral health condition, including preserving Consumer-provider relationships through transitions.

### **14.3 Coordination with External Entities**

- 14.3.1 The Contractor shall appropriately coordinate with external entities including, but not limited to:
- 14.3.1.1 Behavioral Health Organizations for transfers between regions;
  - 14.3.1.2 Apple Health Managed Care plans to support or facilitate enrollment of individuals who are potentially eligible for Medicaid;
  - 14.3.1.3 Tribal entities regarding tribal members who access the crisis system;
  - 14.3.1.4 Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHC);
  - 14.3.1.5 Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections, juvenile justice system);

- 14.3.1.6 Department of Social and Health Services;
  - 14.3.1.7 State and/or federal agencies and local partners that manage access to housing; and
  - 14.3.1.8 Education systems, to assist in planning for local ESD threat assessment process;
  - 14.3.1.9 Accountable Community of Health;
  - 14.3.1.10 First responders as identified in Section 17.
- 14.3.2 The Contractor shall coordinate the transfer of Consumer information, including initial assessments and care plans, with other Contractors and BHOs as needed when a Consumer moves between regions and/or gains or loses Medicaid eligibility, to reduce duplication of services and unnecessary delays in service provision.
- 14.3.3 The Contractor shall participate in disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by HCA, county, or local public health jurisdiction. . The Contractor shall include attending State-sponsored training, participating in emergency/disaster preparedness planning when requested by the county or local public health jurisdictions in the region and providing disaster outreach and post-disaster outreach in the event of a disaster/emergency.

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

- 14.4.1 The Contractor shall collaborate with child serving systems.
- 14.4.1.1 Participate in CFTs for children who are enrolled in WISe and served by the Contractor.
  - 14.4.1.2 Participate in the implementation of a consistent CFT protocol under the timelines and guidance published by DSHS.
  - 14.4.1.3 Participate in the development of a plan of care for Transitional Age Youth 16 – 21. The Contractor shall refer potentially CLIP eligible children to the CLIP Administration.

**14.5 Care Coordination and Continuity of Care: State Hospitals**

- 14.5.1 The Contractor shall abide by HCA agreements for transition from the State Hospitals as they currently exist or are modified in the future. The agreement will address, at a minimum protocols and timelines for referrals to/from the Contractor, State Hospital diversion, exchange of information, discharge planning and problem resolution.
- 14.5.1.1 The Contractor's daily allocation of State Hospital beds will be as stated in Exhibit B. *(Editorial Note: If Exhibit B is not provided with the RFP, it will be provided and posted upon receipt, with a final updated version prior to Contract execution.)*

- 14.5.1.2 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.
- 14.5.1.3 If a request comes in after the thirtieth (30<sup>th</sup>) day of admission and is granted, the effective date of the reassignment will be based on the date HCA receives the reassignment request form.
- 14.5.1.4 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.
- 14.5.2 The Contractor shall ensure Consumers are medically cleared, if possible, prior to admission to a State Psychiatric Hospital.
- 14.5.3 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, within Available Resources.
- 14.5.4 The Contractor or its designee shall monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 to ensure compliance with LRA requirements.
- 14.5.5 The Contractor shall offer mental health services to individuals who are ineligible for Medicaid to ensure compliance with LRA requirements.
- 14.5.6 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 individuals who are ineligible for Medicaid, to ensure compliance with CR requirements.
- 14.5.7 The Contractor ensures provision of mental health services to Consumers that are ineligible for Medicaid on a Conditional Release under RCW 10.77.150.
- 14.5.8 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:
  - 14.5.8.1 Specific roles and responsibilities of the parties related to transitions between the community and the hospital.
  - 14.5.8.2 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.
  - 14.5.8.3 Collaborative discharge planning and coordination with cross-system partners.
  - 14.5.8.4 Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's Service Area.

- 14.5.8.5 When individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the Contractor shall:
  - 14.5.8.5.1 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.
  - 14.5.8.5.2 When the individual meets access to care criteria, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement.
- 14.5.9 Uniform Transfer Agreement - Eastern and Western State Hospital Inter-RSA Transfer Protocol
  - 14.5.9.1 This section describes the inter-RSA transfer process for individuals preparing for discharge from a state hospital, and who require specialized non-Medicaid resources.
  - 14.5.9.2 Generally, individuals are discharged back to the Regional Service Area they resided prior to their hospitalization.
  - 14.5.9.3 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).
  - 14.5.9.4 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.
  - 14.5.9.5 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.
  - 14.5.9.6 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.
  - 14.5.9.7 The Referring BHO or MCO will remain the primary contact for the state hospital social worker and the individual until the placement is completed.
  - 14.5.9.8 The Receiving BHO or MCO will supply the state hospital social worker with options for community placement at discharge.
  - 14.5.9.9 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).
  - 14.5.9.10 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.

- 14.5.9.11 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.

## **15 GENERAL REQUIREMENTS AND BENEFITS**

### **15.1 Special Provisions Regarding Behavioral Health Benefits**

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

- 15.1.1 Unless otherwise noted, crisis triage and referral personnel, and required behavioral health personnel shall be located in Washington State.
  - 15.1.1.1 Outside of business hours, prior authorization for services 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 contracted services, managed care rules, UM protocols, and Level of Care Guidelines.
  - 15.1.1.2 Crisis system operations must be located in Washington during and after business hours. Telephone crisis intervention and triage services may be located in a border state only on an exception basis when prior approved by the HCA and the following conditions are met.
    - 15.1.1.2.1 The location of the telephone crisis intervention and triage services is within two hundred (200) miles of the Contractor's service area.
    - 15.1.1.2.2 Call center staff located in a border state must receive sufficient training to ensure adequate knowledge of the Contractor's operating policies and procedures and Washington's behavioral health service delivery system including, but not limited to regional network and community resources, practice patterns, culture, and other relevant factors.
    - 15.1.1.2.3 A Washington State BHP shall be available on-call to provide ongoing training and consultation to telephone crisis intervention and triage service provider located in a border state regarding changes in operating policies and procedures and service area resources.
    - 15.1.1.2.4 The same staffing requirements as defined in Section 16.2 and the same performance metrics apply regardless of the location of call center operations.
  - 15.1.1.3 Data management and reporting, claims and financial management may be located out of Washington State. If claims are administered in another location, provider relations staff shall have access to the claims payment and reporting platform during PST business hours.

- 15.1.2 Unless otherwise noted, utilization review and mental health crisis services shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.
- 15.1.3 The Contractor shall designate employees who fulfill the following behavioral health key functions:
  - 15.1.3.1 A Behavioral Health Medical Director.
  - 15.1.3.2 A Behavioral Health Clinical Director.
- 15.1.4 The Contractor will designate employees who fulfill following behavioral health managerial functions:
  - 15.1.4.1 A Behavioral Health Crisis Triage Administrator.
  - 15.1.4.2 A Behavioral Health Utilization/Care Management Administrator.
  - 15.1.4.3 A Behavioral Health Network Development Administrator.
  - 15.1.4.4 A Behavioral Health Provider Relations Administrator
  - 15.1.4.5 A Behavioral Health Children's Specialist.
  - 15.1.4.6 An Addictions Specialist.
- 15.1.5 In addition to the key and managerial staff, the Contractor shall have a sufficient number of qualified operational staff to meet its responsibilities under the Contract.
  - 15.1.5.1 The Contractor should have a sufficient number of staff available twenty-four (24) hours, seven (7) days per week, three hundred sixty-five (365) days per year to handle crisis calls, warm-line transfer and triage, and sufficient Designated Mental Health Professionals and Designated Chemical Dependency Specialists to respond to requests for SUD involuntary commitment Services and Mental Health ITA services. Crisis triage staff shall have training in crisis triage and management for individuals of all ages and behavioral health conditions, including SMI, SUDs, and co-occurring disorders.
  - 15.1.5.2 The Contractor shall have access to physician or a mental health nurse practitioner advisers to address specialized needs of callers experiencing crises, and to provide assistance with crisis triage, referral, and resolution.
  - 15.1.5.3 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.
    - 15.1.5.3.1 Clinical peer reviewers may be a Subcontractor or located outside of Washington State but shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center, to include participation in initial orientation and at least annual training on Washington State-specific benefits, protocols, and initiatives.

- 15.1.5.4 The Contractor shall ensure that staffing is sufficient to support behavioral health data analytics and behavioral health data systems, including Federal Block Grant reporting requirements, to oversee all data interfaces and support the behavioral health specific reporting requirements under the Contract.
- 15.1.5.5 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.
- 15.1.6 The Contractor shall develop and maintain a human resources and staffing plan that describe how the Contractor will maintain adequate staffing.
  - 15.1.6.1 The Contractor shall hire employees for the key and required behavioral health functions specified in the Contract.
  - 15.1.6.2 The Contractor shall develop and implement staff training plans that address how all staff will be trained on the requirements of this Contract.
  - 15.1.6.3 The Contractor must locate a sufficient number of Provider Relations staff within the State to meet requirements under this Contract for provider education, training and performance management, including FBG requirements related to pregnant women with intravenous drug use, pregnant women with a SUD, and other individuals with intravenous drug use and scientifically sound outreach models for intravenous drug users.
- 15.1.7 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 Consumers. The Contractor must also work closely with the regional 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.

## 15.2 Scope of Services

- 15.2.1 The Contractor may limit the provision of contracted services to participating providers except crisis services specifically provided in this Contract.
- 15.2.2 Outside the Service Areas
  - 15.2.2.1 The Contractor is responsible for telephone crisis intervention and triage services for Consumers who are temporarily outside the service area.
  - 15.2.2.2 The Contractor is not responsible for coverage of any services other than telephone crisis intervention and triage services when a Consumer is outside the service area.
  - 15.2.2.3 The Contractor is not responsible for coverage of any services when a Consumer is outside the United States of America and its territories and possessions.

### 15.3 General Description of Contracted Services

- 15.3.1 After prioritization of state funding for mental health crisis services, Evaluation and Treatment Services for individuals who are not eligible for Medicaid, and services related to the administration of RCWs 71.05, 71.34 and 70.96A, Available Resources shall be used to cover the following services for the priority populations defined in Section 6.5.1 of the Contract. Refer to Section 16 for additional Crisis and ITA services requirements.
- 15.3.2 The Contractor shall establish and apply medical necessity criteria for the provision or denial of the following services.
  - 15.3.2.1 Assessment – SUD Adult, PPW and Youth (GFS and SAPT).
  - 15.3.2.2 Brief Intervention (GFS and SAPT).
  - 15.3.2.3 Brief Outpatient Treatment (GFS and SAPT).
  - 15.3.2.4 Case Management – SUD Adult, PPW and Youth (GFS and SAPT).
  - 15.3.2.5 Day Support (GFS only).
  - 15.3.2.6 Engagement and Referral (GFS and SAPT)
  - 15.3.2.7 Evidenced Based/Wraparound Services (GFS only).
  - 15.3.2.8 Interim Services (GFS and SAPT).
  - 15.3.2.9 Opiate Dependency/HIV Services Outreach (GFS and SAPT).
  - 15.3.2.10 Evaluation and Treatment (E&T) Services provided at Community Hospitals or Freestanding Evaluation and Treatment facilities (GFS only).
  - 15.3.2.11 Family Treatment (GFS only).
  - 15.3.2.12 Group Therapy – SUD Adult, PPW and Youth (GFS and SAPT).
  - 15.3.2.13 High Intensity Treatment (GFS only).
  - 15.3.2.14 Individual Therapy – SUD Adult, PPW and Youth (GFS and SAPT).
  - 15.3.2.15 Inpatient Psychiatric Services (GFS only).
  - 15.3.2.16 Intake Evaluation (GFS only).
  - 15.3.2.17 Intensive Outpatient Treatment – SUD (GFS and SAPT)
  - 15.3.2.18 Intensive Inpatient Residential Treatment Services – SUD (GFS and SAPT)
  - 15.3.2.19 Long Term Care Residential – SUD (GFS and SAPT)
  - 15.3.2.20 Medication Management (GFS only).
  - 15.3.2.21 Medication Monitoring (GFS only).
  - 15.3.2.22 Mental Health Residential (GFS only).
  - 15.3.2.23 Opiate Substitution Treatment (GFS and SAPT).
  - 15.3.2.24 Outpatient Treatment – SUD (GFS and SAPT)
  - 15.3.2.25 Peer Support (GFS only).
  - 15.3.2.26 Psychological Assessment (GFS only).
  - 15.3.2.27 Recovery House Residential Treatment – SUD (GFS and SAPT)

- 15.3.2.28 Rehabilitation Case Management (GFS Only).
- 15.3.2.29 Special Population Evaluation (GFS only).
- 15.3.2.30 TB Counseling, Screening, Testing and Referral (GFS only).
- 15.3.2.31 Therapeutic Psychoeducation (GFS only).
- 15.3.2.32 Urinalysis/Screening Test (GFS and SAPT).
- 15.3.2.33 TB Screening/Skin Test (GFS only).
- 15.3.2.34 Withdrawal Management – Acute (GFS and SAPT).
- 15.3.2.35 Withdrawal Management – Sub-Acute (GFS and SAPT).
- 15.3.3 The following services are not clinical in nature so medical necessity does not apply. The contractor shall establish criteris, policies and procedures to determine the provision or denial of the following services:
  - 15.3.3.1 Alcohol/Drug Information School (GFS only)
  - 15.3.3.2 Childcare (GFS and SAPT)
  - 15.3.3.3 Community Outreach – SAPT priority populations PPW and IVDU (GFS and SAPT).
  - 15.3.3.4 Continuing Education and Training (GFS and SAPT).
  - 15.3.3.5 PPW Housing Support Services (GFS and SAPT).
  - 15.3.3.6 Recovery support services, as authorized by the FFY 2016 Washington State Combined Block Grant Application, provided in Exhibit F (GFS and SAPT).
  - 15.3.3.7 Sobering Services (GFS and SAPT).
  - 15.3.3.8 Therapeutic Interventions for Children (GFS and SAPT).
  - 15.3.3.9 Transportation (GFS only).
- 15.3.4 Pharmaceutical Products:
  - 15.3.4.1 Prescription drug products may be provided within available funds based on medical necessity. Coverage to be determined by HCA policy.

## **16 Crisis System**

### **16.1 Crisis System General Requirements**

- 16.1.1 The Contractor shall develop a regional behavioral health crisis system that meets the following requirements.
  - 16.1.1.1 Mental Health Crisis Services will be available to all individuals who present with a need for crisis services in the Contractor's service area, as defined in Sections 4.1 and 4.2, regardless of insurance status, ability to pay, level of income or county of residence.
  - 16.1.1.2 Mental Health Crisis Services shall be provided in accordance with CFR 42, WAC 388-865, RCW 71.05, RCW 71.34 and WAC 388-877A-0200.

- 16.1.1.3 ITA services will include all services and administrative functions required for the evaluation of involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05, RCW 71.24.300 and RCW 71.34.700.
- 16.1.1.4 Chemical Dependency Involuntary Treatment Act Services will be administered in accordance with RCW 70.96A.120-140.
- 16.1.2 Menal Health Crisis Services shall be delivered in a manner that is consistent with the following objectives:
  - 16.1.2.1 To stabilize individuals as quickly as possible and assist them in returning to their a level of functioning that no longer qualifies them for crisis services. Stabilization services will be provided in accordance with WAC 388-877A-0260.
  - 16.1.2.2 To provide solution-focused, person-centered and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, institutionalization or out of home placement.
  - 16.1.2.3 To coordinate closely with the regional managed care organizations, community court system, first responders (e.g., police, sheriff, fire, emergency, medical and hospital emergency rooms, 911 call centers), criminal justice system, inpatient/residential service providers, and outpatient behavioral health providers to operate a seamless crisis system and acute care system that is connected to the full continuum of health services.
  - 16.1.2.4 To engage the Consumer in the development and implementation of crisis prevention plans to reduce unnecessary crisis system utilization and to maintain the Consumer's stability in the community.
  - 16.1.2.5 To develop and implement strategies to assess and improve the crisis system over time.

**16.2 Crisis System Staffing Requirements**

- 16.2.1 The Contractor shall comply with agency staff requirements in accordance with WAC 388-877A-0210 and Section 15.1.1 of this Contract. All crisis mental health services shall be provided by, or under the supervision of, a mental health professional. Each staff member working with a Consumer receiving crisis mental health services in WAC [388-877A-0230](#) through [388-877A-0270](#) must receive:
  - 16.2.1.1 Clinical supervision from a mental health professional and/or an independent practitioner licensed by the Department of Health.
  - 16.2.1.2 Annual violence prevention training on the safety and violence prevention topics described in RCW [49.19.030](#). The staff member's personnel record must document the training.
  - 16.2.1.3 Staff access to consultation with one of the following professionals who has at least one year's experience in the direct treatment of individuals who have a mental or emotional disorder:
    - 16.2.1.3.1 A psychiatrist;

16.2.1.3.2 A physician

16.2.1.3.3 An advanced registered nurse practitioner who has prescriptive authority.

- 16.2.2 The Contractor shall comply with DMHP qualification requirements in accordance with RCW 71.05.020(11) and RCW 71.34.020(5).
- 16.2.3 The Contractor shall have clinicians available 24/7 who have expertise in mental health issues pertaining to children and families.
- 16.2.4 The Contractor shall hire, train, and make available at least one Chemical Dependency Specialist (CDP) with experience conducting behavioral health crisis support for consultation by phone or on site during regular business hours.
- 16.2.5 The Contractor shall hire, train, and make available at least one Certified Peer Specialist (CPS) with experience conducting behavioral health crisis support for consultation by phone or on site during regular business hours.
- 16.2.6 The Contractor shall establish policies and procedures for crisis and ITA services that implement the following requirements:
- 16.2.6.1 No DMHP, DCDS or crisis intervention worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act, unless a second trained individual accompanies them.
  - 16.2.6.2 The clinical team supervisor, on-call supervisor, or the individual professional acting alone based on a risk assessment for potential violence, shall determine the need for a second individual to accompany them.
  - 16.2.6.3 The second individual may be a law enforcement officer, a Mental Health Professional, a mental health paraprofessional who has received training required in RCW 49.19.030, or other first responder, such as fire or ambulance personnel.
  - 16.2.6.4 No retaliation may be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.
  - 16.2.6.5 The Contractor must have a plan to provide training, mental health staff back-up, information sharing, and communication for crisis outreach staff who respond to private homes or other private locations.
  - 16.2.6.6 Every Mental Health Professional dispatched on a crisis visit, shall have prompt access to information about any history of dangerousness or potential dangerousness on the client they are being sent to evaluate that is documented in crisis plans or commitment records and is available without unduly delaying a crisis response.
  - 16.2.6.7 Every Mental Health Professional, who engages in home visits to Consumers or potential Consumers for the provision of Crisis Services, shall be provided by the Contractor or Subcontractor with a wireless telephone or comparable device for the purpose of emergency communication.

### 16.3 Crisis System Operational Requirements

- 16.3.1 Crisis Services shall be available twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year.
  - 16.3.1.1 Mobile crisis outreach shall be able to respond within two (2) hours of the referral to an emergent crisis and within 24 hours for referral to an urgent crisis.
- 16.3.2 The Contractor shall provide a toll free crisis line that is available twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year to provide telephone crisis intervention and triage services, including screening and referral to a network of local providers and community resources.
  - 16.3.2.1 The toll-free crisis line will be a separate number from the Contractor's customer service line.
- 16.3.3 Individuals will be able to access Crisis Services without full completion of intake evaluations and/or other screening and assessment processes. Telephone support services will be provided in accordance with WAC 388-877A-0230 and outreach services will be provided in accordance with WAC 388-877A-0240.
- 16.3.4 The Contractor shall establish registration processes for non-Medicaid individuals utilizing Crisis Services for the purposes of maintaining demographic and clinical information, and establishing a medical record/tracking system to manage their crisis care, referrals, and Crisis Services utilization.
- 16.3.5 The Contractor shall establish protocols for providing information about and referral to other available services and resources for individuals who do not meet criteria for Medicaid or GFS/SAPT services (e.g., homeless shelters, domestic violence programs, Alcoholics Anonymous).
- 16.3.6 The Contractor shall ensure that Crisis Services providers document calls, services, and outcomes. The Contractor shall comply with record content and documentation requirements in accordance with WAC 388-877A-0220.

### 16.4 Crisis System Services

- 16.4.1 The Contractor shall make the following services available to all individuals presenting for a need for services in the Contractor's service area regardless of insurance status, ability to pay, county of residence, or level of income:
  - 16.4.1.1 Telephone Crisis Triage and Intervention includes assessment of a caller's needs, to determine the severity and urgency of the needs and to identify the supports and services that are necessary to meet those needs. Dispatch mobile crisis, as appropriate, and/or connect the individual to services consistent with the assessed need, eligibility for resources through GFS/SAPT, Medicaid, other insurance or community resources. For individuals who are already enrolled with a regional managed care organization, assist in connecting the individual with his or her current or prior services providers taking into account individual choice and the expertise necessary to address the caller's needs.

- 16.4.1.2 Administration of the Involuntary Treatment Act 71.05, including making DMHPs available twenty-four (24) hours, seven (7) days a week to conduct evaluation of the need for emergency detention or to determine if a person will receive appropriate care from triage facilities or stabilization units. Emergency involuntary detention services shall be provided in accordance with WAC 388-877A-02820. DMHPs file petitions for detentions and provide testimony for ITA services. The Contractor also shall reimburse the county for court costs associated with ITA and shall provide for Evaluation and Treatment services as ordered by the court for individuals who are not eligible for Medicaid. Individuals who are not eligible for Medicaid may be billed directly for services, in accordance with Section 10.6.2.
- 16.4.1.3 Chemical Dependency Involuntary Treatment Act Services to identify and evaluate alcohol and drug involved individuals requiring protective custody, detention, or involuntary commitment services. Includes investigation activities, assessment activities, management of the case findings, and legal proceedings associated with these cases
- 16.4.2 The Contractor shall provide the following services to individuals who meet Eligibility requirements as defined in Section 4 and who do not qualify for Medicaid when medically necessary and based on Available Resources:
  - 16.4.2.1 Crisis stabilization services, includes short-term (up to fourteen (14) days per episode) face-to-face assistance with life skills training and understanding of medication effects. Services are provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the Mental Health Professional to individuals experiencing a mental health crisis. This service also includes follow up. Crisis stabilization is often referred to as hospital diversion, typically managed by specific programs, apart from initial/emergent stabilization services, and available twenty-four (24) hours a day, seven (7) days a week.
  - 16.4.2.2 SUD Crisis Services: Short term stabilization to include a general assessment of the individual's condition, an interview for therapeutic purposes, and arranging transportation home or to an approved facility for intoxicated or incapacitated individuals on the streets or in other public places. Services may be provided by telephone, in person, in a facility or in the field. Services may or may not lead to ongoing treatment.
  - 16.4.2.3 Peer-to-Peer Warm Line Services are available to callers with routine concerns who could benefit from or who request to speak to a peer for support and help de-escalating emerging crises. Warm line staff may be peer volunteers, who use principles of recovery and empowerment, to provide emotional support, comfort, and information to callers living with a mental illness. All calls to the warm line are confidential.

## 16.5 Coordination with External Entities

- 16.5.1 The Contractor shall collaborate with the HCA and Apple Health Fully-Integrated Managed Care plans operating in the regional service area to develop and implement strategies to coordinate care with community behavioral health providers for Consumers with a history of frequent crisis system utilization. Coordination of care strategies will seek to reduce utilization of Crisis Services by promoting relapse/crisis prevention planning and early intervention and outreach that addresses the development and incorporation of wellness recovery action plans and mental health advance directives in treatment planning.
- 16.5.2 The Contractor shall Contract with HCA selected Apple Health Fully-Integrated Managed Care plans operating in the regional service area to establish the protocols related to the provision of behavioral health Crisis Services by the Contractor to the managed care organization's Medicaid enrollees. The protocols shall, at a minimum, address the following:
- 16.5.2.1 Payment by the managed care organization to the Contractor for Crisis Services arranged for or delivered by the Contractor or the Contractor's provider network to individuals enrolled in the managed care organization's AH-FIMC plan. The reimbursement shall be upon receipt of a valid claim per the requirements for timely accurate claims payment under this Contract or a monthly sub-capitation.
- 16.5.2.1.1 If the Contractor is paid on a fee-for-service basis and delivers Crisis Services through a network of crisis providers, it shall reimburse its providers within fourteen (14) calendar days of receipt of reimbursement from the Contractor.
- 16.5.2.1.2 Any sub-capitation arrangement with the AH-FIMC managed care plans or the Contractor's providers shall be reviewed and approved by the HCA.
- 16.5.2.2 The Contractor and managed care organization(s) shall participate in a semi-annual financial reconciliation process, as directed by the HCA, related to predicted versus actual Crisis Services utilization.
- 16.5.2.3 The Contractor shall submit claims and/or encounters for Crisis Services consistent with the provisions of this Contract including, but not limited to Section 2.3, Billing Limitations. Claims and encounter submission timeliness requirements apply regardless of whether the Contractor directly provides services, acts as a third party administrator for a network of crisis providers, is paid a capitation or on a fee-for-service basis.
- 16.5.2.4 The Contractor shall establish information systems to support data exchange consistent with the requirements under this Contract including, but not limited to eligibility interfaces, exchange of claims and encounter data and sharing of care plans and mental health advance directive necessary to coordinate service delivery in accordance with applicable privacy laws, including HIPAA and 42 CFR Part 2.

16.5.2.5 Requirements for the parties to collaborate in the development and implementation of strategies to coordinate care for individuals with a history of frequent crisis system utilization consistent with Section 16.5.1.

16.5.3 the Contractor shall, in partnership with the Apple Health Fully Integrated Managed Care plans operating in the regional service area, develop protocols to engage and collaborate with first responders, including local law enforcement, to address, protocols to coordinate the discharge and transition of incarcerated adults and TAY with SMI for the continuation of prescribed medications and other BH services prior to re-entry to the community.

**16.6 Tribal Coordination for Crisis and Involuntary Commitment Evaluation Services:**

16.6.1 The Contractor shall submit to the HCA Tribal Liaison a plan for providing crisis and ITA evaluation on Tribal Lands within the SWWA region, on or before (*date to be determined*).

16.6.2 The plan shall be developed in conjunction with the affected Tribal entities within the SWWA region and must be co-signed by the appropriate Tribal representative for each affected Tribe.

16.6.3 The plan shall identify a procedure and timeframe for evaluating the plan's efficacy and a procedure and timeframe for modifying the plan to the satisfaction of all parties at least once per year.

16.6.4 If the Contractor and Tribal entity are not able develop a plan or the tribe does not respond to the request, HCA will work with both the Tribes and Contractor to reach an understanding.

16.6.5 These meetings will be conducted in a manner that comports with the HCA government-to-government relationship with Washington Tribes.

16.6.6 Those Tribes whose Tribal lands lie within multiple regions, may develop joint plans with those regions. If the Contractor has multiple Tribal lands within their service region, one plan may be developed for all Tribes if all parties agree.

16.6.7 The plan must include a procedure for crisis responders and DHMPs (non-Tribal) to access Tribal lands to provide requested services, including crisis response, and ITA evaluations.

16.6.8 Any notifications and authority needed to provide services including a plan for evening, holiday, and weekend access to Tribal lands if different than business hours.

16.6.9 A process for notification of Tribal authorities when Crisis Services are provided on Tribal land, especially on weekends, holidays, and after business hours. This must identify the essential elements included in this notification, who is notified, and timeframe for the notification.

16.6.10 A description of how crisis responders will coordinate with Tribal Mental Health providers and/or others identified in the plan for, including a description of how service coordination and debriefing with Tribal mental health providers will occur after a Crisis Service has occurred.

- 16.6.11 This must include the process for determining when a DMHP is requested and a timeframe for consulting with Tribal mental health providers regarding the determination to detain or not for involuntary commitment.
- 16.6.12 The plan shall include procedures for coordination and implementation of ITA evaluations on Tribal lands, including whether or not DMHPs may conduct ITA evaluations on Tribal lands.
- 16.6.13 If ITA evaluations cannot be conducted on Tribal land, the plan shall specify how and by whom individuals will be transported to non-Tribal lands for ITA evaluations and detentions.
- 16.6.14 If DMHP evaluations cannot be conducted on Tribal Land, the plan shall specify how and by whom individuals will be transported off of Tribal Land to the licensed Evaluation and Treatment facility.
- 16.6.15 The plan shall specify where individuals will be held and under what authority, If no E&T beds are available.

## **17 Criminal Justice Treatment Account and Juvenile Drug Court**

- 17.1 The Contractor shall be responsible for providing services concerning the specific eligibility and funding requirements for Criminal Justice Treatment Account Services (CJTA) (RCW 70.96A, RCW 70.96A.055)
  - 17.1.1 Under 70.96A.350 each County has an established local CJTA panel that creates the local CJTA plan to describe how the CJTA funds will be used locally. The plan shall be approved by the Washington State CJTA panel and submitted to the Contractor. The Contractor must implement the plan as it has been approved by the State panel. The plan will address the priorities for use of funds, for:
    - 17.1.1.1 The treatment of Individuals with an addiction or substance use problem that if not treated would result in addiction against which charges are filed against by a prosecuting attorney in Washington State.
    - 17.1.1.2 The provision of drug and alcohol treatment services and treatment support services for non-violent individuals within a drug court program
  - 17.1.2 The plan must address the Criminal Justice Treatment Account Match Requirement – to provide a local participation match of all DSHS provided criminal justice awards using the following formulas:
    - 17.1.2.1 A dollar-for-dollar participation match for services to patients who are receiving services under the supervision of a drug court.
    - 17.1.2.2 A ten percent (10%) participation match as formulated below, for services to patients who are not under the supervision of a drug court but against whom a prosecuting attorney in Washington State has filed charge.

17.1.2.3 The total CJTA award divided by 0.9 times 0.1. For example the match requirement of \$100,000 would be \$11,111

17.1.3 The Contractor shall provide, as particularized in the approved local CJTA plan, alcohol and drug treatment and treatment support services per Chapter 70.96A RCW: Treatment for alcoholism, intoxication, and substance use disorder to the following eligible offenders:

17.1.3.1 Adults with a substance use disorder problem that, if not treated, would result in addiction, against whom a prosecuting attorney in Washington State has filed charges.

17.1.3.2 Substance use disorder treatment services and treatment support services to adult or juvenile offenders within a drug court program as defined in RCW 70.96A.055: Drug courts and RCW 2.28.170: Drug courts.

17.1.4 CJTA Funding Guidelines

17.1.4.1 No more than ten percent (10%) of the total CJTA funds for the following support services combined:

17.1.4.2 Transportation

17.1.4.3 Child Care Services.

17.1.5 At a minimum thirty percent (30%) of the CJTA funds for special projects that meet any or all of the following conditions:

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

17.1.5.2 An approach utilizing either traditional or best practice approaches to treat significant underserved population(s), or

17.1.5.3 A regional project conducted in partnership with at least one other entity serving the Southwest Washington Service Area, (e.g. the fully-integrated managed plans operating in the RSA or the Accountable Community of Health).

17.1.6 Services eligible to be provided through CJTA funds are defined in the SUD Service Matrix, Exhibit G

17.1.7 Criminal Justice Treatment Account Special Projects Report - The Contractor shall submit a progress report to HCA on a timeline provided by HCA prior to the Contract execution date, that summarizes the status of the Contractor special project and includes the following required information:

17.1.8 Type of project (acknowledge best practice/treatment strategy, significant underserved population(s), or regional endeavor).

17.1.9 Current Status:

17.1.9.1 Describe the project and how it is consistent with your strategic plan.

17.1.9.2 Describe how the project has enhanced treatment services for offenders.

17.1.9.3 Indicate the number of offenders who were served using innovative funds.

17.1.9.4 Indicate the cost of service per participant.

**17.2 Juvenile Drug Court**

17.2.1 The Contractor shall provide the services and staff, and otherwise do all things necessary for or incidental to the maintenance of a juvenile drug court (JDC) and provide the following for each participant:

17.2.2 A drug and alcohol assessment. HCA prefers the GAIN-I assessment tool.

17.2.3 Substance abuse and mental health treatment and counseling as appropriate which may include, but is not limited to, Functional Family Therapy and Aggression Replacement Training.

17.2.4 A comprehensive case management plan which is individually tailored, culturally competent, developmentally and gender appropriate and which include educational goals that draw on the strengths and address the needs of the participant.

17.2.5 Drug testing, scheduled and at random, to support the treatment plan and monitor compliance.

17.2.6 Tracking of attendance and completion of activities, and imposing appropriate incentives for compliance and sanctions for lack of compliance.

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

**17.3 Juvenile Drug Court Reporting Requirements**

17.3.1 The contractor shall provide the following:

17.3.1.1 Quarterly reports, due by the 15th of July 2016, October 2016, January 2017, April 2017 and July 2017 that includes:

17.3.1.1.1 Participant levels, including: number of participants; number of participants terminated for drug use, for new charges, for other reasons; and number of graduates/completions.

17.3.1.2 Drug test information, including: number of UAs, number of positive UAs.

17.3.1.3 Number of sanctions and incentives handed out by the judge.

17.3.1.4 Percentage of participants and their families involved in best and promising practices, including Functional Family Therapy, Aggression

Replacement Therapy, etc.

17.3.1.5 Percentage of participants working on education and/or employment goals.

17.3.1.6 Recidivism rate (conviction-free at six months and at one year following graduation).

17.3.1.7 Percentage of graduates who continue with optional aftercare services

## **18 Mental Health Block Grant (MHBG)**

### **18.1 MHBG Service Provision**

18.1.1 The contractor shall provide services to promote recovery for seriously mentally ill adults (SMI) and resiliency for SED (seriously emotionally disturbed) children, in accordance with federal and State MHBG requirements.

18.1.2 The Contractor shall provide or subcontract for the provision of services in direct accordance from the local Mental Health Block Grant plan, as approved by the Southwest Washington Regional Service Area Community Behavioral Health Advisory Board, and the State Behavioral Health Advisory Council. Samples MHBG services are included in Exhibit H.

18.1.3 Upon request by HCA, the Contractor shall attend and send a representative to the Washington State Behavioral Health Advisory Council meeting to discuss priorities for future Mental Health Block Grant supported services.

18.1.4 The Contractor shall provide the services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

18.1.4.1 The Contractor shall submit a responsive, written, MHBG Final Report by June 1, 2017, for services provided April, 1 2016 through March 31, 2017; and shall do so with such format as directed by HCA.

18.1.4.2 The report format shall at a minimum include the following Sections for the Contractor to complete:

18.1.4.2.1 Actions taken to increase Consumer involvement in services, commonly referred to as Consumer Voice

18.1.4.2.2 Progress taken towards achievement of the Southwest Washington Regional Service Area's Mental Health Block Grant project plan, as approved by the Community Behavioral Health Advisory Board, including barriers encountered and steps taken to remove barriers.

18.1.4.2.3 Lessons learned with recommendations to improve future service delivery outcomes.

## 18.2 Peer Review

The Mental Health Block Grant requires annual peer reviews by individuals with expertise in the field of mental health treatment, of at least five percent of treatment providers. The Contractor and subcontractors shall participate in a peer review process when requested by HCA (42 USC 300x-53 (a) and 45 CFR 96.136).

## 18.3 Target Population

The Contractor shall ensure that Mental Health Block Grant funds are used only for services to individuals who are not enrolled in Medicaid or for services that are not covered by Medicaid, as described below:

Benefits	Services	Use MHBG Funds	Use Medicaid
Consumer is <b>not</b> a Medicaid recipient	Any Allowable Type	Yes	No
Consumer is a Medicaid recipient	Allowed under Medicaid	No	Yes
Consumer is a Medicaid recipient	Not Allowed under Medicaid	Yes	No

## 18.4 Mental Health Block Grant Subcontracts and Subcontract Monitoring

- 18.4.1 All activities and services performed pursuant to this Agreement, which are not performed directly by the Contractor, must be subcontracted in accordance with the terms set forth by the Community Behavioral Health Advisory Board approved Mental Health Block Grant project plan.
- 18.4.2 MHBG funds may not be used to pay for services provided prior to the execution of subcontracts, or to pay in advance of service delivery. All subcontracts and amendments must be in writing and executed by both parties prior to any services being provided.
- 18.4.3 MHBG fee-for-service, set rate, performance-based, cost reimbursement, and lump sum subcontracts shall be based on reasonable costs.
- 18.4.4 The Contractor shall retain, on site, all subcontracts. Upon request by HCA, Contractor will immediately make available any and all copies, versions, including all amendments of subcontracts.
- 18.4.5 The Contractor must obtain prior approval before entering into any subcontracting arrangement. In addition, the Contractor shall submit to the HCA Program Manager identified on Page 1 of the contract at least one of the following for review and approval purposes:
  - 18.4.6 A copy of the proposed subcontract to ensure it meets all HCA requirements; or
  - 18.4.7 A copy of the Contractor's standard contract template to ensure it meets all requirements and approve only subcontracts entered into using that template; or

- 18.4.8 Certification in writing that the subcontractor meets all requirements under the Contract and that the subcontract contains all required language under the contract, including any data security, confidentiality and/or Business Associate language, as appropriate.
- 18.4.9 The Contractor shall ensure that its subcontractors receive an independent audit if the subcontractor expends a total of \$750,000 or more in federal awards from any and/or all sources in any fiscal year. Contractor shall require all subcontractors to submit to the Contractor the data collection form and reporting package specified in 2 CFR Part 200, Subpart F, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor within 10 days of audit reports being completed and received by subcontractors. Contractor shall follow up with any corrective actions for all subcontractor audit findings in accordance with 2 CFR Part 200, Subpart F. Contractor shall retain documentation of all Contractor subcontractor monitoring activities; and, upon request by HCA, shall immediately make all audits and/or monitoring documentation available to HCA.
- 18.4.10 The Contractor shall conduct and/or make arrangements for an annual fiscal review of each subcontractor receiving MHBG funds through fee-for-service, set rate, performance-based or cost reimbursement subcontracts; and, shall provide HCA with documentation of these annual fiscal reviews upon request. The annual fiscal review shall ensure that:
- 18.4.11 Expenditures are accounted for by revenue source.
- 18.4.12 No expenditures were made for items identified in Section 5.1.6 of this Contract
- 18.4.13 Expenditures are made only for the purposes stated in this Contract, and that services were actually provided.

## **19 BUSINESS CONTINUITY AND DISASTER RECOVERY**

### **19.1 Business Continuity and Disaster Recovery**

- 19.1.1 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.
- 19.1.2 The Contractor shall create and maintain a business continuity and disaster recovery plan that insures timely reinstatement of the Consumer 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.

- 19.1.2.1 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:
- 19.1.2.1.1 A mission or scope statement.
  - 19.1.2.1.2 An appointed information services disaster recovery staff.
  - 19.1.2.1.3 Provisions for back up of key personnel, identified emergency procedures, and visibly listed emergency telephone numbers.
  - 19.1.2.1.4 Procedures for allowing effective communication, applications inventory and business recovery priority, and hardware and software vendor list.
  - 19.1.2.1.5 Confirmation of updated system and operations documentation and process for frequent back up of systems and data.
  - 19.1.2.1.6 Off-site storage of system and data backups and ability to recover data and systems from back-up files.
  - 19.1.2.1.7 Designated recovery options which may include use of a hot or cold site.
  - 19.1.2.1.8 Evidence that disaster recovery tests or drills have been performed.

**Exhibit A:  
State Hospital Beds**

To be supplied at a later date.  
After information is received and verified by HCA.

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## **Exhibit B:**

### **Community Behavioral Health Advisory Board Requirements**

#### **Community Behavioral Health Advisory Board Membership**

The Contractor must maintain a Community Behavioral Health Advisory Board that is broadly representative of the demographic character of the region. The Community Behavioral Health Advisory Board may be a Committee or Subcommittee of the regional Accountable Community of Health. Composition of the Advisory Board and the length of terms must be provided to DSHS and HCA upon request and meet the following requirements:

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

**Exhibit C:**  
**Other Performance Measures or Reporting Requirements**

<b>Performance Measure/ Reporting Metric</b>	<b>Minimum Performance Standard</b>	<b>Goal</b>
Number of clients served by service type and by provider, reported separately for GFS and SAPT funded services	## %	## %
Units of service by service type and by provider reported separately for GFS and SAPT funded services	## %	## %
Waiting lists by service type and provider reported separately for GFS and SAPT funded services	## %	## %

## **Exhibit D: Crisis Performance Measures and Reporting Requirements**

1. Crisis System Call Center Performance Metrics
    - A. Ninety-five percent (95%) of crisis calls are answered live within fifteen (15) seconds.
    - B. Call abandonment rate of less than three percent (3%) for the crisis line.
    - C. Provide direct line access to all mobile crisis outreach teams for necessary support and information assistance after dispatch so no caller waits more than thirty (30) seconds for a live answer.
  2. Crisis Reporting
    - A. Call Center Reports
      - i. Caller demographics.
      - ii. Analysis of calls, callers, dispositions, origin of call (e.g., home, emergency room, community, provider), referral sources, and other relevant information to make recommendations and assist in improving the crisis response system.
    - B. Transition Support
      - i. The number of persons served, monitored monthly.
      - ii.
    - C. Mobile Crisis Team
      - i. The number and percentage of persons referred to the program for mobile outreach, monitored monthly.
      - ii. The number and percentage of persons successfully diverted from Emergency Rooms and/or ITA commitments, monitored quarterly.
- Other**
- iii. Mobile crisis outreach dispatch, time of arrival, and disposition of response.
  - iv. The number of unique individuals served in the crisis system by fund source and service type on a monthly and year to date basis.
  - v. Number of individuals who are repeat utilizers of the crisis system, monitored quarterly and year to date and compared to prior year, and reported by frequency of utilization

**Exhibit E:**  
**Combined Block Grant (BG) Application** | **FFY2016**

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**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 10 percent of the grant for systems of integrated services for children.
- Allocate no less than 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 18 and adults with SMI refer to persons age 18 and over; (1) who currently meets or at any time during the past year has met criteria for a mental disorder-including within developmental and cultural contexts-as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, 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 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 (Exhibit E continued)

### 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 F:**  
**Substance Use Disorder – Service Matrix Updated 9/14/15**

	<b>Service</b>	<b>SAPT</b>	<b>GF-S</b>	<b>CJTA/Drug Court</b>	<b>Medicaid</b>
1	Brief Intervention	X	X	X	X
2	Acute Withdrawal Management	X	X	X	X
3	Sub-Acute Withdrawal Management	X	X	X	X
4	Outpatient Treatment	X	X	X	X
5	Intensive Outpatient Treatment	X	X	X	X
6	Brief Outpatient Treatment	X	X	X	X
7	Opiate Substitution Treatment	X	X	X	X
8	Case Management	X	X	X	X
9	Intensive Inpatient Residential Treatment	X	X	X	X
10	Long-term Care Residential Treatment	X	X	X	X
11	Recovery House Residential Treatment	X	X	X	X
12	Assessment	X	X	X	X
13	DUI Assessment	X	X	X	X
14	Engagement and Referral	X	X		
15	Alcohol/Drug Information School		X		
16	Opiate Dependency/HIV Outreach (SAPT only for Opiate)	X	X		
17	Interim Services	X	X	X	
18	Community Outreach	X	X	X	
19	Crisis Services	X	X		
20	Sobering Services	X	X		
21	Involuntary Commitment	X	X	X	
22	Room and Board	X	X	X	
23	Therapeutic Interventions for Children	X	X		
24	Transportation	X	X	X	
25	Childcare Services	X	X	X	
26	PPW Housing Support Services	X	X		
27	Miscellaneous		X		
28	Family Hardship		X		
29	Recovery Support Services	X	X		
30	Continuing Education	X	X		

## Exhibit G: MHBG Sample Service List

<p><b>Prevention and Wellness</b></p> <ul style="list-style-type: none"> <li>• Screening, Brief Intervention and Referral to Treatment (SBIRT)</li> <li>• Brief Motivational Interviews</li> <li>• Parent Training</li> <li>• Facilitated Referrals</li> <li>• Relapse Prevention/Wellness Recovery Support</li> <li>• Warm Line</li> </ul>	<p><b>Recovery Support Services</b></p> <ul style="list-style-type: none"> <li>• Peer Support</li> <li>• Recovery Support Coaching</li> <li>• Recovery Support Center Services</li> <li>• Supports for Self-Directed Care</li> </ul>
<p><b>Engagement Services</b></p> <ul style="list-style-type: none"> <li>• Assessment</li> <li>• Specialized Evaluations (Psychological and Neurological)</li> <li>• Service Planning (including crisis planning)</li> <li>• Consumer/Family Education</li> <li>• Outreach</li> </ul>	<p><b>Other Supports</b></p> <ul style="list-style-type: none"> <li>• Personal Care</li> <li>• Respite</li> <li>• Supported Education</li> <li>• Transportation</li> <li>• Assisted Living Services</li> <li>• Recreational Services</li> <li>• Trained Behavioral Health Interpreters</li> <li>• Interactive Communication Technology Devices</li> </ul>
<p><b>Outpatient Services</b></p> <ul style="list-style-type: none"> <li>• Individual Evidenced-Based Therapies</li> <li>• Group Therapy</li> <li>• Family Therapy</li> <li>• Multi-Family Counseling Therapy</li> <li>• Consultation to Caregivers</li> </ul>	<p><b>Intensive Support Services</b></p> <ul style="list-style-type: none"> <li>• Partial Hospital</li> <li>• Assertive Community Treatment</li> <li>• Intensive Home-Based Services</li> <li>• Multi-Systemic Therapy</li> <li>• Intensive Case Management</li> </ul>
<p><b>Medication Services</b></p> <ul style="list-style-type: none"> <li>• Medication Management</li> <li>• Pharmacotherapy (including MAT)</li> <li>• Laboratory Services</li> </ul>	<p><b>Out of Home Residential Services</b></p> <ul style="list-style-type: none"> <li>• Crisis Residential/Stabilization</li> <li>• Adult Mental Health Residential</li> <li>• Children's Residential Mental Health Services</li> <li>• Therapeutic Foster Care</li> </ul>
<p><b>Community Support Services</b></p> <ul style="list-style-type: none"> <li>• Parent/Caregiver Support</li> <li>• Skill Building (social, daily living, cognitive)</li> <li>• Case Management</li> <li>• Continuing Care</li> <li>• Behavior Management</li> <li>• Supported Employment</li> <li>• Permanent Supported Housing</li> <li>• Recovery Housing</li> <li>• Therapeutic Mentoring</li> <li>• Traditional Healing Services</li> </ul>	<p><b>Acute Intensive Services</b></p> <ul style="list-style-type: none"> <li>• Mobile Crisis</li> <li>• Peer-Based Crisis Services</li> <li>• Urgent Care</li> <li>• 23 Hr. Observation Bed</li> <li>• Medically Monitored Intensive Inpatient</li> <li>• 24/7 Crisis Hotline Services</li> </ul>