Exhibit C-1

1. PURPOSE OF AGREEMENT

The purpose of this Agreement is for the Contractor to operate a Prepaid Inpatient Health Plan (PIHP) to provide medically necessary mental health services, substance use disorder treatment, and related support services to Enrollees. The Contractor shall provide or purchase age, linguistic and culturally competent community behavioral health services for Enrollees for whom services are medically necessary and clinically appropriate pursuant to:

- CFR 42, CFR 438, or any successors, DBHR's Federal 1915 (b) Mental Health and Substance Use Disorder Waiver, and Medicaid (Title XIX) State Plan or any successors.
- Other provisions of Title XIX of the Social Security Act, or any successors.
- RCW 70.96a, 70.96b, 70.02, 71.05, 71.24, and 71.34, or any successors.
- WAC 388-865 or any successors.

2. SPECIAL TERMS AND CONDITIONS

2.1. DEFINITIONS

2.1.1. "Action" in this Contract means:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state; and
- The failure of the Contractor to act within the timeframes provided in section 42 CFR 438.408(b).

2.1.2. "Administration Costs" means costs for the administration of this Agreement for the general operation of the public behavioral health system. These activities cannot be identified with a specific direct services or direct services support function as defined in the Fiscal/Program Requirements Supplementary Instructions for Mental Health Programs administered by DSHS/BHSIA/Mental Health Finance (available upon request).

2.1.3. "Advanced Directive" means written instructions such as, a living will or durable power of attorney, recognized under state law and relating to the provisions of health care if the individual is incapacitated.

2.1.4. "American Society of Addiction Medicine Criteria" (ASAM) means clinical guidelines designed to improve assessment and outcomes-driven treatment and recovery services matching patients to appropriate types and levels of care.

2.1.5. “Annual Revenue” means all revenue received by the Contractor pursuant to the Agreement for July of any year through June of the next year.

2.1.6. “Appeal” means an oral or written request by an Enrollee, or with the Enrollee’s written permission, the Enrollee’s Authorized Representative, for the Contractor to review an Action as defined above. See also Expedited Appeal Process.

2.1.7. “Appeal Process” means one of the processes included in the grievance system that allows an Enrollee to appeal an Action made by the Contractor and communicated on a Notice of Action.

2.1.8. “Assessment” means diagnostic services provided by a CDP or CDP trainee under CDP supervision to determine a client’s involvement with alcohol and other drugs. See WAC 388-877 & 388-877B for a detailed description of assessment requirements.

2.1.9. “Authorized Representative” means any person acting on behalf of an Enrollee who:

- In the case of a minor, the individual's parent or, if applicable, the individual's custodial parent;
- The individual's legal guardian; or
- The individual's representative if the individual gives written permission, this may include a mental health practitioner working on behalf of the individual.

2.1.10. “Behavioral Health Agency” (“BHA”) means a Behavioral Health Agency that is licensed by the State of Washington to provide mental health and/or substance use disorder treatment and is Subcontracted under this agreement to provide services.

2.1.11. “Behavioral Health Organization” (“BHO”) means a county authority or group of county authorities or other entity recognized by the Secretary that contracts for mental health services and substance use disorder treatment services within a defined Regional Service Area

2.1.12. “Capacity Management” means a continually updated system for identifying treatment capacity for clients who cannot be admitted and a mechanism for matching clients to treatment programs with sufficient capacity.

2.1.13. “Capitation Payment” means a payment the Department of Social and Health Services (DSHS) makes monthly to a PIHP on behalf of each recipient enrolled under a Contract for the provision of behavioral health services under the State Medicaid Plan. The Department of Social and Health Services (DSHS) makes the payment regardless of whether the particular recipient receives the services during the period covered by the payment.

2.1.14. "Certified Substance Use Disorder Treatment Agency (SUDTA) "means an Agency that is licensed by the State of Washington to provide Substance Use Disorder Treatment Services and subcontracted to provide services covered under this Agreement.

2.1.15. "CDP" means a Chemical Dependency Professional licensed through the Department of Health (DOH). A CDP is the individual with primary responsibility for implementing an individualized plan for Substance Use Disorder treatment services.

2.1.16. "Children's Long Term Inpatient Programs" ("CLIP") means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from Children's Long Term Inpatient Programs.

2.1.17. "Community Mental Health Agency" ("CMHA") means a Community Mental Health Agency that is licensed by the State of Washington to provide mental health services and Subcontracted to provide services covered under this Agreement.

2.1.18. "Comprehensive Assessment Reporting Evaluation" ("CARE") means the tool used by DSHS Aging and Long-Term Support Administration case managers to document a client's functional ability, determine eligibility for long-term care services, evaluate what and how much assistance a client will receive, and develop a plan of care.

2.1.19. "Contractor" means the BHO named above, recognized by the Secretary, and who has authority to establish and operate a community behavioral health program.

2.1.20. "Consumer" means a person who has applied for, is eligible for or who has received behavioral health services. For a child under the age of thirteen (13), or for a child age thirteen (13) or older whose parents or legal representatives are involved in the treatment plan, the definition of consumer includes parents or legal representatives.

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

2.1.22. "Cultural Competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

2.1.23. "Data" means information that is disclosed or exchanged as described by this Contract.

2.1.24. "Delegation Plan" means either one document or an identified set of documents that show the Contractor's compliance with the Subcontracts Section of this Agreement.

2.1.25. "Deliverable" means items that are required for submission to DSHS to satisfy the work requirements of this Agreement and that are due by a particular date or on a regularly occurring schedule.

2.1.26. "Denial" means the decision by a PIHP, or their formal designee, to not authorize covered Medicaid behavioral health services that have been requested by a provider on behalf of an eligible Medicaid Enrollee. It is also a denial if an intake is not provided upon request by a Medicaid Enrollee.

2.1.27. "Dependent children" means children under age 18 living with the parent or through age 20 if enrolled in school and financially supported by the parent

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

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

2.1.30. "Early Periodic Screening Diagnosis and Treatment" ("EPSDT") means the Early Periodic Screening Diagnosis and Treatment program under Title XIX of the Social Security Act as amended for children who have not reached their 21st birthday.

2.1.31. "Emergent Care" means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

2.1.32. "Emerging Best Practice" or Promising Practice means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.

2.1.33. “Enrollee” means a Medicaid recipient who is enrolled in a Pre-paid Inpatient Health Plan.

2.1.34. “Evidence-Based Practice” means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

2.1.35. “Expedited Appeal Process” allows an Enrollee, in certain circumstances, to file an Appeal that will be reviewed by the Contractor more quickly than a standard Appeal.

2.1.36. “Fair Hearing” means a hearing before the Washington State Office of Administrative Hearings.

2.1.37. “Family” means

- For adult Enrollees, family means those the Enrollee defines as family or those appointed/assigned (e.g., guardians, siblings, caregivers, and significant others) to the consumer.

- For children, family means a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by the department of social and health services, or a Federally Recognized Tribe.

2.1.38. “GAIN-SS” means the Global Appraisal of Individual Needs – Short Screener. A tool used for conducting an integrated comprehensive screening of chemical dependency and mental health issues.

2.1.39. “Grievance” means an expression of dissatisfaction about any matter other than an Action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee’s rights (42 CFR 438.400(b).

2.1.40. “Grievance Process” means the processes through a PIHP in which an Individual applying for, eligible for, or receiving mental health services may express dissatisfaction about a mental health service.

2.1.41. “Grievance System” means the processes through a PIHP in which an Individual applying for, eligible for, or receiving mental health services may express dissatisfaction about services. The Grievance System established by the Contractor shall meet the requirements of 42 CFR 438 Subpart F, and include:

- A grievance process;

- An appeal process; and
- And access to DSHS' administrative hearing process.

2.1.42. "IMD" or Institute for Mental Disease means, per P.L. 100-360, an institution for mental diseases as a hospital, nursing facility, or other institution of more than 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. The term "mental disease" includes alcoholism and chemical dependency.

2.1.43. Individual means a person who applies for, is eligible for, or receives BHO-authorized behavioral health services from an agency licensed by the Department as a behavioral health agency. In the case of a minor, the individual's parent or, if applicable, the individual's custodial parent;

2.1.43.1. For the purposes of accessing the grievance system, the definition of individual also includes the following if another person is acting on the individual's behalf:

- The individual's legal guardian; or
- The individual's representative if the individual gives written permission.

2.1.43.2. For purposes of the Behavioral Health Advisory Board means a person or parent/legal guardian of a person with lived experience and/or self identifies as a person in recovery.

2.1.44. **ITA or Involuntary Treatment Act** (Mental Health) 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 72 hours, but, if necessary, Individuals can be committed for additional periods of 14, 90, and 180 calendar days (RCW 71.05.240 and 71.05.920).

ITA or **Involuntary Treatment Act** (Substance Use Disorder) allows for Individuals to be committed by court order to an approved treatment program for a limited period of time. Involuntary civil commitments are meant to provide for the treatment of Individuals with a substance use disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. Individuals can be committed for a period of 60 days unless sooner discharged if it has been determined that the likelihood of harm no longer exits or treatment is no longer adequate or appropriate, or

incapacity no longer exists. A petition for recommitment can be filed for an additional period of up to 90 days. (RCW 70.96A.140)

2.1.45. "IVDU and IDU" mean Injecting Drug User or Intra-Venous Drug User. The acronyms may be used interchangeably to refer to a person who has used a needle one or more times to illicitly inject drugs.

2.1.46. "Large Rural Area" means areas with a population density of less than 20 people per square miles.

2.1.47. "Medicaid Funds" means funds provided by the Centers for Medicare and Medicaid Services (CMS) Authority under Title XIX of the Social Security Act.

2.1.48. "Medicaid Behavioral Health Benefits Booklet" is the state-produced mechanism to help Medicaid Enrollees understand the requirements and benefits of the Behavioral Health Organization.

2.1.49. "Medical Necessity" or Medically Necessary means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the Individual must be determined to have a behavioral health diagnosis defined in the current Diagnostic and Statistical Manual of Mental Illness, covered by Washington State for public behavioral health services. The Individual's impairment(s) and corresponding need(s) must be the result of a behavioral health diagnosis. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a behavioral health diagnosis. The Individual is expected to benefit from the intervention. The Individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

2.1.50. "Mental Health Care Provider" ("MHCP") means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field or A.A. level with two (2) years' experience in the mental health or related fields.

2.1.51. "Mental Health Professional" means:

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

- 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 person 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;
- A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;
- A person who had an approved waiver to perform the duties of a Mental Health Professional that was requested by the regional support network and granted by DSHS prior to July 1, 2001; or
- A person who has been granted a time-limited exception of the minimum requirements of a Mental Health Professional by DSHS consistent with WAC 388-865-0260.

2.1.52. "Notice of Action" means the written notice the Contractor provides to an Individuals, and if applicable, the Individual's Authorized Representative, to communicate an Action.

2.1.53. "Opiate Substitution Treatment Services" (OST) means provision of treatment services and medication management (methadone, etc.) to individuals addicted to opiates.

2.1.54. "Post Stabilization Services" means covered services, related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e) to improve or resolve the Enrollee's condition.

2.1.55. "Prepaid Inpatient Health Plan" ("PIHP") means an entity that:
- Provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and
- Does not have a comprehensive risk contract.

2.1.56. "PRISM" means the Predictive Risk Intelligence System, a web-based application that provides remote access to integrated health information about DSHS clients.

2.1.57. "PRISM Administrator" means the DSHS official who has responsibility for registering PRISM Users, and providing access to PRISM.

2.1.58. "PRISM DBHR Coordinator" means the DSHS Point of Contact who coordinates with BHO POCs, reviews requests for access received from the BHO POCs and who approves the requests and forwards to the PRISM Administrator.

2.1.59. "PRISM BHO Point of Contact" (POC) means the Contractor official who has primary oversight responsibility for access and use of PRISM. This official has delegated authority to act on behalf of the Contractor with respect to all PRISM issues and serves as the liaison with the PRISM DBHR Coordinator and the PRISM Administrator.

2.1.60. "PRISM User" means the Contractor's employee who has registered access to PRISM.

2.1.61. "Program Agreement" means a written agreement between DSHS and the BHO containing special terms and conditions, including a statement of work to be performed by the BHO and payment to be made by DSHS. The "DSHS and BHO Agreement on General Terms and Conditions" between the parties shall govern work to be performed under any Program Agreement.

2.1.62. "ProviderOne" means the Department's Medicaid Management Information Payment Processing System.

2.1.63. "Publish" means an officially sanctioned document provided by DSHS on DSHS internet or intranet websites for downloading, reading, or printing. The Contractor shall be notified in writing or by e-mail when a document meets these criteria.

2.1.64. "Quality Assurance" means a focus on compliance to minimum requirements (e.g. rules, regulations, and Contract terms) as well as reasonably expected levels of performance, quality, and practice.

2.1.65. "Quality Improvement" means a focus on activities to improve performance above minimum standards/reasonably expected levels of performance, quality, and practice.

2.1.66. "Quality Strategy" means an overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations.

2.1.67. "Receiving BHO" means the BHO into whose region the Referring BHO is pursuing the transfer.

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

2.1.69. "Reduction" means the decision by a PIHP to decrease a previously authorized covered Medicaid behavioral health service described in the Level of Care Guidelines. The clinical decision by a Behavioral Health Agency to decrease or change a covered service in the Individualized Service Plan is not a reduction.

2.1.70. “Referring BHO” means the BHO in whose region the individual being transferred resided and/or from whom they received services prior to state hospital admission.

2.1.71. “Request for Service” means the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an Enrollee or the person authorized to consent to treatment for that Enrollee. For purposes of this Contract, an EPSDT referral is only a Request for Service when the Enrollee or the person authorized to consent to treatment for that Enrollee has confirmed that they are requesting service.

2.1.72. “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.

2.1.73. “Routine Services” means services that are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward behavioral health. These services do not meet the definition of urgent or emergent care.

2.1.74. “Rural Area” means areas with a population density of at least twenty (20) and less than five hundred (500) people per square mile.

2.1.75. “Service Area” means the geographic area covered by this Agreement for which the Contractor is responsible.

2.1.76. “Specialized Non-Medicaid Services” means, for purposes of the BHO Transfer Protocol, IMD admissions, residential placement, and state hospital census.

2.1.77. “Substance Use Disorder (SUD)” means a problematic pattern of alcohol/drug use leading to clinically significant impairment or distress as categorized in the DSM 5.

2.1.78. “Suspension” means the decision by a PIHP, or their formal designee, to temporarily stop previously authorized covered Medicaid behaviorall health services described in their Level of Care Guidelines or addressed by the ASAM PPC. The clinical decision by a Behavioral Health Agency to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

2.1.79. “Termination” means the decision by a PIHP, or their formal designee, to stop previously authorized covered Medicaid behavioral health services described in their Level of Care Guidelines . The clinical decision by a Behavioral Health Agency to stop or change a covered service in the Individualized Service Plan is not a termination.

2.1.80. “Urban Area” means an area that has a population density of at least five hundred (500) people per square mile.

2.1.81. "Urgent Care" means a service to be provided to persons approaching a mental health crisis. If services are not received within twenty four (24) hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

2.1.82. "WISe" means Wraparound with Intensive Services, a program model that includes a range of service components that are individualized, intensive, coordinated, comprehensive and culturally competent and provided in the home and community. WISe is for children, youth, and young adults up to age twenty one (21) who are experiencing mental health symptoms to a degree that is causing severe disruptions in the youth's behavior, interfering with their functioning in family, school or with peers that requires:

- The involvement of the mental health system and other youth, young adults, and child-serving systems and supports;
- Intensive care collaboration; and
- Ongoing intervention to stabilize the child, youth, young adult, and family in order to prevent a more restrictive or institutional placement.

2.1.83. "Young adult" means a person or patient from age 18 through age 20.

2.1.84. "Youth means a person or patient from age 10 through age 17.

2.2. Administrative Review Activities. The Department of Social and Health Services, Office of the State Auditor, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives, may conduct announced and unannounced:

- Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement.
- Reviews regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement.
- Audits and inspections of financial records of the Contractor or subcontractor. 42 CFR 438.6(g)
- Audit and inspect any books and records of the Contractor and of any subcontractor, that pertain to the ability of the entity to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract. 1903(m)(A)(iv)
- on-site inspections of any and all contractor and subcontractor locations

The Contractor shall notify DSHS when an entity other than DSHS performs any audit or review described above related to any activity contained in this Agreement.

2.3. Advisory Board. The Contractor must maintain an Advisory Board that is broadly representative of the demographic character of the region. Composition of the Advisory

Board and the length of terms must be submitted to DSHS upon request and meet the criteria below:

1. Representative of the geographic and demographic mix of service population

2. At least 51% of the membership are persons, parents or legal guardians of persons, with lived experience and/or self identifies as a person in recovery from a behavioral health disorder.

3. Law Enforcement representation

4. County representation, when the BHO is not a County operated BHO

5. No more than four elected officials

6. 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.

7. Three year term limit, multiple terms may be served, based on rules set by the Advisory Board.

2.4. Commercial General Liability Insurance (CGL). If the Contractor is not a member of a risk pool, the Contractor shall carry CGL to include 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, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds.

2.5. Compliance with Additional Laws. The Contractor shall comply with any applicable federal and state laws that pertain to Enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to Enrollees, whether or not a specific citation is identified in various sections of this Agreement:

Title XIX and Title XXI of the Social Security Act and Title 42 CFR.

All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement.

Law enforcement or court inquiries regarding firearm permits. The Contractor shall respond in a full and timely manner to law enforcement or court requests for information necessary to determine the eligibility of a person to possess a pistol or to be issued a concealed pistol license under RCW 9.41.070 or to purchase a pistol under RCW 9.41.090.

2.6. Confidentiality of Personal Information.

2.6.1. The Contractor shall protect all Personal Information, records, and data from unauthorized disclosure in accordance with 42 CFR 431.300 through 431.307, RCWs 70.02, 71.05, 71.34, and for individuals receiving substance abuse services, in accordance with 42 CFR Part 2 and RCW 70.96A. The Contractor shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services. Pursuant to 42 CFR 431.301 and 431.302, personal information concerning applicants and recipients may be disclosed for purposes directly connected with the administration of this Agreement and the State Medicaid Plan. Such purposes include, but are not limited to:

- Establishing eligibility.
- Determining the amount of medical assistance.
- Providing services for recipients.
- Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan.
- Assuring compliance with federal and State laws and regulations, and with terms and requirements of the Agreement.

2.6.2. The Contractor shall (and require its subcontractors and providers to do so) establish and implement procedures consistent with all confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA)(45 CFR Parts 160 and 164) for medical records and any other health and enrollment information that identifies a particular Enrollee.

2.6.3. Declaration That Individuals Served Under the Medicaid and Other Behavioral Health Programs Are Not Third-Party Beneficiaries Under this Agreement: Although DSHS and the Contractor mutually recognize that services under this Agreement shall be provided by the Contractor to individuals receiving services under the Medicaid program, and RCW 71.05, RCW 71.24, RCW 71.34, RCW 70.96a and RCW 70.96b. it is not the intention of either DSHS or the Contractor that such individuals, or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement.

2.6.4. The Contractor shall prevent inappropriate access to confidential data and/or data systems used to hold confidential client information by taking, at a minimum, the following actions:

- Verify the identity or authenticate all of the system's human users before allowing them access to any confidential data or data system capabilities.
- Authorize all user access to client applications.
- Protect application data from unauthorized use when at rest.
- Keep any sensitive data or communications private from unauthorized individuals and programs.
- Notify the appropriate DSHS point of contact within five (5) business days whenever an authorized user with access rights leaves employment or has a

change of duties such that the user no longer requires access. If the removal of access is emergent, include that information with the notification.

2.6.5. In the event of a Breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from any DSHS data system, the Contractor shall comply with all requirements of the HIPAA Security and Privacy for Breach Notifications and as otherwise required by state or federal law.

2.6.6. DSHS reserves the right at any time to conduct audits of system access and use, and to investigate possible violations of this Agreement and/or violations of federal and state laws and regulations governing access to protected health information contained in DSHS data systems.

2.6.7. The Contractor understands that DSHS reserves the right to withdraw access to any of its confidential data systems at any time for any reason.

2.7. Governing Body. The Contractor shall establish a Governing Body responsible for oversight of the Behavioral Health Organization. The Governing Body can be an existing executive or legislative body within a county government. Each member of the Governing Body must be free from conflicts of interest and from any appearance of conflicts of interest between personal, professional and fiduciary interests. Members of the Governing Body must act within the best interests of the Contractor and the Consumers. The Contractor must maintain membership roster(s) and by-laws of the Governing Body demonstrating compliance. The Governing Body by-laws must include:

- Actions to be taken when a conflict of interest, or the appearance of a conflict of interest, becomes evident;
- Requirements that members refrain from voting or joining a discussion when a conflict of interest is present; and
- A process for the Governing Body to assign the matter to others, such as staff or advisory bodies to avoid a conflict of interest.

2.8. Lawsuits. Nothing in this Agreement shall be construed to mean that the Contractor, a County, RSN, or their Subcontractors, agents or employees, can bring a legal claim for declaratory relief, injunctive relief, judicial review under RCW 34.05, or civil liability against the state or state agencies for actions or inactions performed pursuant to the administration of RCW 71.05 or RCW 71.24 with regard to the following: (a) allocation or payment of federal or state funds; (b) the use or allocation of state hospital beds; or (c) financial responsibility for the provision of long term or short term inpatient mental health care.

2.9. Lobby Activities Prohibited. Federal Funds must not be used for Lobbying activities

2.10. Medicaid State Plan Amendments. DSHS may petition CMS to amend the Medicaid State Plan during this Agreement period. If the Medicaid State Plan is amended the Contractor shall implement any changes to the provision of Medically Necessary mental

health services no later than 30 calendar days following CMS approval of the amended plan.

2.11. Nondiscrimination. The Contractor shall ensure that its provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.12. Records Retention. During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records is started before expiration of the six year period, the records shall be retained until completion and resolution of all issues arising there from or until the end of the six (6) year period, whichever is later.

The Contractor shall maintain records sufficient to:

- Maintain the content of all medical records in a manner consistent with utilization control requirements of 42 CFR 456, 42 CFR 456.111, and 42 CFR 456.211.
- Document performance of all acts required by law, regulation, or this Agreement.
- Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance.
- Demonstrate the accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Agreement.

2.13. Transition of Services.

The following requirements are established to ensure the transition of the responsibility to pay for and coordinate services to a Behavior Health Organization (BHO), Managed Care Organization (MCO) or other entity, as mandated by Second Substitute Senate Bill 6312, on the Implementation Date (currently April 1, 2016, or as subsequently revised).

2.13.1. For all DSHS Clients receiving services under this Contract, the Contractor shall cooperate with DSHS and the BHO, MCO or other entity, by participating in the following activities:

2.13.1.1. Identify all who are expected to be engaged in treatment on April 1, 2016.

2.13.1.2. Execute an agreement with the BHO, MCO or other entity that ensures protection of the Clients' confidential and Protected Health Information compliant with HIPAA and CFR 42 Part 2.

2.13.1.3. For each transitioning client, and with client's written consent and proper release in accordance with CFR 42 Part 2, Subpart C, 2.31 "Form of Written Consent", provide current treatment information including:

- What services are being provided,
- Planned treatment end date,
- Services provider information,
- Treatment location, and

- Administrative records.

2.13.1.4. Participate in the development of individual Client transition plans.

2.13.1.5. Other activities as requested by DSHS.

2.13.2. DSHS is responsible for payment for all services delivered up to but not including the Implementation Date.

2.14. Procurement of Recovered Materials. Contractor shall comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act, including procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR Part 247, Subpart B – Item Designation that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

3. PAYMENT

3.1. Contractor shall use all funds provided pursuant to this Agreement including interest earned to support the public mental health system.

3.1.1. Cost sharing and premium charges are not allowed under this contract.

3.1.2. DSHS shall make no payment to a provider other than the Contractor for services available under this contract, except when specifically provided for in XIX of the Act, in CFR 42.

3.1.3. DSHS may suspend some or all payments to the Contractor when there is a pending investigation of a credible allegation of fraud against the Contractor, 1903.(i) (2) (C).

3.2. Rates. The Contractor shall be reimbursed based upon the rates contained in Exhibit C.

3.2.1. Local Match. For those BHOs that provide local matching funds (King County BHO, Peninsula BHO and Spokane County BHO ONLY).

3.2.2. The Local Match Rates are contained in Exhibit C. DSHS will notify the Contractor of the number of Medicaid eligibles in these categories each month. The Contractor shall multiply the Qualifying Local Funds rates by the eligibles in each category and submit this amount in Qualifying Local Funds. Qualifying Local Funds received by DSHS by the 20th day of any month will be paid on the 1st business day of the following month.

3.2.3. DSHS will pay the Contractor the Local Match Rate for each category multiplied by the number of eligibles in each category for each month of the Contract period.

3.2.4. DSHS shall not make payment in the amounts specified if it would result in total payments exceeding the Medicaid rate approved by CMS.

3.2.5. Sources of revenue eligible to be used as Qualifying Local Funds are broad based taxes at the county or other local taxing authority level that are spent and have been certified by the local authority as public funds for mental health services allowable under this Agreement. Qualifying Local Funds under this Agreement may not be used as match for any other federal program. Qualifying Local Funds may be local funds that have not been previously matched with federal funds at any point. Qualifying Local Funds do not include donations.

3.2.6. Participation in local match is not required; the Contractor may participate in the option voluntarily. Performance of all duties and responsibilities by both parties is not contingent on the BHO participating in this option.

3.2.7. The Contractor shall provide a completed Local Match Certification Form as provided by DSHS with the final R&E report for this Agreement period.

3.3. Rate Setting Methodology. DSHS sets actuarially-sound managed care rates that:

- Have been developed in accord with generally accepted actuarial principles and practices;
- Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- Have been certified, as meeting the requirements of 42 CFR 438.6(c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Following the end of the annual legislative session, DSHS shall offer an Amendment with the proposed funds for the next Fiscal Year. If for any reason the Contractor does not agree to continue to provide services using the proposed funds, the Contractor must provide the appropriate notice to DSHS under the requirements of the Termination Section of the Agreement.

3.4. Capitation Payment. During the term of this Agreement, capitation payments are made at the beginning of each month of service. The Contractor shall be responsible to provide all behavioral health services through the end of the month for which it has received a capitation payment.

Payments to the Contractor will be made according to the Health Care Authority Managed Care Organization and Primary Care Case Management Reporting Schedule, and will be no later than the second Monday of each month.

3.5. ProviderOne. Capitation payments made under ProviderOne system will be based on eligibles assigned to a BHO by client zip code. The initial capitation payment will be calculated using eligibles from the current month. Weekly enrollment and payment

updates for eligibility changes occur weekly. Eligibility reconciliations occur continuously for six (6) months.

3.5.1. The Contractor is required to limit Administration costs to no more than ten percent (10% of the annual revenue supporting the public mental health system operated by the Contractor). Administration costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by DSHS.

3.5.2. The Contractor shall reimburse the subcontracted BHO and any crisis service provider accessed by Enrollees while the Enrollee is in or out of the State within sixty (60) calendar days from the date the bill is received from the service provider.

3.5.3. If monies under this Agreement are required by audit or otherwise to be recouped from the Contractor, the Contractor must reimburse the amount identified for recoupment to DSHS within thirty (30) calendar days of notification by DSHS.

3.5.4. If the Contractor chooses to use the ProviderOne system for inpatient claims processing, DSHS or its designee shall provide a bill to the Contractor on a monthly basis for claims paid on behalf of the Contractor. The Contractor has thirty (30) calendar days from the receipt of the inpatient claims bill to pay the costs assessed.

3.5.5. The Contractor must maintain a risk and inpatient reserve of the Contractor's annual Medicaid premium payment at the levels specified in Exhibit C.

3.5.6. If the Contractor spends a portion of the reserve, the funds must be replenished within one (1) year, or at the end of the fiscal year in which the funds were spent, whichever is longer.

3.5.7. These reserve funds are designated into a reserve account by official action of the Contractor's Governing Body. These reserve funds may only be used for in the event costs of providing service exceed the revenue the Contractor receives and for anticipated psychiatric inpatient costs. The amounts available for these funds are specified in Exhibit C.

3.5.8. The Contractor may have an additional Operating Reserve not to exceed the percentage specified in Exhibit C of the Contractor's annual Medicaid premium payments. Operating Reserves are funds set aside into an account by official action of the Contractor's Governing Body. Operating Reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.

3.6. Reporting Requirements. DSHS shall maintain books, records, documents, and other materials relevant to this Agreement which sufficiently and properly reflect all payments

made, including the Department's rate setting activities related to the Contractor, or other actions taken in regard to the Contractor's performance of the services described herein.

3.7. Financial Reporting and Certification: Financial Reports and Certifications are due within forty five (45) calendar days of the end of every second quarter (December and June of each year). Only one report is due within this Agreement period, and shall be submitted to DBHR with accompanying certification, by February 14, 2016. The Contractor shall submit the following components in a single form provided by DBHR:

3.7.1. The **Revenue, Expenditure, Reserves and Fund Balance report in compliance with:**

3.7.1.1. The "Fiscal/Program Requirements Supplementary Instructions - Behavioral Health Programs" including the Chart of Accounts, administered by DSHS/BHSIA/Budget & Finance Division, and

3.7.1.2. The "Behavioral Health Program Revenue and Expenditure (R&E) Report Instructions" published by DSHS/BHSIA/Budget & Finance Division; located at https://www.dshs.wa."gov/bhsia/division-behavioral-health-and-recovery/contractors-and-providers – Select "Behavioral Health Services Contractors/Providers" – listed under "Forms".

3.7.2. Any revenue collected by Subcontractors for services provided under this Agreement. This includes revenue collected from Medicare, insurance companies, co-payments, and other sources. The Contractor must certify that a process is in place to demonstrate that all third party revenue resources for services provided under this Agreement are identified, pursued, and recorded by the Subcontractor.

3.7.3. In addition, the Contractor shall submit a single financial certification form, provided by the DBHR, indicating that administrative costs, as defined in the "Behavioral Health Program Revenue and Expenditure (R&E) Report Instructions" , incurred by the Contractor are no more than ten (10) percent of the annual revenue supporting the public behavioral health system operated by the Contractor. Administrative costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by DBHR.

3.7.4. If the Contractor is unable to provide valid certifications or if DBHR finds discrepancies in the Revenue and Expenditure Report, DBHR may initiate remedial action. Remedial action may include recoupment from funds disbursed during the current or successive Agreement period. Recoupment shall occur within ninety (90) calendar days of the close of the State fiscal year or within ninety (90) calendar days of the DBHR's receipt of the certification, whichever is later.

3.7.5. DBHR reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data. DBHR agrees to involve the BHO in the decision process prior to implementing changes in format, and shall request the RSN to review and comment on format changes before they go into effect whenever possible.

3.8. Contractor DUNS Number. "DUNS" or "Data Universal Numbering System" means a unique identifier for businesses. DUNS numbers are assigned and maintained by Dun and Bradstreet (D&B) and are used for a variety of purposes, including applying for government contracting opportunities. The Contractor's DUNS number is: and "Zip Code+4" numbers are: .

4. ACCESS TO CARE

4.1. The Contractor shall ensure services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. Policies for guidelines shall include all services detailed in Access to Care Standards. https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/contractors-and-providers.

4.2. Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in §440.230.

4.2.1. The Contractor may place appropriate limits on a service for the purpose of utilization control, provided the services furnished can reasonably be expected to be sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. CFR438.210(3)(iii)(B).

4.3. The Contractor shall not deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

4.4. The Contractor shall not discriminate against difficult-to-serve Enrollees. Examples include a refusal to treat an Enrollee because the Enrollee is deemed too dangerous, because housing is not available in the community, or that a particular type of residential placement is not currently available.

4.5. The Contractor may refuse to provide, reimburse for, or provide coverage of certain services based on moral or religious grounds.

4.5.1. If the Contractor chooses to refuse any services or coverages on moral or religious grounds it must provide a list of those services to Enrollees.

4.5.2. If the Contractor establishes any new policy regarding a moral or religious objection to any service or coverage it must notify DSHS 30 days prior to enacting the policy and all of its Enrollees within 90 days of adopting of enacting the policy.

Any policy not expressly conveyed to DSHS prior to the start date of this contract shall be classified as “new”.

4.6. If the Contractor is unable to provide the services covered under this Agreement, the services must be purchased within twenty eight (28) calendar days for an Enrollee with an identified need. The Contractor shall continue to pay for medically necessary mental health services outside the service area until the Contractor is able to provide them within its service area.

4.7. **Network Capacity**. The Contractor shall establish and maintain a network based on the anticipated Medicaid enrollment, expected utilization of services, and the number of network providers who are not accepting new Medicaid patients, with sufficient capacity, including the number, mix, and geographic distribution of Behavioral Health Agencies (BHA) which serve individuals with mental health and/or substance use disorders, Mental Health Care Providers (MHCPs) and CDPs to meet the needs of all eligible Enrollees under this Agreement with (42 C.F.R. § 438.206(b)(1)).

4.7.1. The Contractor shall maintain and monitor an appropriate provider network, supported by written agreements, sufficient to serve all eligible Enrollees under this Contract.

4.7.2. The Contractor shall contract with licensed Behavioral Health Agencies (BHA) to provide plan services for the Enrollees in their service area. If the Contractor is unable to provide services within its network, it must provide services in accordance with the Benefits Section.

4.7.3. The Contractor must maintain documentation regarding its maintenance, monitoring and analysis of the network to determine compliance with the requirements of this Section.

4.7.3.1. The Contractor must provide the required documentation at any time upon DSHS request, when there has been a change in the Contractor’s network or operations that, in the sole judgment of DSHS, would affect adequate capacity and/or the Contractor’s ability to provide services.

4.7.3.2. This information must include at least, the names of all sub-contracted BHAs and the scope of services provided by the sub-contractors.

4.7.4. To the extent necessary to comply with the provider network adequacy and distance standards required under this Agreement, the Contractor shall offer contracts to providers in bordering states (74.09.171 RCW). The Contractor’s provider contracts with providers in bordering states must ensure timely access to necessary care, including inpatient and outpatient services and must coordinate with Oregon and Idaho providers to explore opportunities for reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective.

4.7.4.1. The Contractor shall provide quarterly status reports to DBHR on its contracting activities in border communities and services area.

4.7.5. At a minimum the Contractor shall:

4.7.5.1. Offer a mental health intake evaluation by a MHP within ten (10) business days of an Enrollee request.

4.7.5.2. Offer a substance use disorder treatment assessment by a CDP within ten (10) business days of an Enrollee request

4.7.5.3. Maintain the ability to provide an intake evaluation at an Enrollee's residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to persons discharged from a state hospital or evaluation & treatment facilities to such placements when the Enrollee requires an offsite service due to medical needs.

4.7.5.4. Provide or purchase age, linguistic and culturally competent community mental health services for Enrollees for whom services are medically necessary and clinically appropriate consistent with the Medicaid state plan and the Federal 1915 (b) Behavioral Health Waiver.

4.7.5.5. Maintain the ability to adjust the number, mix, and geographic distribution of mental health and substance use disorder treatment clinicians to meet Access and Distance Standards as the population or Enrollees needing behavioral health services shift within the service area.

4.7.5.6. Maintain the ability to adjust reimbursement amounts for different specialties or for different practitioners in the same specialty to meet Access and Distance Standards as the needs of the Enrollees shift within the service area.

4.7.5.7. The provider network must include providers that has specialized expertise in the provision of manualized, evidence-based chemical dependency treatment services for offenders who meet the Contractors level of care guidelines for medical necessity.

4.7.5.8. The provider network must include providers that have specialized expertise in the provision of SUD services for women who are pregnant and who meet the Contractors level of care guidelines for medical necessity.

4.7.5.9. The provider network must include access to medication assisted treatment when it's clinically appropriate and medically necessary. This

can be provided either through DSHS licensed and certified Opiate Substitution Treatment providers or through a medical Medicaid benefit.

4.7.6. Changes in provider network: A significant change in the provider network is defined as the termination or addition of a Subcontract with an entity that provides mental health services or the closing of a Subcontractor site that is providing services required under this Agreement. The Contractor must notify DSHS and impacted Enrollees thirty (30) calendar days prior to terminating any of its Subcontracts with entities that provide direct services or entering into new Subcontracts with entities that provide direct service. This notification must occur prior to any public announcement of this change.

4.7.6.1. The Contractor must notify all impacted Enrollee's within 15 days after receipt or issuance of a contract termination notice with any of its providers.

4.7.6.2. If either the Contractor or the Subcontractor terminates a Subcontract in less than thirty (30) calendar days or a site closure occurs in less than thirty (30) calendar days, the Contractor must notify DSHS as soon possible and prior to a public announcement.

4.7.6.3. The Contractor shall notify DSHS of any other changes in capacity that results in the Contractor being unable to meet any of the Access Standards as required in this Agreement. Events that affect capacity include: decrease in the number or frequency of a required service, employee strike or other work stoppage related to union activities, closure of a BHA, or any changes that will result in the Contractor being unable to provide timely, medically necessary services.

4.7.6.4. If any significant change network capacity occurs, the Contractor must submit a plan to DSHS for Enrollees and services that include at least:

- Notification to Ombuds services.
- Crisis services plan.
- Client notification plan.
- Plan for provision of uninterrupted services.
- Plan for retention and/or transfer of clinical records.
- Any information released to the media.

4.8. BHA Provider Non-Discrimination.

4.8.1. The Contractor must ensure there is no discrimination in selection of providers based on:

4.8.1.1. The participation, reimbursement, or indemnification of any BHA acting within the scope of its license or certification under applicable State law solely upon the basis of that license or certification.

4.8.1.2. BHAs who serve high risk behavioral health Enrollees or specialize in behavioral health conditions that require costly treatment.

4.8.2. In the event that the Contractor declines to include a provider in the network, the Contractor shall give the provider written notice of the reason for that decision.

4.9. Enrollment Standards. The Contractor is responsible for services within the boundaries of the Counties listed in Exhibit C.

Enrollees of all ages who reside within the Contractor's service area who are enrolled in any of the programs included in the Federal 1915 (b) Behavioral Health Waiver are covered by this Agreement.

4.10. Access Standards. A request for services may be made through a telephone call, walk-in, or written request from an Enrollee or those defined as Family in this Agreement.

4.10.1. The Contractor must verify eligibility for Title XIX prior to the provision of non-crisis services to an Enrollee.

4.10.2. The Contractor must maintain documentation of all requests for service even if no service actually occurs.

4.10.3. The Contractor shall not refer a Washington Apple Health Enrollee to the Enrollee's Apple Health managed care plan for mental health services if the Enrollee is determined to be eligible based on medical necessity and the Access to Care Standards.

4.11. Distance Standards.

4.11.1. The Contractor shall ensure that when Enrollees must travel to service sites, the drive time to the closest provider of the behavioral health service they are seeking is within a standard of not more than:

- In Rural Areas, a thirty (30)--minute drive from the primary residence of the Enrollee to the service site.
- In Large Rural Geographic Areas, a ninety (90)-minute drive from the primary residence of the Enrollee to the service site.

- In Urban Areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed ninety (90)-minutes each way.

4.11.2. Travel standards do not apply: a) when the Enrollee chooses to use service sites that require travel beyond the travel standards; b) to mental health clubhouses when the population is insufficient to support additional clubhouses within the geographic area c) to psychiatric inpatient services including E&T; d) substance use disorder treatment residential treatment facilities and e) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

4.12. Customer Service. The Contractor shall provide customer service that is customer-friendly, flexible, proactive, and responsive to consumers, families, and stakeholders. The Contractor shall provide a toll free number for customer service inquiries. A local telephone number may also be provided for Enrollees within the local calling area.

4.12.1. Promptly answer telephone calls from consumers, family members and stakeholders from 8:00 a.m. until 5:00 p.m. Monday through Friday, holidays excluded.

4.12.2. Respond to consumers, family members and stakeholders in a manner that resolves their inquiry. Staff must have the capacity to respond to those with limited English proficiency or hearing loss.

4.12.3. Customer service staff must be trained to distinguish between a benefit inquiry, third party insurance issue, Appeal or Grievance and how to route these to the appropriate party. At a minimum, logs shall be kept to track the date of the initial call, type of call and date of attempted resolution. This log shall be provided to DSHS for review upon request.

4.13. Miscellaneous Changes. In the event that any of the following is significantly changed the Contractor shall notify it's Enrollees within 30 days of the change occurring.

- restrictions on the Enrollee's freedom of choice among network providers,
- grievance and fair hearing procedures.
- amount, duration, and scope of benefits available
- procedures for obtaining benefits, including authorization requirements.
- extent to which, and how, Enrollees may obtain benefits, including family planning services.
- extent to which, and how, after-hours and emergency coverage are provided.

5. UTILIZATION MANAGEMENT

5.1. Level of Care Guidelines. The Contractor and its subcontractors shall establish written policies and procedures for authorization of Behavioral Health services. Maintain written utilization management criteria that include the Mental Health Access to Care Standards and ASAM Levels of Care placement criteria. The Contractor's Level of Care Guidelines shall be provided to DSHS upon request. DSHS reserves the right to request changes to the Contractor's Level of Care Guidelines.

The Contractor shall use these policies for making decisions about scope, duration, intensity and continuation of services. The Level of Care Guidelines shall include:

5.1.1. Criteria for authorization of initial Routine services including outpatient and residential treatment programs. These services do not meet the definition of urgent or emergent care.

5.1.2. The establishment of a covered Mental Health or Substance Use Disorder diagnosis based on DSM 5.

5.1.3. The ASAM criteria for initial authorizations, continuing stay and discharge for SUD services.

5.1.3.1. ASAM levels of care for outpatient and residential services include the following:

Level 1 - Outpatient Services

Level 2.1 – Intensive Outpatient Services

Level 3.1 – Clinically Managed, Low Intensity Residential Services

Level 3.3 – Clinically Managed, Population Specific, High Intensity, Residential Services. (This level of care not designated for adolescent populations)

Level 3.5 – Clinically Managed, Medium Intensity Residential Services

5.1.3.2. ASAM levels of care for Withdrawal Management (Detoxification Services) Include the following:

Level – 3.2 – WM Clinically managed Residential Withdrawal Management. (Acute and Sub-Acute Certification)

5.1.4. Mental Health Access to Care Standards for mental health services.

5.1.5. Criteria for Authorization of Routine and Inpatient care at a community psychiatric hospital.

5.1.6. Enrollees cannot be required to relinquish custody of minor children in order to access residential SUD treatment services.

5.1.7. Continuing stay and discharge criteria for Routine and Inpatient Care. Mental Health - Access to Care Standards may not be used as continuing stay and discharge criteria from Routine mental health services.

5.1.8. The requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be determined by a professional who meets or exceeds the requirements of a Chemical Dependency Professional or Mental Health Professional with the appropriate clinical expertise.

5.2. Appointment Standards. The Contractor shall comply with appointment standards that are consistent with the following:

5.2.1. The Contractor shall make available crisis mental health services on a twenty four (24)-hour, seven (7) days per week basis that may be accessed without full completion of intake evaluations and/or other screening and assessment processes.

5.2.1.1. Emergent mental health care must occur with two (2) hours of a request for mental health services from any source.

5.2.1.2. Urgent care must occur within twenty four (24) hours of a request for mental health services from any source.

5.2.2. A routine behavioral health intake evaluation or assessment appointment must be available and offered to every Enrollee within fourteen (14) calendar days of the request, with a possible extension of up to an additional fourteen (14) calendar day, unless both of the following conditions are met:

- An intake evaluation or assessment has been provided in the previous twelve (12) months that establishes medical necessity; and
- The Contractor agrees to use the previous intake evaluation or assessment as the basis for authorization decisions.

5.2.3. The time period from request from behavioral health services to the first Routine Service appointment offered must not exceed twenty eight (28) calendar days.

5.2.4. The Contractor must document the reason for any delays. This includes documentation when the consumer declines an intake appointment within the first ten (10) business days following a request or declines a Routine appointment offered within the twenty eight (28) calendar day timeframe.

5.2.5. The Contractor must monitor the frequency of Routine appointments that occur after twenty eight (28) calendar days for patterns and apply corrective action where needed.

5.3. Authorization for Routine Services. The Contractor shall make a determination of eligibility for an initial authorization of Routine services based on Medical Necessity. –

5.3.1. Medical Necessity for Mental Health Services is based on the presence of a covered DSM 5 mental health diagnosis and application of the Mental Health Access to Care Standards following the initiation of the intake evaluation.

5.3.2. Medical Necessity for Substance Use Disorder Treatment Services is based on the presence of a DSM 5 substance related diagnosis and application of the ASAM criteria following an Assessment.

5.3.2.1. An extension of up to fourteen (14) additional calendar days to make the authorization decision is possible upon request by the Enrollee or the BHA or the Contractor justifies (to DSHS upon request) a need for additional information and how the extension is in the Enrollee's interest.

5.3.2.2. The Contractor and its subcontractors must have written policies and procedures to ensure consistent application of extensions within the service area.

5.3.2.3. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary.

5.3.2.4. Authorization decisions must be expedited to no longer than three (3) business days after receipt of the request for services if either of the following is true:

- the Enrollee's presenting mental health condition affects their ability to maintain or regain maximum functioning
- the Enrollee presents a potential risk of harm to self of others

5.3.3. The Contractor must designate at least one (1) Children's Care Manager that is a Children's Mental Health Specialist or is supervised by a Children's Mental Health Specialist who oversees the authorizations of Enrollees under the age of 21 years old.

5.3.4. The Contractor or formal designee must review requests for additional services to determine a re-authorization following the exhaustion of previously authorized services by the Enrollee. This must include:

5.3.4.1. An evaluation of the effectiveness of services provided during the benefit period and recommendations for changes in methods or intensity of services being provided.

5.3.4.2. A method for determining if an Enrollee has met discharge criteria.

5.4. Notice of Adverse Action. The Contractor must notify the requesting provider, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

5.5. Authorization for Inpatient Services. The Contractor must have appropriate clinical staff members available 24 hours a day, 7 days a week to respond to requests for certification of psychiatric inpatient care in community hospitals. The Contractor shall adhere to the requirements set forth in the Washington Apple Health Mental Health Services Provider Guide. A decision regarding certification of psychiatric inpatient care must be made within twelve (12) hours of the initial request.

5.5.1. Only a psychiatrist or doctoral level-clinical psychologist may deny a request for psychiatric inpatient care.

5.5.2. If the authorization is denied, a Notice of Action must be provided to the Enrollee or their Authorized Representative.

5.5.3. If the Contractor denies payment of any portion of a psychiatric inpatient stay and the inpatient facility has a dispute, the Contractor shall follow the dispute process provided in the HCA Inpatient Hospital Services Medicaid Provider Guide, under "Provider Services", "Provider Information", "Claims and Billing".

5.5.4. In the event that a community hospital becomes insolvent, the Contractor shall continue authorized community psychiatric inpatient services for the remainder of the period for which payment has been made, as well as for inpatient admissions up until discharge.

5.6. Institutes of Mental Disease: The Contractor may provide services for individuals who are aged 22 to 64 in Institutes for Mental Disease (IMD) in lieu of covered acute psychiatric or withdrawal management (detoxification) services. For acute psychiatric services this authority is limited to 30 calendar days per admission. For withdrawal management this authority is limited to 5 days per admission. The Contractor is not required to provide these services in IMD settings. These services are substituted only for covered acute inpatient, evaluation and treatment or withdrawal management (detoxification) services and may not be used for long-term IMD services. Encounters of these services shall be reported as described in the Service Encounter Reporting Instructions (SERI).

5.7. Transition of Services The following requirements are established to ensure the transition of the responsibility to pay for and coordinate services to a Behavior Health Organization (BHO), as mandated by Second Substitute Senate Bill 6312, as of April 1, 2016.

5.7.1. For all individuals receiving services under a DSHS fee for service contract ending July 1, 2016, the Contractor shall cooperate with DSHS and previously contracted Counties or other entity, by participating in the following activities:

5.7.1.1. Identify all who are expected to be engaged in treatment on April 1, 2016.

5.7.1.2. For each transitioning client, and with client's written consent and proper release in accordance with CFR 42 Part 2, Subpart C, 2.31 "Form of Written Consent", collect the current treatment information including:

1. **What services are being provided?**
2. **Planned treatment end date,**
3. **Services provider information,**
4. **Treatment location, and**
5. **Administrative records.**
6. **Individual Client transition plans.**
7. **Other activities as requested by DSHS.**

5.7.2. DSHS is responsible for payment for all services delivered up to but not including the Implementation Date.

5.7.3. As of April 1, 2016 the Contractor will be responsible for payment for all services for individuals in a course of treatment that was started under a fee for service arrangement with any DSHS contracted provider for SUD services that are now covered by this contract. Beginning on April 1, 2016 the Contractor must:

5.7.3.1. Develop a safe, medically appropriate transition plan, considering the health and safety of the transitioning individual.

5.7.3.2. Authorize and become responsible for continuing services for individuals in a course of treatment that began prior to April 1, 2016 for up to sixty (60) calendar days after the implementation date, or until one of the following occurs based on the ASAM criteria:

1. **The course of treatment is complete, or**
2. **The Contractor evaluates the client and determines that services are no longer necessary, or**

3. **The Contractor determines that a different course of treatment is indicated.**

5.7.3.3. Authorize and become responsible for Involuntary Treatment services to continue in accordance with RCW 70.96A.140 using ASAM Criteria to determine length of stay.

5.7.4. The Contractor shall ensure that all services are delivered under a subcontract meets all contractual requirements of this Contract including but not limited to Subcontractor, HIPAA, Confidentiality, and Data Security Requirements.

5.8. Utilization Management Plan: The Utilization Plan may not be structured in such a way as to provide incentives to individuals or entities to deny, limit, or discontinue medically necessary services

5.8.1. The Contractor shall have a medical director (consultant or staff) who is qualified to provide guidance, leadership, oversight, utilization and quality assurance for the behavioral health programs. These following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the medical director to oversee. Utilization reviews with the following components:

- Services requested in comparison to services identified as medically necessary.
- A review of youth receiving medication without accompanying behavioral or therapeutic intervention
- Level of Care authorized for SUD treatment services based on ASAM PPC in comparison to treatment services provided.
- A review of which goals identified in the Individual Service Plan have been met, have been discontinued or have continued need.
- Patterns of denials
- Use of Evidence-Based and other identified practice guidelines
- Use of discharge planning guidelines
- Community standards governing activities such as coordination of care among treating professionals
- Coordination with Tribal and Recognized American Indian Organizations (RAIO) and other Individual serving agencies

5.8.2. The Contractor must establish criteria for and document and monitor:

- Consistent application of Medical Necessity criteria and Level of Care Guidelines including the use of Access to Care Standards and ASAM placement criteria
- Consistent application of criteria for authorization decisions for continuing stay and discharge
- Appropriate inclusion of providers in utilization decisions
- Over and under-utilization of services

6. GRIEVANCE SYSTEM

6.1. General Requirements. The Contractor shall have a Grievance system that complies with the requirements of 42 CFR 438 § Subpart F and WAC 388-877A-0410-0460, insofar as those WACs are not in conflict with 42 CFR 438 § Subpart F. The Grievance System shall include a Grievance Process, an Appeal Process, and access to the State Fair Hearing process.

6.1.1. The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Agreement. These shall be provided to DSHS within 60 days of this Contract's Start Date. DSHS shall approve, in writing, all Grievance System policies and procedures and related Notices to Enrollees regarding the Grievance System.

6.1.2. The Contractor shall provide Enrollees with any reasonable assistance necessary to complete forms and other procedural steps for Grievances and Appeals 42 CFR § 438.406(a)(1). Enrollees may also use the free and confidential ombuds services provided by the BHO.

6.2. Grievance Process. The following requirements are specific to the Grievance Process:

6.2.1. Only an Enrollee or the Enrollee's Authorized Representative may file a Grievance with the Contractor to express dissatisfaction in person, orally, or in writing about any matter other than an Action to:

- The Contractor; or
- The BHA providing the behavioral health services.
- The Ombuds serving the Contractor or BHA may assist the Enrollee in resolving the Grievance at the lowest possible level.

6.2.2. An Enrollee may choose to file a Grievance with the Contractor or with the BHA, subject to the following:

6.2.2.1. Filing a Grievance with a BHA.
If the Enrollee first files a Grievance with the BHA and the Enrollee is not satisfied with the BHA's written decision on the Grievance, or if the Enrollee does not receive a copy of that decision from the BHA within the timelines established this Agreement, the Enrollee may then choose to file the Grievance with the Contractor.

6.2.2.2. Filing a grievance with the Contractor.
If the Enrollee first files a grievance with the Contractor (and not the BHA), and the Enrollee either is not satisfied with the Contractor's written decision on the grievance, or does not receive a written copy of the decision within the established timelines in this Agreement, the Enrollee can request a Fair Hearing to review the Contractor's decision or failure to make a timely decision. Once an Enrollee receives a decision on a Grievance from the Contractor, the Enrollee cannot file the same Grievance with the BHA.

6.2.3. When an Enrollee files a Grievance, the Contractor or BHA receiving the Grievance shall:

- Acknowledge the receipt of the Grievance in writing within five (5) business days;
- Investigate the Grievance; and
- Send the Enrollee who filed the Grievance a written notices describing the decision within 90 calendar days from the date the Grievance was filed.

6.2.4. The Contractor or BHA receiving the Grievance shall ensure the following:

6.2.4.1. Other people, if the Enrollee chooses, are allowed to participate in the Grievance process.

6.2.4.2. The Enrollee's right to have currently authorized mental health services continued pending resolution of the Grievance.

6.2.4.3. That a Grievance is resolved even if the Enrollee is no longer receiving mental health services.

6.2.4.4. That the persons who make decisions on a Grievance:

- Were not involved in any previous level of review or decision-making; and
- Are MHPs or CDPs who have appropriate clinical expertise if the Grievance involves clinical issues.

6.2.4.5. That the Enrollee and, if applicable, the Enrollee's Authorized Representative receive a written Notice containing the decision within 90 calendar days from the date a Grievance is received by the Contractor or BHA.

This timeframe can be extended up to an additional 14 calendar days:

- If requested by the Enrollee or the Enrollee's Authorized Representative; or

- By the Contractor or BHA when additional information is needed and the Contractor can demonstrate that it needs additional information and that the added time is in the Enrollee's interest.

6.2.4.6. That the written Notice includes:

- The decision on the Grievance;
- The reason for the decision; and
- The right to request a Fair Hearing and the required timeframe to request the hearing.

6.2.4.7. That full records of all Grievances and materials received or compiled in the course of processing and attempting to resolve the Grievance are maintained and:

6.2.4.7.1. Kept for six (6) years after the completion of the grievance process;

6.2.4.7.2. Made available to DSHS upon request as part of the state quality strategy;

6.2.4.7.3. Kept in confidential files separate from the individual's clinical record; and

6.2.4.7.4. Not disclosed without the Enrollee's written permission, except to DSHS or as necessary to resolve the Grievance.

6.3. Notice of Action.

The Contractor shall provide a written Notice of Action, to the Enrollee or their Authorized Representative, in accordance with 42 CFR§438.404. Notices of Action must be provided in the prevalent non-English languages as described in the Information Requirements section and meet the language and format requirements of 42 CFR §438.10 (c &d).

The Notice of Action shall include an understandable explanation of:

- The Action the Contractor or BHA has taken or intends to take;
- The reasons for the Action and a citation of the rule(s) being implemented;
- The Enrollee's right to file an Appeal with the Contractor, the process to file an appeal, and the required timeframes if the Enrollee does not agree with the decision or Action;
- The circumstances under which an expedited resolution is available and how to request it; and
- The Enrollee's right to receive mental health services while an Appeal is pending, how to make the request that benefits be continued, and that the Enrollee may be held liable for the cost of services received while the Appeal is pending if the Appeal decision upholds the decision or Action.

6.3.1. The Contractor or its agent must mail the Notices of Action within the following timeframes:

6.3.1.1. For Routine Service authorization decisions that deny or limit services, no longer than 14 calendar days from the request for service.

6.3.1.2. For reductions, suspensions, or reductions of previously authorized services, no longer than 10 days before the date of the Action.

6.3.1.3. For Actions that are issued because the Contractor has verifiable information indicating probably beneficiary fraud the notice can be provided in as few as 5 calendar days.

6.3.1.4. When any of the following occur the contractor shall issue the notice on the date of the Action:

6.3.1.5. The recipient has died.

6.3.1.6. The Enrollee submits a signed written statement requesting service termination.

6.3.1.7. The Enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.

6.3.1.8. The Enrollee has been admitted to an institution in which he is ineligible for Medicaid services.

6.3.1.9. The Enrollee's address is determined unknown based on returned mail with no forwarding address.

6.3.1.10. The Enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

6.3.1.11. A change in the level of medical care is prescribed by the Enrollee's physician.

6.3.1.12. The notice involves an adverse determination with regard to preadmission screening requirements.

6.3.1.13. The transfer or discharge from a facility will occur in an expedited fashion as described in 42 CFR 483.12(a)(5)(ii).

6.3.1.14. Under the following circumstances, 14 additional calendar days are possible:

- The Enrollee or the BHA requests an extension.
- The Contractor demonstrates the need for additional information to make an authorization decision and that the extension is in the Enrollee's best interest.

6.3.1.15. If the Contractor extends the timeframe it shall:

- Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and
- Issue and carry out its determination as expeditiously as the Enrollee's mental health condition requires and no later than the date the extension expires.

6.3.2. The Contractor must provide a Notice on the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.

6.4. Appeals Process. The following requirements are specific to the Appeals Process:

6.4.1. The Contractor shall ensure that the Appeals Process allows an Enrollee, the Enrollee's Authorized Representative, a Service Provider, or a BHA acting on behalf of the Enrollee and with the Enrollee's written consent, to appeal a Contractor's Action (42 CFR § 438.402(b)(1)(ii)). If a written Notice of Action was

not received, an appeal may still be filed. The appeal may be filed orally or in writing and unless requests expedited resolution, must follow an oral filing with a written, signed appeal.

6.4.2. The Enrollee requesting review of an Action:

6.4.2.1. Must file an Appeal and receive a Notice of Resolution from the Contractor before requesting a Fair Hearing; and

6.4.2.2. May not file a Grievance with the BHA or the Contractor for the same issue as the Appeal once an Appeal has been filed.

6.4.3. The Appeals process shall:

6.4.3.1. Provide an Enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available during an Expedited Appeal process.

6.4.3.2. Provide the Enrollee the opportunity, before and during the Appeal Process, to examine the Enrollee's clinical record, including medical records and any other documents and records considered during the Appeal Process.

6.4.3.3. Include as parties to the Appeal as applicable:

- The Enrollee.
- The Enrollee's Authorized Representative.
- The legal representative of a deceased Enrollee's estate.

6.4.3.4. The Contractor shall ensure that the persons who make decisions on an Appeal:

- Were not involved in any previous level of review or decision-making; and
- Are mental health professionals or chemical dependency professionals who have appropriate clinical expertise.

6.4.4. **The Contractor shall maintain full records of all Appeals and ensure an Enrollee's records are:**

6.4.4.1. Kept for six (6) years after the completion of the Appeal Process;

6.4.4.2. Made available to DSHS upon request as part of the state quality strategy;

6.4.4.3. Kept in confidential files separate from the Enrollee's clinical record; and

6.4.4.4. Not disclosed without the individual's written permission, except to DSHS or as necessary to revolve the Appeal.

6.4.5. **Standard Appeals Process.** The standard Appeal process includes the following:

6.4.5.1. Standard Appeals for Actions communicated on a Notice of Action – continued services not requested.

6.4.5.2. An Enrollee who disagrees with a decision or Action communicated on a Notice of Action may file an Appeal orally or in writing.

6.4.5.3. All of the following shall apply:

6.4.5.3.1. The Enrollee shall file the Appeal within 90 calendar days from the date on the Notice of Action.

6.4.5.3.2. The Contractor shall confirm receipt of Appeals in writing within five (5) business days.

6.4.5.3.3. The Contractor shall send the Enrollee a written notice of the resolution within 45 calendar days of receiving the Appeal that includes:

- The Contractor's decision and date of decision;
- The reason for the decision; and
- The right to request a Fair Hearing if the Enrollee disagrees with the decision.

6.4.5.4. The Contractor may extend the timeframe up to 14 additional calendar days if the Enrollee requests an extension or the Contractor can demonstrate that it needs additional information and that the added time is in the Enrollee's interest. If the extension is not requested by the Enrollee or the Enrollee's proxy, the Contractor shall provide a written notice to the Enrollee stating the reason for the extension.

6.4.6. Standard Appeals for termination, suspension, or reduction of previously authorized services – continued services requested.

The Contractor shall ensure that an Enrollee receiving a Notice of Action from the Contractor that terminates, suspends, or reduces previously authorize services contains information that the Enrollee may file an Appeal and request continuation of those services pending the Contractor's decision on the Appeal, and how to do so. All of the following apply:

6.4.6.1. The Enrollee must file the Appeal with the Contractor on or before the later of the following:

- ten (10) calendar days after the date on the Notice of Action
- the intended effective date of the Contractor's proposed Action
- request continuation of services.

6.4.6.2. The Contractor must confirm receipt of the Appeal and the request for continued services with the Enrollee orally or in writing;

Send a Notice in writing that follows up on any oral confirmation made: and

Include in the Notice that if the Appeal decision is adverse to the Enrollee, the Contractor may recover the cost of the mental health services provided pending the Contractor's decision.

6.4.6.3. The Contractor's written Notice of the Resolution shall contain:

The Contractor's decision on the Appeal and the date the decision was made;

The reason for the decision; and

The right to request a Fair Hearing and how to do so if the Enrollee disagrees with the decision and include the following timeframes: within ten (10) calendar days from the date on the Notice of the Resolution if the Enrollee is asking that services be continued pending the outcome of the hearing; within 90 calendar days from the date on the Notice of the Resolution if the Enrollee is not asking for continued service.

6.4.6.4. The Contractor may extend the timeframe up to 14 additional calendar days if the Enrollee requests an extension or the Contractor can demonstrate that it needs additional information and that the added time is in the Enrollee's interest. If the extension is not requested by the Enrollee or the Enrollee's proxy, the Contractor shall provide a written notice to the Enrollee stating the reason for the extension.

6.5. Expedited Appeal Process. The Contractor shall establish and maintain an Expedited Appeal Process for Appeals when the Contractor determines or a BHA indicates that taking the time for a standard resolution of an Appeal could seriously jeopardize the Enrollee's life or health and ability to attain, maintain, or regain maximum function (42 CFR § 438.410(a)).

6.5.1. If the Contractor denies the request for the expedited Appeal and resolution of an Appeal, it must transfer the Appeal to the timeframe for standard resolutions under subsection 8.5 of this Agreement, and make reasonable efforts to give the Enrollee prompt oral notice of the denial and follow up within two (2) calendar days with a written Notice.

6.5.2. Both of the following apply to Expedited Appeal requests:

6.5.2.1. The Action taken on the Notice of Action is for termination, suspension, or reduction of previously authorized behavioral health services; and

6.5.2.2. The Enrollee, the Enrollee's Authorized Representative, or a BHA acting on behalf of the Enrollee and with the Enrollee's written consent, may file an Appeal with the Contractor, either orally or in writing, within ten (10) calendar days from the date on the Contractor's written Notice of Action that communicated the Action.

6.5.3. The Enrollee may ask for continued mental health services pending the outcome of the Expedited Appeal.

6.5.4. The Contractor shall make a decision on the Enrollee's request for Expedited Appeal and provide written Notice, as expeditiously as the Enrollee's condition requires, within two (2) calendar days after the Contractor receives the Appeal. (42 CFR § 438.408(b)(3)). The Contractor shall also make reasonable efforts to provide oral notice.

6.5.5. The Contractor shall ensure that punitive action is not taken against a BHA who requests an expedited resolution or supports an Enrollee's Appeal (42 CFR § 438.410(b)).

6.5.6. The Contractor may extend the timeframe up to 14 additional calendar days if the Enrollee requests an extension or the Contractor can demonstrate that it needs additional information and that the added time is in the Enrollee's interest.

6.5.7. For any extension not requested by an Enrollee, the Contractor must give the Enrollee written notice of the reason for the delay.

6.5.8. The Enrollee has a right to file a Grievance regarding the Contractor's denial of a request for expedited resolution. The Contractor shall inform the Enrollee of their right to file a Grievance in the Notice of denial.

6.6. Duration of Continued Services during the Appeal Process. When an Enrollee has requested continued mental health services pending the outcome of the Appeal Process, the Contractor shall ensure that services are continued until the following occurs:

6.6.1. The Enrollee withdraws the Appeal.

6.6.2. Ten (10) calendar days pass from the date on the Notice of Action or:

6.6.3. The Contractor provides a written Notice of the Resolution that contains a decision that is not wholly in favor of the Enrollee: or

6.6.4. The Enrollee, within the ten (10) day timeframe, has not requested a Fair Hearing with continuation of services: or

6.6.5. The time period of a previously authorized service has expired; or

6.6.6. A mental health treatment service limit of a previously authorized service has been fulfilled.

6.7. Recovery of the Cost of Behavioral Health Services in Adverse Decisions of Appeals. If the final written Notice of the Resolution of the Appeal is not in favor of the Enrollee, the Contractor may recover the cost of the mental health services furnished to the Enrollee while the Appeal was pending to the extent that they were provided solely because of the requirements of this Action.

6.8. Fair Hearings.

6.8.1. Only the Enrollee or the Enrollee's Authorized Representative may file a request for a Fair Hearing.

6.8.2. If an Enrollee does not agree with the Contractor's resolution of the Appeal, the Enrollee may file a request for a hearing within the following time frames:

6.8.2.1. For hearings regarding a standard service, within 90 calendar days of the date on the Contractor's mailing of the Notice of the resolution of the Appeal (42 C.F.R. § 438.402(b)(2)).

6.8.2.2. For hearings regarding termination, suspension, or reduction of a previously authorized service, if the Enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the Notice of the resolution of the Appeal. If the Enrollee is notified in a timely manner and the Enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for a hearing regarding a standard service apply (42 C.F.R. § 438.420).

6.8.3. The Enrollee shall exhaust all levels of the Appeals Process prior to filing a request for a Fair Hearing. The parties to the Fair Hearing include the Contractor as well as the Enrollee and his/her Authorized Representative or the legal representative of a deceased Enrollee's estate.

6.8.4. DSHS shall be responsible for the implementation of the hearing decision, even if the hearing decision is not within the purview of this Agreement.

6.8.5. DSHS will notify the Contractor of hearing determinations. The Contractor shall be bound by the hearing determination, whether or not the hearing determination upholds the Contractor's decision.

6.8.6. If the Contractor or the state Fair Hearings officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the

Contractor must authorize or provide the disputed services promptly and as expeditiously as the Enrollee's behavioral health condition requires.

6.9. Recordkeeping and Reporting Requirements.

6.9.1. The Contractor must maintain records of Grievances, Actions, Appeals and Fair Hearings originating at or handled by a BHHA, Ombuds or Contractor.

6.9.2. The Contractor must submit client-level information in a format required by DSHS that will contain at least the following information regarding each Action issued by the Contractor.

- Client's full name, date of birth, and P1 or CIS identifier
- Date and type of action (per WAC 388-877A-0410)
- Date of appeal
- Outcome of review of denials and limited authorizations
- Plan for improvement

6.9.3. The Contractor shall incorporate the results of grievances, Appeals and Fair Hearings into its quality management plan and address any trends in a quality improvement plan.

6.9.3.1. Report Periods will be provided by DBHR.

6.9.3.2. Reports that do not meet the grievance system reporting requirements shall be returned to the Contractor for correction. Corrected reports must be resubmitted to DSHS within 30 calendar days.

7. PROGRAM INTEGRITY

7.1. The Contractor shall ensure compliance by having written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State program integrity standards, including proper payments to providers and methods for detection of fraud, waste, and abuse.

7.2. The Contractor shall include Program Integrity requirements in its subcontracts and provider applications, credentialing and re-credentialing processes. These requirements must also be propagated to any other lower tier subcontracts entered into by a subcontractor.

7.3. The following are relevant citations for Program Integrity compliance. The Contractor is expected to be familiar with, comply with, and require subcontractor compliance with all regulations related to Program Integrity whether those regulations are listed or not. Provider credentialing must incorporate program integrity requirements.

- 42 CFR 438.608(a)
- 42 CFR 455
- 42 CFR 1000 through 1008

7.4. Required Provisions Contractors:

7.4.1. The Contractor shall disclose to the DSHS upon contract execution, and upon request when a contract is renewed or extended [42 CFR 455.104(c)(1)(ii)], and within 35 days after any change in ownership.[42 CFR 455.104(c)(1)(iv)]:

7.4.1.1. The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor, 42 CFR 455.104(b)(1)(i).

7.4.1.2. For a corporate entity, the disclosure must include primary business address, every business location, and P.O. Box address and tax identification number 42 CFR 455.104(b)(1)(i) and (iii)

7.4.1.3. For individuals, date of birth and Social Security Number. 42 CFR 455.104(b)(1)(ii).

7.4.1.4. If the Contractor has a 5% ownership interest in any of its Subcontractors, the tax identification number of the subcontractor(s). 42 CFR 455.104(b)(1)(iii).

7.4.1.5. The name of any other disclosing entity (or fiscal agent or managed care entity) in which the owner of the Contractor has a control or interest. 42 CFR 455.104(b)(3).

7.4.1.6. Whether any person with an ownership or controlling interest is related by marriage or blood to any other person with an ownership or controlling interest.

7.4.1.7. Any other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any subcontractor in which the Contractor has a five (5) percent or more interest. (42 CFR 455.104(b)(1)(iii).

7.4.1.8. Whether the Contractor has a five (5) percent ownership in any of its subcontractors or is related to any person with ownership or controlling interest in a subcontractor is related as a spouse, parent, child, or sibling. 42 CFR 455.104(b)(2)

7.4.2. The Contractor shall to disclose to the DSHS or to the HHS Secretary, within 35 days of a request, full and complete information about [42 CFR 455.105(a)]:

7.4.2.1. The ownership of any subcontractor with whom they have had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request. 42 CFR 455.105(b)(1).

Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request. 42 CFR 455.105(b)(1).

7.4.3. The Contractor to investigate and disclose to the DSHS, at contract execution, or renewal, and upon request of DSHS, 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 CFR 455.106(a)]:

7.4.3.1. A person who has an ownership or control interest in the Contractor. 42 CFR 455.106(a)(1).

7.4.3.2. An agent or person who has been delegated the authority to obligate or act on behalf of the Contractor. 42 CFR 455.101; 42 CFR 455.106(a)(1).

7.4.3.3. An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the Subcontractor. 42 CFR 455.101; 42 CFR 455.106(a)(2).

7.5. Provider Credentialing and Disclosures

7.5.1. The Contractor shall use only BHAs that are licensed and/or certified by DSHS.

7.5.2. The Contractor shall have written policies that require monitoring of provider credentials, including maintenance of their state issued license or certification and any findings or concerns about the agency or any of its employees that is identified by either DSHS or the Department of Health.

7.5.3. The Contractor must require the Subcontractor, at the time they enter into, renew or extend a Subcontract, to report to the Contractor, and when required to DSHS or HHS, all of the required information in section 9.4.

7.5.4. The Contractor must monitor and apply to their subcontracted agencies, all requirements in Section 9.8 Excluded Providers.

7.6. Fraud and Abuse. Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person and includes any act that constitutes fraud under applicable federal or State law. Abuse means provider actions that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

7.6.1. The Contractor shall report suspected fraud or abuse directly to the Medicaid Fraud Control Unit (MFCU) as soon as it is discovered and cooperate in any investigation or prosecution conducted by the MFCU.

7.6.2. When the Contractor notifies MFCU about potential fraud and abuse, the Contractor must also send all information sent to the MFCU to DSHS within one (1) working day, to include the source of the complaint, the involved BHA, the nature of the suspected fraud, waste, abuse or neglect, the approximate dollars involved, and the legal and administrative disposition of the case. The report must also include:

7.6.2.1. The Subject(s) of complaint by name and either provider/subcontractor type or employee position;

7.6.2.2. The source of the complaint;

7.6.2.3. The nature of fraud or abuse;

7.6.2.4. The approximate dollar amount;

7.6.2.5. The legal and administrative disposition of the case.

7.6.2.6. The Contractor and all of its Subcontractors must comply with the following:

- Disclosure requirements specified in 42 CFR 455 Subpart B, 42 CFR 431.107 (b) (3).
- Provide without charge and in the form requested, any computerized data stored by the subcontractor, 45 CFR 455.21 (a) (2)
- For free, upon request, copies of records showing the extent of the services delivered to clients, the extent of payments and any other information kept by the Subcontractor, 42 CFR 431.107 (b) (2), 45 CFR 455.21 (a) (2).
- Obtain and use NPIs, if the contractor or provider agency is eligible for one.

7.6.3. The Contractor's, Fraud and Abuse program shall have procedures for the following requirements:

7.6.3.1. Provision of detailed information to employees and subcontractors regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a) (68) of the Social Security Act.

7.6.3.2. Administrative and management arrangements or procedures, and a mandatory compliance plan.

7.6.3.3. Written policies, procedures, and standards of conduct requiring that the Contractor and the Contractor's officers, employees, agents and subcontractors are in compliance with the requirements of this section.

7.6.3.4. A designated compliance officer and a compliance committee who is accountable to senior management.

7.6.3.5. Effective ongoing training and education for the compliance officer, staff of the Contractor, and selected staff of the BHAs.

7.6.3.6. Effective communication between the compliance officer, the Contractor's employees, and the Contractor's network of BHAs.

7.6.3.7. Enforcement of standards through well-publicized disciplinary guidelines.

7.6.3.8. Internal monitoring and auditing of the Contractor and providers.

7.6.3.9. Provisions for prompt responses to detected offenses and development of corrective action initiatives.

7.6.3.10. Provision for full cooperation with any federal, HCA or Attorney General Medicaid Fraud Control Unit (MFCU) investigation including promptly supplying all data and information requested for their investigation.

7.6.3.11. A methodology to verify that services billed by providers were actually provided to Enrollees.

7.7. Provider Payment Suspensions. The Contractor shall establish policies and procedures for suspending a provider's payments when the Contractor determines a credible allegation of fraud exists and there is a pending investigation (42 CFR 455.23).

7.7.1. All suspensions of payment actions under this section will be temporary and will not continue after either of the following:

7.7.1.1. The Contractor or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider; or

7.7.1.2. Legal proceedings related to the provider's alleged fraud are completed.

7.7.2. The Contractor must send notice of its suspension of program payments to the provider within the following timeframes:

7.7.2.1. Five business days of taking such action unless requested in writing by the Medicaid Fraud Control Unit (MFCU) or law enforcement agency to temporarily withhold such notice.

7.7.2.2. Thirty calendar days if requested by law enforcement in writing to delay sending such notice. The request for delay may be renewed in writing as many as two times and in no event may the delay exceed 90 calendar days.

7.7.3. The notice of payment suspension must include or address the following:

7.7.3.1. State that payment is being suspended in accordance with this provision.

7.7.3.2. Set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation.

7.7.3.3. State that the suspension is for a temporary period and cite the circumstances under which the suspension will be terminated.

7.7.3.4. Specify, when applicable, to which type or types of claims or business units of a provider suspension is effective.

7.7.3.5. Inform the provider of the right to submit written evidence for consideration by the Contractor.

7.7.4. The Contractor must document in writing the termination of a suspension including, where applicable and appropriate, any Appeal rights available to a provider.

7.7.5. Whenever the Contractor's investigation leads to the initiation of a payment suspension in whole or part, the Contractor must make a fraud referral to the Medicaid Fraud Control Unit (MFCU) and notify DSHS.

7.7.6. The fraud referral must be made in writing and provided to the MFCU no later than the next business day after the suspension is enacted.

7.7.7. If the MFCU or other law enforcement agency accepts the fraud referral for investigation, the payment suspension may be continued until the investigation and any associated enforcement proceedings are completed.

7.7.8. On a quarterly basis, the Contractor must request a certification from the MFCU or other law enforcement agency that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of the suspension.

7.7.9. If the MFCU or other law enforcement agency declines to accept the fraud referral for investigation the payment suspension must be discontinued.

7.7.10. A Contractor's decision to exercise the good cause exceptions in this contract not to suspend payments or to suspend payments only in part does not relieve the Contractor of the obligation to refer any credible allegation.

7.7.11. The Contractor may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

7.7.11.1. Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

7.7.11.2. Other available remedies implemented by the Contractor more effectively or quickly protect Medicaid funds.

7.7.11.3. The Contractor determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.

7.7.11.4. Enrollee access to items or services would be jeopardized by a payment suspension because the individual or entity serves a large number of Enrollees within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.

7.7.11.5. Law enforcement declines to certify that a matter continues to be under investigation.

7.7.11.6. The Contractor determines that payment suspension is not in the best interests of the Medicaid program.

7.7.12. The Contractor may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

7.7.12.1. Enrollee access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:

7.7.12.2. An individual or entity is the sole community physician or the sole source of essential specialized services in a community.

7.7.12.3. The individual or entity serves a large number of Enrollees within a federal HRSA designated medically underserved area.

7.7.12.4. The Contractor determines based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.

7.7.12.5. The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and the Contractor determines and documents in writing that a payment

suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

7.7.12.6. Law enforcement declines to certify that a matter continues to be under investigation.

7.7.12.7. The Contractor determines that payment suspension only in part is in the best interests of the Medicaid program.

7.7.13. The Contractor must meet the following documentation and record retention requirements.

7.7.13.1. Maintain for a minimum of 5 years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part, including the following:

7.7.13.2. All notices of suspension of payment in whole or part,

7.7.13.3. All fraud referrals to the MFCU or other law enforcement agency,

7.7.13.4. All quarterly certifications of continuing investigation status by law enforcement,

7.7.13.5. All notices documenting the termination of a suspension.

7.7.13.6. Maintain for a minimum of five (5) years from the date of issuance all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause.

7.7.13.7. This type of documentation must include, at a minimum, detailed information on the basis for the existence of the good cause not to suspend payments, to suspend payments only in part, or to discontinue a payment suspension and, where applicable, must specify how long the Contractor anticipates such good cause will exist.

7.7.13.7.1. Annually report to DSHS summary information on each of the following:

7.7.13.7.2. Suspension of payment, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension.

7.7.13.7.3. Situations in which the Contractor determined good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.

7.7.13.7.4. If the Contractor fails to suspend payments to an entity or individual for which there is a pending investigation of a credible allegation of fraud, without good cause, DSHS may withhold monthly payments.

7.8. Excluded Providers. The Contractor is prohibited from paying with funds received under this Agreement for goods and services furnished, ordered or prescribed by excluded individuals and entities: (Social Security Act (SSA) Section 1903(i)(2); 42 CFR 455.104; 42 CFR 455.106; and 42 CFR 1001.1901(b)). In addition, the Contractor shall ensure that it does not employ or contract with anyone that is excluded from participation in Federal health care programs under Section 1128 or Section 1128A of the SSA, Executive Order 12549 or 45 CFR 92.35.

7.8.1. The Contractor must monitor for excluded individuals and entities by:

7.8.1.1. Screening the Contractor's and subcontractor's directors, officer, and partners prior to entering into a contractual or other relationship.

7.8.1.2. Screening individuals and entities with an ownership or control interest of at least five (5) percent of the Contractor's equity prior to entering into a contractual or other relationship.

7.8.1.3. Screening individuals with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Agreement.

7.8.1.4. Screening monthly newly added Contractor and subcontractor's employees, individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from funds received under this Contract.

7.8.1.5. Screening monthly Contractor and subcontractor's employees, individuals and entities with an ownership or control interest that would benefit from funds received under this Contract for newly added excluded individuals and entities.

7.8.2. The Contractor must report to DSHS:

7.8.2.1. Any excluded individuals and entities discovered in the screening within ten (10) business days.

7.8.2.2. Any payments made by the Contractor that directly or indirectly benefit excluded individuals and entities and the recovery of such payments.

7.8.2.3. Any actions taken by the Contractor to terminate relationships with Contractor and subcontractor's employees and individuals with an ownership or control interest discovered in the screening.

7.8.2.4. Any Contractor and subcontractor's employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 within ten (10) business days of the Contractor becoming aware of the conviction.

7.8.2.5. Any subcontractor terminated for cause within ten (10) business days of the effective date of termination to include full details of the reason for termination.

7.8.2.6. Any Contractor and subcontractor's individuals and entities with an ownership or control interest. The Contractor must provide a list with details of ownership and control no later than August 31, 2015, and notify DSHS of any changes within 30 calendar days.

7.8.3. The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

7.8.3.1. The Contractor will immediately terminate any employment, contractual, and control relationships with an excluded individual and entity that it discovers.

7.8.3.2. Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees. (SSA section 1128A(a)(6) and 42 CFR 1003.102(a)(2)).

7.8.4. An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR 455.104(a), and 42 CFR 1001.1001(a)(1)).

7.8.4.1. In addition, if DSHS notifies the Contractor that an individual or entity is excluded from participation by DSHS in RSN's, the Contractor shall terminate all beneficial, employment and contractual, and control relationships with the excluded individual or entity immediately (WAC 388-502-0030).

7.8.4.2. The list of excluded individuals may be found at: https://oig.hhs.gov/exclusions/.

7.8.4.3. SSA section 1128 may be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm.

8. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

8.1. The Contractor shall participate with DSHS in the implementation, update and evaluation of the DBHR Quality Strategies.

8.2. The Contractor shall provide quality improvement feedback to DBHR, BHAs, the Advisory Board, and other interested parties. The Contractor shall maintain documentation of the activities and provide the documentation to DSHS upon request.

8.3. The Contractor shall have in effect mechanisms to detect both underutilization and overutilization of services; and to assess the quality and appropriateness of care furnished to Enrollees with special behavioral health care needs

8.4. Quality Review Activities. The Contractor shall participate with DSHS in review activities. Participation shall include at a minimum:

8.4.1. The submission of requested materials necessary for a DSHS-initiated review within 30 calendar days of the request.

8.4.2. The completion of site visit protocols provided by DSHS.

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

8.5. Practice guidelines. Practice guidelines are systematically developed statements designed to assist in decisions about appropriate behavioral health treatment. The guidelines are intended to assist practitioners in the prevention, diagnosis, treatment, and management of clinical conditions. The Contractor shall adopt Practice Guidelines that:

8.5.1. Are based on valid and reliable clinical evidence or a generally accepted practice among the Mental Health and Chemical Dependency Professionals in the community;

8.5.2. Consider the needs of the Enrollees;

8.5.3. Are adopted in consultation with MHPs and CDPss in the contracted network of BHAs, when applicable;

8.5.4. Are disseminated to all affected providers and, upon request, to Enrollees;

8.5.5. Are chosen with regard to utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply; and

8.5.6. Are reviewed and updated periodically as appropriate.

8.6. External Quality Review. The Contractor and the Contractor's Subcontractors shall submit to an annual, external independent review of the quality outcomes, timeliness of, and access to, the services covered under each Agreement or contract. In addition, the Contractor and the Contractor's Subcontractors shall work with the External Quality Review Organization (EQRO) Contractor set forth by DSHS to schedule a time for the monitoring review that works for both parties.

8.6.1. The monitoring review process shall use standard methods and data collection tools and methods found in the CMS External Quality Review Protocols to assess

the Contractor's compliance with regulatory requirements, adherence to quality outcomes, and timeliness of, and access to, services provided by the Contractor.

8.6.2. In the event the Contractor or any of the Contractor's Subcontractors do not provide ready access to any information or facilities for the EQRO monitoring review during the scheduled time, the Contractor shall incur any costs for re-scheduling the EQRO Contractor to return and finish its review.

8.6.3. DSHS shall provide a copy of the final EQRO monitoring review report to the Contractor, through print or electronic media and upon request to interested parties such as Enrollees, mental health advocacy groups, and members of the general public.

8.6.4. The Contractor shall, upon request provide evidence of how external quality review findings, agency audits, Contract monitoring activities and consumer Grievances are used to identify and correct problems and to improve care and services to Enrollees.

8.7. Encounter Data Validation (EDV) Reports.

8.7.1. The Contractor shall submit EDV Reports to the Department annually within 90 calendar days after the end of this Agreement. The report shall minimally address the following key areas:

8.7.1.1. Method of validation process (i.e., study time frame, staff involved, request for record and review process)

8.7.1.2. Sampling methodology, including data source and stratification.

8.7.1.3. Record review tool(s) and audit guide employed.

8.7.1.4. Scoring methods.

8.7.1.5. Data analysis, results, and summary of findings.

8.7.1.6. Conclusions, limitations, and opportunities for improvement, including corrective action plans, if applicable.

8.7.2. Performance accountability for this measure is built upon the EDV Reporting. If, during any measurement, the Contractor fails to meet performance expectations, the Contract shall enter a succession of administrative phases until all deficiencies have been mitigated.

8.7.2.1. The first measurement point in which the Contractor fails to meet performance expectations will trigger the Corrective Action Phase in accordance with the Remedial Actions section.

8.7.3. If the Contractor fails to complete corrective action and meet improvement rates, DSHS may take action under the provision of the Remedial Actions section.

8.8. Performance Improvement Projects and Performance Measures. CMS may, in consultation with DSHS and other stakeholders, specify required performance measures and topics for performance improvement projects. These projects must be reviewed and approved by DBHR and the EQRO.

8.8.1. Performance Improvement Projects. The Contractor shall determine where improvement is needed, in alignment with the DSHS Strategic Plan, and continue to conduct or implement at least three (3) Performance Improvement Projects (PIPs), at all times during the Agreement period. PIPs are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on mental health outcomes and Enrollee satisfaction. For purposes of this Agreement, the Contractor shall at all times be conducting two (2) clinical PIP and one (1) non-clinical PIP. One of these three (3) PIPs shall be a Children's PIP. Additionally, one (1) of the PIPs shall be specific to substance use disorder treatment practices.

8.8.1.1. The Contractor shall report the status and results of each PIP to DSHS as requested.

8.8.1.2. PIPs must involve the following:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

8.8.1.3. Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.

8.8.2. Core and Regional Performance Measures

8.8.3. The Contractor shall, on an annual basis, receive from DSHS, Core Performance Measures, based on data collected and measured as described below. Each of these measures, after a baseline of up to one year is established, will be used to establish performance based payment incentives to the Contractor.

8.8.3.1. Core Performance Measures: Core performance Measures are taken from the measures identified through the HB1519/SB5732 process. The measures are required by BHOs. DSHS will generate the measures statewide and by BHO on a quarterly basis with a maximum of a 12-month lag. DSHS will provide baseline data at the start of the Agreement period and establish annual improvement targets by January 1, 2016. Specific to this Agreement period, DSHS has established the following two Core Performance Measures.

8.8.3.1.1. Core Performance Measure #1: Psychiatric Hospitalization Readmission Rate: the proportion of acute psychiatric inpatient stays during the measurement year followed by an acute psychiatric re-admission within 30 days. This measure will be a modified version of the NCQA HEDIS "Plan All-Cause Readmission" metric.

8.8.3.1.2. Core Performance Measure #2: Mental Health Treatment Penetration: Percent of adults identified in need of mental health treatment where treatment is received during the measurement year. This measure will be defined by DSHS and required of all RSNs.

8.8.3.1.3. Core Performance Measure #3 Substance Use Disorder Treatment Penetration (to be defined before the contract start date)

8.8.3.1.4. Substance Use Disorder Retention Core Performance Measure #4 (to be defined before the contract start date)

8.8.4. Regional Performance Measures: Regional Performance Measures are to be developed, calculated, tracked and reported by the Contractor. The Contractor shall be responsible to collect and manage the data necessary to support the Regional Performance Measurement activities, including establishing the baseline, determining demonstrable improvement target, tracking change in performance over time, and reporting the annual findings to the Department. The Regional Performance Measures Report is due to DSHS by January 15, 2018.

8.8.4.1. All Regional Performance Measures shall be chosen based on local relevance, clinical consensus, and research evidence and with input from the local Mental Health Advisory Board. The Contractor is encouraged to develop the Regional Performance Measures that reflect the following areas:

- Access and Availability
- Care Coordination and Continuity
- Effectiveness of Care
- Quality of Care
- Hope, Recovery, and Resiliency
- Empowerment and Shared Decision Making
- Self-Direction
- Cultural Competency
- Health and Safety Measures
- Consumer Health Status and Functioning
- Community Integration and Peer Support
- Quality of Life and Outcomes

- Promising and Evidence-Based Practices
- Provider effectiveness and satisfaction
- Integrated Programs and Systems Integration

8.8.4.2. DSHS will review the annual Regional Performance Measures report submitted by the Contractor, and may request the Contractor to provide an explanation for performance measures that do not meet the Annual Performance Targets. If the explanation is not received or determined to be inadequate, the Contractor shall be required to submit a corrective action plan to the Department.

8.8.4.2.1. The Contractor shall make the results of the Regional Performance Measures available to the public.

8.9. Evidence/Research-Based Practices: The Contractor will participate with DSHS to increase the use of research and evidence-based practices, with a particular focus on increasing these practices for children and youth receiving mental health treatment services as identified through legislative mandates. This includes:

8.9.1. Participation in DBHR sponsored training in the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT/CBT) and CBT-Plus (TF-CBT/CBT+) evidence/research-based practices. The Contractor is expected to maintain a workforce trained in TF-CBT/CBT+ sufficient to implement the practice within the Contractor's service area.

8.9.2. Target wil l percentage will be provided by DBHR.

8.9.3. The Contractor shall track evidence-based and research-based practices identified by the Washington State Institute of Public Policy (WSIPP) and report the services as specified in DBHR's Service Encounter Reporting Instructions (SERI).

9. SUBCONTRACTS

9.1. All Subcontracts must be in writing and specify all duties, responsibilities and reports delegated under this Agreement and require adherence with all federal and state laws that are applicable to the Subcontractor.

9.1.1. Subcontractors are permitted under RCW 71.24.061 to subcontract with individual licensed mental health professionals when necessary to meet the needs of Enrollees.

9.2. The Contractor shall not contract with any subcontractors that are excluded or disqualified from participating in Federal Assistance Programs. The Contractor must verify that the agency they intend to Contract with is not excluded or disqualified. This may be accomplished by any of these options:

- Checking 5 % Exclusions; **or**
- Collecting a self-attestation form from the subcontractor; **or**
- Adding a clause or condition to the covered transaction with that person.

9.2.1. Subcontracts must require participation in enhanced screening activities performed by DSHS as required under CFR 455.450

9.3. The Contractor shall provide information regarding grievance, appeal, and fair hearing procedures and timeframes as set forth in Section 8 GRIEVANCE of this contract at the time the Subcontractor enters into a contract to provide services as stated in 42 CFR 438.10.(g)(1).

9.4. The Contractor shall inform the Subcontractors, at the time they enter into a contract to provide services, of the toll-free number that can be used to file oral grievances and appeals.

9.5. The Contractor must provide written notice to individual BHAs or to groups of BHAs as to the reason for the Contractor's decision if they are not selected for the Contractor's subcontracted network of providers.

9.6. Delegation: A Subcontract does not terminate the legal responsibility of the Contractor to perform the terms of this Agreement. The Contractor shall monitor functions and responsibilities performed by or delegated to a Subcontractor on an ongoing basis.

9.6.1. The Contractor may not delegate its responsibility to contract with a provider network. This does not prohibit an RSN-contracted, licensed provider from subcontracting with other appropriately licensed providers so long as the sub-contracting provisions of this Agreement are met.

9.6.2. The Contractor shall only contract with licensed service providers for the provision of direct services per RCW 71.24.045 and WAC 388-865-0284. Unless a county is a licensed service provider and the Contractor is contracting for direct services, the Contractor shall not provide funds to a county that is a participant in the Contractor's Interlocal Agreement without a delegation of duties agreement. The agreement must identify the specific duties from the Contractor's PIHP or Behavioral Health State Contract that are being delegated. The requirements for delegation in Delegation section of the Agreement must be met.

9.6.3. The Contractor's responsibilities of the Care Management and Quality Assurance and Performance Improvement sections of this Agreement may not be delegated to a Contracted network BHA.

9.6.4. Prior to any new delegation of any Contractor's responsibility or authority described in the Management Information System, Care Management, and Quality Assurance and Performance Improvement sections of this Agreement through a Subcontract or other legal Agreement, the Contractor shall use a delegation plan.

9.6.5. The Contractor shall maintain and make available to DSHS and its External Quality Review Organization Contractors all delegation plans, for currently in place Subcontractors. The delegation plan shall include the following:

9.6.5.1. An evaluation of the prospective Subcontractor's ability to perform delegated activities.

9.6.5.2. A detailed description of the proposed subcontracting arrangements, including: (1) name, address, and telephone number of the Subcontractor(s); (2) specific contracted services; (3) compensation arrangement; and (4) monitoring plan.

9.6.5.3. The required Subcontract language that specifies the activities and responsibilities delegated and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is not adequate.

9.6.6. Within 30 calendar days of execution of this Agreement the Contractor must submit a list of subcontractors and their delegated services in a format provided by DSHS.

9.7. Required Provisions. Subcontracts must require Subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the activity to be performed under this Agreement.

9.7.1. All Subcontracts with BHAs must comply with 42 CFR 438.214(a) as enacted or amended.

9.7.2. Subcontracts must require adherence to the Americans with Disabilities Act.

9.7.3. Subcontracts for the provision of mental health services must require compliance and implementation of the Mental Health Advance Directive statutes.

9.7.4. Subcontracts must require Subcontractors to cooperate with Quality Review Activities and provide access to their facilities, personnel and records.

9.7.5. For Subcontractors providing WISe, Subcontractor must adhere to the most current version of the WISe Manual and participate in all WISe-related quality activities.

9.7.6. Subcontracts for the provision of mental health services must require Subcontractors to provide Enrollees access to translated information and interpreter services as described in the Information Requirements section of this Agreement.

9.7.7. Subcontracts must require Subcontractors to notify the Contractor in the event of a change in status of any required license or certification.

9.7.8. Subcontracts must require Subcontractors to participate in training when requested by DSHS. Requests for DSHS to allow an exception to participation in

required training must be in writing and include a plan for how the required information shall be provided to targeted Subcontractor staff.

9.7.9. Subcontracts must require compliance with State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and DSHS-CIS Data Dictionary or its successor

9.7.10. Subcontracts must define a clear process to be used to revoke delegation, impose corrective action, or take other remedial actions if the Subcontractor fails to comply with the terms of the Subcontract.

9.7.11. Subcontracts must require that the Subcontractor correct any areas of deficiencies in the Subcontractor's performance that are identified by the Contractor or DSHS, as part of a Subcontractor review.

9.7.12. Subcontracts for the provision of mental health services must require best efforts to provide written or oral notification no later than 15 calendar days after termination of a MHCP or CDP to Enrollees currently open for services who had received a service from the affected MHCP in the previous 60 calendar days. Notification must be verifiable in the client medical record at the BHA.

9.7.13. Subcontracts must require that the Subcontracted BHAs comply with the Contractor's policy and procedures for utilization of Access to Care Standards, Distance Standards, and Access Standards.

9.7.14. Subcontracts for the provision of mental health services must require that the Subcontractor implement a Grievance process that complies with 42 CFR 438.400 or any successors as described in this Agreement.

9.7.15. In accordance with Medicaid being the payer of last resort, Subcontracts must require the pursuit and reporting of all Third Party Revenue related to services provided under this Agreement.

9.7.16. Subcontracts for the provision of mental health services must require the use of the GAIN-SS and require staff that will be using the tool to attend trainings on the use of the screening and assessment process that includes use of the tool and quadrant placement. In addition, the Subcontract must contain terms requiring corrective action if the Integrated Co-Occurring Disorder Screening and Assessment process is not implemented and maintained throughout the Contract period of performance.

9.7.17. Subcontracts for the provision of mental health services must require Subcontractors to re-submit data when rejected by DSHS due to errors. The Subcontract must require the data to be re-submitted within 30 calendar days of when the error report was produced.

9.7.18. All Subcontracts must provide for Subcontractors to provide at least 90 calendar days' notice of a contract termination.

9.7.19. Subcontracts must require that consumers are offered assistance with accessing enrollment into health plans if the consumer is uninsured at the time they present for services.

9.8. Physician Incentive Plans. The Contractor must ensure it does not: a) operate any physician incentive plan as described in 42 CFR 422.208; and b) does not Contract with any Subcontractor operating such a plan.

9.9. Background Checks. 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.

9.10. Federally-Qualified Health Centers. The Contractor is required to contract with at least one (1) Federally-Qualified Health Center (FQHC) in their service area if the FQHC makes such a request.

The Contractor shall not pay a FQHC or Rural Health Clinic (RHC) less than the level and amount of payment the Contractor would pay non-FQHC/RHC providers for the same services (42 USC 1396b(m)(2)(A)(ix)).

9.11. Subcontractor Reviews. The Contractor shall conduct periodic reviews of its Subcontractors. The Contractor shall review each Subcontractor at least once per contract period, and shall initiate corrective action when necessary. All collected data including monitoring results, agency audits, sub-contract monitoring activities, Consumer Grievances and services verification shall be incorporated into this review. This review must be included in the Contractors ongoing quality management program.

9.11.1. The Contractor must ensure that periodic Subcontractor reviews do not duplicate monitoring conducted by Washington's contracted External Quality Review Organization, or DSHS.

9.11.2. This review may be combined with a formal review of services performed pursuant to the Behavioral Health State Contract between the Contractor and DSHS.

9.11.3. The periodic review must be based on the specific delegation agreement with each Subcontractor, and must at least address the following:

9.11.3.1. Traceability of Services — The Contractor must ensure that medical necessity is established and documented, and that Access to Care Standards have been met. Once medical necessity has been established and documented, the Contractor must monitor client records to ensure that authorized services are appropriate for the diagnosis that the treatment plan reflects the identified needs, and that progress notes support the use of each authorized state-plan service. The Contractor must also monitor client records to make sure that an appropriate 180 day review is conducted to update the service plan, diagnostic information and provide justification for level of continued treatment.

9.11.3.2. Timeliness of Services – The Contractor must ensure that Enrollees receive services in a timely manner. The Contractor must monitor and, if necessary, measure the timeliness of services rendered to Enrollees according to the following guidelines:

- Emergent Mental Health Services = two (2) hours from request.
- Urgent Mental Health Services = 24 hours from request.
- Initial Inpatient Certification = 12 hours from request.
- Crisis and Phone Service = 24/7/365 availability. Phones answered by live person.
- Post stabilization Services = Individuals need to receive an outpatient service within seven (7) calendar days of discharge from a psychiatric inpatient stay.
- Routine Intake Evaluation = 14 calendar days from request
- First Routine Outpatient Service = 28 calendar days from request

If behavioral health services are not rendered within these guidelines, the Contractor should monitor the reason and appropriateness of the delay as documented in the clinical record.

9.11.3.3. Range of Services/Network Adequacy – The Contractor must ensure that it has the capacity to provide all state-plan services (including second opinions, interpretive services, requests for written information in alternative formats, and referrals to out-of-network providers) to meet the clinical needs of its population. In order to ensure adequate capacity, the Contractor must evaluate its anticipated Medicaid enrollment, 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 Enrollees (including distance, travel time, means of transportation ordinarily used by Enrollees, and whether the location is ADA accessible.

9.11.3.4. Special Populations – The Contractor must ensure that Enrollees who self-identify as having specialized cultural, ethnic, linguistic, disability, or age related needs have those needs addressed. Referrals for specialty service consultation should be tracked through the treatment plan and progress notes. If a provider identifies a need, but it is deferred by the consumer, the provider must document why they are not addressing it at this time.

9.11.3.5. Coordination of Primary Care – The Contractor must ensure that Enrollees with complex medical needs, who have no assigned primary care provider (PCP), are assisted with obtaining a PCP. For Enrollees who already have

a PCP, the Contractor must coordinate care as needed. The Contractor must also ensure that coordination for those with complex medical needs is tracked through the treatment plan and progress notes.

9.11.3.6. Practice Guidelines -- The Contractor must monitor whether the providers are using identified practice guidelines.

9.11.3.7. Grievances – If delegated to BHAs, the Contractor must ensure that network providers have a process in place for reporting, tracking, and resolving customer expressions of dissatisfaction (i.e. grievances). The Contractor must monitor and report grievances documented in the provider level, as well as those documented in the Ombuds records. The Contractor must also monitor the frequency and type of Enrollee grievances to ensure that systematic issues are appropriately addressed.

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

9.11.3.9. Information Security – The Contractor must ensure that network providers and other contractors actively follow federal regulations for managing personal health information (HIPAA/HITECH), and appropriately report any violations.

9.11.3.10. Notices of Action– If delegated to subcontractors, the Contractor must ensure that the subcontractor appropriately notifies Enrollees when an Action has been taken. The Contractor must monitor to ensure that the content of Notices of Action include the required elements and is written in understandable language.

9.11.3.11. Disaster Recovery Plans – The Contractor must ensure that client services and electronic data can be recovered following a natural disaster or computer systems failure. The Contractor must monitor each provider's Disaster Recovery and Business Continuity Plan to ensure that they are periodically tested and updated. The Contractor must also monitor each provider's natural disaster plan to ensure continuation of services and consistency in client care.

9.11.3.12. Excluded Providers – The Contractor must monitor to ensure that provider agencies are providing initial screening and on-going monitoring for excluded providers. The Contractor must monitor their own staff, board, and subcontractors to ensure that they are not excluded entities.

9.11.3.13. Fiscal Management – The Contractor must monitor and document the provider's cost allocations, revenues, expenditures and reserves in order to ensure that Medicaid dollars under this Contract are being spent appropriately under WAC 388-865-0270.

9.11.3.14. Licensing and Certification Issues – The Contractor must ensure that it maintains monitoring oversight of any issues noted during licensing and/or certification reviews conducted by DSHS and communicated to the Contractor.

9.12. Data Verification:

9.12.1. The Contractor shall maintain and either provide to Subcontractors, or require Subcontractors to also maintain, a health information system that complies with the requirements of 42 CFR §438.242 and provides the information necessary to meet the Contractor's obligations under this Agreement.

9.12.2. The Contractor shall have in place mechanisms to verify the health information received from Subcontractors is complete, accurate, and timely.

9.12.3. The Contractor shall conduct encounter validation checks and submit an aggregate data report for all Subcontractors that submit encounters to the Contractor, using the following guidelines specified in the Performance Measures section of this Agreement.

9.13. Data Certification. The Contractor shall comply with the required format provided in the Encounter Data Transaction Guide published by DSHS. Data includes encounters documenting services paid for by the Contractor and delivered to consumers through the Contractor during a specified reporting period as well as other data per the Data Dictionary and Service Encounter Reporting Instructions (SERI). DSHS collects and uses this data for many reasons such as: federal reporting (42 CFR 438.242(b) (1)); rate setting and risk adjustment; service verification, managed care quality improvement program; utilization patterns and access to care; DSHS hospital rate setting; and research studies.

9.13.1. Any information and/or data required by this Contract and submitted to DSHS shall be certified by the Contractor as follows (42 CFR 438.242(b)(2) and 438.600 through 606).

- The information and/or data shall be certified by one of the following:
- The Contractor's Chief Executive Officer.
- The Contractor's Chief Financial Officer.
- An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.

9.13.2. Content of Certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

9.13.3. Timing of Certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

9.14. The Contractor shall provide training and technical assistance to Subcontractors in order to ensure compliance with provisions of this Agreement.

10. ENROLLEE RIGHTS AND PROTECTIONS

10.1. The Contractor and affiliated service providers shall comply with any applicable Federal and State laws that pertain to Enrollee Rights and Protections. The Contractor must ensure that staff takes rights into account when furnishing services to Enrollees. Any changes to applicable law must be implemented within 90 calendar days of the effective date of the change.

10.2. The Contractor must maintain written policies and procedures addressing all requirements under this section. Policies and procedures must comply with 42 CFR, RCW 71.24, and WAC 388-865.

10.3. The Contractor shall have written policies regarding the rights specified below:

- The right to be treated with respect and due consideration of the Enrollee's dignity and privacy.
- The right to receive information on available treatment options and alternatives in a manner appropriate to the Enrollee's ability to understand.
- The right to participate in decisions regarding their health care, including the right to refuse services.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- The right to request and receive a copy of their medical records, and request amendments or corrections as specified in 45 CFR 164.524 and 164.526.

10.4. The Contractor shall establish policies and procedures to ensure that the exercising of any of these rights do not adversely affect the way the Contractor treats the Enrollee.

10.5. The Contractor shall require that mental health professionals, MHCPs, and CDPs acting within the lawful scope of their practice, are not prohibited or restricted from advising or advocating on behalf of an Enrollee with respect to:

- The Enrollee's mental health status.
- Receiving all information regarding mental health treatment options including any alternative or self-administered treatment, in a culturally-competent manner.
- Any information the Enrollee needs in order to decide among all relevant mental health treatment options.
- The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment).
- The Enrollee's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions.
- The Enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy.

- The Enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- The Enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.
- The Enrollee's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the Contractor, BHA, MHCP or CDP treats the Enrollee.

10.6. Planning. The Contractor shall invite Enrollees and Enrollees' families that are representative of the community being served, including all age groups, to participate in planning activities and in the implementation and evaluation of the public behaviorall health system. The Contractor must be able to demonstrate how this requirement is implemented.

10.7. Free Exercise of Rights. The Contractor must ensure that each Enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor and its providers treat the Enrollee.

10.8. The Contractor shall ensure that Mental Health Professionals, MHCPs, and CDPs acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an Enrollee with respect to:

- The Enrollee's behavioral health status.
- Receiving all information regarding mental health treatment options including any alternative or self-administered treatment, in a culturally-competent manner.
- Receiving information the Enrollee needs in order to decide among all relevant mental health treatment options.
- Receiving information about risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment).
- Any of the Enrollee's Rights and Protections as listed in the Washington Medicaid Behavioral Health Benefits Booklet published by DSHS.

10.9. Ombuds. The Contractor shall provide a mental health ombuds as described in WAC 388-865-0250 and RCW 71.24. An entity or Subcontractor independent of the Contractor's Administration must employ the ombuds and provide for the following:

- Separation of personnel functions (e.g. hiring, salary and benefits determination, supervision, accountability and performance evaluations); and
- Independent decision making to include all investigation activities, findings, recommendations and reports.

10.10. Advance Directives. The Contractor shall maintain written policies and procedures for Mental Health Advance Directives that meet the requirements of 42 CFR §422.128. The Contractor shall inform all Enrollees of their right to a Mental Health Advance Directive,

and shall provide technical assistance to those who express an interest in developing and maintaining a Mental Health Advance Directive.

10.10.1. The Contractor shall inquire whether Enrollees have active Medical Advance Directives, and shall provide those who express an interest in developing and maintaining Medical Advance Directives with information about how to initiate a Medical Advance Directive.

10.10.2. The Contractor shall not establish any conditions of treatment or in any way discriminate against an individual based on the existence or absence of an advanced directive.

10.10.3. The Contractor shall provide training to its staff on policies and procedures regarding advanced directives.

10.10.4. The Contractor shall maintain current copies of any Medical and/or Mental Health Advance Directives in the Enrollee's clinical record.

10.10.5. The Contractor shall provide written information to Enrollees that includes:

10.10.5.1. A description of their rights for Mental Health Advance Directives under current RCW 71.32 (changes must be included within 90 days of the effective date of any changes to the RCW);

10.10.5.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of a Mental Health Advance Directive as a matter of Conscience; and

10.10.5.3. Information regarding how to file a Grievance concerning noncompliance with a Mental Health Advance Directive with the Washington State Department of Health.

10.11. Information Requirements. The Contractor must provide information to Enrollees that complies with the requirements of 42 CFR 438.100, 438.10, and 438.6(i)(3).

10.11.1. Alternative Formats

10.11.1.1. Offer every Medicaid Enrollee a Washington Medicaid Behavioral Health Benefit Booklet at Intake which includes information on obtaining the booklet in alternative formats, and inform Enrollee that the booklet is available at: http://dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml.

10.11.1.2. The Contractor and affiliated service providers shall post a translated copy of the Washington Medicaid Behavioral Health Benefits Booklet's section entitled "Your Rights as a Person Receiving Medicaid BehavioralHealth Services" in each of the DSHS-prevalent languages. The DSHS Prevalent languages are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese.

10.11.1.3. The Contractor and affiliated service providers shall post a multilingual notice in each of the DSHS prevalent languages, which advises Enrollees that information is available in other languages and how to access this information.

10.11.1.4. The Contractor shall provide written translations of all written information including, at minimum, applications for services, consent forms, and Notices of Action in each of the DSHS-prevalent languages that are spoken by five percent (5%) or more of the population of the State of Washington; based on the most recent U.S. census. DSHS has determined based on this criteria that Spanish is the currently required language. The Contractor must provide maintain availability of translated documents at all times for the Contractor and its contracted BHAs to distribute.

10.11.1.5. The Contractor shall provide copies of the generally available materials including at minimum, applications for services, consent forms, and Notices of Action in alternative formats that take into consideration the needs of those who have limited vision or impaired reading proficiency.

10.11.1.6. The Contractor and affiliated service providers shall maintain a log of all Enrollee requests for interpreter services, or translated written material.

10.12. Marketing.

10.12.1. The Contractor shall not distribute any marketing materials or engage in any marketing activities.

10.12.2. Distribution of marketing materials that have not been preapproved by DSHS or which contain false or misleading information may result in financial state imposed civil monetary penalties.

10.13. Cultural Considerations.

10.13.1. The Contractor shall participate in and cooperate with DSHS 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. (42 CFR 438.206(c)(2)).

10.13.2. At a minimum, the Contractor and its contracted BHAs shall:

10.13.2.1. Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each Enrollee with limited English proficiency at all points of contact, in a timely manner during all hours of operation. (CLAS Standard 4);

10.13.2.2. Offer language assistance to Enrollees 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);

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

10.13.2.4. 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);

10.13.2.5. Provide easy–to-understand print, and multimedia materials, and signage in the languages commonly used by the populations in the service area, presented in an easily understood format. (CLAS 8);

10.13.2.6. Establish culturally and linguistically appropriate goals. (CLAS Standard 9);

10.13.2.7. Conduct ongoing assessments of the organization's CLAS–related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. (CLAS Standard 10);

10.13.2.8. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (CLAS 11); and

10.13.2.9. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints. (CLAS 14).

10.13.3. The Contractor shall provide DSHS with an annual report evidencing its compliance with each CLAS standard.

10.13.4. The Contractor shall require that contracted network CMHAs provide upon the Enrollee's request:

10.13.4.1. The Contractor shall provide information to Enrollees on the names, locations, telephone numbers of, and non-English service providers in the service area; including providers that are not accepting new Enrollees.

10.13.4.2. Identification of individual MHCPs and CDPs who are not accepting new Enrollees

10.13.4.3. BHA licensure, certification and accreditation status

10.13.4.4. Information that includes but is not limited to, education, licensure, registration, and Board certification and/or-certification of Mental Health Professionals, MHCPs and CDPs.

10.14. Choice of Practitioner. The Contractor shall offer each Enrollee a choice of participating MHCPs and/or CDPs within the Contractor's service area. If the Enrollee does not make a choice within 14 business days of being informed, the Contractor or its designee must assign a MHCP no later than 14 business days following the request for mental health services. The Contractor shall inform the Enrollee that he or she may change MHCPs.

10.15. Second Opinion. The Contractor shall provide, upon request, a second opinion from a MHP at a contracted BHA within the Service Area. If an additional BHA is not currently available within the network, the Contractor must provide or pay for a second opinion provided by a BHA outside the network at no cost to the Enrollee. The BHA providing the second opinion must be currently contracted with a RSN to provide mental health services to Enrollees. The appointment for a second opinion must occur within 30 calendar days of the request. The Enrollee may request to postpone the second opinion to a date later than 30 calendar days.

10.16. Prohibition on Enrollee Charges for Covered Services. The Contractor shall ensure Enrollees are not held liable for any of the following:

- Costs due to receiving services from an out-of-network provider.
- Covered mental health services provided by insolvent community psychiatric hospitals with which the Contractor has directly contracted.
- Covered mental health services, including those purchased on behalf of the Enrollee.
- Covered mental health services for which the State does not pay the Contractor.
- Covered services provided to the Enrollee, for which the State or the Contractor does not pay the MHCP or BHA that furnishes the services under a contractual, referral, or other arrangement.
- Payments for covered services furnished under a Contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Contractor provided the services directly.
- Covered mental health services provided by insolvent federally funded PIHPs.
- Debts of the Contractor if the Contractor becomes financially insolvent.

11. CARE MANAGEMENT

11.1. Care Management is a set of clinical management oversight functions that shall be performed by the Contractor. Care Management functions, except individual service plans and co-occurring disorder assessments, shall be not delegated to a network CMHA. Care Management activities must be performed by a Mental Health Professional.

11.2. Individual Service Plans. Individual Service Plans must be developed in compliance with WAC 388-877-0620.

11.2.1. The Contractor shall require that Enrollees are actively included in the development of their individualized service plans, Advance Directives for psychiatric care and crisis plans.

This shall include but not be limited to children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings).

11.2.2. At a minimum, treatment goals must include the words of the individual receiving services and documentation must be included in the clinical record, describing how the Enrollee sees progress.

11.2.3. The Individual Service Plan must address the overall identified needs of the Enrollee, including those that best met by another service delivery system, such as education, primary medical care, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections and juvenile justice as appropriate.

The Contractor must ensure that there is coordination with the other service delivery systems responsible for meeting the identified needs.

11.3. Continuity of Care. For continuity of care the Contractor shall encourage the Subcontractor(s) to assign Enrollees to clinicians who are anticipated to provide services to the Enrollee throughout the authorization period.

11.3.1. The Contractor must ensure that for Enrollees who have a suspected or identified physical health care problem the following shall occur:

- Appropriate referrals are made to a physical health care provider.
- The individualized service plan identifies medical concerns and plans to address them.

11.3.2. The Contractor shall coordinate with the Children's Long-term Inpatient Programs (CLIP) Administration to develop CLIP resource management guidelines and admissions procedures. The Contractor shall enter into, and comply with, a written agreement with the CLIP Administration regarding resource management guidelines and admissions procedures.

11.4. Allied System Coordination. The Contractor shall coordinate with all entities below as necessary to ensure continuity of care for Enrollees:

- DSHS Aging and Long Term Care Services Administration (ALTSA)
- Chemical Dependency and Substance Abuse services
- DSHS Children's Administration
- Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Apple Health Plans
- Educational Service Districts (ESDs)
- Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections)
- Department of Corrections
- DSHS Division of Vocational Rehabilitation
- DSHS Juvenile Justice and Rehabilitation Administration (JJ&RA)

- Any Offender Re-entry Community Safety Program (ORCSP) within the boundaries of the Contractor that is not a Subcontractor of the Contractor.
- County Government when the BHO is not operated through a County or County created entity.

11.5. Allied System Coordination Plan. The Contractor shall develop new or update an existing allied system coordination plan with each entity above to be updated at least every three years, as requested by DSHS or as necessary. The allied system coordination plan must contain all of the following elements. In the event any of these allied systems chooses not to jointly create a coordination plan, the Contractor must develop a plan that addresses all the requirements in this section by describing how the Contractor proposes to interact with the allied system:

11.5.1. Clarification of roles and responsibilities of the allied systems in serving multi-system consumers. For children this includes EPSDT coordination for any child serving agency, including a process for participation by the agency in the development of a cross-system Individual Service Plan when indicated under EPSDT.

11.5.2. Processes for the sharing of information related to eligibility, access and authorization.

11.5.3. Identification of needed local resources, including initiatives to address those needs.

11.5.4. A process for facilitation of community reintegration from out-of-home placements (e.g. State hospitals, Children's Long- term Inpatient facilities, Juvenile Justice and Rehabilitation Administration facilities, foster care, nursing homes, acute inpatient settings) for consumers of all ages.

11.5.5. A process or format to address disputes related to service or payment responsibility.

11.5.6. A process to evaluate progress in cross-system coordination and integration of services.

11.5.7. For Department of Corrections the agreement will ensure that treatment services provided are coordinated, do not result in duplication of services, and facilitate access to services based on DOC referrals for those under community corrections supervision.

11.6. Children's Mental Health.

11.6.1. Contractors who implement WISe as part of their service delivery shall adhere to the most current version of the WISe Manual and meet the requirements of the WISe Quality Management Plan.

11.6.2. Contractors not yet implementing WISe as part of their service delivery shall incorporate and disseminate the Washington State Children's Behavioral Health Principles as guidelines for providing care to children, youth and their families.

11.7. Transition Age Youth.

11.7.1. The Contractor shall maintain a process for addressing the needs of Transition Age Youth (ages 16 - 21) in their care/treatment plans. The Process must contain or address:

11.7.1.1. A comprehensive transition plan linked across systems that identify goals, objectives, strategies, supports, and outcomes.

11.7.1.2. Individual behavioral health needs in the context of a Transition Age Youth, which include supported transition to meaningful employment, post-secondary education, technical training, housing, community supports, natural supports, and cross-system coordination with other system providers.

11.7.1.3. For youth who require continued services in the adult behavioral health system must identify transitional services that allow for consistent and coordinated services and supports for young people and their parents.

11.7.1.4. Developmentally and culturally appropriate adult services that are relevant to the individual or population.

11.8. State Hospitals. The Contractor shall abide by the current Western State Hospital/Regional Support Network/Home and Community Services Agreement for Home and Community Services Placements from Western State Hospital.

11.8.1. The Contractor shall participate with DSHS, the Division of Home and Community Services (HCS), and other RSNs to develop a common operating agreement.

11.8.1.1. In the event an agreement cannot be executed by that date, DSHS may require the Contractor to follow procedures that meet the intended goals of such an agreement.

11.8.1.2. Upon implementation of this agreement the Contractor shall comply with its terms.

11.8.1.3. The agreement must address the following topics:

- Referrals for service to/from the Contractor and DSHS-HCS services
- Exchange of information needed for treatment and placement planning
- Timelines for activities to occur
- Procedures to assist in the diversion of patients from State Hospitals especially those with dementia and similar diagnoses.

- Procedures for evaluating the operation of the agreement and for addressing problems.

11.9. Co-occurring Disorder Screening. Co-Occurring Disorder Screening and Assessment: The Contractor must maintain the implementation of the integrated, comprehensive screening and assessment process for chemical dependency and mental disorders as required by RCW 70.96C. Failure to maintain the Screening and Assessment process shall result in remedial actions up to and including financial penalties as described in Remedial Action section of this Agreement.

11.9.1. The Contractor must attempt to screen all individuals aged 13 and above through the use of DSHS provided Global Appraisal of Individual Needs – Short Screener (GAIN-SS) during:

11.9.1.1. All new intakes.

11.9.1.2. The provision of each crisis episode of care including ITA investigations services, except when:

- The service results in a referral for an intake assessment.
- The service results in an involuntary detention under RCW 71.05, 71.34 or 70.96B.
- The contact is by telephone only.
- The professional conducting the crisis intervention or ITA investigation has information that the individual completed a GAIN-SS screening within the previous 12 months.

11.9.2. The GAIN-SS screening must be completed as self-reported by the individual and signed by that individual on DSHS-GAIN-SS form. If the individual refuses to complete the GAIN-SS screening or if the clinician determines the individual is unable to complete the screening for any reason this must be documented on DSHS-GAIN-SS form.

11.9.3. The results of the GAIN-SS screening, including refusals and unable-to-completes, must be reported to DSHS through the CIS system.

11.9.4. The Contractor must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by DSHS and outlined in the SAMHSA/CSAT Treatment Improvement Protocol 42, to determine a quadrant placement for the individual when the individual scores a two (2) or higher on either of the first two scales (ID Screen & ED Screen) and a two (2) or higher on the third (SD Screen).

11.9.4.1. The assessment is required during the next outpatient treatment planning review following the screening and as part of the initial evaluation at free-standing, non-hospital, evaluation and treatment facilities. The assessment is not required during crisis interventions or ITA investigations. The quadrant placements are defined as:

- Less severe mental health disorder/less severe substance disorder.
- More severe mental health disorder/less severe substance disorder.
- Less severe mental health disorder/more severe substance disorder.
- More severe mental health disorder/more severe substance disorder.

11.9.5. The quadrant placement must be reported to DSHS through the Integrated Data system.

12. BHO TRANSFER PROTOCOL

12.1. Purpose. The purpose of this BHP Transfer Protocol is to establish an agreed-upon process by which individuals can be transferred from one BHO to another to ensure:

12.1.1. A seamless transition for the individual with no more than minimal interruption of services.

12.1.2. The individual receives care that better meets his or her needs.

12.1.3. The individual has the opportunity to be closer to family and/or other important natural supports.

12.1.4. The individual has access to Medicaid covered services.

12.2. BHOs acknowledge and agree that:

12.2.1. Other Services for purposes of the BHO Transfer Protocol include E&T, chemical dependency residential treatment or community inpatient admissions, residential services, Medicaid Personal Care, and state hospital psychiatric stays.

12.2.2. Medicaid Enrollees are entitled to Medicaid covered services in the community where they live.

12.2.3. Individuals who participate in mental health services have the right to freely move to the community of their choosing.

12.2.4. There are circumstances when an BHO (referring BHO) wishes to place an individual in another BHO's region (receiving RSN) to better meet the needs of that individual, or moving to another BHO's region would allow the individual to be closer to family and/or other important natural supports.

12.2.5. Some individuals require specialized, non-Medicaid services to meet their needs.

12.2.6. Due to the scarcity of specialized, non-Medicaid services, these may not be immediately available upon the request of the transferring individual.

12.2.7. The receiving BHO assumes immediate financial risk for crisis services and Medicaid covered services at the time of transfer.

12.2.8. The referring BHO will continue the financial responsibility for "specialized non-Medicaid services" provided to the individual for the duration of time as determined by the number of risk factors identified at the time of transfer.

Number of Risk Factors	Duration
One risk factor	6 months
Two risk factors	9 months
Three or more risk factors	12 months

12.2.9. Risk Factors include the following:

- Transfer is being requested due to availability of specialized non-Medicaid resource.
- High inpatient utilization – two (2) or more inpatient admissions in the previous twelve (12) months, an inpatient stay in a community hospital for ninety (90) calendar days or more in the previous twelve (12) months, or discharge from a state hospital in the previous twelve (12) months.
- History of felony assaults, Offender Re-entry Community Safety Program (ORCSP) eligibility, or multiple assaultive incidents during inpatient care (that may not have resulted in criminal charges but resulted in injuries).
- Significant placement barriers - behavioral issues resulting in multiple placement failures, level 3 sex offender, arson history, dementia (the RSN would need to be involved even though HCS might be arranging placement), and co-morbid serious medical issues.
- Other confounding clinical risk factors.

12.2.10. After completion of the risk factor time frame, the receiving BHO will assume all financial responsibility for the individual.

12.2.11. The referring BHO will retain the individual on their state hospital census until the individual is discharged. The referring BHO will accept on their census any individual placed in the receiving BHO who returns to the state hospital during the period of financial responsibility as defined above.

12.2.12. This protocol is intended to ensure a seamless transition for individuals with no more than minimal interruption of services.

12.3. Uniform Transfer Agreement-Community Inter-BHO Transfer Protocol.

12.3.1. If a Medicaid Enrollee re-locates to a region outside of their current BHO they are entitled to an intake assessment in the new region and are then provided all medically necessary mental health services required in the Contractor contract, based on the BHO's level of care guidelines and clinical assessment.

12.3.2. Each BHO will establish a procedure to obtain information and records for continuity of care for Enrollees transferring between BHOs.

12.3.3. All Medicaid Enrollees requesting a transfer will be offered an intake assessment and all medically necessary mental health services under the Contractor. The availability of Specialized Non-Medicaid Services cannot be the basis for determining if the Enrollee is offered an intake for services in the desired community of their choice.

12.3.4. There are circumstances when moving between BHOs is necessary to better meet the needs of the individual, or moving to another BHO would allow the individual to be closer to family and/or other natural supports.

12.3.5. The receiving BHO will provide assistance to the Enrollee to update the Enrollee's residence information for Medicaid Benefits.

12.3.6. When an Enrollee is re-locating and may benefit from specialized non-Medicaid services beyond medically necessary services required in the Contractor, the BHOs agree to the following protocol:

12.3.6.1. The placement is to be facilitated by the joint efforts of both BHOs.

12.3.6.2. The referring BHO will provide all necessary clinical information along with the completed Inter-BHO transfer form.

12.3.6.3. The receiving BHO will acknowledge the request within 3 business days.

12.3.6.4. The receiving BHO will follow established procedures for prioritizing the referred Enrollee and must offer an intake assessment to the Enrollee for services Medicaid-covered services even if the specialized non-Medicaid services are not immediately available.

12.3.6.5. The placement may not be completed without written approval on the inter-BHO transfer form from both BHO administrators, and their designees.

12.3.6.6. The receiving BHO shall make a placement determination within 2 weeks of receiving all necessary information/documentation from the referring BHO. The Enrollee and the referring BHO will receive information regarding the placement policy of the receiving BHO for the specialized non-Medicaid service.

12.3.6.7. Placement will only occur when the specialized non-Medicaid service becomes available. If the specialized non-Medicaid service is not available at the time of the intended transfer, the receiving BHO will notify the referring BHO and continue to provide timely updates until such time the specialized non-Medicaid service is available. The referring BHO will keep the individual and others involved in the individual's care informed about the status of the transfer.

12.3.6.8. Payment responsibility for individuals transferring between BHOs will be described in this protocol and specified on the inter-BHO transfer form.

12.3.6.9. Uniform Transfer Agreement - Eastern and Western State Hospital Inter-BHO Transfer Protocol:

12.3.6.10. This section describes the inter-BHO transfer process for individuals preparing for discharge from a state hospital, and who require specialized non-Medicaid resources.

12.3.6.11. Generally, individuals are discharged back to the BHO in whose region they resided prior to their hospitalization (designated by the state hospitals as the “BHO of responsibility”).

12.3.6.12. For all individuals in a state hospital (regardless of risk factors) who intend to discharge to another BHO, an Inter-BHO transfer request is required and will be initiated by the BHO of responsibility (hereinafter referred to as the referring BHO).

12.3.6.13. The financial benefits section at the state hospital will provide assistance to the Enrollee to update the Enrollee’s residence information for Medicaid Benefits.

12.3.6.14. The placement is to be facilitated through the joint efforts of the state hospital social work staff and the BHO liaisons of both the Referring BHO and Receiving BHO.

12.3.6.15. A Request for Inter-BHO Transfer form and relevant treatment and discharge information is to be supplied by the Referring BHO to the Receiving BHO via the liaisons.

12.3.6.16. The Referring BHO will remain the primary contact for the state hospital social worker and the individual until the placement is completed.

12.3.6.17. The Receiving BHO will supply the state hospital social worker with options for community placement at discharge.

12.3.6.18. Other responsible agencies must be involved and approve the transfer plan and placement in the Receiving BHO when that agency’s resources are obligated as part of the plan (e.g., DSHS Home and Community Services or Developmental Disabilities Administration).

12.3.6.19. 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, and other responsible agencies.

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

13. MANAGEMENT INFORMATION SYSTEM

13.1. Data Submission and Error Correction. The Contractor shall collect and provide DSHS with Enrollee and provider characteristics, services, and other data as described in DSHS "Service Encounter Reporting Instructions", the "Data Dictionary", and encounters shall be submitted as described in DSHS "Encounter Data Reporting Guide," or, any successor, incorporated herein by reference.

13.1.1. The Contractor shall report encounters electronically to ProviderOne within 60 calendar days of the close of each calendar month in which the encounters occurred.

13.1.2. The Contractor shall submit all other required data about Enrollees to DSHS CIS within 60 calendar days of collection or receipt from Subcontracted providers.

13.1.3. Upon receipt of data submitted, both ProviderOne and DSHS CIS shall generate error reports. The Contractor shall have in place documented policies and procedures to assure that data submitted and rejected due to errors are corrected and resubmitted within 30 calendar days of when the error report was produced.

13.1.4. The Contractor shall require Subcontractors to resubmit data rejected due to errors. The Subcontractor must resubmit corrected data within 30 calendar days of when an error report was produced.

13.1.5. The Contractor shall attend meetings and respond to inquiries to assist in DSHS decisions about changes to data collection and information systems to meet the terms of this Contract. This may include requests to add, delete or change data elements that may include projected cost analysis.

13.1.6. The Contractor shall implement changes documented in DSHS "Service Encounter Reporting Instructions", the "Data Dictionary" and DSHS "Encounter Data Reporting Guide" within 150 calendar days from the date published. When changes on one document require changes to the other, DSHS shall publish all affected documents concurrently.

13.1.7. In the event that shorter timelines for implementation of changes under this section are required or necessitated by either a court order or agreement resulting from a lawsuit or legislative action, DSHS will provide as much notice as possible of the impending changes and provide specifications for the changes as soon as they are available. The Contractor will implement the changes required by the timeline established in the court order, legal agreement

or legislative action. To the extent possible, DSHS will work through its stakeholder groups to implement any change as necessary.

13.1.8. The Contractor shall implement changes to the content of national standard code sets (such as CPT, HCPC, Place of Service code sets) per the instructions and implementation schedule or deadline from the issuing organization. If the issuing organization does not provide an implementation schedule or deadline, the Contractor shall implement the changes within 150 calendar days.

13.1.9. When DSHS makes changes referenced in Management Information System section, the Contractor shall send at least one test batch of data containing the required changes. The test batch must be received no later than 15 calendar days prior to the implementation date.

- The test batch must include at least 100 transactions that include information effected by the change.
- The processed test batch must result in at least 80% successfully posted transactions or an additional test batch is required.

13.1.10. The Contractor shall respond to requests from DSHS for information not covered by the data dictionary in a timeframe determined by DSHS that will allow for a timely response to inquiries from CMS, the legislature, DSHS, and other parties.

13.1.11. No encounter transaction shall be accepted for initial entry or data correction after one (1) year from the date of service without special exception.

13.2. Business Continuity and Disaster Recovery. The Contractor shall demonstrate a primary and backup system for electronic submission of data requested by DSHS. 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 DSHS approval.

13.2.1. The Contractor shall create and maintain a business continuity and disaster recovery plan that insures timely reinstitution of the consumer information system following total loss of the primary system or a substantial loss of functionality. The plan must be in written format, have an identified update process (at least annually) and a copy must be stored off site.

13.2.2. The Contractor must submit an annual certification statement indicating there is a business continuity disaster plan in place for both the Contractor and Subcontractors. The certification must be submitted by January 1 of each year of this Agreement. 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 DSHS or the contracted EQRO to review and audit. The plan must address the following:

13.2.2.1. A mission or scope statement.

13.2.2.2. An appointed Information Services Disaster Recovery Staff.

13.2.2.3. Provisions for Backup of Key Personnel; Identified Emergency Procedures; Visibly listed emergency telephone numbers.

13.2.2.4. Procedures for allowing effective communication; Applications Inventory and Business Recovery priority; Hardware and software vendor list.

13.2.2.5. Confirmation of updated system and operations documentation; Process for frequent backup of systems and data.

13.2.2.6. Off-site storage of system and data backups; Ability to recover data and systems from backup files.

13.2.2.7. Designated recovery options which may include use of a hot or cold site.

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

14. REPORTING REQUIREMENTS

14.1. The Contractor and its Subcontractors shall cooperate in all reviews, including but not limited to, surveys, and research conducted by DSHS or other Washington State Departments.

14.2. **Evaluations**. Evaluations under this Agreement shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services, and to determine whether the Contractor and its Subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable State and federal regulations as existing or hereafter amended.

14.3. **Information Requests**. The Contractor shall maintain information necessary to promptly respond to written requests by the DBHR Director, an Office Chief or their designee. The Contractor shall submit information detailing the amount spent throughout its service area on specific items upon request by the DBHR Director, an Office Chief or their designee.

14.4. **No Beds Available for Persons Meeting Detention Criteria - Report.**

14.4.1. The BHO shall ensure that their DMHPs make a report to DSHS when he or she determines a person meets detention criteria under RCW 71.05.150, 71.05.153, 71.34.700 or 71.34.710 and there are not any beds available at the evaluation and treatment facility, the person has not been provisionally accepted for admission by a facility, and the person cannot be served on a single bed certification or less restrictive alternative.

14.4.2. Starting at the time when the DMHP determines a person meets detention criteria, the investigation has been completed and when no bed is available, the DMHP must submit a completed report to the DSHS Contact listed on page 1 within twenty-four (24) hours. The notification report must contain at a minimum:

- The date and time that the investigation was completed;
- The identity of the responsible BHO;
- A list of facilities which refused to admit the person;
- Identifying information for the person, including age or date of birth; and
- Other reporting elements deemed necessary or supportive by DSHS.

14.4.3. The BHO receiving the notification report must attempt to engage the person in appropriate services for which the person is eligible and report back within seven (7) days to DSHS.

14.4.4. BHOs are required to implement an adequate plan to provide evaluation and treatment services, which may include the development of less restrictive alternatives to involuntary treatment, or prevention programs reasonable calculated to reduce demand for evaluation and treatment.

14.4.5. DSHS will initiate corrective action when appropriate to ensure an adequate plan is implemented. Corrective actions may include remedies under RCW 71.24.330 and 43.20A.894, including requiring expenditure of reserve funds. DSHS may initiate corrective action plans for those BHOs lacking an adequate network of evaluation and treatment services to ensure access to treatment.

14.5. Financial Reporting and Certification. Financial Reports and Certifications are due within 45 calendar days of the end of every second quarter (December and June of each year). The Contractor shall submit the following components in a single form provided by DSHS:

14.5.1. The Contractor Revenue, Expenditure, Reserves and Fund Balance report in compliance with:

14.5.1.1. The "Fiscal/Program Requirements Supplementary Instructions - Mental Health Programs" including the Chart of Accounts, administered by DSHS/BHSIA/Budget & Finance Division, and

14.5.1.2. The "Mental Health Program Revenue and Expenditure (R&E) Report Instructions" published by DSHS/BHSIA/Budget & Finance Division; located at https://www.dshs.wa."gov/bhsia/division-behavioral-health-and-recovery/contractors-and-providers – Select "Mental Health Services Contractors/Providers" – listed under "Forms".

14.5.2. The amounts paid to Federally Qualified Health Centers for services.

14.5.3. Any revenue collected by Subcontractors for services provided under this Agreement. This includes revenue collected from Medicare, insurance companies, co-payments, and other sources. The Contractor must certify that a process is in place to demonstrate that all third party revenue resources for

services provided under this Agreement are identified, pursued, and recorded by the Subcontractor, in accordance with Medicaid being the payer of last resort.

14.5.4. In addition, the Contractor shall submit a single financial certification form, provided by the DSHS, indicating that administrative costs, as defined in the "Mental Health Program Revenue and Expenditure Report Instructions", incurred by the Contractor are no more than 10 percent of the annual revenue supporting the public mental health system operated by the Contractor. Administrative costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by DSHS.

14.5.5. If the Contractor is unable to provide valid certifications or if DSHS finds discrepancies in the Revenue and Expenditure Report, DSHS may initiate remedial action. Remedial action may include recoupment from funds disbursed during the current or successive Agreement period. Recoupment shall occur within 90 calendar days of the close of the State fiscal year or within 90 calendar days of the DSHS's receipt of the certification, whichever is later.

14.5.6. DSHS reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data. DSHS agrees to involve the Contractor in the decision process prior to implementing changes in format, and shall request the Contractor to review and comment on format changes before they go into effect whenever possible.

14.6. Incident Reporting. The Contractor must maintain policies and procedures regarding mandatory incident reporting and referrals consistent with all applicable state and federal laws. The policies must address the Contractor's oversight and review of the requirements in this section.

14.6.1. The Contractor must have a designated incident manager responsible for meeting the requirements under this section.

14.6.2. The Contractor must report and follow-up on all incidents involving Enrollees, listed below.

14.6.3. The Contractor must report incidents using the Behavioral Health and Recovery Incident Reporting System at https://fortress.wa.gov/dshs/mhdirhrsa/Login.aspx .Access to the Incident Reporting System is restricted to authorized users only. Those needed access to the System may contact the Incident Reporting Manager. If the Incident Reporting System is unavailable for use, a DBHR standardized form with instructions will provided. Incident Reports shall contain the following:

- A description of the incident;
- The date and time of the incident;
- Incident location;
- Incident type;

- Names and ages, if known, of all individuals involved in the incident;
- The nature of each individual's involvement in the incident;
- The service history with the Contractor, if any, of individuals involved;
- Steps taken by the Contractor to minimize harm; and
- Any legally required notifications made by the Contractor.

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

14.6.4.1. Category One Incidents: the Contractor must report and also notify the DBHR Incident Manager by telephone or email immediately upon becoming aware of the occurrence of any of the following Category One incidents involving any individual that was served within 365 calendar days of the incident.

14.6.4.1.1. Death or serious injury of patients, clients, staff, or public citizens at a DSHS facility or a facility that DSHS licenses, contracts with, or certifies

14.6.4.1.2. 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 clients.

14.6.4.1.3. 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 client.

14.6.4.1.4. Any event involving an individual or staff that has attracted media attention.

14.6.4.2. Category Two Incidents: the Contractor must report within one (1) working day of becoming aware that any of the following Category Two Incidents has occurred, involving an Enrollee:

14.6.4.2.1. Alleged client abuse or client neglect of a serious or emergent nature by an employee, volunteer, licensee, Contractor, or another client.

14.6.4.2.2. A substantial threat to facility operation or client safety resulting from a natural disaster (to include earthquake, volcanic eruption, tsunami, fire, flood, an outbreak of communicable disease, etc.).

14.6.4.2.3. Any breach or loss of client 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 client personal information. In addition to the

standard elements of an incident report, BHOs will document and/or attach: 1) the Police report, 2) any equipment that was lost, and 3) specifics of the client information.

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

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

14.6.4.2.6. Any event involving a client or staff, likely to attract media attention in the professional judgment of the Incident Manager.

14.6.4.2.7. Any event involving: a credible threat towards a staff member that occurs at a DSHS facility, a facility that DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community. A credible threat towards staff is defined as "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."

14.6.4.2.8. Any incident that was referred to the Medicaid Fraud Control Unit by the Contractor or its Subcontractor.

14.6.4.2.9. A life safety event that requires an evacuation or that is a substantial disruption to the facility.

14.6.5. Comprehensive Review: DSHS may require the Contractor to initiate a comprehensive review of an incident.

14.6.5.1. The Contractor shall fully cooperate with any investigation initiated by DSHS and provide any information requested by DSHS within the timeframes specified within the request.

14.6.5.2. If the Contractor does not respond according to the timeframe in DSHS' request, DSHS may obtain information directly from any involved party and request their assistance in the investigation.

14.6.5.3. DSHS may request medication management information.

14.6.5.4. DSHS may also review or may require the Contractor to review incidents that involve clients who have received services from the Contractor more than 365 calendar days prior to the incident.

14.6.6. Incident Review and Follow-up: the Contractor will review and follow-up on all incidents reported. The Contractor will provide sufficient information, review, and follow-up to take the process and report to its completion. An incident will not be categorized as complete until the following information is provided:

14.6.6.1. A summary of any incident debriefings or review process dispositions;

14.6.6.2. Whether the person is in custody (jail), in the hospital, or in the community, and if in the community whether the person is receiving services. If the client cannot be located, the Contractor will document in the Incident reporting system the steps that the Contractor took to attempt to locate the client by using available local resources;

14.6.6.3. Documentation of whether the client is receiving or not receiving mental health services from the Contractor at the time the incident is being closed.

14.6.6.4. In the case of a death of the client, the Contractor must provide either a telephonic verification from an official source or via a death certificate.

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

14.6.6.6. If this information is unavailable, the attempt to retrieve it will be documented.

14.7. WISe Reporting - Children's Mental Health.

Contractors who implement WISe as part of their service delivery must report on actions taken in response to WISe Quality Management Plan reports and associated outcomes.

14.8. Duplicative Reports and Deliverables. If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties the Contractor may provide one (1) report or deliverable that contains the information required by both Agreements.

15. BENEFITS

15.1. The Contractor shall ensure that it has provisions to deliver, or has contracted for or arranged for the delivery of each state plan service and in doing so must:

15.1.1. Demonstrate that it has a contract with a licensed service provider to provide each service.

15.1.2. Demonstrate that it has a plan to ensure its Enrollees who need the service have reasonable access to it when the service is required and that its contracted capacity is adequate to meet the needs of its Enrollees.

15.1.3. Demonstrate a plan for referral and coordination of services when a service is available through the Enrollees medical plan under their Apple Health managed care plan or Medicaid fee for service.

15.2. All Medicaid Enrollees requesting covered Behavioral Health Services must be offered an intake evaluation or assessment as outlined in the Access Standards. Authorization for Routine beyond evaluation and assessment must be based on Medical Necessity.

Medical Necessity is established by when there is a covered diagnosis based on the DSM 5 and meeting either the ASAM criteria for SUD services or the Access to Care Standards for mental health.

15.3. Mental Health Services - The Contractor must provide the following mental health services for each Enrollee when they are Medically Necessary. If the Contractor's contracted network is unable to provide medically necessary services covered under the contract to a particular Enrollee, the entity must adequately and timely cover these services out of network for the Enrollee, for as long as the entity is unable to provide them within the network. These out of network services must be provided at no additional cost to the Enrollee. Enrollees are entitled to access Crisis Services, Freestanding Evaluation and Treatment, Stabilization and Rehabilitation Case Management prior to an intake evaluation.

15.3.1. Brief Intervention Treatment: Solution-focused and outcomes-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid Enrollee's Individual Service Plan must include a specific timeframe for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the Enrollee's current level of functioning and assistance with self-care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

15.3.2. Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid-enrolled 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 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 may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a Mental Health Professional.

15.3.3. Day Support: 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 Medicaid Enrollees 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 consumer 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 client (e.g., community mental health agencies, community centers). This service is available 5 hours per day, 5 days per week.

15.3.4. Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid-enrolled individual. 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 will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer 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. This service is provided by or under the supervision of a Mental Health Professional.

15.3.5. Freestanding Evaluation and Treatment: Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by DSHS to provide medically necessary evaluation and treatment to the Medicaid-enrolled individual 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. DSHS must authorize exceptions for involuntary length of stay beyond a fourteen (14) day commitment.

15.3.6. Group Treatment Services: Services provided to Medicaid-enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include: developing self-care and/or life skills enhancing interpersonal skills; mitigating the symptoms of mental illness and lessening the results of traumatic experiences; learning from the perspective and experiences of others and counseling/psychotherapy to establish and/or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a Mental Health Professional to two or more Medicaid-enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

15.3.7. High Intensity Treatment:

15.3.7.1. Intensive levels of service otherwise furnished under this State plan amendment that is provided to Medicaid-enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individuals' needs. Twenty-four hours per day, seven 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 residential placement.

15.3.7.2. 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, or neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the Individual Service Plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning shall be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the Individual Service Plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

Reportable components of this modality include time spent by the Mental Health Professionals, mental health care providers and peer counselors.

15.3.8. Individual Treatment Services: A set of treatment services designed to help a Medicaid-enrolled individual attain goals as prescribed in his/her Individual Service Plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid-enrolled individual. This service is provided by or under the supervision of a Mental Health Professional.

15.3.9. Intake Evaluation: 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) business days of the request for services, establish the medical necessity for treatment and be completed within 30 business days. Routine Services may begin before the completion of the intake once medical necessity is established. This service is provided by a Mental Health Professional.

15.3.10. Medication Management: 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.

15.3.11. Medication Monitoring: Face-to-face, one-on-one cueing, observing, and encouraging a Medicaid-enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid-enrolled individual. 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. Enrollees 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 Enrollee is the only direct service reportable component of this modality.

15.3.12. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non-hospital/non-IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness.

Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., Residential Treatment Facilities (RTFs), boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid Enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is reportable on a daily rate. In order to report the daily for these services, a minimum of eight (8) hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

15.3.13. Peer Support:

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

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

15.3.13.3. Services provided by peer counselors to the consumer are noted in the consumer's Individualized Service Plan which delineates specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

15.3.13.4. Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

15.3.13.5. Peer support is available to each Enrollee for no more than four (4) hours per day. The ratio for this service is no more than 1:20.

15.3.14. Psychological Assessment: 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 consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

15.3.15. Rehabilitation Case Management: A range of activities by the outpatient Community Mental Health Agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities 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.

15.3.16. Special Population Evaluation: 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 consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another BHAor contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, reportable component of this service.

15.3.17. Stabilization Services: Services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis shall 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 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.

15.3.18. Therapeutic Psychoeducation:

15.3.18.1. Informational and experiential services designed to aid Medicaid-enrolled individuals, 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 Medicaid-enrolled individual and are included in the Individual Service Plan.

15.3.18.2. 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 consumer, by or under the supervision of a Mental Health Professional. Classroom style teaching, family treatment and individual treatment are not reportable components of this service.

15.4. Substance Use Disorder Treatment Services - The Contractor must provide the following substance use disorder treatment services for each Enrollee when they are Medically Necessary. If the Contractor's contracted network is unable to provide medically necessary services covered under the contract to a particular Enrollee, the entity must adequately and timely cover these services out of network for the Enrollee, for as long as the entity is unable to provide them within the network. All service delivery settings must meet the requirements of WAC 388-877B and 246-337 and be delivered by professionals practicing within the scope of their licensure or certification as required in the State Plan.

15.4.1. Alcohol/Drug Screening and Brief Intervention- A combination of services designed to screen for risk factors that appear to be related to alcohol and other drug disorders, provide interventions to enhance patient motivation to change and make appropriate referrals as needed.

15.4.2. Inpatient Withdrawal Management (Alcohol and Drug Detoxification)- Services required for the care and/or treatment of individuals intoxicated or incapacitated by alcohol or other drugs while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal form alcohol or other drugs. Services are provided in facilities with 16 beds or less and exclude room and board. Services include:

A. Screening and detoxification; and
B. Counseling of persons admitted to a program within a certified facility, regarding their illness in order to stimulate motivation to obtain further treatment, and referral of detoxified chemically

dependent persons to other appropriate chemical dependency services providers.

15.4.3. Chemical Dependency Treatment- Rehabilitative services of diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques that are provided in certified programs that include:

A. Outpatient treatment in chemical dependency treatment centers; and
B. Treatment services, excluding room and board, provided in residential treatment facilities with 16 beds or less.

15.4.4. Laboratory Services- Drug screens only when medically necessary and when:

A. Ordered by a physician as part of a medical evaluation; or
B. As drug and alcohol screens required to assess suitability for medical tests or treatment. For opiate substitution and pregnant women clients in the department contracted treatment programs, drug screens for monitoring alcohol/drug use are reimbursed through a contract issued by the department.

15.4.5. Case Management Services- An ongoing process to assist eligible clients gain access to and effectively use necessary health and related social services. Case management is used to either involve eligible clients in chemical dependency treatment or to support them as they move through stages of chemical dependency treatment within or between separate treatment agencies. Services are delivered to enrollees with substance use disorders who need assistance in obtaining necessary medical, social, educational, vocational and other services.

15.5. Children's Long Term Inpatient Program (CLIP). The Contractor shall integrate all regional assessment and CLIP referral activities, including the following:

15.5.1. Create and maintain a local process to assess the needs of children being considered for voluntary admission and coordinate referrals to the CLIP Administration.

15.5.2. When a person under age 18 is committed for 180 calendar days under RCW 71.34, the Contractor must assess the child's needs prior to the admission to the CLIP facility. The Contractor must provide a designee who participates in the CLIP Placement Team assignment of children subject to court-ordered involuntary treatment. A Contractor representative will share the community and/or family recommendations for CLIP program assignment of committed adolescents.

15.5.3. Assess the needs of juveniles transferred for evaluation purposes by the Juvenile Rehabilitation Administration (JRA), or under RCW 10.77 to the Child Study and Treatment Center (CSTC).

15.5.4. Ensure that all required CLIP application materials, including community/family CLIP placement recommendations are submitted to the CLIP Administration prior to consideration of voluntary referrals.

15.5.5. The Contractor shall provide the legal guardian and youth aged 13 years and over with a written copy of the CLIP Administration appeal process when the Contractor denies a voluntary application for CLIP services.

15.5.6. After CLIP Admission, the Contractor must provide Rehabilitation Case Management, which includes a range of activities by the Contractor's or CMHA's liaison conducted in or with a facility for the direct benefit of the admitted youth. This person is the primary case contact for CLIP programs responsible for managing individual cases from pre-admission through discharge. The Contractor's liaison or designated BHAmust participate in treatment and discharge planning with the CLIP treatment team.

15.5.7. Review for prior authorization recommendations for short-term/acute hospitalization when it is determined by the CLIP program that this is required.

15.5.8. In the case of an admission directly from a Washington Tribal Authority, the Contractor shall work with the Federally Recognized Tribe during discharge planning as necessary to provide appropriate services to the individual.

15.6. Psychiatric Inpatient Services.

15.6.1. The Contractor or its designee shall contact the inpatient unit within three (3) business days for all Enrollee admissions. The Contractor or its designee shall provide to the inpatient unit:

15.6.1.1. Any available information regarding the Enrollee's treatment history at the time of admission.

15.6.1.2. All available information related to payment resources and coverage

15.6.1.3. A provisional placement plan for the Enrollee to return to the community that can be implemented when the Enrollee is determined to be ready for discharge by the hospital and the Contractor.

15.6.2. The Contractor's liaison or designated BHAmust participate in treatment and discharge planning with the inpatient treatment team.

15.6.3. The Contractor must designate a contracted network BHAto work with an Enrollee and their families seeking community support services prior to discharge

15.6.4. If the provisional placement plan for an Enrollee cannot be implemented when an Enrollee is determined to be ready for discharge, the Contractor's liaison must convene a meeting of the inpatient treatment team and other discharge plan participants to review action taken to implement the plan, barriers and proposed modifications to the plan. Such meetings shall occur every 30 calendar days until the Enrollee has been placed.

15.6.5. The Contractor shall ensure provision of covered mental health services to Enrollees on a Conditional Release under RCW 10.77.150 for Enrollees who meet Medical Necessity and the Access to Care Standards.

15.7. Best Effort. The Contractor shall use best efforts to utilize community resources and covered mental health services to minimize State Hospital admissions.

15.7.1. The Contractor or designee shall use best efforts to secure an appointment, within 30 calendar days of release from the facility, for medication, evaluation and prescription re-fills for Enrollees discharged from inpatient care, to ensure there is no lapse in prescribed medication. This may be arranged with providers other than Subcontractors of the Contractor.

15.7.2. The Contractor shall use best efforts to offer covered mental health services for follow-up and after-care as needed when the Contractor or Subcontractor are aware that an Enrollee has been treated in an emergency room for a psychiatric condition. These services shall be offered in order to maintain the stability gained by the provision of emergency room services.

15.8. The Contractor shall coordinate with the Department of Social and Health Services, Home and Community Services (HCS) regional offices to support the placement of persons discharged or diverted from State Hospitals into HCS placements. In order to accomplish this, the Contractor shall:

15.8.1. Whenever possible, prior to referring a person with a diagnosis of dementia for a 90 day commitment to a State Hospital:

15.8.1.1. Ensure that a request for Comprehensive Assessment Reporting Evaluation (CARE) is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all persons who might be eligible for long-term care services. HCS has agreed to prioritize requests for CARE for individuals who have been detained to an Evaluation & Treatment facility or in another setting.

15.8.1.2. Request and coordinate with HCS, a scheduled CARE for such persons. If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to attempt a community placement prior to referral to the State Hospital.

15.8.2. For individuals (both those being discharged and those being diverted) whose CARE indicates likely functional and financial eligibility for long-term care services:

15.8.2.1. The Contractor will coordinate with HCS placement activities with one entity designated as being responsible for those activities. This designation will be documented in writing and agreed upon by both the Contractor and HCS. Where such designation is not made the responsibility shall be the Contractor's.

15.8.2.2. The responsible entity will establish and coordinate a placement or discharge planning team that includes Contractor staff, HCS assessors, and other community partners, as necessary, to develop a plan of action for finding a safe, sustainable placement.

15.8.2.3. The Contractor will ensure coordination and communication will occur between those participants involved in placement activities as identified by the discharge planning team.

15.8.2.4. If a placement has not been found for an individual referred for long-term care services within 30 calendar days, the designated entity will convene a meeting to review the plan and to make adjustments as necessary. Such review meetings will occur at least every 30 calendar days until a placement is affected.

15.8.2.5. When individuals being discharged or diverted from State Hospitals are placed in a long-term care setting, the Contractor shall:

15.8.2.5.1. 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 DSHS website.

15.8.2.5.2. When the individual meets Access to Care Standards, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement.

15.9. Early Periodic Screening Diagnosis and Treatment (EPSDT). EPSDT services must be structured in ways that are culturally and age appropriate, involve the family and be available to all Enrollees under the age of 21. Intake evaluations provided under EPSDT must include an assessment of the family's needs.

15.9.1. EPSDT requires the Contractor to respond to referrals from medical care providers. This must include at least a written notice replying to the Physician, ARNP, Physician's Assistant, trained public health nurse or RN who made the EPSDT referral. This notice must include at least the date of intake and diagnosis.

15.9.2. In the event the Enrollee does not have a primary care provider, the Contractor may choose to assist or refer the Enrollee to the HCA's Washington Apple

Health Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Provider Guide.

15.9.3. The Contractor shall contact the Enrollee within ten (10) business days of all EPSDT referrals to confirm whether services are being requested by the Enrollee or the person authorized to consent to treatment for that Enrollee. The Contractor shall maintain documentation of its efforts to confirm whether the Enrollee or the person authorized to consent to treatment for that Enrollee requests, declines, or does not respond to efforts within ten (10) business days to confirm whether these services are being requested.

15.10. The Contractor shall participate in local and statewide efforts to assist Consumers in enrolling in healthcare coverage.

16. TRIBAL RELATIONSHIPS

16.1. The Contractor shall develop or attempt to develop a Tribal and Recognized American Indian Organization (RAIO) Coordination Implementation Plan with each Federally Recognized Tribe and RAIO within its service area as defined herein. The Contractor shall provide documentation of attempts to develop a plan if any Federally Recognized Tribe or RAIO declines to participate. The Contractor shall submit the matrix below for each Federally Recognized Tribe or RAIO on or before March 1, 2016.

16.1.1. The Federally Recognized Tribes or RAIOs are defined in the following documents:

- The Indian Health Services map that represents Contract Health Service Delivery areas as published in the Federal Register;
- The Bureau of Indian Affairs Service Area map; and
- The DSHS 7.01 Policy, which identifies the Federally Recognized Tribes and/or Recognized American Indian Organizations (RAIOs). http://one.dshs.wa.lcl/Policies/Administrative/DSHS-AP-07-01.pdf

16.1.2. A Planning Checklist is attached as Exhibit B to assist with developing the Tribal and RAIO Coordination Implementation Plan. The Contractor shall consider the planning checklist in developing the Tribal and RAIO Coordination Implementation Plan.

16.1.3. As part of the Tribal and RAIO Coordination Implementation planning, the Contractor must extend an invitation to those Federally Recognized Tribes and RAIOs within the Contractor's service area to participate as members of the Contractor's Advisory Board. Any issues that arise from this invitation must be detailed in the plan, including a timeline to address these issues and expected outcomes. This includes any Governing Board by-laws or other local rules or regulations that would need to be changed to accommodate the Tribal representation occurring.

Tribal and RAIO Coordination Implementation Plan and Progress Report For Regional Support Networks Due to DSHS on or before March 1, 2016.				
Implementation Plan				**Progress Report**
(1) Goals/ Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Fiscal Year Starting Last July 1

16.2. Subcontracts with Federally Recognized Tribes and Recognized American Indian Organizations (RAIO). Subcontracts with Federally Recognized Tribes and Recognized American Indian Organizations shall include the Special Terms and Conditions as laid out in the Centers for Medicare & Medicaid Services Model QHP Addendum for Indian Health Care Providers.

16.2.1. If the Contractor chooses to enter into a Subcontract with a Federally Recognized Tribe the Subcontract must include one (1) of the following:

16.2.1.1. General Terms and Conditions that are modeled on the DSHS and Indian Nation Agreement General Terms and Conditions.

16.2.1.2. General Terms and Conditions modeled on the Intergovernmental Agreement for Social and Health Services between Federally Recognized Tribes and The Washington State Department of Social and Health Services.

16.2.1.3. General Terms and Conditions that were developed through a process facilitated by a DBHR Tribal Liaison.

16.2.1.4. General Terms and Conditions that were developed between the Federally Recognized Tribe and the Contractor. In this case, a written statement must be provided to DBHR Tribal Liaison from each party that verifies both are in Agreement with the content of the General Terms and Conditions.

16.2.2. If the Contractor chooses to enter into a Subcontract with a RAIO, the Contract must include one (1) of the following:

16.2.2.1. General Terms and Conditions that were developed through a process facilitated by a DBHR Tribal Liaison.

16.2.2.2. General Terms and Conditions that were developed between the RAIO and the Contractor. In this case a written statement must be provided to a

DBHR Tribal Liaison from each party that verifies both are in Agreement with the content in the General Terms and Conditions.

16.2.3. Any Subcontracts with Federally Recognized Tribes and RAIOs must be consistent with the laws and regulations that are applicable to the Federally Recognized Tribe or RAIO. The Contractor must work with each Federally Recognized Tribe to identify those areas that place legal requirements on the Federally Recognized Tribe that do not apply and refrain from passing these requirements on to Federally Recognized Tribes.

16.2.4. DBHR Tribal Liaison may be available for technical assistance in identifying what legal requirements the Contactor can be relieved of in Tribal or RAIO Subcontracts.

16.2.5. The Contractor shall have a policy and procedure that requires efforts to recruit and maintain Ethnic Minority Mental Health Specialists – Native American from each Federally Recognized Tribe or RAIO listed in this Section, for use in specialists consults whenever possible.

16.2.6. The Contractor may not implement fees or policies that would create a charge, deduction, copayment or other similar charges on American Indians and Alaska Natives for services provided under this Agreement.

16.2.7. In the event the liaison is aware that the Enrollee is a Tribal Member or receiving mental health services from a Tribal or Urban Indian Health Program and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in discharge planning and transition for the Enrollee. If the Enrollee chooses to be served only by the Tribal Mental Health Service referral to a contracted network BHAis not required.

16.3. If an Enrollee is a Tribal Member of a Washington State Federally Recognized Tribe and is referred to or presents for non-crisis services and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in treatment planning and service provision for the Enrollee. If the Enrollee chooses to be served only by the Tribal Mental Health Service referral to a contracted network BHAis not required.

17. REMEDIAL ACTIONS

17.1. DSHS may initiate remedial action if it is determined that any of the following situations exist:

17.1.1. A problem exists that negatively impacts individuals receiving services.

17.1.2. The Contractor has failed to perform any of the mental health services required in this Agreement.

17.1.3. The Contractor has failed to develop, produce, and/or deliver to DSHS any of the statements, reports, data, data corrections, accountings, claims, and/or

documentation described herein, in compliance with all the provisions of this Agreement.

17.1.4. The Contractor has failed to perform any administrative function required under this Agreement. For the purposes of this section, “administrative function” is defined as any obligation other than the actual provision of mental health services.

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

17.2. DSHS may impose any one or more of the following remedial actions in any order:

17.2.1. Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to DSHS within 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 Agreement. DSHS may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

17.2.1.1. Corrective action plans must include:

- A brief description of the situation requiring corrective action.
- The specific actions to be taken to remedy the situation.
- A timetable for completion of the actions.
- Identification of individuals responsible for implementation of the plan.

17.2.1.2. Corrective action plans are subject to approval by DSHS, which may:

- Accept the plan as submitted.
- Accept the plan with specified modifications.
- Request a modified plan.
- Reject the plan.

17.2.1.3. Any corrective action plan that was in place as part of a previous PIHP Agreement shall be applied to this Agreement in those areas where the Contract requirements are substantially similar.

17.2.2. Withhold up to five percent (5%) of the next monthly capitation payment and each monthly capitation payment thereafter until the situation has been resolved. DSHS, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

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.

17.2.3. Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which DSHS provides incentives.

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

18. PREDICTIVE RISK INTELLIGENCE SYSTEM (PRISM)

18.1. PRISM data are Protected Health Information (PHI) subject to HIPAA Privacy and Security Rules. As a condition for accessing and using the PRISM application, the Contractor agrees to the following:

18.1.1. The Contractor shall identify their BHO POC for the PRISM system to the DBHR Coordinator at DBHR-RDA-PRISM@dshs.wa.gov.

18.1.2. The Contractor shall be authorized to access and use the PRISM application only for a subset of activities related to treatment, payment, and health care operations as defined in HIPAA.

18.1.3. The DBHR Coordinator will inform the BHO POC on required forms and procedures.

18.1.4. Access to PRISM shall be through the Secure Access Washington (SAW) site maintained by the Washington State Department of Enterprise Services.

18.1.5. The Contractor shall ensure compliance with all HIPAA Security and Privacy standards, requirements, and implementation specifications referenced in 45 CFR Parts 164.302 and 45 CFR 164.500(a), and with applicable sections of the HITECH Act which make Contractors liable to the federal government for HIPAA violations [42 USC 17931 and 17934].

18.1.6. The Contractor shall ensure that only registered PRISM Users access and use the PRISM application, that PRISM Users use only their own User ID and password to access the PRISM application, and that employees who are not registered PRISM Users are not allowed to “borrow” a User ID and password to access PRISM.

18.1.7. The Contractor shall ensure that computers, laptops, and portable devices that are used to access the PRISM application are maintained in secure areas away from the general public and the latest security features are deployed.

18.1.8. The Contractor shall ensure all measures described in the Confidential Personal Information section of this Agreement are employed at all times.

18.1.9. The Contractor BHO POC shall notify the DBHR Coordinator within five (5) business days whenever a PRISM User with access rights leaves employment or has a change of duties such that the employee no longer requires access. If the removal of access is emergent, please include that information with the request.

18.1.10. In the event of a Breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from the PRISM system, the Contractor shall comply with all requirements of the HIPAA Security and Privacy for Breach Notifications and as otherwise required by state or federal law.

18.2. The Contractor understands that PRISM access is continuously tracked and monitored by the PRISM Administrator. DSHS reserves the right at any time to terminate a PRISM User's access for any reason, to conduct audits, and to investigate possible violations of this Agreement.