

# BHO BHSC Program Agreement – April 2016-Exhibit C-3

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## 1. PURPOSE OF PROGRAM AGREEMENT

The purpose of this Program Agreement (Agreement) is for the Contractor to provide community mental health services and substance use disorder treatment and support services to eligible Individuals. The Contractor shall provide or purchase age, linguistic and culturally competent services as specified to the maximum extent possible and within the Available Resources provided under this Agreement for Individuals within the contracted Regional Service Area. The services shall be provided pursuant to: [RCW 70.02](#), [RCW 71.05](#), [RCW 71.24](#), and [RCW 71.34](#), [RCW 70.96\(B\)](#) and [RCW 70.96\(C\)](#), [RCW 70.96A](#), or any successors and [WAC Chapters 388-865, 388-877 and 388-877B](#) or any successors.

Period of Performance – This Agreement is in effect from April 1, 2016, through June 30, 2018.

## 2. DEFINITIONS

- 2.1. **Administrative Cost** means costs for the general operation of the public mental health system. These activities cannot be identified with a specific direct services or direct service support function as defined in the BARS supplemental instructions.
- 2.2. **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.
- 2.3. **Available Resources** means funds appropriated for the purpose of providing community MH programs: federal funds, except those provided according to [Title XIX of the Social Security Act](#), and state funds appropriated under [RCW 71.24](#) or [RCW 71.05](#) by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other MH services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.
- 2.4. **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.
- 2.5. **Behavioral Health Agency (BHA)** means a Behavioral Health Agency that is licensed by the State of Washington to provide behavioral health services and is subcontracted under this Agreement to provide services.
- 2.6. **Behavioral Health Organization (BHO)** means a county authority or group of county authorities or other entity recognized by the Secretary to administer behavioral health services in a defined region.
- 2.7. **Budget Narrative.** The Budget Narrative serves two purposes - it identifies how the costs were estimated and it justifies the need for the cost.
- 2.8. **CDP** means a Chemical Dependency Professional licensed by the Washington Department of Health. "A CDP is the individual with primary responsibility for implementing an individualized plan for Substance Use Disorder treatment services.

- 2.9. **Centers for Medicare and Medicaid Services (“CMS”)** means the agency within the U. S. Department of Health & Human Services responsible for administration of several key federal health care programs.
- 2.10. **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.
- 2.11. **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.
- 2.12. **Child Study and Treatment Center (“CSTC”)** means the Department of Social and Health Services child psychiatric hospital.
- 2.13. **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.
- 2.14. **Contractor** means the BHO named above, recognized by the Secretary, and who has authority to establish and operate a community behavioral health program.
- 2.15. **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.
- 2.16. **Data** means information that is disclosed or exchanged as described by this Contract.
- 2.17. **Delegation Plan** means either one document or an identified set of documents that show the Contractor’s compliance with the Subcontractors clause of this Agreement.
- 2.18. **Deliverable** means items that are required for submission to DBHR to satisfy the work requirements of this Agreement and that are due by a particular date or on a regularly occurring schedule.
- 2.19. **Direct Care Staff** means persons employed by behavioral health agencies whose primary responsibility is providing direct treatment and support to people with behavioral health needs, or whose primary responsibility is providing direct support to such staff in areas such as scheduling, providing intake documents, reception, records-keeping, and facilities maintenance.
- 2.20. **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.
- 2.21. **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.
- 2.22. **E & T or Evaluation and Treatment Center** 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](#).

- 2.23. **Eastern Washington BHOs** includes BHOs contracted by DSHS to provide services in the following Washington counties: Ferry, Stevens, Pend Oreille, Lincoln, Okanogan, Grant, Adams, Chelan, Douglas, Spokane, Klickitat, Yakima, Kittitas, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin, and Whitman.
- 2.24. **Emergent Care** means services provided for a person that, if not provided, would likely result in the need for mental health crisis intervention, or mental health hospital evaluation due to concerns of potential danger to self, others, or grave disability according to [RCW 71.05](#).
- 2.25. **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.
- 2.26. **Enrollee** means a Medicaid recipient who is currently enrolled in a Pre-paid Inpatient Health Plan.
- 2.27. **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.
- 2.28. **Fair Hearing** means a proceeding before an administrative law judge that gives an individual an opportunity to be heard in disputes about DSHS programs and services.
- 2.29. **Family** means:
- 2.29.1. For adults, family means those the identified as family or those appointed/assigned (e.g., guardians, siblings, caregivers, and significant others) to the individual.
  - 2.29.2. 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 tribe.
- 2.30. **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.
- 2.31. **Grievance** means an expression of dissatisfaction about any matter. 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 Individual's rights.
- 2.32. **Grievance Process** is one of the processes included in the grievance system that allows an individual to express concern or dissatisfaction about a mental health service.
- 2.33. **Grievance System** means the processes through a Behavioral Health Organization in which an individual applying for, eligible for, or receiving mental health services may express dissatisfaction about services. The grievance system must be established by the BHO, must meet the requirements of 42 CFR 438 Subpart F, and include:
- 2.33.1. A grievance process; and
  - 2.33.2. Access to the Department's administrative hearing process.

2.34. **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.

2.34.1. **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;

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:

2.34.1.1. The individual's legal guardian; or

2.34.1.2. The individual's representative if the individual gives written permission.

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.

2.35. **Interim Services** means services offered to an eligible individual denied admission to non-Medicaid funded treatment due to a lack of available resources.

2.36. **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 exists or treatment is no longer adequate or appropriate, or incapacity no longer exists. A petition for recommitment can be filed for an additional period of up to 90 days. ([RCW 70.96A.140](#))

2.37. **IVDU and IDU** mean Intra-Venous Drug User or Injecting 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.

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

2.39. **Medical Necessity or Medically Necessary** means a 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.

2.40. **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.

2.41. **Mental Health Professional** means:

- 2.41.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in RCW 71.05 and 71.34 RCW.
- 2.41.2. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such 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.
- 2.41.3. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.
- 2.41.4. A person who had an approved waiver to perform the duties of a Mental Health Professional that was requested by the Behavioral Health Organization and granted by DSHS prior to July 1, 2001.
- 2.41.5. A person who has been granted a time-limited exception of the minimum requirements of a Mental Health Professional by DSHS consistent with WAC 388-865-0265.

2.42. **Notice of Action** is the written notice a BHO provides to an individual and, if applicable, the individual's legal representative, to communicate an "action".

2.43. **Notice of Determination** means a written notice that must be provided to Individuals to inform them that services, available per the Contractor's policy and procedures, have not been authorized, and the reason for this determination. A Notice of Determination must contain the following:

- The reason for denial or offering of alternative services.
- A description of alternative services, if available.
- The right to a Fair Hearing.

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

2.45. **Patient Days of Care** includes all voluntary patients and involuntarily committed patients under RCW 71.05, regardless of where in the State Hospital they reside. Patients who are committed to the State Hospital under RCW 10.77 are not included in the Patient Days of Care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the Patient Days of Care until a petition for ninety (90) days of civil commitment under RCW 71.05 RCW has been filed in court. Patients

who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the Patient Days of Care until the patient is civilly committed under RCW 71.05.

- 2.46. **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.
- 2.47. **ProviderOne** means the Department’s Medicaid Management Information Payment Processing System.
- 2.48. **Publish** means an officially sanctioned document provided by DBHR on the DBHR internet or intranet websites for downloading, reading, or printing. The Contractor will be notified in writing or by e-mail when a document meets this criterion.
- 2.49. **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.
- 2.50. **Quality Improvement** means a focus on activities to improve performance above minimum standards/ reasonably expected levels of performance, quality, and practice.
- 2.51. **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.
- 2.52. **Recovery** means the processes by which people are able to live, work, learn, and participate fully in their communities.
- 2.53. **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.
- 2.54. **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.
- 2.55. **Service Area** means the geographic area covered by this Agreement for which the Contractor is responsible.
- 2.56. **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 or its successor.
- 2.57. **Termination** means the decision by a Contractor, or their formal designee, to stop previously authorized mental health services described in their Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to stop or change a covered service in the Individualized Service Plan is not a termination.
- 2.58. **Urgent Care** means a service to be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person’s situation is likely to deteriorate to the point that Emergent Care is necessary.
- 2.59. **Washington Program of Assertive Community Treatment (WA-PACT)** is a team-based, evidence-based mental health service delivery model that incorporates the values of Recovery and Resiliency. PACT is also a client-centered, recovery-oriented mental health service delivery model

that utilizes a multi-disciplinary team approach providing services to Individuals with severe and persistent mental illnesses and co-occurring disorders.

2.60. **Western Washington BHOs** includes BHOs contracted by DSHS to provide services in the following Washington counties: San Juan, Whatcom, Island, Skagit, Snohomish, Clallam, Jefferson, Kitsap, King, Pierce, Thurston, Mason, Grays Harbor, Lewis, Pacific, Wahkiakum, and Cowlitz.

2.61. **Young adult** means a person or patient from age 18 through age 20.

2.62. **Youth** means a person or patient from age 10 through age 17.

### 3. SPECIAL TERMS AND CONDITIONS

3.1. **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.

3.2. **Compliance with Additional Laws.** At all times during the term of this Agreement, the Contractor shall comply with all applicable federal, State, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations, and the following, whether or not a specific citation is identified in various sections of this Agreement:

- 3.2.1. All applicable Office of Insurance Commissioner's (OIC) statutes and regulations.
- 3.2.2. All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement.
- 3.2.3. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC §1857(h)), Section 508 of the Clean Water Act (33 USC §1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, Department of Health and Human Service (DHHS), and the EPA.
- 3.2.4. Any applicable mandatory standards and policies relating to energy efficiency which are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act.



- 3.2.5. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
- 3.2.6. Those specified in Title 18 RCW for professional licensing.
- 3.2.7. Reporting of abuse as required by RCW 26.44.030.
- 3.2.8. Industrial insurance coverage as required by Title 51 RCW.
- 3.2.9. Any other requirements associated with the receipt of federal funds.
- 3.2.10. Any provision of this Agreement which conflicts with State and federal statutes, or regulations, or Centers for Medicare and Medicaid Services (CMS) policy guidance is hereby amended to conform to the provisions of State and federal law and regulations.
- 3.2.11. 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 be issued a concealed pistol license under RCW 9.41.070 or to purchase a pistol under RCW 9.41.090.

### **3.3. Confidentiality of Personal Information**

- 3.3.1. 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 use disorder treatment 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 behavioral 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. Such purposes include, but are not limited to:
  - 3.3.1.1. Establishing eligibility.
  - 3.3.1.2. Determining the amount of medical assistance.
  - 3.3.1.3. Providing services for recipients.
  - 3.3.1.4. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan.
  - 3.3.1.5. Assuring compliance with Federal and State laws and regulations, and with terms and requirements of the Agreement.
  - 3.3.1.6. Improving quality.
- 3.3.2. 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 individual.
- 3.3.3. In the event an individual's picture or personal story will be used, the Contractor shall first obtain written consent from the individual.

- 3.3.4. 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:
  - 3.3.4.1. Verify the identity or authenticate all of the system's human users before allowing them access to any confidential data or data system capabilities.
  - 3.3.4.2. Authorize all user access to client applications.
  - 3.3.4.3. Protect application data from unauthorized use when at rest.
  - 3.3.4.4. Keep any sensitive data or communications private from unauthorized individuals and programs.
  - 3.3.4.5. 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.
  - 3.3.4.6. 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.
- 3.3.5. 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.
- 3.3.6. The Contractor understands that DSHS reserves the right to withdraw access to any of its confidential data systems at any time for any reason.

3.4. **Declaration That Individuals Served Under Mental Health Programs Are Not Third-Party Beneficiaries Under this Agreement.** Although DSHS and the Contractor mutually recognize that services under this Agreement will be provided by the Contractor to Individuals receiving services under RCW chapters 71.05, 71.24, and 71.34 RCW, 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.

3.5. **Failure to Expend Funds.** In the event that the Contractor fails to expend funds under this Agreement in accordance with state laws and/or the provisions of this Agreement, the Department reserves the right to recapture state funds in an amount equivalent to the extent of the noncompliance. This is in addition to any other remedies available at law or in equity.

- 3.5.1. Such right of recapture shall exist for a period not to exceed twenty four (24) months following contract termination. Repayment by the Contractor of funds under this recapture provision shall occur within sixty (60) calendar days of demand. In the event that the Department is required to institute legal proceedings to enforce the recapture provision, the Department shall be entitled to its costs thereof, including attorneys' fees.

3.6. **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 Individuals. The Contractor must maintain membership roster(s) and by-laws of the Governing Body demonstrating compliance. The Governing Body by-laws must include:

- 3.6.1. Actions to be taken when a conflict of interest, or the appearance of a conflict of interest, becomes evident
  - 3.6.2. Requirements that members refrain from voting or joining a discussion when a conflict of interest is present; and
  - 3.6.3. A process for the Governing Body to assign the matter to others, such as staff or advisory bodies to avoid a conflict of interest
- 3.7. **Lawsuits.** Nothing in this Agreement shall be construed to mean that the Contractor, a County, BHO, 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 70.96A, RCW 70.96B, 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.
- 3.8. **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.
- 3.9. **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 year period, whichever is later.
- 3.9.1. The Contractor shall maintain records sufficient to:
    - 3.9.1.1. Maintain the content of all medical records in a manner consistent with utilization control requirements of [42 CFR §456](#).
    - 3.9.1.2. Document performance of all acts required by law, regulation, or this Agreement.
    - 3.9.1.3. Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance.
    - 3.9.1.4. 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.

#### 4. PAYMENT AND FISCAL MANAGEMENT –

- 4.1.1. The Contractor shall ensure that all funds, including interest earned, provided pursuant to this Agreement are used to support the public behavioral health system.
- 4.1.2. State funds will be paid based upon the categories of services contained in Exhibit C.
- 4.1.3. State funding is provided for the implementation of the Criminal Justice Treatment Account requirements.

- 4.1.4. (SPOKANE AND UBH ONLY) Funding is provided as described in Exhibit C for the costs of Involuntary Court costs for 180-day commitment hearings that occur at the state psychiatric hospital.
- 4.1.5. (Spokane Only) The Contractor is provided funding as contained in Exhibit C to implement the following services to reduce the utilization and the census at Eastern State Hospital.
  - 4.1.5.1. High intensity treatment team for persons who are high utilizers of psychiatric inpatient services, including those with co-occurring disorders and other special needs.
  - 4.1.5.2. Crisis outreach and diversion services to stabilize in the community those individuals who are at risk of requiring inpatient care or jail services.
  - 4.1.5.3. Mental health services provided in nursing facilities to individuals with dementia, and consultation to facility staff treating those individuals.
  - 4.1.5.4. Services at a sixteen (16) bed evaluation and treatment facility.
    - 4.1.5.4.1. The Contractor shall assess the effectiveness of the above services in reducing the utilization at Eastern State Hospital, identify services that are not optimally effective, and modify those services to improve their effectiveness. The Contractor shall submit a report by April 30, 2016.
- 4.1.6. The BHO will be reimbursed up to the statewide average for services described in subsection 15.2.6.3, Implementation of Court Decision Detention of D.W., et al., for facilities listed in Exhibit I, Additional Bed Capacity, Table 1, at the following rates:

<b>Rates</b>	
IMD	Up to \$850 per day
BHO Provided Inpatient Support Services	Up to \$400 per day

- 4.1.6.1. In order to be reimbursed, the BHO must provide a completed A-19 Form, based on the rates listed above, to the DSHS contact listed on page 1. In addition, a completed Single Bed Certification (SBC) Expenditures Form, attached as Exhibit H, must be included as support with the A-19 Form. DBHR will send each BHO a customized A-19.
- 4.1.6.2. The funding for the above services are available through March 31, 2016, and all billings from the BHO must be received by the DSHS contact listed on page 1, prior to April 30, 2016, submitted within sixty (60) days of services provided, or they will not be reimbursed by the Department.
- 4.1.7. (KING COUNTY ONLY) Funds provided according to Exhibit C shall be used solely to maintain services as it works to transition services to settings eligible for federal participation for individuals covered under the Medicaid program. Evaluation and Treatment (E & T) Deliverables are included in Exhibit F.
- 4.1.8. (GRAYS HARBOR, GREATER COLUMBIA AND NORTH SOUND ONLY) Funds provided for Housing And Recovery Through Peer Services (HARPS) will include an annual payment each fiscal year as listed in Exhibit C, Funding, and two payments for housing subsidies

each fiscal year as listed in Exhibit C, Funding. The HARPS program requirements are in Exhibit G.

- 4.1.8.1. Additional funds for housing subsidies will be based on performance and monthly reporting. Monthly reports are due by the 15th of the following month based on the schedule provided.
- 4.2. If for any reason the Contractor does not agree to continue to provide services after July 31, 2018, the Contractor must provide the appropriate notice to DSHS under the requirements of the Termination Section of the Agreement.
- 4.3. If the Contractor elects to use ProviderOne for inpatient claim processing, DBHR, or its designee, will bill the Contractor on a monthly basis for claims paid on behalf of the BHO. The Contractor has thirty (30) calendar days from receipt of the inpatient claim bill to pay the costs assessed.
- 4.4. The Contractor shall provide DSHS Aging and Disabilities Services program funds equal to the general-fund state cost of Medicaid Personal Care Services used by the Contractor for Individuals who are determined to have personal care needs, as per the CARE assessment, and the need is due solely to a psychiatric disability when such payments have been authorized by the Contractor.
- 4.5. DBHR will withhold fifty percent (50%) of the final payment under this Agreement until all reports and data due during this Contract period of performance are received and accepted by DSHS, and until all pending corrective actions, penalties, or unpaid assessments are satisfied.
- 4.6. Each payment will be reduced by the amount paid by DBHR on behalf of the Contractor for unpaid assessments, penalties, and other payments pending a dispute resolution process. If the dispute is still pending July 1, 2018, DBHR will withhold the amount in question from the final payment until the dispute is resolved.
- 4.7. State Hospital reimbursement and State Hospital related payments.
  - 4.7.1. The Contractor shall pay a reimbursement for each State Hospital Patient Day of Care that exceeds the Contractor's daily allocation of State Hospital beds identified in Exhibit D based on a quarterly calculation of the bed usage by the Contractor.
    - 4.7.1.1. The Contractor may not enter into any agreement or make other arrangements for use of State Hospital beds outside of the agreed-upon allocation in Exhibit D.
    - 4.7.1.2. Any changes to the allocation shall require an amendment to the Agreement, and will become effective the 1<sup>st</sup> day of the quarter following the effective date of this Amendment.
    - 4.7.1.3. State Hospital reimbursement payments will be based only on the allocation of beds contained in Exhibit D, and any subsequent Amendments.
  - 4.7.2. The rate of payment for reimbursement for Eastern State Hospital is \$611.00.
  - 4.7.3. The rate of payment for reimbursement for Western State Hospital is \$541.00.
  - 4.7.4. DSHS will bill the Contractor quarterly for State Hospital Patient Days of Care exceeding the Contractor's daily allocation of State Hospital beds. DSHS will assess reimbursement amounts on the Contractor based on the quarterly net census overage. DSHS will process and send bills two months after the last day of each quarter the Contractor exceeds its allocation. (For example, the July through September Quarter of usage will be billed in

December.) The Contractor has thirty (30) calendar days from receipt of the reimbursement bill to pay the assessed costs.

4.7.5. If at the end of a Quarter, the Contractor has utilized less than the Contractor's allocation of State Hospital beds and reimbursements have been collected from other BHOs, the Contractor shall receive a payment in accordance with the following methodology which will be calculated separately for the Western and Eastern BHOs:

4.7.5.1. Fifty percent (50%) of the reimbursements collected by DSHS from Eastern or Western BHOs for State Hospital Patient Days of Care exceeding their quarterly allocation of State Hospital beds will be distributed to those BHOs who used fewer Patient Days of Care than their quarterly allocation of State Hospital beds.

Each BHO using fewer Patient Days of Care than their quarterly allocation of State Hospital beds will receive a portion of the reimbursement collected proportional to its share of the total number of Patient Days of Care that were not used at the appropriate State Hospital.

4.7.5.2. Payment of funds will be made approximately five (5) months after the end of the applicable quarter. (For example, October services will be billed in January and reimbursed in March.)

4.8. If the Contractor terminates this Agreement for any reason or will not be entering into any subsequent Agreements, DSHS shall require that all remaining reserves and fund balances be spent within a reasonable timeframe developed with DSHS. Funds will be deducted from the monthly payments until all reserves and fund balances are spent. Any funds not spent for the provision of services under this contract shall be returned to DBHR within sixty (60) calendar days of the last day this Agreement is in effect.

4.9. 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 DBHR.

4.10. The Contractor must ensure the existence of inpatient reserve at the percentage specified in Exhibit C of the Contractor's annual payment. The Inpatient Reserves are funds set aside into an account by official action of the BHO governing body. Inpatient reserve funds may only be set aside for anticipated psychiatric inpatient costs.

4.11. The Contractor may have an Operating Reserve not to exceed the percentage specified in Exhibit C of the maximum consideration for this Agreement. The Operating Reserves are funds set aside into an account by official action of the BHO governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of behavioral health services.

4.12. 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, based on schedule provided. The Contractor shall submit the following components in a single form provided by DBHR:

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

4.12.1.1. The “[Fiscal/Program Requirements Supplementary Instructions – Behavioral Health Programs](#)” including the Chart of Accounts, administered by DSHS/BHSIA/Budget & Finance Division, and

4.12.1.2. 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>

4.12.2. 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.

4.12.3. 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.

4.12.4. 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.

4.12.5. 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 BHO to review and comment on format changes before they go into effect whenever possible.

4.13. **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: \_\_\_\_\_.

## 5. QUALITY OF CARE

5.1. **DBHR Review Activities.** The Contractor shall participate with DBHR in review activities. Participation will include at a minimum:

5.1.1. The submission of requested materials necessary for a DBHR-initiated review within thirty (30) calendar days of the request.

5.1.2. The completion of site visit protocols provided by DBHR.

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

5.2. **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. The Contractor shall do the following to guard against Fraud and Abuse:

- 5.2.1. Create and maintain a mandatory compliance plan that includes provisions to educate staff and providers of the false claim act and whistle blower protections.
- 5.2.2. Develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State standards.
- 5.2.3. Designate a compliance officer and a compliance committee that is accountable to senior management.
- 5.2.4. Provide effective ongoing training and education for the compliance officer, Contractor staff, and selected staff of the BHAs.
- 5.2.5. Facilitate effective communication between the compliance officer, the CONTRACTOR employees, and the Contractor's network of BHAs.
- 5.2.6. Enforce standards through well-publicized disciplinary guidelines.
- 5.2.7. Conduct internal monitoring and auditing.
- 5.2.8. Respond promptly to detected offenses and develop corrective action initiatives.
- 5.2.9. Report fraud and/or abuse information to DBHR as soon as it is discovered including the source of the complaint, the involved BHA, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

5.3. **Program Evaluation.** The Contractor shall invite Individuals and 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 behavioral health system. The Contractor must be able to demonstrate how this requirement is implemented.

5.4. **Quality Improvement.** The Contractor shall provide Quality Improvement feedback to BHAs and SUDTA, the Advisory Board, and other interested parties. The Contractor will maintain documentation of the activities and provide the documentation to DBHR upon request.

#### 5.5. **Quality Review Activities**

- 5.5.1. The Department of Social and Health Services, Office of the State Auditor, or any of their duly-authorized representatives, may conduct announced and unannounced:
  - 5.5.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement.
  - 5.5.1.2. Audits regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement.
  - 5.5.1.3. Audits and inspections of financial records.



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

5.6. **Quality Review Team.** The Contractor shall establish and maintain the independence of a quality review team as set forth in WAC 388-865-0282. The Quality Review Team shall include current individuals served in the behavioral health system, past Individuals, or Family members. The Contractor shall assure that Quality Review Teams:

- 5.6.1. Fairly and independently review the performance of the BHO and service providers to evaluate systemic customer service issues as measured by objective indicators of Individual outcomes in rehabilitation, recovery, and reintegration into the mainstream of social, employment and educational choices, including:
  - 5.6.1.1. Quality of care;
  - 5.6.1.2. The degree to which services are Individualized and are age and culturally competent;
  - 5.6.1.3. The availability of alternatives to hospitalization, cross-system coordination and range of treatment options; and
  - 5.6.1.4. The adequacy of the BHO's cross system linkages including, but not limited to schools, state and local hospitals, jails and shelters.
- 5.6.2. Have the authority to enter and monitor any agency providing services under contract with a BHO, including state and community hospitals, freestanding E & T facilities, and BHAs;
- 5.6.3. Meet with interested Individuals and Family members, allied service providers, including state or community psychiatric hospitals, BHO-contracted service providers, and persons that represent the age and ethnic diversity of the BHO:
  - 5.6.3.1. Determine if services are accessible and address the needs of Individuals based on sampled individual recipient's perception of services using a standard interview protocol that will be developed by DBHR. The protocol will query the sampled individuals regarding ease of accessing services, the degree to which services address medically necessary needs (acceptability), and the benefit of the service received; and
  - 5.6.3.2. Work with interested Individuals, service providers, the BHO, and DSHS to resolve identified problems.
- 5.6.4. Provide reports and formalized recommendations upon request to the DBHR, the Behavioral Health Advisory Committee, and the BHO advisory and governing boards, and ensure that input from the quality review team is integrated into the overall BHO quality management process, ombuds services, local Individual and family advocacy groups, and provider network.
- 5.6.5. Receive training and adhere to confidentiality standards, and
- 5.6.6. Are allowed to participate in External Quality Review Organization (EQRO) activities that are performed to evaluate the Prepaid Inpatient Health Plan (PIHP) contract, upon request of the EQRO.

## 6. UTILIZATION MANAGEMENT

6.1. **Level of Care Guidelines for Substance Use Disorder Treatment Services.** The Contractor and its subcontractors shall establish policies for authorization that include the ASAM Criteria and written Level of Care Guidelines. 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.

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

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

6.1.1.2. The establishment of a covered SUD diagnosis based on DSM 5.

6.1.1.3. The ASAM Criteria for initial authorizations, continuing stay and discharge.

6.1.1.4. ASAM levels of care to be provided 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 – Clinical Managed, Medium Intensity Residential Services

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

Level – 1 – WM – Ambulatory withdrawal management without extended onsite monitoring.

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

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

6.1.2.1. 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 and has appropriate clinical expertise.

6.1.3. The following Priority Populations may be provided Behavioral Health Services within available resources. Individuals who:

6.1.3.1. Have an income level no more that 220% of the federal poverty level

6.1.3.2. Are not Medical eligible

6.1.3.3. Are uninsured

6.1.3.4. Have insurance but are unable to meet the co-pay or deductible for the services.

6.2. **Level of Care Guidelines for Mental Health Services.** The Contractor and its subcontractors shall establish policies for authorization that include the [Access to Care Standards](#) and written Level of Care Guidelines. 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.

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

6.2.1.1. Criteria for authorization of Routine outpatient services and Inpatient Services at a community psychiatric hospital. These services do not meet the definition of urgent or emergent care.

6.2.1.2. The Access to Care Standards for initial authorizations.

6.2.1.3. Continuing stay and discharge criteria for Routine and Inpatient Care. Access to Care Standards may not be used as continuing stay and discharge criteria.

6.2.1.4. 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 Mental Health Professional and has appropriate clinical expertise in treating the

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

6.3.1. Medical Necessity for Mental Health Service is based on Access to Care Standards following the initiation of the intake evaluation.

6.3.2. Medical Necessity for Substance Use Disorder Treatment Services is based on the presence of DSM 5 diagnosis for a substance use disorder and the ASAM Criteria following an Assessment.

6.3.3. A decision by the Contractor or formal designee whether to authorize initial services must occur within fourteen (14) calendar days of the date the intake evaluation or assessment was initiated, unless the Individual or the BHA requests an extension from the Contractor.

6.3.3.1. Authorization and provision of services may begin once medical necessity has been established through process of beginning an intake evaluation for mental health services or completing an assessment for SUD services.

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

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

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

6.3.3.5. Authorization decisions must be expedited to no longer than three (3) business days after receipt of the request for services:

6.3.3.5.1. When the Individual's presenting behavioral health condition affects their ability to maintain or regain maximum functioning; or

6.3.3.5.2. If the Individual presents a potential risk of harm to self or others.

6.3.4. 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 Individuals under the age of twenty one (21) years old.

6.3.5. The Contractor must have at least one (1) Care Manager who is a licensed Chemical Dependency Professional.

6.3.6. 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 Individual. This must include:

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

6.3.6.2. A method for determining if an Individual has met discharge criteria.

#### 6.4. Transition of Services.

6.4.1. 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.

6.4.2. 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:

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

6.4.2.2. 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.

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

6.4.4. 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:

- 6.4.4.1. Develop a safe, medically appropriate transition plan, considering the health and safety of the transitioning individual.
- 6.4.4.2. 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.
- 6.4.4.3. 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.
- 6.4.4.4. 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.

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- 6.5. **Authorization for Psychiatric 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 Inpatient Hospital Services Provider Guide](#). A decision regarding certification of psychiatric inpatient care must be made within twelve (12) hours of the initial request.
    - 6.5.1. Only a psychiatrist or doctoral level-clinical psychologist may deny a request for psychiatric inpatient care.
      - 6.5.1.1. If the authorization is denied, a Notice of Action must be provided to the Individual or their Authorized Representative.
    - 6.5.2. 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 [Washington Apple Health Inpatient Hospital Services Provider Guide](#), see "Administrative disputes".
    - 6.5.3. 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.
  - 6.6. **Authorization for Withdrawal Management Services:** - The Contractor must have appropriate clinical staff members available 24 hours a day, 7 days a week to respond to requests for

authorization for inpatient withdrawal management and to determine resource availability. Clinical staff will make appropriate referrals as necessary.

- 6.6.1. Services are to be delivered in settings that meet the requirements of WAC 388-877B for individuals who have meet the screening criteria.
- 6.6.2. Services shall be based on a written recommendation for substance use disorder treatment from a licensed health care practitioner functioning within their scope of practice under state law.

6.7. **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.

6.7.1. 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 shall address 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 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

6.7.2. 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

- 6.8. **Medicaid Personal Care:** DSHS Aging and Disabilities Services (ADS) or its designee uses the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine personal care needs. The Contractor or its designee must respond to requests for Medicaid Personal Care (MPC) from ADS within five (5) business days of the request. The Contractor and the local ADS office may mutually agree in writing to extend the five (5) business day requirement. Authorization decisions must be based on the following:
- 6.8.1. A review of the request to determine if the Individual is currently authorized to receive services from the Prepaid Inpatient Health Plan in the Contractor's Service Area.
  - 6.8.2. A verification that need for MPC services is based solely due to a psychiatric disability.
  - 6.8.3. A review of the requested MPC services to determine if the Individual's personal care needs could be met through provision of other available BHO services.
    - 6.8.3.1. The Contractor may not limit or restrict authorization for personal care services due to insufficient resources.
  - 6.8.4. If the Contractor denies authorization of the state match portion for MPC, the written response to ADS must include the reason for the determination and other available BHO provided services that will be used to meet the personal care needs identified in the CARE.
    - 6.8.4.1. When the Contractor denies authorization of the state match portion based on provision of other BHO services, a plan (e.g., Individual Service Plan) must be developed and implemented to meet the personal care needs identified in the CARE assessment.
  - 6.8.5. The Contractor must provide the following documentation to DBHR or ADS on request:
    - 6.8.5.1. The original ADS referral and request for authorization.
    - 6.8.5.2. Any information provided by ADS including the CARE assessment.
    - 6.8.5.3. A copy of the Contractor's determination and written response provided to ADS.
    - 6.8.5.4. A copy of the plan developed and implemented to meet the Individual's needs through provision of other available BHO services when the MPC request has been denied based on this determination.

## 7. **GRIEVANCE SYSTEM.**

- 7.1. The Contractor shall have a Grievance System that complies with the requirements of WAC 388-877A-0400-0430, 0450, and 388-877-0605 or any additional WAC requirements
- 7.1.1. An Individual applying for, eligible for, or receiving mental health services authorized by a BHO, the Individual's representative, or the Individual's legal guardian may access the BHO's Grievance System to express concern about their rights, services, or treatment. The Grievance System shall include:
    - 7.1.1.1. A Grievance Process.
    - 7.1.1.2. Access to Fair Hearing.
  - 7.1.2. Before requesting a Fair Hearing, the Individual must exhaust the Grievance Process, subject to the rules in WAC 388-877A-0420.

7.1.3. Individuals may also use the free and confidential Ombuds services (see WAC 388-865-0250) through the BHO that contracts with the BHA in which they receive mental health services. Ombuds services are provided independent of BHOs and agency services providers, and are offered to Individuals at any time to help them with resolving issues or problems at the lowest possible level during the grievance or Fair Hearing process.

7.2. **Grievance Process.** The Contractor shall ensure its Grievance Process complies with the following:

7.2.1. The Grievance Process may be used by an Individual or his or her representative to express dissatisfaction in person, orally, or in writing about any matter other than an Action to:

7.2.1.1. The BHA providing the mental health services, or

7.2.1.2. The Contractor.

7.2.2. The Ombuds serving the Contractor or BHA may assist the Individual in resolving the Grievance at the lowest possible level.

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

7.2.3.1. Filing a Grievance with a BHA. If the Individual first files a Grievance with the BHA, and the Individual is not satisfied with the BHA's written decision on the Grievance, or if the Individual does not receive a copy of that decision from the BHA within the timelines established herein, the Individual may then choose to file the Grievance with the Contractor. If the Individual is not satisfied with the Contractor's written decision on the Grievance, or if the Individual does not receive a copy of the decision from the Contractor within the timelines established herein, the Individual can request a Fair Hearing to have the Grievance reviewed and the Contractor's decision or failure to make a timely decision about it.

7.2.3.2. Filing a grievance with the Contractor. If the Individual first files a grievance with the Contractor (and not the BHA), and the Individual either is not satisfied with the Contractor's written decision on the Grievance, or does not receive a copy of the decision within the timelines established herein, the Individual can request a Fair Hearing to have the Grievance reviewed and the Contractor's decision or failure to make a timely decision about it. Once an Individual receives a decision on a Grievance from a Contractor, the Individual cannot file the same Grievance with the BHA, even if that agency or its staff member(s) is the subject of the Grievance.

7.2.4. An Individual may also request a Fair Hearing if a written Notice regarding the Grievance was not received within the timelines established herein.

7.2.5. When an Individual files a Grievance, the Contractor or BHA receiving the Grievance shall:

7.2.5.1. Acknowledge the receipt of the Grievance in writing within five (5) business days;

7.2.5.2. Investigate the Grievance; and

7.2.5.3. Send the Individual who filed the Grievance a written notices describing the decision within ninety (90) calendar days from the date the Grievance was filed.

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



- 7.2.6.1. Other people, if the Individual chooses, are allowed to participate in the Grievance process.
- 7.2.6.2. The Individual's right to have currently authorized mental health services continued pending resolution of the Grievance.
- 7.2.6.3. That a Grievance is resolved even if the Individual is no longer receiving mental health services.
- 7.2.6.4. That the persons who make decisions on a Grievance:
  - 7.2.6.4.1. Were not involved in any previous level of review or decision-making; and
  - 7.2.6.4.2. Are mental health professionals who have appropriate clinical expertise if the Grievance involves clinical issues.
- 7.2.6.5. That the Individual and, if applicable, the Individual's Authorized Representative receive a written Notice containing the decision within ninety (90) calendar days from the date a Grievance is received by the Contractor or BHA. This timeframe can be extended up to an additional fourteen (14) calendar days:
  - 7.2.6.5.1. If requested by the Individual or the Individual's Authorized Representative; or
  - 7.2.6.5.2. 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 Individual's interest.
- 7.2.6.6. That the written Notice includes:
  - 7.2.6.6.1. The decision on the Grievance;
  - 7.2.6.6.2. The reason for the decision; and
  - 7.2.6.6.3. The right to request a Fair Hearing and the required timeframe to request the hearing.
- 7.2.7. 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:
  - 7.2.7.1. Kept for six (6) years after the completion of the Grievance process;
  - 7.2.7.2. Made available to DSHS upon request as part of the state quality strategy;
  - 7.2.7.3. Kept in confidential files separate from the Individual's clinical record; and
  - 7.2.7.4. Not disclosed without the Individual's written permission, except to DSHS or as necessary to resolve the Grievance.

### **7.3. Continuation of Services.**

- 7.3.1. During the Grievance Process, the Contractor shall continue the Individual's authorized services if all of the following conditions are met:
  - 7.3.1.1. The Grievance involves the termination, suspension, or reduction of a previously authorized course of treatment.

- 7.3.1.2. The services were provided by an authorized BHA.
- 7.3.1.3. The Individual requests a continuation of services.
- 7.3.1.4. The Individual is currently receiving services at the time of the request.

#### 7.4. Recordkeeping and Reporting Requirements.

- 7.4.1. The Contractor must maintain records of Grievances and Fair Hearings originating at or handled by a BHA, Ombuds or Contractor.
- 7.4.2. 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.
  - 7.4.2.1. Clients full name, date of birth, and P1 or CIS identifier.
  - 7.4.2.2. Date and type of action (per WAC 388-877A-0410).
  - 7.4.2.3. Date of appeal.
  - 7.4.2.4. Outcome of review of denials and limited authorizations.
  - 7.4.2.5. Plan for improvement.
- 7.4.3. The Contractor shall incorporate the results of Grievances and Fair Hearings into its quality management plan and address any trends in a quality improvement plan.
- 7.4.4. The Contractor must submit reports on a schedule provided by DSHS.
- 7.4.5. 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 thirty (30) calendar days.

### 8. SUBCONTRACTS.

All Subcontracts and amendments must be in writing and made available upon request to DBHR. Subcontracts must 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.

- 8.1. **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.
  - 8.1.1. The responsibilities of the Quality of Care section of this Agreement may not be delegated to a Contracted Network BHA.
  - 8.1.2. The Contractor may not delegate its responsibility to contract with a provider network. This does not prohibit an BHO-contracted, licensed provider from subcontracting with other appropriately licensed provider(s) so long as the sub-contracting provision of this Agreement are met.
  - 8.1.3. Prior to any new delegation of any responsibility or authority described in the Care Management, Authorization Standards and Quality of Care sections of this Agreement through a Subcontract or other legal Agreement, the Contractor shall use a delegation plan.

- 8.1.4. Unless a county is a licensed service provider and the Contractor is contracting for direct services, the Contractor shall not provide BHO funds to a county that is a participant in the BHO Interlocal agreement without a delegation of duties agreement. The agreement must identify the specific duties from the Contractor's PIHP or BHSC contract that are being delegated. The requirements for delegation stated within this Agreement must be met.
- 8.1.5. The Contractor shall maintain and make available to DSHS all delegation plans with current Subcontractors. The delegations plans shall include the following:
  - 8.1.5.1. An evaluation of the prospective Subcontractor's ability to perform delegated activities.
  - 8.1.5.2. 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.
  - 8.1.5.3. 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.
- 8.1.6. Within thirty (30) calendar days of execution of this Agreement, the Contractor shall submit a list of subcontractors and their delegated services in a format provided by DBHR.
- 8.2. **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.
  - 8.2.1. Subcontracts must require adherence to any applicable terms in the Americans with Disabilities Act.
  - 8.2.2. Subcontracts for the provision of mental health services must require compliance and implementation of the Mental Health Advance Directive statutes.
  - 8.2.3. Subcontracts must require Subcontractors to cooperate with Quality Review Activities and provide access to their facilities, personnel and records.
  - 8.2.4. Subcontracts for the provision of behavioral health services must require Subcontractors to provide Individuals access to translated information and interpreter services as described in the Information Requirements section of this Agreement.
  - 8.2.5. Subcontracts must require Subcontractors to notify the Contractor in the event of a change in status of any required license or certification.
  - 8.2.6. Subcontracts must require Subcontractors to participate in training when requested by DBHR. Requests for DBHR 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 Subcontracted staff.
    - 8.2.6.1. Annually, all community behavioral employees who work directly with clients shall be provided with training on safety and violence prevention topics described in [RCW 49.19.030](#).
  - 8.2.7. Subcontracts must require compliance with State and federal non-discrimination policies, [Health Insurance Portability and Accountability Act \(HIPAA\)](#), and the DSHS-CIS Data Dictionary or its successor.

- 8.2.8. 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.
- 8.2.9. Subcontracts must require that the Subcontractor correct any areas of deficiencies in the Subcontractor's performance that are identified by the Contractor or DBHR as part of a Subcontractor review.
- 8.2.10. Subcontracts for the provision of behavioral health services must require best efforts to provide written or oral notification no later than fifteen (15) business days after termination of a clinician to Individuals currently open for services who have received a service from the affected clinician in the previous sixty (60) calendar days. Notification must be verifiable in the client medical record at the BHA.
- 8.2.11. Subcontracts must require that the subcontracted BHAs comply with the Contractor's policy and procedures and timeframes as described in the Services section of this Agreement.
- 8.2.12. Subcontracts for the provision of behavioral health services must require that the Subcontractor implement a grievance process that complies with [WAC 388-865](#) or any successors as described in the Grievance Section of this Agreement.
- 8.2.13. Subcontracts must require the pursuit and reporting of all Third Party Revenue related to services provided under this Agreement.
- 8.2.14. Subcontracts for the provision of behavioral health services must require the use of the GAIN-SS and require staff that will be using the tool 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 require corrective action if the Integrated Co-Occurring Disorder Screening and Assessment Tool process is not implemented and maintained throughout the Agreement's period of performance.
- 8.2.15. Subcontracts for the provision of behavioral health services must require Subcontractors to re-submit data when rejected by DBHR due to errors. The Subcontract must require the data to be re-submitted within thirty (30) calendar days of when the error report was produced.
- 8.2.16. Subcontracts must contain the same requirements for crisis services as in this Agreement.
- 8.2.17. Subcontracts for the provision of mental health services must require that the Subcontractor shall respond in a full and timely manner to law enforcement inquiries regarding an Individual's eligibility to possess a firearm under [RCW 9.41.040\(2\)\(a\)\(ii\)](#).
- 8.2.18. The Contractor must obtain prior approval before entering into any subcontract by submitting to the DSHS Contact identified on Page One of this Agreement at least one of the following for review and approval purposes:
  - 8.2.18.1. Copy of the proposed subcontract to ensure it meets all DSHS requirements; or
  - 8.2.18.2. Copy of the contractor's standard contract template to ensure it meets all requirements and approve only subcontracts entered into using that template; or
  - 8.2.18.3. Certify in writing that the subcontractor meets all requirements under the contract and that the subcontract contains all required language under the contract, including any data security, confidentiality and/or Business Associate language, as appropriate.

8.2.19. The BHO must provide information about the Grievance system to all BHAs and Subcontractors at the time they enter into a contract. A condition of the sub-contract will be that all BHAs and other Subcontractors will abide by all Grievance and Fair Hearing decisions.

8.3. **Changes in Capacity.** A significant change in the provider network is defined as the termination or addition of a Subcontract with an entity that provides behavioral health services or the closing of a Subcontractor site that is providing services under this Agreement. The Contractor must notify DBHR 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 services. This notification must occur prior to any public announcement of this change.

8.3.1. 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 Contact on Page One of this Agreement, in writing, as soon possible and prior to a public announcement.

8.3.2. If DSHS issues a stop placement of clients in a subcontracted treatment facility upon finding that a facility is not in substantial compliance with provisions of any WAC related to chemical dependency treatment, the Contractor must work with the subcontracted Contractor to transition care of any impacted individuals.

8.3.3. The Contractor shall notify the DSHS Contact on Page One of this Agreement, in writing, 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, or any changes that result in the Contractor being unable to provide timely, Medically Necessary services.

8.3.4. If any of the events described in this section occur, the Contractor must submit a plan to the DSHS Contact on Page One of this Agreement, in writing, that includes at least:

- Notification to Ombuds services.
- Crisis services plan.
- Client notification plan.
- Plan for provision of uninterrupted services.
- Any information released to the media.

#### 8.4. **Credentialing**

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

8.4.2. 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.

8.4.3. 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 subcontractor information in section 9.2. Required Provisions. – Melena check reference

- 8.4.4. The Contractor shall require criminal history background checks for employees and volunteers of the Contractor who may have unsupervised access to children, people with developmental disabilities or vulnerable adults.

## 8.5. Data Verification

- 8.5.1. 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.
- 8.5.2. The Contractor shall have in place mechanisms by which to verify that the health information received from Subcontractors is complete and accurate.
- 8.5.3. Annual Certification: The Contractor must submit an annual certification statement indicating that the health information received from Subcontractors was verified using the same or similar methodology described in the PIHP Agreement. The Contractor's certification statement must also indicate that the health information received from Subcontractors is complete and accurate. Certification statements shall be submitted to the Department within ninety (90) calendar days after the end of the reporting period.

- 8.6. **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, Individual Grievances and service verification shall be incorporated into this review. This review must be included in the Contractor's ongoing quality management program.

- 8.6.1. The Contractor must ensure that periodic subcontractor reviews do not duplicate monitoring conducted by DBHR's contracted External Quality Review Organization, or DSHS.

- 8.6.2. This review may be combined with a formal review of services performed pursuant to the Prepaid Inpatient Health Plan Contract between the Contractor and DSHS.

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

- 8.6.2.1.1. Traceability of Services – The Contractor must ensure that medical necessity is established and documented, and that Access to Care Standards for mental health or substance use disorder 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.

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

- 8.6.2.1.3. Emergent Mental Health Services = 2 hours from request.

- 8.6.2.1.4. Urgent Mental Health Services = 24 hours from request.
- 8.6.2.1.5. Initial Psychiatric Inpatient Certification = 12 hours from request.
- 8.6.2.1.6. Crisis and Telephone Service = 24/7/365 availability. Phones answered by live person.
- 8.6.2.1.7. Post stabilization Services = Individuals need to receive an outpatient mental service within 7 calendar days of discharge from a psychiatric inpatient or residential substance use disorder treatment stay.
- 8.6.2.1.8. Routine Intake Evaluation or Assessment for Behavioral Health services= 14 calendar days from Request.
- 8.6.2.1.9. First Routine Service = 28 calendar days from request.
- 8.6.2.1.10. If mental 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. This can include documentation that there were no appropriate available resources as allowed under this agreement or that the individual did not meet the definition of a priority population for substance use disorder treatment as defined in this agreement.
- 8.6.2.1.11. Range of Services / Network Adequacy -- The Contractor shall ensure that it has the capacity to provide services based on the requirements of this agreement (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 enrollment levels, expected utilization of services, characteristics and health care needs of the population, the number and types of providers (training, experience and specialization) able to furnish services, and the geographic location of providers and Individuals (including distance, travel time, means of transportation ordinarily used by clients, and whether the location is accessible in accordance with the Americans with Disabilities Act specifications).
- 8.6.2.1.12. Special Populations – The Contractor shall ensure that Individuals 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 Individual, the provider must document why they are not addressing it at this time.
- 8.6.2.1.13. Coordination of Primary Care – The Contractor shall ensure that Individuals with complex medical needs, who have no assigned primary care provider (PCP) are assisted in obtaining a PCP. For Individuals 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.
- 8.6.2.1.14. Grievances – If delegated to BHAs, the Contractor shall 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 at the provider level, as well as those documented in the Ombuds records. The Contractor must also monitor the frequency and type of Individual grievances to ensure that systematic issues are appropriately addressed.

- 8.6.2.1.15. Critical Incidents – The Contractor shall 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 systemic issue is identified, the Contractor must monitor the provider’s actions toward resolving the issue.
- 8.6.2.1.16. Information Security – The Contractor shall ensure that network providers and other contractors actively follow federal regulations for managing personal health information (HIPAA / HI-TECH), and appropriately report any violations.
- 8.6.2.1.17. Disaster Recovery Plans – The Contractor shall 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.
- 8.6.2.1.18. Fiscal Management – the Contractor shall monitor and document the provider’s cost allocations, revenues, expenditures and reserves in order to ensure that funds under this Contract are being spent appropriately under [WAC 388-865-0270](#).
- 8.6.2.1.19. Licensing and Certification Issues – The Contractor shall have the responsibility for the oversight of their providers, including but not limited to ensuring licenses and certifications are current and that any findings during any review are corrected.

## **9. INDIVIDUAL RIGHTS AND PROTECTIONS**

- 9.1. The Contractor and subcontractors shall comply with any applicable Federal and State laws that pertain to individual rights and require that its staff takes those rights into account when furnishing services to Individuals. Any changes to applicable law must be implemented within ninety (90) calendar days of the effective date of the change.
- 9.2. The Contractor shall require 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 Individual with respect to:
  - 9.2.1. The Individual’s behavioral health status.
  - 9.2.2. Receiving all information regarding behavioral health treatment options including any alternative or self-administered treatment, in a culturally-competent manner.
  - 9.2.3. Any information the Individual needs in order to decide among all relevant behavioral health treatment options.



- 9.2.4. The risks, benefits, and consequences of behavioral health treatment (including the option of no mental health treatment).
- 9.2.5. The Individual's right to participate in decisions regarding his or her behavioral health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions.
- 9.2.6. The Individual's right to be treated with respect and with due consideration for his or her dignity and privacy.
- 9.2.7. The Individual's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- 9.2.8. The Individual'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](#).
- 9.2.9. The Individual'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 BHO, BHA, CDP or MHCP treats the Individual.
- 9.3. The Contractor shall provide or purchase age, linguistic and culturally competent behavioral health services for Individuals.
- 9.4. **Individual service plans** must be developed in compliance with [WAC 388-877-0620](#).
  - 9.4.1. The Contractor shall require that Individuals are included in the development of their individualized service plans, advance directives for psychiatric care and crisis plans.
    - 9.4.1.1. 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).
    - 9.4.1.2. At a minimum, treatment goals must include the words of the Individual receiving services and documentation must be included in the clinical record, as part of the 180 day progress review, describing how the Individual sees progress.
- 9.5. **Ombuds.**
  - 9.5.1. The Contractor shall provide a behavioral health Ombuds as described in [WAC 388-865-0250](#) and [RCW 71.24](#). An entity or Subcontractor independent of the BHO Administration must employ the Ombuds and provide for the following:
    - 9.5.1.1. Separation of personnel functions (e.g. hiring, salary and benefits determination, supervision, accountability and performance evaluations).
    - 9.5.1.2. Independent decision making to include all investigation activities, findings, recommendations and reports.
- 9.6. **Advance Directives.**
  - 9.6.1. The Contractor shall maintain written policies and procedures for Advance Directives that respect Individuals' Advance Directives for psychiatric care. Policies and procedures shall comply with the current [RCW 71.32](#) (changes must be included within ninety (90) calendar days of the effective date of any changes to the RCW).

9.6.2. The Contractor shall inform Individuals that Grievances concerning noncompliance with the Advance Directive for psychiatric care requirements may be filed with the Washington State Department of Health.

9.7. **Information Requirements.** The Contractor must provide information to Individuals consistent with [WAC 388-865-0410](#). The Contractor shall maintain written policy and procedures addressing all information requirements, and shall:

9.7.1. Provide interpreter services for Individuals who speak a primary language other than English for all interactions between the Individual and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a Grievance or Fair Hearing.

9.7.2. 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.

9.7.3. The Contractor shall provide written translations of generally available materials 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 maintain availability of translated documents at all times for the Contractor and its contracted BHAs to distribute.

9.7.3.1. The DSHS required languages for translation are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese. The Client rights have been translated and included in the Medicaid Benefits Booklet given to each Individual at intake. The expectation is that this translated document is readily available at all times from the Contractor and its contracted BHAs.

9.7.3.2. Materials may be provided in English if the Individuals primary language is other than English but the Individual can understand English and is willing to receive the materials in English. The Individuals consent to receiving information and materials in English must be documented in the client record.

9.7.3.3. For Individuals whose primary language is not translated, the requirement may be met by providing the information through audio or video recording in the Individuals primary language, having an interpreter read the materials in the Individuals primary language or providing materials in an alternative format that is acceptable to the Individual. If one of these methods is used it must be documented in the client record.

9.7.4. Ensure that Mental Health Professionals, MHCPs and CDPs have an effective mechanism to communicate with Individuals with sensory impairments.

9.7.5. The Contractor shall post a translated copy of the Individual rights as provided by DBHR in each of the DSHS prevalent languages.

9.7.6. Upon an Individual's request, the Contractor shall provide:

9.7.6.1. BHA licensure, certification and accreditation status.

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

## 9.8. Customer Services.

- 9.8.1. The Contractor shall provide Customer Services that are customer-friendly, flexible, proactive, and responsive to Individuals, families, and stakeholders. The Contractor shall provide a toll free number for Customer Service. A local telephone number may also be provided for those Individuals within the local calling area.
- 9.8.2. At a minimum, Contractor Customer Services staff shall:
  - 9.8.2.1. Promptly answer telephone calls from Individuals, family members and stakeholders from 8 a.m. until 5 p.m. Monday through Friday, holidays excluded.
  - 9.8.2.2. Respond to Individuals, family members and stakeholders in a manner that resolves their inquiry. Staff must have the ability to respond to those with limited English proficiency or hearing loss.
  - 9.8.2.3. Customer Services staff must be trained on how to refer these calls to the appropriate party. Logs shall be kept that, at a minimum, track the date of the initial call, type of call and date of attempted resolution. This log will be provided to DBHR for review upon request.

## 10. CARE MANAGEMENT

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 BHA. Care Management activities must be performed by a Mental Health Professional for mental health services and by a CDP for substance disorder services.

- 10.1. **Individual Service Plans.** Individual Service Plans must be developed in compliance with WAC 388-877-0620.
  - 10.1.1. The Contractor shall require that Individuals 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).
  - 10.1.2. At a minimum, treatment goals shall include the words of the individual receiving services and documentation must be included in the clinical record, describing how the Individual sees progress.
  - 10.1.3. Individual Service Plans shall address the overall identified needs of the Individual, 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 shall ensure there is coordination with the other service delivery systems responsible for meeting identified needs.

**10.2. Evidence-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 as identified through legislative mandates. This includes:

- 10.2.1. Participation in state-sponsored training in the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT/CBT) and CBT-Plus (TF-CBT/CBT+) evidence-based practices including those for which state subsidy of training costs is not available. The Contractor is expected to maintain a workforce trained in TF-CBT/CBT+ sufficient to implement the practice in at least one site within the Contractor's service area.
- 10.2.2. Participation in state-sponsored efforts to ensure that the sites offering the TF-CBT/CBT+ evidence-based practice are operated as trauma-informed systems of care.
- 10.2.3. The Contractor shall track evidence-based and research-based practices following guidelines published by the Washington State Institute of Public Policy (WSIPP).

**10.3. Children's Mental Health.**

- 10.3.1. 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.
- 10.3.2. 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.

**10.4. Transition Age Youth.**

- 10.4.1. 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:
  - 10.4.1.1. A comprehensive transition plan linked across systems that identify goals, objectives, strategies, supports, and outcomes.
  - 10.4.1.2. Individual mental 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.
  - 10.4.1.3. For youth who require continued services in the adult mental health system must identify transitional services that allow for consistent and coordinated services and supports for young people and their parents.
  - 10.4.1.4. Developmentally and culturally appropriate adult services that are relevant to the individual or population.

**10.5. State Hospitals.** The Contractor shall abide by the current Western State Hospital/Behavioral Health Organization/Home and Community Services Agreement for Home and Community Services Placements from Western State Hospital.

- 10.5.1. The Contractor shall participate with DSHS, the Division of Home and Community Services (HCS), and other BHOs to develop a common operating agreement. The agreement must be completed within ninety (90) calendar days of contract execution and be maintained and updated or reviewed at least annually.

- 10.5.1.1. 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.
- 10.5.1.2. Upon implementation of this agreement the Contractor shall comply with its terms.
- 10.5.1.3. The agreement must address the following topics:
  - 10.5.1.3.1. Referrals for service to/from the Contractor and DSHS-HCS services
  - 10.5.1.3.2. Exchange of information needed for treatment and placement planning
  - 10.5.1.3.3. Timelines for activities to occur
  - 10.5.1.3.4. Procedures to assist in the diversion of patients from State Hospitals especially those with dementia and similar diagnoses.
  - 10.5.1.3.5. Procedures for evaluating the operation of the agreement and for addressing problems.

## **11. BHO TRANSFER PROTOCOL**

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

- 11.1.1. A seamless transition for the Individual with no more than minimal interruption of services.
- 11.1.2. The Individual receives care that better meets his or her needs.
- 11.1.3. The Individual has the opportunity to be closer to family and/or other important natural supports.
- 11.1.4. The Individual has access to Medicaid covered services.

**11.2. BHOs acknowledge and agree that:**

- 11.2.1. Medicaid Enrollees are entitled to Medicaid covered services in the community where they live.
- 11.2.2. Individuals who participate in mental health services have the right to freely move to the community of their choosing.
- 11.2.3. There are circumstances when an BHO (referring BHO) wishes to place an Individual in another BHO's region (receiving BHO) 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.
- 11.2.4. Some Individuals require specialized, non-Medicaid services to meet their needs.
- 11.2.5. Due to the scarcity of specialized, non-Medicaid services, these may not be immediately available upon the request of the transferring Individual.
- 11.2.6. The receiving BHO assumes immediate financial risk for crisis services and Medicaid covered services at the time of transfer.

- 11.2.7. 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

- 11.2.8. After completion of the risk factor time frame, the receiving BHO will assume all financial responsibility for the Individual.
- 11.2.9. 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.
- 11.2.10. This protocol is intended to ensure a seamless transition for Individuals with no more than minimal interruption of services.

### 11.3. **Uniform Transfer Agreement-Community Inter-BHO Transfer Protocol.**

- 11.3.1. 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 PIHP contract, based on the BHO’s level of care guidelines and clinical assessment.
- 11.3.2. Each BHO will establish a procedure to obtain information and records for continuity of care for Enrollees transferring between BHOs.
- 11.3.3. All Medicaid Enrollees requesting a transfer will be offered an intake assessment and all medically necessary mental health services under the PIHP. 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.
- 11.3.4. 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.
- 11.3.5. The receiving BHO will provide assistance to the Enrollee to update the Enrollee’s residence information for Medicaid Benefits.
- 11.3.6. When a Individual is re-locating and may benefit from specialized non-Medicaid services beyond medically necessary services required in the PIHP, the BHOs agree to the following protocol:
- 11.3.6.1. The placement is to be facilitated by the joint efforts of both BHOs.
  - 11.3.6.2. The referring BHO will provide all necessary clinical information along with the completed Inter-BHO transfer form.
  - 11.3.6.3. The receiving BHO will acknowledge the request within three (3) business days.

- 11.3.6.4. The receiving BHO will follow established procedures for prioritizing the referred Individual and must offer an intake assessment to the Individual for services Medicaid-covered services even if the specialized non-Medicaid services are not immediately available.
- 11.3.6.5. The placement may not be completed without written approval on the inter-BHO transfer form from both BHO administrators, or their designees.
- 11.3.6.6. The receiving BHO shall make a placement determination within two (2) weeks of receiving all necessary information/documentation from the referring BHO. The Individual and the referring BHO will receive information regarding the placement policy of the receiving BHO for the specialized non-Medicaid service.
- 11.3.6.7. 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.
- 11.3.6.8. Payment responsibility for Individuals transferring between BHOs will be described in this protocol and specified on the inter-BHO transfer form.
- 11.3.6.9. Uniform Transfer Agreement - Eastern and Western State Hospital Inter-BHO Transfer Protocol.
- 11.3.6.10. This section describes the inter-BHO transfer process for Individuals preparing for discharge from a State Hospital, and who require specialized non-Medicaid resources.
- 11.3.6.11. 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").
- 11.3.6.12. 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).
- 11.3.6.13. The financial benefits section at the State Hospital will provide assistance to the Individual to update the Individual's residence information for Medicaid Benefits.
- 11.3.6.14. 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.
- 11.3.6.15. 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.
- 11.3.6.16. The Referring BHO will remain the primary contact for the State Hospital social worker and the Individual until the placement is completed.
- 11.3.6.17. The Receiving BHO will supply the State Hospital social worker with options for community placement at discharge.
- 11.3.6.18. 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).

11.3.6.19. 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.

11.3.6.20. Once the discharge plan has been agreed upon, the Request for Inter-BHO transfer will be completed within two (2) weeks. The Receiving BHO has two (2) 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.

## 12. MANAGEMENT INFORMATION SYSTEM

- 12.1. **Data Submission and Error Correction.** The Contractor shall provide DSHS with all data described in DSHS “Service Encounter Reporting Instructions” and the “Data Dictionary,” and encounters shall be submitted as described in DSHS “Encounter Data Reporting Guide,” or, any successor, incorporated herein by reference.
- 12.1.1. The Contractor shall report encounters electronically to ProviderOne within sixty (60) calendar days of the close of each calendar month in which the encounters occurred.
- 12.1.2. The Contractor shall submit all other required data about Enrollees to DSHS CIS within sixty (60) calendar days of collection or receipt from Subcontracted providers.
- 12.1.3. 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 thirty (30) calendar days of when the error report was produced.
- 12.1.4. The Contractor shall require Subcontractors to resubmit data rejected due to errors. The Subcontractor must resubmit corrected data within thirty (30) calendar days of when an error report was produced.
- 12.1.5. 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.
- 12.1.6. 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.
- 12.1.7. 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.



- 12.1.8. The Contractor shall implement changes to the content of national standard code sets (such as Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), 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.
- 12.1.9. When DBHR makes changes referenced in the Management Information 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 fifteen (15) calendar days prior to the implementation date.
  - 12.1.9.1. The test batch must include at least one hundred (100) transactions that include information effected by the change.
  - 12.1.9.2. The processed test batch must result in at least eighty percent (80%) successfully posted transactions or an additional test batch is required.
- 12.1.10. The Contractor shall respond to requests from DBHR for information not covered by the data dictionary in a timeframe determined by DBHR that will allow for a timely response to inquiries from CMS, the legislature, DSHS, and other parties.
- 12.1.11. No BHO encounter transaction shall be accepted for initial entry or data correction after one year from the date of service, except by special exception.
- 12.2. **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.
  - 12.2.1. The Contractor shall create and maintain a business continuity and disaster recovery plan that insures timely reinstatement of the Individual 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.
  - 12.2.2. 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:
    - 12.2.2.1. A mission or scope statement.
    - 12.2.2.2. An appointed Information Services Disaster Recovery Staff.
    - 12.2.2.3. Provisions for Backup of Key Personnel; Identified Emergency Procedures; Visibly listed emergency telephone numbers.
    - 12.2.2.4. Procedures for allowing effective communication; Applications Inventory and Business Recovery priority; Hardware and software vendor list.

- 12.2.2.5. Confirmation of updated system and operations documentation; Process for frequent backup of systems and data.
- 12.2.2.6. Off-site storage of system and data backups; Ability to recover data and systems from backup files.
- 12.2.2.7. Designated recovery options which may include use of a hot or cold site.
- 12.2.2.8. Evidence that disaster recovery tests or drills have been performed.

### 12.3. Information System Security and Protection of Confidential Information

- 12.3.1. The Contractor shall comply with applicable provisions of the [Health Insurance Portability and Accountability Act \(HIPAA\)](#) of 1996, codified in [42 USC §1320\(d\)](#) et.seq. and [45 CFR Parts 160, 162](#) and [164](#).
- 12.3.2. The Contractor shall ensure that confidential information provided through or obtained by way of this Agreement or services provided, is protected in accordance with the Data Security Requirements contained in Exhibit A.
- 12.3.3. The Contractor shall maintain a statement on file for each individual service provider and Contractor staff who has access to the Contractor's mental health information system that is signed by the provider and attested to by a witness's signature, acknowledging that the provider understands and agrees to follow all regulations on confidentiality.
- 12.3.4. The Contractor shall take appropriate action if a Subcontractor or Contractor employee wrongly releases confidential information.

## 13. REPORTING REQUIREMENTS

- 13.1. **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.
- 13.2. **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.
- 13.3. **Incident Reporting.** The Contractor shall 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.
  - 13.3.1. The Contractor shall have a designated incident manager responsible for meeting the requirements under this section.
  - 13.3.2. The Contractor must report and follow-up on all incidents involving Individuals, listed below.
  - 13.3.3. 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 be provided. Incident Reports shall contain the following:

- 13.3.3.1. A description of the incident;
  - 13.3.3.2. The date and time of the incident;
  - 13.3.3.3. Incident location;
  - 13.3.3.4. Incident type;
  - 13.3.3.5. Names and ages, if known, of all Individuals involved in the incident;
  - 13.3.3.6. The nature of each Individual's involvement in the incident;
  - 13.3.3.7. The service history with the Contractor, if any, of Individuals involved;
  - 13.3.3.8. Steps taken by the Contractor to minimize harm; and
  - 13.3.3.9. Any legally required notifications made by the Contractor.
- 13.3.4. 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.
- 13.3.4.1. 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.
    - 13.3.4.1.1. Death or serious injury of patients, Individuals, staff, or public citizens at a DSHS facility or a facility that DSHS licenses, contracts with, or certifies.
    - 13.3.4.1.2. 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.
    - 13.3.4.1.3. 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.
    - 13.3.4.1.4. Any event involving an Individual or staff that has attracted, or that in the professional judgment of the Incident Manager, is likely to attract media attention.
  - 13.3.4.2. Category Two Incidents: the Contractor must report within one (1) business day of becoming aware that any of the following Category Two Incidents has occurred, involving a Individual:
    - 13.3.4.2.1. Alleged client abuse or client neglect of a serious or emergent nature by an employee, volunteer, licensee, Contractor, or another client.
    - 13.3.4.2.2. 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.).

- 13.3.4.2.3. 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.
- 13.3.4.2.4. Any allegation of financial exploitation as defined in [RCW 74.34.020](#).
- 13.3.4.2.5. Any attempted suicide that requires medical care that occurs at a facility that DSHS licenses, contracts with, and/or certifies.
- 13.3.4.2.6. Any event involving a client or staff, likely to attract media attention in the professional judgment of the Incident Manager.
- 13.3.4.2.7. 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.
- 13.3.4.2.8. Any incident that was referred to the Medicaid Fraud Control Unit by the Contractor or its Subcontractor.
- 13.3.4.2.9. A life safety event that requires an evacuation or that is a substantial disruption to the facility.
- 13.3.5. Comprehensive Review: DSHS may require the Contractor to initiate a comprehensive review of an incident.
  - 13.3.5.1. The Contractor will fully cooperate with any investigation initiated by DSHS and provide any information requested by DSHS within the timeframes specified within the request.
  - 13.3.5.2. 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.
  - 13.3.5.3. DSHS may request medication management information.
  - 13.3.5.4. 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.
- 13.3.6. Incident Review and Follow-up: the Contractor shall 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:
  - 13.3.6.1. A summary of any incident debriefings or review process dispositions.
  - 13.3.6.2. 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.

13.3.6.3. Documentation of whether the client is receiving or not receiving mental health services from the Contractor at the time the incident is being closed.

13.3.6.4. 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.

13.3.6.5. 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.

13.3.6.6. If this information is unavailable, the attempt to retrieve it will be documented.

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

13.5. **Reviews.** 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.

13.6. **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.

13.7. **No Beds Available for Persons Meeting Mental Health Detention Criteria - Report.**

13.7.1. 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.

13.7.2. 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.

13.7.3. The notification report must contain at a minimum:

13.7.3.1. The date and time that the investigation was completed;

13.7.3.2. The identity of the responsible BHO;

13.7.3.3. A list of facilities which refused to admit the person;

13.7.3.4. Identifying information for the person, including age or date of birth; and

13.7.3.5. Other reporting elements deemed necessary or supportive by DSHS.

13.7.4. 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.

13.7.5. 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.

- 13.7.6. 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. SERVICES

- 14.1. **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.010](#). Failure to maintain the Screening and Assessment process will result in remedial actions up to and including financial penalties as described in 19. Remedial Actions section of this Agreement.
- 14.1.1. Contractor must attempt to screen all Individuals aged 13 and above through the use of the DBHR provided Global Appraisal of Individual Needs – Short Screener (GAIN-SS) during:
- All new intakes.
  - 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](#), [RCW 71.34](#) or [RCW 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.
- 14.1.1.1. The GAIN-SS screening must be completed as self-reported by the Individual and signed by that Individual on the DBHR-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 the DBHR-GAIN-SS form.
- 14.1.1.2. The results of the GAIN-SS screening, including refusals and anywhere the Individual was unable to complete, must be reported to DBHR through the MHD-CIS system.
- 14.1.1.3. The Contractor must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by DBHR and outlined in SAMHSA Publication Substance Abuse Treatment For Persons With Co-Occurring Disorders, A Treatment Improvement Protocol TIP 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).
- 14.1.1.3.1. 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.
- 14.1.1.3.2. 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.

The quadrant placement must be reported to DBHR through the CIS system.

- 14.2. **Core Mental Health Services.** The Contractor shall provide the following services as described in Crisis Mental Health, Inpatient, Ancillary Costs and Residential Programs Sections and prioritize such services above any other services unless otherwise specified in this Agreement.
- 14.2.1. Crisis Mental Health Services: The Contractor must provide 24-hour, 7 day per week crisis mental health services to Individuals who are within the Contractor's Service Area and report they are experiencing a mental health crisis. There must be sufficient staff available, including Designated Mental Health Professionals, to respond to requests for crisis services. Crisis services must be provided regardless of the Individual's ability to pay. Crisis mental health services may include each of the following:
- 14.2.1.1. **Crisis Services:** Evaluation and treatment of mental health crisis to all Individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, the outcome of which decides whether possible bad consequences will follow. Crisis services must be available on a twenty four (24) hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the Individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services must be provided by or under the supervision of a Mental Health Professional.
- 14.2.1.2. **Stabilization Services:** Services provided to Individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the Individual and the Mental Health Professional. Stabilization services shall include short-term (less than two (2) weeks per episode) face-to-face assistance with life skills training and with the understanding of medication effects and side 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. This service may include cost for room and board.
- 14.2.1.3. **Involuntary Treatment Act Services:** Mental Health - Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of Individuals in accordance with RCW 71.05, RCW 71.24.300, and RCW 71.34. This includes all clinical services, costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional (DMHP) determines an Individual must be evaluated for involuntary treatment. The decision making authority of the DMHP must be independent of the BHO administration. ITA services continue until the end of the involuntary commitment.
- 14.2.1.4. **Freestanding Evaluation and Treatment Services:** Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Washington State Department of Health and certified by DSHS to provide Medically Necessary evaluation and treatment to the 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) calendar day commitment.

- 14.2.2. Crisis mental health services may be provided without an intake evaluation or screening process. The Contractor must provide:
  - 14.2.2.1. Emergent Care within two (2) hours of the request received from any source for crisis mental health services.
  - 14.2.2.2. Urgent care within twenty four (24) hours of the request received from any source for crisis mental health services.
- 14.2.3. The Contractor must provide access to all components of the Involuntary Treatment Act to persons who have mental disorders in accordance with state law ([RCW 71.05](#) and [RCW 71.34](#)) and without regard to ability to pay.
- 14.2.4. The Contractor must incorporate the statewide [Designated Mental Health Professionals \(DMHP\) Protocols](#) listed on the DBHR intranet or its successor into the practice of Designated Mental Health Professionals.
- 14.2.5. The Contractor must have policies and procedures for crisis and mental health ITA services that implement the following requirements:
  - 14.2.5.1. No DMHP or crisis intervention worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act, unless a second trained individual accompanies them.
  - 14.2.5.2. The clinical team supervisor, on-call supervisor, or the individual professional acting alone based on a risk assessment for potential violence, shall determine the need for a second individual to accompany them.
  - 14.2.5.3. The second individual may be a law enforcement officer, a Mental Health Professional, a mental health paraprofessional who has received training required in RCW 49.19.030, or other first responder, such as fire or ambulance personnel.
  - 14.2.5.4. No retaliation may be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.



- 14.2.5.5. The Contractor must have a plan to provide training, mental health staff back-up, information sharing, and communication for crisis outreach staff who respond to private homes or other private locations.
  - 14.2.5.6. Every Mental Health Professional dispatched on a crisis visit, shall have prompt access to information about any history of dangerousness or potential dangerousness on the client they are being sent to evaluate that is documented in crisis plans or commitment records and is available without unduly delaying a crisis response.
  - 14.2.5.7. Every Mental Health Professional who engages in home visits to Individuals or potential Individuals for the provision of crisis services shall be provided by the Contractor or Subcontractor with a wireless telephone or comparable device for the purpose of emergency communication.
- 14.2.6. Psychiatric Inpatient Services: Community Hospitals and Evaluation and Treatment Facilities: The Contractor shall:
- 14.2.6.1. Develop, maintain or purchase Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.300(6)(c).
  - 14.2.6.2. Provide or purchase psychiatric inpatient services for the following:
    - 14.2.6.2.1. Individuals who agree to be admitted voluntarily when it is determined to be Medically Necessary.
    - 14.2.6.2.2. Individuals who are involuntarily detained in accordance with [RCW 71.05](#) or [RCW 71.34](#), and who are either eligible under MCS, or who are not eligible for any other medical assistance program that would cover this hospitalization.
    - 14.2.6.2.3. Individuals at least twenty two (22) years of age and under sixty five (65) years of age who are Medicaid-Individuals and are admitted to a residential facility that is classified as an Institution for Mental Diseases (IMD) defined in [42 CFR 435.1010](#).
  - 14.2.6.3. Implementation of Court Decision Detention of D.W., et al. The BHO shall make use of Detention of D.W., et al funding for only the following expenses:
    - 14.2.6.3.1. Use of IMD beds opened after August 7, 2014, for services provided to non-Medicaid clients when the admission of a non-Medicaid client results in bed days above the average utilization of bed days:
      - 14.2.6.3.1.1. The average utilization of bed days will be calculated from a standard report (WA State DBHR Mental Health Service Reports – Community Hospital and E&Ts Client Counts by BHO) generated by DBHR’s System for Communicating Outcomes, Performance, and Evaluation (SCOPE) and covering the time period of 7/1/2013 – 6/30/2014.
      - 14.2.6.3.1.2. The monthly number of bed days that exceed the average utilization of bed days (“incremental increase”) shall be determined by subtracting the average utilization of bed days from the BHO’s calculation of the actual number of bed days utilized in that month. DBHR will provide this baseline data.

- 14.2.6.3.2. The BHO may bill DSHS monthly for any non-Medicaid bed days or non-Medicaid expenses in approved facilities at current rates for the incremental increase experienced by the BHO during that month. Bills may only be submitted for bed usage in the facilities listed in Exhibit I, Additional Bed Capacity, Table 1.
- 14.2.6.3.3. Expenses incurred after September 18, 2014, for the provision of mental health services as described in the emergency WAC below for individuals hospitalized with a single bed certification in a community hospital, when the hospital does not provide these services directly.
- “The facility that is the site of the proposed single bed certification confirms that it is willing and able to provide directly, or by direct arrangement with other public or private agencies, timely and appropriate mental health treatment to the Individual suffering from a mental disorder for whom the single bed certification is sought”.
- 14.2.6.3.4. The BHO must provide back-up documentation of costs such as a contract or Memorandum of Understanding (MOU) with the hospital to the DSHS Contact listed on page 1 prior to payment being approved by the Department.
- 14.2.6.3.5. Operating funds are provided to North Sound BHO and Pierce/Optum BHO for those E & T facilities listed in Exhibit I, Table 2, as part of the expansion of E & T capacity resulting from the Court Decision Detention of D.W., et al. E & T services may be accessed by all BHOs based on the admission policies and procedures of the operating BHO.
- 14.2.7. Community Hospital Certification Process: The Contractor shall adhere to the requirements set forth in the Community Psychiatric Inpatient Process as provided by DBHR.
- 14.2.7.1. The Contractor shall have a Care Manager available twenty four (24) hours per day to respond to requests for inpatient certification. Certification decisions for psychiatric inpatient care must be made within twelve (12) hours of the initial call.
- 14.2.7.2. A Notice of Determination must be provided if certification is denied for the admission.
- 14.2.8. Psychiatric Inpatient Services: State Hospitals:
- 14.2.8.1. The Contractor shall reimburse DSHS for State Hospital days of care that exceed the daily allocation of State Hospital beds. The Contractor’s daily allocation of State Hospital beds is provided in Exhibit D.
- 14.2.8.1.1. If the Contractor disagrees with the BHO/patient assignment, it must request a reassignment within thirty (30) calendar days of admission. If a request to change the assignment is made within thirty (30) calendar days of admission and the request is granted, the reassignment will be retroactive to the date of admission.
- 14.2.8.1.2. If a request comes in after the 30th calendar day of admission and is granted, the effective date of the reassignment will be based on the date DSHS receives the reassignment request form. All reassignment requests are to be made using the Hospital Correction Request Form. The form is attached to the State Hospital/BHO Working Agreement. This process shall be described in the working Agreement between the Contractor and the State Hospital.

- 14.2.8.2. Ensure Individuals are medically cleared, if possible, prior to admission to a State Psychiatric Hospital.
- 14.2.8.3. Respond to State Hospital census alerts by using best efforts to divert admissions and expedite discharges by utilizing alternative community resources and mental health services.
- 14.2.8.4. The Contractor or its designee shall monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320.
- 14.2.8.5. The Contractor or its designee shall offer mental health services to assist with compliance with LRA requirements.
- 14.2.8.6. The Contractor or its designee shall respond to requests for participation, implementation, and monitoring of Individuals receiving services on Conditional Releases (CR) consistent with RCW 71.05.340. The Contractor or designee shall provide mental health services to assist with compliance with CR requirements.
- 14.2.8.7. The Contractor or designee shall ensure provision of mental health services to Individuals on a Conditional Release under RCW 10.77.150.
- 14.2.8.8. For conditional releases under RCW 10.77, Individuals in transitional status in Pierce or Spokane County will transfer back to the responsible BHO upon completion of transitional care. Individuals discharged to an BHO other than the responsible BHO will be done so according to the Inter-BHO agreement described in the State Hospital Working Agreement.
- 14.2.8.9. Maintain or develop a written working agreement with the State Hospital in its Service Area within 90 calendar days of the effective date of this Agreement. The Agreements must include:
  - 14.2.8.9.1. Specific roles and responsibilities of the parties related to transitions between the community and the hospital.
  - 14.2.8.9.2. A process for the completion and processing of the Inter-BHO Transfer Request Form for Individuals requesting placement outside of the BHO of residence.
  - 14.2.8.9.3. Collaborative discharge planning and coordination with cross-system partners.
  - 14.2.8.9.4. Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's Service Area.
- 14.2.8.10. The Contractor shall coordinate with the Department of Social and Health Services-Home and Community Services (HCS) regional office to support the placement of persons discharged or diverted from State Hospitals into HCS placements. In order to accomplish this, the Contractor will:
  - 14.2.8.10.1. Whenever possible, prior to referring a person with a diagnosis of dementia for a ninety (90) calendar day commitment to a State Psychiatric Hospital:
  - 14.2.8.10.2. Ensure that a request for a CARE assessment is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all persons who might be eligible for long-term care services. HCS has agreed to prioritize requests for CARE

assessments for Individuals who have been detained to an E&T or in another setting.

- 14.2.8.10.3. Request and coordinate with HCS, a scheduled CARE assessment for such persons. If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to attempt a community placement prior to referral to the State Hospital.
- 14.2.8.10.4. For Individuals (both those being discharged and those being diverted) whose CARE assessments indicate likely functional and financial eligibility for long-term care services:  
  
For Individuals (both those being discharged and those being diverted) whose CARE assessments indicate likely functional and financial eligibility for long-term care services:
  - 14.2.8.10.4.1. 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.
  - 14.2.8.10.4.2. The responsible entity will establish and coordinate a placement or discharge planning team that includes Contractor staff, HCS assessors, and other community partners, as necessary, to develop a plan of action for finding a safe, sustainable placement.
  - 14.2.8.10.4.3. The Contractor will ensure coordination and communication will occur between those participants involved in placement activities as identified by the discharge planning team.
- 14.2.8.10.5. If a placement has not been found for an Individual referred for long-term care services within thirty (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 thirty (30) calendar days until a placement is affected.
- 14.2.8.10.6. When Individuals being discharged or diverted from State Hospitals are placed in a long-term care setting, the Contractor will:
  - 14.2.8.10.6.1. Coordinate with HCS and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the DBHR website.
  - 14.2.8.10.6.2. When the Individual meets access to care criteria, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement.

14.2.9. Children's Long-Term Inpatient Programs (CLIP):

- 14.2.9.1. 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.

The Contractor shall integrate all regional assessment and CLIP referral activities, including the following:

- 14.2.9.1.1. Create and maintain a local process to assess the needs of children being considered for voluntary admission and coordinate referrals to the CLIP Administration.
- 14.2.9.1.2. When a person under age eighteen (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 BHO representative will share the community and/or family recommendations for CLIP program assignment of committed adolescents.
- 14.2.9.1.3. 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).
- 14.2.9.1.4. 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.
- 14.2.9.1.5. The BHO shall provide the legal guardian and youth aged thirteen (13) and over with a written copy of the CLIP Administration Appeal Process when the BHO denies a voluntary application for CLIP services.
- 14.2.9.2. After CLIP Admission, the Contractor must provide Rehabilitation Case Management, which includes a range of activities by the Contractor's or BHA'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 BHA must participate in treatment and discharge planning with the CLIP treatment team.
- 14.2.9.3. Review for prior authorization recommendations for short-term/acute hospitalization when it is determined by the CLIP program that this is required.
- 14.2.10. Inpatient Coordination of Care:
  - 14.2.10.1. The Contractor shall ensure that contact with the inpatient staff occurs within three (3) business days of an authorized voluntary or involuntary admission. The Contractor's liaison or BHA must participate throughout the admission in treatment and discharge planning with the hospital staff.
  - 14.2.10.2. The Contractor or its designee shall provide to the inpatient unit any available information regarding the Individual's treatment history at the time of admission. The Contractor or its designee must provide all available information related to payment resources and coverage.
  - 14.2.10.3. The Contractor's liaison or designated BHA must participate in treatment and discharge planning with the inpatient treatment team.

- 14.2.10.4. The Contractor's liaison or designated BHA must participate throughout the inpatient admission to assist with appropriate and timely discharge for all Individuals regardless of diagnosis.
- 14.2.10.5. The assigned BHA must offer, at minimum, one follow-up service within seven (7) calendar days from discharge to an Individual who has been authorized for an inpatient admission or involuntarily committed.
- 14.2.11. Ancillary Costs: With the funds provided under this Agreement the Contractor is also expected to prioritize payments for expenditures associated with providing Medically Necessary crisis and residential services for Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver. Costs include, but are not limited to, room and board in hospital diversion settings or in a residential or freestanding Evaluation and Treatment facilities and Administrative Costs related to the Involuntary Treatment Act.
- 14.2.12. Residential Mental Health Programs: Residential settings and programs shall be available and provided based on the Individual's needs and within Available Resources per the Contractor's policies and procedures. The Contractor must maintain Level of Care Guidelines that detail when a client may receive Residential services. This plan may include memorandums of understanding or contracts to purchase or provide a residential program outside of the Contractor's Service Area when an Individual requires a level of residential support which is not available within the Contractor's Service Area. Residential programs and settings may include the following:
  - 14.2.12.1. Long-term intensive adaptive and rehabilitative psychiatric care such as is provided in Adult Residential Rehabilitation Centers.
  - 14.2.12.2. Supervised living such as residential programs developed to serve Individuals diagnosed with a major mental illness in nursing homes, boarding homes or adult family homes.
  - 14.2.12.3. Supported housing services such as intensive services provided to maintain Individuals in unlicensed individual or group home settings including transitional or permanent housing.
- 14.2.13. The Contractor shall maintain the ability to provide Individuals with an intake evaluation at his or her residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to persons discharged from a State Hospital or evaluation and treatment facilities to such placements when the Individual requires an on-site service due to medical needs.
- 14.2.14. The Contractor shall maintain the ability to provide services to Individuals in their residence, including adult family homes, assisted living facilities and skilled nursing facilities when required due to medical needs.

### 14.3. **Core Substance Use Disorder Services**

- 14.3.1. The Contractor must provide access to all components of the Involuntary Treatment Act to persons who have a substance abuse disorder in accordance with state law (RCW 70.96A.080) and without regard to ability to pay.
- 14.3.2. Involuntary Commitment Act - Substance Use Disorder – - Includes all services and administrative functions required for the evaluation for involuntary commitment of Individuals in accordance with RCW 70.96A.140. This includes all clinical services, costs related to court processes and transportation. The decision making authority of the CDP must be

independent of the BHO administration. ITA services continue until the end of the involuntary commitment.

14.3.2.1. Residential Treatment- Services that are provided to an Individual in a twenty-four-hour-a-day supervised facility that includes room and board in accordance with WAC 388-877B. Services include individual and group counseling, education and related activities.

14.3.3. Ancillary Costs: With the funds provided under this Agreement the Contractor is also expected to prioritize payments for expenditures associated with providing Medically Necessary residential services for Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver. Costs include, but are not limited to, room and board in a residential treatment facilities and Administrative Costs related to the Involuntary Treatment Act.

14.3.4. Withdrawal Management- Services that are provided to an Individual to assist in the process of withdrawal in a safe an effective manor in accordance with ASAM criteria.

14.4. **Services in Support of Core Services.** When the Contractor has Available Resources the Contractor shall provide services necessary to the facilitation of providing or preventing Core Services to members of priority populations ([RCW 71.24](#)). The Contractor must have policies and procedures that determine how the availability of resources for these services is determined, including how decisions are made to authorize intake evaluations or deny provision of services due to insufficient resources.

14.4.1. Within available resources and pursuant to Contractor's policies and procedure, Contractor may use the funds provided under this Agreement to do any of the following:

14.4.2. Provide or purchase any other clinically appropriate outpatient or residential services to a non-Medicaid Individual. For Substance Use Disorder treatment services these must be based on the priority populations in Section 6.1.2 and service descriptions in Exhibit X including recovery support services.

14.4.2.1. Provide or purchase clinically appropriate outpatient services to Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver.

14.4.2.2. Provide assistance with transportation.

14.4.2.3. Provide assistance with application for entitlement programs.

14.4.2.4. Provide assistance with meeting the requirements of the Medically Needy spend down program.

14.4.2.5. Provide Training for Peer Counselors when the training meets the following requirements:

- The Contractor shall submit Peer Counselor Training Applications to DBHR no later than thirty (30) calendar days prior to attendance at the training.
- Each participant is over age 18 and meets the [WAC 388-865-0150](#) definition of Individual, unless DBHR approval for exception has been obtained in writing prior to attendance at the training. Only participants with a DBHR approved Peer Counselor Training Application may sit for the Peer Counselor Exam.

- Training is structured in compliance with the BHO Guidelines for Peer Counseling Training according to guidelines provided by DBHR. The guidelines define BHO, DBHR, and applicant/participant responsibilities.

## 15. COMMUNITY COORDINATION

- 15.1. The Contractor shall participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by DBHR. The Contractor shall:
- 15.1.1. Attend DBHR-sponsored training regarding the role of the public mental health system in disaster preparedness and response.
  - 15.1.2. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.
  - 15.1.3. Provide disaster outreach in Contractor's Service Area in the event of a disaster/emergency; "Disaster Outreach" means contacting persons in their place of residence or in non-traditional settings for the purpose of assessing their mental health and social functioning following a disaster or increasing the utilization of human services and resources.
  - 15.1.4. There are two (2) basic approaches to outreach: mobile (going to person to person) and community settings (e.g. temporary shelters, disaster assistance sites, disaster information forums). The Outreach Process must include the following:
    - 15.1.4.1. Locating persons in need of disaster relief services.
    - 15.1.4.2. Assessing their needs.
    - 15.1.4.3. Engaging or linking persons to an appropriate level of support or disaster relief services.
    - 15.1.4.4. Providing follow-up mental health services when clinically indicated.
    - 15.1.4.5. Disaster outreach can be performed by trained volunteers, peers and/or persons hired under a federal Crisis Counseling Program Grant. These persons should be trained in disaster crisis outreach which is different than traditional mental health crisis intervention.
    - 15.1.4.6. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs.
    - 15.1.4.7. Provide DBHR with the name and contact information for person(s) coordinating the BHO disaster/emergency preparedness and response upon request.
    - 15.1.4.8. Provide information and preliminary disaster response plans to DBHR within seven (7) calendar days following a disaster/emergency or upon request.
    - 15.1.4.9. Partner in disaster preparedness and response activities with DBHR and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations. This must include:
      - 15.1.4.9.1. Participation when requested in local and regional disaster planning and preparedness activities.
      - 15.1.4.9.2. Coordination of disaster outreach activities following an event.



- 15.2. For Individuals enrolled with Developmental Disabilities Administration (DDA), formerly hospitalized at WSH or ESH, currently living in the community, who are in the contracted service area the Contractor shall:
- 15.2.1. Participate in quarterly community comprehensive reviews. Each review must be conducted using the DSHS, DDA Comprehensive Review Tool. This tool is incorporated by reference and is available on the DBHR Intranet.
  - 15.2.2. Work directly with Regional (DDA) representatives in coordinating and conducting these reviews. The Contractor representative and the Regional DDA Quality Assurance Manager will be “lead staff” for Regional Review Teams (RRTs). In addition to coordinating for, and participating in these reviews the “lead staff” will be responsible for preparing and submitting final reports from the reviews to the DBHR Program Administrator.
    - 15.2.2.1. Develop a corrective action plan to address findings based on the results of a review. Require Subcontractors to respond to any identified deficiency and to develop and implement the corrective action plan. Document completion of corrective action on the Comprehensive Review Tool.
    - 15.2.2.2. The completion of the review, including documentation of the completion of required corrective action must be submitted to the identified DBHR Program Administrator no later than the final calendar day of the quarter in which the review was conducted.

## 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 listed on or before March 1, 2016.
- 16.1.1. The Federally Recognized Tribes and/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.
    - The [DSHS 7.01 Policy](#), which identifies the Federally Recognized Tribes and/or Recognized American Indian Organizations (RAIOs).
  - 16.1.2. A Tribal 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 Tribal representation occurring.

<b>For Behavioral Health Organizations</b>				
Due to DBHR on or before March 1 of each year				
<b>Implementation Plan</b>				<b>Progress Report</b>
(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 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 Contract 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 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 the 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 the DBHR Tribal Liaison from each party that verifies both are in Agreement with the content in 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 the 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 the 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 Tribe to identify those areas that place legal requirements on the Tribe that are not applicable and refrain from passing these requirements on to Tribes.
- 16.2.4. The DBHR Tribal Liaison may be available for technical assistance in identifying what legal requirements the Contactor can be relieved of in Federally Recognized Tribes 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. In the event the liaison is aware that the Individual is a Federally Recognized Tribal Member or receiving mental health services from a Tribal or Urban Indian Health Program and the Individual 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 Individual. If the Individual chooses to be served only by the Tribal Mental Health Service referral to a contracted network BHA is not required.
- 16.3. If an Individual is a Tribal Member of a Washington State Federally Recognized Tribe and is referred to or presents for non-crisis services and the Individual 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 Individual. If the Individual chooses to be served only by the Tribal Mental Health Service referral to a contracted network BHA is not required.
- 16.4. Tribal Coordination for Crisis, Voluntary Inpatient and Involuntary Commitment Evaluation Services
- 16.4.1. The Contractor shall work with the DBHR Tribal Liaison and continue to work on their crisis coordination plan. The plan shall outline details for providing crisis, ITA evaluation, voluntary inpatient authorization and discharge planning services on Tribal Lands within the BHO and shall be due within six months of contract execution.
- 16.4.2. The plan shall be developed in partnership with the affected Federally Recognized Tribal entities within the BHO region and must be co-signed by the appropriate Tribal representative for each affected Federally Recognized Tribe.
- 16.4.3. The plan shall identify a procedure and timeframe for evaluating the plan's efficacy and a procedure and timeframe for modifying the plan to the satisfaction of all parties at least once per year.
- 16.4.4. If the BHO and the Federally Recognized Tribal entity are not able develop a plan or the tribe does not respond to the request, DBHR will work with both the Tribes and BHO to reach an understanding. These meetings will be conducted in a manner which comports with the DSHS government-to-government relationship with Washington State Federally Recognized Tribes.
- 16.4.4.1. Those Federally Recognized Tribes, whose Tribal lands lie within multiple BHOs, may develop joint plans with those BHOs. If an BHO has multiple Tribal lands within their service region one plan may be developed for all Tribes if all parties agree.
- 16.4.5. The plan must include a procedure for crisis responders and DMHPs (non-Tribal) to access Tribal lands to provide requested services, including crisis response, and ITA evaluations.
- 16.4.5.1. Any notifications and authority needed to provide services including a plan for evening, holiday and weekend access to Tribal lands if different than business hours.
- 16.4.5.2. A process for notification of Tribal authorities when crisis services are provided on Tribal land, especially on weekends, holidays and after business hours. This must identify the essential elements included in this notification, who is notified and timeframe for the notification.

- 16.4.5.3. A description of how crisis responders will coordinate with Tribal Mental Health providers and/or others identified in the plan for, including a description of how service coordination and debriefing with Tribal mental health providers will occur after a crisis service has occurred.
- 16.4.5.4. This must include the process for determining when a DMHP is requested and a timeframe for consulting with Tribal mental health providers regarding the determination to detain or not for involuntary commitment.
- 16.4.5.5. Include a planned response to Tribal ITA court orders for Substance Use Disorder Treatment .ITA Evaluation Services.
- 16.4.5.6. The plan shall include procedures for coordination and implementation of ITA evaluations on Tribal lands, including whether or not DMHPs may conduct ITA evaluations on Tribal lands.
- 16.4.5.7. If ITA evaluations cannot be conducted on Tribal land, the plan shall specify how and by whom Individuals will be transported to non-Tribal lands for ITA evaluations and detentions.
- 16.4.5.8. If DMHP evaluations cannot be conducted on Tribal Land, the plan shall specify how and by whom Individuals will be transported off of Tribal Land to the licensed Evaluation and Treatment facility.
- 16.4.5.9. The plan shall specify where Individuals will be held and under what authority, If no E&T beds are available.
- 16.4.6. Voluntary Hospital Authorization
  - 16.4.6.1. The plan will include specifics as to how the BHO would like Tribal Mental Health providers to request voluntary psychiatric hospitalization authorizations for Medicaid-eligible Individuals.
  - 16.4.6.2. The BHO shall provide to the Federally Recognized Tribes information on how to request for voluntary authorization, appeals and expedited appeals. The plans shall reiterate that only a psychiatrist or a doctoral level psychologist may issue a denial and that denials may only be issued by the BHO and not the crisis provider.
- 16.4.7. Inpatient Discharge Planning
  - 16.4.7.1. The plan shall address a process for identifying the Tribal mental health provider as the liaison for inpatient coordination of care when the Individual is an identified Tribal member and has not expressed a preference regarding involvement by the Tribe in their care. This includes all liaison activities required in Section 14 of this Agreement.

## 17. SPECIAL PROJECTS

- 17.1. **Jail Coordination Services** – Are to be provided within the identified resources in Exhibit C.
  - 17.1.1. The Contractor shall coordinate with local law enforcement and jail personnel. This shall include the development or maintenance of Memoranda of Understanding (MOU) with local county and city jails in the Contractors' Service Area.
    - 17.1.1.1. The MOU must identify the process and procedures to be implemented when the local jails contract the placement of offenders in other jurisdictions, such as tribal jails or those

in other counties. The MOU must detail a referral process for persons who are incarcerated and have been diagnosed with a mental illness or identified as in need of mental health services. It must also include a process to include services to offenders placed in an out of jurisdiction contract facility.

- 17.1.1.2. The Contractor shall identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.
- 17.1.1.3. The Contractor shall accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24. The Contractor shall conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.
- 17.1.1.4. The Contractor shall develop and execute a memorandum of understanding agreement with local DSHS Community Services Offices (CSOs) for expedited application or reinstatement of medical assistance for Individuals in jails, prisons, or IMDs. The Contractor shall assist Individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.
- 17.1.1.5. Pre-release services shall include:
  - Mental health screening for Individuals who display behavior consistent with a need for such screening or who have been referred by jail staff, or officers of the court.
  - Mental health intake assessments for persons identified during the mental health screening as a member of the priority populations as defined in [RCW 71.24](#).
  - Facilitation of expedited medical and financial eligibility determination with the goal of immediate access to benefits upon release from incarceration.
  - Other prudent pre-release (including pre-trial) case management and transition planning.
- 17.1.1.6. Provision of direct mental health services to Individuals who are in jails that have no mental health staff.
- 17.1.1.7. Implement intensive post-release outreach to ensure best possible follow-up with the CSO and appointments for mental health and other services (e.g. substance abuse) engagement with mental health services to stabilize client in the community.
- 17.1.2. If the Contractor has provided the jail services above the Contractor may use the Jail Coordination Services funds provided to facilitate any of the following activities if there are sufficient resources:
  - 17.1.2.1. Daily cross-reference between new booking and the BHO database to identify newly booked, persons known to the BHO.
  - 17.1.2.2. Development of individual alternative service plans (alternative to the jail) for submission to the courts.
  - 17.1.2.3. Inter-local Agreements with juvenile detentions facilities.

- 17.1.2.4. Provision of up to a seven (7) day supply of medications prescribed for the treatment of mental health symptoms following the release from jail.
- 17.1.2.5. Training to local law enforcement and jail services personnel.
- 17.2. **Expanded Community Services (ECS)** (These terms are only in the following BHOs – King, North Sound, Peninsula, UBH, Thurston/Mason, Timberlands.) The ECS funding provided in Exhibit C is provided for the provision of enhanced community support services for long term State Hospital patients whose treatment needs constitute substantial barriers to community placement.
  - 17.2.1. The Contractor shall provide or maintain community residential and support services for Individuals with treatment needs that constitute substantial barriers to community placement. The Individual must no longer need an inpatient Level of Care and be determined clinically ready for discharge.
  - 17.2.2. The Contractor shall screen all new referrals for ECS using the state developed ECS screening form. Individuals are determined to be eligible for services under ECS by the Contractor. Additional Individuals may be identified during this contract period to participate in ECS if there is capacity.
  - 17.2.3. Prior to placement of a new ECS Individual the Contractor must convene and participate in a team of community professionals who will become familiar with the Individual and treatment plan. This includes:
    - 17.2.3.1. Assessment of the Individual's strengths, preferences and needs.
    - 17.2.3.2. Arrangement of a safe, clinically-appropriate, and stable residence.
    - 17.2.3.3. Assessment and planning for other needed medical, behavioral, and social services.
    - 17.2.3.4. Prior to placement into the community a complete written comprehensive transition plan must be developed. The process to develop the plan must include the participation of the Individual and focus on the Individual's strengths and needs.
    - 17.2.3.5. The Contractor shall utilize the ECS transition guidelines developed by the ECS Implementation Committee or other comparable local tools to assure transition needs of ECS Individuals will be met.
    - 17.2.3.6. The Contractor must provide for face-to-face visits to the identified ECS Individual during the last months of hospitalization. The purpose of the visits is to assess the Individuals mental health needs and any other service needs.
  - 17.2.4. The Contractor shall provide the minimum number of ECS days of service listed in Exhibit C during this Agreement period. ECS days of service include any day an ECS resident is living outside of a State Hospital and being supported by the BHO in community residential or other supported living settings. ECS days of service do not include days in which a patient is residing in a State Hospital, in jail or in a Department of Corrections facility. The Contractor will monitor Subcontractors receiving ECS funds to ensure compliance with meeting the required days of service and shall make available reports to demonstrate this upon request.
- 17.3. **Washington Program of Assertive Treatment (WA-PACT)** – (Only in King, Pierce, Greater Columbia, Chelan/Douglas, Thurston/Mason, Spokane, Peninsula, and North Sound) WA-PACT teams are intended as an appropriate treatment approach for Individuals with a current diagnosis of a severe and persistent mental illness who are experiencing severe symptoms and have significant

impairments. These Individuals must also have demonstrated a combination of continuous high service needs and functional impairments, and have not shown to benefit significantly from other outpatient programs currently available. The Contractor shall:

- 17.3.1. Maintain a WA-PACT team in accordance with the revised [Washington State PACT Program Standards](#). The Contractor shall follow the standards for full or half-teams, as identified below:

<b>WA-PACT BHO</b>	<b>TEAM</b>
Chelan Douglas BHO	1/2 Team
Greater Columbia BHO	One Full Team
King County BHO	Two Full Teams
North Sound BHO	One Full Team
Peninsula BHO	1/2 Team
United Behavioral Health	One Full Team
Spokane County BHO	One Full Team
Thurston-Mason BHO	1/2 Team

- 17.3.2. Require that the primary Individuals served by the WA-PACT team(s) are Individuals who demonstrate or have demonstrated a Medical Necessity for inpatient psychiatric hospitalization. In addition, priority shall be given to referrals from current State Hospital patients who are ready for discharge and meet criteria for admission into PACT teams as delineated in the revised Washington State PACT Program Standards.
- 17.3.3. Admit Individuals in accordance with the revised Washington State PACT Program Standards to maintain the Individual participation at a minimum monthly average of thirty seven (37) Individuals for half teams and eighty (80) Individuals for full teams.
- 17.3.4. Maintain capacity for priority re-admission for discharged Individuals who need re-admission to the PACT team to maintain stability within the community. These Individuals must meet Medical Necessity requirements for this Level of Care.
- 17.3.4.1. In the case of emergent re-admission, the overall maximum team capacity may be exceeded.
- 17.3.5. Incorporate stakeholder involvement in the implementation of the WA-PACT by development of Stakeholder Advisory Groups.
- 17.3.5.1. The Contractor may determine whether the Stakeholder Advisory Group is included within the BHO Advisory Board or is managed by the WA-PACT provider. If the Stakeholder Advisory Group is managed by the provider, the Contractor shall have a representative attend all Stakeholder Advisory Group meetings.
- 17.3.5.2. If the Stakeholder Advisory Group is separate from the BHO Advisory Board, the Contractor shall maintain and make available to DBHR upon request membership rosters of participants on the WA-PACT Stakeholder Advisory Group. The roster must identify each Individual serving as a member, the stakeholder group represented, and the duration of their terms. The revised Washington State PACT Program Standards

requires a representation of at least fifty one percent (51%) Individual and Individual family members.

- 17.3.5.3. Stakeholder Advisory Groups shall meet at least quarterly throughout this Agreement.
- 17.3.6. Require in subcontracts for WA-PACT providers to attend and participate in DBHR required training and technical assistance activities. Contractor shall monitor WA-PACT provider attendance and maintain documentation of monitoring efforts.
- 17.3.7. Any exception to the staffing pattern required by the revised Washington State PACT Program Standards and the Contractor's approved staffing pattern must be submitted to DBHR for prior approval.
- 17.3.8. The Contractor must have teams which comport with the revised Washington State PACT Program Standards identified staffing patterns.
- 17.3.9. The Contractor shall maintain a roster of all PACT staff and their respective positions in accordance with the revised Washington State PACT Program Standards. The roster shall be submitted to DBHR upon request in a format provided by DBHR.
- 17.3.10. If the Contractor is not able to maintain full staffing, the Contractor must immediately notify DBHR, in writing, if staffing falls below the revised Washington State PACT Program Standard's staffing pattern. Prior to significant changes to the staffing plan that are below the specifications in the revised Washington State PACT Program Standards, requests for approval must be submitted to DBHR.
- 17.3.11. Non-Medicaid funds for the WA-PACT program will be provided in accordance with Exhibit C. The Contractor will provide all medically necessary Medicaid WA-PACT services as described in the revised Washington State PACT Program Standards to Medicaid Individuals in the WA-PACT program.
- 17.3.12. The Contractor shall submit to DBHR, by August 31, 2016, an updated WA-PACT budget. The budget shall be detailed and comply with the provided format and include a Budget Narrative which will describe and clarify budget details.
  - 17.3.12.1. The Contractor shall submit outcome data quarterly on Individuals served by the WA-PACT teams in a format provided by DBHR. Reports will be submitted to DBHR within sixty (60) calendar days of the end of the quarter. The Contractor shall also submit to DBHR any other data or reports as required under this Agreement.
  - 17.3.12.2. The Contractor shall submit a roster of PACT Individuals, identifying Medicaid and non-Medicaid status. For those Individuals identified as non-Medicaid, the Contractor shall identify the barriers to obtaining Medicaid funding. The roster will be submitted to DBHR quarterly in a format provided by DBHR.
  - 17.3.12.3. The Contractor shall maintain a waiting list of Individuals referred for PACT who meet the admission criteria but cannot be enrolled because of capacity issues. The list shall include the referral date and shall be provided to DBHR upon request.
  - 17.3.12.4. The contractor shall submit to DBHR for approval revised policies and procedures regarding waiting list maintenance. The revised policies shall address managing Medicaid Individuals who are on the waiting list and an assurance that those Individuals will receive medically necessary care while on the waiting list. DBHR will provide guidelines for developing the policies. Policies shall be submitted by August 31, 2016.



#### 17.3.13. Performance/Fidelity

17.3.13.1. The Contractor shall cooperate with fidelity monitoring by providing to DBHR representatives, upon request, access to all BHO WA-PACT program documentation, Subcontractor facilities, BHO and Subcontractor staff, and records related to this program for review. In addition Contractor and Subcontractor staff shall facilitate and support Individual interviews. The Contractor shall be subject to corrective actions as described in 19. Remedial Action section of this Agreement for failure to adequately meet fidelity requirements as determined by DBHR reviews.

17.3.13.2. WA-PACT Teams are expected to admit Individuals in accordance with the Published WA-PACT Program Standards. The Contractor shall maintain minimum targets of actively enrolled Individuals for WA-PACT teams as identified in the WA-PACT Fidelity Protocols. The active enrollment target must be maintained by the final day of the period in accordance with the schedule in the WA-PACT Fidelity Protocols. Failure to meet targets shall subject the Contractor to corrective actions as described in 19. Remedial Action section of this Agreement.

#### 17.4. Program for Adaptive Living Skills (Western BHOs Only)

17.4.1. Funds will be provided according to Exhibit C for programs that significantly reduce the use of beds at the State Hospitals.

17.4.2. Funds are provided solely for the western Washington Behavioral Health Organizations to provide community based services for persons who would otherwise require a highly structured residential level of care.

#### 17.5. Specific Eligibility and/or Funding Requirements for Criminal Justice Account Services.

Criminal Justice Treatment Account (CJTA) (RCW 70.96A, RCW 70.96A.055: Drug Courts, RCW2.28.170; Drug Courts) and Drug Court funding. Drug court funding is provided to the following counties Clallam, Cowlitz, King, Kitsap, Pierce, Skagit, Spokane, and Thurston/Mason.

17.5.1. Under 70.96A.350 each County has an established local CJTA panel that creates the local CJTA plan to describe how the CJTA funds will be used locally. The plan is submitted to the Washington State CJTA panel and the BHO.

17.5.1.1. The plan will address the priorities for the use of funds for:

1. The treatment of Individuals with an addiction or substance use problem that if not treated would result in addiction against which charges are filed against by a prosecuting attorney in Washington State.
2. The provision of drug and alcohol treatment services and treatment support services for non-violent individuals within a drug court program
3. The administration and overhead costs associated with the operation of a drug court.

17.5.1.2. The plan must address the Criminal Justice Treatment Account Match Requirement – to provide a local participation match of all DSHS provided criminal justice awards using the following formulas:

1. A dollar-for-dollar participation match for services to patients who are receiving services under the supervision of a drug court.
2. A ten percent (10%) participation match as formulated below, for services to patients who are not under the supervision of a drug court but against whom a prosecuting attorney in Washington State has filed charge.

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

17.5.1.3. The BHO must implement the plan as approved by the State panel.

17.5.2. The BHO shall provide, based on the approved plan, alcohol and drug treatment and treatment support services per Chapter 70.96A RCW: Treatment for alcoholism, intoxication, and substance use disorder to the following eligible offenders:

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

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

17.5.2.3. CJTA Funding Guidelines:

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

17.5.2.3.1.1. Transportation

17.5.2.3.1.2. Child Care Services

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

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

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

17.5.2.3.2.3. A regional project conducted in partnership with at least one other BHO.

17.5.2.4. Services provided are defined in the SUD Services Descriptions and Service Matrix.

17.5.2.5. Criminal Justice Treatment Account Special Projects Report - The BHO shall submit a progress report to DSHS Contact that summarizes the status of the BHO's innovative project and includes the following required information:

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

17.5.2.5.2. Current Status:

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

- 17.5.2.5.2.2. Describe how the project has enhanced treatment services for offenders.
- 17.5.2.5.2.3. Indicate the number of offenders who were served using innovative funds.
- 17.5.2.5.2.4. Indicate the cost of service per participant.
- 17.5.2.5.3. Goals and Objectives:
  - 17.5.2.5.3.1. Detail the original goals and objectives of the project.
  - 17.5.2.5.3.2. Document how the goals and objectives were achieved.
  - 17.5.2.5.3.3. If any goals or objectives were not achieved indicate any changes in the project that will allow for the goals and objectives to be met.
- 17.5.2.5.4. Evaluation Strategy.
  - 17.5.2.5.4.1. What is the treatment retention and completion rate for offenders being treated with innovative funds?
  - 17.5.2.5.4.2. Are these rates the same, better, or worse than other offenders?
  - 17.5.2.5.4.3. What is the recidivism rate for offenders being treated with innovative funds?
  - 17.5.2.5.4.4. Is this rate the same, better, or worse than other offenders?
- 17.5.3. The following Priority Populations may be provided Behavioral Health Services within available resources. Individuals who:
  - 17.5.3.1. Have an income level no more that 220% of the federal poverty level
  - 17.5.3.2. Are not Medical eligible
  - 17.5.3.3. Are uninsured
  - 17.5.3.4. With insurance but is unable to meet the co-pay or deductible for the services.

## **18. REMEDIAL ACTIONS**

- 18.1. DSHS may initiate remedial action if it is determined that any of the following situations exist:
  - 18.1.1. A problem exists that negatively impacts individuals receiving services.
  - 18.1.2. The Contractor has failed to perform any of the mental health services required in this Agreement.
  - 18.1.3. 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.
  - 18.1.4. 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.

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

18.2. DSHS may impose any one or more of the following remedial actions in any order:

18.2.1. 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.

18.2.1.1. 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.

18.2.1.2. 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.

18.2.2. Any corrective action plan that was in place as part of a previous SMHC Agreement shall be applied to this Agreement in those areas where the Contract requirements are substantially similar.

18.2.3. 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.

18.2.4. Increase Withholdings identified above by up to an additional three percent (3%) for each successive month during which the remedial situation has not been resolved.

18.2.5. 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.

18.2.6. Terminate for Default as described in the "DSHS and BHO Agreement on General Terms and Conditions".