Greater Columbia Behavioral Health

BEHAVIORAL HEALTH ORGANIZATION
DETAILED PLAN

OCTOBER 30, 2015

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Introduction

In preparation for transitioning mental health and substance use disorders into Medicaid Managed Care in Washington, Greater Columbia Behavioral Health (GCBH) has aggressively pursued a thorough self-assessment and planning process to be prepared to contract with the Department of Social and Health Services (DSHS) in February 2016. Furthermore, GCBH will be fully operational to conduct business in compliance with the GCBH/DSHS contracts for mental health and substance use disorder services, heretofore referred to as behavioral health services, and ensure a seamless transition for its customers beginning April 1, 2016.

Included as Attachment 1 in this Detailed Plan is the Attestations and Responses for Detailed Plan which serves as a cross-reference to locate required responses. A signed and initialed copy of the Attestations and Responses document has been submitted as an acknowledgement that GCBH has read, understands and accepts the statutory and regulatory responsibility for performing its duties as a Behavioral Health Organization (BHO).

Each required Response is addressed in one of the subsequent Sections below and is indicated using the Attestation and Responses spreadsheet row number and Description title (from column B) in that document. For example, the response to row 3 in the spreadsheet can be found under the heading **(3) Behavioral health organizations – contracting process** in **Section 7 Financial and Administrative Plan**.

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General and Overall Transition Plan

Greater Columbia Behavioral Health (GCBH) has served as a Regional Support Network for the past 26 years for 11 counties originally and in 2013 reduced in size to the current 10-county region. GCBH's region is comprised of Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, and Yakima counties and the Yakama Nation. GCBH's vast geography presents challenges that require innovative, efficient, and effective distribution of resources to overcome distance, diversity, and the expectations of its constituency. Given this experience, GCBH is well positioned to make a seamless transition to a fully functional BHO managing an integrated substance use disorder and mental health benefit package.

GCBH currently manages a network of mental health providers in its geographic catchment area. GCBH has a strong governance structure, robust systems for data, contract procurement and monitoring, utilization management, quality improvement and compliance, and stakeholder and customer relations. Facilitating factors to support the transition are: 1) GCBH will continue to serve its same geographic catchment area; 2) GCBH is very familiar with the existing substance use disorder (SUD) services network; 3) GCBH has already begun hiring the staff necessary to support its new role; and 4) GCBH is engaged in planning and communication with key stakeholders to inform its decision-making as it prepares to meet the needs of the impacted communities.

(160) Joint agreements of county authorities – required provisions

(161) Joint agreements of county authorities – permissive provisions

The Greater Columbia Board of Directors has drafted a new Interlocal Agreement to establish GCBH as a BHO which is included in Attachment 2. This draft was presented to the Board members and was discussed at their October meeting. This presentation also began the required 30-day comment and review period and it will be an action item for the Board to approve at the November 5, 2015 meeting. Included in the agreement are all required (160) and permissive provisions (161). The Board has been very supportive of the transition planning and has approved the hiring of staff needed to do the work of becoming a BHO with the capability to manage the business required by the upcoming four DSHS contracts. The management team of GCBH has done a thorough review of the BHO requirements and a self-assessment of existing and needed capacity to manage the new SUD benefits and integrate them into business operations. The creation of this new joint agreement declares GCBH's

dedication to providing mental health, substance use disorder and co-occurring disorder services to the low income/Medicaid population.

The GCBH management team has determined that all of the foundational functions, policies and procedures needed to manage a behavioral health system of care currently exist. However, some modifications need to be made to build out functions and incorporate the SUD benefits into existing policies and procedures. These are noted in the Detailed Plan Response within each section of the plan. GCBH currently has functions such as contract procurement and monitoring, utilization management, care coordination, quality assurance and improvement, grievance resolution and tracking, and data systems for paying providers and tracking encounters. The three most significant areas of development are: 1) revising policies and procedures to incorporate SUD services; 2) putting contracts in place; and 3) enhancing the information technology platform so that it has more functionality than the current system.

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Transition and Coordination of Services Plan

GCBH is committed to creating a system of care that not only integrates SUD services with MH services, but also coordinates with health care systems to treat the "whole person" and support members in their recovery journeys. The high level of comorbidities in the target populations with BH disorders demands the evolution of health care systems to provide services in integrated settings, respecting the help-seeking preferences of its members. Whether its members choose to present in primary care settings or specialty behavioral health care settings, GCBH intends on developing relationships with provider and payer systems that meet their members where they are and provide state-of-the-art evidence-based services. At the same time, a key operating principle being used by GCBH during the initial *transition phase* is to not significantly disrupt the existing network of SUD providers and keep the transition as seamless as possible for its members.

This section of the Detailed Plan will cover:

- Transitioning to Integrated Care
- Transitioning SUD Services into Managed Care
- Voluntary and Involuntary SUD Treatment
- Discharge Planning for Persons under Involuntary Commitment
- Transfer between BHOs

Transitioning to Integrated Care

(280) Primary care and coordination of health care services

GCBH policy QM505, in concert with Center for Medicaid Services (CMS) and the Division of Behavioral Health and Recovery (DBHR) mandates, requires that GCBH and its contracted providers cooperate and actively work with other systems of care (e.g., physical health care, Developmental Disabilities, Child Welfare, Juvenile Justice, Aging and Disabilities Services Administration, Tribes, Vocational Rehabilitation, jails, corrections, informal/natural supports, and education) involved with the same individual to ensure the coordination of mental health services and substance use disorders services.

Ongoing efforts to promote integration include:

- When healthcare needs are identified, individuals of all ages that meet criteria for medical necessity in Washington's BHO system of care are referred to the identified

necessary physical health care, diagnostic services, treatment, and other services within the initial 30-day intake. The intention of this process is:

- To deliver services that are coordinated and delivered safely;
- To minimize duplicative and redundant activities, such as assessments, treatment plans and inter-agency meetings; and
- To achieve continuity and consistency of care.

- Specifically, current provider contracts state that enrollees/consumers who have a suspected or identified physical health care problem will be referred to a physical health care provider and that the individualized service plan will identify medical concerns and plans to address them. In April 2016, this requirement will be expanded to include SUD clients. At intake it is required that if an enrollee/consumer does not have a PCP, they will be referred to one, and a Release of Information is signed to assist in integrated care coordination. Provider contracts state that Individual Service Plans must address the overall identified needs of the enrollee/consumer including those best met by another service delivery system, i.e. primary medical care, and the provider must ensure that there is coordination with the other service delivery systems responsible for meeting the identified need.

- GCBH recently completed a Performance Improvement Project to ensure that consumers were being referred appropriately for Primary Care services. As a result, three of its Provider Agencies have expanded the process noted above and now actively work to ensure referrals are successful and that consumers and truly engaged with their PCP's (regardless of whether there is a suspected or identified physical health care problem). Those agencies are seeking to promote prevention and wellness as part of their approach to all consumers. This approach will be generalized to all SUD related referrals – and also will be encouraged among all the remaining GCBH contract holders.

- Currently, GCBH has Joint Operating Agreements (JOAs) with five managed care organizations (MCOs) contracted for Medicaid in the State, which include Amerigroup, Cenpatico Behavioral Health, Community Health Plan, Molina Healthcare and United Healthcare. GCBH plans to host a meeting with all MCOs in the service area and their identified primary care leadership to discuss the integrated BHO delivery system and to discuss collaboration with their physical health care systems. GCBH will collaborate with the MCOs to review and revise the JOAs as necessary for the inclusion of SUD clients between November 2015 and April 2016.

- GCBH participates in Accountable Community of Health (ACH) activities, which encompasses the 10 counties in the Regional Service Area. GCBH staff members, contracted provider staff and a GCBH governing Board member attend ACH meetings.

The provider staff person and GCBH governing Board member are also on the ACH Board of Directors.

- GCBH currently contracts with Yakima Valley Farm Worker's Clinic in Yakima and Tri-Cities Community Health in Pasco (two Federally Qualified Health Centers) for MH related services. It is GCBH's intent to offer a contract for SUD services to these two providers prior to April 2016 to ensure that their patients (who are receiving medical care) can seamlessly be referred for BH services within one system of care. Since both of these FQHCs already have on-site staff providing SBIRT services to persons with possible SUD issues, the additional scope of services (created by contracting with them for SUD services) will be another step towards integration.

- GCBH has encouraged its provider network to develop local affiliations and relationships to improve the availability of BH services within Medical settings. Examples of this include:

    - Lourdes Counseling Center provides psychiatric services and consultations to inpatients at Kadlec Medical Center.
    - Central Washington Comprehensive Mental Health provides consultation services to Yakima Memorial Medical Center.
    - Quality Behavioral Health (Asotin and Garfield County) has coordinated with a community PCP who provides medication services (including primary care as indicated) at their MH clinic on a weekly basis. This arrangement came about as a result of QBH's participation in a community-wide healthcare networking process that focuses on challenging situations.

- Blue Mountain Counseling Center (Columbia County) employs a licensed PCP to assist in medication management as well as coordinating mental health and physical healthcare in concert with the consumer's PCP.

- GCBH will be enhancing the existing system of SUD services that provide CD Specialist interventions for people being seen in community medical settings (such as Emergency departments) when issues of substance abuse are being considered. This county-based program will be transitioned to GCBH over the next five months.

- Finally, approximately 10 months ago, GCBH resumed contracting with a Medical Director who has over 15 years of experience working in an integrated healthcare system. This physician was recruited back to GCBH specifically because of his MCO experience and prior employment as a Physician Administrator with a fully integrated public sector healthcare plan. The GCBH Medical Director provides routinely scheduled

on-site and tele-consultation in the areas of Performance Improvement, Clinical Care, Integration (with Mental Health, SUD and physical medicine systems) and performance-based contracting.

Attachment 3 contains a sample of the current MCO Joint Operating Agreements, as well as GCBH policy QM505, and contracts for services provided in primary care settings.

Transitioning SUD Services into Managed Care

(19) Comprehensive program of SUD treatment

System of Care for SUD Services. Greater Columbia Behavioral Health intends to transition SUD services into its network by offering a contract to the current County subcontracted SUD agencies identified in the table below.

The SUD outpatient treatment provider network is comprised of 19 agencies throughout the region. These providers offer assessments and services that meet ASAM Level of Care .05 through level 2.5. These services include:

- Intervention;
- Withdrawal Management;
- Opiate Substitute Treatment;
- Outpatient;
- Intensive Outpatient; and
- Co-Occurring Disorders Treatment.

In addition to outpatient services, referrals are made to other specialty care providers that offer mental health counseling, housing, employment, continuing education programs, outreach, case management, and residential treatment services.

In an effort to assist the patient throughout the continuum of care, residential and outpatient providers are expected to develop and formalize relationships with agencies that provide recovery supports in all life domains. It is essential to include discharge planning from residential care to ensure better outcomes, increase harm reduction and prevent relapse, and continue to communicate with one another so that the appropriate services are lined up once the patient is released from residential services. Key goals are to improve access to mainstream housing programs and quickly re-house homeless individuals and families, while reducing trauma and dislocation for the most vulnerable individuals in the community.

The provider network will be required to prioritize services to low income and Medicaid patients who meet the GCBH access to care standards and the ASAM criteria requirements and who are identified as pregnant or post-partum, youth, or intravenous drug users. Pregnant

women and women with dependent children will have immediate assessment/intake/outreach appointments offered to them.

Greater Columbia Behavioral Health County Providers by ASAM Levels of Care							
County	**ASAM Levels of Care**						
	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**	**Level 3.5 Clinically Managed, Medium Intensity Residential Services**	**Level 3.2 WM Clinically managed Residential Withdrawal Management (Acute and Sub-Acute Certification)**	**Population served**
Asotin							
Quality Behavioral Health http://www.qualitybehavioralhealth.com/ 900 7th Street Clarkson, WA 99403	X	X					Adult and youth males and females
Benton							
Benton and Franklin Counties Crisis Response Center 500 North Morain Bldg. 1, Suite 1250 Kennewick, WA 99336	X						Adult
First Step Community Counseling Services http://www.firststepccs.com/	X	X					Adult and youth males and females

Greater Columbia Behavioral Health County Providers by ASAM Levels of Care							
County	**ASAM Levels of Care**						
	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**	**Level 3.5 Clinically Managed, Medium Intensity Residential Services**	**Level 3.2 WM Clinically managed Residential Withdrawal Management (Acute and Sub-Acute Certification)**	**Population served**
415 North Morain St. Kennewick, WA 99336							
Ideal Balance http://idealoption.net/index2.html 8514 W. Gage Blvd. Suite G Kennewick, WA 99336	X	X					
Lourdes Counseling Center http://www.lourdeshealth.net/ 1175 Carondelet Drive Richland, WA 99651	X	X					Adult and youth males and females
Somerset Counseling Center http://www.drugevaluation.com/ 1305 Mansfield Street	X	X					Adult and youth males and females

Greater Columbia Behavioral Health County Providers by ASAM Levels of Care							
County	**ASAM Levels of Care**						
	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**	**Level 3.5 Clinically Managed, Medium Intensity Residential Services**	**Level 3.2 WM Clinically managed Residential Withdrawal Management (Acute and Sub-Acute Certification)**	**Population served**
Suite 6 Richland , WA 99352							
Columbia							
Blue Mountain Counseling 221 E Washington Ave. Dayton, WA 99328	X	X					Adult and youth males and females
Franklin							
Comprehensive Dependency Health Services http://www.cwcmh.org/ 2715 Andrews Loop, Suite C Pasco, WA 99301	X	X					Adult and youth males and females
Tri-Cities Community Health http://www.mytcch.org/ 720 West Court St. Pasco, WA 99301	X	X					Adult and youth males and females

Greater Columbia Behavioral Health County Providers by ASAM Levels of Care							
County	**ASAM Levels of Care**						
	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**	**Level 3.5 Clinically Managed, Medium Intensity Residential Services**	**Level 3.2 WM Clinically managed Residential Withdrawal Management (Acute and Sub-Acute Certification)**	**Population served**
Garfield							
Quality Behavioral Health http://www.qualitybehavioralhealth.com/ 856 Main St. Pomeroy, WA 99347	X	X					Adult and youth males and females
Kittitas							
Alcohol Drug Dependency Service 507 Nanum St., Room 111 Ellensburg, WA 98926	X	X					Adult and youth males and females
Klickitat							
CWCMH http://www.cwcmh.org/ 112 West Main St. Goldendale, WA 98620	X	X					Adult and youth males and females

Greater Columbia Behavioral Health County Providers by ASAM Levels of Care							
County	**ASAM Levels of Care**						
	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**	**Level 3.5 Clinically Managed, Medium Intensity Residential Services**	**Level 3.2 WM Clinically managed Residential Withdrawal Management (Acute and Sub-Acute Certification)**	**Population served**
Walla Walla							
Serenity Point Counseling http://serenitypointcounseling.com/ 919 South 2nd Avenue Walla Walla, WA 99362	X	X					Adult and youth males and females
Whitman							
Palouse River Counseling Center http://www.palouserivercounseling.org/ 1240 SE Bishop Blvd. Suite P Pullman, WA 99163	X	X					Adult and youth males and females
Yakima							

Greater Columbia Behavioral Health County Providers by ASAM Levels of Care							
County	**ASAM Levels of Care**						
	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**	**Level 3.5 Clinically Managed, Medium Intensity Residential Services**	**Level 3.2 WM Clinically managed Residential Withdrawal Management (Acute and Sub-Acute Certification)**	**Population served**
Dependency Health Services – Yakima http://www.cwcmh.org/ 505 S. 4th Avenue Yakima, WA 98902-3240						X	Adult and youth males and females
Ideal Balance http://idealoption.net/index2.html	X						Adult males and females
Merit Resources http://www.meritresources.com/	X	X					Adult and youth males and females
Sundown M. Ranch https://sundown.org/ 2280 SR 821 Selah, WA 98901	X	X			X IMD facility		Adult and youth males and females

Greater Columbia Behavioral Health County Providers by ASAM Levels of Care							
County	**ASAM Levels of Care**						
	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**	**Level 3.5 Clinically Managed, Medium Intensity Residential Services**	**Level 3.2 WM Clinically managed Residential Withdrawal Management (Acute and Sub-Acute Certification)**	**Population served**
Triumph Treatment Services http://triumphtx.org/ 102 S. Naches Ave. Yakima, WA 98907	X	X					Adult and youth males and females
Yakima Valley Farm Workers Clinic http://www.yvfwc.com/ 120 S. 3rd St. Suite 100 Yakima, WA 98901	X	X					Youth males and Females
PATHWAYS http://www.cwcmh.org/				X	X		Co-Occurring Disorders Adult Males and Females
TRIUMPH-Casita http://triumphtx.org/				X- Non IMD			

Greater Columbia Behavioral Health County Providers by ASAM Levels of Care							
County	ASAM Levels of Care						
	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	Level 3.5 Clinically Managed, Medium Intensity Residential Services	Level 3.2 WM Clinically managed Residential Withdrawal Management (Acute and Sub-Acute Certification)	Population served
TRIUMPH-Inspirations http://triumphtx.org/					X- non-IMD		Women and Children under 5
James Oldham Treatment Center http://triumphtx.org/					X- IMD		Adult males
RIEL House http://triumphtx.org/				X-non-IMD			Adult Females
TRIUMPH-Beth's Place http://triumphtx.org/				X-non-IMD			Adult Females

Funding for SUD Services. For SUD services beginning in April 2016, GCBH intends to fund the provider network using a GCBH Board approved capitated formula in which each provider receives funding based upon the number of eligible enrollees/consumers in their catchment area. Within available resources, GCBH will make every effort to provide additional services to the SUD population not otherwise covered by Medicaid by using State dollars and Federal Block Grants. These services may include, but are not limited to: childcare, transportation, outreach services and pre-authorized incentives.

Only one of ten counties in the GCBH catchment area collects additional taxes for SUD services. In that county the funds are used to support its Drug Court.

Emerging SUD Challenges. GCBH will address SUD challenges such as new trends in opiate, methamphetamine or marijuana use and treatment using the following strategies:

- Review available epidemiological data to identify emerging SUD trends;
- Collaborate with the Substance Use Prevention Coalitions in the catchment area that work in the highest needs communities and provide SUD education and prevention services and activities to youth and their families in an effort to reduce risk factors that negatively impact their families and communities;
- Continue working with the local community hospitals and their Consistent Care Teams in an effort to increase intervention strategies such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) for those consumers who present in hospital settings and reduce high utilization of emergency departments due to SUD disorders by making referrals to appropriate SUD providers;
- Support the provision of Public Service Announcements regarding SUD services, holding public forums, and using the GCBH website to provide information to local consumers and their families;
- Hold public forums and use the GCBH website to provide information to local consumers and their families;
- Work closely with the juvenile and adult justice system in an effort to identify strategies for diversion from the justice system and into treatment;
- Train and provide technical assistance staff to stakeholders and provider staff as needed or required; and
- Review the evidence-based and promising practices identified by the state and SAMHSA and incentivize the prevention and intervention practices best suited to address these trends.

Voluntary and Involuntary SUD Treatment

There are several aspects to voluntary and involuntary SUD treatment that GCBH will address as it assumes responsibility for these services.

(23) Review of admission and inpatient treatment of minors – determination of medical necessity – department review – minor declines necessary treatment – at-risk youth petition – costs – public funds

GCBH will develop and implement the following policy and procedure by April 1, 2016:

- Once the minor has been admitted under RCW 70.96A.245, authorization staff will review and determine the medical necessity for involuntary inpatient services within one business day of admission.
- If it is determined that a lesser level of care is appropriate, the appropriate authorization staff will collaborate with the appropriate provider agency in assisting the enrollee/consumer in transitioning to the lower level of care.

(25) Voluntary treatment of individuals with a substance use disorder

GCBH will conduct site visits per contract requirements on all its SUD contractors within the GCBH catchment area. By contract, the contractor agrees to cooperate with GCBH in the evaluation of the contractor's performance, and to make available all information reasonably required by any such evaluation process.

(26) Treatment program and facilities – admissions – peace officer duties – protective custody

GCBH will develop and maintain a provider network that includes approved substance use disorder treatment facilities capable of accepting persons incapacitated or gravely disabled by alcohol or other drugs and who are in a public place or who have threatened, attempted, or inflicted physical harm on themselves or another, and have been taken into protective custody by a peace officer or staff designated by the county. Furthermore, GCBH will ensure that providers contracted to accept individuals taken into protective custody are aware of and have policies and procedures in place that meet the requirements of RCW.96A.120 (3), (4), (5), (6) and (8), pertaining to provision of assessment, treatment, and information and referral services as relevant to an individual's circumstances.

Compliance will be monitored per contract requirements or more frequently if indicated by complaints or critical incidents.

(27) Involuntary commitment

GCBH, in coordination with each county authority, will designate one agency that will provide access to a Chemical Dependency Specialist (CDS) and will be responsible for investigating SUD ITA as it relates to RCW 70.96A.140. The CDS will investigate and evaluate alleged facts and information in order to determine if a case exists for possible involuntary commitment. The CDS will interview the individual, gather more information, and give the individual an opportunity to

go to treatment on a voluntary basis. Upon completion of the interview, the CDS may assist the person in accessing voluntary treatment or process the case for a hearing in civil commitment court. If a court hearing is necessary, evidence will be examined, testimony will be heard from witnesses, and the individual will have an opportunity to address the court. If the court determines that grounds for involuntary commitment have been established by clear, cogent, and convincing proof, an order of commitment will be issued committing the individual to an approved treatment program.

GCBH will assure that the agency designated to investigate CD ITAs has working agreements with:

- Local Emergency Departments to provide primary care if needed
- Law Enforcement to assist when needed;
- Transportation agency that can securely transport detained individuals to and from Court hearings and treatment facilities;
- Pioneer Center East to provide secure residential treatment services;
- Outpatient agencies to provide aftercare services; and
- Oxford Houses to provide secure housing once released from residential services.

(29) Evaluation by designated chemical dependency specialist - when required - required notifications

GCBH will develop policies and procedures and contract language for SUD providers that provide the information and authority to require compliance with the provisions of RCW 70.96A.142 as indicated below.

(1) When a designated chemical dependency specialist is notified by a jail that a defendant or offender who was subject to a discharge review under RCW 71.05.232 is to be released to the community, the designated chemical dependency specialist shall evaluate the person within seventy-two hours of release, if the person's treatment information indicates that he/she may need chemical dependency treatment.

(2) When an offender is under court-ordered treatment in the community and the supervision of the department of corrections, and the treatment provider becomes aware that the person is in violation of the terms of the court order, the treatment provider shall notify the designated chemical dependency specialist of the violation and request an evaluation for purposes of revocation of the conditional release.

(3) When a designated chemical dependency specialist becomes aware that an offender who is under court-ordered treatment in the community and the supervision of the department of corrections is in violation of a treatment order or a condition of

supervision that relates to public safety, or the designated chemical dependency specialist detains a person under this chapter, the designated chemical dependency specialist shall notify the person's treatment provider and the department of corrections.

(4) When an offender who is confined in a state correctional facility or is under supervision of the department of corrections in the community is subject to a petition for involuntary treatment under this chapter, the petitioner shall notify the department of corrections and the department of corrections shall provide documentation of its risk assessment or other concerns to the petitioner and the court if the department of corrections classified the offender as a high risk or high needs offender.

(5) Nothing in this section creates a duty on any treatment provider or designated chemical dependency specialist to provide offender supervision.

Designated providers will be expected to have agreements in place with relevant entities. Compliance will be monitored, per contract requirement, unless a greater frequency is indicated by complaints or critical incidents.

(48) Criminal justice treatment account

GCBH will use the panels of key leaders from the local criminal justice system as designated by RCW 70.96A.350 to plan for and assure that the treatment needs for its offenders are being met. Currently, every agency with a county contract has the ability to serve CJTA individuals, including those involved with Drug Court. GCBH will meet with the Drug Court Coordinators on a regular basis to determine if the same strategy needs to continue and or to determine if the number of providers that serve Drug Court clients needs to be reduced.

The CJTA funds will be used to continue providing SUD services, primarily to individuals involved with the Drug Court Program services for nonviolent adult, DUI misdemeanor and felony drug and property offenders. The CJTA funds will also be used to provide services to non-Medicaid individuals who meet the CJTA criteria. In addition, a portion of the CJTA Innovative funds will be set aside to develop and implement evidence-based "brief intervention" programs for offenders who are incarcerated due to non-compliance to their treatment needs, and to assess and prepare incarcerated individuals who are in need of SUD services.

GCBH's goal is to maximize the CJTA funds to reduce involvement with the criminal justice system by:

- Promoting cross-system awareness of unmet behavioral health needs and their impact on local criminal justice systems;

- Incentivizing greater collaboration between behavioral health agencies and the local Drug Court (e.g., create memorandums of understanding or rules to increase communication about shared clients);
- Encouraging outreach by behavioral health agencies and engagement with persons with criminal justice involvement and behavioral health needs;
- Encouraging behavioral health agencies to assist eligible adults involved in the criminal justice system to enroll into Medicaid and other available health care plans; and
- Incentivizing behavioral health agencies that use effective EBPs.

Discharge Planning for Persons under Involuntary Commitment

(124) Involuntary commitment – Individualized discharge plan (Effective July 1, 2018)

Below is a description of the current discharge planning process used by GCBH which meets the requirement for transitioning to the process which will be effective July 1, 2018.

- Inpatient and community care coordination promotes rapid and successful reintegration of consumers to the community from hospital.
- Greater Columbia delegates, through the contracted provider network, the responsibility of providing this care coordination.
- The contracted providers contact the inpatient staff within three days of the admission to begin the treatment planning and discharge planning process. This assures appropriate and timely discharge of all individuals regardless of diagnosis and legal status. This coordination with inpatient staff allows all parties to develop appropriate community placements and treatment service plans.
- GCBH's authorization staff, who authorize the initial admission and any/all concurrent reviews, discuss the treatment planning and discharge planning taking place to ensure that it continues for the duration of the inpatient stay. Recommendations for after-care are sometimes made by authorization staff and/or in conjunction with the GCBH Medical Director's suggestions.
- Periodic doctor-to-doctor reviews will occur to ensure that all medical and psychiatric issues are part of the treatment plan and discharge planning activities.
- The contracting entities provide, at a minimum, one follow-up service within seven days of the individual's discharge from inpatient care.
- The timelines discussed in this section are reviewed during the clinical audits that each of the contracted providers has during the contract period.
- Because of the providers' ongoing participation in treatment and discharge planning from admission to discharge and through the continued stay reviews conducted by GCBH authorization personnel, individualized discharge plans are developed and ready for implementation on the day of discharge. This is all accomplished well within the 21 days required in RCW 71.05.365.

Court-ordered Treatment for Minors

(231) Petition for one hundred eighty-day commitment – hearing – requirements – findings by court – commitment order – release – successive commitments

GCBH uses the following procedures to coordinate with the Children's Long-term Inpatient Treatment Committee (CLIP):

- The Authorization Center staff and Children's Care Coordinator at GCBH discuss with the hospital appropriate, less restrictive options to CLIP, including WISe.
- The hospital or Evaluation and Treatment facility contacts the CLIP Administration to have the youth placed on the wait list for a bed at a CLIP facility. The hospital provides the CLIP Administration with a referral packet.
- The CLIP Administrator schedules a Pre-Admit meeting to take place prior to the admission of the youth to the CLIP facility. The GCBH Children's Care Coordinator participates in this meeting and arranges for relevant outpatient mental health providers to participate, as well.
- For voluntary referrals to CLIP - GCBH has formed a GCBH CLIP Steering Committee. The GCBH Committee's purpose is to review voluntary applications submitted requesting CLIP, approve or disapprove the request and provide feedback to applicants about other less restrictive options, not already attempted or considered, if appropriate.
- When it is determined all other efforts to keep the child in the community have been exhausted, a CLIP referral will then be made to the State CLIP Committee. The CLIP Administration will then start their review process. If the CLIP application is denied by the GCBH Committee, the referring party may re-submit the application with additional information and/or new perspectives. The GCBH Committee will request input from an independent Child Mental Health Specialist. If the application is denied a second time, the referring party may utilize the GCBH Grievance Process.

(234) Minor's failure to adhere to outpatient conditions – deterioration of minor's functioning – transport to inpatient facility – order of apprehension and detention – revocation of alternative treatment or conditional release – hearings

GCBH uses and/or delegates the following procedures to coordinate, assess and monitor intensive community services and coordinate with inpatient/residential resources:

- GCBH assigns responsibility for carrying out processes associated with detaining individuals for involuntary treatment to the contracted network providers and authorizes its providers to designate employees with specific responsibility for making the decision to detain individuals for involuntary treatment. These are the Designated Mental Health Professionals (DMHPs).
- Provider agencies and DMHPs work with GCBH Care Coordinators to oversee/provide monitoring for all GCBH consumers discharged from inpatient

psychiatric units on Conditional Release (CR) or Least Restrictive Alternative court order (LRA). This includes:

- Keeping a master list of all consumers on either a CR or LRA;
- Providing a copy of clients' rights; and
- Monitoring their progress in accordance with the conditions of the court order.

- A consumer's CR or LRA may be revoked for non-compliance with the conditions of their order. This may result in the DMHP ordering the consumer back into the hospital for treatment.

Transfer between BHOs

(187) Behavioral health organizations – transfers between organizations

Current provider contracts include a Transfer Protocol (Attachment 4) which GCBH intends to expand on to include SUD clients. GCBH foresees the use of this Protocol with all future BHOs and any integrated system.

4

Communications and Stakeholder Plan

This section of the plan describes GCBH's activities to prepare its stakeholders for the impending transition. The stakeholders include: consumers, providers, Advisory Board members, staff and other stakeholders.

GCBH began meeting with stakeholders impacted by the impending transition from an RSN to a BHO beginning in the fall of 2014. GCBH has every intention of making the transition as seamless as possible for enrollees/consumers. A critical link between GCBH and the enrollees/consumers is the provider network. While there is very little change expected in the mental health network, the SUD service system will experience a significant transition.

Early in 2015, GCBH invited SUD providers from across the region to become part of a steering group to address the impending transition. This forum was intended to create, and has resulted in, a mechanism for bidirectional exchange of information and preparation between GCBH and the SUD provider network. GCBH is learning about the dynamics and operational intricacies of SUD services, and the region's SUD providers are learning about the expectations and obligations of providing services in the GCBH network.

(151) Legislative intent and policy

GCBH involves people with lived experience, family members and advocates in designing and implementing behavioral health services in numerous ways, such as:

- Membership and participation in GCBH Regional Advisory Board (RAB).
- Currently GCBH has a highly active Regional Advisory Board (RAB) whose membership is comprised of at least 51% mental health consumers. The RAB has an ad-hoc member on the Board of Directors and a RAB representative is on every other subcommittee of GCBH. The RAB reviews all GCBH policies and makes recommendations to the Board of Directors. The RAB is also the stakeholder group for both of the PACT teams who report to them monthly. In 2016 the role and membership of the RAB will be expanded to include SUD activities and SUD client membership.
- Membership and participation in GCBH Committees: Quality Management Oversight Committee (QMOC), Multicultural Cultural Competency Committee (MC3), Clinical Directors' Committee, Children's Committee, Chemical Dependency/Mental Health Integration.
- Trainings and presentations provided by GCBH Customer Service, GCBH Ombuds Service and Quality Review Team staff.

- Quality Review Team surveys provided to individuals and/or family members receiving behavioral health services, agency staff, and allied providers.
- GCBH staff provides and hosts trainings to GCBH's current provider network and to consumers, family members and the general public. In 2016 trainings will be expanded to include future SUD provider staff and SUD clients.
- Currently GCBH contracts with Mental Health Ombuds, Inc. to provide mental health ombudsman and Quality Review Team (QRT) services. The Ombuds service staff and QRT staff also provide trainings to GCBH's current provider network and to consumers, family members and the general public. In 2016 trainings will be expanded to include future SUD provider staff and SUD clients.
- The Ombuds reports monthly to the RAB and quarterly to the Quality Oversight Management Oversight Committee (QMOC). Should issues/concerns arise, recommendations are presented to the Board of Directors (BOD). In 2016 these reports will be expanded to include SUD data.
- The QRT provides and collects data on satisfaction surveys from consumers, agency staff and allied provider agency staff. Annual reports are presented to the RAB and the QMOC, and should issues/concerns arise, recommendations are presented to the BOD. In 2016 these reports will be expanded to include SUD data.
- Currently GCBH has a Children's Committee that meets quarterly and has representation by GCBH staff, consumers, family members and allied providers. In 2016 this committee will expand to include SUD clients, family members and providers.

(47) Counties may create alcoholism and other drug addiction board – generally

GCBH currently has and will maintain an Advisory Board that is broadly representative of the demographic character of the region. While the current Advisory Board is representing mental health, the bylaws and membership will be revised to incorporate SUD stakeholders. GCBH plans to integrate SUD representatives from existing County SUD Advisory Boards or other interested parties through invitations. Per the requirements, 51% of the membership will be persons with lived experience, parents or legal guardians of persons with lived experience as a person in recovery from a behavioral health disorder. The current GCBH Advisory Board has a law enforcement representative which will continue with the integration of SUD. GCBH will recruit County representation, with no more than four elected officials. Per current bylaws, members serve three-year terms that are renewable. No person on the Board who is an employee of a subcontracted agency shall have authority to make decisions on behalf of the subcontractor. Appointed members are provided mileage reimbursement and an honorarium.

(245) Information requirements – Enrollee/consumers

GCBH will continue to educate its SUD provider network on the impending changes and the benefits and rights enrollees/consumers have as service recipients. Furthermore, GCBH will

actively educate its enrollees/consumers and stakeholders on how to access SUD services which are under its purview. There will be a multimodal approach to this information and education adapted to the various audiences who are impacted by the changes. For example, providers and other stakeholders will primarily receive written communication via electronic means and presentations by GCBH staff at key meetings. Once DSHS/HCA posts a revised Enrollee/Consumer Handbook, GCBH and its provider network will access the handbook and make it available to its enrollees/consumers. In addition to DSHS/HCA-provided information, enrollees/consumers will be informed in a more individualized mode depending upon their capacity to receive and process information at key points of interface with the behavioral health system in the region. Providers will be expected to provide relevant information to service recipients at their respective points of service. If the enrollee/consumer is unable to read the written material or requires information presented in their native language, GCBH will have a contractual expectation that providers deliver the information in a fashion understandable to the individual. Information will be available to all stakeholders on the GCBH website.

5

Network Analysis and Development Plan

GCBH currently has approximately 240,000 Medicaid enrollee/consumers in its 10-county Regional Service Area. It is anticipated that there will be a penetration rate of approximately 10% of total enrollees/consumers who will receive mental health services, which is approximately 24,000 unique individuals annually. For SUD services, GCBH expects to serve approximately 5300 individuals in the OP system and another 1,200 receiving SUD residential services for a total of 6,500, as well as about 1,000 through the detox system, for a total SUD penetration rate of approximately 3.1%. Based on these assumptions, GCBH believes the current and planned provider networks can adequately meet the needs of its enrollees/consumers. While the overall transition was described previously in Section 3, this section will provide a more specific analysis of the network and plans for how it will be developed and managed.

Mental Health

GCBH's analysis of the mental health provider network meets the adequacy standards required by the DSHS contracts. In many ways, the mental health network will not be immediately impacted by the integration of SUD services into GCBH. However, mental health providers will see increased emphasis and expectations on the integration of behavioral health and primary care.

Substance Use Disorder

GCBH's preliminary analysis of the SUD provider network is that, assuming all invited providers will join the network, it is adequate to meet the current needs of the population requiring SUD services. The SUD provider network will undergo significant change as it moves from a County-run fee-for-service system to one managed by a BHO.

(273) Delivery network

GCBH has completed an initial analysis of the mental health and SUD networks and believes them to be adequate to meet the immediate demands for service utilization. In preparation for the April 1, 2016 integration between Mental Health and Substance Use Disorders, GCBH has already created a subcommittee of the Board of Directors which meets monthly and is called the Mental Health/Chemical Dependency Integration Committee. It is charged with gathering and processing information from current and projected providers, allied community partners, consumers and concerned citizens, and passing on recommendations to the full GCBH Board of Directors for action.

GCBH has also formed a committee of all current and projected SUD providers which also meets monthly at the GCBH administration office. It is used to process the myriad of issues related to the pending merger and makes recommendations to the Mental Health/Chemical Dependency Integration Committee. It is also the front line for exchanging information between the current Mental Health and Substance Use Disorder systems. GCBH staff are currently completing a cost analysis and gaps analysis of all current SUD providers, as well as geo-mapping for contractually required time and distance standards for the integrated system. GCBH has already hired a SUD manager who is currently working with these committees on the issues mentioned above. GCBH has the Board of Directors' approval for additional staff that will be hired beginning November 2015 and will be fully trained and ready prior to the April 1 implementation date.

GCBH is currently completing a cost analysis, geo-mapping, and network sufficiency assessments of the current SUD service delivery system. It is expected that these processes will be complete by early January 2016 in readiness for signing BHO contracts. Once completed and funding for the new capitation SUD system is known, GCBH will complete its contract arrangements with SUD service providers in time for the April 1 implementation date. Ongoing monitoring and analysis will occur to ensure an adequate network that meets the requirements of the DSHS contracts and, more importantly, meets the needs and expectations of the enrollees/consumers. A list of all existing and planned contracted providers is included below (under item 287).

Current GCBH provider contracts include the following requirements (including requirements to address language and cultural considerations) and these will be incorporated in the contracts for SUD providers beginning April 1, 2016:

- Intakes must be offered within 10 business days of request.
- Routine service appointment must be offered within 14 calendar days of intake.
- The time period from request for service to first routine service appointment offered must not exceed 28 calendar days.
- Providers must participate in GCBH approved Performance Improvement Plans (PIPs) and comply with GCBH recommendations for improvement.
- Providers must participate in Encounter Data Validation (EDV) audits. If the provider fails to meet performance expectations, Corrective Action may be initiated. If the provider fails to complete corrective action and meet improvement rates, GCBH may take Remedial Actions.
- Providers must participate in GCBH Regional Performance Measures. GCBH may request the provider to provide an explanation for performance measures that do not meet the Annual Performance Targets. If the explanation is not received or is determined to be

inadequate, the provider must submit a Corrective Action Plan and may be subject to Remedial Action.

- Providers must adopt and implement GCBH approved Practice Guidelines.
- GCBH may conduct announced and unannounced reviews regarding the quality, appropriateness and timeliness of services provided.
- Providers must provide information on available treatment options and alternatives in a manner appropriate to the enrollee/consumer's ability to understand.
- Providers must provide interpreter services for enrollees/consumers who speak a primary language other than English for all interactions between the enrollees/consumers and the provider.
- Providers must ensure that they have an effective mechanism to communicate with enrollees/consumers with sensory impairments.
- Providers must post multilingual notices and a copy of Consumer Rights in English and in each of the DSHS prevalent languages.
- Providers must provide age, linguistic and culturally competent community services to enrollees/consumers.
- Providers must provide all information to enrollees/consumers regarding MH treatment options including alternative or self-administered treatment in a culturally-competent manner.
- Providers must participate in and cooperate with DSHS efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

In addition to prioritizing services to the pregnant, postpartum and/or parenting women (PPW), every SUD agency within the provider network will have the ability to provide services to individuals involved with the criminal justice system, including those identified and targeted to receive services through the Criminal Justice Treatment Account (CJTA). Agencies shall have Memorandums of Understanding with local Superior Courts, Probation Department, Department of Corrections, and local Drug Courts.

PPW treatment needs will be a priority, in part because of the danger that women's substance abuse poses to children they are carrying or caring for. Agencies within the provider network will be contractually required to prioritize services to pregnant and parenting women. Treatment services for this population include the provision of a continuum of care that includes medical and mental health services at the treatment site, residential treatment options that allow women to be accompanied by their children, and availability of gender specific treatment groups. Treatment services for this population also include: information, education, and group therapy that address the high prevalence of sexual abuse and domestic violence, and the resulting trauma, in the lives of chemically dependent women.

Documentation of the sufficiency of the provider network is described below.

(279) Documentation of adequate capacity and services

GCBH monitors the adequacy of its network in a variety of ways, described below, using data from reports, regular on-site monitoring, grievance tracking and follow up, consumer surveys, consumer and family voice, and geo-mapping.

- A key measure of adequacy used by GCBH includes reports on timeliness of:
  - Appointments made seven (7) days after discharge from inpatient
  - Intakes completed within timeframes
  - First routine appointment from intake made within timeframes
  - Authorizations made within timeframes
  - Reports on out-of-network utilization are also used as a measure of network adequacy
- Provider credentialing records allow GCBH to access the number and qualifications of existing provider staff to meet the needs of enrollees/consumers in terms of race/ethnicity, languages spoken, and specific expertise in treatment modalities such as evidence-based practices.
- GCBH relies on its on-site monitoring to validate reports and to observe service settings and practices experienced by its enrollees/consumers.
- By tracking and following up on grievances, and input from consumer surveys as well as consumer and family voice, GCBH is able to identify potential inadequacies in the network and follow up with increased monitoring and interventions that may be necessary.
- Geo-mapping of enrollee/consumer zip codes to service locations allows GCBH to track the geographic distribution of services as a measure of time and distance standards.

GCBH is able and willing to work with DBHR on developing a format, prior to April 2016, that demonstrates the sufficiency of the mental health and SUD networks.

(287) Contracts with providers

Currently most MH providers are required by contract to provide all modalities, and if they are unable to provide a covered service to an enrollee/consumer with an identified need, the provider must purchase the service within 28 calendar days and continue to pay for the medically necessary MH service until they are able to provide the service. There are a few agencies that provide specific services. For example, Benton Franklin Crisis Response Unit only provides crisis services in Benton and Franklin counties. GCBH will ensure all SUD modalities are provided per contract requirements. GCBH plans to contract with all SUD providers who

currently have a contract with the Counties in the service area. This will ensure minimal disruption to enrollees/consumers who are currently receiving services.

Provider(s) by County	Mental Health Services	SUD Services
ASOTIN		
Quality Behavioral Health	X	X
BENTON		
Benton Franklin Crisis Response Unit	X	X
First Step Community Counseling Services		X
Ideal Balance		X
Lourdes Counseling Center	X	X
Somerset Counseling Center		X
Lutheran Community Services	X	
Catholic Family and Child Services	X	
Nueva (Tri-City Community Health)	X	X
COLUMBIA		
Blue Mountain Counseling Center	X	X
FRANKLIN		
Catholic Family and Child Services	X	
Nueva (Tri-City Community Health)	X	X
Comprehensive Dependency Health Services	X	X
GARFIELD		
Quality Behavioral Health	X	X
KITTITAS		
Central Washington Comprehensive Mental Health (CWCMH)	X	
Alcohol Drug Dependency Service (operated by CWCMH)		X

Provider(s) by County	Mental Health Services	SUD Services
KLICKITAT		
CWCMH	X	X
WALLA WALLA		
CWCMH	X	
Serenity Point Counseling		X
WHITMAN		
Palouse River Counseling	X	X
YAKIMA		
CWCMH	X	
Dependency Health Services (operated by CWCMH)		X
Ideal Balance		X
Merit Resources		X
Sundown M Ranch		X
Triumph Treatment Services		X
Yakima Valley Farm Workers	X	X
PATHWAYS (operated by CWCMH)		X
Triumph – Casita (operated by Triumph)		X
Triumph – Inspirations (operated by Triumph)		X
James Oldham Treatment Center (operated by Triumph)		X
Catholic Family and Child Services	X	
Riel House (operated by Triumph)		X

(275) Out-of-network services

Out-of-network services are provided according to Policy CL314, which will be updated to apply to SUD services prior to April 2016. The policy addresses the situation when the GCBH delivery network is unable to provide medically necessary covered services to an enrollee/consumer within the required timeframes. Out-of-network services are provided at no cost to the enrollee/consumer until they become available within the network. According to CL314:

- All requests for out-of-network referrals are processed by the GCBH Care Coordinators. These requests may be made by enrollees/consumers (or legal guardians) or through a network provider.

- Before a referral for out-of-network outpatient services can be made, the following must occur:
  - An Intake done by a network provider;
  - A service authorization confirming Medicaid eligibility and medical necessity for a level of care; and
  - The development of a treatment plan identifying the goals necessitating a specific out-of-network service.
- Requests for out-of-network services are processed within 14 calendar days.
- The decision to request an out-of-network service is reached via a collaborative process involving the network provider responsible for the enrollee/consumer's treatment plan, the GCBH director, the medical director, and the care coordinators.
- Out-of-network care is provided only when it has been mutually determined by all parties that the requested service is essential to the enrollee/consumer's treatment plan and that there are no resources within the delivery network which will adequately address the enrollee/consumer's needs.
- The network provider responsible for the treatment plan of an enrollee/consumer requiring out-of-network services, or the GCBH Member Government, is responsible for covering any costs associated with such services.
- When an out-of-network service is authorized or reauthorized, a copy of the Notice of Determination is provided to the referring network provider, the out-of-network provider, and the Care Coordinators. When such a service is denied, a copy of the Notice of Action is provided to the network providers and the GCBH Care Coordinators.
- All documentation regarding out-of-network referrals and the disposition of these referrals are kept by the GCBH Care Coordinators.

Tracking of out-of-network services is another mechanism by which GCBH monitors the adequacy of its provider network.

(50) Opiate substitution treatment – declaration of regulation by state

Medication assisted therapies are offered by Ideal Options in Yakima, Benton, Franklin, and soon in Walla Walla counties. In addition, Comprehensive Mental Health offers a Methadone Maintenance therapy in Yakima County. Also, Contracted Agencies will participate in Consistent Care, when appropriate, and have access to EDIE (Emergency Department Information Exchange) in order to help manage the growing problem of prescription drug abuse. Consistent Care is a multi-disciplinary, community-supported team that addresses over-use of the Emergency Department. This team is made up of local doctors, nurses and social workers who have direct contact with local opiate users frequenting the emergency department. They work to intervene and connect users with local CD agencies and services.

As for individuals in need of withdrawal management (WM), this catchment area has one ASAM level 3.2 WM facility. It is anticipated that an additional facility will be in operation on or shortly after April 1, 2016. Individuals in need of medication assisted treatment while in a withdrawal management facility are transported to the local primary care facility. Once stabilized, the individuals are transported back to the WM facility where arraignments will be made for either outpatient or residential SUD services. If an individual with a moderate to severe opioid use disorder is interested in long-term medication assisted treatment, they are referred to the outpatient treatment program at Central Washington Comprehensive Mental Health or Ideal Balance.

(174) Behavioral health organizations – agreements with city and county jails

Line Item: #174

GCBH currently delegates jail services and the requirement to develop MOUs with the criminal justice system to the network providers. In 2016, this process will continue. Should the State require BHOs to also have MOUs with the Jails, GCBH will collaborate and make every effort to fulfill this requirement.

Current provider contracts have language regarding the provision of jail services (a separate proviso in contracts with DSHS) that also requires MOUs with all Community Services Offices (CSOs), the Department of Corrections (DOC) and jails. The provider network has established close working relationships with CSOs, the DOC, and jails in their respective counties and currently have established MOUs with each.

See Attachment 5 for a sample of current Jail MOUs.

(158) Children's mental health services – children's access to care standards and benefit package

GCBH began delivering WISe services in July 2014. As of September 2015, GCBH is serving approximately 160 youth and families in 9 out of 10 counties in the Region Service Area. GCBH is steadily adding youth and families to its WISe programs and has set a goal to serve 250 by October 2016.

In an effort to meet the WISe monthly capacity goal, GCBH is engaging child-serving systems, such as agencies that fall under the auspice of the DSHS (i.e., Children's Administration, Juvenile Justice and Rehabilitation, Development Disabilities Administration), as well as school personnel, county and community providers, and tribal service providers, and informing and planning for their assistance in the identification and referral of youth who might benefit from WISe. Considerations for referral to WISe may include, but are not limited to:

- Youth with involvement in multiple child-serving systems (e.g., child welfare, mental health, juvenile justice, developmental disabilities, special education, substance use disorder treatment).
- Youth for whom restrictive services such as psychiatric hospitalizations, residential placement or foster care placement due to mental/behavioral health challenges have been requested.
- Youth at risk of school failure and/or who have experienced significant and repeated disciplinary issues at school due to mental/behavioral health challenges.
- Youth who have been significantly impacted by childhood or adolescent trauma.
- Youth prescribed multiple or high dosages of psychotropic medications for mental/behavioral health challenges.
- Youth with a history of detentions, arrests, or other referrals to law enforcement due to behaviors that result from mental/behavioral health challenges.
- Youth exhibiting risk factors such as suicidal ideation, danger to self or others, behaviors due to mental/behavioral health challenges.
- Youth whose mental/behavioral health challenges have resulted in parents'/caregivers', siblings', or other family members' significant emotional stress and/or disruption in employment.

6

Staffing and Workforce Analysis and Development Plan

Training

All GCBH staff and provider staff are required to receive training in numerous topical areas important to managing social and clinical services for vulnerable citizens. These topics include:

1. *Grievance, Appeals and Fair Hearing (provided by GCBH Consumer Advocate)*
2. *Consumer Rights (provided by GCBH Consumer Advocate)*
3. *Recovery & Resiliency (provided by GCBH Consumer Advocate)*
4. *Stigma Reduction (provided by GCBH Consumer Advocate)*
5. *Advocacy (provided by GCBH Consumer Advocate)*
6. *Peer Counseling (provided by GCBH Consumer Advocate)*
7. *Cultural Competency Training (provided by the Multi Cultural Competence Committee)*
8. *Substance Use Disorder Training*
    i. *Use of GCBH Provider Portal*
    ii. *Authorization requests*
9. *ASAM Training (provided for current and future providers on October 29 & 30, 2015)*
10. *WISe Training*
11. *PRISM Training*
12. *HIPAA Training*
13. *Local Crisis Intervention Team Training provided to local law enforcement and open to provider network staff*
14. *DMHP Safety Training*

Personnel

GCBH began preparing for the transition of SUD services into managed care by hiring a CDP in July 2015. The Governing Board has approved additional positions that will be filled between September 2015 and April 2016. In addition, all authorization and care management staff have attended the comprehensive two day ASAM training mentioned above. An organizational chart with the staffing planned for GCBH in preparing for 2016 is included as Attachment 6.

Ombuds

(175) Mental health Ombuds office

GCBH plans to provide behavioral health Ombuds services meeting the needs of those accessing both the mental health and substance use disorder treatment services. Currently, GCBH contracts with Mental Health Ombuds, Inc. to provide mental health Ombuds and Quality

Review Team (QRT) services. In 2016, their role will expand to include SUD Ombuds and QRT services. GCBH will work with Mental Health Ombuds, Inc. to develop marketing and training materials and provide training to SUD providers prior to April 2016. GCBH currently employs a Consumer Advocate/Grievance and Appeals Coordinator who is the liaison to the Ombuds/QRT staff. This position is responsible for the provision of consumer advocacy, technical assistance to the Ombuds/QRT staff, and training and presentations to consumers, provider agency staff and the general public. Per contract, the Ombuds staff is required to notify the Consumer Advocate/Grievance and Appeals Coordinator of all grievances in which Ombuds staff are assisting. Additionally, they are responsible for keeping the Consumer Advocate/Grievance and Appeals Coordinator informed of the progress towards resolution. The Ombuds/QRT staff is required to report monthly, or as requested, to the Regional Advisory Board and Quality Management Oversight Committee. Should any concerns be raised upon review of these reports, recommendations are made by these Committees to the Board of Directors for action. The Ombuds/QRT reports are also reviewed for trends and included in the GCBH Annual Quality Management Report.

7

Financial and Administrative Plan

GCBH has successfully managed mental health care for its enrollees/consumers for over 20 years. GCBH has well-established managed care functions including, provider contracting and monitoring, utilization management, quality management, grievance systems, financial management, and MIS supports. It is well on its way to becoming a BHO that manages both MH and SUD services. GCBH is operating under a new interlocal joint agreement and has begun hiring the additional staff needed to operate under the new 2016 DSHS contracts. The GCBH management team has developed and implemented action plans to prepare to meet all the requirements necessary to comply and perform under the DSHS 2016 contract.

A high level timeline for key activity areas is provided below:

Activity	Anticipated Completion
Policy and Procedures Development	February 1, 2016
Staffing	February 1, 2016
Training for internal staff	March 1, 2016
Training for providers and external stakeholders	March 1, 2016
Contract Execution	March 1, 2016
MIS modifications and user training	March 1, 2016

(3) Behavioral health organizations – contracting process.

GCBH will provide all the required services and meet its deliverables under the terms of the GCBH/DSHS contracts. GCBH has historically funded its provider network through performance-based contracts. For example, using a capitated formula, each provider is funded based on the number of eligible enrollees/consumers in their catchment area. Outpatient providers bear the risk for all costs of inpatient care, therefore, they are incentivized to provide an appropriate level of care in the community to avoid any unnecessary inpatient stays. The impact has been a lower number of inpatient days resulting in a larger portion of funding available for outpatient services. This approach to performance-based contracting incentivizes providers to use the least restrictive alternatives to inpatient care by providing high quality care in community-based settings.

Current contract language in DSHS contracts related to coordination of care and referrals to primary care are passed through to the GCBH/Provider contracts that require that providers identify any medical issues and develop strategies to include in the individualized plan of care. If the enrollee/consumer has no identified primary care practitioner (PCP), an expectation is to assist them in finding one and to encourage the execution of a Release of Information. Additionally, agreements currently exist between GCBH and Medicaid managed care organizations (MCOs) for care coordination. With the integration of SUD services and providers into the GCBH network, the contractual requirement used in the mental health system will be extended to these providers, and agreements with MCOs will be amended to include SUD services. This will occur by April 1, 2016.

GCBH has recruited a Chemical Dependency Professional, who is a former county administrator of SUD contracts, to support its management team in identifying and addressing the integration of these benefits under the new scope of work in the GCBH/DSHS contracts. The SUD provider network available in the 10-county region has been assessed, and contracting has begun to keep the existing network in place during the transition of SUD services into managed care. In order to avoid disruption and smooth the transition, GCBH will initially minimize significant changes in expectations. However, as soon as the transition has stabilized in 2016, an increased focus on improvements in processes and outcomes, including incentives, will be implemented.

GCBH is working to enhance its value-based purchasing (VBP) strategies beginning in the 2016 contract year with planning and involvement of providers, consumers and other stakeholders. Implementation of new strategies will occur in 2017. Although capitation has strong financial incentives, looking to the future, GCBH will use VBP as a way to improve quality, improve outcomes, and reduce cost from a more holistic perspective. It is well documented that people with serious mental illness die twenty-five (25) years younger than the general population. Eighty seven percent (87%) of years lost are due to medical illness, especially infectious, pulmonary and cardiovascular diseases and diabetes. In the state of Washington, studies have found up to 40% of Medicaid beneficiaries have SUD diagnoses. GCBH will use incentives that comply with state and federal regulations to effectively shape provider behavior in the desired direction, and create a positive experience for enrollee/consumer.

GCBH looks extensively at how the system can work to improve the overall health of the individuals it serves. So the VBP strategies will include incentives for integrated treatment plans, tobacco cessation, screening/monitoring for diabetes and prevention strategies for tuberculosis and diseases associated with metabolic syndromes. In addition, VBP will be used to focus on specific behavioral health related outcomes that have been identified as high priority through the DSHS contract and/or regional performance measures.

GCBH is aware that different providers have different operational capabilities, membership volume and services capacity. All of these factors play an important role in the type of VBP contracting that will work for the provider. Therefore, the GCBH cannot identify the exact strategies to be used, but rather, will propose potential strategies that will be refined and developed starting in Year 2 with input from providers and other stakeholders. GCBH will have a multi-year strategy to increase the percentage of contracts that are driven by value-based purchasing taking into consideration the approaches and issues outlined in the table below.

VBP Strategy	Brief Description	Considerations
Capitation	An actuarially sound, single per member per month payment for all services within the provider's contract.	• Provider must be able to take financial risk • Risk corridors need consideration • Assessing negative consequences such as avoiding members with higher risk or complex conditions • Outcome measures must be included with decision on whether performance bonuses are made out of the capitation • Must have volume to spread risk
Behavioral Health Accreditation	A provider group is eligible to receive additional payments with behavioral health accreditation. Accreditation can be for a behavioral health home or a behavioral health organization.	• Requires a provider meet national standards for quality of care • May consider additional requirements, such as use of GCBH practice guidelines • Can be a one-time bonus or ongoing payment enhancement
Payment for Coordination	Payments made to providers furnishing care coordination that integrate care between providers and between care systems.	• Payments may be a base for the function and a bonus for outcomes • Evaluation criteria for effectiveness of coordination must be identified, baseline data gathered and targets for change determined in advance • GCBH must work with MCOs to provide information on inpatient admissions, prescribers and other utilization data to the coordinating provider to enhance the ability to integrate systems
Pay for Performance	Providers receive differential payments for meeting or missing	• Specified outcome measures identified, baseline data gathered and performance targets determined in advance

VBP Strategy	Brief Description	Considerations
	performance benchmarks.	• Providers receive bonus payments for meeting or exceeding targets • Provider may face financial penalties for performance below targets • Providers and GCBH must be able to track progress in real time, in order for adjustments to clinical practice to occur to change outcomes
Shared Savings	Providers receive a portion of savings identified from outcomes on specific performance improvement plans.	• Similar to pay for performance, however the focus in on sharing the financial savings from a particular strategy • Focuses on a PIP that has been identified at the regional level with performance targets for quality and cost • GCBH and provider must clearly understand the design and implementation for both financial and clinical outcomes • Factors beyond the provider or GCBH control may impact the level of savings

(5) Behavioral health organizations – access to chemical dependency and mental health professionals

GCBH is committed to the integration of primary care and behavioral health care (including SUD services) for its members. Incentivizing and creating truly integrated care sites is a complex multi-year process that GCBH has begun with Managed Care Organizations (MCOs) and some of its primary care partners.

Currently, GCBH has Joint Operating Agreements (JOAs) with five MCOs contracted for Medicaid in the State, which include Amerigroup, Cenpatico Behavioral Health, Community Health Plan, Molina Healthcare and United Healthcare. These JOAs articulate the roles and responsibilities of GCBH and the MCOs to coordinate care for Medicaid enrollees. GCBH will collaborate with the MCOs to review and revise the JOAs as necessary for the inclusion of SUD treatment benefits between November 2015 and April 2016.

In addition to previous work done to integrate behavioral health services with primary care, between November 2015 and April 2016, GCBH plans to host meetings with all the MCOs in the service area and their identified primary care leadership to discuss the integrated BHO delivery system and collaboration with the MCO's physical health care systems. GCBH will use these same forums to assess the degree to which SUD services are being provided in these and other primary care settings as well as the extent to which MCOs are contracting for MH and SUD services in primary care. Based on what is learned, GCBH will strategically (and within available

resources) offer contracts to organizations that are prepared to best leverage resources and create effective integrated care settings.

Ongoing efforts to promote integration through contracts include:

- GCBH currently contracts with Yakima Valley Farm Worker's Clinic in Yakima and Tri-Cities Community Health in Pasco (two Federally Qualified Health Centers) for MH related services. It is GCBH's intent to offer a contract for SUD services to these two providers prior to April 2016 to ensure that their patients (who are receiving medical care) can seamlessly be referred for BH services within one system of care. Since both of these FQHCs already have on-site staff providing SBIRT services to persons with possible SUD issues, the additional scope of services (created by contracting with them for SUD services) will be another step towards integration.

- GCBH has encouraged its contracted provider network to develop local affiliations and relationships to improve the availability of BH services within Medical settings. Examples of this include:

    - Lourdes Counseling Center provides psychiatric services and consultations to inpatients at Kadlec Medical Center.
    - Central Washington Comprehensive Mental Health provides consultation services to Yakima Memorial Medical Center.
    - Quality Behavioral Health (Asotin and Garfield County) has coordinated with a community PCP who provides medication services (including primary care as indicated) at their MH clinic on a weekly basis. This arrangement came about as a result of QBH's participation in a community wide healthcare networking process that focuses on challenging situations.

- Blue Mountain Counseling Center (Columbia County) employs a licensed PCP to assist in medication management as well as coordinating mental health and physical healthcare in concert with the consumer's PCP.

- GCBH will be enhancing the existing system of SUD services that provide CD Specialist interventions for people being seen in community medical settings (such as Emergency departments) when issues of substance abuse are being considered. This county-based program will be transitioned to GCBH over the next five months.

Attachment 3 contains the current MCO Joint Operating Agreements and contracts for services provided in primary care settings.

(37) Payment for treatment – Financial ability of patients

RCW 70.96A.180 (Payment for treatment-financial ability of patients)

GCBH expects each contracted service provider to be responsible for administration of client charges and billings. Service providers receive non-Medicaid funding, primarily State and Federal Block Grant funds, under a capitation model. These non-Medicaid resources, by contract, are prioritized and must be used to fund the following:

1) Inpatient Hospitalization (non-Medicaid Clients)
2) Crisis Services (non-Medicaid Clients)
3) Residential Services (Medicaid and non-Medicaid Clients)
4) Outpatient Treatment (to the extent funding is available)

SUD providers, upon funding availability, may provide non-Medicaid services to the following Priority Populations:

1) Individuals who have an income level of no more than 220% of the federal poverty level;
2) Are not Medicaid eligible;
3) Are uninsured; or
4) Insured but unable to meet the co-pay or deductible for the services.

The following contract language is currently used by Counties for their SUD providers and GCBH is evaluating it for inclusion in the SUD contracts it offers:

Determine Patient Financial Eligibility: Low-income Services

1.1.1.1. The Contractor shall ensure that all persons applying for services supported by County Community Services are screened for financial eligibility and shall:

- Conduct an inquiry regarding each patient's continued financial eligibility no less than once each month.
- Document the evidence of each financial screening in individual patient records.
- Refer client to Health Plan Finder website for eligibility determination.

1.1.1.2. **Low-income**

Charging Fee Requirements – Low-income Patients

- If any service defined in this agreement is available free of charge from the Contractor to persons who have the ability to pay, the Contractor shall ensure the Counties are not charged for Fee Requirements for low-income patients.

- The Contractor shall use 220% of the Federal Poverty Guidelines to determine low-income service eligibility. The Federal Poverty Guidelines can be found by accessing the Provider page of the DSHS website at http://www.dshs.wa.gov/DBHR/.
- The Contractor shall ensure sliding fee schedules are used in determining the fees for low-income eligible services.
- The Contractor shall ensure that persons who have a gross monthly income (adjusted for family size) that does not exceed the 220% of the Federal Poverty Guidelines are eligible to receive services partially supported by funds included in this Contract.
- The Contractor shall charge fees in accordance with the Low-income Service Eligibility Table to all patients receiving assessment and treatment services that are determined through a financial screening, to meet the requirements of the Low-income Service Eligibility Table.
- If a Contractor determines that the imposition of a fee on an individual will preclude the low-income eligible patient from continuing treatment, the fee requirement may be waived by the Contractor.
- The minimum fee per counseling visit is $2.00. The maximum fee per service is the reimbursement cost of the service provided as identified on the SRP.
    - Indigent patients are exempt from this fee requirement.
    - Interim Services are exempted from this fee requirement.

Every six months, the BHO requires providers to submit a signed Revenue and Expense Report to GCBH. Included in this report is a summary of all third party revenue received by the service provider. This report provides detailed information on the amount of third party revenue collected by each service provider. GCBH performs annual fiscal audits to monitor cost allocations, revenues, expenditures and reserves in order to ensure dollars are being spent appropriately.

Please refer to Attachment 7, "Substance Abuse Disorders-Service Matrix" for a list of reimbursable SUD services.

8

Utilization Management Plan

GCBH does, and will continue to adhere to the statewide "Access to Care Standards" (ATC) that describes the minimum standards and criteria for clinical eligibility for behavioral health services in the GCBH care delivery system. Medicaid enrollees/consumers are eligible for all outpatient and residential levels of care and clinical services based on medical necessity and the ATC standards. Currently, all authorization requests are submitted to GCBH and are processed by GCBH's Mental Health Professionals. GCBH assists the service providers with assigning authorized individuals appropriate service packages, with the appropriate service intensity.

Prior to the initiation of treatment in an inpatient setting or outpatient setting, Medicaid-eligible consumers must be authorized to receive such services. Medicaid eligibility is confirmed by the service authorization Mental Health Professionals (MHPs) at GCBH at the time an authorization is requested from a network provider.

Consumers who are not Medicaid eligible must be authorized prior to admission to inpatient settings. Authorization is not required prior to the provision of outpatient services to these consumers, but services can only be provided if there is sufficient non-Medicaid funding available at the network provider.

This existing utilization management system will be modified prior to April 2016 and used for SUD services. Additional service authorization staff will be added to support the additional workload that will accompany the integration of SUD services into the GCBH system. This capacity expansion will result in the addition of a CDP or mental health professional with appropriate clinical expertise as specified in PIHP BHO contract section 5.1.8. GCBH will also add a Care Manager/Coordinator who is a licensed CDP.

The following is a more detailed description of the current utilization management system in place for mental health services. The modifications planned for SUD services will benefit from what GCBH has learned over the years while managing the mental health benefit.

Outpatient Authorizations (Current Practice):

- Persons may qualify for services under Seriously Emotionally Disturbed (SED) or Seriously Mentally Ill (SMI) determinations.
- Persons aged 18, 19 or 20 years old may qualify for services under SED or SMI determinations.

- The Level of Care recommended by the network provider is submitted to GCBH's authorization staff for review.
- Outpatient authorizations, denials and adverse change decisions are made by the GCBH MHPs based upon a determination of medical necessity.
- Assignment into an appropriate array of services is based on the individual's need(s) and specific SED criteria. The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity, and individual need.
- The individual's needs and specific SED criteria must be reflected on the individualized and mutually-developed treatment plans.
- The treatment plan must demonstrate that the selected interventions are reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.
- For transition age youth (ages 16 – 21) GCBH ensures providers have a comprehensive treatment plan that is linked across systems that identify goals, objectives, strategies, supports, and outcomes. This allows for consistent and coordinated services and supports for young people and their parents.
- The authorization period may be up to 12 months of care as determined by medical necessity and treatment goals.
- Consumers who require services beyond the initial authorization period must continue to meet medically necessity criteria. GCBH will establish continuing stay criteria that allows for movement along a continuum of care inclusive of discharge.
- All demographic and clinical information relating to the authorization of outpatient services is put into GCBH's Consumer Information System (CIS) by the MHPs at GCBH.

Inpatient Authorizations (Current Practice):

- The GCBH MHPs authorize all inpatient involuntary placement for adults and children 13 years and older, using the period of time established by Washington State Statute (20 days initially).
- The length of voluntary admissions and continued stay authorizations are based upon the individual's diagnosis and clinical needs. Any continued stay reviews that are necessary are conducted by the GCBH MHPs in collaboration with inpatient staff. Consultation with the GCBH Medical Director occurs on a weekly basis or more frequently if needed.
- Authorization for admission to inpatient level of care is based upon danger to self, grave disability, severe symptoms unresponsive or unmanageable with treatment at a lower level of care, or a co-morbid medical condition that creates the need for psychiatric treatment to be provided at this level of care. There is a verified failure of treatment at a lesser level of care, or it is determined that the individual cannot be managed at a lower level of care due to the severity of symptoms and intensity of treatment required. Also,

the individual requires round-the-clock psychiatric care and observation to maintain their safety and health.

- Authorization for stays beyond the initially-approved period may occur if new psychiatric symptoms become evident, or the individual continues to pose a danger to self, others, or property, the individual requires this level of intensive treatment to stabilize symptoms and behaviors, there is a clear treatment plan with measureable objectives and goals, and the individual is making progress toward treatment goals. GCBH MHPs make the determination on when continued stay is warranted.
- GCBH provides the initial and extended stay authorizations for inpatient care as directed in the current version of the "Inpatient Hospital Services Provider Guide/July 2015."
- The consumer is discharged when his/her symptoms and functioning have sufficiently improved so as to no longer warrant 24-hour observation and treatment.
- GCBH is notified of the discharge date and disposition, and the MHP ensures that appropriate after-care is scheduled with the consumer.
- The GCBH MHPs input all required inpatient information into the state Provider One system for billing purposes. All consumer demographics, admission/discharge, dates/dispositions, and clinical information are put into GCBH's Consumer Information System (CIS).

(24) Acceptance for approved treatment

GCBH contracts with SUD providers will require that Medicaid enrollees/consumers receive all the services for which they are medically necessary. Enrollees/consumers meeting medical necessity and placed in level 2.5 or below will be authorized for up to 12 months. Enrollees/consumers meeting medical necessity and placed in level 3.1 or above will be initially authorized for a period of time to be determined with the possibility of an extension if determined using the ASAM criteria. Monitoring will occur through utilization reports, chart reviews, and on-site reviews.

For non-Medicaid enrolled consumers, providers will be contractually required to work within the limits of available funding and prioritize services to youth, pregnant or post-partum women, and intravenous drug users.

(284) Authorization of services

GCBH, using the ASAM criteria, will develop an authorization request form that SUD providers will use to make the initial and concurrent request for services. These requests will be managed using the current system of utilization management which is provided by a staff of in-house GCBH service authorization professionals. Training for providers will occur prior to April 2016 on the use of the form and the overall utilization process. Additionally, an assessment of each provider's caseload will be done to ensure that consumers currently in service prior to April 1,

2016 will not experience a disruption of service due to lack of authorization.

9

Quality Assurance Plan

The GCBH vision for quality improvement is based on a commitment to the development, implementation, and maintenance of a model mental health and substance use disorder system of care that incorporates principles and practices of managed care and maintains the public trust. Existing GCBH quality policies and protocols are applicable and consistent with GCBH substance use disorder service delivery system.

(292) Quality assessment and performance improvement program

GCBH Quality Improvement involves two primary activities:

- Measuring and assessing the performance of mental health and substance use disorder clinical services through the collection and analysis of data; and
- Conducting quality improvement initiatives and taking action where indicated.

The GCBH Quality Management Program encompasses Care Management, Utilization Management, and Performance Improvement for its integrated services. These functions are defined as follows:

- **Care Management (CM)** includes both system-oriented and consumer-oriented activities relating to the delivery of care, i.e. assessing capacity, compliance with access to care, adherence to practice guidelines. If co-occurring issues exist, both concerns will be addressed in outpatient services. Also, the appropriate SUD referrals will follow discharge from inpatient psychiatric care.
- **Utilization Management (UM)** will focus on the most appropriate services provided following applicable access to care guidelines, including ASAM criteria for SUD services. UM includes processes for authorizing the provision of services to individual consumers, evaluating the appropriateness of authorized services, and monitoring system-wide and provider-specific performance relative to the volume (i.e., under/over utilization) and timeliness of service delivery. This will include monitoring for the ability to get into services following discharge from an acute medical care facility, by using GCBH established mechanisms to identify care using appropriate levels of ASAM.
- **Performance Improvement (PI)** is a systematic approach to assessing services and improving them as a priority. GCBH considers the collaborative efforts and feedback from its providers and other stakeholders regarding areas of need or concern, as identified in committee meetings, in surveys, from audits, and from performance

measures and other reports. Beginning April 2016, a third PIP will focus on SUD issues and may address issues related to access to primary care or identification of health disorders.

The four state-mandated core performance measures are:

1) Psychiatric Hospitalization Readmission Rate: the proration of acute psychiatric inpatient stays during the measurement year followed by an acute psychiatric readmission within 30 days.
2) Mental Health Treatment Penetration: Percent of adults identified in need of mental health treatment where treatment is received during the measurement year.
3) Use Disorder Treatment Penetration (to be defined by State before contract date)
4) Substance Use Disorder Retention Care (to be defined by State before contract date)

Performance Improvement is at the core of ensuring that addiction, like other chronic treatable conditions, is treated appropriately and within acceptable standards of care and evidence-based practices. This can be challenging as substance use often goes unrecognized in many behavioral health settings. The purpose of a Performance Improvement program within a managed care context must encompass areas related to prevention, recognition, treatment and finally maintenance all within an ASAM-based, trauma informed framework to fully address the continuum of needs for individuals with SUD disorders. The QI continuum described below consists of eight different dimensions, each representing a level and/or core philosophical component to care. The following measures represent these areas and form the foundation to the QI program:

1) *Prevention/Education:* The goal for GCBH is for providers to raise the awareness of its enrollees/consumers in relation to the potentially harmful effects of substance use. Measures will focus on the percentage of enrollees/consumers who are given information or advised about substance use in their initial session with a provider. Prevention/education should also include the family members/significant others of enrollees/consumers with AOD as they are at higher risk for such disorders, especially children. Toxicology screens may also be of use to help determine who should move into recognition/brief intervention.

2) *Recognition/Brief Intervention:* This area looks at the effectiveness of GCBH providers in conducting alcohol/drug screening and then providing brief interventions intended to help enhance the enrollee/consumer's motivation to change and agree to an appropriate referral follow-up. To help ensure there is appropriate recognition of clients, the GCBH can look at the number of individuals referred into treatment who have substance abuse or dependence diagnoses on an annual basis and compare this to local and/or national averages.

3) *Inpatient Withdrawal Management (Alcohol and Drug Detoxification):* This section is defined by services required for the care and/or treatment of individuals intoxicated or incapacitated by alcohol or other drugs while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. Key performance indicators will focus on the percentage of clients who connect with appropriate chemical dependency service providers within seven days post discharge. Documentation reviews will examine utilization of the stages of change and if clinical interventions are consistent with these stages.

4) *Treatment:* This domain looks at the type of interventions provided to GCBH enrollees/consumers in the treatment of substance use disorders. Interventions will include medications, counseling, skill building, etc. for each episode of care. It should be noted that detox and/or emergency rooms should be viewed as the potential for initiation of treatment, but unto themselves do not constitute treatment. The same is true for 12-step programs. QI measures will include the following:

    a. Established medical necessity: A covered diagnosis based on the DSM-5 that meets ASAM criteria for SUD services.
    b. Initiation of AOD Services: Percentage of individuals with an index diagnosis of abuse or dependence who receive any additional services within 14 days.
    c. Treatment Engagement: Percentage of clients diagnosed with AOD disorders who receive three plan-provided services within 30 days of the initiation of care. The length of stay is enormously important as length of stay relates directly to reductions in substance use and post-treatment employment status. Engagement in treatment also is important to the reduction of risk for drug-related illnesses. Other areas that could be explored include co-occurring mental health and addictive disorders, a treatment measure on the use of laboratory tests and treatment for pregnant women.
    d. Individual clinical measures: Percentages will be established to determine (i) the extent to which a review of goals identified in the Individual Service Plan have been met, have been discontinued or have continued need; and (ii) the use of evidence-based and other identified practice guidelines; and (iii) use of discharge planning guidelines, coordinated with ASAM levels of care.

5) *Interventions for family members/significant others of AOD clients in treatment:* This domain looks at the percentage of enrollees/consumers who report using AOD services while their family/significant other receives concurrent preventative interventions, including psychoeducation. This domain is enormously important for children of parents with serious substance use disorders as they have significantly higher rates of use in

adulthood.

6) *Maintenance:* This domain reviews the percentage of patients who report receiving a specific service by the provider to promote and sustain positive treatment outcomes post discharge. This could be in conjunction with 12-step programs, peer support, life style changes, etc. It should be noted this correlates directly to the issue of medical necessity as many managed care companies cease payment when a client reports three months clean and sober. This is unfortunately a highly problematic policy as cutting clients off from treatment after 90 days is clinically shortsighted. Within this model, six months is viewed as a more viable timeframe, dependent upon the severity of the disorder.

7) *Level of Care authorized for SUD treatment services based on ASAM PPC in comparison to treatment services provided*: This domain looks at the percentage of clients maintained in the correct level of care according to ASAM and documentation of connection with new providers within seven (7) days of discharge from any ASAM level of care.

8) *Trauma Informed Care:* Ensuring care is trauma informed and sensitive to clients is of enormous importance. Areas that will be measured include: consumer engagement and consumer satisfaction.

Quality Review and Remediation

GCBH quality reviews begin with ensuring effective communication with contracted agency leadership, their boards of directors, personnel and staff, and most importantly, plan enrollee/consumers. On a regular basis, agencies will be required to submit data consistent with Sections 1-8 above. Results will be posted statewide allowing for provider comparison and informed decision-making on behalf of plan enrollees/consumers. If deficiencies are identified, the agency will be required to submit a root-cause analysis and action plan which addresses each area specifically with a timeline for their correction. All action plans will be reviewed and approved by the GCBH and monitored throughout the year to ensure agency implementation and progress. To supplement this, GCBH will also conduct on-site visits. While in most cases, agencies will remediate quality concerns, in some cases, more stringent measures may need to take place.

Quality Manager is Jamie Rundhaug, Ph.D.

(274) Second opinion

Building on the existing process in place for mental health services currently, modifications will be made to include SUD services. The process will be as follows:

Eligible enrollees/consumers and/or those with legal custody of a enrollee/consumer are informed about the right to a second opinion at the Intake assessment and at any time dissatisfaction, disagreement, or concern about a clinical decision regarding their treatment is expressed. Additionally, information regarding this right will be included in the GCBH Behavioral Health Services Handbook provided to the consumer as part of the Intake process. Information about second opinions will also be included in all Notices of Actions. If a request is made to the contracted Ombudsman office or to the provider, they will advise the consumer to contact GCBH.

Enrollees/consumers who are eligible and requesting a second opinion are referred by GCBH to a Mental Health Professional (MHP) or Chemical Dependency Professional within the GCBH network of providers who is qualified to assess and treat the behavioral health condition that is to be reviewed.

GCBH ensures that a Release of Information is signed as part of the referral process and that current clinical documentation is made available by the treating provider to the MHP/CDP selected to provide the second opinion. Second opinions are documented in writing and made available to the consumer, the GCBH office, and the treating provider. Covered services determined medically necessary by the MHP/CDP rendering the second opinion are provided by the network provider treating the consumer. When indicated, the treating provider communicates directly with the MHP/CDP regarding his/her findings and may continue to consult with him/her. All such communication is included in the enrollee/consumer's clinical record. If a denial of services is upheld and the enrollee/consumer disagrees, he/she may file an appeal with GCBH. On-site audits of network providers are conducted by GCBH for evidence of compliance with the policies and procedures related to second opinions.

These procedures will be in place for SUD services by April 2016.

(277) Timely access

Medicaid enrollee/consumers are eligible for all outpatient and residential levels of care and clinical services in the Medicaid State Plan based on medical necessity and the Access to Care Standards for mental health and substance use treatment. Contractual requirements mandate that behavioral health services must be accessible and made available in a timely manner. Minimally, intakes for either mental health evaluation by an MHP, or for substance use intake evaluation by a CDP, must occur within 10 business days of enrollee/consumer request. This also includes services which are considered to be Routine, Urgent, and Emergent:

- Routine services = Fourteen (14) calendar days from request
- Urgent services = Twenty-four (24) hours from request
- Emergent services = Two (2) hours from request

To assure that services are available and accessible within the GCBH catchment area, GCBH delegates the provision of all direct mental health services to contracted network providers, who are responsible for assuring that crisis services are available 24 hours per day, 7 days per week, and that the scope of covered outpatient services provided is sufficient to address the clinical needs of the majority of enrollees/consumers within their service area.

In addition, GCBH has implemented numerous standard reports, including timeliness of outpatient and inpatient authorization requests, penetration rates, time from intake evaluation to first routine service. All existing reports for mental health services will also be developed to monitor SUD services beginning April 1, 2016.

Currently, GCBH assures timely access to care by monitoring the provider network and by including the following provisions in provider contracts. In 2016, GCBH will assure timely access to care by monitoring the MH and SUD provider network per contract requirements. GCBH will also ensure that access to care requirements, including timelines, corrective action and remedial action, are included in all MH and SUD contracts respectively.

GCBH, the Department of Social and Health Services, Office of the State Auditor, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives may conduct, on the Contractor or its subcontractors, announced and unannounced reviews regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement.

GCBH may initiate Remedial Action if it is determined that a problem exists that negatively impacts individuals receiving services and/or the Contractor has failed to perform any of the mental health services required in this Agreement.

GCBH may impose any one or more of the following remedial actions in any order:

- Require the Contractor to develop and execute a corrective action plan with specific timeframes. GCBH may accept, modify or reject the plan.
- Withhold up to five percent (5%) of the next monthly capitation payment and each monthly capitation payment thereafter until the situation has been resolved.
    - 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.
- Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which GCBH provides incentives.
- Terminate for Default as described in the General Terms and Conditions.

(290) Sub-contractual relationships and delegation

Currently, GCBH delegates the responsibility to provide services to enrollees/consumers eligible for services under the DSHS contracts using Policy and Procedure QM508. GCBH staff perform audits of the MH providers as required by contract. Clinical staff perform chart audits, fiscal staff perform fiscal audits, IS staff perform IS audits and EDV audits, and Contracts staff perform policy and procedure audits. In all cases, GCBH staff use audit tools designed for the area they are reviewing. GCBH currently ensures that all required contract provisions are included in all mental health contracts by having internal staff (fiscal, IS, clinical and legal counsel) review proposed provider contract language before contracts are recommended to the GCBH Board of Directors for approval.

In 2016, GCBH will extend the same policy and procedures to SUD provider contracts. Attachment 8 contains a sample subcontract, Policy and Procedure QM508, and monitoring reports from three entities.

(4) Adult Behavioral Health System – Improvement Strategy

GCBH will identify areas of needed improvement based upon the outcome of four State mandated performance measures. Following analyses by various GCBH committees and quality procedures, improvement strategies will be developed and implemented. The primary purpose of the strategies is to bring about desired levels of performance. Initially, the Contractor's incremental improvement targets are established by DSHS, and will be based on the Contractor's baseline performance. Performance will be compared to first year baseline measures. Collaborative efforts toward improvement can be facilitated through the implementation of Performance Improvement Projects (PIPs). PIPs are planned efforts to facilitate integration at the utilization management level, and are relevant applications for both incentive purposes as well as for promotion of access to all BHO services.

At the time of this submission, the four Performance Measures are:

1) Psychiatric Hospitalization Readmission Rate: the proration of acute psychiatric inpatient stays during the measurement year followed by an acute psychiatric readmission within 30 days.
2) Mental Health Treatment Penetration: Percent of adults identified in need of mental health treatment where treatment is received during the measurement year.
3) Use Disorder Treatment Penetration (to be defined by State before contract date)
4) Substance Use Disorder Retention Care (to be defined by State before contract date)

Additional description of the quality and performance improvement activities were described earlier in this section under DPR item 292.

10

Grievance System Plan

(296) – Grievance system - general requirements

GCBH has a comprehensive Grievance System that is applied to all mental health services and will be applied to substance use services and incorporates all State and Federal regulations and contractual requirements. GCBH maintains policies regarding grievances, appeals and fair hearing processes. An individual applying for, eligible for, or receiving mental health services authorized by GCBH, or the individual's representative may access the GCBH Grievance System to express dissatisfaction about their rights, services, and treatment. Individuals or their representative may access the GCBH Grievance System directly with the GCBH provider agency or with GCBH. Should they choose to, individuals may be assisted by the Ombuds service free of cost. Requirements regarding the Grievance System are included in all provider contracts, including the requirement that all providers must develop and maintain policies regarding the Grievance System in compliance with GCBH contractual requirements as well as State and Federal regulations.

GCBH maintains policies regarding purchasing of medically necessary mental health services, for enrollees/consumers with an identified need, outside of the service area if those services are unavailable within the GCBH service area. This provision is included in all provider contracts. Enrollees/consumers may access the Grievance System at any time regarding this issue. GCBH also maintains policies regarding enrollee/consumer information requirements that comply with 42 CFR 438.100, 438.10 and 438.6(i)(3). This provision is included in all provider contracts.

GCBH provides technical assistance to all providers and offers Grievance System trainings to all providers, consumers and the general public. The GCBH Ombuds and QRT provider also offers Grievance System trainings to all providers, consumers and the general public. In 2016 GCBH will expand the Ombuds' provider role to include SUD Ombuds and QRT services.

Since November 2014, GCBH has been meeting with SUD providers in preparation for MH & SUD integration. In 2016, GCBH will revise the Grievance System policies, along with others, to include SUD clients and processes. GCBH and the Ombuds/QRT provider will continue to offer Grievance System technical support and trainings to MH & SUD providers, clients and the general public. GCBH analyzes trends and patterns in type, frequency and resolution of grievances for quality improvement activities.

All MH & SUD provider contracts will have Grievance System provisions that will be monitored through quarterly grievance reporting and Administrative audits that will include the review of Grievance System policies and grievance logs. GCBH will analyze trends and patterns in type, frequency and resolution of grievances for quality improvement activities.

GCBH has the following detailed policies and procedures that are maintained by staff, approved by the GCBH Board of Directors and used throughout the organization to support authorizations, grievances and appeals:

- CA402 – Fair Hearings
- CA403 – Consumer Grievances
- CA405 – Enrollee/consumer Service Authorizations, Notices and Appeals

Common definitions used throughout the identified policies and procedures include:

I. Action – In the context of GCBH-funded service provision to Medicaid enrollees/consumers, this term means: (1) the denial or limited authorization of a requested service, including the type or level of service and any service denial based on Access to Care; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by the State; (5) the failure of GCBH to act within the timeframes provided in section 42 CFR 438.408(b); (6) for covered services that are not provided within the GCBH service area, the denial of an Enrollee/consumer's request to exercise his or her right, under section 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or (7) an enrollee/consumer's disagreement with their treatment plan.

II. Appeal – A request for review of an action as defined above.

III. Consumer – A person who has applied for, is eligible for or has received mental health services from a Greater Columbia Behavioral Health (GCBH) network provider, regardless of Medicaid eligibility. For a child under the age of thirteen, or for a child thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians. Additionally, for the purposes of this policy, references to the consumer are understood to include the individual(s) designated by the consumer to represent him/her during the grievance process.

IV. Enrollee/consumer – A Medicaid recipient who is currently enrolled with GCBH. For a child under the age of thirteen, or for a child thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of enrollee/consumer includes parents or legal guardians. Additionally, for the purposes of this policy, references to enrollee/consumer notification, or to the filing of appeals, are understood to include an enrollee/consumer's guardians and/or representatives, or the representative of a deceased enrollee/consumer's estate.

V. Fair Hearing – A hearing before the Washington State Office of Administrative Hearings. Also referred to as a "state administrative hearing."

VI. Grievance – A consumer's request that his/her expression of dissatisfaction with any aspect of care or services provided be formally heard and resolved via the GCBH grievance process. NOTE: When a Medicaid enrollee/consumer indicates disagreement with a decision to suspend, reduce or terminate services and asks that the decision be reconsidered, the request is an appeal rather than a grievance and is addressed via the GCBH appeal process.

VII. Medical Necessity or Medically Necessary – A service 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 mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

VIII. Mental Health Professional (MHP) – An individual who meets the criteria established by WAC 388-877-0200, or its successors.

IX. Notice of Action – A written notice issued by GCBH which communicates the decision of an action, as defined above.

X. Notice of Determination - A written notice issued by GCBH, which communicates a decision to authorize mental health services or a decision that the person seeking services is not eligible to receive them. The notice includes a description of authorized services and timeframes, if applicable, and notice of the individual's right to a second opinion and how to access it, if services beyond the intake or previously authorized benefit have not been determined to be medically necessary and no services are authorized by GCBH. If not authorized, the notice must include information about the availability of other services under EPSDT for enrollees/consumers under 21 and their legal guardians.

XI. Service Authorization, Expedited – An accelerated process for responding to service requests when a provider determines that following the standard timeframe could

seriously jeopardize the enrollee/consumer's ability to maintain, or regain maximum function or if the enrollee/consumer presents a potential risk of harm to self or others.

XII. Service Authorization, Standard – The process for responding to requests for initial and/or ongoing mental health services.

XIII. Service Denial – A decision by GCBH not to authorize covered mental health services requested by a network provider for a Medicaid enrollee/consumer.

XIV. Service Reduction – A decision by GCBH to decrease a previously authorized covered Medicaid mental health service described in the Level of Care Guidelines. A provider's clinical decision to decrease or change a covered service in the Individualized Service Plan is not a reduction.

XV. Service Suspension – A decision by GCBH to temporarily stop previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. A provider's clinical decision to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

XVI. Service Termination – A decision by GCBH to stop a previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. A provider's clinical decision to stop a covered service in the Individualized Service Plan is not a termination.

(297) – Grievance system – action

GCBH has existing policies and procedures for the grievance system. In the documentation, Action is defined as:

> Action – In the context of GCBH-funded service provision to Medicaid enrollees/consumers, this term means: (1) the denial or limited authorization of a requested service, including the type or level of service and any service denial based on Access to Care; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by the State; (5) the failure of GCBH to act within the timeframes provided in section 42 CFR 438(b); (6) Enrollee/consumer disagreement with the treatment plan.

All consumers have the right to request a Fair Hearing when they believe GCBH or one of its network providers has violated a State rule or timeline, or when they disagree with the outcome of a grievance. Additionally, Medicaid-eligible consumers may request a Fair Hearing if they disagree with a decision made by GCBH regarding their eligibility for services or they disagree with the resolution of an appeal.

When a consumer submits a grievance to a network provider from which he/she receives services, that agency's Director (or his/her designee) provides a written decision regarding the resolution of the grievance to the consumer, and to the GCBH Director (or his/her designee), within twenty (20) calendar days. The following provisions are also described in the policy:

- The timeframe may be extended up to fourteen (14) days if the consumer requests an extension or if the agency determines a need for additional information and that the extension is in the consumer's best interest.
- If the agency extends the timeframe, the consumer is provided written notice of the delay and the reason for it.
- If the Director of a network provider (or his/her designee) determines that it may not be possible to reach a decision within the 20-day timeframe, or that the consumer is not satisfied with the decision, he/she notifies the GCBH Director (or his/her designee) immediately. The GCBH Director/designee has 10 days to provide resolution to the grievance.

(298) – Grievance system – service authorization

Service authorizations include the following types and actions:

I. Service Authorization, Expedited – An accelerated process for responding to service requests when a provider determines that following the standard timeframe could seriously jeopardize the enrollee/consumer's ability to maintain or regain maximum function, or if the enrollee/consumer presents a potential risk of harm to self or others.

II. Service Authorization, Standard – The process for responding to requests for initial and/or ongoing mental health services.

III. Service Denial – A decision by GCBH not to authorize covered mental health services requested by a network provider for a Medicaid enrollee/consumer.

IV. Service Reduction – A decision by GCBH to decrease a previously authorized covered Medicaid mental health service described in the Level of Care Guidelines. A provider's clinical decision to decrease or change a covered service in the Individualized Service Plan is not a reduction.

V. Service Suspension – A decision by GCBH to temporarily stop previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. A provider's clinical decision to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

VI. Service Termination – A decision by GCBH to stop a previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. A provider's clinical decision to stop a covered service in the Individualized Service Plan is not a termination.

Based on requests from providers, GCBH will carry out authorization and notification processes for inpatient and outpatient mental health services, including major diagnostic and therapeutic services directly related to the treatment of mental health disorders for enrollees/consumers. Decisions to authorize or deny services are based on the *Level of Care and Authorization Criteria* established by GCBH. Decisions to deny services on the basis of medical necessity are approved by a licensed psychologist or a qualified physician prior to issuance of written notification regarding the decision. Apple Health, formally Healthy Options, enrollees/consumers are not referred to the enrollee/consumer's Apple Health managed care plan for mental health services if the enrollee/consumer is determined to be eligible for RSN-funded mental health services based on medical necessity and the *Access to Care Standards.*

(299) - Grievance system – service authorization process

The authorization process begins with a face-to-face clinical intake assessment by an MHP. If the MHP believes the enrollee/consumer meets GCBH *Level of Care and Authorization Criteria*, a request for service authorization is faxed or sent electronically to GCBH. The request includes:

- The amount, duration and scope of each service requested;
- Clinical information supporting the service(s) requested; and
- A request for expedited authorization if the MHP believes it necessary.

1. Requests made to GCBH are reviewed by an MHP who authorizes them subsequent to review of the information provided and confirmation of financial eligibility. If GCBH has questions or concerns regarding the authorization of services, the decision is made in consultation with the provider and/or GCBH, as appropriate.

    1.1. **Standard Service Authorizations**. Except when a provider requests an expedited authorization process, decisions regarding the authorization of routine outpatient mental health services must occur within fourteen (14) calendar days of the date the intake evaluation was initiated, unless an extension is requested.

    Providers must submit an authorization request to GCBH within five (5) business days from the date of intake.

    - Notice of service approval (i.e., Notice of Determination): Written notification is provided by GCBH to the network provider and the enrollee/consumer within the timeframe above.
    - Notice of denial (i.e., Notice of Action): Written notification is provided GCBH to the network provider and the enrollee/consumer within the timeframe above.

    1.2. **Expedited Service Authorizations.** When a provider determines that an accelerated authorization process is in the best interest of the enrollee/consumer, the authorization decision is made and notice given to the requesting provider and the enrollee/consumer, as expeditiously as the enrollee/consumer's condition requires

and within three (3) working days from receipt of the service authorization request, unless an extension is requested.

- Notice of service approval (i.e., Notice of Determination): Written notification is provided by GCBH to the network provider and the enrollee/consumer within the timeframe above.
- Notice of denial (i.e., Notice of Action): Written notification is provided by GCBH to the network provider and the enrollee/consumer within the timeframe above.

1.3. **Extensions**. For both Standard and Expedited service authorizations, the decision-making timeframe may be extended up to fourteen (14) additional calendar days if the enrollee/consumer or the provider requests it, or if GCBH determines a need for additional information and how the extension is in the enrollee/consumer's best interest.

- If the timeframe is extended, the determination must be issued and carried out as expeditiously as the enrollee/consumer's health condition requires, and no later than the date the extension expires.
- Extension requests made by enrollees/consumers or providers are automatically granted.
- When an extension occurs at the request of GCBH or a provider, GCBH provides the enrollee/consumer written notice of the reason for the extension and of his/her right to file a grievance if he or she disagrees with the delay.
- GCBH tracks extension requests, monitoring for patterns in their use and reports such patterns to the Quality Management Oversight Committee.

2. When, on the basis of an Intake Assessment, an MHP determines that medical necessity and access criteria are not met, the assessment and other relevant documentation or medical records are submitted to GCBH for review. If GCBH does not reverse the recommendation of the MHP, it initiates the Notice of Action process, described below.

3. The GCBH Children's Care Manager reviews initial intake evaluations of all enrollees/consumers under the age of 21 for medical necessity and makes Level I or Level II assignments, authorizing Level II services for children who are:
    - Involved with the Children's Administration, the Division of Developmental Disabilities, and/or the Juvenile Rehabilitation Administration/Department of Corrections in addition to mental health;
    - Diagnosed with substance abuse or addiction;
    - Receiving special education services; or
    - Have a chronic and disabling medical condition.

4. If an enrollee/consumer under the age of 21 receives the maximum services allowed under Level I and there is a request for additional services, the GCBH Children's Care Manager reviews the Individual Treatment Plan and determines the appropriate level of care. Level II

services are authorized when the enrollee/consumer meets the criteria in the preceding paragraph, or when services continue to be medically necessary after one re-authorization of Level I services. It is noted that at the time of this submission GCBH recognizes that the State is transitioning to ICD-10 Access to Care Standards. GCBH will adjust its system accordingly.

5. GCBH maintains written records and a log of all denied requests for service.

Re-Authorization of Services

6. When a provider believes there is a need for continuation or re-authorization following the exhaustion of previously authorized services, the request to do so includes:
    - An evaluation of the effectiveness of each service modality provided during the benefit period and recommendations for changes in methods or intensity of services being provided;
    - An evaluation of the progress the enrollee/consumer made towards recovery or resiliency;
    - An identification of unmet goals in the Individual Service Plan including those identified by the enrollee/consumer; and
    - A determination of whether the enrollee/consumer has met discharge criteria.
7. GCBH's decision to re-authorize services is sent electronically or faxed to the provider and includes the time period for which services are re-authorized.
8. A request to extend services that were previously authorized as time-limited may be treated as a new request. However, if the provider presents the request as a necessary continuation of the original authorization and the request is denied, the denial is treated as a service termination that may be appealed by an enrollee/consumer.

(300) – Grievance system – notice of action

In the context of GCBH-funded service provision to Medicaid enrollees/consumers, actions mean: (1) the denial or limited authorization of a requested service, including the type or level of service and any service denial based on Access to Care; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by the State; (5) the failure of GCBH to act within the timeframes provided in section 42 CFR 438(b); (6) enrollee/consumer disagreement with the treatment plan.

Notices of Action

Notification of a decision to deny a service authorization request, or to authorize services in an amount, duration, or scope that is less than requested, is made via a Notice of Action form approved by GCBH, in the enrollee/consumer's primary language. Denial decisions can only be

made by an MHP who has the appropriate clinical expertise to make the decision. GCBH mails this notice to enrollee/consumers. The form provides the following information:

- The date of the action;
- The action taken, and the reason(s) for it;
- An explanation of the enrollee/consumer's right to file an appeal or request a Fair Hearing, and how to do so, including the timelines to do so;
- Definitions of denial, reduction, suspension and termination;
- A statement that the enrollee/consumer has twenty (20) days from the postmark date on the Notice of Action to file an appeal;
- A statement that the enrollee/consumer must file an appeal within ten (10) days of the postmark date if the action is in regards to previously authorized services which he/she wishes to continue receiving during the appeal process;
- The circumstances under which a 3-day expedited appeal process is available, and how to request it;
- Statements regarding the enrollee/consumer's right to have services continued pending resolution of the appeal, how to request continuation or reinstatement of services during the appeal, and the circumstances under which the enrollee/consumer may be required to pay for services received during the appeal process;
- The circumstances under which the enrollee/consumer may request a Fair Hearing; and
- A statement that the enrollee/consumer has ninety (90) days from the postmark date on the resolution of a Notice of Action to file Fair Hearing.

For all denials, a Notice of Action is mailed to the enrollee/consumer within the timeframes noted below. The provider from which the enrollee/consumer receives outpatient services, and, if applicable, the facility providing inpatient services are also notified within these timeframes, though not necessarily in writing.

For **termination, suspension, or reduction of previously authorized services** – Notice must be mailed at least ten (10) calendar days before the effective date of the action, except as noted below.

- A Notice of Action may be mailed not later than the date of action if:
  - GCBH has factual information confirming the enrollee/consumer's death;
  - GCBH has a clear written statement signed by the enrollee/consumer that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the enrollee/consumer understands that this must be the result of supplying that information;
  - GCBH has learned that the enrollee/consumer has been admitted to an institution where he/she is ineligible for further services;

  - GCBH has no knowledge of the enrollee/consumer's whereabouts and returned mail has no forwarding address;
  - GCBH has knowledge that the enrollee/consumer has been accepted into another state's Medicaid program; or
  - GCBH has knowledge that the MHP treating the enrollee/consumer has prescribed a change in the level of services.
  - If GCBH has facts (verified through secondary resources, if possible) indicating that action should be taken because of probable fraud by the enrollee/consumer, the advance notice may be shortened to five (5) days.
- For **denial of payment** – At the time of any action affecting the payment.
- For **Standard and Expedited Service Authorization** decisions that deny or limit services – as expeditiously as the enrollee/consumer's condition requires, and **not longer than the notification timeframes established in the "Authorization of Services" section,** above.
  - For decisions to deny a request for voluntary Medicaid inpatient services, the Notice of Action is delivered on the day the decision is made.
  - Failure to meet the timeframes for standard or expedited service authorization requests constitutes a denial. In such instances, the Notice of Action must be mailed on the date the timeframe expires.

A copy of each Notice of Action issued is maintained at the GCBH central office.

(301) – General Requirements – notice of action – timeframes – termination, suspension or reduction of services
CONTAINED IN THE PREVIOUS RESPONSE ITEM (300).

(302) Grievance system – notice of action – timeframes – denial of payment
Whenever a payment denial is processed, notifications of the action affecting non-payment are made immediately.

- Notice of service approval (i.e., Notice of Determination): Written notification is provided by GCBH to the network provider and the enrollee/consumer within the timeframe above.
- Notice of denial (i.e., Notice of Action): Written notification is provided by GCBH to the network provider and the enrollee/consumer within the timeframe above.

(303) Grievance system – notice of action – timeframes – denial of standard authorization
CONTAINED IN THE PREVIOUS RESPONSE ITEM (300).

(304) Grievance system – notice of action – timeframes – denial of expedited authorization
CONTAINED IN THE PREVIOUS RESPONSE ITEM (300).

(305) Grievance system – notice of action – timeframes – untimely authorization
Failure to meet the timeframes for standard or expedited service authorization requests constitutes a denial. In such instances, the Notice of Action must be mailed on the date the timeframe expires.

(306) Grievance system – information to providers and subcontractors
All consumers receive a copy of the GCBH *Mental Health Service Benefit Handbook,* which includes information about requesting Fair Hearings, when admitted to community support services. Additionally, the Mental Health *Benefits Booklet* produced by DSHS, which also provides instructions regarding Fair Hearings, is made available to Medicaid enrollees/consumers at intake and upon request, and brochures from the GCBH Ombuds service are available at network provider sites and the GCBH office. Consumers are also provided with information regarding their right to request a Fair Hearing, and the process for doing so under the following circumstances:

- When they file a grievance, and when a written response to that grievance is provided;
- When a Medicaid enrollee/consumer is notified of a decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested; and
- When a Medicaid enrollee/consumer is notified of a decision regarding his/her appeal of an action as defined herein.

All consumers receive a copy of the GCBH *Mental Health Service Benefit Handbook,* which includes information about filing grievances, at intake. As needed, explanation is provided through qualified interpreters for non-English speaking consumers and those who are deaf or visually impaired. Additionally, Medicaid enrollees/consumers are informed that the *Benefits Booklet* produced by the Department of Social and Health Services (DSHS), which also provides instructions regarding grievances, is available upon request, and a copy is provided if an enrollee/consumer requests one.

Upon application for mental health services, enrollees/consumers receive a copy of the GCBH *Mental Health Service Benefit Handbook,* which includes information relating to enrollee/consumers' right to appeal decisions and how to do so. As needed, explanation is provided through qualified interpreters for non-English speaking enrollees/consumers and those who are deaf or visually impaired. Additionally, enrollees/consumers are informed that the *Benefits Booklet* produced by the DSHS, which also provides instructions regarding filing appeals, is available upon request, and a copy is provided if an enrollee/consumer requests one.

(307) Grievance system – record keeping and reporting

A confidential record of each grievance is maintained for six (6) years following the completion of the grievance resolution process. Such records are maintained apart from the consumer's clinical record and are not disclosed without the consumer's written permission, except as necessary to resolve the grievance or to DSHS if the consumer requests a Fair Hearing.

Network providers notify GCBH upon receipt of all grievances filed and provide information on all steps taken to resolve them.

A confidential record of each appeal is maintained for six (6) years following the completion of the appeal resolution process. At a minimum, such records include the enrollee/consumer's name, dates and times of all milestones in the appeal process, the decision appealed, the provider involved, and the disposition of the appeal. Such records are maintained apart from the enrollee/consumer's clinical record, and are not disclosed without the enrollee/consumer's written permission, except as necessary to resolve the appeal or to DSHS if the enrollee/consumer requests a Fair Hearing.

On-site audits of network providers, conducted by GCBH, include checks for evidence of compliance with the provisions of this policy. When a need for corrective action is identified during such audits, network providers address compliance issues via their quality improvement processes and provide evidence of sustained improvement. GCBH staff review audit findings for trends requiring system level intervention, and report such to the GCBH Quality Management Oversight Committee for recommendations that are presented to the GCBH Board of Directors for action.

(308) Grievance system – appeal

The topic of appeals – with regards to definitions – has been addressed in previous sections of this Detailed Plan. GHBH recognizes and adopts the definitions of "Action," "Appeal" and "Grievance" as presented by 42 CFR 438.400(b).

(309) Grievance system – authority to file

All consumers have the right to request a Fair Hearing when they believe GCBH or one of its network providers has violated a state rule or timeline, or when they disagree with the outcome of a grievance. Additionally, Medicaid-eligible consumers may request a Fair Hearing if they disagree with a decision made by GCBH regarding their eligibility for services or they disagree with the resolution of an appeal.

Consumers may enlist family members, Ombuds service staff, advocates, friends, network provider staff or others to represent or assist them in filing a grievance.

(310) Grievance system – timing

Appeals must be filed within twenty (20) calendar days of the postmark on the Notice of Action. If the enrollee/consumer wishes to continue receiving previously authorized services during the appeal process, the appeal must be filed within ten (10) calendar days of the postmark on the Notice of Action or the intended effective date of the action, whichever is later.

(311) Grievance system – appeal process – procedures

Requests made to GCBH are reviewed by an MHP, who authorizes them subsequent to review of the information provided and confirmation of financial eligibility. If GCBH has questions or concerns regarding the authorization of services, the decision is made in consultation with the provider and/or GCBH, as appropriate.

- **Standard Service Authorizations**. Except when a provider requests an expedited authorization process, decisions regarding the authorization of routine outpatient mental health services must occur within fourteen (14) calendar days of the date the intake evaluation was initiated, unless an extension is requested. Providers must submit an authorization request to GCBH within five (5) business days from the date of intake.
  - Notice of service approval (i.e., Notice of Determination): Written notification is provided by GCBH to the network provider and the enrollee/consumer within the timeframe above.
  - Notice of denial (i.e., Notice of Action): Written notification is provided by GCBH to the network provider and the enrollee/consumer within the timeframe above.
- **Expedited Service Authorizations.** When a provider determines that an accelerated authorization process is in the best interest of the enrollee/consumer, the authorization decision is made and notice given to the requesting provider and the enrollee/consumer, as expeditiously as the enrollee/consumer's condition requires and within three (3) working days from receipt of the service authorization request, unless an extension is requested.
  - Notice of service approval (i.e., Notice of Determination): Written notification is provided by GCBH to the network provider and the enrollee/consumer within the timeframe above.
  - Notice of denial (i.e., Notice of Action): Written notification is provided by GCBH to the network provider and the enrollee/consumer within the timeframe above.

Upon application for mental health services, enrollees/consumers receive a copy of the GCBH *Mental Health Service Benefit Handbook,* which includes information relating to enrollee/consumers' right to appeal decisions and how to do so. As needed, explanation is provided through qualified interpreters for non-English speaking enrollees/consumers and those who are deaf or visually impaired. Additionally, enrollees/consumers are informed that the *Benefits Booklet* produced by DSHS, which also provides instructions regarding filing appeals, is available upon request, and a copy is provided if an enrollee/consumer requests

one. Brochures from the GCBH Ombuds service are also available at network provider sites and the GCBH office.

When an enrollee/consumer indicates a desire to appeal an action relating to his/her care, appeal-related processes are reviewed with the enrollee/consumer, access to the Ombuds Service is facilitated if desired, and the enrollee/consumer is reminded of his/her right to involve others.

- A staff member of a network provider may file an appeal on behalf of the enrollee/consumer if written consent is given by the enrollee/consumer, or a guardian or representative.
- As needed, enrollees/consumers are provided interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- Appeals must be filed within twenty (20) calendar days of the postmark on the Notice of Action. If the enrollee/consumer wishes to continue receiving previously authorized services during the appeal process, the appeal must be filed within ten (10) calendar days of the postmark on the Notice of Action or the intended effective date of the action, whichever is later.
- Appeals may be initiated either orally or in writing. Those initiated orally must be confirmed in writing and signed by the enrollee/consumer within seven (7) calendar days unless an expedited resolution has been requested.
- Oral inquiries seeking to appeal an action are treated as appeals and the date of the inquiry becomes the filing date of the appeal. If an oral inquiry is not confirmed in writing, it will be considered incomplete. This does not preclude another filing within twenty (20) days of the date on the Notice of Action.

The GCBH Director and/or designee conducts a thorough review of each appeal ensuring that those making the decision on the appeal were not involved in any previous level of review or decision-making in regards to it.

- If the appeal is in regards to a denial based on lack of medical necessity, or involves clinical issues, the GCBH Director or designee ensures that the final decision is made by a Mental Health Professional with the appropriate clinical expertise.
- The enrollee/consumer is provided, before and during the appeal process, the opportunity to examine his/her case file, including medical records and any other documents and records considered during the appeal process.

(312) Grievance system – appeal process – resolution and notification

For standard resolutions of appeal, the appeal is resolved and written notice provided by GCBH to the enrollee/consumer within forty-five (45) days of its receipt.

Requests for an expedited appeal resolution process are reviewed the day of receipt, and a decision as to whether an expedited process is warranted is communicated verbally by GCBH to the enrollee/consumer no later the twenty-four (24) hours after receipt of the request.

For both Standard and Expedited Resolution processes, the timeframe may be extended up to fourteen (14) additional calendar days if the enrollee/consumer requests it, or if GCBH determines a need for additional information and how the extension is in the enrollee/consumer's best interest. If an extension occurs at the request of GCBH rather than the enrollee/consumer, written notice of the reason for the delay is provided to the enrollee/consumer.

The results of the resolution process, the date it was completed and the clinical rationale for the decision, including how to obtain the Utilization Management clinical review or decision-making criteria will be communicated to the enrollee/consumer.

(313) Grievance system – appeal process – format and content of resolution notice
CONTAINED IN THE PREVIOUS RESPONSE ITEM (312)

(314) Grievance system – appeal and state fair hearing process – continuation of benefits
When a consumer has requested and received a continuation of disputed services during the Fair Hearing process, and the Fair Hearing officer upholds a GCBH decision to deny, limit or delay services, the consumer may be asked to pay for these services, to the extent they were provided solely for continuation of benefits during the Fair Hearing process.

For **termination, suspension, or reduction of previously authorized services** – Notice must be mailed at least ten (10) calendar days before the effective date of the action, except as noted below.

- A Notice of Action may be mailed not later than the date of action if:
  - GCBH has factual information confirming the enrollee/consumer's death;
  - GCBH has a clear written statement signed by the enrollee/consumer that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the enrollee/consumer understands that this must be the result of supplying that information;
  - GCBH has learned that the enrollee/consumer has been admitted to an institution where he/she is ineligible for further services;
  - GCBH has no knowledge of the enrollee/consumer's whereabouts and returned mail has no forwarding address;
  - GCBH has knowledge that the enrollee/consumer has been accepted into another state's Medicaid program; or

  - GCBH has knowledge that the MHP treating the enrollee/consumer has prescribed a change in the level of services.
- If GCBH has facts (verified through secondary resources, if possible) indicating that action should be taken because of probable fraud by the enrollee/consumer, the advance notice may be shortened to five (5) days.

Appeals must be filed within twenty (20) calendar days of the postmark on the Notice of Action. If the enrollee/consumer wishes to continue receiving previously authorized services during the appeal process, the appeal must be filed within ten (10) calendar days of the postmark on the Notice of Action or the intended effective date of the action, whichever is later.

GCBH continues an enrollee/consumer's benefits pending resolution of an appeal if all of the following conditions are met:

- The appeal was filed within ten (10) days of the postmark on the Notice of Action or the intended effective date of the proposed action;
- The appeal involves the termination, suspension, or reduction of a previously authorized service;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The enrollee/consumer requests extension of benefits.

If, at the enrollee/consumer's request, benefits are continued or reinstated while the appeal is pending, they must be continued until one of the following occurs:

- The enrollee/consumer withdraws the appeal;
- Ten (10) days pass after GCBH mails the notice, providing the resolution of the appeal against the enrollee/consumer, unless the enrollee/consumer, within the 10-day timeframe, has requested a Fair Hearing with continuation of benefits until a hearing decision is reached;
- A Fair Hearing office issues a decision adverse to the enrollee/consumer; or
- The time periods or service limits of a previously authorized service have been met.

If the final resolution of the appeal is adverse to the enrollee/consumer, GCBH may recover the cost of the services furnished to the enrollee/consumer while the appeal is pending, to the extent the services were provided solely for continuation of benefits during the appeal process.

(315) Grievance system – appeal and state fair hearing process – effectuation when services were not furnished

When a Fair Hearing officer reverses a GCBH decision to deny, limit, or delay services that were not furnished to a Medicaid enrollee/consumer while an appeal was pending, the disputed

services are authorized and provided promptly, and as expeditiously as the enrollee/consumer's health condition requires.

When a Fair Hearing officer reverses a GCBH decision to deny authorization of services to a Medicaid enrollee/consumer, and the enrollee/consumer received the disputed services while the appeal was pending, the services are paid for by GCBH or the network provider from which the enrollee/consumer received them.

If GCBH reverses a decision to deny, limit or delay mental health services that were not furnished while the appeal was pending, the disputed services are authorized promptly and as expeditiously as the enrollee/consumer's health condition requires.

(316) Grievance system – appeal and state fair hearing process – effectuation when services were furnished

If GCBH reverses a decision to deny authorization of services, and the enrollee/consumer received the disputed services while the appeal was pending, GCBH must pay for those services in accordance with DSHS policy and regulations.

(317) Grievance system – expedited appeals process – general Expedited Resolution of Appeal

An expedited process is provided when it is determined that the standard time for resolution would jeopardize the enrollee/consumer's ability to maintain or regain maximum functioning. In these cases, the appeal is resolved, and written notice provided by GCBH to the enrollee/consumer, within three (3) working days of its receipt, unless extended as noted below.

- Requests for an expedited appeal resolution process are reviewed the day of receipt, and a decision as to whether an expedited process is warranted is communicated verbally by GCBH to the enrollee/consumer no later than twenty-four (24) hours after receipt of the request.
- If the request for an expedited resolution process is denied, GCBH provides written notice within two (2) calendar days. The appeal is then addressed in accord with timelines for the Standard Resolution process.
  - Denial of access to an expedited process is grounds for the filing of a grievance, if the enrollee/consumer desires to do so.

(318) Grievance system – expedited appeals process – authority to file

Appealing an action: Upon application for mental health services, enrollees/consumers receive a copy of the GCBH *Mental Health Service Benefit Handbook,* which includes information relating to enrollees/consumers' right to appeal decisions and how to do so. As needed, explanation is provided through qualified interpreters for non-English speaking enrollee/consumers and those who are deaf or visually impaired. Additionally,

enrollee/consumers are informed that the *Benefits Booklet* produced by DSHS, which also provides instructions regarding filing appeals, is available upon request, and a copy is provided if an enrollee/consumer requests one. Brochures from the GCBH Ombuds service are also available at network provider sites and the GCBH office.

When an enrollee/consumer indicates a desire to appeal an action relating to his/her care, appeal-related processes are reviewed with the enrollee/consumer, access to the Ombuds Service is facilitated if desired, and the enrollee/consumer is reminded of his/her right to involve others. A staff member of a network provider may file an appeal on behalf of the enrollee/consumer if written consent is given by the enrollee/consumer, or a guardian or representative. As needed, enrollees/consumers are provided interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Appeals must be filed within twenty (20) calendar days of the postmark on the Notice of Action. If the enrollee/consumer wishes to continue receiving previously authorized services during the appeal process, the appeal must be filed within ten (10) calendar days of the postmark on the Notice of Action or the intended effective date of the action, whichever is later.

Appeals may be initiated either orally or in writing. Those initiated orally must be confirmed in writing and signed by the enrollee/consumer within seven (7) calendar days unless an expedited resolution has been requested.

- Oral inquiries seeking to appeal an action are treated as appeals and the date of the inquiry becomes the filing date of the appeal.
- If an oral inquiry is not confirmed in writing, it will be considered incomplete. This does not preclude another filing within twenty (20) days of the date on the Notice of Action.

When an appeal is filed, the enrollee/consumer is provided the following:

- Contact names and telephone numbers of the Ombuds Service, the involved network provider, and the GCBH Central Office.
- Information about the appeal process, including but not limited to timeframes for resolution and the enrollee/consumer's right to request a Fair Hearing at the state level (a) if the enrollee/consumer does not agree with GCBH's decision regarding the appeal, (b) if GCBH does not provide a written response within the required timeframes, or (c) if the enrollee/consumer believes there has been a violation of Washington State Department of Social and Health Services rules.

The Notice of Action form instructs enrollees/consumers to file their appeals directly with GCBH. However, because enrollees/consumers may request assistance from a network provider in filing an appeal, the first knowledge of an impending appeal may be at the network provider level. Accordingly, if an enrollee/consumer indicates to a network provider that he/she wishes to appeal a Notice of Action, the Director of the network provider (or his/her designee) notifies the GCBH Director:

- Within one (1) working day of receipt of this information for Standard appeals;

- Within the same day of receipt of this information for Expedited appeals.

(319) Grievance system – expedited appeals process – procedures
The enrollee/consumer is provided a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. When expedited resolution is requested, the enrollee/consumer is informed of the limited time available for this.

(320) Grievance system – expedited appeal process – resolution and notification
An expedited process is provided when it is determined that the standard time for resolution would jeopardize the enrollee/consumer's ability to maintain or regain maximum functioning. In these cases, the appeal is resolved, and written notice provided by GCBH to the enrollee/consumer within three (3) working days of its receipt, unless extended as noted below.

Requests for an expedited appeal resolution process are reviewed the day of receipt, and a decision as to whether an expedited process is warranted is communicated verbally by GCBH to the enrollee/consumer no later the twenty-four (24) hours after receipt of the request.

If the request for an expedited resolution process is denied, GCBH provides written notice within two (2) calendar days. The appeal is then addressed in accord with timelines for the Standard Resolution process.

Denial of access to an expedited process is grounds for the filing of a grievance, if the enrollee/consumer desires to do so.

Extensions. For both Standard and Expedited Resolution processes, the timeframe may be extended up to fourteen (14) additional calendar days if the enrollee/consumer requests it, or if GCBH determines a need for additional information and how the extension is in the enrollee/consumer's best interest. If an extension occurs at the request of GCBH rather than the enrollee/consumer, written notice of the reason for the delay is provided to the enrollee/consumer.

At the conclusion of both Standard and Expedited resolution processes, the GCBH Director or his/her designee provides the enrollee/consumer a written notice of disposition. For expedited processes, the GCBH Director or his/her designee also makes reasonable efforts to provide an oral notice of disposition prior to the written notice. The written notice includes the results of the resolution process, the date it was completed and the clinical rationale for the decision, including how to obtain the Utilization Management clinical review or decision-making criteria.

For appeals not wholly resolved in the enrollee/consumer's favor, the enrollee/consumer is informed of:

- The right to request a Fair Hearing, and how to do so;

- The right to request to receive benefits while the hearing is pending, and how to make the request; and
- The possibility that the enrollee/consumer may be held liable for the cost of those benefits if the hearing decision upholds GCBH's decision regarding the appeal.

(321) Grievance system – expedited appeal process – punitive action
GCBH ensures that no punitive or discriminatory action is taken against an enrollee/consumer who requests an expedited resolution process or a provider who supports an enrollee/consumer's appeal.

(322) Grievance system – state fair hearing process – notification of state procedures
All consumers have the right to request a Fair Hearing when they believe GCBH or one of its network providers has violated a State rule or timeline, or when they disagree with the outcome of a grievance. Additionally, Medicaid-eligible consumers may request a Fair Hearing if they disagree with a decision made by GCBH regarding their eligibility for services or they disagree with the resolution of an appeal.

All consumers receive a copy of the GCBH *Mental Health Service Benefit Handbook,* which includes information about requesting Fair Hearings, when admitted to community support services. Additionally, the Mental Health *Benefits Booklet* produced by DSHS, which also provides instructions regarding Fair Hearings, is made available to Medicaid enrollee/consumers at intake and upon request, and brochures from the GCBH Ombuds service are available at network provider sites and the GCBH office. Consumers are also provided with information regarding their right to request a Fair Hearing, and the process for doing so. All consumers receive a copy of the GCBH *Mental Health Service Benefit Handbook,* which includes information about filing grievances, at intake. As needed, explanation is provided through qualified interpreters for non-English speaking consumers and those who are deaf or visually impaired. Additionally, Medicaid enrollee/consumers are informed that the *Benefits Booklet* produced by the Department of Social and Health Services (DSHS), which also provides instructions regarding grievances, is available upon request, and a copy is provided if an enrollee/consumer requests one. Brochures from the GCBH Ombuds service are also available at network provider sites and the GCBH office.

(323) Grievance system – state fair hearing – parties
All consumers have the right to request a Fair Hearing when they believe GCBH or one of its network providers has violated a State rule or timeline, or when they disagree with the outcome of a grievance. Additionally, Medicaid-eligible consumers may request a Fair Hearing if they disagree with a decision made by GCBH regarding their eligibility for services or they disagree with the resolution of an appeal.

(324) Grievance system – grievance – definition

Grievance: A consumer's request that his/her expression of dissatisfaction with any aspect of care or services provided be formally heard and resolved via the GCBH grievance process. NOTE: When a Medicaid enrollee/consumer indicates disagreement with a decision to suspend, reduce or terminate services and asks that the decision be reconsidered, the request is an appeal rather than a grievance and is addressed via the GCBH appeal process. The consumer is made aware that, at any time during the investigation and resolution process, he/she may interact directly with GCBH and is made aware of his/her rights relative to requesting a Fair Hearing and the process for doing so.

(325) Grievance system – grievance process – procedures and authority to file

Consumers may file grievances, verbally or in writing, with either the network provider from which they receive services or directly to GCBH. Grievances are acknowledged in writing by the agency receiving them within five (5) working days following receipt; acknowledgements are documented in the confidential grievance file.

(326) Grievance system – grievance process – disposition and notification

When a consumer submits a grievance to a network provider from which he/she receives services, that agency's Director (or his/her designee) provides a written decision regarding the resolution of the grievance to the consumer and to the GCBH Director (or his/her designee) within twenty (20) calendar days.

- The timeframe may be extended up to fourteen (14) days if the consumer requests an extension or if the agency determines a need for additional information and that the extension is in the consumer's best interest.
- If the agency extends the timeframe, the consumer is provided written notice of the delay and the reason for it.
- If the Director of a network provider (or his/her designee) determines that it may not be possible to reach a decision within the 20-day timeframe, or that the consumer is not satisfied with the decision, he/she notifies the GCBH Director (or his/her designee) immediately.

A decision is rendered within thirty (30) calendar days of the initial request for a grievance. The timeframe may be extended up to fourteen (14) days if the consumer requests an extension or if GCBH determines a need for additional information and that the extension is in the consumer's best interest. If GCBH extends the timeframe, the consumer is provided written notice of the delay and the reason for it.

11

Tribal Communication and Coordination Plan

(169) Behavioral health organization – inclusion of tribal authorization – roles and responsibilities

The GCBH Interlocal Agreement allows for the Tribal Director of the Yakama Nation, a federally recognized tribal organization, to have a seat on the GCBH Board of Directors. A Yakama Nation representative regularly attends Board meetings. The Yakama Nation has indicated that it is not interested in entering a contract relationship with GCBH.

GCBH and the Yakama Nation regularly coordinate in the development of:

- The Policy 7.01 Implementation Plan;
- The American Indian Addendum; and
- The ITA Crisis Coordination Plans.

All GCBH provider contracts indicate services are to be provided to all enrollees/consumers who qualify and that services be provided in a culturally competent manner. Current contracts also state that the provider will participate, upon request, in the development of a Tribal and Recognized American Indian Organization Coordination Implementation Plan and will comply with any such plan developed. These provisions will be monitored as part of the GCBH contract and quality oversight functions.

The largest provider in Yakima County is Central Washington Comprehensive Mental Health (CWCMH) who has a long history of collaborating with Yakama Nation mental health and SUD providers. CWCMH provides crisis services to tribal members on or off tribal land and provides routine services to tribal members so long as they qualify for services. CWCMH provides consultation on individual cases and also provides training to Yakama Nation staff upon request. GCBH and CWCMH staff have met with the Yakama Nation and developed a draft Policy 7.01 Implementation Plan. The Plan was reviewed and approved at the Board of Directors meeting in October 2015 and is included in Attachment 9.

When tribal members require ITA services for SUD treatment they will have access to all available resources and use the county-designated CDP. Through the collaboration on ITA Crisis Coordination Plans, the Yakama Nation and GCBH will be clear on roles and responsibilities for accessing this service.

12

Behavioral Health Data Consolidation Project Plan

(295) Health information systems

The Behavioral Health Data Consolidation project has identified the draft set of data elements required for collection from the BHOs. Many of the data elements have standing definitions in current data dictionaries or reporting instructions and this is indicated in the attached Tables. Reporting rules and definitions and values for new elements will be developed with the RSN/BHO representatives between July 1 – September 11, 2015 either through the SERI workgroup or the BHDC data group.

GCBH's solution for addressing the additional SUD requirements to meet all of the State's reporting requirements includes implementing a new version of existing software. This new software is currently being developed by the vendor. The vendor has indicated as of October 28, 2015 that the new product is on schedule for delivery on January 1, 2016. Analysis for the new product is complete and development activities are well underway (see details below).

1. Provide your plan and timeline to collect and report on the data elements contained in Table 1 (Non-Provider One data elements) and Table 2 (Provider One data elements).
    - GCBH's solution for meeting the State's data collection and file submission requirements is to implement a new version of the existing software product. The vendor is actively addressing the changes to the software. The product will meet all of the State's file submission requirements including the new elements supporting SUD. A list of key milestones and dates include the following:

DESCRIPTION	DATE / STATUS
Data definitions and associated documentation (ERDs)	Complete
Software specifications documented	Complete
EDI implementation guides	Complete
State requirements analysis	Complete
Data tables, security, database maintenance documentation	Complete
Stored procedures & error handling	11/14/15
User training with test data	Complete

DESCRIPTION	DATE / STATUS
Foundation libraries	Complete
Native file import processes	Complete
Provider record processes	11/21/2015
Native import process training	11/21/2015
Agency data requirements/system enhancements confirmed	11/30/2015
EDI import processes	12/6/2015
Provider EDI import processes	12/13/2015
EDI import process training	12/13/2015
Native export processes	12/28/2015
EDI export processes	1/12/2016
Export process training	1/12/2016
Error processes	1/27/2016
Agency testing begins	2/1/2016
State testing begins	2/1/2016
Data management interface processes	2/11/2016
Critical reports	2/26/2016
Management systems training	3/12/2016

2. Describe your plan to assess and ensure the provider agencies in your network (or subcontractors) are able to submit client and service data that meets the BHO reporting requirements (as specified in table below).
    a. Describe any barriers your substance use disorder treatment agencies have in meeting the data collection and transmission requirements.
        - Most providers have an EHR system that will be used to collect and transmit the required information. However, not every provider has procured or is using an EHR system. For those that don't, they will be asked to electronically submit their data, including the new SUD elements, to the BHO. For those provider agencies that do not have systems that can collect the necessary information, the BHO will provide an Excel template that can be used. Technical training will be available for all provider agencies. Completeness and accuracy of data will be assessed and additional training opportunities will be presented on a case-by-case basis.
        - Another barrier for data collection could be the systems work needed to align the export functions of their EHR systems to provide the data elements in the correct format to meet GCBH/State import requirements. To mitigate this, GCBH has already met with all provider agencies multiple times. Agencies that have difficulty meeting the requirements and timelines will

have additional consulting services made available through the BHO's software vendor. Finally, if the agency simply cannot meet the requirements upon go-live the Excel templates can be used on a short-term basis to supply the needed information.

b. How are you communicating the data reporting requirements?
   - GCBH is providing copies of the draft BHDC Data Dictionary to the SUD groups and the MIS Committee.
   - GCBH will provide final copies to these same groups and include them as agenda items in the appropriate committees.
   - GCBH will update the Data Dictionaries and TPAs as necessary to meet the data submission requirements detailed in the final BHDC Data Dictionary. These updates will be reviewed and approved by the MIS Committee and distributed to all providers.

c. Describe technical assistance or other support you are providing to substance use disorder treatment agencies.
   - GCBH provides technical assistance to all provider agencies whenever they update their current EHR or move to a new EHR system. Technical assistance includes:
     - Consultation services to both the provider and the application vendor on the interpretation and understanding of the GCBH data dictionary, 837P / 837I file formats, layouts and other technical aspects.
     - Assistance in the interpretation of errors on all test files submitted to the test environment until the provider's new system is capable of submitting data in the required formats consistently.
     - GCBH-developed custom queries to assist in determining why submitted test data fails to be submitted properly.

d. Describe the IT systems/EHRs used by the provider agencies in your network to collect and submit client and services information.
   - Most of the outpatient providers utilize the same EHR solution, which streamlines software enhancements and associated testing.
   - Some of the provider agency solutions are complex, running in virtualized environments and capable of handling both MH and SUD data. For example, the EHR solutions of both Yakima Valley Farm Worker's Clinic and Tri-Cities Community Health handle medical information in addition to MH and SUD.
   - Most of the provider agency EHR solutions are simplified systems focused on either Mental Health or SUD, running either on standalone servers or a hosted solution and supported by a vendor.

3. Document your plan to collect client and services data from the substance use residential providers located throughout the state.

- In addition to contracting with the residential providers within the capitation area, GCBH is considering having contracts with several key residential providers outside of the capitation area, where these providers would submit the data to us just like any of the other service providers.

4. Document your systems capacity to collect, store, and submit funding source information associated with a person and service, in order to meet block grant reporting requirements.
    - Because block grants are non-Medicaid funded services, current billing and data submittal is a monthly manual process using the A1-19 form. As the new BHDC system is developed and provides mechanisms for the BHOs to submit this data electronically, GCBH will update the system to enable electronic submission of this data.

5. Describe how you will ensure that encounters are submitted within 30 days after the close of the month of service.
    - GCBH currently submits native (demographic) and 837/EDI (service/Encounter) data to the State on a daily basis (M-F).
    - GCBH monitors data receipt from providers in monthly encounter summary reports that are distributed and discussed in the MIS Committee.
    - GCBH provider contracts require submissions within pre-defined timeframes that allow the BHO to meet or exceed the State's requirements.

Attachment 1: Attestations and Responses for Detailed Plan

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
2	**RCW 43.20A**	**DEPARTMENT OF SOCIAL AND HEALTH SERVICES**				
3	RCW 43.20A.894	Behavioral health organizations - contracting process.	R	Address each requirement of these provisions. Specifically, describe how you will use provider reimbursement methods that incentivize improved performance with contractually required client outcomes, integration of behavioral and primary care services at the clinical level, and improved care coordination for individuals with complex care needs (address Apple Health coordination).	**Item (3), page 38, Section 7**	
4	RCW 43.20A.895	Adult Behavioral Health System - Improvement Strategy	R	Address the requirements of these provisions. Specifically, describe how you will address performance improvement in compliance with the PIHP Contract for those measures included in that contract.	**Item (4), page 55, Section 9**	
5	RCW 43.20A.896	Behavioral health organizations - access to chemical dependency and mental health professionals.	R	Describe how you will comply with the requirement to offer contracts to managed health care systems or primary care practice settings to promote access to the services of chemical dependency professionals and mental health professionals for the purposes of integrating such services into primary care settings for individuals with behavioral health and medical comorbidities. Provide a list of existing contracting arrangements and a description of planned efforts to promote clinical integration.	**Item (5), page 41, Section 7**	
6	RCW 70.96	**ALCOHOLISM**				
7	**RCW 70.96A.430**	**Inability to contribute to cost no bar to admission - department may limit admissions**	**A**			
8	RCW 70.96A.010	Declaration of policy.	A			
9	RCW 70.96A.011	Legislative finding and intent.	A			
10	RCW 70.96A.020	Definitions.	A			

Attestation Signature:_____Date:_____

The BHO has reviewed and understood and accepts any BHO duties created by all regulatory requirements on this page.

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
11	RCW 70.96A.030	Substance use disorder program.	A			
12	RCW 70.96A.035	Integrated comprehensive screening and assessment process - implementation.	A			
13	RCW 70.96A.040	Program authority.	A			
14	RCW 70.96A.043	Agreements authorized under the Interlocal Cooperation Act.	A			
15	RCW 70.96A.045	Funding prerequisites, facilities, plans, or programs receiving financial assistance.	A			
16	RCW 70.96A.050	Duties of department.	A			
17	RCW 70.96A.055	Drug court.	A			
18	RCW 70.96A.060	Interdepartmental coordinating committee.	A			
19	RCW 70.96A.080	Comprehensive program of treatment.	R	(1) Describe your system of care for substance use disorder treatment. Include specifically how it will include a full continuum of care, in accordance with ASAM levels of care as described in the PIHP Draft Contract, that includes withdrawal management, residential treatment and outpatient treatment for youth, pregnant and parenting women, and adults. (2) Describe how you will fund the services and incorporate and coordinate with public and private resources. (3) Describe how you will address emerging substance use disorder challenges, such as new trends in opiate, methamphetamine or marijuana use adn treatment. ~~(3) Describe your involuntary commitment program. (4) Describe your use of Medication Assisted Treatment therapies. (5) Provide a comprehensive assessment of evidence based, research based and promising practices both currently provided and planned to address substance use disorder treatment. Separate the these by youth, adult and older adult.~~	**Item (19), page 7, Section 3**	

Attestation Signature:_____Date:_____

The BHO has reviewed and understood and accepts any BHO duties created by all regulatory requirements on this page.

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
20	RCW 70.96A.090	Standards for treatment programs - enforcement procedures - penalties - evaluation of treatment of children - treatment during pregnancy.	A			
21	RCW 70.96A.095	Age of consent - outpatient treatment of minors for chemical dependency.	A			
22	RCW 70.96A.096	Notice to parents, school contacts for referring students to inpatient treatment.	A			
23	RCW 70.96A.097	Review of admission and inpatient treatment of minors - determination of medical necessity - department review - minor declines necessary treatment - at-risk youth petition - costs - public funds.	R	How will you assure an independent review occurs for minors admitted under the provisions of 70.96A.245 that meets these requirements? This requirement will be delegated to the BHO by the Department.	**Item (23), page 18, Section 3**	
24	RCW 70.96A.100	Acceptance for approved treatment.	R	Describe your utilization management system and how you will ensure substance use disorder treatment services are provided to Medicaid enrollees for whom they are medically necessary. Include a process for determining when and how much treatment is offered for other non-Medicaid populations based on the state's priorities. ~~Describe how will you address emerging substance use disorder challenges, such as new trends in opiate, methamphetamine or marijuana use and treatment.~~	**Item (24), page 47, Section 8**	
25	RCW 70.96A.110	Voluntary treatment of individuals with a substance use disorder.	R	Describe how you will document compliance with these requirements by any organization directly providing services to clients.	**Item (25), page 18, Section 3**	
26	RCW 70.96A.120	Treatment program and facilities - admissions - peace officer duties - protective custody.	R	Describe how you will assure compliance with the requirements.	**Item (26), page 18, Section 3**	
27	RCW 70.96A.140	Involuntary commitment.	R	Describe your program for involuntary commitment, including all agreements and arrangements in-place or planned with all entities with a required role in the involuntary commitment process.	**Item (27), page 18, Section 3**	
28	RCW 70.96A.141	Joinder of petitions for commitment.	A			

Attestation Signature:_____Date:_____

The BHO has reviewed and understood and accepts any BHO duties created by all regulatory requirements on this page.

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
29	RCW 70.96A.142	Evaluation by designated chemical dependency specialist - when required - required notifications.	R	Describe how you will assure that required evaluations and notifications are performed. Include all agreements and arrangements in-place or planned with all entities with shared responsibility for administration, i.e., CDPs, jails, courts, and Department of Corrections.	**Item (29), page 19, Section 3**	
30	RCW 70.96A.145	Involuntary commitment proceedings - prosecuting attorney may represent specialist or program.	A			
31	RCW 70.96A.148	Detention, commitment duties - designation of county designated mental health professional.	A			
32	RCW 70.96A.150	Records of persons treated for alcoholism and drug addiction.	A			
33	RCW 70.96A.155	Court ordered treatment - required notification.	A			
34	~~RCW 70.96A.157~~	~~Persons subject to court ordered treatment or supervision - documentation.~~	~~R~~	~~For individuals who are under the supervision of the Department of Corrections, describe how you would meet the coordination of care requirements under this provision.~~		
35	RCW 70.96A.160	Visitation and communication with patients.	A			
36	RCW 70.96A.170	Emergency service patrol - Establishment - Rules.	A			
37	RCW 70.96A.180	Payment for treatment - Financial ability of patients.	R	Describe how will you administer patient financial responsibility for non-Medicaid services	**Item (37), page 43, Section 7**	
38	RCW 70.96A.190	Criminal laws limitation.	A			
39	RCW 70.96A.230	Minor - When outpatient treatment provider must give notice to parents.	A			
40	RCW 70.96A.235	Minor - Parental consent for inpatient treatment - Exception.	A			
41	RCW 70.96A.240	Minor - Parents not liable for payment unless consented to treatment - No right to public funds.	A			

Attestation Signature:_____Date:_____

The BHO has reviewed and understood and accepts any BHO duties created by all regulatory requirements on this page.

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
42	RCW 70.96A.245	Minor - Parent may request determination whether minor has chemical dependency requiring inpatient treatment - Minor consent not required - Duties and obligations of professional person and facility.	A			
43	RCW 70.96A.250	Minor - parent may request determination whether minor has chemical dependency requiring outpatient treatment - minor consent not required - discharge of minor.	A			
44	RCW 70.96A.255	Minor - petition to superior court for release from facility.	A			
45	RCW 70.96A.260	Minor - not released by petition under RCW 70.96A.255 - release within thirty days - professional may initiate proceedings to stop release.	A			
46	RCW 70.96A.265	Eligibility for medical assistance under chapter 74.09 RCW - payment by department.	A			
47	RCW 70.96A.300	Counties may create alcoholism and other drug addiction board - generally.	R	Address advisory board membership in compliance with Exhibit F, BHO Advisory Board Membership.	**Item (47), page 25, Section 4**	
48	RCW 70.96A.350	Criminal justice treatment account.	R	Describe how you will ensure substance use disorder treatment services are provided to persons enrolled in substance use disorder treatment under the criminal justice treatment account. Describe how you will develop your local plan in conjunction with the stakeholder groups described in this section and as described in the draft PIHP contract.	**Item (48), page 20, Section 3**	
49	RCW 70.96A.400	Opiate substitution treatment - declaration of regulation by state.	A			
50	RCW 70.96A.410	Opiate substitution treatment - program certification by department, department duties - definition of opiate substitution treatment.	~~A~~R	Describe your use of Medication Assited Treatment Therapies.	**Item (50), page 33, Section 5**	
51	RCW 70.96A.420	Statewide treatment and operating standards for opiate substitution programs - evaluation and report.	A			

Attestation Signature:_____Date:_____

The BHO has reviewed and understood and accepts any BHO duties created by all regulatory requirements on this page.

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
52	RCW 70.96A.430	Inability to contribute to cost no bar to admission - department may limit admissions.	A			
53	RCW 70.96A.915	Department allocation of funds - construction.	A			
54	~~RCW 70.96B.030~~	~~Designated crisis responder - qualifications.~~	~~A~~			
55	~~RCW 70.96B.040~~	~~Powers of designated crisis responder.~~	~~A~~			
56	~~RCW 70.96B.045~~	~~Emergency custody - procedure.~~	~~A~~			
57	~~RCW 70.96B.050~~	~~Petition for initial detention - order to detain for evaluation and treatment period - procedure.~~	~~A~~			
58	~~RCW 70.96B.060~~	~~Exemption from liability.~~	~~A~~			
59	~~RCW 70.96B.070~~	~~Detention period for evaluation and treatment.~~	~~A~~			
60	~~RCW 70.96B.080~~	~~Detention for evaluation and treatment of mental disorder - Chapter 71.05 RCW applies.~~	~~A~~			
61	~~RCW 70.96B.090~~	~~Procedures for additional chemical dependency treatment.~~	~~A~~			
62	~~RCW 70.96B.100~~	~~Detention for involuntary chemical dependency treatment - petition for less restrictive treatment - appearance before court - representation - hearing less restrictive order - failure to adhere to terms of less restrictive order.~~	~~A~~			
63	~~RCW 70.96B.110~~	~~Involuntary chemical dependency treatment proceedings - prosecuting attorney shall represent petitioner.~~	~~A~~			
64	~~RCW 70.96B.120~~	~~Rights of involuntarily detained~~	~~A~~			
65	~~RCW 70.96B.130~~	~~Evaluation by a designated crisis responder - when required - required notifications.~~	~~A~~			
66	~~RCW 70.96B.140~~	~~Secretary may adopt rules.~~	~~A~~			
67	~~RCW 70.96B.150~~	~~Application of RCW 71.05.550~~	~~A~~			
68	~~RCW 70.96B.800~~	~~Evaluation of pilot programs - reports.~~	~~A~~			
69	RCW 71.05	**MENTAL ILLNESS**				
70	RCW 71.05.010	Legislative intent.	A			
71	RCW 71.05.012	Legislative intent and finding.	A			

Attestation Signature:_____Date:_____

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	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
72	RCW 71.05.020	Definitions.	A			
73	RCW 71.05.025	Integration with chapter 71.24 RCW - behavioral health organizations.	A			
74	RCW 71.05.026	Behavioral health organizations contracts - limitation on state liability.	A			
75	RCW 71.05.030	Commitment laws applicable.	A			
76	RCW 71.05.032	Joinder of petitions for commitment.	A			
77	RCW 71.05.040	Detention or judicial commitment of persons with developmental disabilities, impaired by chronic alcoholism or drug abuse, or suffering	A			
78	RCW 71.05.050	Voluntary application for mental health services - rights - review of condition and status - detention - person refusing voluntary admission, temporary detention.	A			
79	RCW 71.05.100	Financial responsibility.	A			
80	RCW 71.05.110	Compensation of appointed counsel.	A			
81	RCW 71.05.120	Exemptions from liability.	A			
82	RCW 71.05.130	Duties of prosecuting attorney and attorney general.	A			
83	RCW 71.05.132	Court-ordered treatment - required notifications.	A			
84	RCW 71.05.135	Mental health commissioners - appointment.	A			
85	RCW 71.05.137	Mental health commissioners - authority.	A			
86	RCW 71.05.140	Records maintained.	A			
87	RCW 71.05.145	Offenders with mental illness who are believed to be dangerous - less restrictive alternative.	A			
88	RCW 71.05.150	Detention of persons with mental disorders for evaluation and treatment - procedure.	A			
89	RCW 71.05.153	Emergent detention of persons with mental disorders - procedure.	A			
90	RCW 71.05.154	Detention of persons with mental disorders - evaluation - consultation with emergency room physician.	A			

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91	RCW 71.05.156	Detention of persons with mental disorders - evaluation - consultation with emergency room physician.	A			
92	RCW 71.05.157	Evaluation by designated mental health professional - when required - required notifications.	A			
93	RCW 71.05.160	Petition for initial detention.	A			
94	RCW 71.05.170	Acceptance of petition - notice - duty of state hospital.	A			
95	RCW 71.05.180	Detention period for evaluation and treatment.	A			
96	RCW 71.05.190	Persons not admitted - transportation - detention of arrested person pending return to custody.	A			
97	RCW 71.05.195	Not guilty by reason of insanity - detention of persons who have fled from state of origin - probable cause hearing.	A			
98	RCW 71.05.210	Evaluation - treatment and care - release or other disposition.	A			
99	RCW 71.05.212	Evaluation - consideration of information and records.	A			
100	RCW 71.05.214	Protocols - development - submission to governor and legislature.	A			
101	RCW 71.05.215	Right to refuse antipsychotic medicine - rules.	A			
102	RCW 71.05.217	Rights - posting of list.	A			
103	RCW 71.05.220	Property of committed person.	A			
104	RCW 71.05.230	Procedures for additional treatment.	A			
105	RCW 71.05.232	Discharge reviews - consultations, notifications required.	A			
106	RCW 71.05.235	Examination, evaluation of criminal defendant - hearing.	A			
107	RCW 71.05.237	Judicial proceedings - court to enter findings when recommendations of professional person not followed.	A			
108	RCW 71.05.240	Petition for involuntary treatment or alternative treatment - probable cause hearing.	A			

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109	RCW 71.05.245	Determination of grave disability or likelihood of serious harm - use of recent history evidence.	A			
110	RCW 71.05.260	Release from involuntary intensive treatment - exception.	A			
111	RCW 71.05.270	Temporary release.	A			
112	RCW 71.05.280	Additional confinement - grounds.	A			
113	RCW 71.05.285	Additional confinement - prior history evidence.	A			
114	RCW 71.05.290	Petition for additional confinement - affidavit.	A			
115	RCW 71.05.300	Filing of petition - appearance - notice - advice as to rights - appointment of attorney, expert, or professional person.	A			
116	RCW 71.05.310	Time for hearing - due process — jury trial - continuation of treatment.	A			
117	RCW 71.05.320	Remand for additional treatment - less restrictive alternatives - duration - grounds - hearing.	A			
118	RCW 71.05.325	Release - authorized leave - notice to prosecuting attorney.	A			
119	RCW 71.05.330	Early release - notice to court and prosecuting attorney - petition for hearing.	A			
120	RCW 71.05.335	Modification of order for inpatient treatment - Intervention by prosecuting attorney.	A			
121	RCW 71.05.340	Outpatient treatment or care - conditional release - procedures for revocation.	A			
122	RCW 71.05.350	Assistance to released persons.	A			
123	RCW 71.05.360	Rights of involuntarily detained	A			
124	RCW 71.05.365	Involuntary commitment - Individualized discharge plan. (Effective July 1, 2018.)	R	Describe your current process for discharge planning and describe how you would propose transitioning that process to meet the requirement to work with the hospital to develop an individualized discharge plan and arrange for a transition to the community in accordance with the person's individualized discharge plan within twenty-one days of the determination by July 1, 2018.	**Item (124), page 21, Section 3**	

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125	RCW 71.05.380	Rights of voluntarily committed persons.	A			
126	RCW 71.05.425	Persons committed following dismissal of sex, violent, or felony harassment offense - notification of conditional release, final release, leave, transfer, or escape - to whom given - definitions.	A			
127	RCW 71.05.435	Discharge of person from evaluation and treatment facility or state hospital - notice to designated mental health professional office.	A			
128	RCW 71.05.445	Court-ordered mental health treatment of persons subject to department of corrections supervision - initial assessment inquiry - required notifications - rules.	A			
129	RCW 71.05.500	Liability of applicant.	A			
130	RCW 71.05.510	Damages for excessive detention.	A			
131	RCW 71.05.520	Protection of rights - staff.	A			
132	RCW 71.05.525	Transfer of person committed to juvenile correction institution to institution or facility for juveniles with mental illnesses.	A			
133	RCW 71.05.530	Facilities part of comprehensive mental health program.	A			
134	RCW 71.05.560	Adoption of rules.	A			
135	RCW 71.05.570	Rules of court.	A			
136	RCW 71.05.575	Less restrictive alternative treatment - consideration by court.	A			
137	RCW 71.05.620	Court files and records closed - exceptions - rules.	A			
138	RCW 71.05.660	Treatment records - privileged communications unaffected.	A			
139	RCW 71.05.680	Treatment records - access under false pretenses, penalty.	A			
140	RCW 71.05.700	Home visit by designated mental health professional or crisis intervention worker - accompaniment by second trained individual.	A			

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1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
141	RCW 71.05.705	Provider of designated mental health professional or crisis outreach services - policy for home visits.	A			
142	RCW 71.05.710	Home visit by mental health professional - wireless telephone to be provided.	A			
143	RCW 71.05.715	Crisis visit by mental health professional - access to information.	A			
144	RCW 71.05.720	Training for community mental health employees.	A			
145	RCW 71.05.730	Judicial services - civil commitment cases - reimbursement.	A			
146	RCW 71.05.732	Reimbursement for judicial services - assessment.	A			
147	RCW 71.05.740	Reporting of commitment data.	A			
148	RCW 71.05.801	Persons with developmental disabilities - service plans - habilitation services.	A			
149	RCW 71.24	**COMMUNITY MENTAL HEALTH SERVICES ACT**				
150	RCW 71.24.015(1)	Legislative intent and policy.	R-A	~~(1) Describe how you will address access to care, the provision of a full array of services and identification of needs for youth, adults and older adults in compliance with this section. (2) Provide a comprehensive assessment of Evidence-Based Practices, Research Based and Promising Practices currently available and a plan to address any gaps and expansion of practices, including workforce development. staffing and training. Separate the response by Youth, Adults and Older Adults.~~		
151	RCW 71.24.015(2)	Legislative intent and policy.	R	Describe how you will involve persons with lived behavioral health experience, their families and advocates in designing and implementing behavioral health services in compliance with this section.	**Item (151), page 24, Section 4**	
152	RCW 71.24.015(3 -	Legislative intent and policy.	A			
153	RCW 71.24.016	Intent - management of services for people with mental disorders.	A			
154	RCW 71.24.025	Definitions.	A			
155	RCW 71.24.035	Secretary's powers and duties as state mental health authority.	A			

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1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
156	RCW 71.24.037	Licensed service providers, residential services, community support services - minimum standards.	A			
157	RCW 71.24.045	Behavioral health organization powers and duties.	A			
158	RCW 71.24.055	Children's mental health services - children's access to care standards and benefit package.	~~A~~ R	~~Describe your current capacity for WISe services and your planning to have sufficient capacity to provide fully-compliant WISe services in accordance with the WISe Manual and the PIHP Draft Contract.~~ Based on the WISe Capacity Expansion document attached as Exhibit G. As of April 1, 2016, what caseload capacity will the BHO have to provide WISe? What is the plan for the BHO to meet the FY16 June 30, 2016 WISe monthly capacity ~~goal~~?	**Item (158), page 34, Section 5**	
159	RCW 71.24.061	Children's mental health providers - children's mental health evidence-based practice institute - pilot program.	A			
160	RCW 71.24.100	Joint agreements of county authorities - required provisions.	R	If the proposed Behavioral Health Organization involves more than one county, provide a copy of the required agreement that meets the requirements of this section.	**Item (160), page 2, Section 2**	
161	RCW 71.24.110	Joint agreements of county authorities - permissive provisions.	R	If the proposed Behavioral Health Organization involves more than one county, provide a copy of the required agreement that addresses this section.	**Item (161), page 2, Section 2**	
162	~~**RCW 71.24.155**~~	~~**Grants to behavioral health organizations - accounting.**~~	~~**A**~~			
163	RCW 71.24.160	Proof as to uses made of state funds - use of maintenance of effort funds.	A			
164	RCW 71.24.200	Expenditures of county funds subject to county fiscal laws.	A			
165	RCW 71.24.215	Clients to be charged for services.	A			
166	RCW 71.24.220	Reimbursement may be withheld for noncompliance with chapter or related rules.	A			
167	RCW 71.24.240	County program plans to be approved by secretary prior to submittal to federal agency.	A			
168	RCW 71.24.250	Behavioral health organizations - gifts and grants.	A			

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1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
169	RCW 71.24.300 (1, 2, 3, 4, & 5)	Behavioral health organization - inclusion of tribal authorization - roles and responsibilities.	R	(1) ~~Describe how you will comply with the tribal requirements of these sections.~~ How will the BHO allow for the inclusion of the tribal authority to be represented as a party to the behavioral health organization?(2) Provide a work plan for the implementation of the American Indian Addendum, Exhibit E to the DPR. (3) Address how you will assure that AI/AN enrollees have equal access to behavioral health services. (4) Describe how you will provide culturally competent services to AI/AN. (5) ~~Describe your plan to respond to Tribal ITA court orders for Substance Use Disorder Treatment.~~ How will the BHO provide for a	**Item (169), page 77, Section 11**	
170	RCW 71.24.300(6)	Behavioral health organization - inclusion of tribal authorization - roles and responsibilities.	A			
171	RCW 71.24.300 (7, 8, & 9)	Behavioral health organization - inclusion of tribal authorization - roles and responsibilities.	A			
172	RCW 71.24.310	Administration of chapters 71.05 and 71.24 RCW through behavioral health organizations - implementation of chapter 71.05.	A			
173	RCW 71.24.330	Behavioral health organizations - contract with department - requirements.	A			
174	RCW 71.24.340	Behavioral health organizations - agreements with city and county jails.	R	Provide copies of any agreements with jails or plans for agreements with jails.	**Item (174), page 34, Section 5**	
175	RCW 71.24.350	Mental health ombuds office.	R	Describe plans to provide behavioral health ombuds services, that will meet the needs of those who access both the mental health and substance use disorder treatment	**Item (175), page 36, Section 6**	
176	RCW 71.24.370	Behavioral health organizations contracts - limitation on state liability.	A			
177	RCW 71.24.385	Behavioral health organizations - mental disorder program development.	A			
178	RCW 71.24.400	Streamlining delivery system - finding.	A			
179	RCW 71.24.405	Streamlining delivery system.	A			
180	RCW 71.24.415	Streamlining delivery system - department duties to achieve outcomes.	A			
181	RCW 71.24.420	Expenditure of federal funds.	A			
182	RCW 71.24.430	Collaborative service delivery.	A			

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1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
183	RCW 71.24.450	Offenders with mental illnesses - findings and intent.	A			
184	RCW 71.24.805	Mental health system review - performance audit recommendations affirmed.	A			
185	RCW 71.24.810	Mental health system review - implementation of performance audit recommendations.	A			
186	RCW 71.24.840	Mental health system review - study of long-term outcomes.	A			
187	RCW 71.24.845	Behavioral health organizations - Transfers between organizations.	R	Discuss how your transfer process to ensure a seamless and safe transition in services, including the sharing of information. Discuss how your transfer process will work with a region that is fully integrated and is not managed by a	**Item (187), page 23, Section 3**	
188	RCW 71.24.850	Regional service areas - report - managed care integration.	A			
189	RCW 71.34	Mental Health Services for Minors				
190	RCW 71.34.10	Purpose - parental participation in treatment decisions - parental control of minor children during treatment.	A			
191	RCW 71.34.020	Definitions.	A			
192	RCW 71.34.300	Responsibility of counties for evaluation and treatment services for	A			
193	RCW 71.34.305	Notice to parents, school contacts for referring students to inpatient treatment.	A			
194	RCW 71.34.310	Jurisdiction over proceedings under chapter - venue.	A			
195	RCW 71.34.315	Mental health commissioners - authority.	A			
196	RCW 71.34.320	Transfer of superior court proceedings to juvenile department.	A			
197	RCW 71.34.325	Court proceedings under chapter subject to rules of state supreme court.	A			
198	RCW 71.34.330	Attorneys appointed for minors - compensation.	A			
199	RCW 71.34.335	Court records and files confidential - availability.	A			
200	RCW 71.34.355	Rights of minors undergoing treatment - posting.	A			

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1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
201	RCW 71.34.360	No detention of minors after eighteenth birthday - exceptions.	A			
202	RCW 71.34.365	Release of minor - requirements.	A			
203	RCW 71.34.370	Antipsychotic medication and shock treatment.	A			
204	RCW 71.34.375	Parent-initiated treatment - notice to parents of available treatment options.	A			
205	RCW 71.34.377	Failure to notify parent or guardian of treatment options - civil penalty.	A			
206	RCW 71.34.379	Notice to parent or guardian - treatment options - policy and protocol adoption - report.	A			
207	RCW 71.34.380	Department to adopt rules to effectuate chapter.	A			
208	RCW 71.34.385	Uniform application of chapter - training for county-designated mental health professionals.	A			
209	~~RCW 71.34.390~~	~~Redirection of Title XIX funds to fund placements within the state.~~	~~A~~			
210	RCW 71.34.395	Availability of treatment does not create right to obtain public funds.	A			
211	RCW 71.34.400	Eligibility for medical assistance under chapter 74.09 RCW - payment by department.	A			
212	RCW 71.34.405	Liability for costs of minor's treatment and care - rules.	A			
213	RCW 71.34.410	Liability for performance of duties under this chapter limited.	A			
214	RCW 71.34.415	Judicial services - civil commitment cases - reimbursement.	A			
215	RCW 71.34.500	Minor thirteen or older may be admitted for inpatient mental treatment without parental consent - professional person in charge must concur - written renewal of consent required.	A			
216	RCW 71.34.510	Notice to parents when minor admitted to inpatient treatment without parental consent.	A			

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1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
217	RCW 71.34.520	Minor voluntarily admitted may give notice to leave at any time.	A			
218	RCW 71.34.530	Age of consent - outpatient treatment of minors.	A			
219	~~RCW 71.34.600~~	~~Parent may request determination whether minor has mental disorder requiring inpatient treatment - minor consent not required - duties and obligations of professional person and facility.~~	~~R~~	~~Describe the process for responding to a parent request, including documentation of resources offered.~~		
220	RCW 71.34.610	Review of admission and inpatient treatment of minors - determination of medical necessity - department review - minor declines necessary treatment - at-risk youth petition - costs - public funds.	A			
221	RCW 71.34.620	Minor may petition court for release from facility.	A			
222	RCW 71.34.630	Minor not released by petition under RCW 71.34.620 - release within thirty days - professional may initiate proceedings to stop release.	A			
223	RCW 71.34.640	Evaluation of treatment of minors.	A			
224	RCW 71.34.650	Parent may request determination whether minor has mental disorder requiring outpatient treatment - consent of minor not required - discharge of minor.	A			
225	RCW 71.34.660	Limitation on liability for admitting or accepting minor child.	A			
226	RCW 71.34.700	Evaluation of minor thirteen or older brought for immediate mental health services - temporary detention.	A			
227	RCW 71.34.710	Minor thirteen or older who presents likelihood of serious harm or is gravely disabled - transport to inpatient facility - petition for initial detention - notice of commitment hearing - facility to evaluate and admit or release minor.	A			

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1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
228	RCW 71.34.720	Examination and evaluation of minor approved for inpatient admission - referral to chemical dependency treatment program - right to communication, exception - evaluation and treatment period.	A			
229	~~RCW 71.34.730~~	~~Petition for fourteen-day commitment requirements.~~	~~R~~	~~Describe the process for identifying alternatives to commitment.~~		
230	RCW 71.34.740	Commitment hearing - requirements - findings by court - commitment - release.	A			
231	RCW 71.34.750	Petition for one hundred eighty-day commitment - hearing - requirements - findings by court - commitment order - release - successive commitments.	R	(1) Describe how you coordinate with the CLIP administration. (2) Describe the process for identifying alternatives to commitment.	**Item (231), page 22, Section 3**	
232	RCW 71.34.760	Placement of minor in state evaluation and treatment facility - placement committee - facility to report to committee.	A			
233	RCW 71.34.770	Release of minor - conditional release - discharge.	A			
234	RCW 71.34.780	Minor's failure to adhere to outpatient conditions - deterioration of minor's functioning - transport to inpatient facility - order of apprehension and detention - revocation of alternative treatment or conditional release - hearings.	R	Describe how you will coordinate, assess and monitor intensive community services and coordinate with inpatient/residential resources.	**Item (234), page 22, Section 3**	
235	RCW 71.34.790	Transportation for minors committed to state facility for one hundred eighty-day treatment.	A			
236	RCW 71.34.795	Transferring or moving persons from juvenile correctional institutions or facilities to evaluation and treatment facilities.	A			
237		**FEDERAL REGULATIONS**				
238	42 CFR 438.6(g)	Contract requirements - inspection and audit of financial records.	A			

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1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
239	42 CFR 438.6(i)(1, 3, & 4), 42 CFR 438.10(g)(2), 42 CFR 422.128, 42 CFR 489 (Subpart I), 42 CFR 489.100	Contract requirements - advance directives.	A			
240	42 CFR 438.10(a)	Information requirements - terminology - enrollee and potential	A			
241	42 CFR 438.10(b)(1), State Medicaid Director (SMD) Letter 02/20/98	Information requirements - basic rules - provide understandable materials.	A			
242	42 CFR 438(b)(3)	Information requirements - understanding requirements and benefits.	A			
243	42 CFR 438(c)(3, 4 & 5), 42 CFR 438.10(d)(1)(i), 42 CFR 438.10(d)(1)(ii), 42 CFR 438.10(d)(2)	Information requirements - language requirements - format and alternative format requirements.	A			
244	42 CFR 438.10(f)(5)	Information requirements - notice of provider termination.	A			

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245	42 CFR 422.208, 42 CFR 422.210, 42 CFR 431.230, 42 CFR 438(10)(f), 42 CFR 438.10(f)(3), 42 CFR 438.10(f)(6), SMD Letter 01/21/98, 42 CFR 438.10(f)(6)(iv), 42 CFR 438.10(g)(1), 42 CFR 438.10(h), 42 CFR 438.102(c), 42 CFR 400 - 424, 42 CFR 438.6(h), 42 CFR 438.6(i)(1&2), 42 CFR 489.102(a), State Medicaid Manual (SMM) 2900, SMM 2902.2	Information requirements - enrollees.	R	Describe how you will notify and provide information regarding changes from BHO Integration to enrollees, providers and allied systems with whom you coordinate care.	**Item (245), page 25, Section 4**	
246	42 CFR 438.12(a)(1), 42 CFR 438.214)c), SMD Letter 02/20/98	Provider discrimination - general.	A			
247	42 CFR 438.12(a)(1), 42 CFR 438.12(b)(1)	Provider discrimination - declining providers.	A			
248	42 CFR 438.6(m)	Choice of health professional.	A			
249	42 CFR 438.6(d)(1)	Enrollment discrimination prohibited.	A			
250	42 CFR 438.6(d)(3&4)	Enrollment not discriminatory.	A			
251	~~42 CFR 438.56(d)(2)~~	~~Cause for disenrollment.~~	~~A~~			
252	42 CFR 438.100(a)(1)	Enrollee rights - general rule.	A			
253	42 CFR 438.100(c)	Free exercise of rights.	A			

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254	42 CFR 438.6(f)(1), 42 CFR 438.100(a)(2), 42 CFR 438.100(d)	Compliance with other state laws and federal laws and regulations.	A			
255	1932(b)(3)(D), 42 CFR 438.102(a)(1)(ii, iii & iv), SMD Letter 02/20/98	Anti-gag clause.	A			
256	1932(b)(3)(B)(i), 42 CFR 438.102(a)(2), SMD Letter 02/20/98	Moral or religious objections.	A			
257	42 CFR 438.104(a)	Terminology.	A			
258	1932(d)(2)(A)(I), 42 CFR 438.104(b)(1)(i), SMD Letter 12/30/97	State approval.	A			
259	1932(d)(2)(A)(i)(II), 1932(d)(2)(B, C, D & E), 42 CFR 438.104(b)(1)(ii, iii, iv & v), 42 CFR 438.104(b)(2)(i & ii), SMD Letter 12/30/97, SMD Letter 02/20/98, SMM 2090.1, SMM 2101	Informed decision.	A			
260	1916(a)(2)(D), 1916(b)(2)(D), 42 CFR 438.108, SMM 2089.8, SMD Letter 12/30/97	Cost sharing - general.	A			
261	1932(b)(2), 42 CFR 438.114(a), SMD Letter 02/20/98	Emergency medical condition.	A			

Attestation Signature:_____Date:_____

The BHO has reviewed and understood and accepts any BHO duties created by all regulatory requirements on this page.

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
262	1932(b)(2), 42 CFR 438.114(a), SMD Letter 02/20/98	Emergency services.	A			
263	1852(d)(2), 42 CFR 438.114(a), 42 CFR 422.113(c)(1), SMD Letter 08/05/98	Post stabilization services.	A			
264	1852(d)(2), 42 CFR 438.114(b), 42 CFR 422.113(c), SMD Letter 08/05/98	Emergency services.				
265	1932(b)(2), 42 CFR 438.114(c)(1)(i), SMD Letter 02/20/98	Emergency services.	A			
266	1932(b)(2), 42 CFR 438.114(c)(1)(ii)(A), SMD Letter 02/20/98	Emergency medical condition.	A			
267	42 CFR 438.114(c)(1)(ii)(B), SMD Letter 02/20/98	Emergency services.	A			
268	42 CFR 438.114(d)(1)(i & ii)	Emergency and post-stabilization services - additional rules.	A			
269	42 CFR 114(d)(2 & 3)	Emergency and post-stabilization services - additional rules.	A			
270	42 CFR 438.114(e), 42 CFR 422.113(c)(2)(i, ii, iii & iv), SMD Letter 08/05/98	Post-stabilization - financial responsibility - limitation on charges.	A			
271	42 CFR 438.114(e), 42 CFR 422.113(c)(3)	Post-stabilization - end of financial responsibility.	A			
272	42 CFR 438.204	Access standards - independent review.	A			

Attestation Signature:_____Date:_____

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	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
273	42 CFR 438.206(b)(1)	Delivery network.	R	1. Provide a detailed analysis of your delivery network that demonstrates that the network: a. Is or will be supported by written agreements. b. Is sufficient to provide adequate access to all services covered under the contracts, and, if it is not sufficient, provides a plan to correct the deficiency. Consider the time and distance standards in the draft PIHP contract attached. c. Considers anticipated Medicaid enrollment, expected utilization, provider requirements (number and type), provider capacity, and location and physical access to providers. Include how language and cultural considerations will be addressed. d. Includes providers who can meet the needs of pregnant women, as identified in the contracts as a special healthcare need, with a Substance Use Disorder diagnosis. . e. Includes providers who can address the needs of individuals who have either been referred through the Department of Corrections, Drug Courts or identified through activities funded by the Criminal Justice Treatment	**Item (273), page 27, Section 5**	
274	42 CFR 438.206(b)(3)	Second opinion.	R	Provide information on how enrollees obtain a second opinion for all behavioral health services.	**Item (274), page 52, Section 9**	
275	42 CFR 438.206(b)(3)	Out-of-network services.	R	Provide information on how enrollees can receive medically necessary out-of-network SUD services when those services are not obtainable within your network or not obtainable within the timeframes specified in the contract.	**Item (275), page 32, Section 5**	
276	42 CFR 438.206(b)(5)	Out-of-network services - payment.	A			
277	42 CFR 438.206)c)((1)(i, ii, iii, iv, v, & vi)	Timely access.	R	Describe how you will assure and monitor timely access to care. Consider the Access standards in the draft PIHP contract attached for Routine, Urgent and Emergent.	**Item (277), page 53, Section 9**	
278	42 CFR 438.2060c)(2)	Cultural considerations.	A			
279	42 CFR 438.207(b & c)	Documentation of adequate capacity and services.	R	Describe the documentation that you would be prepared to submit to DSHS on a periodic basis to demonstrate the sufficiency of your network.	**Item (279), page 30, Section 5**	
280	42 CFR 438.208(b)(1, 2, & 3)	Primary care and coordination of health care services.	R	Fully describe how you will coordinate services with the health care system in compliance with this provision, the PIHP contract and good practice. Provide agreements, proposed agreements and policies and procedures.	**Item (280), page 4, Section 3**	

Attestation Signature:_____Date:_____

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	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
281	42 CFR 438.208(c)(2, 3, &	Enrollees with special health care needs.	A			
282	42 CFR 438.210(a)(1, 2 & 3)	Coverage.	A			
283	42 CFR 438.210(a)(4)	Medically Necessary Services.	A			
284	42 CFR 438.210(b)(1, 2, & 3)	Authorization of services.	R	Describe your utilization management system and how it will be modified to provide all utilization management activities, including authorization of services, for substance use disorder services.	**Item (284), page 47, Section 8**	
285	42 CFR 438.210(d)(1)	Timeframe for decisions.	A			
286	42 CFR 438.210(e)	Compensation for utilization management activities.	A			
287	42 CFR 438.12(a)(2), 42 CFR 438.214	Contracts with providers.	R	Provide a list of contracted or anticipated contracted providers and the services they will provide.	**Item (287), page 30, Section 5**	
288	42 CFR 438.214(a, b, c, & d)	Provider requirements.	A			
289	42 CFR 438.224	Confidentiality.	A			
290	42 CFR 438.6(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1, 2, & 3), SMM 2087.4	Subcontractual relationships and delegation.	R	Provide sample subcontracts and/or delegation agreements. Provide policies and procedures for subcontracting and delegation that address these regulatory requirements and specifically address how subcontracted/delegated entities are evaluated and monitored. Provide the most recent monitoring reports for three entities. Describe in detail your current and planned subcontracting/delegation activities for substance use disorder treatment services.	**Item (290), page 55, Section 9**	
291	42 CFR 438.236(b, c, & d)	Practice guidelines.	A			
292	42 CFR 438.240(a)(1 & 2), 42 CFR 438.240(b)(2, 3 & 4), 42 CFR 438.240(c) and (4), SMM 2091.7	Quality assessment and performance improvement program.	R	(1) Describe your plan for quality assessment and a performance improvement program that will assess the implementation of substance use disorder treatment services that meets the standards in the attached contracts. Include the quality structure and planned measurements and activities. (2) Provide a plan to correct any deficiencies identified. (3) Provide the name of the quality manager.	**Item (292), page 49, Section 9**	

Attestation Signature:_____Date:_____

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	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
293	42 CFR 438.240(b)(1), 42 CFR 438.240(d)(1 & 2)	Performance improvement projects.	A			
294	42 CFR 438.240(e)(2)	Program review by the state.	A			
295	42 CFR 438.242(a), 42 CFR 438.242(b)(1, 2 & 2)	Health information systems.	R	Provide a response to the Behavioral Health Data Consolidation Requirements, Exhibit A to the Detailed Plan Request.	**Item (295), page 78, Section 12**	
296	42 CFR 438.228,42 CFR 438.402(a),42 CFR 438.400(b), 42 CFR 438.406(a)	Grievance system - general requirements.	R	Provide a comprehensive assessment of your current compliance with all State and Federal Grievance System requirements, regulatory and contractual. For any deficiencies identified, provide a detailed work plan to correct the deficiencies to be completed no later than April	**Item (296), page 56, Section 10**	
297	42 CFR 431.201, 42 CFR 438.400(b), 42 CFR 438.52(b)(2)(ii), 42 CFR 438.56(f)(2)	Grievance system - action.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (297), page 59, Section 10**	
298	42 CFR 431.201	Grievance system - service authorization.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (298), page 60, Section 10**	
299	42 CFR 438.210(b)(3)	Grievance system - service authorization process.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (299), page 61, Section 10**	
300	42 CFR 438.210(c), 42 CFR 431.200(b), 42 CFR 431.206, 42 CFR 438.404(a, b & c), 42 CFR 438.10(c & d)	Grievance system - notice of action.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (300), page 63, Section 10**	
301	42 CFR 438.404(c), 42 CFR 431.211, 42 CFR 431.213, 42 CFR 431.214, 42 CFR 483.12(a)(5)(ii)	Grievance system - notice of action - timeframes - termination, suspension or reduction of services.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (301), page 65, Section 10**	

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	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
302	42 CFR 438.404(c)(2)	Grievance system - notice of action - timeframes - denial of payment.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (302), page 65, Section 10**	
303	42 CFR 438.210(c), 42 CFR 438.210(d)(1), 42 CFR 438.404(c)(3 & 4)	Grievance system - notice of action - timeframes - denial of standard authorization.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (303), page 65, Section 10**	
304	42 CFR 438.210(d)(2), 42 CFR 438.404(c)(6)	Grievance system - notice of action - timeframes - denial of expedited authorization.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (304), page 65, Section 10**	
305	42 CFR 438.404(c)(5)	Grievance system - notice of action - timeframes - untimely authorization.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (305), page 66, Section 10**	
306	42 CFR 438.41442 CFR 438.10(g)(1)	Grievance system - information to providers and subcontractors.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (306), page 66, Section 10**	
307	42 CFR 438.416	Grievance system - record keeping and reporting.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (307), page 67, Section 10**	
308	42 CFR 438.400(b)	Grievance system - appeal.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (308), page 67, Section 10**	
309	42 CFR 438.402(b)(1)	Grievance system - authority to file.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (309), page 67, Section 10**	
310	42 CFR 438.402(b)(2)	Grievance system - timing.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (310), page 68, Section 10**	

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	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
311	42 CFR 438.402(b)(3)(ii), 42 CFR 438.406(b)	Grievance system - appeal process - procedures.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (311), page 68, Section 10**	
312	42 CFR 438.408(a), 42 CFR 438.408(b)(2), 42 CFR 438.408(c)	Grievance system - appeal process - resolution and notification.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (312), page 69, Section 10**	
313	42 CFR 438.408(d)(2)(i), 42 CFR 438.408(e)	Grievance system - appeal process - format and content of resolution notice.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (313), page 70, Section 10**	
314	42 CFR 438.420(b, c, & d), 42 CFR 438.402(b)(2), 42 CFR 438.404(c)(1), 42 CFR 431.230(b)	Grievance system - appeal and state fair hearing process - continuation of benefits.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (314), page 70, Section 10**	
315	42 CFR 438.424(a)	Grievance system - appeal and state fair hearing process - effectuation when services were not furnished.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (315), page 71, Section 10**	
316	42 CFR 438.424(b)	Grievance system - appeal and state fair hearing process - effectuation when services were furnished.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (316), page 72, Section 10**	
317	42 CFR 438.410(a)	Grievance system - expedited appeals process – general.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (317), page 72, Section 10**	
318	42 CFR 438.402(b)(3)(ii)	Grievance system - expedited appeals process – authority to file.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (318), page 72, Section 10**	
319	42 CFR 438.406(b)(2)	Grievance system - expedited appeals process – procedures.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (319), page 74, Section 10**	

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	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
320	42 CFR 438.408(a)42 CFR 438.408(b)(3)42 CFR 438.408(c), 42 CFR 438.408(d)(2)(ii)	Grievance system - expedited appeal process - resolution and notification.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (320), page 74, Section 10**	
321	42 CFR 438.410(b)	Grievance system - expedited appeal process - punitive action.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (321), page 75, Section 10**	
322	42 CFR 431.200(b) 42 CFR 431.220(5)42 CFR 438.41442 CFR 438.10(g)(1)	Grievance system - state fair hearing process - notification of state procedures.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (322), page 75, Section 10**	
323	42 CFR 438.408(f)(2)	Grievance system - state fair hearing - parties.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (323), page 75, Section 10**	
324	42 CFR 438.400	Grievance system - grievance - definition.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (324), page 76, Section 10**	
325	42 CFR 438.402(b)(3)(i), 42 CFR 438.402(b)(1)(i), 42 CFR	Grievance system - grievance process - procedures and authority to file.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (325), page 76, Section 10**	
326	42 CFR 438.408(a), 42 CFR 438.408(b)(1), 42 CFR 438.408(d)(1)	Grievance system - grievance process - disposition and notification.	R	Answer as part of the response to the requirement with the description: Grievance system - general requirements. Provide a specific reference here to where this specific requirement is addressed in your response.	**Item (326), page 76, Section 10**	
327	42 CFR 438.604(a), (b), and (c) 42 CFR 438.604(b)42 CFR 438.606	Data Certifications.	A			
328	~~42 CFR 438.608.(a & b)~~	~~Program integrity - general requirements.~~	~~A~~			

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	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
329	~~42 CFR 438.610(a), 42 CFR 438.610(b), SMD letter 2/20/98~~	~~Program integrity - prohibited affiliations with individuals debarred by federal agencies and excluded providers - general.~~	~~A~~			
330	~~1932 (d)(4)~~	~~Program integrity - physician identifier (National Provider Identifier (NPI)).~~	~~A~~			
331	~~42 CFR 455.1(a)(1), 42 CFR 455.17~~	~~Program integrity - fraud and abuse reporting.~~	~~A~~			
332	~~42 CFR 455.1(a)(2)~~	~~Program integrity - service verification.~~	~~A~~			
333	1903(m)(5)(A & B), 1932(e)(1 & 2), 42 CFR 438.700, 45 CFR 92.36(i)(1), 42 CFR 438.702, 42 CFR 422.208, 42 CFR 422.210, 42 CFR 438.704	Sanctions.	A			
334	42 CFR 438.6(g)SMM 2087.742 CFR 434.6(a)(5)	Finance and payment - inspection and audit of financial records.	A			
335	1932(b)(6), 42 CFR 438.106(a, b, & c), 42 CFR 438.6(l), 42 CFR 438.230, 42 CFR 438.204(a), SMD letter 12/30/97	Finance and payment - insolvency.	A			
336	1932(b)(6), 42 CFR 438.106(c), 42 CFR 438.6(l), 42 CFR 438.230, 42 CFR 438.204(a), SMD letter 12/30/97	Finance and payment - protect against liability – subcontractors and referrals.	A			

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	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plar	Initial
337	1932(d)(3), 45 CFR 74.48, 45 CFR 74 Appendix A, 42 CFR 438.610(c)(3), 42 CFR 434.6(a)(6), 45 CFR 74.53 (a & b), 42 CFR 433 Sub D, 42 447.20, 42 CFR 434.6(a)(9), 45 CFR 74.42, 45 CFR 74.43, 45 CFR 74.44	Contract requirements - general.	A			

Attestation Signature:_____Date:_____

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Attachment 2: Interlocal Agreement

FOURTH AMENDED INTERLOCAL AGREEMENT
GREATER COLUMBIA BEHAVIORAL HEALTH

This Agreement is made and entered into by and among the several counties organized and existing as political subdivisions under the Constitution and laws of the State of Washington which are signatory to this Agreement and shall replace all prior Agreements concerning Greater Columbia Behavioral Health ("GCBH"), Greater Columbia Behavioral Health Regional Support Network, and/or Greater Columbia Regional Support Network which are hereby terminated and revoked.

RECITALS

WHEREAS, The State of Washington legislature has adopted RCW 71.24 as amended from time to time, instituting behavioral health reform and authorizing behavioral health organizations, hereinafter called BHOs; and

WHEREAS, The State of Washington has adopted RCW 71.24.025 and 71.24.300 thereby making tribal authorities eligible to participate in the administration and management of behavioral health organizations; and

WHEREAS, counties benefit from RCW 39.34 which permits local governmental units to make the most efficient use of their powers by enabling them to cooperate with other localities on a basis of mutual advantage thereby to provide services and facilities in a manner and pursuant to forms of governmental organization that will accord best with geographic, economic, population, and other factors influencing the needs and development of local communities; and

WHEREAS, each member county desires to join together for the purpose of planning, authorizing, and coordinating behavioral health services; and

WHEREAS, it appears economically feasible and practical to do so;

NOW, THEREFORE, for and in consideration of the mutual benefits, covenants, and agreements contained herein, the member counties agree as follows:

ARTICLE 1

PURPOSE

This Agreement is entered into for continuing and expanding GCBH, which shall be organized under RCW 71.24-Community Mental Health Services Act, and RCW 39.34-Interlocal Cooperation Act, to provide programs of comprehensive behavioral health services and economy of resources for all member counties.

ARTICLE 2

PARTIES TO AGREEMENT

The counties that are party to this Agreement are as follows: Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima. Each member county that is a party to

this Agreement certifies that it intends to participate with all other member counties to this Agreement on its effective date and with such other parties as may later be added to and become signatories to this Agreement. Each party also agrees that the cancellation or withdrawal of a party shall not affect this Agreement nor any other rights or duties under this Agreement.

ARTICLE 3

EFFECTIVE DATE AND DURATION OF AGREEMENT

This Agreement shall become effective when signed by all member counties and posted on the GCBH website and shall continue until terminated by a majority of the member counties.

ARTICLE 4

MEMBERSHIP COMPOSITION

Membership, pursuant to RCW 71.24 as amended from time to time, shall be limited to the several counties of and in the State of Washington. GCBH through its Bylaws shall provide for the reasonable admission of new member counties. In accordance with RCW 71.24.300 the member counties shall include tribal authorities in the administration and management of GCBH if requested by the tribal authority. As signatories to the Agreement the counties shall be known as the "member counties." The tribal authority appointed to GCBH, if any, shall be known as the "member tribal authority." A new member county may join GCBH after approval of majority vote of the Board as defined in Article 6, Section A, and shall become an active participant member of GCBH commencing on the date specified by the Board.

ARTICLE 5

NATURE OF THE REGION

GCBH shall be a Behavioral Health Organization (BHO) as defined by RCW 71.24 as amended and shall act through a Board of Directors ("Board") of the BHO performing all the functions and duties normally expected of a Board of Directors. The Board of Directors of the BHO shall be responsible for implementation of all requirements of RCW 71.24 as amended from time to time.

ARTICLE 6

ORGANIZATION

A. BOARD OF DIRECTORS. GCBH shall be governed by a Board of Directors which shall be composed of one Director from each member county, and a Tribal Director from each participating federally recognized tribal organization. Directors shall be County Commissioners of each member county, appointed by the member's Boards of County Commissioners. Each member county shall also appoint an Alternate Director to act on behalf of the county in the event that the Director is not available. Alternate Directors, the Tribal Director, and the Tribal alternate Director may be either a County Commissioner or any other designee of the member counties.

Each county shall appoint a Director and one Alternate Director in the manner set forth above. Directors shall have the authority to attend, participate in, and vote at any meeting of the Board or a Committee. Alternate Directors shall have the same authority when the Director is absent as herein provided. However, only Directors shall vote on the following: (1) adoption of bylaws; (2) the approval of biennial budgets for expenditures and supplements; (3) the Funding Allocation Policy or (4) the involuntary cancellation of a member county. If, however, the Alternate Director is a County Commissioner then, as such, would have full voting rights as if they were a Director. Each Director shall have one vote.

B. OFFICERS. The Board shall elect officers to govern GCBH as provided by its Bylaws. Each officer must be a Director and may not be an Alternate Director. An Alternate Director may not act in place of an Officer in the capacity of the Officer.

C. MEETINGS. The Board shall provide for regular meetings and shall be subject to the Open Public Meetings Act, Chapter 42.30 RCW. A quorum of the Board shall be defined as a majority of the Directors (or Alternate Director if the Director is not present) from the member counties.

D. AUTHORITY OF THE BOARD. The Board shall have the authority and power to adopt Bylaws which shall be consistent with this Agreement and shall be binding on all members. The Board also shall have the authority to establish necessary committees to assist the Board in the performance of its duties. The Board shall establish all policies for GCBH, and shall approve all budgets for expenditures.

ARTICLE 7

INSURANCE AND INDEMNIFICATION

A. The member counties shall obtain and maintain throughout the term of this Agreement, general liability and malpractice insurance coverage in the amount per occurrence and in the aggregate in accordance with the applicable laws of their respective county for any acts or omissions related to the performance of services under this Interlocal Agreement but not less than $5 million dollars. The member counties shall assure the coverage applies to claims after termination of this Agreement that relate to services provided under this Interlocal Agreement in accordance with the applicable laws of their respective county. The member counties shall be solely responsible for any deductible amounts required under such policies, however, said costs are normal business expenses to be paid out of available GCBH funds provided to the member county. Evidence of such insurance shall be promptly provided to GCBH upon its written request. The member county shall not permit such policy(ies) to lapse without first providing GCBH at least thirty (30) calendar days written notice of its intention to allow the policy(ies) to lapse.

B. The member counties shall indemnify and hold harmless each and every other member county of GCBH, including each member county's officers, directors, employees, agents and representatives, from all claims, including reasonable attorney's fees, which arise out of that member county's actions or obligations under this Agreement.

C. GCBH shall obtain and maintain throughout the term of this Agreement, general liability and malpractice insurance coverage in the amount per occurrence and in the aggregate in accordance with the applicable Bylaws of GCBH and consistent with the laws of the member county for any acts or omissions related to the performance of services. GCBH shall name each member county as an additional insured and this coverage shall be the primary coverage in order to shield the governmental interests of the member county. GCBH shall assure the coverage applies to claims after termination of the Agreement that relate to services provided under this Interlocal Agreement and any other agreements of GCBH in accordance with the applicable laws of the member county. GCBH shall be solely responsible for any deductible amounts required under such policies; however, said costs are normal business expenses to be paid out of available GCBH funds without any offset to the funds provided to the member county(ies). Evidence of such insurance shall be promptly provided to the member county(ies) upon its written request. GCBH shall not permit such policy(ies) to lapse without first providing the member county at least thirty (30) calendar days written notice of its intention to allow the policy(ies) to lapse.

D. GCBH shall indemnify and hold harmless each and every other member county of GCBH, including but not limited to, each member county's officers, director, employees, agents, and representatives, from any and all claims, including reasonable attorneys' fees, which arise out of GCBH's actions or obligations under this Agreement.

E. The member counties have no obligation to indemnify and hold harmless GCBH, including but not limited to, each officer, director, employee, agent and representative; except for member county's own omissions or neglect.

F. The member counties agree that in all agency delegation and other subsidiary agreements under which GCBH functions are to be performed or GCBH funds allocated, the agent, delegee or other contractor shall be obligated to indemnify and hold GCBH and its members harmless for all negligent or wrongful acts by such agent, delegate, or contractor relating to such agreement, and for reasonable attorney's fees incurred in actions based on such acts and actions of indemnification. If such agent, delegate or contractor is an Indian tribe, the agreement shall also contain an express and absolute waiver of immunity from suit so that such indemnification may be effective. Any such agency, delegation or other subsidiary agreement which does not contain the terms required in this paragraph shall be unenforceable against the GCBH.

G. Each Director and Alternate Director of the Board shall be a covered insured by GCBH for any and all official acts performed by such individual.

ARTICLE 8

ADMINISTRATIVE ENTITY

The Board shall have a Business Office which shall be given general administrative responsibility for the GCBH activities including acting as the fiscal agent for GCBH.

ARTICLE 9

BUDGET AND RECORDS

A. BUDGET. The Board shall establish and maintain biennial budgets for the operation of GCBH.

B. AUDIT REPORT. GCBH, on behalf of the Board, shall establish and maintain such funds and accounts as may be required by good accounting practices and the State Budget Accounting Reporting System ("BARS"). Financial records of GCBH shall be open to inspection at all reasonable times at the request of the Board of Director(s). GCBH shall be subject to audit by the Washington State Auditor. A complete written report of the financial activities of GCBH, including an annual audit of the accounts and records of GCBH, shall be provided to each Board Director and Alternate Director. Said audit of GCBH shall be performed by the Washington State Auditor's Office as required by law. Costs of said audit shall be a normal expense of GCBH.

The member counties shall provide necessary financial data to GCBH in order to allow GCBH to meet compliance requirements for all funds.

ARTICLE 10

RIGHTS AND RESPONSIBILITIES OF MEMBER GOVERNMENTS

In addition to all of the rights and responsibilities granted to member counties under this Interlocal Agreement and through the By-Laws of GCBH, including through participation with the Board and committee processes, member counties, and their respective member county governments, have the right and the responsibility to determine the level of their county's participation in the governing of GCBH. As such, member county governments shall have rights and responsibilities which include, but are not limited to, the following:

A. Assist with performance of WAC 388-865-0280 (Quality Management Process)

Member counties may:

1. provide recommendations and strategies for system and clinical care improvements, including information from exit interviews, consumer complaints, and practitioner interviews through Board and/or committee involvement.
2. assist, in monitoring complaints, grievances and adverse incidents for adults and children that occurs with the member county's area behavioral health service providers.
3. assist the BHO, in helping to investigate and report allegations of fraud and abuse of contractors/subcontractors to the Department of Social and Health Services.

4. assist the BHO in evaluating the quality and intensity of behavioral health services provided to the citizens of the member county through Board and/or committee involvement.
5. provide recommendations and strategies for making improvements to the member county's behavioral health services through Board and/or committee involvement.
6. assist the BHO, in obtaining feedback from consumers, service providers, and other interested parties regarding behavioral health services.
7. provide recommendations regarding service provider on-site monitoring, evaluation and reviews conducted by the BHO through Board and/or committee involvement.
   The BHO will make available, upon request, service provider on-site monitoring, evaluations and reviews conducted by the BHO

B. Assist with performance of WAC 388-865-0221 (Public Awareness of Mental Health Services)

Member counties may provide assistance to the BHO regarding public awareness of behavioral health services, including, but not limited to:

1. post listings of behavioral health services and providers in telephone directories and other public places.
2. disseminate brochures and other informational materials or methods for describing services and hours of operation for behavioral health services.
3. provide consumers with information regarding Ombuds service consistent with WAC 388-865-0250 as contracted by the BHO.

C. Assist with performance of WAC 388-865-0255 (Consumer Grievance Process)\

Member counties may:

1. assist the BHO, in the consumer grievance process involving the citizens and users of behavioral health services in the member county.
2. encourage resolution of complaints at the lowest level possible and attempt to help consumers reach appropriate assistance for their grievances and complaints.
3. assist the BHO to ensure that grievances are resolved.

D. The BHO shall use a Board approved funding mechanism. Member counties with multiple service providers in their county shall have the right to determine the amount of funding allocated to each service provider, in their county. In addition to, and in collaboration with the BHO, member counties may develop a mechanism to determine the following:

1. which licensed service provider(s) of behavioral health services, as defined by RCW 71.24.045 and WAC 388-865-0284, that the BHO shall contract with.

2. what services shall be provided by each service provider.
3. how much funding each service provider shall receive from the total of allocated funding to the citizens of the member county from the BHO.
4. changes of behavioral health service providers, behavioral health services provided and/or level of behavioral health services provided by licensed service providers, in adherence with all applicable laws, regulations and contract requirements.

ARTICLE 11

CANCELLATION AND WITHDRAWAL

A. CANCELLATION. A member county's participation in this Agreement and in GCBH may be involuntarily cancelled for cause at any time by an affirmative vote of three quarters (3/4) of the entire Directors of the Board. Cause for cancellation shall include, but not be limited to:

1. failure to participate in a majority of meetings of the Board,
2. failure to meet applicable regional goals and standards in a good faith effort, as set forth by the State of Washington and the GCBH Board,
3. failure to notify the Board of known incidents, claims, and lawsuits which may have an adverse impact on GCBH,
4. failure to comply with the applicable terms and conditions of the GCBH contract with the Division of Behavioral Health and Recovery or other contract, or, as otherwise defined in the Bylaws of GCBH. The effective date of cancellation shall be six (6) months after the date of Board action unless a different period is otherwise determined by the Board. Until the effective date, the cancelled member county shall still benefit from the services of GCBH.

B. WITHDRAWAL. No member county may voluntarily withdraw from GCBH until the member county has given GCBH a three (3) month written notice of its intent to withdraw or as otherwise provided in other sections of this Agreement.

C. EFFECT OF CANCELLATION AND WITHDRAWAL. The cancellation or withdrawal of one or more member counties shall not terminate this Agreement for the other remaining parties. Member counties are entitled to payment for services rendered up to and before the effective date of their withdrawal or cancellation. Member counties are entitled to the return of their pro rata share of all personal and/or real property in accordance with applicable Federal and State law. The member county is entitled to receive reasonable compensation for the personal or real property retained by GCBH.

D. CONTRACT RENEWAL/APPROVAL/EXCEPTION. Notwithstanding any other provision of this Interlocal Agreement, each member county reserves the right to approve the renewal of the initial contract between the State of Washington and GCBH. Any member county not approving the renewal contract shall be permitted to terminate its obligation under this Agreement, withdraw from GCBH, and be free and clear from any liability occurring after termination under this Agreement, except for that terminating member county's proportionate share of any obligations incurred prior to termination. A member county shall only terminate under this section by giving written notice of its intent to terminate within 30 days

after receipt by that member county of a copy of the State of Washington GCBH contract. Termination shall be effective within five (5) calendar days after the Business Office receives the written notice of intent to terminate.

ARTICLE 12

TERMINATION OF GCBH

This Agreement may be terminated at any time by the written consent of the Boards of County Commissioners of at least two thirds (2/3) of the member counties. Upon termination, this Agreement and GCBH shall continue for the purpose of disposing of all claims, distribution of assets, and all other functions necessary to wind up the affairs of GCBH.

ARTICLE 13

PROPERTY OF THE REGION

A. PROPERTY. GCBH shall acquire, hold and dispose of real and personal property subject to the same restrictions as any of the member counties as provided for in the Bylaws. The method of acquiring, holding, and disposal shall be defined in the Bylaws.

B. CONTINGENT LIABILITIES. Upon termination, the Board shall wind up and dissolve the business affairs of GCBH. The assets, reserves, property, and bonds or insurance policies shall first be applied to the claims against GCBH. The Board shall then determine, and member counties shall pay, each member county's fair share of any additional amounts necessary for final disposition of all claims and if applicable divide all assets in the manner set forth in the bylaws.

ARTICLE 14

LEGAL NOTICES

Legal Notices to each member county shall be sent prepaid by certified mail to its Director of the respective member county at such addresses as may be given in writing to GCBH.

ARTICLE 15

AMENDMENTS

This Agreement may be amended at any time by the written approval of the Boards of Commissioners of all member counties except as provided in Article 3, Duration of Agreement.

ARTICLE 16

PROHIBITION AGAINST ASSIGNMENT

No member county may assign any right, claim, or interest it may have under this Agreement. No creditor, assignee, or third-party beneficiary of any member county shall have any right, claim, or title to any part, share, interest, fund, or asset of GCBH.

ARTICLE 17

ENFORCEMENT AND VENUE

This Agreement and others subsidiary hereto, including agency and delegation agreements with GCBH, shall be interpreted according to the laws of Washington State. Exclusive jurisdiction over cases arising under it shall be in Washington State courts. Venue shall be determined by the GCBH Board prior to commencement of any such action.

ARTICLE 18

DEFAULT

If any member county fails to perform any term or condition of this Agreement and such failure continues for a period of sixty (60) days after GCBH has given the member county written notice of such failure, the member county shall be in default thereunder. Upon default, GCBH may immediately cancel the member county's membership effective immediately without further notice, or exercise any remedies herein provided or otherwise provided by law. The rights and remedies of GCBH are cumulative in nature and pursuit of any particular remedy shall not be deemed an election of remedies or a waiver of any other remedies available thereunder or otherwise available by law.

This article may be invoked if any member county fails to perform any applicable term or condition of this Agreement as established by applicable law, and GCBH having provided technical assistance to correct the problem within the sixty (60) day period.

ARTICLE 19

NO WAIVERS

No waiver or forbearance of a breach of any covenant, term, or condition of this Agreement shall be construed to be a waiver or forbearance of any other or subsequent breach of the same or of any other covenant, term, or condition, and the acceptance of any performance thereunder, or the payment of any sum of money after the same has become due or at a time when any other default exists thereunder, shall not constitute a waiver of the right to demand payment of all other sums owing or a waiver of any other default then or thereafter existing.

ARTICLE 20

SEVERABILITY

If any term or provision of this Agreement shall to any extent be determined by a court of competent jurisdiction to be invalid or unenforceable, the remainder of this Agreement shall not be affected thereby, and each term and provision in the Agreement shall be valid and be enforceable to the fullest extent permitted by law

ARTICLE 21

TIME

Time is of the essence in the Agreement and each and every provision hereof.

ARTICLE 22

HEADINGS

The Article and Section headings in this Agreement are inserted for convenience only and are not intended to be used in the interpretation of the contents of the Articles and Sections they introduce.

ARTICLE 23

GOVERNING LAW

This Agreement shall be governed by and construed in accordance with the laws of the State of Washington.

ARTICLE 24

COUNTERPART COPIES

This Agreement may be signed in counterpart or duplicate copies, and any signed counterpart or duplicate copy shall be equivalent to a signed original for all purposes.

ARTICLE 25

AGREEMENT COMPLETE

The foregoing constitutes the full and complete Agreement of the parties. All oral understandings and agreements are set forth in writing herein.

IN WITNESS WHEREOF, the member counties have executed this Agreement by authorized officials thereof on the dates indicated.

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

ASOTIN COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Asotin County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Prosecuting Attorney

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

BENTON COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Benton County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Deputy Prosecuting Attorney

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

COLUMBIA COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Columbia County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Prosecuting Attorney

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

FRANKLIN COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Franklin County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Deputy Prosecuting Attorney

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

GARFIELD COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Garfield County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Deputy Prosecuting Attorney

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

KITTITAS COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Kittitas County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Deputy Prosecuting Attorney

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

KLICKITAT COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Klickitat County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Deputy Prosecuting Attorney

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

WALLA WALLA COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Walla Walla County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Deputy Prosecuting Attorney

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

WHITMAN COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Whitman County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Deputy Prosecuting Attorney

The member counties to this Agreement do hereby agree by their signature to approve this Agreement which replaces all prior agreements concerning Greater Columbia Behavioral Health.
This agreement is signed on this _____day of _____, 2013.

YAKIMA COUNTY, WASHINGTON

_____
Chairman

_____
Member

_____
Member

Constituting the Board of County Commissioners of Yakima County, Washington.

Attest:

_____
Clerk of the Board

Approved as to form:

_____
Deputy Prosecuting Attorney

Attachment 3: Primary Care and Coordination of Health Care Services – Agreements and Policies and Procedures

JOINT OPERATING AGREEMENT
BETWEEN
AMERIGROUP WASHINGTON, INC, MANAGED HEALTH CARE ORGANIZATION
AND
GREATER COLUMBIA BEHAVIORAL HEALTH REGIONAL SUPPORT NETWORK

The Operational Agreement is between Amerigroup Washington, Inc. a managed health care organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan (herein after referred to as the **Health Plan**) and Greater Columbia Behavioral Health Regional Support Network (RSN) contracted with Washington State Division of Behavioral Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP) (herein after referred to as the **RSN**) and serves Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima counties.

I. PURPOSE

This Agreement delineates the roles and responsibilities of the **Health Plan** and the **RSN** related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

The Agreement also demonstrates a shared commitment by both the **Health Plan** and the **RSN** to coordinate care for persons who are involved in or require services from both systems of care.

II. BACKGROUND

A. Health Plan

The **Health Plan** provides managed health care services to eligible individuals insured under the Healthy Options and Basic Health Plan in Washington State.

B. RSN

The **RSN** provides Medicaid covered mental health services to eligible consumers in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima Counties in Washington State.

III. RESPONSIBILITIES AND ROLES

A. Sharing Protected Health Information

The parties agree that information shared under this Agreement is shared for the purpose of coordination of treatment and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). The parties shall use and disclose protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e).

B. Referrals between the Health Plan and the RSN

While both the **Health Plan** and the **RSN** benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the **Health Plan** is a limited benefit. The **RSN** mental health benefit has a broad scope and serves individuals with need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program, Pre-paid Inpatient Health Plan (PIHP), requires enrollees to meet both medical necessity and Mental Health Access to Care Criteria to define member qualification for **RSN** mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this Agreement. Therefore, enrollees covered under Healthy Options may approach either the **Health Plan** or the **RSN** network providers for mental health services.

Enrollees who choose to access the **Health Plan** may be referred to the **RSN** by the **Health Plan** providers if it appears that they may meet access to care criteria. Enrollees who choose to access a **RSN** network provider will be assessed and either authorized by the **RSN** into care or referred to the **Health Plan** based on PIHP criteria.

1. **RSN** Responsibility

   a. The **RSN** has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and access to care criteria for **RSN** mental health services. The **RSN** shall accept a referral from the **Health Plan** for a face-to-face assessment when the **Health Plan** believes the individual may meet Access to Care criteria for the **RSN** mental health benefit.
   b. The **RSN** will authorize and serve any individual who meets medical necessity and the Access to Care Criteria and chooses to be served by the **RSN** contracted provider.
   c. The **RSN** will refer individuals to the **Health Plan** for mental health benefits when the individual does not meet Access to Care criteria or medical eligibility, or has graduated from **RSN** services and/or no longer meets Access to Care Criteria but still may meet medical necessity for the **Health Plan** mental health benefit.

2. **Health Plan** Responsibility

   a. The **Health Plan** has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the **RSN** for an assessment is warranted. The **Health Plan** is also responsible to provide a mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the **RSN** PIHP Access to Care Criteria.
   b. The **Health Plan** may refer individuals at any time to the **RSN** even if they have been served in the **Health Plan's** mental health benefit to determine if the individual meets Access to Care Criteria for **RSN** mental health benefits.

C. Coordination of Care and Care Transitions

The **RSN** and the **Health Plan** have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The **RSN** and the **Health Plan** and their respective designees (e.g. care managers, contractors, provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care

1. **RSN** Responsibility
   a. The **RSN** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the **RSN** contract with the Washington State Division of Behavioral Health and Recovery (DBHR).
   b. The **RSN** shall provide timely information related to psychiatric hospital admission and discharge for **Health Plan** Healthy Options members.
   c. The **RSN** and its designees will collaborate with **Health Plan** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this Agreement the **RSN** will work with the **Health Plan** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.

2. **Health Plan** Responsibility
   a. The **Health Plan** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the Washington State Health Care Authority (HCA).
   b. The **Health Plan** shall provide timely information related to medical hospital admissions and discharge for **Health Plan** Healthy Options members receiving **RSN** PIHP services.
   c. The **Health Plan** and its designees will collaborate with **RSN** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this Agreement the **Health Plan** will work with the **RSN** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.

D. Communications

1. Contacts for the **RSN**:

Mailing/Physical Address:
Greater Columbia Behavioral Health Regional Support Network
101 N Edison St
Kennewick, WA 99336
Phone: (509) 735-8681 or 800-795-9296
Fax: (509) 783-4165

Department	Contact	Email
Director	Kenneth Roughton, Ph.D.	kenr@gcbh.org
Administration	Julie LaPierre, Office Manager	juliel@gcbh.org
Authorizations	Sindi Saunders, Authorization Center Staff	sindis@gcbh.org
	Melissa Morasch, Authorization Center Staff	melissam@gcbh.org
	Kris Brown, Authorization Center Staff	krisb@gcbh.org
	Jackie Davidson, Authorization Center Manager	jackied@gcbh.org
	Vonie Aeschliman, Authorization Center Manager	voniea@gcbh.org
Care Coordination and Care Management	Jackie Davidson, Children Care Coordinator	jackied@gcbh.org
	Vonie Aeschliman, Adult Care Coordinator	voniea@gcbh.org
Consumer Advocate	Cindy Adams, Customer Service & Consumer Advocate	cindya@gcbh.org
Contracts	Mary Garza, Contracts Coordinator	maryg@gcbh.org
Critical Incidents	Julie LaPierre, Office Manager	juliel@gcbh.org
Customer Service	Cindy Adams, Customer Service & Consumer Advocate	cindya@gcbh.org
Finance	Troy Wilson, CFO	troyw@gcbh.org
Information Systems	Troy Wilson, CFO	troyw@gcbh.org
Performance Improvement & Quality Management	Jamie Rundhaug, Ph.D., QM Manager	jamier@gcbh.org

2. Contacts for the **Health Plan:**

Mailing/Physical Address:
Amerigroup Washington Inc
705 5th Avenue South, Suite 300
Seattle, WA 98104
Phone: (206) 695-7081 or toll free (855) 323-4688
Fax: (206) 674-4466

Department	Contact	Title	Email/Phone
Executive	Rosy Cozad	President/CEO	Rosy.Cozad@amerigroup.com (206) 695-7081 ext 54468
Administration	Raj Ghimire	Sr. Exec. Assistant	Rajendra.Ghimire@amerigroup.com (206) 695-7081 ext 54462
Plan Medical Director	Dr. Melicent Whinston	Medical Director	Melet.Whinston@amerigroup.com (206) 695-7081 ext 54473
Health Care Management Services (HCMS)	Lani Spencer	Vice President	Lani.Spencer@amerigroup.com (206) 695-7081 ext 54470
HCMS – Case Management	Michael Russo	Manager	Michael.Russo@amerigroup.com (206) 695-7081 ext 54586
HCMS – Case Manager	**Jeannine Vinson**	**Case Manager, Behavioral Health**	**Jeannine.Vinson@amerigroup.com** **(206) 695-7081 ext 54577**
HCMS-Quality	Pat Ford	Asst. Vice President	Pat.Ford@amerigroup.com (206) 695-7081 ext 54461
HCMS-Quality	Rosalind Harvey	Member Advocate	Rosalind.Harvey@amerigroup.com (206) 695-7081 ext 54581
Provider Relations	Bill Jarvis	Asst. Vice President	Williams.Jarvis@amerigroup.com (206) 695-7081 ext 54463
Health Plan Operations	Jessica Cromer	Vice President	Jessica.Cromer@amerigroup.com (206) 695-7081 ext 54474
Authorizations – Inpatient Behavioral Health			**Tel: (800) 454-3730** **Fax: (877) 434-7578**
Authorizations – Outpatient Behavioral Health			**Fax: (800) 505-1193**

IV. Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this Agreement, nothing in this Agreement is intended to establish a legally binding Agreement between the parties.
2. The parties of this Agreement will hold one another including their contractors, employees, interns and volunteers harmless for failure to perform any of the roles identified above, including termination of this Agreement with or without advance notice.
3. There shall be no remedy available to one party for failure to perform any role identified above by the other party, or a third party.

V. Dispute Resolution

1. All disputes occurring between the parties of this Agreement shall be resolved through informal negotiation between the parties of the Agreement. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of this Agreement.

VI. Term and Termination

1. The effective date of this Agreement will be upon the final signature of the parties to this Agreement and it shall remain in effect until it is terminated in accordance with the terms of this Agreement.
2. Any of the parties to this Agreement may withdraw and terminate their participation from this Agreement for any reason and at any time. Thirty (30) days written notice is preferred but not required. Such notice and other correspondence related to this Agreement should be sent to the contacts and addresses listed above.

VII. Amendment

This Agreement may be amended at any time by written Agreement and signature of all the parties.

IN WITNESS WHEREOF, the parties hereto have caused this Joint Operating Agreement (JOA) to be executed by the dates and signatures herein under affixed. The persons signing this JOA on behalf of the parties represent that each has authority to execute the JOA on behalf of the party entering into this JOA.

Ken Roughton, Ph.D.

Name: Ken Roughton, Ph.D.
Title: Director, GCBH RSN

1-3-2013
Date

Name: Rosa M. Cozad
Title: President/CEO, Amerigroup Washington, Inc.

1/3/13
Date

SCOPE OF SERVICES AND COLLABORATION ATTACHMENT

This Scope of Services and Collaboration Attachment ("***Attachment***") shall supplement the Operational Agreement ("***Agreement***") by and between Cenpatico Behavioral Health, LLC ("***Cenpatico***"), a managed behavioral health organization under contract with Coordinated Care Corporation ("***Plan***"), an Indiana corporation qualified to do business in the state of Washington and Greater Columbia Regional Support Network *(insert name of organization)* ("***RSN***"), a Regional Support Network duly licensed in the State of Washington ("***State***"). Cenpatico and RSN to be referred to collectively herein as the "***Parties***". The Parties agree as follows:

ARTICLE I
CARE COORDINATION PROCESSES AND PROCEDURES

1.1 **Screening Guidelines.**

A. Cenpatico will utilize Access to Care Standards as a screening tool attached hereto and incorporated herein by reference prior to referring patients enrolled with Plan ("***Members***") to RSN for intake.

B. RSN will screen members to determine eligibility for services through the RSN system.

1.2 **Referral Procedures.**

A. **Non-Crisis Referrals**

(i) RSN, through its Provider Network, will refer all non-RSN eligible Members who are enrolled with the Health Plan back to the Cenpatico liaison with one (1) business day of a non-eligible determination.

(ii) Cenpatico will refer Healthy Options eligible Members who appear to meet Access to Care Standards to the RSN through a phone call to the appropriate contact listed below in Article II.

(iii) RSN will provide Cenpatico with a monthly list of active Members.

B. **Crisis-Referrals**

(i) All residents are referred directly to crisis lines by calling the crisis hotline for their county.

(ii) RSN understands that Cenpatico maintains after-hours coverage through "Nurse Wise" and all Members are eligible to utilize Nurse Wise for after-hours crisis calls.

1.3 **Notification of Admissions to Institutional Care & Care Transitions.**

A. **Inpatient Admissions.** RSN agrees to notify Cenpatico within twenty-four (24) hours, or next business day, of being notified of a Member's admission to an inpatient setting and shall provide two (2) business days notice of a Member's discharge from an inpatient setting. Such notification shall be made through the GCBH Provider Portal or secured fax to the identified Cenpatico RSN liaison. RSN further agrees to notify Cenpatico prior to Member's discharge and shall ensure the Member is scheduled for an outpatient visit with their behavioral health provider to occur within seven (7) days of discharge. RSN, through its Provider Network shall encourage the Member to attend the visit, and shall make best efforts to assit the Member in the removal of any barriers to keeping the appointment, including transportation issues.

B. **Notifications of Emergent Care.** Cenpatico agrees to notify RSN through the GCBH Provider Portal or Secure Fax within seven (7) business days of any RSN-eligible Member visits to emergency rooms. Cenpatico further agrees to notify RSN of RSN-eligible Member's discharge.

C. **Notifications of Medical/Surgical Inpatient Admissions.** Cenpatico agrees to notify RSN within seven (7) business days of any RSN-eligible Member admissions for inpatient medical/surgical care. Such notification shall be made through to the identified Cenpatico RSN liaison through the GCBH Provider Portal or Secure Fax. Cenpatico further agrees to notify RSN of RSN-eligible Member's discharge.

1.4 **Continuing Care Transitions From the RSN System.** RSN agrees to notify the Cenpatico RSN liaison via the GCBH Provider Portal or secure fax within two (2) business days of a Member's discharge from the RSN system

to provide information relative to previous services the Member received and recommended services the Member is in need of obtaining.

1.5 **High Risk Members**. Cenpatico and RSN will follow high risk member coordination procedures as outlined High Risk Members. The Parties agree to adhere to the processes set forth in in the Agreement section III, C.

1.6 **Data Sharing**. RSN and Cenpatico will provide each other with all required data elements in a mutually agreed upon, structured file format, until such time that the State of Washington shares eligibility data with the RSN that identifies a Member's affiliated managed care organization. RSN will provide, in a secure manner, all required data no later than the 30th calendar day of the month following the end of the measurement period for all monthly reports. RSN and Cenpatico agree to submit all data one another within the timeframes specified in this Attachment. The Parties agree to submit valid, reliable data to one another by the required due date The Parties agree to provide report/data sharing specifications, including file formats and report templates, to one another, prior to implementation of data sharing activities.

1.7 **Dispute Resolution**. In the event of a dispute between the Parties regarding the terms of this Attachment, the Parties agree to attempt resolution through good faith negotiations between designated representatives of the Parties that have authority to settle the dispute. If the matter has not been resolved within forty-five (45) days of the request for negotiation, either party may initiate dispute resolution in accordance with the terms of the Agreement by providing written notice to the other party.

ARTICLE II
CONTACT LISTING

Functional Area	Cenpatico Contact	RSN Contact
Referrals	Department: Case Management/Care Coordination Title: Case Manager/Care Coordinator Phone: (877) 644-4613	See Exhibit I to the Scope of Services and Collaboration Attachment
Care Coordination & Care Management	Department: Case Management/Care Coordination Title: Case Manager/Care Coordinator Phone: (877) 644-4613	Title: Care Coordinator Phone: (509) 735-8681 or (800) 795-9296
Crisis Services	Department: Case Management/Care Coordination Title: Case Manager/Care Coordinator Phone: (877) 644-4613	See Exhibit I to the Scope of Services and Collaboration Attachment

Data Sharing	Department: Case Management/Care Coordination Title: Case Manager/Care Coordinator Phone: (877) 644-4613	Department: Information Systems Phone: (509) 735-8681 or (800) 795-9296
Performance Improvement & Quality Management	Department: Case Management/Care Coordination Title: Case Manager/Care Coordinator Phone: (877) 644-4613	Title: Quality Manager Phone: (509) 735-8681 or (800) 795-9296
Dispute Resolution	Department: Case Management/Care Coordination Title: Case Manager/Care Coordinator Phone: (877) 644-4613	: Title: Director Phone: (509) 735-8681 or (800) 795-9296

ARTICLE III
MISCELLANEOUS

3.1 **Confidentiality** Neither party shall disclose the substance of this Attachment nor any information, including proprietary information, acquired from the other party during the course of, or pursuant to, the Agreement to any third party, unless required by law, including RCW 42.56 – the Washington State Public Records Act.

3.2 **Authority**. The parties whose signatures are set forth below represent and warrant that they are duly empowered to execute this Attachment.

Cenpatico:

Cenpatico Behavioral Health, LLC

Signature: Leonard W Whyte

Print:_____

Title:_____

Date: 3-24-14

RSN:

Greater Columbia Regional Support Network

Signature: Ken Laughton

Print: Ken Laughton

Title: Director

Date: 3/17/14

EXHIBIT 1
to the
SCOPE OF SERVICES AND COLLABORATION ATTACHMENT

GCBH Provider Contact List

Greater Columbia Behavioral Health provider listing as of 02/01/2014. This listing is also available at http://www.gcbh.org/ConsumerInformation/ClinicianListing.cfm. Some providers offer services at multiple locations.

COUNTY	PROVIDER
Asotin County	Quality Behavioral Health (Clarkston, WA) 509-758-3341
Benton & Franklin Counties	Catholic Family & Child Services (Richland, WA) 509-946-4645 Lourdes Counseling Center (Richland, WA) 509-943-9104 Lutheran Community Services (Kennewick, WA) 509-735-6446 Nueva Esperanza (Pasco, WA) 509-543-1903
Columbia County	Blue Mountain Counseling (Dayton, WA) 509-382-1164
Garfield County	Quality Behavioral Health (Pomeroy) 509-843-3791
Kittitas County	Central Washington Comprehensive Mental Health (Ellensburg, WA) 509-925-9861
Klickitat County	Central Washington Comprehensive Mental Health (Goldendale, WA) 509-773-5801 Central Washington Comprehensive Mental Health (White Salmon, WA) 509-493-3400
Walla Walla County	Walla Walla County Department of Human Services (Walla Walla, WA) 509-524-2920
Whitman County	Palouse River Counseling Center (Pullman, WA) 509-334-1133
Yakima County	Catholic Family & Child Services (Yakima, WA) 509-965-7100 Central Washington Comprehensive Mental Health (Yakima, WA) 509-575-4084 Yakima Valley Farm Workers (Yakima, WA) 509-453-1344

GCBH Crisis Provider Contact List

Greater Columbia Behavioral Health provider listing as of 02/01/2014. This listing is also available in the GCBH Mental health Service Benefit Handbook which can be accessed at http://www.gcbh.org/ConsumerInformation/index.cfm. Some providers offer services at multiple locations.

COUNTY	PROVIDER
Asotin County	Quality Behavioral Health (Clarkston, WA) 509-758-3341 1-888-475-5665
Benton & Franklin Counties	Benton & Franklin Counties Crisis Response Unit (Kennewick, WA) 509-783-0500
Columbia County	Blue Mountain Counseling (Dayton, WA) 509-382-1164 1-866-382-1164
Garfield County	Quality Behavioral Health (Pomeroy, WA) 509-843-3791 1-888-475-5665
Kittitas County	Central Washington Comprehensive Mental Health (Ellensburg, WA) 509-925-4168
Klickitat County	Central Washington Comprehensive Mental Health (Goldendale, WA) Weekdays: 509-773-5801 Afterhours: 1-800-572-8122 Central Washington Comprehensive Mental Health (White Salmon, WA) Weekdays: 509-493-3400 Afterhours: 1-800-572-8122
Walla Walla County	Walla Walla County Department of Human Services (Walla Walla, WA) 509-524-2999
Whitman County	Palouse River Counseling Center (Pullman, WA) 1-866-871-6385
Yakima County	Central Washington Comprehensive Mental Health (Yakima, WA) Weekdays: 509-575-4200 Afterhours: 1-800-572-8122

Confidential & Proprietary

JOINT OPERATING AGREEMENT

BETWEEN

CENPATICO BEHAVIORAL HEALTH, LLC

AND

GREATER COLUMBIA BEHAVIORAL HEALTH REGIONAL SUPPORT NETWORK

The Operational Agreement is between Cenpatico Behavioral Health, LLC a managed health care Organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan (herein after referred to as the Health Plan) and the Greater Columbia Behavioral Health Regional Support Network (RSN) contracted with Washington State Division of Behavior Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP)(herein after referred to as the RSN) and serves Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima counties.

I. PURPOSE

This agreement delineates the roles and responsibilities of the Health Plan and the RSN related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

The agreement also demonstrates a shared commitment by both the Health Plan and the RSN to coordinate care for persons who are involved in or require services from both systems of care.

II. BACKGROUND

A. Health Plan

The Health Plan provides managed health care services to eligible individuals insured under the Healthy Options Plan in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima counties.

B. RSN

The RSN provides Medicaid covered mental health services to eligible consumers in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima counties.

III. RESPONSIBILITIES AND ROLES

A. Sharing Protected Health Information

The parties agree that information shared under this agreement is shared for the purpose of coordination of treatment and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). The parties shall use and disclose protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e).

B. Referrals between the Health Plan and the RSN

While both the Health Plan and the RSN benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the Health Plan is a limited benefit. The RSN mental health benefit has a broad scope and serves individuals with need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program, Pre-paid Inpatient Health Plan (PIHP), requires enrollees to meet both medical necessity and Mental Health Access to Care Criteria to define member qualification for RSN mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this agreement. Therefore, enrollees covered under Healthy Options may approach either the Health Plan or the RSN network providers for mental health services.

Enrollees who choose to access the Health Plan may be referred to the RSN by the Health Plan providers if it appears that they may meet access to care criteria. Enrollees who choose to access a RSN network provider will be assessed and either authorized by the RSN into care or referred to the Health Plan based on PIHP criteria.

1. **RSN Responsibility**

   a. The RSN has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and access to care criteria for RSN mental health services. The RSN shall accept a referral from the Health Plan for a face-to-face assessment when the Health Plan believes the individual may meet Access to Care criteria for the RSN mental health benefit.
   b. The RSN will authorize and serve any individual who meets medical necessity and the Access to Care Criteria and chooses to be served by the RSN contracted provider.
   c. The RSN will refer individuals to the Health Plan for mental health benefits when the individual does not meet Access to Care criteria or medical eligibility, or has graduated from RSN services and/or no longer meets Access to Care Criteria but still may meet medical necessity for the Healthy Options mental health benefit.

2. **Health Plan Responsibility**

   a. The Health Plan has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the RSN for an assessment is warranted. The Health Plan is also responsible to provide a mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the RSN PIHP Access to Care Criteria.

b. The Health Plan may refer individuals at any time to the RSN even if they have been served in the Health Plan's mental health benefit to determine if the individual meets Access to Care Criteria for RSN mental health benefits.

C. Coordination of Care and Care Transitions

The RSN and the Health Plan have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The RSN and the Health Plan and their respective designees (e.g. care managers, contractors, provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care.

1. **RSN Responsibility**
   a. The RSN shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the RSN contract with the state Division of Behavioral Health and Recovery Services Division (DBHR).
   b. The RSN shall provide timely information related to psychiatric hospital admission and discharge for Health Plan Healthy Options members.
   c. The RSN and its designees will collaborate with Health Plan care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the RSN will work with the Health Plan to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.

2. **Health Plan Responsibility**
   a. The Health Plan shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the state Health Care Authority (HCA).
   b. The Health Plan shall provide timely information related to medical hospital admission and discharge for Health Plan Healthy Options members receiving RSN PIHP services.
   c. The Health Plan and its designees will collaborate with RSN care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the Health Plan will work with the RSN to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.

D. Communications

1. Contacts for the RSN:

Mailing/Physical Address:
Greater Columbia Behavioral Health Regional Support Network
101 N Edison St
Kennewick, WA 99336
Phone: (509) 735-8681 or (800) 795-9296
Fax: (509) 783-4165

Department	Contact	Email
Director	Kenneth Roughton, Ph.D.	kenr@gcbh.org
Administration	Julie LaPierre, Office Manager	juliel@gcbh.org
Authorizations	Jackie Davidson and Vonie Aeschliman, Authorization Managers	jackied@gcbh.org voniea@gcbh.org
Care Coordination and Care Management	Jackie Davidson, Children Vonie Aeschliman, Adults	jackied@gcbh.org voniea@gcbh.org
Consumer Advocate	Cindy Adams, Customer Service & Consumer Advocate	cindya@gcbh.org
Contracts	Mary Garza, Contracts Coordinator	maryg@gcbh.org
Critical Incidents	Julie LaPierre, Office Manager	juliel@gcbh.org
Customer Service	Cindy Adams, Customer Service & Consumer Advocate	cindya@gcbh.org
Finance	Troy Wilson, CFO	troyw@gcbh.org
Information Systems	Ryan Angle, IS Manager	ryana@gcbh.org
Performance Improvement & Quality Management	Jamie Rundhaug, Ph.D., QM Manager	jamier@gcbh.org

2. Contacts for the **Health Plan**:

Mailing/Physical Address:
Cenpatico
504 Lavaca Street, Suite 850
Austin, TX 78701
Phone: (512) 406-7200 or (877) 644-4613
Fax: (866) 739-3424

Department	Contact	Phone
Referrals	Washington Case Manager/Care Coordinator	(877) 644-4613
Care Coordination & Care Management	Washington Case Manager/Care Coordinator	(877) 644-4613
Crisis Services	Washington Case Manager/Care Coordinator	(877) 644-4613
Data Sharing	Washington Case Manager/Care Coordinator	(877) 644-4613
Performance Improvement & Quality Management	Washington Case Manager/Care Coordinator	(877) 644-4613
Dispute Resolution	Washington Case Manager/Care Coordinator	(877) 644-4613

IV. Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this Agreement, nothing in this Agreement is intended to establish a legally binding agreement between the parties.
2. The parties of this agreement will hold one another including their contractors, employees, interns and volunteers harmless for failure to perform any of the roles identified above, including termination of this agreement with or without advance notice.
3. There shall be no remedy available to one party for failure to perform any role identified above by the other party, or a third party.

V. Dispute Resolution

1. All disputes occurring between the parties of this agreement shall be resolved through informal negotiation between the parties of the agreement. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of this agreement.

VI. Term and Termination

1. The effective date of this Agreement will be upon the final signature of the parties to this Agreement and it shall remain in effect until it is terminated in accordance with the terms of this Agreement.
2. Any of the parties to this Agreement may withdraw and terminate their participation from this Agreement for any reason and at any time. Thirty (30) days written notice is preferred but not required. Such notice and other correspondence related to this Agreement should be sent to the contacts and addresses listed above.

VII. Amendment

This Agreement may be amended at any time by written agreement and signature of all the parties.

IN WITNESS WHEREOF, the parties hereto have caused this Joint Operating Agreement (JOA) to be executed by the dates and signatures herein under affixed. The persons signing this JOA on behalf of the parties represent that each has authority to execute the JOA on behalf of the party entering this JOA.

Greater Columbia Behavioral Health:

Ken Roughton, Ph.D.
Director, GCBH RSN

11.29.12
Date

Cenpatico Behavioral Health, LLC:

Leonard W Whyte

Len Whyte
Chief Operating Officer

12/6/12
Date

JOINT OPERATING AGREEMENT
BETWEEN
COMMUNITY HEALTH PLAN OF WASHINGTON MANAGED HEALTH CARE ORGANIZATION
AND
GREATER COLUMBIA BEHAVIORAL HEALTH REGIONAL SUPPORT NETWORK

The Operational Agreement is between Community Health Plan of Washington a managed health care organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan (herein after referred to as the **Health Plan**) and Greater Columbia Behavioral Health Regional Support Network (RSN) contracted with Washington State Division of Behavioral Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP) (herein after referred to as the **RSN**) and serves Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima counties.

I. PURPOSE

This Agreement delineates the roles and responsibilities of the **Health Plan** and the **RSN** related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

The Agreement also demonstrates a shared commitment by both the **Health Plan** and the **RSN** to coordinate care for persons who are involved in or require services from both systems of care.

II. BACKGROUND

A. Health Plan

The **Health Plan** provides managed health care services to eligible individuals insured under the Healthy Options and Basic Health Plan in Washington State.

B. RSN

The **RSN** provides Medicaid covered mental health services to eligible consumers in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima Counties in Washington State.

III. RESPONSIBILITIES AND ROLES

A. Sharing Protected Health Information

The parties agree that information shared under this Agreement is shared for the purpose of coordination of treatment and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). The parties shall use and disclose protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e).

B. Referrals between the Health Plan and the RSN

While both the **Health Plan** and the **RSN** benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the **Health Plan** is a limited benefit. The **RSN** mental health benefit has a broad scope and serves individuals with need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program, Pre-paid Inpatient Health Plan (PIHP), requires enrollees to meet both medical necessity and Mental Health Access to Care Criteria to define member qualification for **RSN** mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this Agreement. Therefore, enrollees covered under Healthy Options may approach either the **Health Plan** or the **RSN** network providers for mental health services.

Enrollees who choose to access the **Health Plan** may be referred to the **RSN** by the **Health Plan** providers if it appears that they may meet access to care criteria. Enrollees who choose to access a **RSN** network provider will be assessed and either authorized by the **RSN** into care or referred to the **Health Plan** based on PIHP criteria.

1. **RSN** Responsibility

   a. The **RSN** has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and access to care criteria for **RSN** mental health services. The **RSN** shall accept a referral from the **Health Plan** for a face-to-face assessment when the **Health Plan** believes the individual may meet Access to Care criteria for the **RSN** mental health benefit.
   b. The **RSN** will authorize and serve any individual who meets medical necessity and the Access to Care Criteria and chooses to be served by the **RSN** contracted provider.
   c. The **RSN** will refer individuals to the **Health Plan** for mental health benefits when the individual does not meet Access to Care criteria or medical eligibility, or has graduated from **RSN** services and/or no longer meets Access to Care Criteria but still may meet medical necessity for the **Health Plan** mental health benefit.

2. **Health Plan** Responsibility

   a. The **Health Plan** has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the **RSN** for an assessment is warranted. The **Health Plan** is also responsible to provide a mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the **RSN** PIHP Access to Care Criteria.
   b. The **Health Plan** may refer individuals at any time to the **RSN** even if they have been served in the **Health Plan's** mental health benefit to determine if the individual meets Access to Care Criteria for **RSN** mental health benefits.

C. Coordination of Care and Care Transitions

The **RSN** and the **Health Plan** have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The **RSN** and the **Health Plan** and their respective designees (e.g. care managers, contractors, provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care.

1. **RSN** Responsibility
   a. The **RSN** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the **RSN** contract with the Washington State Division of Behavioral Health and Recovery (DBHR).
   b. The **RSN** shall provide timely information related to psychiatric hospital admission and discharge for **Health Plan** Healthy Options members.
   c. The **RSN** and its designees will collaborate with **Health Plan** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this Agreement the **RSN** will work with the **Health Plan** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.

2. **Health Plan** Responsibility
   a. The **Health Plan** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the Washington State Health Care Authority (HCA).
   b. The **Health Plan** shall provide timely information related to medical hospital admissions and discharge for **Health Plan** Healthy Options members receiving **RSN** PIHP services.
   c. The **Health Plan** and its designees will collaborate with **RSN** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this Agreement the **Health Plan** will work with the **RSN** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.

D. Communications

1. Contacts for the **RSN**:

Mailing/Physical Address:
Greater Columbia Behavioral Health Regional Support Network
101 N Edison St
Kennewick, WA 99336
Phone: (509) 735-8681 or 800-795-9296
Fax: (509) 783-4165

Department	Contact	Email
Director	Kenneth Roughton, Ph.D.	kenr@gcbh.org
Administration	Julie LaPierre, Office Manager	juliel@gcbh.org
Authorizations	Sindi Saunders, Authorization Center Staff Melissa Morasch, Authorization Center Staff Kris Brown, Authorization Center Staff Jackie Davidson, Authorization Center Manager Vonie Aeschliman, Authorization Center Manager	sindis@gcbh.org melissam@gcbh.org krisb@gcbh.org jackied@gcbh.org voniea@gcbh.org
Care Coordination and Care Management	Jackie Davidson, Children Care Coordinator Vonie Aeschliman, Adult Care Coordinator	jackied@gcbh.org voniea@gcbh.org
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Contracts	Mary Garza, Contracts Coordinator	maryg@gcbh.org
Critical Incidents	Julie LaPierre, Office Manager	juliel@gcbh.org
Customer Service	Cindy Adams, Customer Service & Consumer Advocate	cindya@gcbh.org
Finance	Troy Wilson, CFO	troyw@gcbh.org
Information Systems	Michael Roberts, IS Manager	michaelr@gcbh.org
Performance Improvement & Quality Management	Jamie Rundhaug, Ph.D., QM Manager	jamier@gcbh.org

2. Contacts for the **Health Plan**:

Mailing/Physical Address:
Community Health Plan of Washington
720 Olive Way, Ste 300
Seattle, WA 98101
Phone: (206) 521-8833
Fax: (206) 613-5018

Department	Contact	Email
Referrals	Patrick Johnson, PhD	(206) 613-8942
Care Coordination and Care Management	Patrick Johnson, PhD	(206) 613-8942
Crisis Services Contracts	Helen Harte	(206) 613-8839
Data Sharing	Patrick Johnson, PhD	(206) 613-8942
Performance Improvement and Quality Management	Helen Harte	(206) 613-8839
Dispute Resolution	Dorothy Hardin	(206) 652-7185
Critical Incidents	Helen Harte	(206) 613-8839

IV. Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this Agreement, nothing in this Agreement is intended to establish a legally binding Agreement between the parties.
2. The parties of this Agreement will hold one another including their contractors, employees, interns and volunteers harmless for failure to perform any of the roles identified above, including termination of this Agreement with or without advance notice.
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Name: Ken Roughton, Ph.D.
Title: Director, GCBH RSN

5·20·13
Date

Name: Able Castillo
Title: Vice President, Network Development

5/20/13
Date

JOINT OPERATING AGREEMENT

BETWEEN

MOLINA HEALTHCARE OF WASHINGTON, MANAGED HEALTH CARE ORGANIZATION

AND

GREATER COLUMBIA BEHAVIORAL HEALTH RSN, REGIONAL SUPPORT NETWORK

The Joint Operating Agreement is between **Molina Healthcare of Washington,** a Managed Health Care Organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan (herein after referred to as the **Health Plan**) and **Greater Columbia Behavioral Health RSN**, a Regional Support Network contracted with Washington State Division of Behavior Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP)(herein after referred to as the **RSN**) and serves Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima Counties.

I. PURPOSE

This Agreement delineates the roles and responsibilities of the **Health Plan** and the **RSN** related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

The Agreement also demonstrates a shared commitment by both the **Health Plan** and the **RSN** to coordinate care for persons who are involved in or require services from both systems of care.

This Agreement is not intended to identify the operational procedures specific to each Health Plan and each RSN. To ensure that both Health Plan and RSN responsibilities are fully met, details of the local procedures and agreements between each Health Plan and each RSN will be provided in an Attachment to this Joint Operating Agreement (*Referred to as the Joint Operating Agreement Attachment*).

II. BACKGROUND

A. Health Plan

The **Health Plan** provides managed health care services to eligible individuals insured under the Healthy Options Plan in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima Counties.

B. RSN

The **RSN** provides covered mental health services to eligible consumers in Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima Counties.

III. RESPONSIBILITIES AND ROLES

A. Sharing Protected Health Information

The parties agree that information shared under this Agreement is shared for the purpose of coordination of treatment and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH) and/or other applicable law.

B. Referrals between the Health Plan and the RSN

While both the **Health Plan** and the **RSN** benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the **Health Plan** is a limited benefit. The **RSN** mental health benefit has a broad scope and serves individuals with need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program PIHP requires enrollees to meet both medical necessity and Mental Health Access to Care Criteria to define members' qualification for **RSN** mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this Agreement. Therefore, enrollees covered under Healthy Options may approach either the **Health Plan** or the **RSN** network providers to request mental health services.

Enrollees who choose to access the **Health Plan** may be referred to the **RSN** by the **Health Plan** providers if it appears that they may meet Access to Care criteria. Enrollees who choose to access an RSN network provider will be assessed and either authorized by the RSN into care or referred to the Health Plan based on PIHP criteria.

1. **RSN** Responsibility

   a. The **RSN** has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and Access to Care criteria for **RSN** mental health services. The **RSN** shall accept a referral from the **Health Plan** for a face-to-face assessment when the **Health Plan** believes the individual may meet Access to Care criteria for the **RSN** mental health benefit.
   b. The **RSN** will authorize and serve any individual who meets medical necessity and the Access to Care criteria and chooses to be served by the **RSN** contracted provider.
   c. The **RSN** will refer individuals to the **Health Plan** for mental health benefits when the individual does not meet Access to Care criteria or medical necessity, or has graduated from RSN services and/or no longer meets criteria for access to **RSN** services but still may meet medical necessity for the **Health Plan** mental health benefit.

2. **Health Plan** Responsibility

   a. The **Health Plan** has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the **RSN** for an assessment is warranted. The **Health Plan** is also responsible to provide a mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the **RSN** PIHP Access to Care criteria.
   b. The **Health Plan** may refer individuals at any time to the **RSN** even if they have been served under the **Health Plan's** mental health benefit to determine if the individual meets Access to Care criteria for **RSN** mental health benefits.

C. Coordination of Care and Care Transitions

The **RSN** and the **Health Plan** have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The **RSN** and the **Health Plan** and their respective designees (e.g. care managers, contractors, provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care.

1. **RSN** Responsibility

   a. The **RSN** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the RSN contract with the state Division of Behavioral Health and Recovery Services (DBHR)
   b. The **RSN** shall provide timely information related to psychiatric hospital admission and discharge for **Health Plan** Healthy Options members.
   c. The **RSN** and its designees will collaborate with **Health Plan** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the **RSN** will work with the **Health Plan** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
   d. Additional region specific procedures are provided in the Joint Operating Agreement Attachment.

2. **Health Plan** Responsibility

   a. The **Health Plan** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the state Health Care Authority (HCA).
   b. The **Health Plan** shall provide timely information related to medical hospital admission and discharge for **Health Plan** Healthy Options members receiving **RSN** PIHP services.

c. The **Health Plan** and its designees will collaborate with **RSN** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this Agreement the **Health Plan** will work with the **RSN** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
d. Additional region specific procedures are provided in the Joint Operating Agreement Attachment.

D. Communications

1. Each **Health Plan** and each **RSN** will provide contact information for functions that will be coordinated between the **Health Plan** and the **RSN.** The individual contacts provided in the Joint Operating Agreement Attachment will include at minimum:
   a. Referrals
   b. Care Coordination and Care Management
   c. Crisis Services Contacts
   d. Data Sharing
   e. Performance Improvement and Quality Management
   f. Dispute Resolution
   g. Critical Incidents

2. The **Health Plan** and the **RSN** agree to participate in further development of additional guidelines and operational procedures that will enhance the bi-directional care coordination between entities. The areas to be addressed may include, but are not limited to the following:
   a. Referral Procedures
   b. Screening Guidelines
   c. Notification of Admissions to Institutional Care
   d. Care Transitions/Discharge Planning from Institutional Care
   e. Continuing Care Transitions
   f. Care Management and Coordination
   g. Performance Measures and Improvement Processes
   h. Notifications of Emergent Care
   i. Data Sharing
   j. Dispute Resolution
   k. Notification of Critical Incidents

IV. Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this Agreement, nothing in this Agreement is intended to establish a legally binding agreement between the parties.
2. The parties of this Agreement will hold one another including their contractors, employees, interns and volunteers harmless for failure to perform any of the roles identified above, including termination of this Agreement with or without advance notice.
3. There shall be no remedy available to one party for failure to perform any role identified above by the other party, or a third party.

V. Dispute Resolution

1. All disputes occurring between the parties of this Agreement shall be resolved through informal negotiation between the parties of the Agreement. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of the Agreement.

VI. Term and Termination

1. The effective date of this Agreement will be upon the final signature of the parties to this Agreement and it shall remain in effect until it is terminated in accordance with the terms of this Agreement.
2. Any of the parties to this Agreement may withdraw and terminate their participation from this Agreement for any reason and at any time upon thirty (30) days written notice to the other party. Such notice and other correspondence related to this Agreement should be sent to the contacts and addresses listed above.

VII. Amendment

This Agreement may be amended at any time by written agreement and signature of all the parties.

IN WITNESS WHEREOF, the parties hereto have caused this Joint Operating Agreement to be executed by the dates and signatures herein under affixed. The persons signing this Joint Operating Agreement on behalf of the parties represent that each has authority to execute the Joint Operating Agreement on behalf of the party entering this Joint Operating Agreement.

Ken Roughton
RSN Director

1-3-2013
Date

Bela Biro
President

1/18/2013
Date

ATTACHMENT

Joint Operating Agreement Attachment

This Attachment, as identified in the Joint Operating Agreement between **Molina Healthcare of Washington**, a Managed Care Health Organization and **Greater Columbia Behavioral Health RSN**, a Regional Support Network, Article I. PURPOSE, details the local procedures and agreements between the Health Plan and RSN.

1. **Coordination of Care/Care Transition**

   A. **RSN Sharing:**
   For members who meet Access to Care Criteria and are currently receiving services from the RSN provider network; and, are enrolled in the HealthPlan:
   - Psychiatric Hospital Admissions
   - If receiving services from RSN provider network, the Case Manager name, agency name, and contact information

   B. **Molina Healthcare Sharing:**
   For members who:
   - Meet Access to Care Standards and are currently receiving services from RSN provider network AND
   - Are enrolled in the Molina Case Management Program:
     a. Medical Hospital Admissions
     b. Emergency Department visits

   C. **Collaboration on High Risk Cases**
   The RSN and Molina Healthcare will coordinate and collaborate to assure best patient outcomes for high risk cases.

2. **Communication**

   A. **Contact List**

MOLINA HEALTHCARE

i. Referrals: Erin Darrah (back up Christi Sahlin)
ii. Care Coordination and Care Management: Erin Darrah (back up Christi Sahlin)
iii. Medical Crisis Services Contacts: 24 hour Molina Nurse Advice Line
   a. English: 1-888-275-8750
   b. Spanish: 1-866-648-3537
   c. TTU: 1-866-735-2929
iv. Data Sharing: Christi Sahlin (back up Lisa Andrade)
v. Performance Improvement and Quality Management: Christi Sahlin (back up Lisa Andrade)
vi. Dispute Resolution: Christi Sahlin (back up Lisa Andrade)
vii. Critical Incidents: Christi Sahlin (back up Lisa Andrade)

Christi Sahlin, MSW, LICSW
Manager of Integrated Case Management
(425) 424-7103

Erin Darrah, RN, CCM
Supervisor of Integrated Case Management
(425) 424-7171

Lisa Andrade, RN, MSN, MBA
Director of Health Care Services
(425) 424-7172

GREATER COLUMBIA BEHAVIORAL HEALTH

101 N Edison St
Kennewick, WA 99336
Phone: (509) 735-8681 or 800-795-9296
Fax: (509) 783-4165

Director	Kenneth Roughton, Ph.D.	kenr@gcbh.org
Administration	Julie LaPierre, Office Manager	juliel@gcbh.org
Authorizations	Sindi Saunders, Authorization Center Staff Melissa Morasch, Authorization Center Staff Kris Brown, Authorization Center Staff Jackie Davidson, Authorization Center Mgr. Vonie Aeschliman, Authorization Center Mgr.	sindis@gcbh.org melissam@gcbh.org krisb@gcbh.org jackied@gcbh.org voniea@gcbh.org
Care Coordination and Care Management	Jackie Davidson, Children Care Coordinator Vonie Aeschliman, Adult Care Coordinator	jackied@gcbh.org voniea@gcbh.org
Consumer Advocate	Cindy Adams, Customer Service & Consumer Advocate	cindya@gcbh.org
Contracts	Mary Garza, Contracts Coordinator	maryg@gcbh.org
Critical Incidents	Julie LaPierre, Office Manager	juliel@gcbh.org
Customer Service	Cindy Adams, Customer Service & Consumer Advocate	cindya@gcbh.org
Finance	Troy Wilson, CFO	troyw@gcbh.org
Information Systems	Troy Wilson, CFO	troyw@gcbh.org
Performance Improvement & Quality Management	Jamie Rundhaug, Ph.D., QM Manager	jamier@gcbh.org

B. Mechanism for Sharing & Updating Contact List:
Contact list included in Attachment. Updated contact list will be shared as information changes.

C. Other Data Sharing:
Molina Healthcare will share the following information with the RSN for members who are:

- Currently enrolled in Molina Healthcare AND
- Eligible for services from the RSN provider network
    a. Name
    b. Provider One ID#
    c. Address
    d. Phone Number
    e. DOB
    f. PCP
    g. Enrollment Date
    h. Currently enrolled in Case Management Program and if yes – name of assigned Case Manager

Molina Healthcare will share the following information with the RSN for members who are:

- Currently enrolled in Molina Healthcare AND
- Meet Access to Care Standards and are actively receiving services from the RSN provider network
    a. Diagnosis(s): both medical and psychiatric
    b. Physician visits in past 90 days (include both primary care and specialty care visits)
    c. All medications filled in the past 90 days
    d. Currently enrolled in Patient Review and Coordination Program (PRC)

SCOPE OF SERVICES AND COLLABORATION ATTACHMENT

This Scope of Services and Collaboration Attachment ("***Attachment***") shall supplement the Joint Operating Agreement ("***Agreement***") by and between Molina Healthcare of Washington, a Managed Health Care Organization in the State of Washington ("***Plan***"), and Greater Columbia Behavioral Health Regional Support Network ("***RSN***") Regional Support Network duly licensed in the State of Washington ("***State***"). Molina Healthcare of Washington and RSN to be referred to collectively herein as the "***Parties***". The Parties agree as follows:

ARTICLE I
CARE COORDINATION PROCESSES AND PROCEDURES

1.1 **Screening Guidelines.**

A. Molina Healthcare of Washington will utilize Access to Care Standards as a screening tool prior to referring members enrolled with Molina Healthcare of Washington to the RSN for an intake.

B. RSN will screen members to determine eligibility for services through the RSN system.

1.2 **Referral Procedures.**

A. **Non-Crisis Referrals**

(i) RSN, through its Provider Network, will refer all non-RSN eligible Members (those who do not meet Access to Care Standards criteria), who are enrolled with the Plan, back to the Molina Healthcare of Washington liaison with one (1) business day of a non-eligible determination.

(ii) Molina Healthcare of Washington will refer Healthy Options Members who are screened and appear to meet Access to Care Standards (eligible for RSN services) to the RSN. RSN will provide Molina Healthcare of Washington with a monthly list of active Members.

B. **Crisis-Referrals**

(i) All residents are referred directly to crisis lines by calling the crisis hotline for their county

(ii) RSN understands that Molina Healthcare of Washington maintains after-hours coverage through the "24 Hour Nurse Advice Line" and all Members are eligible to utilize this provider for after-hours crisis calls.

1.3 **Notification of Admissions to Institutional Care & Care Transitions.**

A. **Inpatient Admissions.** RSN agrees to notify Molina Healthcare of Washington within twenty-four (24) hours, or next business day, of being notified of a Member's admission to an inpatient setting and shall provide two (2) business days notice of a Member's discharge from an inpatient setting. Such notification shall be made through the GCBH Provider Portal or other secure method to the identified Molina Healthcare of Washington RSN liaison. RSN further agrees to notify Molina Healthcare of Washington prior to Member's discharge and shall ensure the Member is scheduled for an outpatient visit with their behavioral health provider to occur within seven (7) days of discharge. RSN, through its Provider Network, shall encourage the Member to attend the visit, and shall make best efforts to assist the Member in the removal of any barriers to keeping the appointment, including transportation issues.

B. **Notifications of Emergent Care.** Molina Healthcare of Washington agrees to notify RSN through the GCBH Provider Portal or other secure method within seven (7) business days, of any RSN eligible Member's visits to emergency rooms. Molina Healthcare of Washington further agrees to notify RSN of RSN eligible Member's discharge.

C. **Notifications of Medical/Surgical Inpatient Admissions.** Molina Healthcare of Washington agrees to notify RSN through the GCBH Provider Portal or other secure method within seven (7) business days of any RSN eligible Member's admissions for inpatient medical/surgical care. Molina Healthcare of Washington further agrees to notify RSN of RSN eligible Member's discharge.

D. **Continuing Care Transitions From the RSN System.** RSN agrees to notify the Molina Healthcare of Washington liaison via GCBH Provider Portal or other secure method within two (2) business days of a Member's discharge from the RSN system to provide information relative to previous services the Member received and recommended services the Member is in need of obtaining.

1.4 **High Risk Members**. Molina Healthcare of Washington and RSN will follow high risk member coordination procedures as outlined in High Risk Members. The Parties agree to adhere to the processes set forth in the Agreement section III, C.

1.5 **Data Sharing**. RSN and Molina Healthcare of Washington will provide each other with all required data elements in a mutually agreed upon, structured file format.RSN will provide, in a secure manner, all required data within an agreed upon time frame for all reports. The Parties agree to submit valid, reliable data to one another by the required due date. The Parties agree to provide report/data sharing specifications, including file formats and report templates, to one another, prior to implementation of data sharing activities.

1.6 **Dispute Resolution**. In the event of a dispute between the Parties regarding the terms of this Attachment, the Parties agree to attempt resolution through good faith negotiations between designated representatives of the Parties that have authority to settle the dispute. If the matter has not been resolved within forty-five (45) days of the request for negotiation, either party may initiate dispute resolution in accordance with the terms of the Agreement by providing written notice to the other party.

ARTICLE II
CONTACT LISTING

Functional Area	Molina Healthcare of Washington Contact	RSN Contact
Referrals	Case Management (800) 869-7165	See attached GCBH Provider Contact List
Care Coordination & Care Management	Case Management (800) 869-7165	Care Coordinator Phone: (509) 735-8681 or (800) 795-9296
Crisis Services	Nurse Advice Line (888) 275-8750	See attached GCBH Crisis Provider Contact List
Data Sharing	Manager, Case Management (800) 869-7165	Information Systems Phone: (509) 735-8681 or (800) 795-9296
Performance Improvement & Quality Management	Manager, Case Management (800) 869-7165	Quality Manager Phone: (509) 735-8681 or (800) 795-9296
Dispute Resolution	Manager, Case Management (800) 869-7165	Director Phone: (509) 735-8681 or (800) 795-9296

ARTICLE III
MISCELLANEOUS

1.7 **Confidentiality.** Neither Party shall disclose the substance of this Attachment nor any information, including proprietary information, acquired from the other Party during the course of, or pursuant to, the Agreement to a third party, unless required by law, including RCW 42.56 – Washington State Public Records Act.

1.8 **Authority**. The parties whose signatures are set forth below represent and warrant that they are duly empowered to execute this Attachment.

Molina Healthcare of Washington

Signature: _____

Print: Andrew Nelson

Title: VP, Provider Network

Date: 5/8/15

Greater Columbia Behavioral Health Regional Support Network

Signature: _____

Print: Ken Roughton, Ph.D.

Title: Director

Date: 4.30.15

Greater Columbia Behavioral Health

GREATER COLUMBIA BEHAVIORAL HEALTH AND NUEVA ESPERANZA COMMUNITY COUNSELING SERVICES

STATE MENTAL HEALTH AGREEMENT

GCBH Agreement Number

NECCSS15-00

[X] New Agreement

[ ] Amendment No.

This Agreement is made and entered into by, and between Greater Columbia Behavioral Health, hereinafter referred to as "GCBH" and the Member Government identified below, hereinafter referred to as the "Contractor".

RSN/PHP NAME		
Greater Columbia Behavioral Health		
RSN/PHP ADDRESS 101 N. Edison Street Kennewick, WA 99336		RSN/PHP CONTACT NAME Mary Garza
RSN/PHP CONTACT TELEPHONE (509) 735-8681/1-800-795-9296	RSN/PHP CONTACT FAX (509) 783-4165	RSN/PHP CONTACT E-MAIL maryg@gcbh.org

CONTRACTOR NAME		
Nueva Esperanza Community Counseling Services		
CONTRACTOR CONTACT NAME Dell Anderson, Director		CONTRACTOR CONTACT ADDRESS Nueva Esperanza Community Counseling Services 720 W Court St, #8 Pasco, WA 99301
CONTRACTOR CONTACT TELEPHONE (509) 545-6506	CONTRACTOR CONTACT FAX (509) 546-0520	CONTRACTOR CONTACT E-MAIL danderson@tcc-health.org
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS AGREEMENT? No		CFDA NUMBERS (Federal Block Grant)

START DATE	END DATE	FUNDING
July 01, 2015	March 31, 2016	See Funding Schedule posted on the GCBH website www.gcbh.org

ATTACHMENTS: When the box(s) below are marked with an X, the following exhibits are attached to and incorporated into this Agreement by reference:

[X] **Exhibit(s): A – Data Security Requirements; B – RSN Transfer Protocol**

By their signatures on the attached signature page, the parties agree to the terms and conditions of this Agreement and all documents attached or incorporated by reference.

IN WITNESS WHEREOF, the parties below have executed this Agreement:

GREATER COLUMBIA BEHAVIORAL HEALTH

Chair, GCBH Board of Directors

CONTRACTOR

CEO

Nueva Esperanza Community Counseling Services

Approved as to Content:

GCBH Director

Approved as to Form:

GCBH Legal Counsel

Fiscal Review:

GCBH Chief Financial Officer

Content and Form Prepared By:

GCBH Contracts Coordinator

PURPOSE OF AGREEMENT

›vide or purchase age, linguistic and culturally competent community mental health services listed below to the maximum extent possible and within the Available Resources provided under this Agreement for individuals within the contracted Service Area. The services shall be provided pursuant to: RCW 70.02, 71.05, 71.24, and 71.34, 70.96(B) and 70.96(C) or any successors and WAC Chapter 388-865 or any successors.

Period of Performance – This Agreement is in effect from July 1, 2015, through March 31, 2016.

1. DEFINTIONS

a. **Action** means:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the State: or
- The failure to act within the grievance system timeframes as provided in WAC 388-877A-0420 through 388-877A-0450.

b. **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.

c. **Available Resources** means funds appropriated for the purpose of providing community mental health 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 mental health services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

d. **Budget Narrative.** The Budget Narrative serves two purposes - it identifies how the costs were estimated and it justifies the need for the cost.

e. **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.

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

g. **Community Mental Health Agency ("CHMA")** means a Community Mental Health Agency that is licensed by the State of Washington to provide mental health services covered under this Agreement.

h. **Consumer** means a person who has applied for, is eligible for, or who has received mental health services. For a child under the age of thirteen, or for a child age thirteen or older, whose

parents or legal guardians are involved in the treatment plan, the definition of Consumer includes parents or legal guardians.

i. **Counties** means Benton County and Franklin County and any of their officers, employees, and authorized agents.

j. **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.

k. **Day** for purposes of this Agreement means calendar days unless otherwise indicated in the Agreement.

l. **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.

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

n. **Direct Care Staff** means persons employed by community mental health agencies whose primary responsibility is providing direct treatment and support to people with mental illness, c whose primary responsibility is providing direct support to such staff in areas such as client scheduling, client intake, client reception, client records-keeping, and facilities maintenance.

o. **Division of Behavioral Health and Recovery or DBHR** means the DSHS-designated state mental health authority to administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.

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

q. **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.

r. **Enrollee** means a Medicaid recipient who is currently enrolled in a Pre-paid Inpatient Health Plan.

s. **Evaluation and Treatment (E&T)** 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.

t. **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.

u. **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.

v. **Family** means:
(1) For adult Consumers, family means those the consumer defines as family or those appointed/assigned (e.g., guardians, siblings, caregivers, and significant others) to the consumer.
(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.

t. **Greater Columbia Behavioral Health (GCBH)** means GCBH's officers, employees, and authorized agents. GCBH's service area includes the counties of Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima.

u. **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 mental health Consumer's rights.

v. **Grievance Process** means one of the processes included in the grievance system that allows an individual to express concern or dissatisfaction about a mental health service.

w. **Grievance System** means the processes through a regional support network in which an individual applying for, eligible for, or receiving mental health services may express dissatisfaction about services. The grievance system must meet the requirements of 42 CFR 438 Subpart F, and include a grievance process and access to the Fair Hearing process.

x. **Individual** means a person who applies for, is eligible for, or receives RSN-authorized mental health services from an agency licensed by the Department as a behavioral health agency. 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:
- In the case of a minor, the individual's parent or, if applicable, the individual's custodial parent;
- The individual's legal guardian; or
- The individual's representative if the individual gives written permission.

y. **Institute for Mental Disease (IMD)** 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.

z. **Involuntary Treatment Act (ITA)** means Individuals 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).

aa. **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.

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

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. 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.

cc. **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.

dd. **Mental Health Professional** means:

(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in Chapters 71.05 and 71.34 RCW.

(2) A person with a masters 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.

(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(4) A person who had an approved waiver to perform the duties of a Mental Health

Professional that was requested by the regional support network and granted by DSHS prior to July 1, 2001.

(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.

ee. **Notice of Action** means the written notice GCBH provides to an individual and, if applicable, the individual's legal representative, to communicate an Action, as defined in this Seciton.

ff. **Notice of Determination** means a written notice that must be provided to Consumers 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.

gg. **Patient Days of Care** includes all voluntary patients and involuntarily committed patients under Chapter 71.05 RCW, regardless of where in the State Hospital they reside. Patients who are committed to the State Hospital under 10.77 RCW 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 90 days of civil commitment under Chapter 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 Chapter 71.05 RCW.

hh. **Publish** means an officially sanctioned document provided by DBHR and/or GCBH on the DBHR and/or GCBH 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.

ii. **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.

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

kk. **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.

ll. **Receiving RSN** means the RSN into whose region the Referring RSN is pursuing the transfer.

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

nn. **Referring RSN** means the RSN in whose region the individual being transferred resided and/or

from whom they received services prior to state hospital admission.

oo. **Regional Support Network (RSN)** means a county authority or group of county authorities o. other entity recognized by the Secretary to administer mental health services in a defined region.

pp. **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.

qq. **Service Area** means the geographic area covered by this Agreement for which the Contractor is responsible. The Contractor is responsible for the provision of services within the boundaries of Benton and Franklin Counties.

rr. **Specialized Non-Medicaid Services** means, for purposes of the RSN Transfer Protocol, IMD admissions, residential placement, and state hospital census.

ss. **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.

tt. **Urgent** 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. CREDENTIALING

a. The Contractor shall hold all necessary licenses, certifications and/or permits as required by law for the performance of the activity to be performed under this Agreement. The Contractor shall notify GCBH in the event of a change in status of any required license or certification.

b. The Contractor shall have written policies that require monitoring of credentials. The Contractor shall only use CMHAs that are licensed and/or certified by DSHS. Clubhouses must meet all credentialing requirements put in place by the State. The Contractor shall maintain documentation that all MHCPs are currently licensed in the State of Washington.

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

3. MHCP TERMINATION

The Contractor must use best efforts to provide written or oral notification no later than 15 working days after termination of a MHCP to Individuals currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the CMHA.

4. CHANGES IN CAPACITY

a. The Contractor shall notify GCBH and the Counties of any changes in capacity. A significant

change in capacity is defined as the termination or addition of a Subcontract with an entity that provides mental health services or the closing of a Contractor or Subcontractor site that is providing services under this Agreement. The Contractor must notify GCBH thirty (30) calendar days prior to terminating this Contract or any Subcontracts with entities that provide direct services, including mental health clubhouses, or entering into new Subcontracts with entities that provide direct services, including mental health clubhouses. This notification must occur prior to any public announcement.

(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 the GCBH Contracts Coordinator, in writing, as soon possible and prior to a public announcement.

(2) The Contractor shall notify the GCBH Contracts Coordinator, in writing, of any other changes in capacity that results in the Contractor being unable to meet any of the requirements 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.

(3) If any of the events described in this Section occur, the Contractor must collaborate with the Counties and submit a plan, in writing, to the GCBH Contracts Coordinator 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.

5. TRAINING

a. The Contractor shall participate in trainings, meetings and/or conferences when requested by GCBH, the Counties and/or DSHS.

b. Requests for GCBH, the Counties and/or DSHS to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to targeted Contractor staff.

c. The Contractor must participate in GCBH, Counties and/or DSHS offered training on the implementation of Evidence-Based Practices and Promising Practices..

d. Annually, all community mental health employees who work directly with clients shall be provided with training on safety and violence prevention topics described in RCW 49.19.030.

6. INCIDENT REPORTING

a. The Contractor must maintain policies and procedures regarding mandatory incident reporting and referrals consistent with all applicable state and federal laws. The policies must address the Contractor's oversight and review of the requirements in this Section.

b. The Contractor must report and follow-up on all incidents involving Enrollees, listed below. In

addition the Contractor must notify and collaborate with the Counties in reporting incidents to GCBH.

c. The Contractor must provide initial notification and any follow up to the GCBH Incident Manager. Contractor may use the standardized form found in the GCBH Incident Report policy. Reports shall contain, at a minimum, the following:

- A description of the incident;
- The date and time of the incident;
- Incident location;
- Incident type;
- Names and ages, if known, of all individuals involved in the incident;
- The nature of each individual's involvement in the incident;
- The service history with the Contractor, if any, of individuals involved;
- Steps taken by the Contractor to minimize harm; and
- Any legally required notifications made by the Contractor.

d. 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:

(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.

i. Death or serious injury of patients, clients, staff, or public citizens at a DSHS facility or a facility that DSHS licenses, contracts with, or certifies.

ii. 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.

iii. 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.

iv. Any event involving an individual or staff that has attracted media attention.

(2) Category Two Incidents: the Contractor must report within one (1) working day of becoming aware that any of the following Category Two Incidents has occurred, involving an Enrollee.

i. Alleged client abuse or client neglect of a serious or emergent nature by an employee, volunteer, licensee, Contractor, or another client.

ii. 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.).

iii. 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, RSNs will document and/or attach: 1) the Police report, 2) any equipment that was lost, and 3) specifics of the client information.

iv. Any allegation of financial exploitation as defined in RCW 74.34.020.
v. Any attempted suicide that requires medical care that occurs at a facility that DSHS licenses, contracts with, and/or certifies.
vi. Any event involving a client or staff, likely to attract media attention in the professional judgment of the Contractor.
vii. 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."
viii. Any incident that was referred to the Medicaid Fraud Control Unit by the Contractor or its Subcontractor.
ix. A life safety event that requires an evacuation or that is a substantial disruption to the facility.

e. Comprehensive Review: GCBH may require the Contractor to initiate a comprehensive review of any incident.
(1) If the Contractor does not respond according to the timeframe in GCBH's request, GCBH may obtain information directly from any involved party and request their assistance in the investigation.
(2) GCBH may request medication management information.
(3) GCBH 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.

f. Incident Review and Follow-up: the Contractor will review and follow-up on all incidents reported. The Contractor will provide sufficient information, review, and follow-up to take the process and report to its completion. An incident will not be categorized as complete until the following information is provided:
(1) A summary of any incident debriefings or review process dispositions;
(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;
(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;
(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;
(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; and
(6) If this information is unavailable, the attempt to retrieve it will be documented.

g. GCBH and/or the Counties may require the Contractor to provide additional information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

7. INFORMATION REQUIREMENTS

a. 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:

(1) Provide interpreter services for Consumers who speak a primary language other than English for all interactions between the consumer 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.

(2) Provide written translations of generally available materials including, at minimum, applications for services, consent forms, and Notice of Determination 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 US census. DSHS has determined based on this criteria that Spanish is the currently required language.

(3) The DSHS Prevalent languages are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese. The Client rights have been translated and included in the Washington Medicaid Benefit Booklet that the Contractor must provide to each Individual at intake. The expectation is that this translated document is readily available at all times.

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

(5) For Individual whose primary language is not translated, the requirement may be met by providing the information through audio or video recording in the Individual's primary language, having an interpreter read the materials in the Individual's 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.

(6) Ensure that Mental Health Professionals and MHCPs have an effective mechanism to communicate with Individuals with sensory impairments.

(7) Post a multilingual notice in each of the DSHS prevalent languages, which advises Consumers that information is available in other languages and how to access this information.

(8) The Contractor shall post a translated copy of the consumer rights as provided by DSHS in each of the DSHS prevalent languages.

(9) Upon an Individual's request, the Contractor shall provide:

i. CMHA licensure, certification and accreditation status.

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

8. CUSTOMER SERVICES

a. The Contractor shall provide Customer Services that are customer-friendly, flexible, proactive, and responsive to Consumers, families, and stakeholders. The Contractor shall provide a toll free number for Customer Service. A local telephone number may also be provided for those

Consumers within the local calling area.

b. At a minimum, Contractor Customer Services staff shall:
   - Promptly answer telephone calls from Individuals, family members and stakeholders from 8 a.m. until 5:00 p.m. Monday through Friday, holidays excluded.
   - Respond to Consumers, 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.

c. Customer Services staff must be trained on how to refer these calls to the appropriate party.

9. PAYMENT AND FISCAL MANAGEMENT

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

b. The Contractor shall be paid monthly using a payment methodology developed by the Counties using non-Medicaid client counts and/or service hours provided to Non-Medicaid Consumers. Each Contractor's percentage of the total number of Non-Medicaid Consumers served and/or service hours provided to Non-Medicaid Consumers the previous month will be used to calculate the payment amount from the available State-Only funding as compensation for services provided to Non-Medicaid Consumers for each month. For purposes of this Agreement, available State-Only funding is defined as the amount of State-Only funding received each month from GCBH less reasonable setaside funding which includes, but is not limited to, county administration costs, crisis services provided to Non-Medicaid Consumers, special projects serving Non-Medicaid Consumers, and other direct service and support costs incurred in the support of services for Non-Medicaid Consumers and for services not covered in the State Plan provided to Medicaid Enrollees. The Funding Schedule, as amended, revised and/or replaced, is available on the GCBH website: www.gcbh.org.

c. If the Contractor terminates this agreement or will not be entering into any subsequent agreements, GCBH will require that all remaining reserves and fund balances be spent within a reasonable timeframe developed with and approved by GCBH and the Counties. Funds will be deducted from the monthly payments until all reserves and fund balances are spent. The Contractor must provide the appropriate notice to GCBH under the requirements of the Termination Section of the Agreement. Any funds not spent for the provision of services under this Agreement shall be returned to GCBH within 60 days of the last day this Agreement is in effect.

d. Rates for July 1, 2015 through March 31, 2016- Following the end of the annual legislative session, the Counties will offer a proposed capitation payment for the next Fiscal Year; the revised Funding Schedule will be posted to the GCBH website: www.gcbh.org. If the Contractor does not agree to continue to provide services using the proposed payment, the Contractor shall notify GCBH and the Counties no later than thirty (30) days after the revised Funding Schedule is posted. If the Contractor so notifies GCBH, this Agreement shall terminate, without penalty to either party, effective thirty (30) days after GCBH receives Contractor's notice. The termination will be considered a Termination for Convenience, but neither party shall have the right to assert a claim for costs.

(1) The Contractor shall work with GCBH and the Counties to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services to Consumers. The transition plan shall address all issues leading to the transition of Contractor functions to GCBH such as the use of Reserves, claims reconciliation, and of all items and/or requirements of the Agreement that extend beyond the termination of services.

e. The Contractor shall limit Administration Costs to no more than 15 percent of the annual revenue provided under this Agreement. Administration costs shall be measured on a fiscal year basis and based on the information reported in the Financial Reports and reviewed by the Counties and GCBH.

f. Each capitation payment will be reduced by the amount paid by GCBH on behalf of the Contractor for unpaid assessments, penalties, damages, and other payments pending a dispute resolution process. If the dispute is still pending at the end of this Agreement, GCBH will withhold the amount in question from the final payment until the dispute is resolved.

g. GCBH will withhold 50 percent of the final payment under this Agreement until all final reports and data are received and accepted by GCBH, and until all pending corrective actions, penalties, or unpaid assessments are satisfied. If the dispute is still pending July 1, 2016, GCBH will withhold the amount in question from the final payment until the dispute is resolved.

h. Financial Reporting and Certification: Certification: Financial Reports and Certifications are due within 30 days of the second quarter end (December and June of each year). Only one report due within this Agreement period, and shall be submitted to GCBH with accompanying certification, by January 30, 2016. The Contractor shall submit the following components in a single form provided by GCBH:

(1) The PIHP Revenue, Expenditure, report in compliance with the BARS Supplemental for Mental Health Services promulgated by the Washington State Auditor's Office and the Revenue and Expenditure Report Instructions published by GCBH. Contractor must maintain fiscal records that clearly separate revenue received from GCBH (i.e Medicaid, State, MHBG, Jail, etc.)

(2) The amounts paid, if any, to Federally Qualified Health Centers for services.

(3) Any 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, in accordance with Medicaid being the payer of last resort.

(4) In addition, the Contractor shall submit a single financial certification form, provided by GCBH, indicating that financial information reported on Revenue and Expenditure documents are true and correct to the best of their knowledge per instructions provided by GCBH.

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

(6) GCBH reserves the right to modify the form, content, instruction, and timetables for

collection and reporting of financial data at any time.

(7) The Contractor and all Subcontractors must have an independent annual financial audit completed within 275 days of the Contractor's fiscal year end. This audit must be performed by either the Washington State Auditor's Office or an independent accounting firm licensed to perform such audits. A copy of the completed audit report and management letter must be submitted to GCBH within thirty (30) days of the reports issuance. Failure for the Contractor or its Subcontractors to comply with this term may result in corrective action, the withholding of payment and/or termination in accordance with the terms of this Agreement.

10. **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.
    - Create and maintain a mandatory compliance plan that includes provisions to educate staff and providers of the false claim act and whistle blower protections.
    - Develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State standards.
    - Designate a compliance officer and a compliance committee that is accountable to senior management.
    - Provide effective ongoing training and education for the compliance officer and Contractor staff.
    - Facilitate effective communication between the compliance officer, the Contractor employees and GCBH.
    - Enforce standards through well-publicized disciplinary guidelines.
    - Conduct internal monitoring and auditing.
    - Respond promptly to detected offenses and develop corrective action initiatives.
    - Report fraud and/or abuse information to GCBH as soon as it is discovered including the source of the complaint, the involved CMHA, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

11. **COST ALLOCATION PLAN.** Within sixty (60) days following execution of this Agreement, the Contractor shall submit to the Counties and GCBH a copy of its Cost Allocation Plan describing the methodology the Contractor uses to allocate costs to the public mental health system for reporting purposes under this Agreement.

12. **REVIEW ACTIVITIES**
    a. GCBH, the Counties, the Department of Social and Health Services, Office of the State Auditor, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives, may conduct announced and unannounced:
        (1) Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement.

(2) Audits regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement.
(3) Audits and inspections of financial records.

b. The Contractor and its subcontractors shall notify and provide copies of all letters, notices, audits, reviews, results from audits/reviews including corrective actions to the GCBH Quality Manager when an entity other than GCBH performs any audit or review described above related to any activity contained in this Agreement.

c. The Contractor and its subcontractors shall participate in an annual EQRO monitoring review and collaborate with the EQRO Contractor set forth by DSHS to schedule a time for the monitoring review.
(1) In the event the Contractor or Subcontractors do not provide ready access to any information or facilities for the EQRO monitoring review during the scheduled time, the Contractor shall incur any costs for re-scheduling the EQRO Contractor to return and finish its review.
(2) GCBH shall provide a copy of the final EQRO monitoring review report to the Contractor, through print or electronic media and upon request to interested parties such as Enrollees, mental health advocacy groups, and members of the general public.

d. 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.

e. The Contractor shall participate with GCBH, the Counties and/or DBHR in review activities. Participation will include at a minimum:
(1) The submission of requested materials necessary for a GCBH, the Counties and/or DBHR initiated review within 30 days of the request.
(2) The completion of site visit protocols provided by GCBH, the Counties and/or DBHR.
(3) Assistance in scheduling interviews and agency visits required for the completion of the review.

13. CONSUMER RIGHTS AND PROTECTIONS

a. The Contractor and any 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.

b. The Contractor shall require that Mental Health Professionals and MHCPs, 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:
(1) The individual's mental health status.
(2) Receiving all information regarding mental health treatment options including any alternative or self administered treatment, in a culturally-competent manner.
(3) Any information the Consumer needs in order to decide among all relevant mental

health treatment options.

(4) The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment).

(5) The Consumer's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions.

(6) The Consumer's right to be treated with respect and with due consideration for his or her dignity and privacy.

(7) The Consumer's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

(8) The Consumer's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.

(9) The Consumer's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the CMHA or MHCP treats the Individual.

c. The Contractor shall provide or purchase age, linguistic and culturally competent community mental health services for Individuals.

d. Individual service plans must be developed in compliance with WAC 388-877-0620.

(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.

(2) 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).

(3) 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.

e. Advance Directives

(1) The Contractor shall maintain a written Advance Directive policy and procedure that respects individuals' Advance Directives for psychiatric care. Policy and procedures must comply with RCW 71.32. If State law changes, those changes must be made and included in policies and procedures within ninety (90) calendar days of the effective date of any changes to the RCW.

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

14. UTILIZATION MANAGEMENT

a. The Contractor must ensure the requirements of WAC 388-877-0620 are being met regarding Individual Service Plans (ISP). The Contractor shall:

(1) Require that Individuals are actively included in the development of their ISPs, 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).

(2) Require, at a minimum, treatment goals include the words of the individual receiving services and documentation must be included in the clinical record, describing how the Individual sees progress.

(3) Ensure that ISPs address the overall identified needs of the Consumer, 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.

b. The Contractor shall ensure services are provided in accordance with the GCBH approved Level of Care Guidelines and the Contractor's policies and procedures for determining Available Resources and are not arbitrarily denied or reduced (e.g. the amount, duration, or scope of a service) based solely upon the diagnosis, type of mental illness, or the individual's mental health condition.

c. GCBH shall make a determination of eligibility for an initial authorization of services based on Medical Necessity and the Access to Care Standards following the initiation of the intake evaluation.

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

(2) Authorization and provision of services may begin before the completion of the intake evaluation once medical necessity has been established.

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

(4) The Contractor and its subcontractors must have written policies and procedures to ensure consistent application of extensions.

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

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

d. The Contractor may provide services for individuals who are aged 22 to 64 in Institutes of Mental Disease (IMD) in lieu of covered acute psychiatric services for up to thirty (30) calendar days per admission. The Contractor is not required to provide these services in IMD settings. These services are substituted only for covered acute inpatient or evaluation and treatment and may not be used for long-term IMD services.

e. The Contractor will participate with GCBH and/or 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:

- Participation, when requested, 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.

- Participation, when requested, 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.
- The Contractor shall track evidence-based and research-based practices following guidelines published by the Washington State Institute of Public Policy (WSIPP).

f. Contractors and any Subcontractors 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. In addition, Contractors and any Subcontractors must report on actions taken in response to WISe Quality Management Plan reports and associated outcomes.
   - Contractors and any Subcontractors 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.

g. 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:
   (1) A comprehensive transition plan linked across systems that identify goals, objectives, strategies, supports, and outcomes.
   (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.
   (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.
   (4) Developmentally and culturally appropriate adult services that are relevant to the individual or population.

15. MEDICAID PERSONAL CARE (MPC): The Contractor must comply with the MPC Agreement, as amended, revised and/or replaced, between GCBH and Home and Community Services and Aging and Long Term Care agencies. The MPC Agreement is available on the GCBH website: www.gcbh.org.

16. MANAGEMENT INFORMATION SYSTEM

a. Data Submission and Error Correction:
   (1) The Contractor shall provide GCBH with all data described in the GCBH "Data Dictionary" and encounters shall be submitted as described in the GCBH Trading Partner Agreement(s) and DBHR's "Encounter Data Reporting Guide" or any successor, incorporated herein by reference.
   (2) The Contractor shall submit encounters electronically to GCBH management information system within 30 days of the close of each calendar month in which the encounters occurred.
   (3) The Contractor shall submit all other required consumer data to GCBH within 30 days of collection.
   (4) Upon receipt of data submitted, GCBH shall generate error reports. The Contractor shall have in place documented policies and procedures to assure that data submitted and

rejected due to errors are corrected and resubmitted within 30 calendar days of when the error report was produced.

(5) The Contractor shall attend meetings and respond to inquiries to assist in GCBH 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.

(6) The Contractor shall implement changes documented in GCBH "Data Dictionary" and Trading Partner Agreement(s) and in DBHR's "Encounter Data Reporting Guide" within 90 days from the date published. When changes on one document require changes to the other, GCBH shall publish all affected documents concurrently.

(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, GCBH 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, GCBH will work with the Contractor to implement any change as necessary.

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

(9) When GCBH makes changes referenced in this Section the Contractor shall send at least one test batch of data containing the required changes. The test batch must be received no later than 15 days prior to the implementation date.

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

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

(11) No RSN encounter transaction shall be accepted for initial entry or data correction after one (1) year from the date of service, except by special exception.

b. Business Continuity and Disaster Recovery

(1) The Contractor shall demonstrate a primary and backup system for electronic submission of data requested by GCBH. This must include secure electronic transmission. In the event a secure method of transmission is unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on GCBH approval.

(2) The Contractor shall create and maintain a business continuity and disaster recovery plan that insures timely reinstitution of the consumer information system following total loss of the primary system or a substantial loss of functionality. The plan must be in

written format, have an identified update process (at least annually) and a copy must be stored off site.

(3) The Contractor must submit an annual certification statement indicating there is a business continuity disaster plan in place for the Contractor. The certification must be submitted by December 20 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's plan are available for GCBH or the DBHR-contracted EQRO to review and audit. The plan must address the following:

i. A mission or scope statement;
ii. An appointed Information Services Disaster Recovery Staff.
iii. Provisions for Backup of Key personnel; Identified Emergency Procedures; Visibly listed emergency telephone numbers.
iv. Procedures for allowing effective communication; Applications Inventory and Business Recovery priority; Hardware and software vendor list.
v. Confirmation of updated system and operations documentation; Process for frequent backup of systems and data.
vi. Off site storage of system and data backups; Ability to recover data and systems from backup files.
vii. Designated recovery options which may include use of a hot or cold site.
viii. Evidence that disaster recovery tests or drills have been performed.

c. Information System Security and Protection of Confidential Information:

(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 CFR Parts 160, 162 and 164.

(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 (Exhibit A).

(3) The Contractor shall take appropriate action if the Contractor's employees wrongly release confidential information.

d. Data Quality Verification:

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

17. GRIEVANCE SYSTEM

a. The Contractor must have a Grievance system that complies with the following procedures. The Contractor must provide information about the Grievance System to all Subcontractors at the time they enter into an Agreement.

b. General Requirements:

(1) An Individual or representative may file a Grievance either orally or in writing with the Contractor and may request a Fair Hearing from the State of Washington Office of Administrative Hearings. An Individual may also file a Grievance with his or her provider which must have policies and procedures consistent with the requirements in this Section.

(2) A representative, including a staff person of the Individual's provider, acting on behalf of the Individual and with Individual's written consent, may request a Grievance or a Fair Hearing.

(3) The Individual must be given reasonable assistance in pursuing a Grievance or Fair Hearing.

- The Individual may be provided assistance from the Ombuds service, the Individual's provider, the Contractor, or any other person of the Individual's choice.

(4) The Individual shall be provided access to interpreter services and toll-free numbers that have adequate TTU/TTD and interpreter capability.

(5) The Contractor shall:

- Ensure that there is no retaliation against Individuals or providers, who on behalf of the Individual, file a Grievance or Fair Hearing, or request an expedited resolution.
- Abide by all Grievance and Fair Hearing decisions.
- The Contractor must notify the GCBH Grievance and Appeals Coordinator within (1) working day of receiving a Grievance.

c. Handling of Grievances:

(1) The Contractor or its agent shall:

i. Acknowledge receipt of each Grievance, received either orally or in writing, within five (5) working days. If acknowledgement is made orally, it must be followed in writing within five (5) working days.

ii. Ensure that the individuals who make decisions on Grievances are individuals who were not involved in any previous level of review or decision-making and when the Grievance involves medical necessity the Contractor shall ensure that individuals involved with making decisions are Mental Health Professionals with the appropriate clinical expertise.

d. Resolution and Notification: The Contractor must resolve each Grievance and provide written notice as expeditiously as the Individual's mental health condition requires and not more than twenty (20) days from the receipt of the statement of Grievance by the Contractor.

(1) If a resolution cannot be reached, to the Consumer's satisfaction within the 20 day timeframe, the Contractor must forward the Grievance to GCBH immediately.

(2) GCBH shall provide written notice of resolution within 30 days from statement of Grievance.

(3) The Contractor may extend the timeframe by up to 14 calendar days if:

i. The Consumer request the extension; or

ii. The Contractor shows (to the satisfaction of GCBH upon request) that there is a need for additional information and how the delay is in the Consumer's interest.

(4) If the Contractor extends the timeframes, the Contractor must, for any extension, give the Individual written notice of the reason for the delay.

(5) Failure to meet the timeframes above or provide a written notice of any extension constitutes a denial and an adverse action for which the Individual shall be sent a Notice of Action. The Contractor must notify GCBH in the event timeframes are not met. A Notice of Action must be provided by GCBH.

(6) The written notice of resolution must include the decision on the Grievance, the reason for the decision, the date the decision was made and the right to request a Fair Hearing and the required timeframe to request the Hearing.

(7) For notice of expedited resolution the Contractor shall:

i. Provide written notice of the disposition within three (3) working days.

ii. Make reasonable effort to provide oral notice of disposition prior to written notice.

iii. Failure to meet the timeframes above or provide a written notice of any extension constitutes a denial and an adverse action for which the Individual shall be sent a Notice of Action. The Contractor must notify GCBH in the event timeframes are not met. A Notice of Action must be provided by GCBH.

iv. The written notice of resolution must include the results of the resolution process and the date it was completed.

v. For expedited Grievances not resolved wholly in favor of the Individual, the notice must include:

- The right to request a Fair Hearing and how to do so.
- The right to request to continue to receive previously authorized benefits while the hearing is pending and how to make the request.
- Notice that the Individual may be asked to pay for the cost of those benefits if the hearing decision upholds the original action.

e. Fair Hearings:

(1) Individuals may request a Fair Hearing conducted by DSHS in accordance with Chapter 388-02 WAC and provisions of mental health services per 42 CFR 438.402(b)(2).

- The parties to a Fair Hearing include the Contractor as well as the Individual and his or her representative or the legal representative of a deceased Individual's estate.

(2) A Fair Hearing may be requested from the State of Washing Office of Administrative Hearings when:

- An Individual believes there has been a violation of DSHS rule.
- The Contractor or its agent does not provide a written response to a grievance within the required timeframes.
- An Individual receives an adverse ruling by the Contractor or its agent to a grievance.

(3) If the Individual elects to request a Fair Hearing, regarding a standard service, the request must be filed within ninety (90) calendar days of the date on GCBH's mailing of the Notice of the resolution of the Appeal.

(4) If the Individual elects to request a Fair Hearing, regarding termination, suspension or reduction of a previously authorized service and if the Individual requests continuation of services, the request must be filed within ten (10) calendar days of the date on GCBH's mailing of the Notice of the resolution of the Appeal.

(5) GCBH will notify the Contractor of Fair Hearing determinations. The Contractor will be bound by the Fair Hearing determination, whether or not the Fair Hearing determination upholds the Contractor's decision.

f. Record-keeping and Reporting Requirements

(1) The Contractor must maintain records of Grievances and Fair Hearings for six (6) years.

(2) The Contractor must maintain records of Grievances and Fair Hearings separate from medical records. The Contractor must notify the GCBH Grievance and Appeals Coordinator at the time a grievance is filed. Notification must include the Individuals name and contact information.

(3) The Contractor must submit a report in a format provided by GCBH that includes:

i. The number and nature of Grievances and Fair Hearings.

ii. The timeframes within which they were disposed of or resolved.

iii. The nature of the decisions.

vi. A summary and analysis of the implications of the data, including what measures shall be taken to address undesirable patterns.

v. The Contractor shall submit to DSHS a total of three (3) reports covering the following periods:

- July 1, 2015 – September 30, 2015 (due October 20, 2015)
- October 1, 2015 – December 31, 2015 (due January 20, 2016)
- January 1, 2016 – March 31, 2016 (due April 01, 2016)

18. SERVICES

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

(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, 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.

(2) The GAIN-SS screening must be completed as self report by the individual and signec

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.

(3) The results of the GAIN-SS screening, including refusals and any where the Consumer was unable to complete, must be reported to GCBH through the CIS system.

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

(5) The assessment is required during the next outpatient treatment planning review following the screening and as part of the initial evaluation at free-standing, non-hospital, evaluation and treatment facilities. The assessment is not required during crisis interventions or ITA investigations.

The quadrant placements are defined as:

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

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

b. Core 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.

(1) Crisis Mental Health Services: The Contractor must provide crisis mental health services to individuals who are within the Contractor's Service Area and report they are experiencing a mental health crisis. Crisis mental health services must include each of the following:

i. 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 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.

ii. 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 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.

iii. 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. These are not-for-profit organizations. 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. GCBH must authorize exceptions for involuntary length of stay beyond a fourteen (14) calendar day commitment.

(2) Crisis mental health services may be provided without an intake evaluation or screening process. 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.

(3) Psychiatric Inpatient Services: Community Hospitals and Evaluation and Treatment Facilities: The Contractor shall provide or purchase psychiatric inpatient services for the following:

i. Individuals who agree to be admitted voluntarily and who are beneficiaries of the Psychiatric Indigent Inpatient (PII) and Disability Lifeline when it is determined to be medically necessary.

ii. 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.

iii. Individuals at least 22 years of age and under 65 years of age who are Medicaid-Enrollees and are admitted to a residential facility that is classified as an Institution for Mental Diseases (IMD) defined in 42 CFR 435.1010.

(4) Psychiatric Inpatient Services: State Hospitals:

i. Ensure Consumers are medically cleared, if possible, prior to admission to a State Psychiatric Hospital.

ii. 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.

iii. The Contractor or its designee shall monitor Individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320.

iv. The Contractor or its designee shall offer mental health services to assist with compliance with LRA requirements for individuals who meet medical necessity.

v. 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.

vi. The Contractor or designee shall ensure provision of covered mental health services to Individuals on a Conditional Release under RCW 10.77.150.

vii. For conditional releases under RCW 10.77, if the individual is placed on a transitional status in the RSN which holds the State psychiatric hospital, it is expected that the individual will transfer back to the RSN for the individual's county of residence once transitional care is complete. The Inter-RSN Transfer process described in the State Hospital Working Agreement will be used when an individual is on Conditional Release or discharged to an area other than the RSN responsible for the individual's county of residence.

(5) Children's Long-Term Inpatient Programs (CLIP): The Contractor shall comply with GCBH Children's Long-Term Inpatient Program (CLIP) policies/procedures, as amended, replaced and/or revised. GCBH policies are available on the GCBH website: www.gcbh.org.

(6) Inpatient Coordination of Care:

i. The Contractor shall ensure that contact with the inpatient staff occurs within three (3) working days of an authorized voluntary or involuntary admission. The Contractor or its designee must participate throughout the admission in treatment and discharge planning with the hospital staff.

ii. 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.

iii. The Contractor or designee must participate in treatment and discharge planning with the inpatient treatment team.

iv. The Contractor or designee must participate throughout the inpatient admission to assist with appropriate and timely discharge for all individuals regardless of diagnosis.

v. The Contractor must offer, at minimum, one follow–up service within seven (7) days from discharge to an individual who has been authorized for an inpatient admission or involuntarily committed.

(7) 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 services 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 Freestanding Evaluation and Treatment facilities and Administrative Costs related to the Involuntary Treatment Act.

(8) Residential Programs: Residential settings and programs shall be available and provided based on the individual's needs, medical necessity and within Available Resources per the Contractor's policies and procedures. The Contractor must maintain a detailed plan to meet individual needs for residential programs. 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:

i. Long-term intensive adaptive and rehabilitative psychiatric care such as is provided in Adult Residential Rehabilitation Centers.

ii. 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.

iii. Supported housing services such as intensive services provided to maintain individuals in unlicensed individual or group home settings including transitional or permanent housing.

c. 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). Services must be provided in accordance with GCBH approved Level of Care Guidelines.

(1) Within available resources and pursuant to Contractor's policies and procedures, the Contractor may use the funds provided under this Agreement to do any of the following:

i. Provide or purchase any other clinically appropriate outpatient or residential services to a non-Medicaid individual:

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

iii. Provide assistance with transportation.

iv. Provide assistance with application for entitlement programs.

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

19. SUBCONTRACTS

a. All Subcontracts and amendments must be in writing and made available, upon request, to GCBH. All Subcontracts must be in writing and specify all duties, responsibilities and reports delegated under this Agreement and require adherence with all federal and state laws that are applicable to the Subcontractor.

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

b. The Contractor shall provide information regarding grievance and fair hearing procedures and timeframes as set forth in the Grievance Section of this contract at the time the Subcontractor enters into a contract. A condition of the sub-contract will be that all CMHAs and other Subcontractors will abide by all Grievance and Fair Hearing decisions.

c. 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.
   (1) Prior to any new delegation of any responsibility or authority described in this Agreement through a Subcontract or other legal Agreement, the Contractor shall use a delegation plan.
   (2) The Contractor shall maintain and make available to GCBH, DBHR and its EQRO all delegation plans, for currently in place Subcontractors. The delegation plan must include the following:
      i. An evaluation of the prospective Subcontractor's ability to perform delegated activities.
      ii. 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.
      iii. 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.

d. Within 30 days of execution of a Subcontract to perform any function under this Agreement, the Contractor shall submit copies of the Subcontracts to GCBH.
   - When substantially similar Agreements are executed with multiple Subcontractors an example Agreement may be provided with a list by Subcontractor of any terms that deviate from the example. A list of all Subcontractors for each Agreement and the period of performance must also be submitted.

e. 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. Furthermore, the Contractor shall use only CMHAs that are licensed and/or certified by DSHS.

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

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

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

i. Subcontracts for the provision of mental 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.

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

k. Subcontracts must require Subcontractors to participate in training when requested by GCBH and/or DSHS. Requests for GCBH and/or DSHS to allow an exception to participation in required training must be in writing and include a plan for how the required information shall be provided to targeted Subcontractor staff.
   - Annually, all community mental health employees who work directly with clients shall be provided with training on safety and violence prevention topics described in RCW 49.19.030.

l. Subcontracts must require compliance with State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and DBHR-CIS Data Dictionary.

m. 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.

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

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

p. Subcontracts must require that the Subcontracted CMHAs comply with the Contractor's policy and procedures and timeframes as described in the Services section of this Agreement.

q. Subcontracts for the provision of mental 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.

r. Subcontracts must require the pursuit and reporting of all Third Party Revenue related to services provided under this Agreement.

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

t. Subcontracts for the provision of mental health services must require Subcontractors to resubmit data when rejected by GCBH and/or DBHR due to errors. The Subcontract must require the data to be re-submitted within 30 days of when the error report was produced.

u. Subcontracts must contain the same requirements for crisis services as in this Agreement.

v. 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).

w. Subcontracts must require notification to GCBH in the event of 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 mental health services or the closing of a Subcontractor site that is providing services required under this Agreement. The Contractor must notify GCBH 30 days prior to terminating any of its Subcontracts with entities that provide direct service including mental health clubhouses or entering into new Subcontracts with entities that provide direct service including mental health clubhouses. This notification must occur prior to any public announcement of this change.
   (1) If either the Contractor or the Subcontractor terminates a Subcontract in less than 30 days or a site closure occurs in less than 30 days, the Contractor must notify GCBH as soon possible and prior to a public announcement.
   (2) The Contractor shall notify GCBH 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.
   (3) If any event in this section occurs, the Contractor must submit a plan to GCBH for Enrollees and services 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.

x. Subcontracts must include the following Physician Incentive Plans language:
   - The Contractor must ensure it does not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) does not contract with any Subcontractor operating such a plan.

y. Subcontracts must include the following Credentialing language:
   - The Contractor shall have written policies that require monitoring of provider credentials. The Contractor shall only use CMHAs that are licensed and/or certified by the State. Mental Health Clubhouses may be directly contracted with the PIHP

without being a licensed CMHA. Clubhouses must meet all credentialing requirements put in place by the State.

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

20. COORDINATION

a. The Contractor must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by GCBH, the Counties and/or DBHR. The Contractor shall:

(1) Attend DBHR-sponsored training regarding the role of the public mental health system in disaster preparedness and response.

(2) Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.

(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.

(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:

i. Locating persons in need of disaster relief services.
ii. Assessing their needs.
iii. Engaging or linking persons to an appropriate level of support or disaster relief services.
iv. Providing follow-up mental health services when clinically indicated.

(5) Disaster outreach can be performed by trained volunteers, peers and/or persons hired under a federal Crisis Counseling Grant. These persons should be trained in disaster crisis outreach which is different than traditional mental health crisis intervention.

(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.

(7) Provide the name and contact information to GCBH for person(s) coordinating the RSN disaster/emergency preparedness and response upon request.

(8) Provide information and preliminary disaster response plans to GCBH within seven (7) days following a disaster/emergency or upon request.

(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:

i. Participation when requested in local and regional disaster planning and preparedness activities.
ii. Coordination of disaster outreach activities following an event.

b. For individuals enrolled with the 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:

(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.

(2) Participate directly with Regional DDA representatives in coordinating and conducting these reviews, upon GCBH or the Counties request. The GCBH representative and the Regional DDA Quality Assurance Manager will be "lead staff" for Regional Review Teams (RRTs).

(3) Collaborate with the Counties to develop a corrective action plan to address findings based on the results of a review.

c. Law Enforcement - In accordance with 71.05.390(17), the Contractor 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).

d. The Contractor shall comply with Exhibit B, RSN Transfer Protocol.

e. The Contractor shall coordinate with DSHS, Home and Community Services (HCS) regional office to support the placement of persons discharged or diverted from state hospitals into HCS placements. The Contractor shall comply with any GCBH MOU and/or Agreement established with HCS. GCBH MOUs and Agreements can be found at www.gcbh.org.

(1) Whenever possible, prior to referring a person with a diagnosis of dementia for a 90 day commitment to a State Hospital:

i. Ensure that a request for Comprehensive Assessment Reporting Evaluation (CARE) is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all persons who might be eligible for long-term care services. HCS has agreed to prioritize requests for CARE for individuals who have been detained to an Evaluation & Treatment facility or in another setting.

ii. Request and coordinate with HCS, a scheduled CARE for such persons. If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to attempt a community placement prior to referral to the State Hospital.

(2) For individuals (both those being discharged and those being diverted) whose CARE indicates likely functional and financial eligibility for long-term care services:

i. 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.

ii. 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.

iii. The Contractor will ensure coordination and communication will occur between those participants involved in placement activities as identified by the discharge planning team.

iv. If a placement has not been found for an individual referred for long-term care services within 30 calendar days, the designated entity will convene a meeting to review the plan and to make adjustments as necessary. Such review meetings will occur at least every 30 calendar days until a placement is affected.

(3) When individuals being discharged or diverted from State Hospitals are placed in a long-term care setting, the Contractor shall:

i. Coordinate with HCS and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the DSHS website.

ii. When the individual meets Access to Care Standards, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement.

21. REMEDIAL ACTIONS

a. GCBH may initiate remedial action if it is determined that any of the following situations exist:

(1) A problem exists that negatively impacts Consumers receiving services.

(2) The Contractor has failed to perform any of the mental health services required in this Agreement.

(3) The Contractor has failed to develop, produce, and/or deliver to GCBH, the Counties and/or DSHS any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions or this Agreement.

(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.

(5) The Contractor has failed to implement corrective action required by the State, the Counties and/or GCBH and within DSHS, Counties and/or GCBH prescribed timeframes.

b. GCBH may impose any of the following remedial actions:

(1) Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor, in collaboration with the Counties, must be submitted for approval to GCBH 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. GCBH may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

i. Corrective action plans must include:

(A) A brief description of the situation requiring corrective action.

(B) The specific actions to be taken to remedy the situation.

(C) A timetable for completion of the actions.

(D) Identification of individuals responsible for implementation of the plan.

ii. Corrective action plans are subject to approval by GCBH, which may:

(A) Accept the plan as submitted.
(B) Accept the plan with specified modifications.
(C) Request a modified plan.
(D) Reject the plan.

(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.

(3) Withhold up to five percent (5%) of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. GCBH, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.
   i. 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.

(4) Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which GCBH provides incentives.

(5) Terminate for Default as described in the General Terms and Conditions.

22. GENERAL TERMS AND CONDITIONS

a. **Definitions.** The words and phrases listed below, as used in the Agreement, shall each have the following definitions:

(1) **Agreement** means this document, the General Terms and Conditions, and the Special Terms and Conditions, including any Exhibits and other documents attached or incorporated by reference.

(2) **CFR** means Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation. The CFR may be accessed at http://www.ecfr.gov/.

(3) **Confidential Information** means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Personal Information.

(4) **Contractor** means the Contractor, its employees and agents.

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

(6) **DSHS or the department or the Department** means the Department of Social and Health Services of the State of Washington and its Secretary.

(7) **Personal Information** means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers, and any financial identifiers.

(8) **RCW** means the Revised Code of Washington. All references in this Agreement to RCW chapters or sections shall include any successor, amended, or replacement statute. The RCW can be accessed at http://apps.leg.wa.gov/rcw.

(9) **Subcontract** means a separate contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor shall perform pursuant to this Agreement.

(10) **USC** means United States Code. All references to USC chapters or sections in this Agreement shall include any successor, amended, or replacement statute. The USC may be accessed at http://www.gpoaccess.gove/uscode/.

(11) **WAC** means the Washington Administrative Code. All references in this Agreement to WAC chapters or sections shall include any successor, amended, or replacement regulation. The WAC can be accessed at http://apps.leg.wa.gov/wac/.

b. **Amendment.** This Agreement, or any term or condition, may be modified only by a written amendment signed by both parties. Only personnel authorized to bind each of the parties shall sign an amendment.

c. **Assignment.** Except as otherwise provided herein, the Contractor shall not assign rights or obligations derived from this Agreement to a third party without the prior, written consent of the GCBH Director or their designee and the written assumption of the Contractor's obligations by the third party.

d. **Billing Limitations.** Unless otherwise specified in this Agreement, GCBH shall not pay any claims for services submitted more than twelve (12) months after the calendar month in which the services were performed.

e. **Compliance with Applicable Law**. At all times during the term of this Agreement the Contractor and GCBH shall comply with all applicable federal, state, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations.

f. **Confidentiality.** The parties shall not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Agreement for any purpose that is not directly connected with the performance of the services contemplated there under, except as provided by law; or in the case of Personal Information, as provided by law or with the prior written consent of the person or personal representative of the person who is the subject of the Personal Information.

The parties shall protect and maintain all Confidential Information gained by reason of this Agreement against unauthorized use, access, disclosure, modification or loss. This duty requires the parties to employ reasonable security measures, which include restricting access to the Confidential Information by:

- Allowing access only to staff that have an authorized business requirement to view the Confidential Information.
- Physically securing any computers, documents, or other media containing the Confidential Information.
- Ensure the security of Confidential Information transmitted via fax (facsimile) by:
    - Verifying the recipient phone number to prevent accidental transmittal of Confidential Information to unauthorized persons.
    - Communicating with the intended recipient before transmission to ensure that the fax will be received only by an authorized person.
    - Verifying after transmittal that the fax was received by the intended recipient.
- Following the requirements in Exhibit B.
- Sending paper documents containing Confidential Information via a Trusted System.

- Upon request by GCBH, at the end of the Contract term or when no longer needed, Confidential Information shall be returned to GCBH or Contractor shall certify in writing that they employed a GCBH approved method to destroy the information. Contractor may obtain information regarding approved destruction methods from the GCBH HIPAA Compliance Officer.
- Paper documents with Confidential Information may be recycled through a contracted firm, provided the contract with the recycler specifies that the confidentiality of information will be protected, and the information destroyed through the recycling process. Paper documents containing Confidential Information requiring special handling (e.g., protected health information) must be destroyed through shredding, pulping, or incineration.
- Notification of Compromise or Potential Compromise. The compromise or potential compromise of Confidential Information must be reported to the GCBH HIPAA Compliance Officer within one (1) business day of discovery. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or GCBH.

g. **Contractor Certification Regarding Ethics**. By signing this Agreement, the Contractor certifies that the Contractor is in compliance with Chapter 42.23 RCW and shall comply with Chapter 42.23 RCW throughout the term of this Agreement.

h. **Debarment Certification**. The Contractor, by signature to this Agreement, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency from participating in transactions (Debarred). The Contractor shall immediately notify GCBH if, during the term of this Contract, Contractor becomes debarred. GCBH may immediately terminate this Contract by providing Contractor written notice if Contractor becomes Debarred during the term hereof. The Contractor also agrees to include the above requirement in all subcontracts into which it enters.

i. **Entire Agreement**. This Agreement, including all documents attached to or incorporated by reference, contain all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or bind the parties.

j. **Governing Law and Venue**. The laws of the State of Washington govern this Agreement. In the event of a lawsuit by the Contractor against GCBH involving this Agreement, venue shall be proper only in Benton County, Washington. In the event of a lawsuit by GCBH against the Contractor involving this Agreement, venue shall be proper only as provided in RCW 36.01.050.

k. **HIPAA Compliance.** This section of the Agreement is the Business Associate Agreement as required by HIPAA.

(1) Definitions:

i. Breach means the acquisition, access, use or disclosure of Protected Health Information (PHI) in a manner not permitted under the HIPAA Privacy Rule which compromises the security of privacy of the PHI, with the exclusions and exceptions listed in 45 CFR 164.402.

ii. Business Associate means the "Contractor" and generally has the same meaning as the term "Business Associate" in 45 CFR 160.103. Any reference

to Business Associate in this Contract includes Business Associate's employees, agents, officers, Subcontractors, third party contractors, volunteers or directors.

iii. Business Associate Agreement means this HIPAA Compliance section of the Contract and includes the Business Associate provisions required by the US Department of Health and Human Services, Office for Civil Rights.

iv. Covered Entity means GCBH, a Covered Entity as defined in 45 CFR 160.103, in its conduct of covered functions by its health care components.

v. Designated Record Set means a group of records maintained by or for a Covered Entity, that is: the medical and billings records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or used in whole or part by or for the Covered Entity to make decisions about Individuals.

vi. Electronic Protected Health Information (EPHI) means PHI that is transmitted by electronic media or maintained in any medium described in the definition of electronic media in 45 CFR 160.103.

vii. HIPAA means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as modified by the American Recovery and Reinvestment Act of 2009 (ARRA), Sec. 13400-13424, H.R. 1 (2009) (HITECH Act).

viii. HIPAA Rules means the Privacy, Security, Breach Notification and Enforcement Rules in 45 CFR Parts 160 and 164.

ix. Individual(s) means the person(s) who is the subject of PHI and includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

x. Minimum Necessary means the least amount of PHI necessary to accomplish the purpose for which the PHI is needed.

xi. Protected Health Information or PHI means individually identifiable health information created, received, maintained or transmitted by Business Associate on behalf of a health care component of the Covered Entity that relates to the provision of health care to an Individual; the past, present or future physical or mental health or condition of an Individual; or the past, present or future payment for provision of health care to an Individual, see 45 CFR 160.103. PHI includes demographic information that identifies the Individual or about which there is reasonable basis to believe can be used to identify the Individual, see 45 CFR 160.103. PHI is information transmitted or held in any form or medium and includes EPHI, see 45 CFR 160.103. PHI does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USCA 1232g(a)(4)(B)(iv) or employment records held by a Covered Entity in its role as employer.

xii. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

xiii. Subcontractor, as used in this section, means a Business Associate that creates, receives, maintains or transmits PHI on behalf of another Business Associate.

xiv. Use means the sharing, employment, application, utilization, examination or analysis of PHI within an entity that maintains such information.

(2) Compliance. Business Associate shall perform all Contract duties, activities and tasks in compliance with HIPAA, HIPAA Rules and all attendant regulation as promulgated by the US Department of Health and Human Services, Office of Civil Rights.

(3) Use and Disclosure of PHI. Business Associate is limited to the following permitted and required uses or disclosures of PHI:

i. Duty to Protect PHI. Business Associate shall protect PHI from and shall use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 (Security Standards for the Protection of Electronic Protected Health Information) with respect to EPHI, to prevent the unauthorized use or disclosure of PHI other than as provided in this Contract or as required by law, for as long as the PHI is within its possession and control, even after the termination or expiration of this Contract.

ii. Minimum Necessary Standard. Business Associate shall apply this standard to any use or disclosure of PHI necessary to achieve the purposes of this Contract, see 45 CFR 164.514(d)(2) through (d)(5).

iii. Disclosure of Part of the Provision of Services. Business Associate shall only use or disclose PHI as necessary to perform the services specified in this Contract or as required by law, and shall not use or disclose such PHI in any manner that would violate Subpart E of 45 CFR Part 164 (Privacy of Individually Identifiable Health Information) if done by Covered Entity, except for the specific uses and disclosures set forth below.

iv. Use for Proper Management and Administration. Business Associate may use PHI for the proper management and administration of the Business Associate to carry out the legal responsibilities of the Business Associate.

v. Disclosure for Proper Management and Administration. Business Associate may disclose PHI for the Proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

vi. Impermissible Use or Disclosure of PHI. Business Associate shall report to GCBH in writing all uses or disclosures of PHI not provided for by this Contract within one (1) business day of becoming aware of the unauthorized use or disclosure of PHI, including breaches of unsecured PHI as required in 45 CFR 164.410 (Notification by a Business Associate), as well as any security incident of which it becomes aware. Upon request by GCBH, Business Associate shall mitigate, to the extent practicable, any harmful effect resulting from the impermissible use or disclosure.

vii. Failure to Cure. If GCBH learns of a pattern or practice of the Business Associate that constitutes a violation of the Business Associate's obligations under the terms of this Contract and reasonable steps by GCBH do not end

the violation, GCBH shall terminate this Contract, if feasible. In addition, if the Business Associate learns of a pattern or practice of its subcontractors that constitutes a violation of the Business Associate's obligations under the terms of their contract and reasonable steps by the Business Associate do not end the violation, Business Associate shall terminate the subcontract, if feasible.

viii. Termination for Cause. Business Associate authorizes immediate termination of this Contract by GCBH, if GCBH determines that Business Associate has violated a material term of this Business Associate Agreement. GCBH may, at its sole option, offer Business Associate an opportunity to cure a violation of this Business Associate Agreement before exercising a termination for cause.

ix. Consent to Audit. Business Associate shall give reasonable access to PHI, its internal practices, records, books, documents, electronic data and/or all other business information received from, or created or received by Business Associate on behalf of GCBH for use in determining compliance with HIPAA privacy requirements.

x. Obligations of Business Associate Upon Expiration or Termination. Upon expiration or termination of this Contract for any reason, with respect to PHI received from GCBH or created, maintained or received by Business Associate, or any subcontractors, on behalf of GCBH, Business Associate shall:

(A) Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

(B) Return to GCBH or destroy the remaining PHI that the Business Associate or any subcontractors shall maintain in any form;

(C) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR 165 (Security Standards for the Protection of Electronic Protected Health Information) with respect to Electronic Protected Health Information to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate or any subcontractors retain the PHI;

(D) Not use or disclose the PHI retained by Business Associate or any subcontractors other than for the purposes for which such PHI was retained and subject to the same conditions set out in the "Use and Disclosure of PHI" section of this Contract which applied prior to termination; and

(E) Return to GCBH or destroy the PHI retained by Business Associate, or any subcontractors, when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

(4) Survival. The obligations of this Business Associate under this section shall survive the termination or expiration of this Contract.

(5) Individual Rights.

i. Accounting of Disclosures.

(A) Business Associate shall document all disclosure, except those disclosures that are exempt under 45 CFR 164.528, of PHI and information related to such disclosures.

(B) Within ten (10) business days of a request from GCBH, Business Associate shall make available to GCBH the information in Business Associate's possession that is necessary for GCBH to respond in a timely manner to a request for an accounting of disclosure of PHI by the Business Associate. See 45 CFR 164.504(e)(2)(ii)(G) and 164.528 (b)(1).

(C) At the request of GCBH or in response to a request made directly to the Business Associate by an Individual, Business Associate shall respond, in a timely manner and in accordance with HIPAA and the HIPAA Rules, to requests by Individuals for an accounting of disclosure of PHI.

(D) Business Associate record keeping procedures shall be sufficient to respond to a request for an accounting under this section for the six (6) years prior to the date on which the accounting was requested.

(6) Access.

i. Business Associate shall make available PHI that it holds that is part of a Designated Record Set when requested by GCBH or the Individual as necessary to satisfy GCBH's obligations under 45 CFR 164.524 (Access of Individuals to Protected health Information).

ii. When the request is made by the Individual to the Business Associate or if GCBH asks the Business Associate to respond to a request, the Business Associate shall comply with requirements in 45 CFR 164.524 (Access of Individuals to Protected Health Information) on form, time and manner of access. When the request is made by GCBH, the Business Associate shall provide the records to GCBH within (10) business days.

(7) Amendment.

i. If GCBH amends, in whole or in part, a record or PHI contained in an Individual's Designated Record Set and GCBH has previously provided the PHI or record that is the subject of the amendment to Business Associate, then GCBH will inform Business Associate of the amendment pursuant to 45 CFR 164.526(c)(3) (Amendment of Protected Health Information).

ii. Business Associate shall make any amendments to PHI in a Designated Record Set as directed by GCBH or as necessary to satisfy GCBH's obligations under 45 CFR 164.526 (Amendment of Protected health Information).

(8) Subcontracts and other Third Party Agreements. In accordance with 45 CFR 164.502(e)(1)(ii), 164.504(e)(1)(i) and 164.308(b)(2), Business Associate shall ensure that any agents, subcontractors, independent contractors or other third parties that create, receive, maintain, or transmit PHI on Business Associate's behalf, enter into a written contract that contains the same terms, restrictions, requirements, and conditions as the HIPAA compliance provision in this Contract with respect to such PHI. The same provision must also be included in any contracts by a Business Associate's subcontractor with its own business associates as required by 45 CFR 164.314(a)(2)(b) and 164.504(e)(5).

(9) Obligations. To the extent the Business Associate is to carry out one or more of GCBH's obligation(s) under Subpart E of 45 CFR Part 164 (Privacy of Individually Identifiable Health Information), Business Associate shall comply with all requirements that would apply to GCBH in the performance of such obligation(s).

(10) Liability. Within ten (10) days, Business Associate must notify GCBH of any complaint, enforcement or compliance action initiated by the Office for civil Rights based on an allegation of violation of the HIPAA Rules and must inform GCBH of the outcome of that action. Business Associate bears all responsibility for any penalties, fines or sanctions imposed against the Business Associate for violations of the HIPAA Rules and for any imposed against its subcontractors or agents for which it is found liable.

(11) Breach Notification.

i. In the event of a breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from GCBH or involving GCBH clients, Business Associate will take all measures required by state or federal law.

ii. Business Associate will notify GCBH within one (1) business day by telephone and in writing of any acquisition, access, use or disclosure of PHI not allowed by the provisions of this Contract or not authorized by HIPAA Rules or required by law of which it becomes aware which potentially compromises the security or privacy of the PHI as defined in 45 CFR 164.402 (Definitions).

iii. Business Associate will notify the GCBH HIPAA Compliance Officer within one (1) business day by telephone or email of any potential breach of security or privacy of PHI by the Business Associate or its subcontractors or agents. Business Associate will follow telephone or email notification with a faxed or other written explanation of the breach, to include the following: date and time of breach, date breach was discovered, location and nature of the PHI, type of breach, origination and destination of PHI, Business Associate unit and personnel associated with the breach, detailed description of the breach, anticipated mitigation steps, and the name, address, telephone number, fax, number and email of the individual who is responsible as the primary point of contact. Business Associate will address communications to the GCBH HIPAA Compliance Officer. Business Associate will coordinate and cooperate with GCBH to provide a copy of its investigation and other information requested by GCBH, including advance copies of any notifications required for GCBH review before disseminating and verification of the dates notifications were sent.

iv. If GCBH determines that Business Associate or its subcontractors or agents are responsible for a breach of unsecured PHI:

(A) Requiring notification of Individuals under 45 CFR 164.404 (Notification to Individuals), Business Associate bears the responsibility and costs for notifying the affected Individuals and receiving and responding to those Individuals' questions or requests for additional information;

(B) Requiring notification of the media under 45 CFR 164.406 (Notification to the media), Business Associate bears the responsibility and costs for notifying the media and receiving and responding to media questions or requests for additional information;

(C) Requiring notification of the US Department of Health and Human Services Secretary under 45 CFR 164.408 (Notification to the Secretary), Business Associate bears the responsibility and costs for notifying the Secretary and receiving and responding to the Secretary's questions or requests for additional information; and

(D) GCBH will take appropriate remedial measures, up to termination of this Contract.

(12) Miscellaneous Provisions. Regulatory Reference. A reference in this Contract to a section in the HIPAA Rules means the section as in effect or amended

(13) Interpretation. Any ambiguity in this Contract shall be interpreted to permit compliance with the HIPAA Rules.

l. **Independent Status**. For purposes of this Agreement, the Contractor acknowledges that the Contractor is not an officer, employee, or agent of DSHS or the State of Washington. The Contractor shall not hold out itself or any of its employees as, nor claim status as, an officer, employee, or agent of GCBH or the State of Washington. The Contractor shall not claim for itself or its employees any rights, privileges, or benefits, which would accrue to an employee of the State of Washington. The Contractor shall indemnify and hold harmless GCBH from all obligations to pay or withhold federal or state taxes or contributions on behalf of the Contractor or the Contractor's employees.

m. **Inspection**. Either party may request reasonable access to the other party's records and place of business for the limited purpose of monitoring, auditing, and evaluating the other party's compliance with this Agreement, and applicable laws and regulations. During the term of this Agreement and for one (1) year following termination or expiration of this Agreement, the parties shall, upon receiving reasonable written notice, provide the other party with access to its place of business and to its records which are relevant to its compliance with this Agreement, and applicable laws and regulations. This provision shall not be construed to give either party access to the other party's records and place of business for any other purpose.

n. **Insurance**. GCBH certifies that it is self-insured under the State's self-insurance liability program, as provided by RCW 4.92.130, and shall pay for losses for which it is found liable. The Contractor certifies that it is self-insured, is a member of a risk pool, or maintains insurance coverage as required in this Agreement. The Contractor shall pay for losses for which it is found liable.

o. **Maintenance of Records**. The Contractor shall maintain records relating to this Contract and the performance of the services described herein. The records include, but are not limited to, accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Contract. All records and other material relevant to this Contract shall be retained for six (6) years after expiration or termination of this Contract. Without agreeing that litigation or claims are legally authorized, if any litigation, claim, or audit is started before the expiration of the six (6) year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved.

p. **Order of Precedence**. In the event of an inconsistency in this Agreement, unless otherwise

provided herein, the inconsistency shall be resolved by giving precedence, in the following order, to:

(1) Applicable Federal and State of Washington statutes and regulations.
(2) The General Terms & Conditions of this Agreement.
(3) The Special Terms & Conditions of this Agreement.
(4) Any Exhibits attached or incorporated into this Agreement by reference.

q. **Ownership of Material**. Material created by the Contractor and paid for by GCBH as a part of this Agreement shall be owned by GCBH and shall be "work made for hire" as defined by Title 17 USCA, Section 101. This material includes, but is not limited to: books; computer programs; documents; films; pamphlets; reports; sound reproductions; studies; surveys; tapes; and/or training materials. Material which the Contractor uses to perform this Agreement but is not created for or paid for by GCBH is owned by the Contractor and is not "work made for hire"; however, GCBH shall have a perpetual license to use this material for GCBH internal purposes at no charge to GCBH, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.

r. **Responsibility**. Each party to this Agreement shall be responsible for the negligence of its officers, employees, and agents in the performance of this Agreement. No party to this Agreement shall be responsible for the acts and/or omissions of entities or individuals not party to this Agreement. GCBH and the Contractor shall cooperate in the defense of tort lawsuits, when possible. Both parties agree and understand that this provision may not be feasible in all circumstances. GCBH and the Contractor agree to notify the attorneys of record in any tort lawsuit where both are parties if either GCBH or the Contractor enters into settlement negotiations. It is understood that the notice shall occur prior to any negotiations, or as soon as possible, and the notice may be either written or oral.

s. **Severability**. The provisions of this Agreement are severable. If any court holds any provision of this Agreement, including any provision of any document incorporated by reference, invalid, that invalidity shall not affect the other provisions this Agreement.

t. **Subcontracting**. The Contractor may subcontract services to be provided under this Agreement. If GCBH, the Contractor, and a subcontractor of the Contractor are found by a jury or other trier of fact to be jointly and severally liable for personal injury damages arising from any act or omission under this Agreement, then GCBH shall be responsible for its proportionate share, and the Contractor shall be responsible for its proportionate share. Should a subcontractor to the Contractor pursuant to this Agreement be unable to satisfy its joint and several liability, GCBH and the Contractor shall share in the subcontractor's unsatisfied proportionate share in direct proportion to the respective percentage of their fault as found by the trier of fact. Nothing in this section shall be construed as creating a right or remedy of any kind or nature in any person or party other than GCBH and the Contractor. This provision shall not apply in the event of a settlement by either GCBH or the Contractor.

u. **Sub-recipients**.

(1) General. If the Contractor is a sub-recipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Agreement, the Contractor shall:

i. Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity.
ii. Maintain internal controls that provide reasonable assurance that the Contractor is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant Agreements that could have a material effect on each of its federal programs.
iii. Prepare appropriate financial statements, including a schedule of expenditures of federal awards.
iv. Incorporate 2 CFR Part 200, Subpart F audit requirements into all Agreements between the Contractor and its Subcontractors who are subrecipients.
v. Comply with the applicable requirements of 2 CFR Part 200, including any future amendments to 2 CFR Part 200 and any successor or replacement Office of Management and Budget (OMB) Circular or regulation.
vi. Comply with the Omnibus Crime Control and Safe Streets Act of 1968; Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; Title II of the Americans with Disabilities Act of 1990; Title IX of the Education Amendments of 1972; The Age Discrimination Act of 1975; and The Department of Justice Non-Discrimination Regulations through 28 CFR Part 42, Subparts C, D, E, and G, and 28 CFR Parts 35 and 39. (Go to www.ojp.usdoj.gov/ocr/ for additional information and access to the aforementioned federal laws and regulations.)

(2) Single Audit Act Compliance. If the Contractor is a sub-recipient and expends $750,000 or more in federal awards from all sources in any fiscal year, the Contractor shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the Contractor shall:
i. Submit to the GCBH Chief Financial Offer or their designee, the data collection form and reporting package specified in 2 CFR Part 200, Subpart F, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor.
ii. Follow-up and develop corrective action for all audit findings, in accordance with 2 CFR Part 200, Subpart F, and prepare a "Summary Schedule of Prior Audit Finding", reporting the status of all audit findings included in the prior audit's schedule of findings and questioned costs.

v. **Overpayments**. If it is determined by DSHS, or during the course of a required audit, that the Contractor has been paid unallowable costs under this Agreement, DSHS may require the Contractor to reimburse DSHS in accordance with 2 CFR Part 200.

w. **Survivability**. The terms and conditions contained in this Agreement, which by their sense and context, are intended to survive the expiration of the particular Agreement shall survive. Surviving terms include, but are not limited to the following Sections: Confidentiality, Disputes, Inspection, Maintenance of Records, Ownership of Material, Responsibility, Subcontracting, Termination for Default, Termination Procedure, and Title to Property.

x. **Termination Due to Change in Funding**. If the funds upon which GCBH relied to establish this

Agreement are withdrawn, reduced, or limited, or if additional or modified conditions are placed on such funding, GCBH may terminate this Agreement by providing at least fifteen (15) calendar days' written notice to the Contractor. The termination shall be effective on the date specified in the notice of termination.

y. **Termination Due to Change in GCBH/DSHS Agreement**. In the event that changes to the terms of the 1915(b) (Medicaid) Mental Health Services Waiver program render this Agreement invalid in any way after the effective date of this Agreement and prior to its normal completion, GCBH may terminate this Agreement by providing at least fifteen (15) calendar days' written notice to the Contractor, subject to re-negotiation (if applicable) under those new special terms and conditions.

z. **Termination for Convenience**. GCBH may terminate this Agreement in whole or in part for convenience by providing the Contractor at least thirty (30) calendar days' written notice addressed to the Contractor at the address shown on the cover page of this Agreement. The Contractor may terminate this Agreement for convenience by providing GCBH at least thirty (30) calendar days' written notice addressed to: GCBH, Attn: GCBH Contracts Coordinator, 101 N Edison St, Kennewick, WA 99336.

aa. **Termination for Default**.

(1) The Contracts Administrator may terminate this Agreement for default, in whole or in part, by written notice to the Contractor, if GCBH has a reasonable basis to believe that the Contractor has:

i. Failed to meet or maintain any requirement for contracting with GCBH.
ii. Failed to perform under any provision of this Agreement.
iii. Violated any law, regulation, rule, or ordinance applicable to this Agreement; and/or
iv. Otherwise breached any provision or condition of this Agreement.

(2) Before GCBH may terminate this Agreement for default, GCBH shall provide the Contractor with written notice of the Contractor's noncompliance with the Agreement and provide the Contractor a reasonable opportunity to correct the Contractor's noncompliance. If the Contractor does not correct the Contractor's noncompliance within the period of time specified in the written notice of noncompliance, the Contracts Administrator may then terminate the Agreement. The Contracts Administrator may terminate the Agreement for default without such written notice and without opportunity for correction if GCBH has a reasonable basis to believe that a client's health or safety is in jeopardy.

(3) The Contractor may terminate this Agreement for default, in whole or in part, by written notice to GCBH, if the Contractor has a reasonable basis to believe that GCBH has:

i. Failed to meet or maintain any requirement for contracting with the Contractor.
ii. Failed to perform under any provision of this Agreement.
iii. Violated any law, regulation, rule, or ordinance applicable to this Agreement; and/or
iv. Otherwise breached any provision or condition of this Agreement.

(4) Before the Contractor may terminate this Agreement for default, the Contractor shall provide GCBH with written notice of GCBHs noncompliance with the Agreement and provide GCBH a reasonable opportunity to correct GCBHs noncompliance. If GCBH

does not correct GCBHs noncompliance within the period of time specified in the written notice of noncompliance, the Contractor may then terminate the Agreement.

bb. **Termination Procedure**. The following provisions apply in the event this Agreement is terminated:

(1) The Contractor shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of clients, distribution of property, and termination of services.

(2) The Contractor shall promptly deliver to GCBH, all GCBH assets (property) in the Contractor's possession, including any material created under this Agreement. Upon failure to return GCBH property within ten (10) working days of this Agreement termination, the Contractor shall be charged with all reasonable costs of Recovery, including transportation. The Contractor shall take reasonable steps protect and preserve any property of GCBH that is in the possession of the Contractor pending return to GCBH.

(3) GCBH shall be liable for and shall pay for only those services authorized and provided through the effective date of termination. GCBH may pay an amount mutually agreed by the parties for partially completed work and services, if work products are useful to or usable by GCBH.

(4) If GCBH terminates this Agreement for default, GCBH may withhold a sum from the final payment to the Contractor that GCBH determines is necessary to protect GCBH against loss or additional liability. GCBH shall be entitled to all remedies available at law, in equity, or under this Agreement due to Contractor's default. If it is later determined that the Contractor was not in default, or if the Contractor terminated this Agreement for default, the Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement except as to the limitations set forth in section 23.n. entitled "Lawsuits".

cc. **Treatment of Client Property**. Unless otherwise provided in this Agreement, the Contractor shall ensure that any adult client receiving services from the Contractor under this Agreement has unrestricted access to the client's personal property. The Contractor shall not interfere with any adult client's ownership, possession, or use of the client's property. The Contractor shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon termination or completion of this Agreement, the Contractor shall promptly release to the client and/or the client's guardian or custodian all of the client's personal property. This section does not prohibit the Contractor from implementing such lawful and reasonable policies, procedures and practices as the Contractor deems necessary for safe, appropriate, and effective service delivery (for example, appropriately restricting client access to, or possession or use of, lawful or unlawful weapons and drugs).

dd. **Title to Property**. Title to all property purchased or furnished by GCBH for use by the Contractor during the term of this Agreement shall remain with GCBH. Title to all property purchased or furnished by the Contractor for which the Contractor is entitled to reimbursement by GCBH under this Agreement shall pass to and vest in GCBH. The Contractor shall take reasonable steps to protect and maintain all GCBH property in its possession against loss or

damage and shall return GCBH property to GCBH upon Agreement termination or expiration, reasonable wear and tear excepted.

ee. **Waiver**. Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Agreement unless amended as set forth in section 23.b. Only the GCBH Director or designee has the authority to waive any term or condition of this Agreement on behalf of GCBH.

23. SPECIAL TERMS AND CONDITIONS

a. **Commercial General Liability Insurance (CGL).** If the Contractor is not a member of a risk pool, the Contractor shall carry CGL to include coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products, completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. GCBH and its elected and appointed officials, agents, and employees shall be named as additional insureds. The Contractor shall provide up to date copies of the policy to GCBH upon execution of this Agreement. The Contractor shall notify GCBH within one (1) working day of any changes in coverage.

b. **Compliance with Applicable Law.** 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, whethe or not a specific citation is identified in various sections of this Agreement:

(1) All applicable Office of Insurance Commissioner's (OIC) statutes and regulations.
(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) 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.
(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.
(5) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
(6) Those specified in Title 18 RCW for professional licensing.
(7) Reporting of abuse as required by RCW 26.44.030.
(8) Industrial insurance coverage as required by Title 51 RCW.
(9) Any other requirements associated with the receipt of federal funds.
(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.

(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.

c. **Confidentiality of Personal Information**

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

i. Establishing eligibility.
ii. Determining the amount of medical assistance.
iii. Providing services for recipients.
iv. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan.
v. Assuring compliance with Federal and State laws and regulations, and with terms and requirements of the Agreement.
vi. Improving quality.

(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) In the event a Consumer's picture or personal story will be used, the Contractor shall first obtain written consent from the Consumer.

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

- Verify the identity or authenticate all of the system's human users before allowing them access to any confidential data or data system capabilities.
- Authorize all user access to client applications.
- Keep any sensitive data or communications private from unauthorized individuals and programs.
- Notify the GCBH Information Systems Manager within one (1) business day 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.
- In the event of a Breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from any GCBH 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.

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

d. **Declaration That Individuals Served Under Mental Health Programs Are Not Third-Party Beneficiaries Under this Agreement.** Although GCBH 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 GCBH 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.

e. **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.

f. **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, GCBH reserves the right to recapture state funds in an amount equivalent to the extent of the noncompliance, compliant DBHR requirements. This is in addition to any other remedies available at law or in equity.

(1) Such right of recapture shall exist for a period not to exceed 24 months following contract termination. Repayment by the Contractor of funds under this recapture provision shall occur within 60 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.

g. **Information Requests**. The Contractor shall maintain information necessary to promptly respond to written requests by GCBH. The Contractor shall submit information detailing the amount spent throughout its Service Area on specific items upon request by GCBH.

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

i. **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 actio 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. The Contractor shall maintain records sufficient to:

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

Data Security Requirements

1. **Data Transport.** When transporting GCBH Confidential Information electronically, including via email the data will be protected by:
   a. Transporting the data within the contractor's internal network, or;
   b. Encrypting any data that will be in transit outside the contractor's internal network. This includes transit over the public Internet.

2. **Protection of Data.** The contractor agrees to store data on one or more of the following media and protect the data as described:

   a. **Hard disk drives.** Data stored on local workstation hard disks. Access to the data will be restricted to authorized users by requiring logon to the local workstation using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards.

   b. **Network server disks.** Data stored on hard disks mounted on network servers and made available through shared folders. Access to the data will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

      For GCBH confidential data stored on these disks, deleting unneeded data is sufficient as long as the disks remain in a secured area and otherwise meets the requirements listed in the above paragraph. Destruction of the data as outlined in Section 4. Data Disposition may be deferred until the disks are retired, replaced, or otherwise taken out of the secure environment.

   c. **Optical discs (CDs or DVDs) in local workstation optical disc drives.** Data provided by GCBH on optical discs which will be used in local workstation optical disc drives and which will not be transported out of a secure area. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only authorized users have the key, combination or mechanism required to access the contents of the container. Workstations which access GCBH data on optical discs must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

   d. **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers.** Data provided by GCBH on optical discs which will be attached to network servers and which will not be transported out of a secure area. Access to data on these discs will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

   e. **Paper documents.** Any paper records must be protected by storing the records in a secure area which is only accessible to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

   f. **Access via remote terminal/workstation.** Data accessed and used interactively over the Internet.

Access to the data will be controlled by GCBH staff who will issue authentication credentials (e.g. a unique user ID and complex password) to authorized contractor staff. Contractor will notify GCBH IS staff on the same day an authorized person in possession of such credentials is terminated or otherwise leaves the employment of the contractor, and whenever a user's duties change such that the user no longer requires access to perform work for this Agreement.

g. **Data storage on portable devices or media.**
   (1) GCBH data shall not be stored by the Contractor on portable devices or media unless specifically authorized within the Special Terms and Conditions of the contract. If so authorized, the data shall be given the following protections:
      (a) Encrypt the data with a key length of at least 128 bits
      (b) Control access to devices with a unique user ID and password or stronger authentication method such as a physical token or biometrics.
      (c) Manually lock devices whenever they are left unattended and set devices to lock automatically after a period of inactivity, if this feature is available. Maximum period of inactivity before lockout is 20 minutes.
      (d) Physically protect the portable device(s) and/or media by:
         i. Keeping them in locked storage when not in use;
         ii. Using check-in/check-out procedures when they are shared; and
         iii. Taking frequent inventories.
   (2) When being transported outside of a secure area, portable devices and media with confidential GCBH data must be under the physical control of contractor staff with authorization to access the data.
   (3) Portable devices include, but are not limited to; handhelds/PDAs, Ultramobile PCs, flash memory devices (e.g. USB flash drives, personal media players), smart phones or cellular phones, portable hard disks, and laptop/notebook computers if those computers may be transported outside of a secure area.
   (4) Portable media includes, but is not limited to; optical media (e.g. CDs, DVDs), magnetic media (e.g. floppy disks, tape, Zip or Jaz disks), or flash media (e.g. CompactFlash, SD, MMC).

3. **Data Segregation**.
   a. GCBH data must be segregated or otherwise distinguishable from non-GCBH data. This is to ensure that when no longer needed by the contractor, all GCBH data can be identified for return or destruction. It also aids in determining whether GCBH data has or may have been compromised in the event of a security breach.

   b. GCBH data will be kept on media (e.g. hard disk, optical disc, tape, etc.) which will contain no non-GCBH data. Or,

   c. GCBH data will be stored in a logical container on electronic media, such as a partition or folder dedicated to GCBH data. Or,

   d. GCBH data will be stored in a database which will contain no non-GCBH data. Or,

   e. GCBH data will be stored within a database and will be distinguishable from non-GCBH data by the value of a specific field or fields within database records. Or,

   f. When stored as physical paper documents, GCBH data will be physically segregated from non-GCBH data in a drawer, folder, or other container.

   g. When it is not feasible or practical to segregate GCBH data from non-GCBH data, then both the GCBH data and the non-GCBH data with which it is commingled must be protected as described in this exhibit.

4. **Data Disposition.** When the contracted work has been completed or when no longer needed, data shall be returned to GCBH or destroyed. Media on which data may be stored and associated acceptable methods of destruction are as follows:

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

5. **Notification of Compromise or Potential Compromise.** The compromise or potential compromise of GCBH shared data must be reported to the GCBH Contact designated on the contract within one (1) business day of discovery.

6. **Data shared with Sub-contractors**. If GCBH data provided under this contract is to be shared with a sub-contractor, the contract with the sub-contractor must include all of the data security provisions within this contract and within any amendments, attachments, or exhibits within this contract. If the contractor cannot protect the data as articulated within this contract, then the contract with the sub-contractor must be submitted to the GCBH Contact specified for this contract for review and approval.

RSN Transfer Protocol

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

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

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

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

   d. The individual has access to Medicaid covered services.

2. **RSNs acknowledge and agree that:**

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

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

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

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

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

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

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

   h. The referring RSN 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

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

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

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

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

3. Uniform Transfer Agreement-Community Inter-RSN Transfer Protocol

a. If a Medicaid enrollee re-locates to a region outside of their current RSN 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 RSN's level of care guidelines and clinical assessment.

b. Each RSN will establish a procedure to obtain information and records for continuity of care for enrollees transferring between RSNs.

c. 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.

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

e. The receiving RSN will provide assistance to the enrollee to update the enrollee's residence information for Medicaid Benefits.

f. When an enrollee is re-locating and may benefit from specialized non-Medicaid services beyond medically necessary services required in the PIHP, the RSNs agree

to the following protocol:

(1) The placement is to be facilitated by the joint efforts of both RSNs.

(2) The referring RSN will provide all necessary clinical information along with the completed Inter-RSN transfer form.

(3) The receiving RSN will acknowledge the request within 3 working days.

(4) The receiving RSN will follow established procedures for prioritizing the referred enrollee and must offer an intake assessment to the enrollee for services Medicaid-covered services even if the specialized non-Medicaid services are not immediately available.

(5) The placement may not be completed without written approval on the inter-RSN transfer form from both RSN administrators, and their designees.

(6) The receiving RSN shall make a placement determination within 2 weeks of receiving all necessary information/documentation from the referring RSN. The enrollee and the referring RSN will receive information regarding the placement policy of the receiving RSN for the specialized non-Medicaid service.

(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 RSN will notify the referring RSN and continue to provide timely updates until such time the specialized non-Medicaid service is available. The referring RSN will keep the individual and others involved in the individual's care informed about the status of the transfer.

(8) Payment responsibility for individuals transferring between RSNs will be described in this protocol and specified on the inter-RSN transfer form.

4. Uniform Transfer Agreement - Eastern and Western State Hospital Inter-RSN Transfer Protocol

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

b. Generally, individuals are discharged back to the RSN in whose region they resided prior to their hospitalization (designated by the state hospitals as the "RSN of responsibility").

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

d. The financial benefits section at the state hospital will provide assistance to the enrollee to update the enrollee's residence information for Medicaid Benefits.

e. The placement is to be facilitated through the joint efforts of the state hospital social

work staff and the RSN liaisons of both the Referring RSN and Receiving RSN.

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

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

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

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

j. 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 RSN, and other responsible agencies.

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

Greater Columbia Behavioral Health

GREATER COLUMBIA BEHAVIORAL HEALTH AND NUEVA ESPERANZA COMMUNITY COUNSELING SERVICES

PREPAID INPATIENT HEALTH PLAN AGREEMENT

GCBH Agreement Number

NECCSP15-00

[X] New Agreement

[ ] Amendment No.

This Agreement is made and entered into by, and between Greater Columbia Behavioral Health, hereinafter referred to as "GCBH" and the Member Government identified below, hereinafter referred to as the "Contractor".

RSN/PHP NAME		
Greater Columbia Behavioral Health		
RSN/PHP ADDRESS 101 N. Edison Street Kennewick, WA 99336		RSN/PHP CONTACT NAME Mary Garza
RSN/PHP CONTACT TELEPHONE (509) 735-8681/1-800-795-9296	RSN/PHP CONTACT FAX (509) 783-4165	RSN/PHP CONTACT E-MAIL maryg@gcbh.org

CONTRACTOR NAME		
Nueva Esperanza Community Counseling Services		
CONTRACTOR CONTACT NAME Dell Anderson, Director		CONTRACTOR CONTACT ADDRESS Nueva Esperanza Community Counseling Services 720 W Court St, #8 Pasco, WA 99301
CONTRACTOR CONTACT TELEPHONE (509) 545-6506	CONTRACTOR CONTACT FAX (509) 546-0520	CONTRACTOR CONTACT E-MAIL danderson@tcc-health.org
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS AGREEMENT? No		CFDA NUMBERS (Federal Block Grant)

START DATE	END DATE	FUNDING
July 01, 2015	March 31, 2016	See Funding Schedule posted on the GCBH website www.gcbh.org

ATTACHMENTS: When the box(s) below are marked with an X, the following exhibits are attached to and incorporated into this Agreement by reference:

[X] **Exhibit(s): A: Access to Care Standards; B: Data Security Requirements; C: Washington State Children's Behavioral Health Principles; D: RSN Transfer Protocol**

By their signatures on the attached signature page, the parties agree to the terms and conditions of this Agreement and all documents attached or incorporated by reference.

IN WITNESS WHEREOF, the parties below have executed this Agreement:

GREATER COLUMBIA BEHAVIORAL HEALTH

Chair, GCBH Board of Directors

CONTRACTOR

Nueva Esperanza Community Counseling Services

Approved as to Content:

GCBH Director

Approved as to Form:

GCBH Legal Counsel

Fiscal Review:

GCBH Chief Financial Officer

Content and Form Prepared By:

GCBH Contracts Coordinator

PURPOSE OF AGREEMENT

The purpose of this Agreement is for the Contractor to provide medically necessary mental health services to Enrollees. He Contractor shall provide or purchase age, linguistic and culturally competent community mental health services for Enrollees for whom services are medically necessary and clinically appropriate pursuant to:

(1) CFR 42 CFR 438, or any successors and Federal 1915 (b) Mental Health Waiver, Medicaid (Title XIX) State plan or any successors.
(2) Other provisions of Title XIX of the Social Security Act, or any successors.
(3) RCW 70.02, 71.05, 71.24, and 71.34, or any successors.
(4) WAC 388-865 or any successors.

This Agreement is in effect from July 01, 2015 through March 31, 2016.

1. DEFINITIONS

a. **Action** means:
   (1) The denial or limited authorization of a requested service, including the type or level of service;
   (2) The reduction, suspension, or termination of a previously authorized service;
   (3) The denial, in whole or in part, of payment for a service;
   (4) The failure to provide services in a timely manner, as defined by the State; or
   (5) The failure of the Contractor to act within the timeframes provided in section 42 CFR 438.408(b).

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

c. **Annual Revenue** means all revenue received by the Contractor pursuant to this Agreement for July of any year through June of the next year.

d. **Appeal** means an oral or written request to GCBH by an Enrollee, or with the Enrollee's written permission, the Enrollee's Authorized Representative, for GCBH to review an Action as defined above. See also Expedited Appeal Process.

e. **Appeal Process** means one of the processes included in the grievance system that allows an Enrollee to appeal an Action made by GCBH and communicated on a Notice of Action.

f. **Authorized Representative** means any person acting on behalf of an Enrollee who:
   - In the case of a minor, the individual's parent or, if applicable, the individual's custodial parent;
   - The individual's legal guardian; or
   - The individual's representative if the individual gives written permission, this may include a mental health practitioner working on behalf of the individual.

g. **Capitation Payment** means a payment GCBH makes monthly to the Contractor on behalf of each recipient enrolled under a Contract for the provision of mental health services under the

State Medicaid Plan. GCBH makes the payment regardless of whether the particular recipient receives the services during the period covered by the payment.

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

i. **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.

j. **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.

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

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

m. **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.

n. **Day** for purposes of this Agreement means calendar days unless otherwise indicated in this Agreement.

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

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

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

r. **Division of Behavioral Health and Recovery or DBHR** means the DSHS-designated State mental health authority to administer the state and Medicaid funded mental health programs

authorized by RCW chapters 71.05, 71.24, and 71.3.

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

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

u. **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.

v. **Enrollee** means a Medicaid recipient who is enrolled in a Pre-paid Inpatient Health Plan.

w. **Evaluation and Treatment (E&T)** 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 DSHS. A physically separate and separately operated portion of a state hospital may be designated as an E&T facility. A facility which is part of, or operated by, DSHS or any federal agency will not require certification. No correctional institution of facility, or jail, shall be an E&T facility within the meaning of RCW Chapter 71.05.020.

x. **Evidence Based Practice (EBP)** 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.

y. **Expedited Appeal Process** means a process that allows an Enrollee, in certain circumstances, to file an Appeal that will be reviewed by GCBH more quickly than a standard Appeal.

z. **Fair Hearing** means a hearing before the Washington State Office of Administrative Hearings.

aa. **Family means**:
(1) For adult Enrollees, those the Enrollee defines as family or those appointed/assigned (e.g., guardians, siblings, caregivers, and significant others) to the Enrollee.
(2) For children, a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by the department of social and health services, or a Federally Recognized Tribe.

bb. **Greater Columbia Behavioral Health (GCBH)** means GCBH's officers, employees, and authorized agents. GCBH's service area includes the counties of Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman and Yakima.

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

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

- A Grievance process;
- An Appeal process; and
- Access to DSHS's administrative hearing (fair hearing) process.

ee. **Institute for Mental Disease (IMD)** 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.

ff. **Individual** means a person who applies for, is eligible for, or receives PIHP-authorized mental health services from an agency licensed by DSHS as a behavioral health agency. For purposes of accessing the Grievance System, the definition of Individual also includes the Individual's Authorized Representative if the Individual gives written permission or, in the case of a minor, the Individual's custodial parent or legal guardian.

gg. **Involuntary Treatment Act (ITA)** means a court order that allows for individuals to be committed 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).

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

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

jj. **Medicaid Mental Health Benefits Booklet** means the state-produced mechanism to help Medicaid Enrollees understand the requirements and benefits of the Regional Support Network.

kk. **Medical Necessity or Medically Necessary** means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate, no treatment at all. Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of

a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. 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.

ll. **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.

mm. **Mental Health Professional** means:

(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW.

(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 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.

(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(4) A person who had an approved waiver to perform the duties of a Mental Health Professional that was requested by the regional support network and granted by DSHS prior to July 1, 2001; or

(5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by DBHR consistent with WAC 388-865-0265.

nn. **Notice of Action** means a written notice GCBH provides to an Individual, and if applicable, the Individual's Authorized Representative, to communicate an Action.

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

pp. **Prepaid Inpatient Health Plan (PIHP)** means an entity that:

- Provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and
- Does not have a comprehensive risk contract.

qq. **ProviderOne** means the Department of Social and Health Services' Medicaid Management Information Payment Processing System.

rr. **Publish** means an officially sanctioned document provided by DSHS and/or GCBH on DBHR and/or GCBH internet or intranet websites for downloading, reading, or printing. The Contractor

shall be notified in writing or by e-mail when a document meets these criteria.

ss. **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.

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

uu. **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.

vv. **Receiving RSN** means the RSN into whose region the Referring RSN is pursuing the transfer.

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

xx. **Reduction** means the decision by GCBH, or their designee, to decrease a previously authorized covered Medicaid mental health service described in the Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to decrease or change a covered service in the Individualized Service Plan is not a reduction.

yy. **Referring RSN** means the RSN in whose region the individual being transferred resided and/or from whom they received services prior to State hospital admission.

zz. **Regional Support Network (RSN)** means a county authority or group of county authorities or other entity recognized by the Secretary to administer mental health services in a defined region.

aaa. **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.

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

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

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

eee. **Service Area** means the geographic area covered by this Agreement for which the Contractor is responsible. The Contractor is responsible for the provision of services within the boundaries of Benton and Franklin Counties.

fff. **Specialized Non-Medicaid Services** means, for purposes of the RSN Transfer Protocol, IMD admissions, residential placements and state hospital census.

ggg. **Suspension** means the decision by GCBH, or their formal designee, to temporarily stop previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.

hhh. **Termination** means the decision by GCBH, or their formal designee, to stop previously authorized covered Medicaid 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.

iii. **Urban Area** means areas that have a population density of at least five hundred (500) people per square mile.

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

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

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

2. PROVIDER CREDENTIALING

a. The Contractor shall hold all necessary licenses, certifications and/or permits as required by law for the performance of the activity to be performed under this Agreement. The Contractor shall notify GCBH in the event of a change in status of any required license or certification.

b. The Contractor shall have written policies that require monitoring of provider credentials. The Contractor shall only use CMHAs that are licensed and/or certified by the State. Clubhouses must meet all credentialing requirements put in place by the State.

c. The Contractor shall maintain documentation that all MHCPs are currently licensed in the State of Washington.

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

3. EXCLUDED PROVIDERS

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

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

b. The Contractor must participate in enhanced screening activities performed by DSHS as required under CFR 455.450.

c. The Contractor is prohibited from paying with funds received under this Agreement for goods and services furnished, ordered or prescribed by excluded individuals and entities (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b)). The Contractor shall:

(1) Monitor for excluded individuals and entities by:

- Screening Contractor employees and individuals and entities with an ownership or control interest for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Agreement.
- Provide information to GCBH, via the transactions designated by the GCBH Data Dictionary, concerning newly added Contractor employees, subcontractors and County Commissioners, as required by GCBH policy OIG and Federal Exclusion Check Requirements as amended, revised and/or replaced. GCBH policies are available on the GCBH website: www.gcbh.org.

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

e. If GCBH notifies the Contractor that an individual or entity is excluded from participation, the Contractor shall immediately terminate all beneficial, employment, contractual, and control relationships with the excluded individual or entity (WAC 388-502-0030). The list of excluded individuals will be found at: http://www.oig.hhs.gov/fraud/exclusions.asp.

f. Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees. (SSA section 1128A(a)(6) and 42 CFR 1003.102(a)(2). SSA section 1128 will be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm).

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

PHYSICIAN INCENTIVE PLANS
The Contractor must ensure it does not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) does not contract with any Subcontractor operating such a plan.

5. TRAINING

a. The Contractor shall participate in trainings, meetings and/or conferences when requested by GCBH and/or DSHS.

b. The Contractor must participate in GCBH and/or DSHS offered training on the implementation of Evidence-Based Practices and Promising Practices. Requests for GCBH and/or DSHS to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to targeted Contractor staff.

6. INCIDENT REPORTING

a. The Contractor must maintain policies and procedures regarding mandatory incident reporting and referrals consistent with all applicable state and federal laws. The policies must address the Contractor's oversight and review of the requirements in this section.

b. The Contractor must report and follow-up on all incidents involving Enrollees, listed below.

c. The Contractor must provide initial notification and any follow up to the GCBH Incident Manager. Contractor may use the standardized form found in the GCBH Incident Report policy. Reports shall contain, at a minimum, the following:
- A description of the incident;
- The date and time of the incident;
- Incident location;
- Incident type;
- Names and ages, if known, of all individuals involved in the incident;
- The nature of each individual's involvement in the incident;
- The service history with the Contractor, if any, of individuals involved;
- Steps taken by the Contractor to minimize harm; and
- Any legally required notifications made by the Contractor.

d. 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:

(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.

(A) Death or serious injury of patients, clients, staff, or public citizens at a DSHS facility or a facility that DSHS licenses, contracts with, or certifies.

(B) 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.

(C) 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.

(D) Any event involving an individual or staff that has attracted media attention.

(2) Category Two Incidents: the Contractor must report within one (1) working day of becoming aware that any of the following Category Two Incidents has occurred, involving an Enrollee:

(A) Alleged client abuse or client neglect of a serious or emergent nature by an employee, volunteer, licensee, Contractor, or another client.

(B) 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.).

(C) 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, RSNs will document and/or attach: 1) the Police report, 2) any equipment that was lost, and 3) specifics of the client information.

(D) Any allegation of financial exploitation as defined in RCW 74.34.020.

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

(F) Any event involving a client or staff, likely to attract media attention in the professional judgment of the Contractor.

(G) 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."

(H) Any incident that was referred to the Medicaid Fraud Control Unit by the Contractor or its Subcontractor.

(I) A life safety event that requires an evacuation or that is a substantial disruption to the facility.

e. Comprehensive Review: GCBH may require the Contractor to initiate a comprehensive review of any incident.

(1) If the Contractor does not respond according to the timeframe in GCBH's request, GCBH may obtain information directly from any involved party and request their assistance in the investigation.

(2) GCBH may request medication management information.

(3) GCBH 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.

f. Incident Review and Follow-up: the Contractor will review and follow-up on all incidents reported. The Contractor will provide sufficient information, review, and follow-up to take the process and report to its completion. An incident will not be categorized as complete until the following information is provided:

(1) A summary of any incident debriefings or review process dispositions;
(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;
(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;
(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;
(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; and
(6) If this information is unavailable, the attempt to retrieve it will be documented.

g. GCBH may require the Contractor to provide additional information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

7. ENROLLMENT

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

8. DELEGATION

a. 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.
   (1) Prior to any new delegation of any contracted responsibility or authority described in this Agreement through a Subcontract or other legal Agreement, the Contractor shall use a delegation plan.
   (2) The Contractor shall only contract with licensed service providers for the provision of direct services per RCW 71.24.045 and WAC 388-865-0284.
   (3) The Contractor shall maintain and make available to GCBH, DSHS and its EQRO Contractors all delegation plans, for currently in place Subcontractors. The delegation plan must include the following:
      i. An evaluation of the prospective Subcontractor's ability to perform delegated activities.
      ii. 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.
      iii. 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.

b. Subcontract Submission:
   (1) Within 30 days of execution of a Subcontract to perform any function under this Agreement, the Contractor shall submit copies of the Subcontracts to GCBH.
      • When substantially similar Agreements are executed with multiple Subcontractors an example Agreement may be provided with a list by Subcontractor of any terms that deviate from the example. A list of all

Subcontractors for each Agreement and the period of performance must also be submitted.

9. INFORMATION REQUIREMENTS

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

(1) The Contractor and its subcontractors shall maintain written policy and procedures addressing all information requirements, and shall:

i. Use the Washington Medicaid Mental Health Benefit Booklet published by DSHS and the GCBH Benefit Handbook published by GCBH as the mechanisms by which Enrollees are notified of their benefits, rights, and responsibilities.

ii. Offer every Enrollee at the time of an intake evaluation the Washington Medicaid Mental Health Benefit Booklet published by DSHS and the GCBH Benefit Handbook published by GCBH. The Washington Medicaid Mental Health Benefit Booklet can be downloaded from: http://dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml. The GCBH Benefit Handbook can be downloaded from: http://www.gcbh.org.

iii. Provide to GCBH the information necessary to update the Medicaid Mental Health Benefits Booklet and the GCBH Benefit Handbook within 14 days of any changes that are made to any Contractor or Subcontractor(s) content contained in the booklets.

iv. Provide interpreter services for Enrollees who speak a primary language other than English for all interactions between the Enrollee and the Contractor and/or Subcontractor(s) including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a Grievance or Appeal.

v. Provide written translations of generally available materials including, at a minimum, applications for services, consent forms, Notice 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 US census. DSHS has determined based on this criteria that Spanish is the currently required language.

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

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

viii. Ensure that Mental Health Professionals and MHCPs have an effective mechanism to communicate with Enrollees with sensory impairments.

ix. Post a multilingual notice in English and in each of the DSHS prevalent languages, which advises consumers that information is available in other languages and how to access this information. The DSHS prevalent languages are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese.

xi. Post an English copy as well as a translated copy of the Washington Medicaid Mental Health Benefits Booklet's section entitled "Your Rights as a Person Receiving

Medicaid Mental Health Services" in each of the DSHS-prevalent languages. The DSHS Prevalent languages are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese.

xii. Maintain a log of all Enrollee requests for interpreter services, or translated written material and provide copies of the logs to GCBH upon request.

b. Customer Service:

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

(2) At a minimum, Customer Service staff shall:

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

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

iii. Customer service staff must be trained to distinguish between a benefit inquiry, third party insurance issue, Appeal or Grievance and how to route these to the appropriate party.

c. The Contractor shall participate in and cooperate with DSHS efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (42 CFR 438.206(c)(2)). At a minimum the Contractor and its subcontractors shall:

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

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

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

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

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

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

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

(8) Collect and maintain accurate and reliable demographic data to monitor and evaluate the

impact of CLAS on health equity and outcomes and to inform service delivery. (CLAS 11); and

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

(10) No later January 20, 2016, for the period of July 1, 2015, through December 31, 2015, the Contractor shall provide GCBH with an annual report evidencing its compliance with each CLAS standard.

d. The Contractor shall provide upon the Enrollee's request:

(1) Information to on the names, locations, telephone numbers of, and non-English service providers in the service area; including providers that are not accepting new Enrollees.

(2) Identification of individual MHCPs who are not accepting new Enrollees.

(3) CMHA licensure, certification and accreditation status.

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

10. PAYMENT

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

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

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

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

e. The Contractor shall be paid monthly using a payment methodology developed by the Counties using Medicaid client counts and/or service hours provided to Medicaid Enrollees. Each Contractor's percentage of the total number of Medicaid clients served and/or service hours provided to Medicaid Enrollees the previous month will be used to calculate the payment amount from the available PIHP funding as compensation for all covered services provided to Medicaid Enrollees for each month. For purposes of this Agreement, available PIHP funding is defined as the amount of PIHP funding distributed to Benton and Franklin Counties each month from GCBH less reasonable setaside funding which includes, but is not limited to, county administration costs, crisis services provided to Medicaid Enrollees, special projects serving Medicaid Enrollees, and other direct service and support costs incurred in the support of services for Medicaid Enrollees. PIHP funding may only be used for covered services provided to Medicaid Enrollees. Covered services are defined in this Agreement and in the State Plan. The Funding Schedule, as amended, revised and/or replaced, is available on the GCBH website: www.gcbh.org.

f. During the term of this Agreement, capitation payments are made at the beginning of each month of service. The Contractor shall provide mental health services in accordance with this Agreement through the end of the month for which it has received a capitation payment.

h. If the Contractor terminates this Agreement or will not be entering into any subsequent Agreements, GCBH will require that all remaining reserves and fund balances be spent within a reasonable timeframe developed with and approved by GCBH. Funds will be deducted from the monthly payments until all reserves and fund balances are spent. The Contractor must give notice at least 90 days prior to the end of the Agreement if a decision is made not to enter into a subsequent Agreement. Any funds not spent for the provision of services under this Agreement shall be returned to GCBH within 60 days of the last day this Agreement is in effect.

i. GCBH shall reimburse the Contractor and any crisis service provider accessed by Enrollees while the Enrollee is in or out of the State within 60 calendar days from the date the bill is received by GCBH.

j. If Federal Financial Participation (FFP) is recouped GCBH, the Contractor must reimburse the amount recouped to GCBH within 30 days of notification by GCBH.

k. Rates for July 1, 2015 through March 31, 2016 - Following the end of the annual legislative session, GCBH will offer a revised Funding Schedule posted to the GCBH website: www.gcbh.org with the proposed capitation payment for the next Fiscal Year. If for any reason the Contractor does not agree to continue to provide services using the proposed funds, the Contractor must provide comply with the Termination Notice Requirements Section of the Agreement.

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

m. Each capitation payment will be reduced by the amount paid by GCBH on behalf of the Contractor for unpaid assessments, penalties, damages, and other payments pending a dispute resolution process. If the dispute is still pending at the end of this Agreement, GCBH will withhold the amount in question from the final payment until the dispute is resolved.

n. GCBH will withhold 50 percent of the final payment under this Agreement until all final reports and data are received and accepted by GCBH, and until all pending corrective actions, penalties, or unpaid assessments are satisfied.

o. The Contractor is shall limit Administration costs to no more than 15 percent of the annual revenue provided under this Agreement. Administration Costs shall be measured on a fiscal year basis and based on the information reported in the Financial Reports and reviewed by the Counties and GCBH.

p. Financial Reporting and Certification: Financial Reports and Certifications are due within 30 days of the second quarter end (December and June of each year). Only one report is due within this Agreement period, and shall be submitted to GCBH with accompanying certification, by January

30, 2016. The Contractor shall submit the following components in a single form provided by GCBH:

(1) The PIHP Revenue and Expenditure, report in compliance with the BARS Supplemental for Mental Health Services promulgated by the Washington State Auditor's Office and the Revenue and Expenditure Report Instructions published by GCBH. Contractor must maintain fiscal records that clearly separate revenue received from GCBH (i.e Medicaid, State, MHBG, Jail, etc.).

(2) The amounts paid, if any, to Federally Qualified Health Centers for services.

(3) Any revenue collected by Subcontractors for services provided under this Agreement. This includes revenue collected from Medicare, insurance companies, co-payments, and other sources. The Contractor must certify that a process is in place to demonstrate that all third party revenue resources for services provided under this Agreement are identified, pursued, and recorded by the Subcontractor, in accordance with Medicaid being the payer of last resort.

(4) In addition, the Contractor shall submit a single financial certification form, provided by GCBH, indicating that financial information reported on Revenue and Expenditure documents are true and correct to the best of their knowledge per instructions provided by GCBH.

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

(6) GCBH reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data at any time.

(7) The Contractor and all Subcontractors must have an independent annual financial audit completed within 275 days of the Contractor's fiscal year end. This audit must be performed by either the Washington State Auditor's Office or an independent accounting firm licensed to perform such audits. A copy of the completed audit report and management letter must be submitted to GCBH within thirty (30) days of the reports issuance. Failure for the Contractor or its Subcontractors to comply with this term may result in corrective action, the withholding of payment and/or termination in accordance with the terms of this Agreement.

11. COST ALLOCATION PLAN

a. Within sixty (60) days following execution of this Agreement, the Contractor shall submit to the Counties and GCBH a copy of its Cost Allocation Plan describing the methodology the Contractor uses to allocate costs to the public mental health system for reporting purposes under this Agreement.

12. ACCESS TO CARE

a. The Contractor shall ensure services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

b. Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-

service Medicaid, as set forth in §440.230.

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

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

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

f. The Contractor may refuse to provide, reimburse for, or provide coverage of certain services based on moral or religious grounds.
   (1) If the Contractor chooses to refuse any services or coverages on moral or religious grounds it must provide a list of those services to Enrollees.
   (2) If the Contractor establishes any new policy regarding a moral or religious objection to any service or coverage it must notify GCBH 30 days prior to enacting the policy and all of its Enrollees within 90 days of adopting of enacting the policy. Any policy not expressly conveyed to GCBH prior to the start date of this contract shall be classified as "new".

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

h. At a minimum the Contractor shall:
   (1) Offer an intake evaluation by a MHP within ten (10) business days of an Enrollee request.
   (2) Maintain the ability to provide an intake evaluation at an Enrollee's residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to persons discharged from a state hospital or evaluation & treatment facilities to such placements when the Enrollee requires an offsite service due to medical needs.
   (3) Provide or purchase age, linguistic and culturally competent community mental health services for Enrollees for whom services are medically necessary and clinically appropriate consistent with the Medicaid state plan and the Federal 1915 (b) Mental Health Waiver.
   (4) Maintain the ability to provide services to Enrollees in their residence, including adult family homes, assisted living facilities and skilled nursing facilities when required due to medical needs.

i. Changes in capacity: A significant change in capacity is defined as the termination of this

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

(1) The Contractor must notify all impacted Enrollee's within 15 days after receipt or issuance of a contract termination notice with any of its providers.
(2) If either the Contractor or the Subcontractor terminates a Subcontract in less than thirty (30) calendar days or a site closure occurs in less than thirty (30) calendar days, the Contractor must notify GCBH as soon possible and prior to a public announcement.
(3) The Contractor shall notify GCBH of any other changes in capacity. Events that affect capacity include, but are not limited to: 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.
(4) If any significant change occurs, the Contractor must submit a plan to GCBH for Enrollees and services that include at least:
    - Notification to Ombuds services.
    - Crisis services plan.
    - Plan for provision of uninterrupted services.
    - Plan for retention and/or transfer of clinical records.
    - Any information released to the media.

j. A routine intake evaluation appointment must be available and offered to every Enrollee within fourteen (14) calendar days of the request, with a possible extension of up to an additional fourteen (14) calendar day, unless both of the following conditions are met:
    - An intake evaluation has been provided in the previous twelve (12) months that establishes medical necessity; and
    - The Contractor agrees to use the previous intake evaluation as the basis for authorization decisions.

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

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

m. GCBH will monitor the frequency of Routine appointments that occur after twenty eight (28) calendar days for patterns and apply corrective action where needed.

n. The Contractor must offer consumers assistance with accessing enrollment into health

plans if the consumer is uninsured at the time they present for services.

o. The Contractor shall comply with Exhibit D, RSN Transfer Protocol.

13. UTILIZATION MANAGEMENT

a. Authorization General Requirements:
   (1) GCBH, or its formal designee, shall make a determination of eligibility based on GCBH's Access to Care Standards (Exhibit A) and Level of Care Guidelines as amended, replaced or revised. GCBH's Level of Care Authorization policy is available on the GCBH website: www.gcbh.org.
   (2) GCBH, or its formal designee, shall provide a written Notice of Determination or Notice of Action (in accordance with 42 CFR§438.404), to the CMHA and the Enrollee or their legal representative within 14 days of the authorization decision.

b. Authorization for Routine Services:
   (1) GCBH, or its formal designee, shall make a determination of eligibility for an initial authorization of routine services based on medical necessity and the Access to Care Standards (Exhibit A) following the initiation of the intake evaluation.
   (2) A decision by GCBH, or its formal designee, whether to authorize initial routine services shall occur within 14 days of the date the intake evaluation was initiated, unless the Enrollee or the CMHA requests an extension from GCBH or its formal designee.
   (3) Authorization and provision of routine Services may begin before the completion of the intake evaluation once medical necessity has been established.
   (4) An extension of up to 14 additional days to make the authorization decision is possible upon request by the Enrollee or the CMHA or the Contractor justifies (to GCBH upon request) a need for additional information and how the extension is in the Enrollee's interest.
   (5) Authorization decisions must be expedited to no longer than three (3) business days after receipt of the request for services if either of the following is true:
      - the Enrollee's presenting mental health condition affects their ability to maintain or regain maximum functioning; or
      - the Enrollee presents a potential risk of harm to self of others.

c. Authorization for Inpatient Services:
   (1) GCBH, or its formal designee, shall adhere to the requirements set forth in the Community Psychiatric Inpatient Instructions and Requirements available on GCBH's website: www.gcbh.org.
   (2) GCBH, or its formal designee, shall make a decision regarding certification of psychiatric inpatient care within twelve (12) hours of the initial request.
      - If the authorization is denied, GCBH, or its formal designee, shall provide a Notice of Action to the CMHA and the Enrollee or their legal representative.
   (3) The Contractor shall ensure that authorized community psychiatric inpatient services are continued through an Enrollee's discharge should a community hospital become insolvent, including any requirement for transfer.
   (4) Institutes of Mental Disease: The Contractor may provide services for individuals who are aged 22 to 64 in Institutes for Mental Disease (IMD) in lieu of covered acute

psychiatric services for up to 30 calendar days per admission. The Contractor is not required to provide these services in IMD settings. These services are substituted only for covered acute inpatient or evaluation and treatment and may not be used for long-term IMD services. Encounters of these services shall be reported as described in the Service Encounter Reporting Instructions (SERI).

(5) Choice of MHCP: The Contractor shall offer each Enrollee a choice of participating MHCPs in accordance with WAC 388-865-0345. If the Enrollee does not make a choice, the Contractor or its designee must assign a MHCP no later than 14 working days following the request for mental health services. The Contractor shall inform the Enrollee that he or she may change MHCPs.

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

(3) The Contractor must use best efforts to provide written or oral notification no later than 15 working days after termination of a MHCP to Enrollees currently open for services who had received a service from the affected MHCP in the previous 60 days.

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

(1) The Contractor must attempt to screen all individuals aged thirteen (13) and above through the use of 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, 71.34 or 70.96B.
  - The contact is by telephone only.
  - The professional conducting the crisis intervention or ITA investigation has information that the individual completed a GAIN-SS screening within the previous 12 months.

(2) The GAIN-SS screening must be completed as self report by the individual and signed by that individual on 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 DBHR-GAIN-SS form.

(7) The results of the GAIN-SS screening, including refusals and unable-to-completes, must be reported to GCBH through the CIS system.

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

(9) The assessment is required during the next outpatient treatment planning review following the screening and as part of the initial evaluation at free-standing, non-hospital, evaluation and treatment facilities. The assessment is not required during crisis interventions or ITA investigations. The quadrant placements are defined as:
- Less severe mental health disorder/less severe substance disorder.
- More severe mental health disorder/less severe substance disorder.
- Less severe mental health disorder/more severe substance disorder.
- More severe mental health disorder/more severe substance disorder.

(10) The quadrant placement must be reported to GCBH through the CIS system.

14. QUALITY MANAGEMENT

a. The Contractor shall participate with DSHS and/or GCBH in the implementation, update and evaluation of the DSHS Quality Strategies.

b. Performance Improvement Project (PIP): GCBH shall implement at least two (2) PIPs. This must include at least one clinical and one non-clinical project. GCBH shall evaluate the PIPs for increased or sustained improvement over time. The Contractor must participate in GCBH approved PIPs and comply with GCBH recommendations for improvement.

c. The Contractor shall participate with GCBH and/or DBHR in review activities. Participation shall include at a minimum:
(1) The submission of requested materials necessary for a GCBH and/or DBHR initiated review within 30 days of the request.
(2) The completion of site visit protocols provided by GCBH and/or DBHR.
(3) Assistance in scheduling interviews and agency visits required for the completion of the review.

d. Encounter Data Validation (EDV) Reports.
(1) The Contractor shall participate in EDV audits performed by GCBH. GCBH shall submit EDV reports to the Department annually within 90 calendar days after the end of this Agreement.
(2) Performance accountability for this measure is built upon the EDV Reporting. If, during any measurement, the Contractor fails to meet performance expectations, Corrective Action may be initiated in accordance with the Remedial Action Section of this Agreement.
(3) If the Contractor fails to complete corrective action and meet improvement rates, GCBH may take action under the provision of the Remedial Actions section of this Agreement.

e. Performance Measures:
(1) There are two (2) sets of performance measures included in this Agreement: Core Performance Measures and Regional Performance Measures. Core Performance Measures are statewide measures established by DSHS.
(2) Core Performance Measures: Core performance Measures are taken from the measures identified through the HB1519/SB5732 process. DSHS will generate the measures statewide and by RSN on a quarterly basis with a maximum of a 12-month lag. DSHS will

provide baseline data at the start of the Agreement period and establish annual improvement targets by January 1, 2016. Specific to this Agreement period, DSHS has established the following two Core Performance Measures:

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

(b) **Core Performance Measure #2:** Mental Health Treatment Penetration: Percent of adults identified in need of mental health treatment where treatment is received during the measurement year. This measure will be defined by DSHS.

(3) Regional Performance Measures: Regional Performance Measures shall be developed, calculated and tracked by GCBH. The Contractor and/or its subcontractors shall implement GCBH approved Regional Performance Measures. The Contractor shall participate in the collection of data. GCBH shall manage the data necessary to support the Regional Performance Measurement activities, including establishing the baseline, determining demonstrable improvement target, tracking change in performance over time and reporting the annual findings to DSHS with a copy provided to the Contractor.

(a) All Regional Performance Measures shall be chosen based on local relevance, clinical consensus, and research evidence and with input from the local Mental Health Advisory Board. GCBH shall develop the Regional Performance Measures that reflect the following areas:

- Access and Availability
- Care Coordination and Continuity
- Effectiveness of Care
- Quality of Care
- Hope, Recovery, and Resiliency
- Empowerment and Shared Decision Making
- Self Direction
- Cultural Competency
- Health and Safety Measures
- Consumer Health Status and Functioning
- Community Integration and Peer Support
- Quality of Life and Outcomes
- Promising and Evidence-Based Practices
- Provider effectiveness and satisfaction
- Integrated Programs and Systems Integration

(b) GCBH shall calculate and monitor the Regional Performance Measures against the established Improvement Targets throughout the year. GCBH shall submit an annual report calculating all the Regional Performance Measures and their progress relating to the Improvement Targets to DSHS with a copy provided to the Contractor. GCBH is required to submit the annual report to DSHS by January 15 of each year.

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

(d) GCBH shall make the results of the Regional Performance Measures available to the public.

f. Evidence/Research-Based Practices: The Contractor will participate with GCBH and/or 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:

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

(2) At a minimum, 17 percent of the children/youth enrolled in treatment services will receive an Evidence/Research Based Practice by March 31, 2016.

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

g. Quality Review Activities:

(1) GCBH, the Department of Social and Health Services, Office of the State Auditor, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives, may conduct, on the Contractor or its subcontractors, announced and unannounced:

(a) Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement.

(b) Reviews regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement.

(c) Audits and inspections of financial records.

(2) The Contractor and its subcontractors shall notify and provide copies of all letters, notices, audits, reviews, results from audits/reviews including corrective actions to the GCBH Quality Manager when an entity other than GCBH performs any audit or review described above related to any activity contained in this Agreement.

(3) The Contractor and its subcontractors shall participate in an annual EQRO monitoring review and collaborate with the EQRO Contractor set forth by DSHS to schedule a time for the monitoring review.

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

(b) GCBH shall provide a copy of the final EQRO monitoring review report to the Contractor, through print or electronic media and upon request to interested

parties such as Enrollees, mental health advocacy groups, and members of the general public.

h. Practice guidelines. Practice guidelines are systematically developed statements designed to assist in decisions about appropriate mental health treatment. The guidelines are intended to assist practitioners in the prevention, diagnosis, treatment, and management of clinical conditions. The Contractor shall adopt and implement GCBH approved Practice Guidelines. These guidelines:

- Are based on valid and reliable clinical evidence or a generally accepted practice among the Mental Health Professionals in the community;
- Consider the needs of the Enrollees;
- Are adopted in consultation with Mental Health Professionals in the contracted network of CMHAs, when applicable;
- Are disseminated to all affected providers and, upon request, to Enrollees;
- Are chosen with regard to utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply; and
- Are reviewed and updated periodically as appropriate.

15. PROGRAM INTEGRITY

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

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

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

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

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

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

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

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

(4) If the Contractor has a 5% ownership interest in any of its Subcontractors, the tax identification number of the subcontractor(s). 42 CFR 455.104(b)(1)(iii).
(5) The name of any other disclosing entity (or fiscal agent or managed care entity) in which the owner of the Contractor has a control or interest. 42 CFR 455.104(b)(3).
(6) Whether any person with an ownership or controlling interest is related by marriage or blood to any other person with an ownership or controlling interest.
(7) Any other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any subcontractor in which the Contractor has a five (5) percent or more interest. (42 CFR 455.104(b)(1)(iii).
(8) Whether the Contractor has a five (5) percent ownership in any of its subcontractors or is related to any person with ownership or controlling interest in a subcontractor is related as a spouse, parent, child, or sibling. 42 CFR 455.104(b)(2).

e. The Contractor shall to disclose to GCBH, within 35 days of a request, full and complete information about [42 CFR 455.105(a)]:
(1) The ownership of any subcontractor with whom they have had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request. 42 CFR 455.105(b)(1).
(2) Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request. 42 CFR 455.105(b)(1).

f. The Contractor shall to investigate and disclose to GCBH, at contract execution, or renewal, and upon request of GCBH, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs and who is [42 CFR 455.106(a)]:
(1) A person who has an ownership or control interest in the Contractor. 42 CFR 455.106(a)(1).
(2) An agent or person who has been delegated the authority to obligate or act on behalf of the Contractor. 42 CFR 455.101; 42 CFR 455.106(a)(1).
(3) An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to- day operation of, the Subcontractor. 42 CFR 455.101; 42 CFR 455.106(a)(2).

g. The Contractor shall use only CMHAs that are licensed and/or certified by DSHS.

h. 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 GCBH, DSHS or the Department of Health.

i. 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 GCBH, all of the required information in sections d. – f. of this Section.

j. The Contractor must monitor and apply to their subcontracted agencies, all requirements in Section m of this Section.

k. 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.

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

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

- The Subject(s) of complaint by name and either provider/subcontractor type or employee position;
- The source of the complaint;
- The approximate dollar amount; and
- The legal and administrative disposition of the case.

(3) The Contractor and all of its Subcontractors must comply with the following:

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

(4) The Contractor's, Fraud and Abuse program shall have procedures for the following requirements:

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

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

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

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

v. Effective ongoing training and education for the compliance officer, staff of the Contractor, and selected staff of the CMHAs.

vi. Effective communication between the compliance officer, the Contractor's employees, and the Contractor's network of CMHAs.
vii. Enforcement of standards through well-publicized disciplinary guidelines.
viii. Internal monitoring and auditing of the Contractor and providers.
ix. Provisions for prompt responses to detected offenses and development of corrective action initiatives.
x. Provision for full cooperation with any federal, HCA or Attorney General Medicaid Fraud Control Unit (MFCU) investigation including promptly supplying all data and information requested for their investigation.
xi. A methodology to verify that services billed by providers were actually provided to Enrollees.

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

(1) All suspensions of payment actions under this section will be temporary and will not continue after either of the following:
- The Contractor or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider; or
- Legal proceedings related to the provider's alleged fraud are completed.

(2) The Contractor must send notice of its suspension of program payments to the provider within the following timeframes:
- Five business days of taking such action unless requested in writing by the Medicaid Fraud Control Unit (MFCU) or law enforcement agency to temporarily withhold such notice.
- Thirty calendar days if requested by law enforcement in writing to delay sending such notice. The request for delay may be renewed in writing as many as two times and in no event may the delay exceed 90 calendar days.

(3) The notice of payment suspension must include or address the following:
- State that payment is being suspended in accordance with this provision.
- Set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation.
- State that the suspension is for a temporary period and cite the circumstances under which the suspension will be terminated.
- Specify, when applicable, to which type or types of claims or business units of a provider suspension is effective.
- Inform the provider of the right to submit written evidence for consideration by the Contractor.

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

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

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

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

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

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

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

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

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
- Other available remedies implemented by the Contractor more effectively or quickly protect Medicaid funds.
- The Contractor determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.
- Enrollee access to items or services would be jeopardized by a payment suspension because the individual or entity serves a large number of Enrollees within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.
- Law enforcement declines to certify that a matter continues to be under investigation.
- The Contractor determines that payment suspension is not in the best interests of the Medicaid program.

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

- Enrollee access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:
    - An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
    - The individual or entity serves a large number of Enrollees within a federal HRSA designated medically underserved area.
    - The Contractor determines based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.

- The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and the Contractor determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.
- Law enforcement declines to certify that a matter continues to be under investigation.
- The Contractor determines that payment suspension only in part is in the best interests of the Medicaid program.

(13) The Contractor must meet the following documentation and record retention requirements:

- Maintain for a minimum of 5 years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part, including the following:
  - All notices of suspension of payment in whole or part;
  - All fraud referrals to the MFCU or other law enforcement agency;
  - All quarterly certifications of continuing investigation status by law enforcement; and
  - All notices documenting the termination of a suspension.
- Maintain for a minimum of five (5) years from the date of issuance all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause.
- This type of documentation must include, at a minimum, detailed information on the basis for the existence of the good cause not to suspend payments, to suspend payments only in part, or to discontinue a payment suspension and, where applicable, must specify how long the Contractor anticipates such good cause will exist.
  - Annually report to DSHS summary information on each of the following:
    - Suspension of payment, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension.
    - Situations in which the Contractor determined good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.
    - If the Contractor fails to suspend payments to an entity or individual for which there is a pending investigation of a credible allegation of fraud, without good cause, DSHS may withhold monthly payments.

m. The Contractor is prohibited from paying with funds received under this Agreement for goods and services furnished, ordered or prescribed by excluded individuals and entities (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b)). In addition, the Contractor shall ensure that it does not employ or contract with

anyone that is excluded from participation in Federal health care programs under Section 1128 or Section 1128A of the SSA, Executive Order 12549 or 45 CFR 92.35.

(1) The Contractor must monitor for excluded individuals and entities by:
- Screening Contractor employees and individuals and entities with an ownership or control interest for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Agreement.
- Provide information to GCBH, via the transactions designated by the GCBH Data Dictionary, concerning newly added Contractor employees, subcontractors and County Commissioners, as required by GCBH policy OIG and Federal Exclusion Check Requirements as amended, revised and/or replaced. GCBH policies are available on the GCBH website: www.gcbh.org.

(2) The Contractor must report to GCBH:
- Any excluded individuals and entities discovered in the screening within ten (10) business days.
- Any payments made by the Contractor that directly or indirectly benefit excluded individuals and entities and the recovery of such payments.
- Any actions taken by the Contractor to terminate relationships with Contractor and subcontractor's employees and individuals with an ownership or control interest discovered in the screening.
- Any Contractor and subcontractor's employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 within ten (10) business days of the Contractor becoming aware of the conviction.
- Any subcontractor terminated for cause within ten (10) business days of the effective date of termination to include full details of the reason for termination.
- Any Contractor and subcontractor's individuals and entities with an ownership or control interest. The Contractor must provide a list with details of ownership and control no later than August 31, 2015, and notify GCBH of any changes within 30 calendar days.

(3) The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.
- The Contractor will immediately terminate any employment, contractual, and control relationships with an excluded individual and entity that it discovers.
- Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees. (SSA section 1128A(a)(6) and 42 CFR 1003.102(a)(2)).

(4) An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR 455.104(a), and 42 CFR 1001.1001(a)(1)).
- In addition, if GCBH notifies the Contractor that an individual or entity is excluded from participation by DSHS, the Contractor shall terminate all

beneficial, employment and contractual, and control relationships with the excluded individual or entity immediately (WAC 388-502-0030).
- The list of excluded individuals may be found at: https://oig.hhs.gov/exclusions/
- SSA section 1128 may be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm

16. SUBCONTRACTS

a. All Subcontracts must be in writing and specify all duties, responsibilities and reports delegated under this Agreement and require adherence with all federal and state laws that are applicable to the Subcontractor.
   - Subcontractors are permitted under RCW 71.24.061 to subcontract with individual licensed mental health professionals when necessary to meet the needs of Enrollees.

b. Subcontracts must include the requirements in Section 3. Excluded Providers.

c. The Contractor shall provide information regarding grievance, appeal, and fair hearing procedures and timeframes as set forth in Section 17 of this contract at the time the Subcontractor enters into a contract to provide services as stated in 42 CFR 438.10.(g)(1).

d. 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.
   (1) Prior to any new delegation of any responsibility or authority described in this Agreement through a Subcontract or other legal Agreement, the Contractor shall use a delegation plan.
   (2) The Contractor shall maintain and make available to GCBH, DBHR and its EQRO Contractors all delegation plans, for currently in place Subcontractors. The delegation plan must include the following:
      i. An evaluation of the prospective Subcontractor's ability to perform delegated activities.
      ii. 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.
      iii. 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.

e. Subcontract Submission:
   (1) Within 30 days of execution of a Subcontract to perform any function under this Agreement, the Contractor shall submit copies of the Subcontracts to GCBH.
      - When substantially similar Agreements are executed with multiple Subcontractors an example Agreement may be provided with a list by Subcontractor of any terms that deviate from the example. A list of all Subcontractors for each Agreement and the period of performance must also be submitted.

f. 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.

g. All Subcontracts with CMHAs must comply with 42 CFR §438.214(a) as enacted or amended.

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

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

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

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

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

m. Subcontracts must require Subcontractors to participate in training when requested by GCBH and/or DSHS. Requests for GCBH and/or DSHS to allow an exception to participation in required training must be in writing and include a plan for how the required information shall be provided to targeted Subcontractor staff.

n. Subcontracts must require compliance with State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and DBHR-CIS Data Dictionary.

o. 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.

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

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

r. Subcontracts must require that the Subcontracted CMHAs comply with the Contractor's policy and procedures for utilization of Access to Care Standards and Access Standards.

s. Subcontracts for the provision of mental health services must require that the Subcontractor implement a Grievance process that complies with 42 CFR §438.400 or any successors as described in section 17 of this Agreement.

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

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

v. Subcontracts for the provision of mental health services must require Subcontractors to resubmit data when rejected by GCBH and/or DBHR due to errors. The Subcontract must require the data to be re-submitted within 30 days of when the error report was produced.

w. Subcontracts must require notification to GCBH in the event of 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 mental health services or the closing of a Subcontractor site that is providing services required under this Agreement. The Contractor must notify GCBH 30 days prior to terminating any of its Subcontracts with entities that provide direct service including mental health clubhouses or entering into new Subcontracts with entities that provide direct service including mental health clubhouses. This notification must occur prior to any public announcement of this change.
   (1) If either the Contractor or the Subcontractor terminates a Subcontract in less than 30 days or a site closure occurs in less than 30 days, the Contractor must notify GCBH as soon possible and prior to a public announcement.
   (2) The Contractor shall notify GCBH 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.
   (3) If any event in this section occurs, the Contractor must submit a plan to GCBH for Enrollees and services 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.

y. Subcontracts must include the following Physician Incentive Plans language:
   (1) The Contractor must ensure it does not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) does not contract with any Subcontractor operating such a plan.

z. Subcontracts must include the following Provider Credentialing language:
   (1) The Contractor shall have written policies that require monitoring of provider credentials.

The Contractor shall only use CMHAs that are licensed and/or certified by the State. Mental Health Clubhouses may be directly contracted with the PIHP without being a licensed CMHA. Clubhouses must meet all credentialing requirements put in place by the State.

(2) The Contractor shall require a criminal history background check through the Washington State Patrol for employees and volunteers of the Contractor who may have unsupervised access to children, people with developmental disabilities or vulnerable adults.

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

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

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

17. ENROLLEE RIGHTS AND PROTECTIONS

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

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

- The right to be treated with respect and due consideration of the Enrollee's dignity and privacy.
- The right to receive information on available treatment options and alternatives in a manner appropriate to the Enrollee's ability to understand.
- The right to participate in decisions regarding their health care, including the right to refuse services.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- The right to request and receive a copy of their medical records, and request amendments or corrections as specified in 45 CFR 164.524 and 164.526.
- Ensuring that the exercising of any of these rights do not adversely affect the way the Contractor treats the Enrollee.

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

(1) The Enrollee's mental health status.

(2) Receiving all information regarding mental health treatment options including any alternative or self-administered treatment, in a culturally-competent manner.

(3) Any information the Enrollee needs in order to decide among all relevant mental health

treatment options.

(4) The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment).

(5) The Enrollee's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions.

(6) The Enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy.

(7) The Enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

(8) The Enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164.

(9) The Enrollee's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the Contractor, CMHA or MHCP treats the Enrollee.

(10) Any of the Enrollee's Rights and Protections as listed in the Washington Medicaid Mental Health Benefits Booklet published by DSHS.

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

(1) The Contractor shall require that consumers are actively included in the development of their individualized service plans, advance directives for psychiatric care and crisis plans.

i. 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).

(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 consumer sees progress.

(3) The Individual Service Plan must address the overall identified needs of the Enrollee, including those that best met by another service delivery system, such as education, primary medical care, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections and juvenile justice as appropriate. The Contractor must ensure that there is coordination with the other service delivery systems responsible for meeting the identified needs.

e. The Contractor shall ensure Enrollees are not held liable for any of the following:

(1) Covered mental health services provided by insolvent community psychiatric hospitals with which the Contractor has directly contracted.

(2) Covered mental health services, including those purchased on behalf of the Enrollee.

(3) Covered mental health services for which the State does not pay the Contractor.

(4) Covered services provided to the Enrollee, for which the State or the Contractor does not pay the MHCP or CMHA that furnishes the services under a contractual, referral, or other arrangement.

(5) Payments for covered services furnished under a Contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Contractor provided the services directly.

(6) Covered mental health services provided by insolvent federally funded PIHPs.

(7) Debts of the Contractor if the Contractor becomes financially insolvent.

(8) Costs due to receiving covered services from an out-of-network provider when those covered services are not available within the Service Area.

f. Advance Directives:

(1) The Contractor shall maintain written policies and procedures for Mental Health Advance Directives that meet the requirements of 42 CFR §422.128. The Contractor shall inform all Enrollees of their right to a Mental Health Advance Directive, and shall provide technical assistance to those who express an interest in developing and maintaining a Mental Health Advance Directive.

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

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

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

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

(6) The Contractor shall provide written information to Enrollees that includes:

- A description of their rights for Mental Health Advance Directives under current RCW 71.32 (changes must be included within 90 days of the effective date of any changes to the RCW);
- The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of a Mental Health Advance Directive as a matter of Conscience; and
- Inform Enrollees' how to file a complaint concerning noncompliance with a Mental Health Advance Directive by contacting the Washington State Department of Health at Health Systems Quality Assurance Complaint Intake, PO Box 47857, Olympia, WA 98504-7857, 360-236-4700 or HSQAComplaintIntake@doh.wa.gov

18. MANAGEMENT INFORMATION SYSTEM

a. Data Submission and Error Correction:

(1) The Contractor shall provide GCBH with all data described in the GCBH "Data Dictionary" and encounters shall be submitted as described in the GCBH Trading Partner Agreement(s) and DBHR's "Encounter Data Reporting Guide" or any successor, incorporated herein by reference.

(2) The Contractor shall submit encounters electronically to GCBH management information system within 30 days of the close of each calendar month in which the encounters occurred.

(3) The Contractor shall submit all other required Enrollee data to GCBH within 30 days of collection or receipt from subcontracted providers.

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

(5) The Contractor shall attend meetings and respond to inquiries to assist in GCBH decisions about changes to data collection and information systems to meet the terms of this

Agreement. This may include requests to add, delete or change data elements that may include projected cost analysis.

(6) The Contractor shall implement changes documented in GCBH "Data Dictionary" and Trading Partner Agreement(s) and in DBHR's "Encounter Data Reporting Guide" within 90 days from the date published. When changes on one document require changes to the other, GCBH shall publish all affected documents concurrently.

(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, GCBH 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, GCBH will work with the Contractor to implement any change as necessary.

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

(9) When GCBH makes changes referenced in this Section the Contractor shall send at least one test batch of data containing the required changes. The test batch must be received no later than 15 days prior to the implementation date.

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

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

(11) No encounter transaction shall be accepted for initial entry or data correction after one (1) year from the date of service, except by special exception.

b. Business Continuity and Disaster Recovery:

(1) The Contractor shall demonstrate a primary and backup system for electronic submission of data requested by GCBH. This must include secure electronic transmission. In the event a secure method of transmission is unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on GCBH approval.

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

(3) 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 December 20 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 GCBH or the DBHR-contracted EQRO to review and audit. The plan must address the following:

i. A mission or scope statement;
ii. An appointed Information Services Disaster Recovery Staff.
iii. Provisions for Backup of Key personnel; Identified Emergency Procedures; Visibly listed emergency telephone numbers.
iv. Procedures for allowing effective communication; Applications Inventory and Business Recovery priority; Hardware and software vendor list.
v. Confirmation of updated system and operations documentation; Process for frequent backup of systems and data.
vi. Off site storage of system and data backups; Ability to recover data and systems from backup files.
vii. Designated recovery options which may include use of a hot or cold site.
viii. Evidence that disaster recovery tests or drills have been performed.

c. Information System Security and Protection of Confidential Information:
(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 CFR Parts 160, 162 and 164.
(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 (Exhibit B).
(3) The Contractor shall take appropriate action if the Contractor or any of its Subcontractors employees wrongly releases confidential information.

d. Data Quality Verification:
(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. The Contractor shall have in place mechanisms to verify the health information received from Subcontractors is complete, accurate and timely.

19. GRIEVANCE SYSTEM

a. The Contractor must have a Grievance system that complies with the following procedures. The Contractor must provide information about the Grievance System to all Subcontractors at the time they enter into an Agreement.

b. General Requirements:
(1) An Enrollee or representative may file a Grievance either orally or in writing with the Contractor and may request a Fair Hearing from the State of Washington Office of Administrative Hearings. An Enrollee may also file a Grievance with his or her provider which must have policies and procedures consistent with the requirements in this Section.
(2) A representative, including a staff person of the Enrollee's provider, acting on behalf of the Enrollee and with Enrollee's written consent, may request a Grievance or an Appeal or a Fair Hearing.

(3) The Enrollee must be given reasonable assistance in pursuing a Grievance, Appeal, or Fair Hearing.
   i. The Enrollee may be provided assistance from the Ombuds service, the Enrollee's provider, the Contractor, or any other person of the Enrollee's choice.
(4) The Enrollee shall be provided access to interpreter services and toll-free numbers that have adequate TTU/TTD and interpreter capability.
(5) The Contractor shall:
   i. Ensure that there is no retaliation against Enrollees or providers, who on behalf of the Enrollee, file a Grievance, Appeal, or Fair Hearing, or request an expedited resolution.
   ii. Abide by all Appeal, Grievance and Fair Hearing decisions.
   iii. Provide information about the Grievance system to all CMHAs and Subcontractors at the time they enter into an Agreement. A condition of the Agreement will be that all CMHAs and Subcontractors will abide by all Appeal, Grievance and Fair Hearing decisions.
(6) The Contractor must notify the GCBH Grievance and Appeals Coordinator within (1) working day of receiving a Grievance.

c. Handling of Grievances:
(1) The Contractor or its agent shall:
   i. Acknowledge receipt of each Grievance, received either orally or in writing, within five (5) working days. If acknowledgement is made orally, it must be followed in writing within five (5) working days.
(2) Ensure that the individuals who make decisions on Grievances are individuals who:
   i. Were not involved in any previous level of review or decision-making; and
   ii. When the Grievance involves medical necessity or a request for expedited resolution to an appeal, the Contractor shall ensure that individuals involved with making decisions are Mental Health Professionals with the appropriate clinical expertise.

d. Grievance Resolution and Notification: The Contractor must resolve each Grievance and provide written notice as expeditiously as the Enrollee's mental health condition requires and not more than twenty (20) days from the receipt of the statement of Grievance by the Contractor.
(1) If a resolution cannot be reached, to the Enrollee's satisfaction, within the twenty (20) day timeframe, the Contractor must forward the Grievance to GCBH immediately.
(2) GCBH shall provide written notice of resolution within thirty (30) days from statement of Grievance.
(3) The Contractor may extend the timeframe by up to 14 calendar days if:
   i. The Enrollee request the extension; or
   ii. The Contractor shows (to the satisfaction of the state agency upon its request) that there is a need for additional information and how the delay is in the Enrollee's interest.
(4) If the Contractor extends the timeframes, the Contractor must, for any extension, give the Enrollee written notice of the reason for the delay.
(5) Failure to meet the timeframes above or provide a written notice of any extension constitutes a denial and an adverse action for which the Enrollee shall be sent a Notice of Action. The Contractor must notify GCBH in the event timeframes are not met. A Notice of Action must be provided by GCBH.

(6) The written notice of resolution must include the decision on the Grievance, the reason for the decision, the date the decision was made and the right to request a Fair Hearing and the required timeframe to request the Hearing.

(7) For notice of expedited resolution the Contractor shall:

i. Provide written notice of the disposition within three (3) working days; and

ii, Make reasonable effort to provide oral notice of disposition prior to written notice.

iii. Failure to meet the timeframes above or provide a written notice of any extension constitute a denial and an adverse action for which the Enrollee shall be sent a Notice of Action. The Contractor must notify GCBH in the event timeframes are not met. A Notice of Action must be provided by GCBH.

iv. The written notice of resolution must include the results of the resolution process and the date it was completed.

v. For expedited Grievances not resolved wholly in favor of the Enrollee, the notice must include:

- The right to request a Fair Hearing and how to do so.
- The right to request to continue to receive previously authorized benefits while the hearing is pending and how to make the request.
- Notice that the Enrollee may be asked to pay for the cost of those benefits if the hearing decision upholds the original action.

e. Fair Hearings:

(1) Enrollees may request a Fair Hearing conducted by DSHS in accordance with Chapter 388-02 WAC and provisions of mental health services per 42 CFR 438.402(b)(2).

vi. The parties to a Fair Hearing include the Contractor as well as the Enrollee and his or her representative or the legal representative of a deceased Enrollee's estate.

(2) A Fair Hearing may be requested from the State of Washing Office of Administrative Hearings when:

vii. An Enrollee believes there has been a violation of DSHS rule.

viii. The Contractor or its agent does not provide a written response to a grievance or appeal within the required timeframes.

ix. An Enrollee receives an adverse ruling by the Contractor or its agent to a grievance or an appeal.

(3) If the Enrollee elects to request a Fair Hearing, regarding a standard service, the request must be filed within ninety (90) calendar days of the date on GCBH's mailing of the Notice of the resolution of the Appeal.

(4) If the Enrollee elects to request a Fair Hearing, regarding termination, suspension or reduction of a previously authorized service and if the Enrollee requests continuation of services, the request must be filed within ten (10) calendar days of the date on GCBH's mailing of the Notice of the resolution of the Appeal.

(5) GCBH will notify the Contractor of Fair Hearing determinations. The Contractor will be bound by the Fair Hearing determination, whether or not the Fair Hearing determination upholds the Contractor's decision.

f. Recordkeeping and Reporting Requirements

(1) The Contractor must maintain records of Grievances and Fair Hearings for six (6) years.

(2) The Contractor must maintain records of Grievances and Fair Hearings separate from medical records. The Contractor must notify the GCBH Grievance and Appeals Coordinator at the time a grievance is filed. Notification must include the consumers name and contact information.

(5) The Contractor must submit a report in a format provided by GCBH that includes:
   i. The number and nature of Grievances and Fair Hearings.
   ii. The timeframes within which they were disposed of or resolved.
   iii. The nature of the decisions.
   iv. A summary and analysis of the implications of the data, including what measures shall be taken to address undesirable patterns.
   v. The Contractor shall submit to DSHS a total of three (3) reports covering the following periods:
      - July 1, 2015 – September 30, 2015 (due October 20, 2015)
      - October 1, 2015 – December 31, 2015 (due January 20, 2016)
      - January 1, 2016 – March 31, 2016 (due April 01, 2016)

20. BENEFITS

a. All Medicaid Enrollees requesting covered Mental Health Services must be offered an intake evaluation as outlined in the Access Standards. Authorization for further services shall be based on medical necessity and the Access to Care Standards (Exhibit A).

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

c. The Contractor shall ensure services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

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

e. The Contractor must provide the following mental health services for each Enrollee when they are Medically Necessary. If the Contractor is unable to provide medically necessary services covered under the contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them . These services must be provided at no additional cost to the Enrollee. Enrollees are entitled to access Crisis Services, Freestanding Evaluation and Treatment, Stabilization and Rehabilitation Case Management prior to an intake evaluation

(1) Brief Intervention Treatment: Solution-focused and outcomes-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances

which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid Enrollee's Individual Service Plan must include a specific timeframe for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the Enrollee's current level of functioning and assistance with self care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

(2) Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid-enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a Mental Health Professional.

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

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

(5) Freestanding Evaluation and Treatment: Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and

certified by DBHR to provide medically necessary evaluation and treatment to the Medicaid-enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. 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. DBHR must authorize exceptions for involuntary length of stay beyond a fourteen (14) day commitment.

(6) Group Treatment Services: Services provided to Medicaid-enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills;, enhancing interpersonal skills; mitigating the symptoms of mental illness, and lessening the results of traumatic experiences;, learning from the perspective and experiences of others; and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a Mental Health Professional to two or more Medicaid-enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

(7) High Intensity Treatment: Intensive levels of service otherwise furnished under this State plan amendment that is provided to Medicaid-enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individuals' needs. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a Mental Health Professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*,

etc. Team members work together to provide intensive coordinated and integrated treatment as described in the Individual Service Plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning shall be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the Individual Service Plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15. Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality. Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

(8) Individual Treatment Services: A set of treatment services designed to help a Medicaid-enrolled individual attain goals as prescribed in his/her Individual Service Plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include developing the individual's self care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid-enrolled individual. This service is provided by or under the supervision of a Mental Health Professional.

(9) Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a Mental Health Professional.

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

(11) Medication Monitoring: Face-to-face, one-on-one cueing, observing, and encouraging a Medicaid-enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid-enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a Mental Health Professional. Time spent with the Enrollee is the only direct service billable component of this modality.

(12) Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely

provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid Enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of eight (8) hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

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

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

Services provided by peer counselors to the consumer are noted in the consumer's Individualized Service Plan which delineates specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available to each Enrollee for no more than four (4) hours per day. The ratio for this service is no more than 1:20.

(14) Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

(15) Rehabilitation Case Management: A range of activities by the outpatient Community Mental Health Agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-

enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, maximize the benefits of the placement, minimize the risk of unplanned re-admission and to increase the community tenure for the individual. Services are provided by or under the supervision of a Mental Health Professional.

(16) Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

(17) Stabilization Services: Services provided to Medicaid-enrolled 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 weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

(18) Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid-enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increase knowledge of mental illnesses and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the Medicaid-enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a Mental Health Professional. Classroom style teaching, family treatment and individual

treatment are not billable components of this service.

f. DSHS may petition CMS to amend the Medicaid State Plan during this Contract period. If the Medicaid State Plan is amended the Contractor shall implement any changes to the provision of Medically Necessary mental health services no later than 30 days following CMS approval of the plan.

g. Coordination of Care:
   (1) Coordination with Primary Medical Care Services:
      i. The Contractor must ensure that for Enrollees who have a suspected or identified physical health care problem the following shall occur:
         - Appropriate referrals are made to a physical health care provider.
         - The individualized service plan identifies medical concerns and plans to address them.
   (2) The Contractor shall comply with GCBH Children's Long-Term Inpatient Program (CLIP) policies/procedures, as amended, replaced and/or revised. GCBH policies are available on the GCBH website: www.gcbh.org.
   (3) Psychiatric Inpatient Services:
      i. The Contractor or its designee shall contact the inpatient unit within three (3) working days for all Enrollee admissions.
      ii. The Contractor or its designee shall provide to the inpatient unit any available information regarding the Enrollee's treatment history at the time of admission, all available information related to payment resources and coverage and a provisional placement plan for the Enrollee to return to the community that can be implemented when the Enrollee is determined to be ready for discharge by the hospital and the Contractor.
      iii. The Contractor must participate in treatment and discharge planning with the inpatient treatment team.
      iv. The Contractor must work with an Enrollee and their families seeking community support services prior to discharge.
      v. If the provisional placement plan for an Enrollee cannot be implemented when an Enrollee is determined to be ready for discharge, the Contractor must convene a meeting of the inpatient treatment team and other discharge plan participants to review action taken to implement the plan, barriers and proposed modifications to the plan. Such meetings shall occur every 30 calendar days until the Enrollee has been placed.
      vi. For Enrollees on Less Restrictive Alternatives (LRA) who meet medical necessity and the Access to Care Standards (Exhibit A), the Contractor or designee shall offer covered mental health services to assist with compliance with LRA requirements.
      vii. The Contractor shall ensure provision of covered mental health services to Enrollees on a Conditional Release under RCW 10.77.150 for Enrollees who meet medical necessity and the Access to Care Standards (Exhibit A).
      viii. The Contractor shall use best efforts to utilize community resources and covered mental health services to minimize State Hospital admissions.
      ix. The Contractor or designee shall use best efforts to secure an appointment, within 30 days of release from the facility, for medication, evaluation and prescription re-fills for

Enrollees discharged from inpatient care, to ensure there is no lapse in prescribed medication. This may be arranged with providers other than Subcontractors of the Contractor.

x. The Contractor shall use best efforts to offer covered mental health services for follow-up and after-care as needed when the Contractor or Subcontractor are aware that an Enrollee has been treated in an emergency room for a psychiatric condition. These services shall be offered in order to maintain the stability gained by the provision of emergency room services.

xi. The Contractor 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.

(A) 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 DSHS within twenty-four (24) hours. The notification report must contain at a minimum:

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

(B) The RSN 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.

h. Early Periodic Screening Diagnosis and Treatment (EPSDT):

(1) EPSDT services must be structured in ways that are culturally and age appropriate, involve the family and be available to all Enrollees under the age of 21. Intake evaluations provided under EPSDT must include an assessment of the family's needs.

(2) EPSDT requires the Contractor to respond to referrals from medical care providers. This must include at least a written notice replying to the Physician, ARNP, Physician's Assistant, trained public health nurse or RN who made the EPSDT referral. This notice must include at least the date of intake and diagnosis.

(3) In the event the Enrollee does not have a primary care provider, the Contractor may choose to assist or refer the Enrollee to the HCA's Washington Apple Health Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Provider Guide.

(4) The Contractor shall contact the Enrollee within ten (10) working days of all EPSDT referrals to confirm whether services are being requested by the Enrollee or the person authorized to consent to treatment for that Enrollee. The Contractor shall maintain documentation of its efforts to confirm whether the Enrollee or the person authorized to consent to treatment for that Enrollee requests, declines, or does not respond to efforts within ten (10) working days to confirm whether these services are being requested.

(5) The Contractor shall participate in local and statewide efforts to assist Consumers in enrolling in healthcare coverage.

i. Allied System Coordination:

(1) The Contractor shall comply with the following GCBH Allied System Coordination Plans as amended, replaced or revised. GCBH Allied System Coordination Plans are available on the GCBH website: http://www.gcbh.org.

i. DSHS Aging and Long Term Care Services Administration (ALTSA).
ii. Chemical Dependency and Substance Abuse services.
iii. DSHS Children's Administration.
iv. Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Apple Health Plans.
v. Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections).
vi. DSHS Division of Vocational Rehabilitation.
vii. DSHS Juvenile Justice and Rehabilitation Administration (JJ & RA).
viii. Any Offender Re-entry Community Safety Program (ORCSP) within the boundaries of the RSN that is not a Subcontractor of the Contractor.

j. 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. WISe documents can be found at http://www.dshs.wa.gov/dbhr/childrensbehavioralhealth.shtml.

(1) 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.
(2) Contractors not yet implementing WISe as part of their service delivery shall incorporate and disseminate the Washington State Children's Behavioral Health Principles (Exhibit C) as guidelines for providing care to children, youth and their families.

k. 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:

(1) A comprehensive transition plan linked across systems that identify goals, objectives, strategies, supports, and outcomes.
(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.
(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.
(4) Developmentally and culturally appropriate adult services that are relevant to the individual or population.

l. The Contractor shall coordinate with DSHS, Home and Community Services (HCS) regional office to support the placement of persons discharged or diverted from state hospitals into HCS

placements. The Contractor shall comply with any GCBH MOU and/or Agreement established with HCS. GCBH MOUs and Agreements can be found at www.gcbh.org.

(1) Whenever possible, prior to referring a person with a diagnosis of dementia for a 90 day commitment to a State Hospital:
   i. Ensure that a request for Comprehensive Assessment Reporting Evaluation (CARE) is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all persons who might be eligible for long-term care services. HCS has agreed to prioritize requests for CARE for individuals who have been detained to an Evaluation & Treatment facility or in another setting.
   ii. Request and coordinate with HCS, a scheduled CARE for such persons. If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to attempt a community placement prior to referral to the State Hospital.

(2) For individuals (both those being discharged and those being diverted) whose CARE indicates likely functional and financial eligibility for long-term care services:
   i. 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.
   ii. 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.
   iii. The Contractor will ensure coordination and communication will occur between those participants involved in placement activities as identified by the discharge planning team.
   iv. If a placement has not been found for an individual referred for long-term care services within 30 calendar days, the designated entity will convene a meeting to review the plan and to make adjustments as necessary. Such review meetings will occur at least every 30 calendar days until a placement is affected.

(3) When individuals being discharged or diverted from State Hospitals are placed in a long-term care setting, the Contractor shall:
   i. Coordinate with HCS and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the DSHS website.
   ii. When the individual meets Access to Care Standards, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement.

21. REMEDIAL ACTIONS

a. GCBH may initiate remedial action if it is determined that any of the following situations exist:
   (1) A problem exists that negatively impacts individuals receiving services.
   (2) The Contractor has failed to perform any of the mental health services required in this Agreement.
   (3) The Contractor has failed to develop, produce, and/or deliver to GCBH and/or DBHR any of

the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Agreement.

(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.

(5) The Contractor has failed to implement corrective action required by GCBH and/or the State and within GCBH and/or DSHS prescribed timeframes.

b. GCBH may impose any one or more of the following remedial actions in any order:

(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 GCBH 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. GCBH may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

i. Corrective action plans must include:
   (A) A brief description of the situation requiring corrective action.
   (B) The specific actions to be taken to remedy the situation.
   (C) A timetable for completion of the actions.
   (D) Identification of individuals responsible for implementation of the plan.

ii. Corrective action plans are subject to approval by GCBH, which may:
   (A) Accept the plan as submitted.
   (B) Accept the plan with specified modifications.
   (C) Request a modified plan.
   (D) Reject the plan.

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

(2) Withhold up to five percent (5%) of the next monthly capitation payment and each monthly capitation payment thereafter until the situation has been resolved. GCBH, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

i. 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.

(3) Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which GCBH provides incentives.

(4) Terminate for Default as described in the General Terms and Conditions.

22. GENERAL TERMS AND CONDITIONS

a. **Definitions**. The words and phrases listed below, as used in the Agreement, shall each have the following definitions:

(1) **Agreement** means this document, the General Terms and Conditions, and the Special Terms and Conditions, including any Exhibits and other documents attached or incorporated by reference.

(2) **CFR** means Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation. The

CFR may be accessed at http://www.ecfr.gov.

(3) **Confidential Information** means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Personal Information.

(4) **Contractor** means the entity with which GCBH enters into this Agreement with.

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

(6) **DSHS or the department or the Department** means the Department of Social and Health Services of the State of Washington.

(7) **Personal Information** means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers, and any financial identifiers.

(8) **RCW** means the Revised Code of Washington. All references in this Agreement to RCW chapters or sections shall include any successor, amended, or replacement statute.

(9) **Secretary** means the individual appointed by the Governor, State of Washington as the head of DSHS or his/her designee.

(10) **Subcontract** means a separate Contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor shall perform pursuant to this Agreement.

(11) **USC** means United States Code. All references to USC chapters or sections in this Agreement shall include any successor, amended, or replacement statute. The USCA may be accessed at http://www.gpoaccess.gov/uscode/.

(12) **WAC** means the Washington Administrative Code. All references in this Agreement to WAC chapters or sections shall include any successor, amended, or replacement regulation.

b. **Amendment**. This Agreement, or any term or condition, may be modified only by a written amendment signed by both parties. Only personnel authorized to bind each of the parties shall sign an amendment.

c. **Assignment**. Except as otherwise provided herein, the Contractor shall not assign rights or obligations derived from this Agreement to a third party without the prior, written consent of GCBH and the written assumption of the Contractor's obligations by the third party.

d. **Billing Limitations**. Unless otherwise specified in this Agreement, GCBH shall not pay any claims for services submitted more than twelve (12) months after the calendar month in which the services were performed.

e. **Compliance with Applicable Law**. At all times during the term of this Agreement the Contractor and GCBH shall comply with all applicable federal, state, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations.

f. **Confidentiality**. The parties shall not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Agreement for any purpose that is not directly

connected with the performance of the services contemplated there under, except as provided by law; or in the case of Personal Information, as provided by law or with the prior written consent of the person or personal representative of the person who is the subject of the Personal Information.

The parties shall protect and maintain all Confidential Information gained by reason of this Agreement against unauthorized use, access, disclosure, modification or loss. This duty requires the parties to employ reasonable security measures, which include restricting access to the Confidential Information by:

- Allowing access only to staff that have an authorized business requirement to view the Confidential Information.
- Physically securing any computers, documents, or other media containing the Confidential Information.
- Ensure the security of Confidential Information transmitted via fax (facsimile) by:
  - Verifying the recipient phone number to prevent accidental transmittal of Confidential Information to unauthorized persons.
  - Communicating with the intended recipient before transmission to ensure that the fax will be received only by an authorized person.
  - Verifying after transmittal that the fax was received by the intended recipient.
- Following the requirements in Exhibit B.
- Sending paper documents containing Confidential Information via a Trusted System.
- Upon request by GCBH, at the end of the Contract term or when no longer needed, Confidential Information shall be returned to GCBH or Contractor shall certify in writing that they employed a GCBH approved method to destroy the information. Contractor may obtain information regarding approved destruction methods from the GCBH HIPAA Compliance Officer.
- Paper documents with Confidential Information may be recycled through a contracted firm, provided the contract with the recycler specifies that the confidentiality of information will be protected, and the information destroyed through the recycling process. Paper documents containing Confidential Information requiring special handling (e.g., protected health information) must be destroyed through shredding, pulping, or incineration.
- Notification of Compromise or Potential Compromise. The compromise or potential compromise of Confidential Information must be reported to the GCBH HIPAA Compliance Officer within one (1) business day of discovery. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or GCBH.

g. **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:

- All applicable Office of Insurance Commissioner's (OIC) statutes and regulations.
- All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement.

- 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.
- 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.
- Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
- Those specified in Title 18 RCW for professional licensing.
- Reporting of abuse as required by RCW 26.44.030.
- Industrial insurance coverage as required by Title 51 RCW.
- Any other requirements associated with the receipt of federal funds.
- 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.
- 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.

h. **Contractor Certification Regarding Ethics**. By signing this Agreement, the Contractor certifies that the Contractor is in compliance with Chapter 42.23 RCW and shall comply with Chapter 42.23 RCW throughout the term of this Agreement.

i. **Debarment Certification**. The Contractor, by signature to this Agreement, certifies that the Contractor and any Owners are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal department or agency from participating in transactions (Debarred) and is not listed in the Excluded Parties List System in the System for Award Management (SAM) website. The Contractor shall immediately notify GCBH if, during the term of this Contract, Contractor becomes debarred. The Contractor also agrees to include the above requirement in all Subcontracts into which it enters.

j. **Disputes**. When a dispute arises over an issue concerning the terms of this Agreement, the parties agree to the following process to address the dispute:

- Unless otherwise stated herein, disputes shall be determined by a Dispute board in the following manner: Each party to this Agreement shall appoint one member to the Dispute board. The members so appointed shall jointly appoint an additional member to the Dispute Board. The Dispute Board shall review the facts, Agreement terms, and applicable statutes and rules and make a determination of the dispute. This dispute resolution procedure shall not modify or reduce either party's rights to judicial

proceedings.

k. **Entire Agreement**. This Agreement, including all documents attached to or incorporated by reference, contains all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or bind the parties.

l. **Governing Law and Venue**. The laws of the State of Washington govern this Agreement. In the event of a lawsuit by the Contractor against GCBH involving this Agreement, venue shall be proper only in Benton County, Washington. In the event of a lawsuit by GCBH against the Contractor involving this Agreement, venue shall be proper only as provided in RCW 36.01.050.

m. **HIPAA Compliance.** This section of the Agreement is the Business Associate Agreement as required by HIPAA.

(1) Definitions:

(a) Breach means the acquisition, access, use or disclosure of Protected Health Information (PHI) in a manner not permitted under the HIPAA Privacy Rule which compromises the security of privacy of the PHI, with the exclusions and exceptions listed in 45 CFR 164.402.

(b) Business Associate means the "Contractor" and generally has the same meaning as the term "Business Associate" in 45 CFR 160.103. Any reference to Business Associate in this Contract includes Business Associate's employees, agents, officers, Subcontractors, third party contractors, volunteers or directors.

(c) Business Associate Agreement means this HIPAA Compliance section of the Contract and includes the Business Associate provisions required by the US Department of Health and Human Services, Office for Civil Rights.

(d) Covered Entity means GCBH, a Covered Entity as defined in 45 CFR 160.103, in its conduct of covered functions by its health care components.

(e) Designated Record Set means a group of records maintained by or for a Covered Entity, that is: the medical and billings records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or used in whole or part by or for the Covered Entity to make decisions about Individuals.

(f) Electronic Protected Health Information (EPHI) means PHI that is transmitted by electronic media or maintained in any medium described in the definition of electronic media in 45 CFR 160.103.

(g) HIPAA means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as modified by the American Recovery and Reinvestment Act of 2009 (ARRA), Sec. 13400-13424, H.R. 1 (2009) (HITECH Act).

(h) HIPAA Rules means the Privacy, Security, Breach Notification and Enforcement Rules in 45 CFR Parts 160 and 164.

(i) Individual(s) means the person(s) who is the subject of PHI and includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

(j) Minimum Necessary means the least amount of PHI necessary to accomplish the purpose for which the PHI is needed.

(k) Protected Health Information or PHI means individually identifiable health information created, received, maintained or transmitted by Business Associate on behalf of a health care component of the Covered Entity that relates to the provision of health care to an Individual; the past, present or future physical or mental health or condition of an Individual; or the past, present or future payment for provision of health care to an Individual, see 45 CFR 160.103. PHI includes demographic information that identifies the Individual or about which there is reasonable basis to believe can be used to identify the Individual, see 45 CFR 160.103. PHI is information transmitted or held in any form or medium and includes EPHI, see 45 CFR 160.103. PHI does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USCA 1232g(a)(4)(B)(iv) or employment records held by a Covered Entity in its role as employer.

(l) Security Incident means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

(m) Subcontractor, as used in this section, means a Business Associate that creates, receives, maintains or transmits PHI on behalf of another Business Associate.

(n) Use means the sharing, employment, application, utilization, examination or analysis of PHI within an entity that maintains such information.

(2) Compliance. Business Associate shall perform all Contract duties, activities and tasks in compliance with HIPAA, HIPAA Rules and all attendant regulation as promulgated by the US Department of Health and Human Services, Office of Civil Rights.

(3) Use and Disclosure of PHI. Business Associate is limited to the following permitted and required uses or disclosures of PHI:

(a) Duty to Protect PHI. Business Associate shall protect PHI from and shall use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 (Security Standards for the Protection of Electronic Protected Health Information) with respect to EPHI, to prevent the unauthorized use or disclosure of PHI other than as provided in this Contract or as required by law, for as long as the PHI is within its possession and control, even after the termination or expiration of this Contract.

(b) Minimum Necessary Standard. Business Associate shall apply this standard to any use or disclosure of PHI necessary to achieve the purposes of this Contract, see 45 CFR 164.514(d)(2) through (d)(5).

(c) Disclosure of Part of the Provision of Services. Business Associate shall only use or disclose PHI as necessary to perform the services specified in this Contract or as required by law, and shall not use or disclose such PHI in any manner that would violate Subpart E of 45 CFR Part 164 (Privacy of Individually Identifiable Health Information) if done by Covered Entity, except for the specific uses and disclosures set forth below.

(d) Use for Proper Management and Administration. Business Associate may use PHI for the proper management and administration of the Business Associate to carry out the legal responsibilities of the Business Associate.

(e) Disclosure for Proper Management and Administration. Business Associate may disclose PHI for the Proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the

disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(f) Impermissible Use or Disclosure of PHI. Business Associate shall report to GCBH in writing all uses or disclosures of PHI not provided for by this Contract wihin one (1) business day of becoming aware of the unauthorized use or disclosure of PHI, including breaches of unsecured PHI as required in 45 CFR 164.410 (Notification by a Business Associate), as well as any security incident of which it becomes aware. Upon request by GCBH, Business Associate shall mitigate, to the extent practicable, any harmful effect resulting from the impermissible use or disclosure.

(g) Failure to Cure. If GCBH learns of a pattern or practice of the Business Associate that constitutes a violation of the Business Associate's obligations under the terms of this Contract and reasonable steps by GCBH do not end the violation, GCBH shall terminate this Contract, if feasible. In addition, if the Business Associate learns of a pattern or practice of its subcontractors that constitutes a violation of the Business Associate's obligations under the terms of their contract and reasonable steps by the Business Associate do not end the violation, Business Associate shall terminate the subcontract, if feasible.

(h) Termination for Cause. Business Associate authorizes immediate termination of this Contract by GCBH, if GCBH determines that Business Associate has violated a material term of this Business Associate Agreement. GCBH may, at its sole option, offer Business Associate an opportunity to cure a violation of this Business Associate Agreement before exercising a termination for cause.

(i) Consent to Audit. Business Associate shall give reasonable access to PHI, its internal practices, records, books, documents, electronic data and/or all other business information received from, or created or received by Business Associate on behalf of GCBH for use in determining compliance with HIPAA privacy requirements.

(j) Obligations of Business Associate Upon Expiration or Termination. Upon expiration or termination of this Contract for any reason, with respect to PHI received from GCBH or created, maintained or received by Business Associate, or any subcontractors, on behalf of GCBH, Business Associate shall:

i. Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

ii. Return to GCBH or destroy the remaining PHI that the Business Associate or any subcontractors shall maintain in any form;

iii. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR 165 (Security Standards for the Protection of Electronic Protected Health Information) with respect to Electronic Protected Health Information to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate or any subcontractors retain the PHI;

iv. Not use or disclose the PHI retained by Business Associate or any subcontractors other than for the purposes for which such PHI was retained and subject to the same conditions set out in the "Use and Disclosure of PHI" section of this Contract which applied prior to termination; and

v. Return to GCBH or destroy the PHI retained by Business Associate, or any subcontractors, when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

(4) Survival. The obligations of this Business Associate under this section shall survive the termination or expiration of this Contract.

(5) Individual Rights.

(a) Accounting of Disclosures.

i. Business Associate shall document all disclosure, except those disclosures that are exempt under 45 CFR 164.528, of PHI and information related to such disclosures.

ii. Within ten (10) business days of a request from GCBH, Business Associate shall make available to GCBH the information in Business Associate's possession that is necessary for GCBH to respond in a timely manner to a request for an accounting of disclosure of PHI by the Business Associate. See 45 CFR 164.504(e)(2)(ii)(G) and 164.528 (b)(1).

iii. At the request of GCBH or in response to a request made directly to the Business Associate by an Individual, Business Associate shall respond, in a timely manner and in accordance with HIPAA and the HIPAA Rules, to requests by Individuals for an accounting of disclosure of PHI.

iv. Business Associate record keeping procedures shall be sufficient to respond to a request for an accounting under this section for the six (6) years prior to the date on which the accounting was requested.

(b) Access.

i. Business Associate shall make available PHI that it holds that is part of a Designated Record Set when requested by GCBH or the Individual as necessary to satisfy GCBH's obligations under 45 CFR 164.524 (Access of Individuals to Protected health Information).

ii. When the request is made by the Individual to the Business Associate or if GCBH asks the Business Associate to respond to a request, the Business Associate shall comply with requirements in 45 CFR 164.524 (Access of Individuals to Protected Health Information) on form, time and manner of access. When the request is made by GCBH, the Business Associate shall provide the records to GCBH within (10) business days.

(c) Amendment.

i. If GCBH amends, in whole or in part, a record or PHI contained in an Individual's Designated Record Set and GCBH has previously provided the PHI or record that is the subject of the amendment to Business Associate, then GCBH will inform Business Associate of the amendment pursuant to 45 CFR 164.526(c)(3) (Amendment of Protected Health Information).

ii. Business Associate shall make any amendments to Phi in a Designated Record Set as directed by GCBH or as necessary to satisfy GCBH's

obligations under 45 CFR 164.526 (Amendment of Protected health Information).

(6) Subcontracts and other Third Party Agreements. In accordance with 45 CFR 164.502(e)(1)(ii), 164.504(e)(1)(i) and 164.308(b)(2), Business Associate shall ensure that any agents, subcontractors, independent contractors or other third parties that create, receive, maintain, or transmit PHI on Business Associate's behalf, enter into a written contract that contains the same terms, restrictions, requirements, and conditions as the HIPAA compliance provision in this Contract with respect to such PHI. The same provision must also be included in any contracts by a Business Associate's subcontractor with its own business associates as required by 45 CFR 164.314(a)(2)(b) and 164.504(e)(5).

(7) Obligations. To the extent the Business Associate is to carry out one or more of GCBH's obligation(s) under Subpart E of 45 CFR Part 164 (Privacy of Individually Identifiable Health Information), Business Associate shall comply with all requirements that would apply to GCBH in the performance of such obligation(s).

(8) Liability. Within ten (10) days, Business Associate must notify GCBH of any complaint, enforcement or compliance action initiated by the Office for civil Rights based on an allegation of violation of the HIPAA Rules and must inform GCBH of the outcome of that action. Business Associate bears all responsibility for any penalties, fines or sanctions imposed against the Business Associate for violations of the HIPAA Rules and for any imposed against its subcontractors or agents for which it is found liable.

(9) Breach Notification.

(a) In the event of a breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from GCBH or involving GCBH clients, Business Associate will take all measures required by state or federal law.

(b) Business Associate will notify GCBH within one (1) business day by telephone and in writing of any acquisition, access, use or disclosure of PHI not allowed by the provisions of this Contract or not authorized by HIPAA Rules or required by law of which it becomes aware which potentially compromises the security or privacy of the PHI as defined in 45 CFR 164.402 (Definitions).

(c) Business Associate will notify the GCBH HIPAA Compliance Officer within one (1) business day by telephone or email of any potential breach of security or privacy of PHI by the Business Associate or its subcontractors or agents. Business Associate will follow telephone or email notification with a faxed or other written explanation of the breach, to include the following: date and time of breach, date breach was discovered, location and nature of the PHI, type of breach, origination and destination of PHI, Business Associate unit and personnel associated with the breach, detailed description of the breach, anticipated mitigation steps, and the name, address, telephone number, fax, number and email of the individual who is responsible as the primary point of contact. Business Associate will address communications to the GCBH HIPAA Compliance Officer. Business Associate will coordinate and cooperate with GCBH to provide a copy of its investigation and other information requested by GCBH, including advance copies of any notifications required for GCBH review before disseminating and verification of the dates notifications were sent.

(d) If GCBH determines that Business Associate or its subcontractors or agents are

responsible for a breach of unsecured PHI:

i. Requiring notification of Individuals under 45 CFR 164.404 (Notification to Individuals), Business Associate bears the responsibility and costs for notifying the affected Individuals and receiving and responding to those Individuals' questions or requests for additional information;

ii. Requiring notification of the media under 45 CFR 164.406 (Notification to the media), Business Associate bears the responsibility and costs for notifying the media and receiving and responding to media questions or requests for additional information;

iii. Requiring notification of the US Department of Health and Human Services Secretary under 45 CFR 164.408 (Notification to the Secretary), Business Associate bears the responsibility and costs for notifying the Secretary and receiving and responding to the Secretary's questions or requests for additional information; and

iv. GCBH will take appropriate remedial measures, up to termination of this Contract.

(e) Miscellaneous Provisions.

i. Regulatory Reference. A reference in this Contract to a section in the HIPAA Rules means the section as in effect or amended.

ii. Interpretation. Any ambiguity in this Contract shall be interpreted to permit compliance with the HIPAA Rules.

n. **Independent Status**. For purposes of this Agreement, the Contractor acknowledges that the Contractor is not an officer, employee, or agent of GCBH, DSHS or the State of Washington. The Contractor shall not hold out itself or any of its employees as, nor claim status as, an officer, employee, or agent of GCBH, DSHS or the State of Washington. The Contractor shall not claim for itself or its employees any rights, privileges, or benefits, which would accrue to an employee of the State of Washington. The Contractor shall indemnify and hold harmless GCBH from all obligations to pay or withhold federal or state taxes or contributions on behalf of the Contractor or the Contractor's employees.

o. **Inspection**. Either party may request reasonable access to the other party's records and place of business for the limited purpose of monitoring, auditing, and evaluating the other party's compliance with this Agreement, and applicable laws and regulations. During the term of this Agreement and for one (1) year following termination or expiration of this Agreement, the parties shall, upon receiving reasonable written notice, provide the other party with access to its place of business and to its records which are relevant to its compliance with this Agreement, and applicable laws and regulations. This provision shall not be construed to give either party access to the other party's records and place of business for any other purpose. Nothing herein shall be construed to authorize either party to possess or copy records of the other party for any other purpose.

p. **Insurance**. GCBH certifies that it is self-insured under the State's self-insurance liability program, as provided by RCW 4.92.130, and shall pay for losses for which it is found liable. The Contractor certifies that it is self-insured, is a member of a risk pool, or maintains insurance coverage as required in this Agreement. The Contractor shall pay for losses for which it is found

liable.

q. **Maintenance of Records**. The Contractor shall maintain records relating to this Contract and the performance of the services described herein. The records include, but are not limited to, accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Contract. All records and other material relevant to this Contract shall be retained for six (6) years after expiration or termination of this Contract. Without agreeing that litigation or claims are legally authorized, if any litigation, claim, or audit is started before the expiration of the six (6) year period, the records shall be retained until all litigation, claims; or audit findings involving the records have been resolved.

r. **Order of Precedence**. In the event of an inconsistency in this Agreement, unless otherwise provided herein, the inconsistency shall be resolved by giving precedence, in the following order, to:
(1) Applicable Federal and State of Washington statutes and regulations.
(2) The General Terms & Conditions of this Agreement.
(3) The Special Terms & Conditions of this Agreement.
(4) Any Exhibits attached or incorporated into this Agreement by reference.

s. **Ownership of Material**. Material created by the Contractor and paid for by GCBH as a part of this Agreement shall be owned by DSHS and shall be "work made for hire" as defined by Title 17 USCA, Section 101. This material includes, but is not limited to: books; computer programs; documents; films; pamphlets; reports; sound reproductions; studies; surveys; tapes; and/or training materials. Material which the Contractor uses to perform this Agreement but is not created for or paid for by DSHS is owned by the Contractor and is not "work made for hire"; however, GCBH shall have a perpetual license to use this material for DSHS internal purposes at no charge to GCBH, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.

t. **Responsibility**. Each party to this Agreement shall be responsible for the negligence of its officers, employees, and agents in the performance of this Agreement. No party to this Agreement shall be responsible for the acts and/or omissions of entities or individuals not party to this Agreement. GCBH and the Contractor shall cooperate in the defense of tort lawsuits, when possible. Both parties agree and understand that this provision may not be feasible in all circumstances. GCBH and the Contractor agree to notify the attorneys of record in any tort lawsuit where both are parties if either GCBH or the Contractor enters into settlement negotiations. It is understood that the notice shall occur prior to any negotiations, or as soon as possible, and the notice may be either written or oral.

u. **Severability**. The provisions of this Agreement are severable. If any court holds any provision of this Agreement, including any provision of any document incorporated by reference, invalid, that invalidity shall not affect the other provisions this Agreement.

v. **Subcontracting**. The Contractor may Subcontract services to be provided under this Agreement. If GCBH, the Contractor, and a Subcontractor of the Contractor are found by a jury or trier of fact to be jointly and severally liable for personal injury damages rising from any act or

omission from the Contract, then GCBH shall be responsible for its proportionate share, and the Contractor shall be responsible for its proportionate share. Should the Subcontractor be unable to satisfy its joint and severable liability, GCBH and the Contractor shall share in the Subcontractor's unsatisfied proportionate share in direct proportion to the respective percentage of their fault as found by the jury or trier of fact. Nothing in this term shall be construed as creating a right or remedy of any kind or nature in any person or party other than GCBH and the Contractor. This term shall not apply in the event of a settlement by either GCBH or the Contractor.

w. **Subrecipients.**

(1) General. If the Contractor is a sub-recipient of federal awards as defined by the 2 CFR Part 200 and this Agreement, the Contractor shall:

i. Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity.

ii. Maintain internal controls that provide reasonable assurance that the Contractor is managing federal awards in compliance with laws, regulations, and provisions of Contracts or grant Agreements that could have a material effect on each of its federal programs.

iii. Prepare appropriate financial statements, including a schedule of expenditures of federal awards.

iv. Incorporate 2 CFR Part 200, Subpart F audit requirements into all Agreements between the Contractor and its Subcontractors who are subrecipients.

v. Comply with the applicable requirements of 2 CFR Part 200, including any future amendments to 2 CFR Part 200 and any successor or replacement Office of Management and Budget (OMB) Circular or regulation; and

vi. Comply with the Omnibus Crime Control and Safe Streets Act of 1968; Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; Title II of the Americans with Disabilities Act of 1990; Title IX of the Education Amendments of 1972; The Age Discrimination Act of 1975; and The Department of Justice Non-Discrimination Regulations through 28 CFR Part 42, Subparts C, D, E, and G, and 28 CFR Parts 35 and 39. (Go to www.ojp.usdoj.gov/ocr/ for additional information and access to the aforementioned federal laws and regulations.)

(2) Single Audit Act Compliance. If the Contractor is a subrecipient and expends $750,000 or more in federal awards from all sources in any fiscal year, the Contractor shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the Contractor shall:

i. Submit to the GCBH Chief Financial Offer or their designee, the data collection form and reporting package specified in 2 CFR Part 200, Subpart F, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor.

ii. Follow-up and develop corrective action for all audit findings, in accordance with 2 CFR Part 200, Subpart F, and prepare a "Summary Schedule of Prior Audit Finding", reporting the status of all audit findings included in the prior audit's schedule of findings and questioned costs.

x. **Overpayments**. If it is determined by DSHS, or during the course of a required audit, that the Contractor has been paid unallowable costs under this Agreement, DSHS may require the Contractor to reimburse DSHS in accordance with 2 CFR Part 200.

y. **Survivability**. The terms and conditions contained in this Agreement, which by their sense and context, are intended to survive the expiration of the particular Agreement shall survive. Surviving terms include, but are not limited to the following Sections: Confidentiality, Disputes, Inspection, Maintenance of Records, Ownership of Material, Responsibility, Subcontracting, Termination for Default, Termination Procedure, and Title to Property.

z. **Termination Due to Change in Funding**. If the funds upon which GCBH relied to establish this Agreement are withdrawn, reduced, or limited, or if additional or modified conditions are placed on such funding, GCBH may terminate this Agreement by providing at least fifteen (15) calendar days' written notice to the Contractor. The termination shall be effective on the date specified in the notice of termination.

aa. **Termination Due to Change in GCBH/DSHS Agreement**. In the event that changes to the terms of the 1915(b) (Medicaid) Mental Health Services Waiver program render this Agreement invalid in any way after the effective date of this Agreement and prior to its normal completion, GCBH may terminate this Agreement by providing at least fifteen (15) calendar days' written notice to the Contractor, subject to re-negotiation (if applicable) under those new special terms and conditions.

bb. **Termination for Convenience**. GCBH may terminate this Agreement in whole or in part for convenience by providing the Contractor at least thirty (30) calendar days' written notice addressed to the Contractor at the address shown on the cover page of this Agreement. The Contractor may terminate this Agreement for convenience by providing GCBH at least thirty (30) calendar days' written notice addressed to: GCBH, Attn: GCBH Contracts Coordinator, 101 N Edison St, Kennewick, WA 99336.

cc. **Termination for Default.**

(1) GCBH may immediately terminate this Agreement for default, in whole or in part, by written notice to the Contractor, if GCBH has a reasonable basis to believe that the Contractor has:

i. Failed to meet or maintain any requirement for contracting with GCBH.
ii. Failed to protect the health or safety of any GCBH client.
iii. Failed to perform under, or otherwise breached, any term or condition of this Agreement, or any provision of this Agreement.
iv. Violated any law, regulation rule or ordinance applicable to this Agreement.

(2) Before GCBH may terminate this Agreement for default, GCBH shall provide the Contractor with written notice of the Contractor's noncompliance with the Agreement and provide the Contractor a reasonable opportunity to correct the Contractor's noncompliance. If the Contractor does not correct the Contractor's noncompliance within the period of time specified in the written notice of noncompliance, the Contracts Administrator may then terminate the Agreement. GCBH may terminate the Agreement for default without such written notice and without opportunity for correction if GCBH has a reasonable basis to believe that a client's health or safety is in jeopardy.

(3) The Contractor may terminate this Agreement for default, in whole or in part, by written notice to GCBH, if the Contractor has a reasonable basis to believe that GCBH has:
   i. Failed to meet or maintain any requirement for contracting with the Contractor;
   ii. Failed to perform under any provision of this Agreement;
   iii. Violated any law, regulation, rule, or ordinance applicable to this Agreement; and/or
   iv. Otherwise breached any provision or condition of this Agreement.

(4) Before the Contractor may terminate this Agreement for default, the Contractor shall provide GCBH with written notice of GCBH's noncompliance with the Agreement and provide GCBH a reasonable opportunity to correct GCBH's noncompliance. If GCBH does not correct GCBH's noncompliance within the period of time specified in the written notice of noncompliance, the Contractor may then terminate the Agreement.

dd. **Termination for Failed Program Integrity**. GCBH may immediately terminate this Contract by providing Contractor written notice if any of the following occurs:

(1) Any owner of the Contractor becomes Debarred.

(2) Failure to provide accurate and timely information required by 42 CFR 455.106(a), 42 CFR 455 Subpart E, 42 CFR 455.416(d) by the Contractor, any Owner, Agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational control, or who directly or indirectly conducts operations of the Contractor.

(3) The Contractors owners do not cooperate with any screening methods required under 42 CFR 455.455, Subpart E, 42 CFR 455.416(a).

(4) The Contractor's owners are convicted of a criminal offense related to the persons involvement with the Medicare, Medicaid or Title XXI program in the last 10 years, 42 CFR 455.416(b).

(5) The Contractor has been terminated under Title XVIII of the Social Security Act, or under any States Medicaid or CHIP program, 42 CFR 455.416(c).

(6) Failure to comply with this a request for the Contractor or its owners, to provide to DSHS fingerprints in a form determined by DSHS within 30 days of a CMS or DSHS agency request, 42 CFR 455.434(b) (2), 42 CFR 455.416 (e), 42 CFR 455.450(d).

(7) Failed to permit GCBH access to any of the Contractors locations for site visits under 42 CFR 455.432, 42 CFR 455.416(f).

(8) GCBH determines that the Contractor has falsified any information provided to GCBH and/or DSHS, 42 CFR 455.16(g).

ee. **Termination Procedure**. The following provisions apply in the event this Agreement is terminated:

(1) The Contractor shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of clients, distribution of property, and termination of services.

(2) The Contractor shall promptly deliver to the GCBH contact person (or to his or her successor) listed on the first page of this Agreement, all GCBH assets (property) in the Contractor's possession, including any material created under this Agreement. Upon failure to return GCBH property within ten (10) working days of this Agreement termination, the Contractor shall be charged with all reasonable costs of recovery, including transportation.

The Contractor shall take reasonable steps to protect and preserve any property of GCBH that is in the possession of the Contractor pending return to GCBH.

(3) GCBH shall be liable for and shall pay for only those services authorized and provided through the effective date of termination. GCBH may pay an amount mutually agreed upon by the parties for partially completed work and services, if work products are useful to or usable by GCBH.

(4) If GCBH terminates this Agreement for default, GCBH may withhold a sum from the final payment to the Contractor that GCBH determines is necessary to protect GCBH against loss or additional liability. GCBH shall be entitled to all remedies available at law, in equity, or under this Agreement due to Contractor's default. If it is later determined that the Contractor was not in default, or if the Contractor terminated this Agreement for default, the Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement except as to the limitations set forth in section 21.n. entitled "Lawsuits".

ff. **Termination Notice Requirements.** Contractor must provide the GCBH Contracts Coordinator with at least ninety (90) calendar days written notice if Contractor decides to voluntarily terminate, refuses to renew, or refuses to sign a mandatory amendment to this Agreement. If the Contractor terminates this Agreement or will not be entering into any subsequent Agreements, GCBH shall require that all remaining reserves and fund balances be spent within a reasonable timeframe developed with GCBH. Funds shall be deducted from the monthly payments until all reserves and fund balances are spent. The Contractor must give notice at least ninety (90) calendar days prior to the end of the contract if a decision is made not to enter into a subsequent agreement. Any funds not spent for the provision of services under this Contract shall be returned to GCBH with sixty (60) calendar days of the last day this Agreement is in effect. In addition, the Contractor will work with GCBH to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services to GCBH consumers. The transition plan shall address all issues leading to the transition of the Contractor functions to GCBH, or another service provider, such as the use of Reserves, claims reconciliation, and of all items and/or requirements of the Contractor that extend beyond the termination of services.

gg. **Treatment of Client Property**. Unless otherwise provided in this Agreement, the Contractor shall ensure that any adult client receiving services from the Contractor under this Agreement has unrestricted access to the client's personal property. The Contractor shall not interfere with any adult client's ownership, possession, or use of the client's property. The Contractor shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon termination or completion of this Agreement, the Contractor shall promptly release to the client and/or the client's guardian or custodian all of the client's personal property. This section does not prohibit the Contractor from implementing such lawful and reasonable policies, procedures and practices as the Contractor deems necessary for safe, appropriate, and effective service delivery (for example, appropriately restricting client access to, or possession or use of lawful or unlawful weapons and drugs).

hh. **Title to Property**. Title to all property purchased or furnished by GCBH for use by the Contractor during the term of this Agreement shall remain with GCBH. Title to all property purchased or furnished by the Contractor for which the Contractor is entitled to reimbursement by GCBH under this Agreement shall pass to and vest in GCBH. The Contractor shall take reasonable steps to

protect and maintain all GCBH property in its possession against loss or damage and shall return GCBH property to GCBH upon Agreement termination or expiration, reasonable wear and tear accepted.

ii. **Waiver**. Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Agreement unless amended as set forth in section 21.b, Amendment. Only GCBH Director or their designee has the authority to waive any term or condition of this Agreement on behalf of GCBH.

23. SPECIAL TERMS AND CONDITIONS

a. **Administrative Review Activities.**

(1) The Contractor shall notify GCBH when an entity other than GCBH performs any audit or review described below related to any activity contained in this Agreement. GCBH, the Department of Social and Health Services, Office of the State Auditor, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives, may conduct announced and unannounced:

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

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

(3) 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.

(4) The Contractor shall maintain information necessary to promptly respond to written requests by GCBH. The Contractor shall submit information detailing the amount spent throughout its service area on specific items upon request by GCBH.

b. **Commercial General Liability Insurance (CGL).** If the Contractor is not a member of a risk pool, the Contractor shall carry CGL to include coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products, completed operations, personal injury, advertising injury, and

liability assumed under an insured Contract. GCBH and its elected and appointed officials, agents, and employees shall be named as additional insureds. The Contractor shall provide up to date copies of the policy to GCBH upon execution of this Agreement. The Contractor shall notify GCBH within one (1) working day of any changes in coverage.

c. **Compliance with Applicable Law**. 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:
   (1) Title XIX and Title XXI of the Social Security Act and Title 42 of the Code of Federal Regulations.
   (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) Law enforcement or court inquiries regarding firearm permits. The Contractor shall respond in a full and timely manner to law enforcement or court requests for information necessary to determine the eligibility of a person to possess a pistol or to be issued a concealed pistol license under RCW 9.41.070 or to purchase a pistol under RCW 9.41.090.

d. **Confidentiality of Personal Information**:
   (1) The Contractor shall protect all Personal Information, records, and data from unauthorized disclosure in accordance with 42 CFR §431.300 through §431.307, RCWs 70.02, 71.05, 71.34, and for individuals receiving substance abuse services, in accordance with 42 CFR Part 2 and RCW 70.96A. The Contractor shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services. Pursuant to 42 CFR §431.301 and §431.302, personal information concerning applicants and recipients may be disclosed for purposes directly connected with the administration of this Agreement and the State Medicaid Plan. Such purposes include, but are not limited to:
      i. Establishing eligibility.
      ii. Determining the amount of medical assistance.
      iii. Providing services for recipients.
      iv. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan.
      v. Assuring compliance with federal and State laws and regulations, and with terms and requirements of the Agreement.
   (2) The Contractor shall (and require its subcontractors and providers to do so) establish and implement procedures consistent with all confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA)(45 CFR Parts 160 and 164) for medical records and any other health and enrollment information that identifies a particular Enrollee.
   (3) The Contractor shall prevent inappropriate access to confidential data and/or data systems used to hold confidential client information by taking, at a minimum, the following actions:
      - Verify the identity or authenticate all of the system's human users before

allowing them access to any confidential data or data system capabilities.
- Authorize all user access to client applications.
- Protect application data from unauthorized use when at rest.
- Keep any sensitive data or communications private from unauthorized individuals and programs.
- Notify the GCBH HIPAA Compliance Officer 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.

(4) In the event of a Breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from any GCBH 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.

(5) GCBH 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 GCBH data systems.

(6) The Contractor understands that GCBH reserves the right to withdraw access to any of its confidential data systems at any time for any reason.

e. **Declaration That Individuals Served Under the Medicaid and Other Mental Health Programs Are Not Third-Party Beneficiaries Under this Agreement**. Although GCBH and the Contractor mutually recognize that services under this Agreement shall be provided by the Contractor to individuals receiving services under the Medicaid program, and RCW 71.05, RCW 71.24, and RCW 71.34, it is not the intention of either GCBH 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.

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

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

h. **Medicaid State Plan Amendments.** If the Medicaid State Plan is amended the Contractor shall implement any changes to the provision of Medically Necessary mental health services no later than 30 calendar days following CMS approval of the amended plan.

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

period, whichever is later.

(1) The Contractor shall maintain records sufficient to:
   i. Maintain the content of all medical records in a manner consistent with utilization control requirements of 42 CFR §456, 42 CFR §456.111, and 42 CFR §456.211.
   ii. Document performance of all acts required by law, regulation, or this Agreement.
   iii. Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance.
   iv. Demonstrate the accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to GCBH and all expenditures made by the Contractor to perform as required by this Agreement.

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

(3) 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.

(4) GCBH shall maintain books, records, documents, and other materials relevant to this Agreement which sufficiently and properly reflect all payments made, including the Department's rate setting activities related to the Contractor, or other actions taken in regard to the Contractor's performance of the services described herein.

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

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* 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.

* = ***Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **<u>Must be the result of a mental illness.</u>**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate serious functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs

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* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* 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.

** = Descriptive Only*

	Level One - Brief Intervention	Level Two - Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)
Supports & Environment*	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One</u>, individuals may be referred for the following treatment: * Individual Treatment * Medication Monitoring * Peer Support The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

* = ***Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of an emotional disorder or a mental illness.**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 60 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 50 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

** = Descriptive Only*

	Level One - Brief Intervention	Level Two - Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)
Supports & Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

* = ***Descriptive Only***

	Level One - Brief Intervention	Level Two - Community Support
Minimum Modality Set	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:** * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment * Family Supports The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One,</u> individuals may be referred for the following treatment:** * Individual Treatment * Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults & Medicaid Older Adults
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for eligibility.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
	DEMENTIA	
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance	B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance	B
290.40	Vascular Dementia Uncomplicated	B
290.41	Vascular Dementia With Delirium	B
290.42	Vascular Dementia With Delusions	B
290.43	Vascular Dementia With Depressed Mood	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	B
294.10	Dementia Due to... (*Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance	B
294.11	Dementia Due to... (*Indicate the General Medical Condition not listed above)* With Behavioral Disturbance	B
---.--	Substance-Induced Persisting Dementia (*refer to Substance-related Disorders for substance specific codes)*	B
---.--	Dementia Due to Multiple Etiologies	B
294.8	Dementia NOS	B
	OTHER COGNITIVE DISORDERS	
294.9	Cognitive Disorder NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS **DEPRESSIVE DISORDERS**	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children & Youth
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental

health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for coverage.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B
307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A

	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	ANXIETY DISORDERS	

300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B

301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.
[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness
* At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
* Child is under six years of age and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:
    1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers).
    2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

Data Security Requirements

1. **Data Transport.** When transporting GCBH Confidential Information electronically, including via email, the data will be protected by:
   a. Transporting the data within the contractor's internal network, or;
   b. Encrypting any data that will be in transit outside the contractor's internal network. This includes transit over the public Internet.

2. **Protection of Data.** The contractor agrees to store data on one or more of the following media and protect the data as described:

   a. **Hard disk drives.** Data stored on local workstation hard disks. Access to the data will be restricted to authorized users by requiring logon to the local workstation using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards.

   b. **Network server disks.** Data stored on hard disks mounted on network servers and made available through shared folders. Access to the data will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

      For GCBH confidential data stored on these disks, deleting unneeded data is sufficient as long as the disks remain in a secured area and otherwise meets the requirements listed in the above paragraph. Destruction of the data as outlined in Section 4. Data Disposition may be deferred until the disks are retired, replaced, or otherwise taken out of the secure environment.

   c. **Optical discs (CDs or DVDs) in local workstation optical disc drives.** Data provided by GCBH on optical discs which will be used in local workstation optical disc drives and which will not be transported out of a secure area. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only authorized users have the key, combination or mechanism required to access the contents of the container. Workstations which access GCBH data on optical discs must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

   d. **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers.** Data provided by GCBH on optical discs which will be attached to network servers and which will not be transported out of a secure area. Access to data on these discs will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

   e. **Paper documents.** Any paper records must be protected by storing the records in a secure area which is only accessible to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

   f. **Access via remote terminal/workstation.** Data accessed and used interactively over the Internet.

Access to the data will be controlled by GCBH staff who will issue authentication credentials (e.g. a unique user ID and complex password) to authorized contractor staff. Contractor will notify GCBH IS staff on the same day an authorized person in possession of such credentials is terminated or otherwise leaves the employment of the contractor, and whenever a user's duties change such that the user no longer requires access to perform work for this Agreement.

g. **Data storage on portable devices or media.**
   (1) GCBH data shall not be stored by the Contractor on portable devices or media unless specifically authorized within the Special Terms and Conditions of the contract. If so authorized, the data shall be given the following protections:
      (a) Encrypt the data with a key length of at least 128 bits
      (b) Control access to devices with a unique user ID and password or stronger authentication method such as a physical token or biometrics.
      (c) Manually lock devices whenever they are left unattended and set devices to lock automatically after a period of inactivity, if this feature is available. Maximum period of inactivity before lockout is 20 minutes.
      (d) Physically protect the portable device(s) and/or media by:
         i. Keeping them in locked storage when not in use;
         ii. Using check-in/check-out procedures when they are shared; and
         iii. Taking frequent inventories.
   (2) When being transported outside of a secure area, portable devices and media with confidential GCBH data must be under the physical control of contractor staff with authorization to access the data.
   (3) Portable devices include, but are not limited to; handhelds/PDAs, Ultramobile PCs, flash memory devices (e.g. USB flash drives, personal media players), smart phones or cellular phones, portable hard disks, and laptop/notebook computers if those computers may be transported outside of a secure area.
   (4) Portable media includes, but is not limited to; optical media (e.g. CDs, DVDs), magnetic media (e.g. floppy disks, tape, Zip or Jaz disks), or flash media (e.g. CompactFlash, SD, MMC).

3. **Data Segregation.**
   a. GCBH data must be segregated or otherwise distinguishable from non-GCBH data. This is to ensure that when no longer needed by the contractor, all GCBH data can be identified for return or destruction. It also aids in determining whether GCBH data has or may have been compromised in the event of a security breach.

   b. GCBH data will be kept on media (e.g. hard disk, optical disc, tape, etc.) which will contain no non-GCBH data. Or,

   c. GCBH data will be stored in a logical container on electronic media, such as a partition or folder dedicated to GCBH data. Or,

   d. GCBH data will be stored in a database which will contain no non-GCBH data. Or,

   e. GCBH data will be stored within a database and will be distinguishable from non-GCBH data by the value of a specific field or fields within database records. Or,

   f. When stored as physical paper documents, GCBH data will be physically segregated from non-GCBH data in a drawer, folder, or other container.

   g. When it is not feasible or practical to segregate GCBH data from non-GCBH data, then both the GCBH data and the non-GCBH data with which it is commingled must be protected as described in this exhibit.

4. **Data Disposition.** When the contracted work has been completed or when no longer needed, data shall be returned to GCBH or destroyed. Media on which data may be stored and associated acceptable methods of destruction are as follows:

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

5. **Notification of Compromise or Potential Compromise.** The compromise or potential compromise of GCBH shared data must be reported to the GCBH Contact designated on the contract within one (1) business day of discovery.

6. **Data shared with Sub-contractors**. If GCBH data provided under this contract is to be shared with a sub-contractor, the contract with the sub-contractor must include all of the data security provisions within this contract and within any amendments, attachments, or exhibits within this contract. If the contractor cannot protect the data as articulated within this contract, then the contract with the sub-contractor must be submitted to the GCBH Contact specified for this contract for review and approval.

WA State Children's Mental Health System Principles

The Contractor agrees to move as quickly as is practicable to deliver services according to the Principles set forth below.

- **Family and Youth Voice and Choice**: Family and child voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and child-centered from the first contact with or about the family or child.
- **Team based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the family's vision.
- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved children and their caregivers, including children in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based**: Children are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant**: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the child/youth and family and their community.
- **Individualized**: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each child and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths Based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
- **Outcome-based**: Based on the family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional**: A child and family team's commitment to achieving its goals persists regardless of the child's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

CORE PRACTICE MODEL

PURPOSE

The Washington State Division of Behavioral Health and Recovery core practice model is an overarching framework for providing comprehensive behavioral health services and supports for children and youth with complex emotional and behavioral issues. The practice model provides the broad principles that inform and guide the management and delivery of mental health services and supports; describes the treatment and support activities that providers undertake; governs how services are coordinated among systems and providers; prescribes the means to measure and account for outcomes; provides relevant feedback to managers and clinicians so as to continuously improve system and services quality; and ensures cost-effective use of resources.

PRACTICE MODEL COMPONENTS

Practice components embrace wraparound principles employed within a statewide System of Care to the fullest extent feasible. Each individual case affords the child and family all of components 1-6 (below) over the course of treatment and transition.

1. ***Engagement***: Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the child and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.

2. ***Assessing***: Information gathering and assessing needs is the practice of gathering and evaluating information about the child and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children.

3. ***Service Planning and Implementation***: Service planning is the practice of tailoring supports and services unique to each child and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the child, family, and caregivers.

4. ***Teaming:*** Teaming is a process that brings together individuals agreed upon by the family who are committed to them through informal, formal and community support and service relationships. Where medically necessary and/or with cross system involvement, a formal Child and Family Team will be used.

5. ***Monitoring and Adapting***: Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.

6. ***Transition***: The successful transition away from formal supports can occur as informal supports are in place and providing needed support. Transition to the most normalizing activities and environments is consistent with the principle of treatment at the least restrictive level and the system values of recovery and resilience.