Thurston Mason BHO

BEHAVIORAL HEALTH ORGANIZATION
DETAILED PLAN

OCTOBER 29, 2015

CONTENTS

1

Introduction

Thurston and Mason counties appreciate the opportunity to submit the Thurston Mason Behavioral Health Organization (TMBHO) Detail Plan. This Plan describes how TMBHO is moving toward integration of mental health and substance use disorder services to become a fully operational behavioral health organization.

Thurston and Mason counties, herein after referred to as the "Counties," have had the good fortune of operating both the Regional Support Network and our chemical dependency programs (now called substance use disorder) together under the same county organizational structure for over twenty five (25) years. Five (5) years ago, the Counties made a decision to improve cross-system services by creating a new Counties-wide position to provide oversight to both substance use disorder programs and the Regional Support Network. This has allowed TMBHO to promote the beginnings of integration through the understanding that it is primarily a system that serves the same consumer population. When TMBHO looks at inappropriate utilization of the local jail population and emergency rooms by consumers displaying behavioral health issues, it is known that co-occurring services are necessary if the system is going to have a positive impact directing care in the most effective way.

In 2014, the Board of County Commissioners made a decision to merge both substance use disorder and the Regional Support Network programs into one program for both Counties. This program is now called Thurston Mason Behavioral Health Organization (TMBHO). This single entity has allowed TMBHO to begin the formulation of how it will integrate managed care administrative functions and services. Instead of discreet administrative functions for separate programs, TMBHO will now have an integrated managed care administrative staff of Care Managers, contract staff and management information system staff.

TMBHO submits this Plan with full intention and dedication to create an effective network for behavioral health care to serve the local community – one that will move it toward total integration with primary care. TMBHO has begun looking at how it can expand both current service capacity, continuum of care collaboration and service planning, and improve upon the overall quality of care provided. TMBHO is working closely with the local planning effort for health improvement called Thurston Thrives. This planning entity not only looks at behavioral health but at all social determinants of health for the local community. TMBHO is also working closely with the regional Accountable Community of Health entity – Cascade Pacific Action Alliance (CPAA). The TMBHO administrator is a member of the CPAA and participates on issues

related to how the behavioral health system can improve the five (5) county region for overall health care indicators.

As a result of TMBHO's participation in these planning entities – in anticipation of transitioning mental health and substance use disorder services into a single Medicaid Managed Care approach in Washington – TMBHO 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, TMBHO will be fully operational to conduct business in compliance with the TMBHO/DSHS contracts for mental health and substance use disorder services, hereafter 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 document, which serves as a cross reference to locate required responses and acknowledgement that TMBHO has read, understands and accepts the statutory and regulatory responsibility for performing its duties as a behavioral health organization (BHO).

2

General and Overall Transition Plan

Thurston Mason Regional Support Network (TMRSN) is well positioned to make a seamless transition to a fully functional behavioral health organization. TMRSN currently manages a network of mental health services for its counties through a strong governance structure, excellent stakeholder and customer relations, and robust systems for data, contract procurement and monitoring, utilization management, quality improvement, and compliance. Factors that will facilitate this transition include: 1) TMBHO will continue to serve its same geographic catchment area, 2) TMBHO is very familiar with the existing substance use disorder (SUD) services network, and 3) TMBHO has already begun hiring the staff necessary to support its new role and engaged in planning and communicating with key stakeholders to inform its decision-making as it prepares to meet the needs of the impacted communities.

In 2015, Thurston and Mason Counties reaffirmed their dedication to provide comprehensive health care, managed at the local level, to their two-county region. The prospect of becoming a behavioral health organization led to new discussions about the value of two counties working together to assure access to behavioral health services for the most vulnerable population. Part of the value and motivation of pursuing this initiative stems from the work that both counties, along with five other counties, are doing to form a regional Accountable Community of Health (ACH). These two counties have taken the lead to help create this new ACH called Cascade Pacific Action Alliance. These efforts helped clarify how the communities will require behavioral health care and work together as a region to promote effective and efficient care. As a result, these counties have agreed to continue to provide behavioral health care and to upgrade the existing Interlocal agreement for social services to create a behavioral health organization called Thurston Mason Behavioral Health Organization (TMBHO). The creation of this new organization declares its dedication to providing mental health, substance use disorder, and co-occurring disorder services to the low income/Medicaid population. The new TMBHO governance further ensures participation, parity, and accountability by both counties to meet the needs of their communities. The new TMBHO governance includes commissioners from both counties who will assume responsibility and lead the decision making process for the BHO. As a result, both counties now have a clear voice and ability to provide direction to meet the needs of their communities.

(160) Joint agreements of county authorities – required provisions.

(161) Joint agreements of county authorities – permissive provisions.

The Thurston Mason board has approved a new joint agreement to establish TMBHO (please see Attachment 2 – *TMBHO Interlocal Agreement 9-15*). 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 with the capability to lead the transition process and manage the business required by the four draft DSHS contracts. The management team of TMBHO has thoroughly reviewed the BHO requirements and completed a self-assessment of existing and needed capacity to manage the new SUD benefits and integrate them into business operations.

The TMBHO 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 (DPR) within each section of the plan. TMBHO 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 two most significant areas of development involved putting contracts in place and converting to an information technology (IT) platform that has more functionality than the current system.

3

Transition and Coordination of Services Plan

A key operating principle guiding TMBHO's initial *transition phase* is to avoid any significant disruption of the existing network of SUD providers and make the transition as seamless as possible for its consumers/enrollees. At the same time, TMBHO is committed to creating a system of care that integrates SUD services with mental health (MH) services, and also coordinates with the health care system to treat the "whole person" and support consumers / enrollees in their recovery. The high level of comorbidities in target populations with behavioral health disorders demands the evolution of health care systems to provide services in integrated settings, respecting the help-seeking preferences of its consumers/enrollees. Whether its consumers/enrollees choose to present in primary care settings or specialty behavioral health care settings, TMBHO is intent on developing relationships with provider and payer systems that meet their consumers/enrollees where they are and provides state-of-the-art evidence-based services.

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, and
- Transfer between BHOs.

Transitioning to Integrated Care

(280) Primary care and coordination of health care services

It is TMBHO's expectation that all of its Network Providers coordinate with primary health care providers (PCPs) as part of their overall obligations to the consumers/enrollees they serve. There are several different ways in which providers collect and gather physical health care information on consumers/enrollees. In the substance use disorder arena, clinicians use a bio-psychosocial assessment and as part of the American Society of Addiction Medicine (ASAM) Criteria, they gather any physical health information that can impede progress in a consumer's/enrollee's recovery process. Similarly, mental health clinicians and intake workers are required to ask physical health information on their intakes, as well as consider it when completing the LOCUS/CALOCUS – TMBHO's level of care instrument.

There are numerous TMBHO policies and procedures that support the coordination of care with PCPs. For example, the primary policy and procedure, "Care Coordination with Primary Care Providers and ERs" (CM-506), states:

A. TMBHO understands that physical disorders can impede progress toward mental health/substance use disorder (behavioral health) treatment goals, and may complicate an individual's ability to adhere to medical treatment plans. TMBHO will ensure the coordination of a consumer's/enrollee's physical and behavioral health care by:
    1. Contracting with Network Providers to communicate and coordinate with consumers'/enrollees' primary care providers and with emergency room services;
    2. Assuring that if a consumer/enrollee does not have a primary care provider, Network Providers and TMBHO Care Managers will make referrals and support access to a primary care provider;
    3. If the consumer/enrollee has a primary care provider, documenting the name and the date of the last physical;
    4. Collaborating with the local community health clinics and other available providers to assure that consumers/enrollees have access to physical care as needed.

Another policy and procedure, "Coordination and Continuity of Care" (CM-502), states:

A. TMBHO and contracted providers shall ensure that the behavioral health service delivery system protocols incorporate the coordination and integration of services across all systems of care, to include but not be limited to:
    1. Populations with special health care needs;
    2. Native American/Indian children;
    3. Children served by DSHS Juvenile Rehabilitation Administration;
    4. Children served by Children's Administration;
    5. Adults and older adults served by DSHS Aging and Adult Services Administration;
    6. Adults transitioning out of the criminal justice system;
    7. Enrollees/consumers being discharged to another system of care;
    8. Enrollees transitioning between levels of care and/or care providers;
    9. Individuals transitioning to or from outpatient and inpatient services;
    10. Individuals integrating back into the community; and
    11. Individuals dually enrolled in allied systems.
B. TMBHO and contracted providers will assure that care coordination activities are provided for at least the following:
    1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT);
    2. High risk consumers/enrollees;
    3. Frequent users of crisis services, the emergency room and inpatient services;
    4. Primary care and emergency room care utilized by consumers/enrollees;
    5. Inpatient and community care; and
    6. Special populations to include:

a) Children,
b) Older adults,
c) Ethnic minorities, and
d) Persons with disabilities in addition to mental illness.

C. Contracted providers shall:
1. Assure coordination and continuity of care in the delivery of behavioral health services;
2. Implement a mechanism to identify enrollees/consumers with other special health care needs or involvement in other systems; and
3. Implement procedures that address the identification, assessment, and treatment planning for coordination of care, and a mechanism for direct access to specialists as warranted.

While this policy (CM-502) is broad in its scope – to include many different ancillary providers and different consumer/enrollee experiences – it clearly obligates the Network Provider to assist consumers/enrollees with health care challenges.

Yet another TMBHO policy and procedure, "Allied System Coordination" (SD-220), requires that TMBHO develop relationships (through contracts and/or MOUs) with other allied community partners. This fairly broad policy requirement, which TMBHO must fulfill, obligates TMBHO to develop ongoing relationships with PCPs within the community. Key policy statements and procedural requirements from this policy include:

B. TMBHO will develop written allied system coordination plans for each of the programs identified in the Prepaid Inpatient Health Plan Contract (PIHP) between the Department of Social and Health Services (DSHS) and TMBHO. Programs will be added/dropped as needed per contract requirements.
C. Each allied system coordination plan will contain, at a minimum, the following:
1. Clarification of roles and responsibilities of allied systems in serving persons mutually served;
a) For children this includes EPSDT coordination for any child serving agency, including a process for participation by the agency in the development of cross-system Individual Service Plan when indicated under EPSDT;
2. Processes for sharing of information related to eligibility, access, and authorization;
3. Identification of needed local resources, including initiatives to address those needs;
4. Process for facilitation of community reintegration from out-of-home placements (e.g., state hospitals, CLIP, Juvenile Rehabilitation Administration facilities, foster care, skilled nursing facilities, acute inpatient settings) for consumers/enrollees of all ages;
5. A process to address disputes related to service or payment responsibility; and
6. A process to evaluate cross-system coordination and integration of services.

Procedures:

A. TMBHO Administrator will assign responsibility for development of the coordination plans and any written agreements or Memorandum of Understanding (MOU) that support each allied system to a designated TMBHO Care Manager.
B. The TMBHO Care Manager will be responsible for working collaboratively with the designated liaison(s) from each allied system to identify any concerns and to assure that mutual consumers/enrollees are provided with the most appropriate care and continuous services without interruption.
C. TMBHO will monitor the coordination plans to evaluate processes for effectiveness and efficiency of coordination and integration of service delivery.
D. TMBHO will review the coordination plans at least annually, update plans as required, and identify and address additional allied systems of care as needed.
E. TMBHO will review and update policies, plans and agreements as needed to maintain compliance with requirements of federal or state legislation or DSHS contracts.
F. Per contract, Network Providers will adhere to TMBHO's Allied System Plan, Agreements, or MOU's and will work collaboratively with all identified Allied Systems.

With regards to actual care coordination between providers of behavioral health services and PCPs, TMBHO has offered guidance in the form of protocols and procedures (CM-506). During regular and ongoing clinical chart reviews, TMBHO checks that this coordination is occurring on a regular basis. Procedures designed to assist Network Providers include:

A. Network Providers shall assure that case managers assist consumers/enrollees with communication and coordination of care with primary care providers.
B. Providers shall assure that consumer's/enrollee's medical issues and need for medical care are addressed at intake and at any treatment juncture that the issues arise. The case manager and the consumer/enrollee will develop a treatment plan to include the appropriate use of medical and emergency care services, with the goal of supporting the consumer/enrollee in overcoming barriers and progressing toward recovery.
C. Provider case managers shall collaborate with PCPs to develop or modify the consumer's/enrollee's medical treatment plan to effectively identify and address behavioral health symptoms that may complicate the consumer's/enrollee's recovery.
D. Providers shall ensure that appropriate release(s) of information are obtained from consumers/enrollees for other healthcare providers, in compliance with HIPAA and 42 CFR Part 2 rules and regulations.
E. Providers shall collaborate with the consumer's/enrollee's PCP to exchange information relating to past, present, and future treatment interventions, so involved providers have a comprehensive case overview of the individual. Consumer/enrollee information exchanged may include:
    1. Medical History and Physical (H&P);

2. Demographic Information;
3. Assessments;
4. Treatment Plan;
5. Progress Notes;
6. Diagnosis;
7. Pharmacology; and
8. Social Assessments.

F. Provider case managers should collaborate with the primary care physician to update information when there is a change in the treatment plan or general condition of the consumer/enrollee.

G. TMBHO Care Managers will assist consumers/enrollees by making referrals to appropriate community or Medicaid providers and by providing assistance in completing the application if needed.

H. For enrollees that are stabilized and in recovery, providers may transfer the management of medications and prescriptive authority to the enrollee's PCP in accordance with standard medical protocol, in a manner that does not leave the enrollee without medication or medical management. Providers shall continue to be available to the enrollee's PCP for telephone consultation on psychotropic medication management as needed. Enrollees shall be provided with support during the transition that includes education and information about their medication and the reason for the transfer. TMBHO Care Managers may be consulted to assist with coordination of care.

I. Other points of coordination with PCPs include:
   1. TMBHO's contracted Network Provider's psychiatric medical staff provides consultation and support to community PCPs that may have concerns regarding psychotropic medications and/or behavioral health issues for TMBHO enrolled consumers/enrollees. Entities such as Healthy Option Plan physicians, PCPs at nursing homes, and other community-based physicians providing services to TMBHO consumers/enrollees have access to this service.
   2. With the support of TMBHO, Network Provider clinical staff provides outreach to a consumer's/enrollee's primary care provider to facilitate care coordination as requested by either party.
   3. A Network Provider clinical staff coordinates consumers/enrollees in participating in specialized medical services in the community as needed. For instance, TMBHO consumers/enrollees are encouraged to participate in Hospice and Grief and Bereavement Services, when appropriate. This is an important part of treating the whole person.
   4. PCPs that work with or refer to TMBHO through EPSDT to provide services to children are included in the individual service plan as part of our interdisciplinary team approach to treatment.

5. In accordance with the TMBHO's service contract with Network Providers, in all instances of care where a consumer/enrollee also requests involvement of their PCP in the treatment, the Network Provider will comply.

J. Key points of coordination with emergency rooms include:
   1. Provider case managers and/or provider crisis staff shall respond to requests and collaborate with emergency room (ER) staff and the enrollee/consumer, to identify the reasons the individual requests emergency care, and if any less restrictive, less costly and more appropriate interventions are available. TMBHO Care Manager(s) may assist/consult with the emergency room staff to identify resources, remove barriers, and problem solve.
   2. Contracted providers and crisis service (E&T) have 24 hours a day, seven days a week access to TMBHO consumer's/enrollee's BHO enrollment status and crisis plans to assist the consumer's/enrollee's individualized care when presenting to the ER.
   3. Local law enforcement will have 24 hours a day, seven days a week access to a triage facility so that consumers are diverted from correctional placements in jails, when appropriate. This will reduce unnecessary placements into jails and/or emergency rooms.
   4. Consumers/enrollees may choose to have Advanced Directives available to emergency rooms to assist the crisis service staff as necessary.
   5. Behavioral health services provided in emergency rooms are available to divert a consumer/enrollee from inpatient psychiatric care or to help support a consumer's/enrollee's compliance with appropriate medical care.
   6. All regional ERs have access to the TMBHO hospital liaison/Care Manager to coordinate placement, diversion or follow-up service needed to assist TMBHO consumers/enrollees and un-enrolled persons presenting at the ER.
   7. Designated Mental Health Professional (DMHPs) are able to refer individuals to inpatient care and to hospital diversion services, including the E&T Crisis Stabilization and Transitional Unit (CSTU) and Fairfax, Two Rivers Landing, and Kitsap E&T for children when appropriate.
   8. Admission to inpatient/E&T care from the ER is coordinated for all referrals requiring voluntary admission through 24/7 direct access with the TMBHO Care Manager, the Evaluation and Treatment Unit (ETU) of the E&T, and community inpatient psychiatric providers. An inpatient certification specialist works with the ER to coordinate care and all placement issues.
   9. Network Providers are required by contract with TMBHO to respond to requests from the emergency room staff to provide supportive services to TMBHO consumers/enrollees when requested to do so by the ER staff, family member, consumer/enrollee, advance directive.

10. TMBHO Care Managers maintain primary contact with the local emergency rooms and coordinate referrals to contracted Network Providers to ensure that there is appropriate access for behavioral health services.
11. Staff from the E&T crisis, inpatient and triage units meet regularly with emergency room physicians and crisis services staff to ensure coordination of care.

For children and adolescents TMBHO, along with all other BHO's, still must follow the requirements set forth under EPSDT. TMBHO has a policy and procedure on EPSDT (CM-504) that outlines these requirements. Major policy statements under this include:

A. TMBHO will ensure that Network Providers coordinate EPSDT assessment and early intervention in accordance with the Pre-paid Inpatient Health Plan (PIHP) contract, or any successor.
B. TMBHO will incorporate the following requirements into its care management, network management, and quality management activities:
    1. Identification of a children's Care Manager to assure communication between behavioral health providers and physicians, juvenile justice, K-12 education, child welfare staff, and foster care to reduce fragmentation and duplication of efforts among systems serving children and to control costs.
    2. Provision of intake evaluations for EPSDT-eligible children by qualified Child Mental Health Specialists for children/youth ages birth through seventeen (17) years and/or by a mental health professional for Medicaid enrollees' ages eighteen (18) through 20 years.
    3. Provision of behavioral health services to EPSDT children in a culturally- and age-appropriate manner that involves family members, when appropriate.
    4. Communication between Network Providers and medical providers regarding the coordination of EPSDT services.
    5. Assignment of appropriate level of care (LOC) for EPSDT children/youth.
    6. Provision of an Individual Service Team (IST) for all appropriate EPSDT level of care multi-system children/youth that develops cross-system treatment goals.
    7. Monitoring of EPSDT services at both the Network Provider and TMBHO level.

The above referenced policies and procedures as well as existing agreements can be found in Attachment 3.

Transitioning SUD Services into Managed Care

(19) Comprehensive program of SUD treatment.

As Thurston Mason RSN moves into becoming TMBHO, it has hired two additional Care Managers both with a Chemical Dependency Professional certification to ensure substance use disorder services merge into managed care in a seamless way. TMBHO plans to issue new contracts with the current provider network that covers outpatient and intensive outpatient

services from April 1 through December 31, 2016. This intentional strategy is to ensure that providers have intensive technical assistance from Care Managers to adjust to the new contracting requirements throughout the beginning stages of this transition into managed care. For residential services, TMBHO intends to contract with the statewide BHO residential network and establish a qualified provider network of residential providers.

TMBHO fully anticipates being ready to offer the full continuum of behavioral health services on April 1, 2016. This includes SUD residential placements. While there may be additional work establishing the SUD residential network in the coming year, TMBHO has already begun to develop strategies to solidify the immediate network soon after it officially becomes a BHO. On and after January 1, 2017, with the goal of regionalizing the Provider Network and offering specialty services, TMBHO plans to issue Requests for Information/Proposals as well as continuing with existing contracts. This also includes solidifying contracts with the statewide BHO residential network.

All of this is to ensure that full continuum of care is offered across the entire behavioral health spectrum, including the full ASAM continuum of care. TMBHO will be ready to serve consumers/enrollees, both Medicaid and non-Medicaid (as resources allow), by April 1, 2016. Please also see DPR items #273 and 279 for the current and proposed SUD services and the SUD modalities and additional services available). For SUD services, the full ASAM continuum will be included:

- 0.5 Early Intervention
- 1.0 Outpatient Services
- 2.0 Intensive Outpatient/Partial Hospitalization Services
  - 2.1 Intensive Outpatient Services
  - 2.5 Partial Hospitalization Services
- 3.0 Residential/Inpatient Services
  - 3.1 Clinically Managed Low-Intensity Residential Services
  - 3.3 Clinically Managed Population-Specific High-Intensity Residential Services
  - 3.5 Clinically Managed High-Intensity Residential Services
- 3.2 Clinically Managed Residential Withdrawal Management

Priority Populations

TMBHO will conduct a needs assessment to identify populations in Thurston and Mason counties in need of treatment services. The following language will be present in all TMBHO contracts to address priority populations:

A. The Contractor shall ensure treatment admissions are prioritized in the order as follows:
   1) Medicaid eligible individuals
   2) Pregnant injecting drug users
   3) Pregnant substance abusers

4) Injecting drug users
5) Other (in no priority order)
    a) Postpartum (up to one year, regardless of pregnancy outcome)
    b) Parenting persons
    c) Youth
    d) Offenders
    e) Patients transitioning from residential care to outpatient care.

B. The Contractor shall publicize information on priority populations. Priority population information must be posted in a public area.

Funding

TMBHO will fund SUD services with a combination of federal, state, and local resources. It will also incorporate private funds and coordinate with other sources of supports for the benefit of its consumers/enrollees. The use of the county's Treatment Sales Tax is described below:

The Revised Code of Washington (RCW) 82.14.460 stipulated that one tenth (1/10) of one percent (1%) of collected sales tax dollars go towards services that would reduce the negative impacts of mental health and substance abuse on children, families and adults with an emphasis on those individuals involved with, or at risk of, involvement with the jail/correctional system. In 2009, the Thurston County Board of County Commissioners adopted Ordinance #14138 that further defined how this revenue should be spent. After a lengthy cross-departmental collaborative process and public review, TMRSN secured funding for several programs during this period, looking to either offset state funding reductions for services or to fund services not otherwise covered by Medicaid. Some of these programs included:

- **The Mentally Ill Offender Program (MIO)** – MIO is a program that provides mental health and crisis services to incarcerated adults in the Thurston and Mason County Jails. MIO services include: (1) identifying incarcerated adults who are mentally ill and in need of mental health services, (2) on-site crisis services, (3) referrals to other key services such as outpatient mental health treatment, (4) enrollment in publicly-funded benefits when the participant is released from jail, and (5) diversion alternatives to incarceration (i.e. Thurston County Mental Health Court), if appropriate.
- **Mentally Ill Juvenile Offender Program (MIJOP)** – Similar to the adult MIO program, MIJOP provides on-site services to youth in the Thurston and Mason County Juvenile Justice system. Services emphasize support of the family to help the adolescents re-engage successfully in the community.
- **Multisystemic Therapy (MST)** – MST is a program used with severely behaviorally challenged and substance-abusing juvenile offenders (ages 11 – 17). Therapy focuses on promoting positive social behavior while decreasing antisocial behavior and can occur in the home, school, or other community setting. MST is family-oriented, based on the

philosophy that the most effective and ethical route to help youth includes helping their families.

- **Mason-Thurston Wraparound Initiative (MTWI)** – MTWI provides high-fidelity wraparound supports modeled after the principles of the national wraparound model. MTWI is not a treatment program; rather, it is a community-based family planning process that shows promise in reducing the number of children placed in more restrictive settings (e.g. therapeutic foster care, psychiatric hospitals) due to improvements in behavior and functioning. MTWI is voluntary; however, the approach is highly participatory as the family or caregiver of the child must be committed to engage in team development, goal setting, and implementing the strategies and/or services identified by the team.
- **Co-occurring Disorders Intensive Case Management** – These services provide case management services to adults to reduce their risk for future justice involvement and support their entry into recommended substance use disorder and/or mental health treatment, including housing assistance and additional housing case management**.**
- **Thurston County Superior Court Felony Drug/DUI Court Program** – This program provides behavioral health services for consumers/enrollees who would benefit, and are expected to succeed, from a diversion program. The court is a specialized program wherein treatment services are mandated in lieu of jail time, or a reduced jail sentence.
- **Mental Health Court** – An evidence-based practice that combines a specialized court docket with mental health care coordination and treatment for individuals who can be diverted from jail or have their length of stay in jail reduced.
- **Youth Outpatient Treatment (YOT)** – YOT provides substance use disorder treatment services to adolescents from rural areas with the goal of reducing their risk for future justice involvement and dropping out of school.
- **Family Recovery Court** – This program provides a holistic, integrated, and collaborative response to help parents with substance use disorders recover in order to rebuild their lives, reclaim their futures, and reunite with their children.

Mason County also passed a one tenth (1/10) of one percent (1%) of collected sales tax dollars to go towards treatment services. With the new TMBHO Governance Board, level of parity, and commitment to the needs of both communities, TMBHO anticipates Mason County will also contribute a portion of their funding towards behavioral health treatment programs, allowing for additional and expanded services.

There are several new SUD trends emerging in TMBHO communities that will require attention during the transition of services into managed care. These trends, and TMBHO's plans for addressing them, are described below.

Through epidemiological resources within Thurston County Public Health and Social Services and the WA Department of Social and Health Services, TMBHO will continually monitor substance use trends as related to the Thurston Mason region through data from sources such as the WA Healthy Youth Survey and the Behavioral Risk Factor Surveillance System.

Additionally, within our provider network, TMBHO will monitor substance use trends through service encounter reporting, and work with SUD service providers to implement programming changes to best address drug specific challenges. Further, TMBHO will offer continuing education opportunities through federal and state accredited sources, such as the Washington State Division of Behavioral Health and Recovery (DBHR) and SAMHSA, for providers to stay informed of emerging trends and regulatory changes.

Voluntary and Involuntary SUD Treatment

There are several aspects to voluntary and involuntary SUD treatment that TMBHO 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.

The following procedures for the review and determination of medical necessity for minors admitted to inpatient facilities for SUD treatment will be implemented beginning April 1, 2016:

- Once admitted under RCW 70.96A.245, the TMBHO Care Manager, a chemical dependency professional, conducts a review not less than seven nor more than fourteen days following the date the minor is brought to the facility to determine if inpatient services are medically necessary, which includes:
  - The clinical expertise of the treatment provider,
  - The safety of the minor,
  - The likelihood the minor's chemical dependency recovery will deteriorate if the minor is released from inpatient treatment,
  - The wishes of the parent/guardian.
- If TMBHO determines it is no longer medically necessary for a minor to receive inpatient treatment, TMBHO shall immediately notify the parent/guardian and the professional person in charge. The professional person in charge shall release the minor to the parent/guardian within twenty-four hours of receiving notice.
- If the professional and parent/guardian believe it is medically necessary for the minor to remain in inpatient treatment, the minor is discharged on the second judicial day following TMBHO’s determination to allow the parent/guardian time to file an at-risk youth petition.

- If TMBHO determines outpatient services are medically necessary for the minor and he/she refuses services, this refusal is grounds for at-risk youth petition.

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

TMBHO will insert the following language from RCW 70.96A.110 into contracts to adhere to voluntary treatment of individuals with a substance use disorder. Compliance will be monitored during onsite visits.

1. An individual with a substance use disorder may apply for voluntary treatment directly to an approved treatment program. If the proposed patient is a minor or an incompetent person, he or she, a parent, a legal guardian, or other legal representative may make the application.
2. Subject to rules adopted by the secretary, the administrator in charge of an approved treatment program may determine who shall be admitted for treatment. If a person is refused admission to an approved treatment program, the administrator, subject to rules adopted by the secretary, shall refer the person to another approved treatment program for treatment if possible and appropriate.
3. If a patient receiving inpatient care leaves an approved treatment program, he or she shall be encouraged to consent to appropriate outpatient treatment. If it appears to the administrator in charge of the treatment program that the patient is an individual with a substance use disorder who requires help, the department may arrange for assistance in obtaining supportive services and residential programs.
4. If a patient leaves an approved public treatment program, with or against the advice of the administrator in charge of the program, the discharging program may make reasonable provisions for his or her transportation to another program or to his or her home. If the patient has no home, he or she should be assisted in obtaining shelter. If the patient is less than fourteen years of age or an incompetent person, the request for discharge from an inpatient program shall be made by a parent, legal guardian, or other legal representative or by the minor or incompetent person if he or she was the original applicant.

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

TMBHO will insert the following language into contracts to adhere to requirements set forth in RCW 70.96A.120. Compliance will be monitored during onsite visits.

1. An intoxicated person may come voluntarily to an approved treatment program for services. A person who appears to be intoxicated in a public place and to be in need of help, if he or she consents to the proffered help, may be assisted to his or her home, an approved treatment program, or other health facility.

2. Except for a person who may be apprehended for possible violation of laws not relating to alcoholism, drug addiction, or intoxication, and except for a person who may be apprehended for possible violation of laws relating to driving or being in physical control of a vehicle while under the influence of intoxicating liquor or any drug, and except for a person who may wish to avail himself or herself of the provisions of RCW 46.20.308, a person who appears to be incapacitated or gravely disabled by alcohol or other drugs and who is in a public place or who has threatened, attempted, or inflicted physical harm on himself, herself, or another, shall be taken into protective custody by a peace officer or staff designated by the county and as soon as practicable, but in no event beyond eight hours, brought to an approved treatment program for treatment. If no approved treatment program is readily available, he or she shall be taken to an emergency medical service customarily used for incapacitated persons. The peace officer or staff designated by the county, in detaining the person and in taking him or her to an approved treatment program, is taking him or her into protective custody and shall make every reasonable effort to protect his or her health and safety. In taking the person into protective custody, the detaining peace officer or staff designated by the County may take reasonable steps, including reasonable force if necessary, to protect himself or herself. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.
3. A person who comes voluntarily or is brought to an approved treatment program shall be examined by a qualified person. He or she may then be admitted as a patient or referred to another health facility, which provides emergency medical treatment, where it appears that such treatment may be necessary. The referring approved treatment program shall arrange for his or her transportation.
4. A person who is found to be incapacitated or gravely disabled by alcohol or other drugs at the time of his or her admission or to have become incapacitated or gravely disabled at any time after his or her admission, may not be detained at the program for more than seventy-two hours after admission as a patient, unless a petition is filed under RCW 70.96A.140, as now or hereafter amended, provided that the treatment personnel at an approved treatment program are authorized to use such reasonable physical restraint as may be necessary to retain an incapacitated or gravely disabled person for up to seventy-two hours from the time of admission. The seventy-two hour periods specified in this section shall be computed by excluding Saturdays, Sundays, and holidays. A person may consent to remain in the program as long as the physician in charge believes appropriate.
5. A person who is not admitted to an approved treatment program, is not referred to another health facility, and has no funds, may be taken to his or her home, if any. If he or she has no home, the approved treatment program shall provide him or her with information and assistance to access available community shelter resources.

6. If a patient is admitted to an approved treatment program, his or her family or next of kin shall be notified as promptly as possible by the treatment program. If an adult patient who is not incapacitated requests that there be no notification, his or her request shall be respected.
7. The peace officer, staff designated by the county, or treatment facility personnel who act in compliance with this chapter and are performing in the course of their official duty are not criminally or civilly liable therefor.
8. If the person in charge of the approved treatment program determines that appropriate treatment is available, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

TMBHO, upon approval of its governing board, will provide secure ASAM Level 3.7 – Withdrawal Management in a medically monitored inpatient program at the Thurston County Triage Center. This level of care will be suitable to provide emergency medical service as outlined in Section 2 of RCW 70.96A.120 as it is a 24-hour service delivered by medical and nursing professionals and staffed by physicians. The chemical dependency professionals and/or chemical dependency professional trainees, will work closely with the TMBHO Intensive Case Manager (ICM), TMBHO Housing Case Manager (HCM), and the Provider Network for coordination of continued care. Additionally, TMBHO plans to contract with withdrawal management providers through a Request for Information (RFI) process for those consumers/enrollees needing a lower level of withdrawal management services. See the program descriptions below for more information on the TMBHO ICM/HCM program.

(27) Involuntary commitment.

The program for involuntary commitment (ITA) for SUD treatment includes:

- Intensive Case Management,
- Designated Involuntary Commitment Specialist,
- Housing Case Management.

Intensive Case Management (ICM): Northwest Resources provides ICM services (funded by local Treatment Sales Tax) to consumers/enrollees in the community who need mental health or substance use disorder treatment. These referrals come from Providence St. Peter Hospital, Capital Medical Center, Thurston County Jail, Olympia Jail, Providence St. Peter Hospital One-South, Syringe Exchange, Crisis Clinic, and concerned family and friends. ICM facilitates rapid access to services for individuals by providing assessments and placing consumers/enrollees into withdrawal management or treatment. The case manager contacts the Designated Involuntary Commitment Specialist after the assessment if the consumer/enrollee has presenting needs suitable to involuntary commitment services.

Designated Involuntary Commitment Specialist: Any contractor providing ITA services will adhere to the following Network Provider contract language:

The Contractor shall provide Involuntary Commitment Services to Thurston and Mason County residents in accordance with the provisions outlined in RCW 70.96A120-70.96A.140 and WAC 388-805.

The Contractor shall:

1. Designate a staff member as the Involuntary Commitment Specialist and provide the County with the staff member's name. The Contractor shall inform the County of any staff changes that may occur during the Contract period.
2. Investigate and evaluate the allegations, reliability and credibility of information presented for alcohol and drug involved individuals who may require protective custody, detention and/or involuntary commitment services, according to the following:
    a. The person is chemically dependent and presents the likelihood of serious harm or is gravely disabled by alcohol or drug addiction, or has twice before in the preceding 12 months been admitted for detoxification, sobering services, or chemical dependency treatment and is in need of more sustained treatment; or
    b. Chemically dependent and has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed to an appropriate program;
    c. Referrals for ITA evaluation may be made by family members, friends, attorneys, Department of Corrections, jails, shelters, chemical dependency or mental health professionals, detoxification facilities and others;
    d. If allegations are substantiated, the Contractor shall petition the Court and perform the necessary duties relative to the Court process.
3. Arrange for placement and transportation in a state-approved facility for involuntary treatment.
4. Participate in cross systems training as required by the County with the Crisis Triage Center staff.

The current contract is with Providence St. Peter's Chemical Dependency Center. They have a current MOU with Behavioral Health Resources to present at mental health ITA commitment hearings.

Furthermore, when a TMBHO Designated Involuntary Commitment Specialist determines that the initial needs of an evaluated person would be better met by a mental health professional, the specialist will refer the consumer/enrollee to a TMBHO Designated Mental Health Professional (DMHP) or to TMBHO's mental health evaluation and treatment (E&T) facility. TMBHO intends to ensure future Designated Involuntary Commitment Specialists are dually

credentialed, as it continues to enhance its workforce to strengthen integrated care coordination. The DMHP will follow the protocol established for evaluating the person's mental health needs and whether criteria are met for an involuntary mental health detainment. If so, the DMHP will follow TMBHO and state of Washington regulations for beginning the legal process for involuntary detainment.

Currently, TMRSN has the facility, personnel, and processes in place for DMHPs to evaluate and make determinations regarding involuntary mental health detainments. The facility, personnel, and processes will remain in operation by April 1, 2016 and thereafter.

Housing Case Management (HCM): This local Treatment Sales Tax funded program is provided by Northwest Resources. Referrals are secured from ICM, Thurston County Drug Court, Thurston County consumers/enrollees and their families, Thurston County Mental Health Court, and the Thurston County Jail. The part-time Housing Case Manager helps consumers/enrollees to access housing and provides case management support for employment, life skills, and individualized services geared to support consumer's/enrollee's housing stability and recovery.

In order to ensure high quality care management, TMBHO intends to create a process in which the TMBHO Care Managers work with an ICM team to provide timely and effective assessments, placements, and transitions between levels of care.

In addition to the services mentioned above, TMBHO has established informal agreements with the following correction facilities to facilitate access to incarcerated individuals in order to conduct interviews with those who may qualify for ITA services:

- Nisqually Tribal Jail
- Skokomish Tribal Jail
- Olympia City Jail
- Lewis County Jail
- Thurston County Jail
- Mason County Jail

Residential: TMBHO expects to secure contracts with residential providers through an RFI process identifying criteria unique to the needs of the ITA population.

Partial Hospitalization Services/Day Treatment and Supportive Housing: TMBHO intends to provide day treatment for SUD consumers/enrollees in need of higher intensity services than traditional outpatient services. This service will be used as an initial ASAM placement along with a step-down from residential services. Day treatment, funded by Medicaid, coupled with Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars for Supportive Housing, fills a significant gap – lack of housing – in the current ITA process.

Emergency Departments: TMBHO intends to work collaboratively with regional emergency departments to establish formal protocols for referrals to the ICM/HCM program.

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

TMBHO will insert language into contracts to adhere to requirements set forth in RCW 70.96A.142 regarding evaluation by a chemical dependency specialist. Compliance will be monitored during onsite visits. Additionally, procedures will be developed, with the current designated chemical dependency specialist, to ensure coordination of care.

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 or she may need chemical dependency treatment.
2. When an offender under supervision of the department of corrections is court-ordered to treatment in the community, 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 supervision of the department of corrections and court-ordered to treatment in the community 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.

(48) Criminal justice treatment account.

TMBHO is aware of and will adhere to the CJTA regulation language set forth in RCW 70.96A.350. Specifically, TMBHO will ensure substance use disorder treatment services are

provided to persons enrolled in treatment under the criminal justice treatment account (CJTA) by inserting specific language into contracts and by conducting onsite monitoring to ensure compliance, no less than annually.

TMBHO intends to continue the process of utilizing the CJTA panels to update and submit strategic plans for Thurston and Mason. These panels have the ability to identify service needs in the communities and use funds accordingly. The current funds support two drug courts, one outpatient treatment program, and one specialty SUD assessment program.

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 TMRSN and a proposal for transitioning the process to meet the requirements which will be effective July 1, 2018.

TMRSN's current process for discharge planning (based on WSH-RSN Agreement):
When a TMRSN patient is admitted to Western State Hospital (WSH), TMRSN's WSH Liaison meets with the consumer/enrollee, contacts the consumer's/enrollee's ward social worker, and participates in the consumer's/enrollee's scheduled treatment team meetings at WSH. The Liaison collaborates with the consumer's/enrollee's WSH treatment team to monitor the consumer's/enrollee's treatment progress, legal status, and WSH's determination of the consumer's/enrollee's readiness for discharge. WSH's Patient Financial Services team researches the consumer's/enrollee's financial status and benefit eligibility for the time of discharge. Home and Community Services personnel located on the WSH campus evaluate consumers/enrollees likely to be eligible for Medicaid benefits at the time of discharge to determine eligibility for Home and Community placement and personal care services following discharge from the hospital to the community. The Liaison researches appropriate placement and follow-up outpatient treatment options accordingly. TMRSN facilitates a monthly meeting of professionals from multiple organizations that play a role in discharge planning and service provision for consumers/enrollees nearing discharge readiness. The purpose of the meeting is to identify discharge obstacles and establish plans to address them so the discharge can move forward.

Below is the proposal for transitioning the existing process to meet the requirement to arrange for WSH discharge for the consumer/enrollee within 21 days of WSH's determination that the person no longer requires active psychiatric treatment at the inpatient level of care:

- TMBHO proposes the development of expanded step-down placement and service options available for consumers/enrollees discharging from WSH.

- TMRSN currently discharges the majority of consumers/enrollees to Adult Family Homes, the Crisis Stabilization and Transition Unit, or to independent community living.
- TMBHO plans to establish a step-down program located in a community residential setting for consumers/enrollees discharging from hospital care and not qualifying for current placement options.
- Consumers/enrollees will be referred to Intensive Outpatient Program services, already established within the network.

The TMRSN process for discharge of minors and the TMBHO proposal is below:

- TMRSN closely monitors all involuntary commitments of minors. When a youth is placed on a 180-Day involuntary commitment, that youth is placed in the queue for Children's Long-term Inpatient Program (CLIP) services. Upon notification, TMRSN immediately assigns the case to the TMRSN CLIP Liaison to begin tracking and care coordination.
- The CLIP Liaison obtains necessary releases from the minor and begins coordinating with the family, CLIP Coordinator, and CLIP facility. The CLIP Liaison facilitates a family visit to the CLIP facility, when desired and time allows. The Liaison also participates in the CLIP admission meeting.
- Following admission, the Liaison coordinates with the CLIP facility as needed and participates in all Treatment Plan Reviews (TPR). The Liaison also discusses the wraparound process with the minor and family and facilitates enrollment into one of the TMBHO fidelity wraparound programs.
- The Liaison and Wraparound Team work very closely with CLIP staff and are keenly aware of the minor's progress. Because the minor's readiness for a successful transition back into the community is so dependent on a strong community plan (stable living environment, education plan, prosocial activities, appropriate treatment/supports, etc.), collaborative discharge planning is ongoing and includes the minor, family, CLIP staff (including the attending psychiatrist), and Thurston Mason community team (Liaison and Wraparound Team). Therefore, when the attending psychiatrist determines that inpatient psychiatric services are no longer medically necessary, it is not a surprise and much of the discharge plan is already developed.
- The TMBHO proposal for meeting the 2018 requirements is that the CLIP Liaison and Wraparound Team make themselves available in-person and by phone to ensure that a formal individualized discharge plan is completed within 21 days of determination. This always includes a screening for Wraparound with Intensive Services (WISe) and then enrollment in that program, continuation of fidelity wraparound, or enrollment in other supports as needed.

Court-ordered Treatment for Minors

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

Coordination with the CLIP Administration. Although a BHO authorization is not required for involuntary placement into an inpatient setting, TMBHO is immediately notified when an individual is detained under the Involuntary Treatment Act (ITA). TMBHO closely monitors all involuntary commitments of minors and engages the TMBHO Children's Mobile Crisis and Stabilization Team in the treatment process. If the court determines that the youth does not meet criteria for a 180 commitment, transition planning, care, and linkage to appropriate community based services is provided by and/or coordinated through the Mobile Crisis Team.

If the youth is committed for a 180 day hold, TMBHO is notified (typically by the next working day) by the hospital, the Mobile Crisis Team, and the CLIP Administration. TMBHO immediately assigns the case to the TMBHO CLIP Liaison for tracking and coordination.

The TMBHO CLIP Liaison communicates regularly with the CLIP Coordinator who is on the CLIP Placement Team and is responsible for assigning/transferring involuntary committed youth to one of the CLIP facilities in Western Washington. Within a maximum of 10 working days, the TMBHO CLIP Liaison and CLIP Coordinator collaborate to make available any supplemental materials needed (e.g., immunization records, school records, hospital and residential records, DCFS records, psychiatric records, and other outpatient records). The Liaison also works with the family and the CLIP Coordinator to identify the CLIP facility that will best meet the unique needs of the detained youth.

The TMBHO CLIP Liaison obtains necessary releases to communicate with and support the family through the CLIP admission process. If the family is interested and time allows, the Liaison arranges and attends a preplacement visit to the CLIP facility with the family. The Liaison participates in the preadmission meeting with the CLIP Administration, CLIP facility, and family. The TMBHO CLIP Liaison participates in all of the CLIP Treatment Plan Reviews (TPR) and functions as the community contact to facilitate linkages and support transition planning.

All youth (including those on ITA commitments) and their families are encouraged to enroll in Thurston Mason wraparound supports while in CLIP. The CLIP Administration and CLIP facilities are very supportive of this model. This is required for families wishing to access Roads to Community Living (RCL) transitional supports post-discharge as this is the only program that has capacity to facilitate the RCL planning and purchase services/items identified on the RCL Plan. All Thurston Mason youth discharging from CLIP are screened for Wraparound with Intensive Services (WISe); having youth already enrolled in wraparound facilitates a seamless transition into WISe for youth that qualify.

Process for identifying alternatives to commitment. TMBHO and the allied child-serving systems/providers are highly invested in serving Thurston Mason children/youth within the community, when appropriate, and to providing quality alternatives to commitment. Ideally, the BHO is notified/identifies at-risk youth before an ITA detention occurs. Once a youth is detained, the length of commitment is ultimately determined by the court. Regardless of the disposition (i.e., prior to commitment or during the initial 14 day commitment), TMBHO proactively attempts to engage the youth and his/her family to determine the least restrictive, most appropriate level of care. If the youth is already detained, this information is provided to the courts as a possible alternative to a 180 day commitment.

TMBHO has implemented several strategies and programs to effectively engage youth, support their families, and avert the need for ITA commitment or 180 day commitment (for those already detained). These efforts/programs include:

- TMBHO Mobile Crisis and Stabilization Program,
- Integrated Case Management Meetings,
- Wraparound with Intensive Services,
- Children's Community Consensus Team,
- Family Alliance for Mental Health,
- High-fidelity Wraparound,
- Multisystemic Therapy, and
- The Juvenile Justice Liaison.

The TMBHO Mobile Crisis and Stabilization Program is available to all Medicaid-enrolled children/youth ages birth to 21 years in Thurston and Mason counties, 24 hours per day, seven (7) days per week. This program targets youth experiencing serious/acute mental health episodes that need supports above and beyond what is available through routine outpatient supports and who, without this intervention, might otherwise require hospitalization. Services include up to three days intensive crisis with an additional 60 days intensive stabilization supports in the consumer's/enrollee's home/community. Any Medicaid-enrolled youth, regardless of current outpatient enrollment status, may be referred to this program. As discussed in the response to the previous question, this team is also engaged any time a Medicaid youth appears at the local emergency department. Access to this level of support significantly reduces the rate of involuntary detentions in this community and also makes it more likely that youth will not receive a 180 day commitment.

The Integrated Case Management (ICM) Team convenes bi-monthly to assist families experiencing complex challenges (typically involving multiple systems) in developing a plan that can support their needs in the community. The team is comprised of youth, parents, Tribes, and

representatives from local child-serving agencies/systems. Families are encouraged to bring natural supports (friends, family members, mentors, etc.) to the meeting. The meeting is facilitated in a wraparound format with an emphasis on identifying and building on strengths, optimizing existing resources, identifying needs, and then developing realistic strategies (with necessary supports) to address unmet needs. This family-centered process engages families to ensure that safety plans and appropriate supports are in place, often mitigating the need for hospitalization/involuntary commitment.

Thurston Mason is an early implementation location for Wraparound with Intensive Services (WISe). This program targets children/youth with complex emotional/behavioral health needs, which are also those most at risk of involuntary commitment. It provides intensive care coordination, intensive treatment, and 24/7 crisis intervention and stabilization services to eligible consumers/enrollees, which greatly decreases the need for voluntary/involuntary hospitalization. For greater detail about WISe, please see TMBHO's response to **DPR item 158**.

Children's Community Consensus Team (CCCT) functions as the gatekeeper for Children's Long-Term Inpatient Program (CLIP) services. CLIP is considered a last option and is only utilized when less restrictive, community-based options are not viable. However, there are times when it is the appropriate level of care to appropriately meet the child/youth's needs. This team and the Thurston Mason CLIP coordinator work closely with the youth and family to assess the need and educate them about the service. If it is determined that CLIP is the appropriate level of care, the team and liaison work closely with the family and youth to pursue a voluntary application, which is far less traumatic and more empowering for the youth than an involuntary commitment.

The Family Alliance for Mental Health (FAMH) plays a key role in supporting families and linking them to appropriate resources/services in the community which can reduce crises, including the need for involuntary commitments. The founder and director of FAMH is also the coordinator for the WISe programs in Thurston Mason and also has direct access to many other services in the community, including the mobile crisis program. Because the director is a parent with lived experience, she has a unique ability (credibility) to connect with families in a meaningful way to facilitate linkages to appropriate supports and often avert hospitalization / involuntary commitment.

High-fidelity Wraparound is available to youth/families who do not desire or do not qualify for WISe, but who need intensive care coordination to avert hospitalization or shorten the stay. This support allows the youth and family to form a caring team of natural and professional supports, develop a safety plan, create (and implement) a cross-system care plan that builds on strengths, and then help access needed resources/services, which reduces need for hospitalization/involuntary commitment.

Multisystemic Therapy is another intensive, outpatient program with 24/7 crisis supports built in that can provide stabilization and decrease the need for hospitalization/involuntary commitment. This is an evidence-based practice that has proven to be very effective in Thurston Mason in decreasing suicidal attempts/gestures, physical violence, property damage, substance use, and anxiety, which are all predictors of need for hospitalization/involuntary commitment.

The TMBHO Juvenile Justice Liaison is a mental health professional embedded in the Thurston and Mason county juvenile detention facilities and courts. The liaison is engaged any time juvenile justice staff, family members, youth, or other individuals request support for the youth while s/he is involved with the justice system. This is an opportunity to assess need and link the youth to appropriate, intensive supports (e.g., MST, WISe, mobile crisis services) the moment they discharge and avoid the likelihood of hospitalization/involuntary commitment.

(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.

In Thurston and Mason counties, all minors released on less restrictive alternative (LRA) treatment or conditional release are assigned to TMBHO Crisis Resolution Services (CRS) for monitoring. CRS is the program that houses all Designated Mental Health Professionals in Thurston and Mason counties.

All minors released from inpatient care on a less restrictive alternative treatment order (LRA) or conditional release are screened for Wraparound with Intensive Services (WISe). If eligible for WISe, minors are encouraged to enroll in in this program. If enrolled in WISe, the WISe provider monitors the LRA and informs CRS if there are concerns regarding adherence to the LRA or deterioration of functioning.

If the minor is not eligible for WISe or the minor/family prefers another intensive outpatient service, that outpatient provider monitors the youth's LRA and informs CRS if there are concerns. The outpatient provider monitors the minor's progress to ensure that conditions of court order are being met and to ensure that there is not substantial deterioration in functioning.

If the provider determines that the minor is failing to adhere to the conditions of the less restrictive order/conditional release, or determines that substantial deterioration in functioning has occurred, the provider notifies CRS. A CRS DMHP reviews available information, meets with the minor (when feasible), and then determines if it is necessary to order that the minor be taken into custody and transported to an inpatient evaluation and treatment facility. If it is

determined that detention is necessary, the DMHP files the order of apprehension and detention and serves it upon the minor. The DMHP also notifies the minor's parent/caregiver and attorney within two days, and also files a petition (with clear rationale) for revocation of the less restrictive alternative treatment in the county where the LRA was ordered. If the originating county is other than Thurston or Mason, a motion for good cause is typically filed, which allows the transfer of the hearing to the consumer's/enrollee's home community.

Per RCW 71.34.780, the hearing occurs within seven days. If it is determined that the minor did not adhere to the LRA/conditional release, the court either orders a modification to the LRA or orders return to inpatient care.

When a minor is ordered back into inpatient treatment, TMBHO follows protocols as discussed in the previous response (**DPR 231**).

Transfer between BHOs

(187) Behavioral health organizations – Transfers between organizations.

There are currently, and will continue to be, instances when a consumer/enrollee will require transfer to another service area. It is anticipated that as of April 1, 2016, TMBHO will continue to use the established BHO Transfer Protocol to facilitate the transfer of Medicaid enrollees into and out of network services. The purpose of the protocol is to ensure, 1) seamless transition with minimal interruption of services, 2) better care to meet the individual's needs, 3) opportunity for the individual to be closer to family and/or natural supports, 4) access to Medicaid covered services, and 5) access to "specialized non-Medicaid services" when appropriate, including E&T or community inpatient admissions, residential services, Medicaid Personal Care, and state hospital psychiatric stays.

TMBHO will agree to and follow the Uniform Transfer Agreement-Community Inter-BHO Transfer Protocol per the Prepaid Inpatient Health Plan as follows:

a) If a Medicaid Enrollee re-locates to a region outside of their current BHO they are entitled to an intake assessment in the new region and are then provided all medically necessary mental health services required in the Contractor contract, based on the BHO's level of care guidelines and clinical assessment.
b) Each BHO will establish a procedure to obtain information and records for continuity of care for Enrollees transferring between BHOs.
c) All Medicaid Enrollees requesting a transfer will be offered an intake assessment and all medically necessary mental health services under the Contractor. The availability of Specialized Non-Medicaid Services cannot be the basis for determining if the Enrollee is offered an intake for services in the desired community of their choice.

d) The receiving BHO will provide assistance to the Enrollee to update the Enrollee's residence information for Medicaid Benefits.
e) When an Enrollee is re-locating and may benefit from specialized non-Medicaid services beyond medically necessary services required in the Contractor, the BHOs agree to the following protocol:
   - The placement is to be facilitated by the joint efforts of both BHOs.
   - The referring BHO will provide all necessary clinical information along with the completed Inter-BHO transfer form.
   - The receiving BHO will acknowledge the request within three business days.
   - The receiving BHO will follow established procedures for prioritizing the referred Enrollee and must offer an intake assessment to the Enrollee for Medicaid-covered services, even if the specialized non-Medicaid services are not immediately available.
   - The placement may not be completed without written approval on the inter-BHO transfer form from either BHO administrators or their designees.
   - The receiving BHO shall make a placement determination within two weeks of receiving all necessary information/documentation from the referring BHO. The Enrollee and the referring BHO will receive information regarding the placement policy of the receiving BHO for the specialized non-Medicaid service.
   - Placement will only occur when the specialized non-Medicaid service becomes available. If the specialized non-Medicaid service is not available at the time of the intended transfer, the receiving BHO will notify the referring BHO and continue to provide timely updates until such time the specialized non-Medicaid service is available. The referring BHO will keep the individual and others involved in the individual's care informed about the status of the transfer.
f) Uniform Transfer Agreement: Eastern and Western State Hospital Inter-BHO Transfer Protocol – the inter-BHO transfer process for individuals preparing for discharge from a state hospital, and who require specialized non-Medicaid resources.
   - Generally, individuals are discharged back to the BHO in whose region they resided prior to their hospitalization (designated by the state hospitals as the "BHO of responsibility").
   - For all individuals in a state hospital (regardless of risk factors) who intend to discharge to another BHO, an Inter-BHO transfer request is required and will be initiated by the BHO of responsibility (hereinafter referred to as the referring BHO).
   - The financial benefits section at the state hospital will provide assistance to the Enrollee to update the Enrollee's residence information for Medicaid benefits.
   - The placement is to be facilitated through the joint efforts of the state hospital social work staff and the BHO liaisons of both the referring BHO and receiving BHO.

- A Request for Inter-BHO Transfer form and relevant treatment and discharge information is to be supplied by the referring BHO to the receiving BHO via the liaisons.
- The referring BHO will remain the primary contact for the state hospital social worker and the individual until the placement is completed.
- The receiving BHO will supply the state hospital social worker with options for community placement at discharge.
- Other responsible agencies must be involved and approve the transfer plan and placement in the receiving BHO when that agency's resources are obligated as part of the plan (e.g., DSHS Home and Community Services or Developmental Disabilities Administration).
- Should there be disagreement about the discharge and outpatient treatment plan, a conference will occur. Participants will include the individual, state hospital social worker or representative of the state hospital treatment team, liaisons, the mental health care provider from the referring BHO, and other responsible agencies.
- Once the discharge plan has been agreed upon, the request for Inter-BHO transfer will be completed within two weeks. The receiving BHO has two weeks to complete and return the form to the Referring BHO. This process binds both the referring and receiving BHOs to the payment obligations as detailed above.

In addition, included in the Protocol is the process for fiscal responsibility, with which TMBHO will also comply:

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

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

Number of Risk Factors	Duration
One (1) Risk Factor	Three (3) Months
Two (2) Risk Factors	Six (6) Months
Three (3) or More Risk Factors	Nine (9) Months

c) 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 BHO would need to be involved even though HCS might be arranging placement), and co-morbid serious medical issues.
- Other confounding clinical risk factors.

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

TMBHO does not foresee any reason why the BHO Transfer Protocol process would not work effectively with Fully Integrated Medicaid Regions. TMBHO will coordinate with any region that is fully integrated and amend the Protocol as necessary to ensure a continued seamless transition process for Medicaid enrollees.

4

Communications and Stakeholder Plan

Beginning in late 2014, TMBHO began actively engaging and communicating with all of its stakeholders about the impending change as it transitions from TMRSN to TMBHO and assumes responsibility for managing SUD services. Below is a description of this activity and how the transition will impact consumers, providers, the advisory board, other stakeholders, and TMBHO staff.

The new TMBHO has the obligation to inform all consumers/enrollees, providers, and interested community partners of changes in the care delivery system. Moreover, TMBHO also has the obligation – along with DBHR – to inform all Medicaid enrollees within its catchment area of changes to the service delivery system. In this context, this primarily means informing all interested parties about the behavioral health organizations and what changes one can reasonably to see as a result of this integration. To this end, TMBHO has developed a multifaceted approach to providing information – not only to current consumers/enrollees of publically-funded mental health and substance use disorder services and providers, but also to the community at large.

TMBHO believes that services will not be disrupted in any significant way for consumers of traditional **mental health** services by the creation of a behavioral health organization. *The most significant changes in the system will be noticed by consumers/enrollees of substance use disorder services.* However, with such a significant transformation as the integration of mental health and substance use disorder services, it is inevitable, and expected, that system-wide changes will be noticed by all consumers/enrollees. Specifically, all consumers/enrollees will:

- Notice increased access to appropriate services for behavioral health treatment services for both children and adults. It is expected that access, along with care coordination and collaboration, will improve as a result of BHOs. Since both services will be under one umbrella, it is expected that coordination of appropriate services will greatly improve.
- Be preauthorized for services for a pre-determined and limited amount of time – with a start and end date. If clinically appropriate, services will be allowed to be re-authorized and extended if requested by the qualified agency. Staff of the newly formed BHO will authorize and re-authorize services using an electronic authorization process. This is **not** new for traditional consumers of mental health services under the RSN system. This is new for those who are currently engaged in substance use disorder services.

- Receive a Notice of Determination (NOD) when they have been authorized for services. This notice will inform the consumer of what level of care they have been authorized to receive (based on either Access to Care Standards and/or ASAM guidelines), who their requested provider will be, and how to appeal information contained in the NOD. If the requested level of care is **not** authorized by the BHO, or is in any way minimized or limited, the consumer will receive a Notice of Action (NOA). The letter will explain why services have been denied, altered or limited and provide information on how to file an appeal.
- Continue to be part of the grievance system. With integration, all publically-funded consumers with services funded by TMBHO will be able to file a grievance with the TMBHO Ombuds and/or Quality Manager. This is new for consumers of substance use disorder services. Being part of the grievance system will allow a SUD consumer to get attention and resolution to problematic issues they are experiencing within strict and predetermined timeframes.

These are just some of the known changes that consumers might notice after April 1, 2016. As the new system evolves, many other changes might arise – necessitating further communication with consumers, providers and community stakeholders. Prior to April 1, 2016, TMBHO plans on engaging the community in the following manner:

- **Quality Management Meetings (Thurston Mason Regional Support Network):** TMRSN has been talking with Network Providers for the past year about the BHO and possible anticipated changes. Every quarter, TMRSN hosts a quality management meeting with agency directors, supervisors and quality leads in attendance. TMRSN has been in the process of soliciting feedback from the mental health provider community, as well as providing information about what to expect come April 1, 2016. TMRSN will continue to provide BHO information to Providers throughout the transition and integration process.
- **Partnership Meetings (county-operated substance use disorder programs):** Every other month, the county-sponsored Partnership Meetings are held. These meetings involve representatives from the substance use disorder provider community, other community partners, and state-level staff. Information about BHOs have been shared in these meetings over the past year and will continue to be a focus of future meetings.
- **Website:** Thurston County Public Health and Social Services (TC-PHSS) hosts a website specifically for social services – the division where the new BHO resides. Information about the new BHO will be posted there, along with a FAQ page and a private feedback form. In addition, there will be an interactive blog where community members can pose questions or concerns and have open discussions about the new behavioral health organization.
- **Social Media:** Thurston County Public Health and Social Services (TC-PHSS) also hosts a Facebook and Twitter page. TMBHO plans on posting information about the new BHO

through social media to Facebook and Twitter, along with links to other BHO information and resources.

- **Newspapers:** TMBHO is considering approaching local newspapers to solicit articles about the new BHO structure and implications for community members. TMBHO is also considering posting legal notices in local newspapers.
- **Consumer notification letters:** Staff from TMRSN and the county-operated substance use services program is currently working on a letter to distribute to all enrolled consumers of publically-funded mental health and substance use disorder services. This letter would explain what BHOs are and what some of the anticipated changes would be under a BHO.

One of the major changes brought about by the formation of BHOs is the new reality of pre-authorized services. For many years, TMRSN has made authorization decisions for mental health services. CMHAs typically submit an electronic authorization request to the RSN and Care Managers take action on that request. There are many different authorization decisions that Care Managers can make on a request, include approval, modification, denial, or limitation of requested service. When mental health and substance use disorders are fully integrated, all requests for service will flow into TMBHO for action. Authorization decisions are made on TMBHO's level of care system. These levels of care are either based on the Level of Care Utilization System (LOCUS) / Children and Adolescent Level of Care Utilization System (CALOCUS) for mental health or the ASAM Criteria for substance use disorder services.

Consumers who are pre-authorized for services are provided with a written letter explaining the benefits that have been authorized. This meets the 42 CFR Part 438 requirements for consumer notification. TMBHO notifications will either be in the form of a Notice of Determination (NOD) or a Notice of Action (NOA). NOD letters are generated after the authorization request has been approved (as requested) by TMBHO care management staff. An NOA is generated only if the authorization request was not approved as requested. This means that the request was either denied, modified, or limited. Letters are currently sent in all cases where an authorization is sought by a community mental health agency for mental health services; after April 1, 2016, letters will be sent to all consumers where an authorization request has been submit by a qualified agency on the consumer's behalf.

Notification letters contain all required information as mandated by 42 CFR Part 438. This includes the level of care the consumer has been authorized for, the duration of the authorization, any limitations or restrictions on the authorization request, the consumer's appeal rights if they disagree with the authorization decision, and information on how to contact the TMBHO Ombuds.

TMBHO is currently exploring the possibility of allowing consumers the option of "opting out" of receiving notification letters. This issue is being explored primary to protect consumer /enrollee confidentiality under 42 CFR Part 2. If this recommendation is carried out, consumers will be allowed to "opt out" of receiving regular notification letters. Opting out of receiving notifications will, however, have an effect on the consumer's ability to file an appeal if they disagree with an authorization decision. These issues are currently being explored, but a decision will be made when the BHO is fully operational.

(151) Legislative intent and policy.

TMBHO highly values parent, youth, and family involvement at all levels of system design and implementation.

TMBHO programs/initiatives that demonstrate this commitment include:

- Family Alliance for Mental Health (FAMH)
- High-Fidelity Wraparound
- Wraparound with Intensive Services (WISe)
- Multisystemic Therapy (MST)
- Integrated Case Management (ICM)
- Children's Community Consensus Team (CCCT)
- Family Youth System Partners Round Table (FYSPRT)
- Youth Wellness & Recovery Learning Collaborative
- Capital Recovery Center
- National Alliance on Mental Illness (NAMI) Thurston/Mason
- Program of Assertive Community Treatment (PACT)

The **Family Alliance for Mental Health (FAMH)** is a network developed by a local parent with lived experience. The purpose is to provide parent-to-parent support, connecting families with common experiences/challenges, identifying strengths and strategies that work, sharing information/resources, and organizing training opportunities. FAMH was developed in 2007 in partnership with TMRSN and has grown to multiple meetings and functions each month in Thurston and Mason counties. FAMH has been instrumental in helping many volunteers transition into paid certified peer counselor and data collection positions. FAMH is also a natural support for families as they transition out of formal services, but still wish to feel "connected".

TMRSN implemented **High-Fidelity Wraparound** (adherent to the National Wraparound Initiative) in 2010. TMRSN contracted with Catholic Community Services (CCS) for the provision of wraparound, but contracted with Donna Obermeyer, the parent who developed FAMH network, to function as the Wraparound Coordinator. This strategy assured TMBHO that family

voice would always be the centerpiece of this program. This program also has a Parent or Youth Partner assigned to every Child and Family Team (CFT), ensuring that the youth's/family's voice is always heard and understood.

TMRSN became an early implementation region for **Wraparound with Intensive Services (WISe)**, beginning July 2014. The readiness to participate as an early adopter was directly tied to how well the Fidelity Wraparound program, with a parent in the coordinator role, was functioning. Most of the CCS Wraparound Program's capacity was converted to WISe, with the exception of 18 non-WISe slots (funded by local sales tax dollars) that were preserved for non-Medicaid families and Medicaid youth in hospital/juvenile justice settings. TMRSN also contracted with Community Youth Services (CYS) for the provision of WISe services for the Transitional Age Youth (TAY) population and Multisystemic Therapy, which is considered a "WISe enhancement." Under the Wraparound Coordinator oversight, there is a capacity to serve 140 youth and their families at all times with WISe services. In addition to oversight of day-to-day operations, this role also includes overseeing data collection (performed by parents trained by the University of Washington) and facilitation of quarterly WISe Steering Meetings that include youth, parents/caregivers, Tribes, and representatives from allied child-serving agencies/systems.

The Multisystemic Therapy (MST) Program provided by CYS is a gold standard evidence-based practice that is producing excellent outcomes locally. Although this program is now a WISe enhancement, it still has a stand-alone Steering Committee to ensure fidelity. This committee has excellent representation of youth and family members, ensuring that family voice is present at all levels.

The **Integrated Case Management (ICM)** Team convenes bi-monthly to assist families experiencing complex challenges (typically involving multiple systems) in developing a plan that can support their needs in the community. In addition to representation from Tribes and child-serving agencies/systems, this team has robust youth and parent involvement. Furthermore, the meeting is facilitated in a wraparound format, which is extremely strength-based and family-centered.

The **Children's Community Consensus Team (CCCT)** functions as the gatekeeper for Children's Long-Term Inpatient Program (CLIP) services. This team is also represented by multiple youth and family members, ensuring that it is a family-friendly, client-centered process.

The **Family, Youth, and System Partner Round Table (FYSPRT)** provides an equitable forum for families, youth, systems, and communities. FYSPRT strengthens sustainable resources by providing community-based approaches to address the individualized behavioral health needs of children, youth, and families. They leverage the experiences and expertise of all participants

dedicated to building seamless behavioral health services. Regional FYSPRT membership is comprised of Family, Youth and System Partner Regional and Local Tri Leads. Participants outside the membership are also welcome to attend and provide input and feedback regarding community needs.

The **Youth Wellness & Recovery Learning Collaborative** is a developing workgroup that functions to establish and maintain a community devoted to youth and transitional age recovery supports. Identified goals include: youth involvement at all levels; youth feel safe, wanted, and a sense of belonging; community education and inclusion, particularly about the value of youth and services to the community; and to provide fun activities and/or learning experiences for youth with caring adults. With priority given to these four needs and recovery principles, each workgroup will have a minimum of one adult and one youth co-leading the group.

Capital Recovery Center is a non-profit community mental health agency that provides an array of services to people working towards recovery in their lives. CRC provides avenues for its participants to pursue individualized recovery goals and to be engaged in their community through a peer-to-peer model of support.

National Alliance on Mental Illness (NAMI) Thurston/Mason is a local group of volunteers, mainly family members of individuals with mental illnesses, which undertakes a variety of activities to improve the quality of life and mental health treatment for individuals with mental illness in Thurston and Mason counties. They provide family/caregiver classes, Peer-to-Peer classes with trained mentors, public education sessions or forums, community education and training, and an annual NAMI meeting.

Program of Assertive Community Treatment (PACT) is a team dedicated to serving consumers with a current diagnoses of a severe and persistent mental illness who are experiencing severe symptoms and have significant impairments. A peer specialist provides guidance and encouragement to consumers to take responsibility for and actively participate in their own recovery. The peer specialist is well versed in the principles of wellness and recovery services that validate consumer's experience and promote independence.

Additionally, TMBHO anticipates an increased number of consumers/enrollees participating as substance use disorder services become covered under the BHO structure.

TMBHO will recruit new members and expand the role of its advisory board as substance use disorder services become managed through the organization. The advisory board will provide TMBHO with consumer/enrollee and family member voice regarding access to services, quality of care, and effectiveness of the organization's service array.

Furthermore, TMBHO will expand the role of the Quality Review Team (QRT). The QRT specialist will administer satisfaction surveys to samples of consumers/enrollees participating in all levels of care at all service provider agencies. Summaries of those surveys will be made available to the advisory board, TMBHO managers, and to the public through the Annual Report. The QRT specialist will report observations and trends to TMBHO for consideration in further program and policy development.

TMBHO will provide access to an Ombuds who will address consumer/enrollee and family member concerns and grievances. The Ombuds will respond to concerns reported directly by consumers, family members, and advocates regarding obstacles impeding recovery and employment of persons with behavioral health problems. In all cases, the Ombuds will investigate the concerns and follow up with consumer grievances per TMBHO's policies.

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

TMBHO has already begun the work of creating an integrated advisory board, using, in part, mandates set forth in Exhibit F of this Detailed Plan. While TMRSN has a long history of having an active advisory board, the county's chemical dependency program has not. In creating an integrated advisory board, TMRSN worked with its existing board to bring forth the new membership requirements and to begin immediate recruitment, especially in the area of new substance use disorder consumers/enrollees. In addition, a draft TMBHO handbook was developed and distributed among current consumers/enrollees. This Advisory Board Handbook was approved at the July 27, 2015 TMRSN Advisory Board meeting.

The handbook clearly defines the TMBHO Advisory Board as follows:

- The Thurston/Mason Behavioral Health Organization Advisory Board is the result of integration between the Thurston/Mason Regional Support Network and Thurston/Mason Chemical Dependency Advisory Boards. Integration between mental health and chemical dependency was a result of Senate Bill 61312. This document represents the first Membership Handbook for the newly integrated advisory boards.
- Regional Support Networks (RSNs) and Prepaid Health Plans (PHPs) are required to have an advisory board as part of its governance structures in compliance with 71.24 Section 300 RCW and WAC 388-865-0315. The Chemical Dependency Advisory Board exists as a result of State Law RCW 70.96 and 70.96A (Section 300), and related state regulations. Both boards are citizen advisory boards which represent the citizens of Thurston and Mason counties.
- Consumers, past consumers, and family members must comprise at least 51% of the advisory board, and the board must be demographically representative of the BHO. Advisory board bylaws require a minimum of nine (9), maximum of fifteen (15) advisory

board members. A minimum of six (6) members will be representative of Thurston County and three (3) of Mason County, with a maximum of eleven (11) Thurston County Representatives and four (4) seats reserved for Mason County residents. Each voting member is appointed to a three-year term by their respective Board of County Commissioners. Members may be re-appointed to a second three-year term. Elected officials include a Chairman and Vice-Chairman, which are elected in March of every year.

- The TMBHO Advisory Board meets the fourth Monday every month at 5:30 p.m. Meetings last approximately 1.5 hours. Voting member attendance is required. From the member roster of the BHO Advisory Board, smaller subcommittees have been formed to address specific issues and processes. This includes the Advocacy Committee and the Services & Administration Committee.
- Thurston County Public Health and Social Services (PHSS) staff and the board chairperson will prepare an agenda for each meeting. Agendas will consistently include standing committee reports (when applicable) and a designated time for community input.
- Members of this board have certain responsibilities and duties. This handbook has been prepared to acquaint members with these responsibilities and to provide some background information to assist in carrying them out.

In addition to this general discussion of the TMBHO Advisory Board, further membership details are provided in the Membership section of the Handbook. Specifically:

B. MEMBERSHIP

1. Body: Each advisory board shall be composed of not less than nine (9) and not more than fifteen (15) members.
2. Representation:
   a. Members shall be representative of the community and shall include at least three (3) Mason County residents.
   b. At least 51% of the membership are persons, parents or legal guardians or persons, with lived experience and/or self-identified as a person in recovery from a behavioral health disorder.
   c. At least one (1) member shall be a representative from law enforcement and/or the criminal justice system.
   d. The body shall have County representation (when the BHO is **not** a County operated BHO), but have no more than four (4) elected officials.
3. Service Providers: No persons either receiving funds by contract or employed by an organization in receipt of funds subject to the advice of the respective board may be appointed to that board. On a case by case basis, members of the board may be part of a subcontracted agency only with a special vote of the existing board. If an advisory board member works for a subcontracted agency the member must:

   a. Recuse themselves from any vote of the board that has to do with financing of any agency funded by the BHO; and
   b. Publically announce the inherent conflict of interest in discussions of their agency's performance or quality improvement initiatives.
4. Tenure: Members of the board shall serve three (3) year terms and until their successor is appointed and qualified. Members may succeed themselves not more than once, for a total of six (6) years. Final authority for term limit exemptions will rest with the County Commissioners.
5. Appointment: Members of the Thurston/Mason BHO Advisory Board are appointed by the Thurston County Board of County Commissioners. When notified by the Thurston County Social Services Department, Thurston/Mason County Commissioners will announce openings on the board through press releases. Persons wishing to serve as a member of the Thurston/Mason BHO Advisory Board will send a letter of interest to the Social Services Department for advisory board and staff review. Recommendations for appointment will be forwarded to the Thurston County Board of County Commissioners. Final authority for such appointments will rest with the County Commissioners.
6. Qualifications: Members shall be appointed on the basis of their ability to give guidance and direction to the legal, fiscal and program aspects of the respective program activities within Thurston and Mason counties.
7. Compensation: Members of the Thurston/Mason BHO Advisory Board may not be compensated for the performance of their duties as members of a board, but may be paid subsistence and mileage. Requests for and rates of such reimbursement shall be governed by current county policy.
8. Removal: Any board member may be removed from his or her appointment by the County Commissioners for good cause. The board may recommend the removal of a member to the Commissioners by a majority vote of the board at any regular or special meeting of the board. Notice of the proposed removal recommendation must be sent to the member in writing one week prior to the date of the meeting at which such a removal recommendation is to be voted upon. Such notice must state the cause of the proposed recommendation.
9. Leave of Absence: A member may request a leave of absence for up to one (1) year if the member is temporarily unable to attend board meetings and/or participate in board activities. The request, in writing, must state the length of leave, and it must be submitted to the advisory board. The advisory board's recommended action will be forwarded to the respective County Commissioner Board. No more than two members will be granted leave of absence at a given time.

(245) Information requirements – enrollees.

TMBHO will track DSHS/HCA's communication to Medicaid enrollees regarding the change from a fee for service SUD system to an integrated substance use disorder/mental health (SUD/MH) managed care system and their development of a new enrollee handbook. Once posted, TMBHO will access the handbook and make it available to its enrollees in a manner that is useful for individual enrollee. TMBHO will also continue to educate its SUD provider network on the impending changes and the benefits and rights enrollees have as a service recipient of the provider's services. Furthermore, TMBHO will actively educate its enrollees 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 TMBHO staff at key meetings. In addition to DSHS/HCA-provided information, enrollees will be informed in a more individualized mode depending upon their capacity to receive and process information a key points of interface with the behavioral health system in the region. For instance, providers will be expected to provide relevant information to service recipients at their respective points of service. If the enrollee is unable to read the written material or needs information presented in their native language, TMBHO 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 TMBHO web site.

For non-Medicaid consumers, the Thurston/Mason RSN Medicaid Mental Health Benefits Handbook will be modified and expanded to the TMBHO Medicaid Behavioral Health Benefits Handbook and delivered with the same expectations as the Medicaid enrollee handbook. This handbook contains the following information:

- Provider Network Listing
- Definitions
- Out of Network Services
- Eligibility
- Mental Health Services (change to Behavioral Health Services)
- Access to Mental Health Specialists (change to Behavioral Health Specialists)
- Advance Directives
- Complaints and Grievances
- Ombuds
- Quality Review Team
- Rights and Responsibilities: Client Rights
- Confidentiality Rights: HIPAA

5

Network Analysis and Development Plan

Mental Health

TMBHO's analysis of the existing mental health network is that it meets the adequacy standards required by the contract with DSHS. Therefore, the mental health network will essentially remain the same moving into 2016.

Substance Use Disorder

(273) Delivery network.

Historically, there were 76,000 Medicaid enrollees in Thurston and Mason counties. As TMBHO plans for anticipated utilization, it anticipates 9,000 of those enrollees will need behavioral health services (7,000-mental health services and 2,000-substance use disorder services, including residential). To ensure each substance use disorder provider has capacity to serve these enrollees with the services needed for the network, TMBHO Care Managers s are currently meeting individually with providers to ensure each are fully prepared. To help keep track of each provider's transition progress, TMBHO is in the process of developing a document entitled 'BHO Preparedness Checklist,' which outlines key topic areas such as workforce, monitoring access to services, readiness for data collection, and understanding of payment structure. Additionally, TMBHO has inserted the following language into SUD providers' contracts to assist with the transition:

Transition of Services.

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

A. For all DSHS Clients receiving services under this Contract, the Contractor shall cooperate with DSHS and the County, BHO, or other entity, by participating in the following activities:
    1) Identify all who are expected to be engaged in treatment on April 1, 2016.
    2) Execute an agreement with the BHO that ensures protection of the Clients' confidential and Protected Health Information compliant with HIPAA and CFR 42 Part 2.

3) For each transitioning client, and with client's written consent and proper release in accordance with CFR 42 Part 2, Subpart C, 2.31 "Form of Written Consent", provide current treatment information including:
    a. What services are being provided,
    b. Planned treatment end date,
    c. Services provider information,
    d. Treatment location, and
    e. Administrative records.
    f. Participate in the development of individual Client transition plans.
    g. Other activities as requested by the County.
    h. Purpose of disclosure is to allow for coordination of services and payment.
4) Contractor shall make efforts to refer to the residential provider network in collaboration with the County.

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

Please see Attachment 4 (TMBHO Service Matrix) for more information on the MH/SUD levels of care, intensity of services, and anticipated services. There is currently no wait list for any of the outpatient providers.

Cultural Considerations

TMBHO currently provides culturally competent trainings, interpreters, and client surveys to ensure services are offered in a way that fits with the individual needs of each enrollee.

Culture is an ongoing consideration for staff at TMBHO and all TMBHO and Network Provider employees are required to complete cultural competence training at time of hire and annually. The training addresses standard cultural competency requirements as well as information about different health disparities, disabilities, and chronic conditions. Staff are challenged to recognize and consider how these disparities relate to an individual's cultural needs as they work with a diverse population.

In addition, TMBHO also encourages staff to think of cultural diversity in terms outside of the standard definitions of race, gender, ethnicity, etc. Culture can be how a person identifies with a group within their community (e.g., if an individual is homeless, LGBTQ, a person's political views or religious beliefs, even if an individual is vegan or chooses another form of alternative lifestyle). These are all part of what makes up a person's culture, not just their race and gender, and TMBHO will continue to expand on supporting this type of training with all new providers in 2016.

Language Services

TMBHO will continue to ensure that it and its Network Providers follow the Information requirements per the Prepaid Inpatient Health Plan as follows:

1. The Contractor must provide information to Enrollees that complies with the requirements of 42 CFR 438.100, 438.10, and 438.6(i)(3).
    a) Alternative Formats
        i) Offer every Medicaid Enrollee a Washington Medicaid Behavioral Health Benefit Booklet at Intake which includes information on obtaining the booklet in alternative formats, and inform Enrollee that the booklet is available at: http://dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml.
        ii) The Contractor and affiliated service providers shall post a translated copy of the Washington Medicaid Behavioral Health Benefits Booklet's section entitled "Your Rights as a Person Receiving Medicaid Behavioral Health Services" in each of the DSHS-prevalent languages. The DSHS Prevalent languages are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese.
        iii) The Contractor and affiliated service providers shall post a multilingual notice in each of the DSHS prevalent languages, which advises Enrollees that information is available in other languages and how to access this information.
        iv) The Contractor shall provide written translations of all written information including, at minimum, applications for services, consent forms, and Notices of Action in each of the DSHS-prevalent languages that are spoken by five percent (5%) or more of the population of the State of Washington; based on the most recent U.S. census. DSHS has determined based on this criteria that Spanish is the currently required language. The Contractor must provide and maintain availability of translated documents at all times for the Contractor and its contracted BHAs to distribute.
        v) The Contractor shall provide copies of the generally available materials including, at minimum, applications for services, consent forms, and Notices of Action in alternative formats that take into consideration the needs of those who have limited vision or impaired reading proficiency.
        vi) The Contractor and affiliated service providers shall maintain a log of all Enrollee requests for interpreter services or translated written material.

Pregnant, Post-Partum, and/or Parenting Women (PPW)

All of our providers are required to have pregnant, postpartum, and/or parenting women as a priority population when it comes to accessing substance use disorder services. Additionally,

TMBHO has a designated behavioral health Care Manager responsible for overseeing the contract for Pregnant, Post-Partum, and/or Parenting Women (PPW) Housing Support Services through Behavioral Health Resources' Harvest Program in both Thurston and Mason counties. Available programs include intensive outpatient treatment, daily group sessions, weekly individual counseling sessions, weekly/monthly aftercare groups, and parenting classes, as well as childcare available during treatment. TMBHO intends to contract with a PPW residential facility to ensure access to intensive inpatient services, when a client meets that level of care. Additionally, interim services are available within 48 hours if a client is seeking treatment and unable to access services. When a pregnant woman is unable to access residential treatment due to capacity issues, and is in need of withdrawal management, the client is referred to a Chemical Using Pregnant (CUP) program for admission.

In addition to the provider list document (see **DPR Item 287,** below), there is also an attached document titled 'TMBHO Service Matrix – Detailed Plan' outlining the contracted and anticipated contracted behavioral health service providers based on the state plan modalities. As Network Providers move into offering focused co-occurring disorder services, TMBHO will develop a similar matrix to track those services.

Department of Corrections (DOC), Drug Courts, or CJTA

A dedicated behavioral health Care Manager is assigned to contracts pertaining to the Department of Corrections (DOC) and CJTA services within the Provider Network. TMBHO intends to continue contractual relationships with existing drug courts in Thurston and Mason counties through the continued work with each CJTA panel. TMBHO expects to collaborate with DOC to develop a Request for Proposal to secure providers capable of meeting the needs of clients historically served by DOC.

As for the documentation and sample format that TMBHO will submit to DSHS on a periodic basis to demonstrate the sufficiency of the network, please see Detailed Plan Response Item 279 below.

(279) Documentation of adequate capacity and services.

Prior to April 01, 2016, TMBHO will collaborate with DBHR and other BHO's, as appropriate, to develop a format in which to submit documentation to meet this requirement. Timing of submission, including any updates or changes, will be included as part of this collaborative effort.

TMBHO currently collects and analyses information and data (described below) to determine adequate network capacity and services. TMBHO collects this data through three (3) distinct methods, including a GeoData Report, staffing reports, and Network Provider credentialing

applications. Each report/application provides information necessary for TMBHO to build a comprehensive "Network Profile" allowing TMBHO to monitor the network to ensure that its available capacity is sufficient to meet the needs of Thurston Mason Medicaid eligible enrollees.

Geographic Distribution

TMBHO's service area consists of a two (2) county region which includes Thurston County, a "rural" area and Mason County, a "large rural" area. At a minimum of every three (3) years, TMBHO conducts a GeoData Report to monitor the distance standards within the provider network to ensure the following distance standards are met:

1. In Rural Areas, a thirty (30) minute drive from the primary residence of the enrollee to the service site.
2. In Large Rural Geographic Areas, a ninety (90) minute drive from the primary residence of the Enrollee to the service site.
3. In Urban Areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed ninety (90)-minutes each way.

TMBHO utilizes a GEO mapping system to plot each Network Provider location by zip code and each zip code within the service area to determine the travel time between the two points. The GEO mapping system allows TMBHO to plot the travel time in a variety of travel methods including private vehicle, public transportation, walking, and bicycling. This process allows TMBHO to then determine the time it takes for an enrollee to travel between a residential zip code and the location of each provider within the network. From this, TMBHO can easily identify gaps in distance standards and determine where there is a need for increased access to services.

Number and Mix of Providers

TMBHO expects to continue to see an annual penetration rate of behavioral health services at about 10% in 2016. One of the goals of 2016 is for TMBHO to determine what the national average and standards are for caseloads at every level, from prescribers to case aids, to assist with determining if TMBHO meets the ratio for total number of providers needed for penetration within the network.

TMBHO collects data on employees, volunteers, and interns from Network Providers on a quarterly and annual basis to build a network workforce profile. This allows TMBHO to analyze gaps and determine where there may be a need for a certain level of staffing.

1. The staffing report includes:
    - Provider Position (case manager, therapist, prescriber, etc.)
    - Type of Degree / Education Level

- Department of Health Licenses
- Certifications
- Mental Health Professional Status
- Mental Health Specialist Credential
- Chemical Dependency Professional Status *(to be added by 2016)*
- Current Case Load
- Languages Spoken

2. The employee, volunteer, intern, and contracted staffing diversity report includes:

Job Categories	*Caucasian*		*African American*		*Asian/Pacific Islander*		*Native American/ Alaskan*		*Hispanic*		*Disabled*		*Multi-Racial*	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Managerial														
Professional														
Technical														
Clerical														
Service														
Labor														
Trainees														
Interns														
Total														

Preventive, Primary, Specialty Services

On an annual or biennial basis, TMBHO collects service data through the Network Provider Credentialing Application Process. Before April 2016, the application will be updated to include a SUD modality as well as specialty and evidence-based/emerging best practices. This process allows TMBHO to determine what services are available to Medicaid enrollees within the network. This data is utilized to determine gaps in services, areas where services can be expanded, and if a modality is not available, plans to make it available within the network or contract for it out of network.

1. The Credentialing Application includes:
   - List of locations – this allows TMBHO to add any new branch sites to the Geo Data Report.

- Services modalities, per the State Plan, to determine what services each Network Provider is licensed to provide:

Mental Health Modalities		*Substance Use Disorder Modalities*	
Brief Intervention	☐	Assessment	☐
Crisis Services	☐	Alcohol/Drug Screen & Brief Intervention	☐
Day Support	☐	Brief Outpatient Treatment	☐
Family Treatment	☐	Case Management	☐
Free Standing Evaluation and Treatment	☐	Inpatient Withdrawal Management	☐
Group Treatment	☐	Intensive Outpatient Treatment	☐
High Intensity Treatment	☐	Intensive Residential Services	☐
Individual Treatment Services	☐	Long-term Care Residential Services	☐
Intake Evaluation	☐	Laboratory Services	☐
Medication Management	☐	Opiate Substitution Treatment Services	☐
Medication Monitoring	☐	Outpatient Treatment	☐
Mental Health Services in Residential	☐	Recovery House Residential Services	☐
Peer Support	☐	Subacute Withdrawal Management	☐
Psychological Assessment	☐		
Rehabilitation Case Management	☐		
Special Population Evaluation	☐		
Stabilization Services	☐		
Therapeutic Psychoeducation	☐		

- Age group(s) served – children/youth, transition age youth, adult, and/or older adult.
- Practice information:
  - What arrangements does the provider have in place to provide 24/7 coverage for enrollees?
  - What arrangements does the provider have to accommodate walk-in clients?
- What specialty and evidence-based or emerging practices does the agency offer?

Mental Health Specialty Services	*Yes*	*No*
Children < 6 years old	☐	☐
Transition Age Youth (18 – 25)	☐	☐

Mental Health Specialty Services	***Yes***	***No***
Ethnic Minorities (specify identified ethnicity):	☐	☐
• African American	☐	☐
• Asian (specify all)	☐	☐
• Native American/Alaskan Native	☐	☐
• Hispanic	☐	☐
• Other (specify)	☐	☐
• GLBTQ	☐	☐
Deaf/Hearing Impaired	☐	☐
Anger Management	☐	☐
Co-occurring Disorders (COD)	☐	☐
Multiple Personality Disordered Persons	☐	☐
Post-Traumatic Stress Disorder (PTSD)	☐	☐
Homeless Mentally Ill	☐	☐
Mental Illness and Developmental Disabilities	☐	☐
Psychosexual Analysis / Sex Offenders	☐	☐
Other:		
Other:		
Mental Health Evidence Based/Emerging Practices *(fully trained and qualified)*	***Yes***	***No***
Dialectical Behavior Therapy (DBT)	☐	☐
Integrated treatment for co-occurring disorders	☐	☐
Family psycho-education	☐	☐
Multi-systemic treatment	☐	☐
Illness management recovery	☐	☐
Triple P – Positive Parenting Program	☐	☐
Cognitive Behavioral Therapy (CBT) or Trauma Focused CBT	☐	☐
Wellness Recovery Action Plan (WRAP)	☐	☐
Coping and Support Training (CAST)	☐	☐
Other:		
Other:		

Substance Use Disorder Specialty Services	***Yes***	***No***
Transportation	☐	☐
Family Hardship	☐	☐
Continuing Education/Training	☐	☐
Involuntary Commitment	☐	☐
Recovery Support Services	☐	☐
Tuberculosis Screening/TB Skin Test	☐	☐
Childcare Services	☐	☐
Therapeutic Interventions for Children	☐	☐
Pregnant, Post-Partum, or Parenting (PPW) Women's Housing Support Services	☐	☐
Crisis Services	☐	☐
Sobering Services	☐	☐
Outreach Services	☐	☐
Interim Services	☐	☐
Other:		
Other:		
Substance Use Disorder Evidence Based/Emerging Practices *(fully trained and qualified)*	***Yes***	***No***
Dialectical Behavior Therapy (DBT)	☐	☐
Seeking Safety	☐	☐
Seven Challenges	☐	☐
Living in Balance	☐	☐
Moral Reconation Therapy (MRT)	☐	☐
Adolescent Community Reinforcement Approach	☐	☐
Motivational Enhancement Therapy and Cognitive Behavioral Therapy	☐	☐
Recovery Support Service	☐	☐
Opioid Medication Assisted Treatment	☐	☐
Other:		
Other:		

Furthermore, TMBHO collects additional documentation on the credentialing application that assists with developing a profile of the provider network to ensure access and sufficiency in services, including:

1. Emergency/Disaster Operations Plans – this helps TMBHO determine what the provider network needs would be in the event of a disaster, including emergency services for enrollees.
2. ADA facilities plan.
3. After-hours crisis contact procedures.
4. Policy and procedure and any forms for credentialing MHP's and MHS's.
5. Current sliding fee scale and related policies.
6. Policy and procedure on wait lists (to ensure they do not occur) and utilization management.
7. List of formal and informal agreements with support systems indicating cross system working partnerships (i.e., schools, primary care providers, healthcare systems, other Network Providers, etc.).
8. List of any American Psychiatric Association or American Medical Association practice guidelines that have been implemented and are being utilized as part of service delivery.
9. Organizational chart.
10. Annual training plan (i.e. safety/violence, cultural diversity, professional, ethical, etc.).
11. Copy of all brochures and marketing materials, including translated versions.
12. Copy of all written materials and forms translated into Spanish and any other DSHS prevalent language.

Additional Services/Resources

TMBHO publishes a resource booklet every six (6) months called "The Toolbox." It was developed in collaboration with the consumer-run peer program and the consumer council as a portable resource guide for both Medicaid and non-Medicaid individuals within the service area. This resource guide provides information about services above and beyond what is available within the provider network. It contains contact information for providers not under contract with TMBHO, as well as additional supports for housing, medication, transportation, support groups, children's services, veteran's services, and more.

This booklet is made available at Network Provider locations, locations listed in the booklet, and settings such as jails and inpatient programs so individuals being released have access to some resources. Even though many of the agencies and businesses listed in the booklet are not a part of the TMBHO Network as contract providers, they are considered a part of the overall network and community that supports the individuals TMBHO serves.

(287) Contracts with providers.

Agency	Services Provided
Alternatives Professional Counseling **203 4th Ave E. Suite 301** **Olympia, WA 98501**	• CJTA (SUD services)
Behavioral Health Services (BHR) **3857 Martin Way East** **Olympia, WA 98506** **6128 Capital Blvd SE** **Tumwater, WA 98501** **110 West "K" Street** **Shelton, WA 98584**	• Outpatient MH services – children and adults • Pregnant and parenting women's SUD outpatient and transitional support • Brief MH treatment and medication • PACT services • Intensive outpatient / community-based services • MIO MH jail services
Capital Recovery Services **1000 Cherry St SE** **Olympia, WA 98506**	• Peer support services (MH) • Group and individual services (MH) • Day treatment services (2016)
Catholic Community Services **148 NW Rogers Street** **Olympia, WA 98502**	• Children's crisis (mobile) services • WISe (MH)
Community Youth Services **711 State Ave NE** **Olympia, WA 98506**	• WISe (MH) • MST (MH) • MIJOP (youth corrections) • Transitional age youth outpatient MH services
Evergreen Treatment Services **6700 Martin Way East, Suite 117** **Olympia, WA 98516**	• Opiate substitution
Family Education and Support Services **1202 Black Lake Blvd, Suite B** **Olympia, WA 98502**	• Parenting/MRT classes (SUD)
Providence St. Peter's Hospital **413 Lilly Road NE** **Olympia, WA 98506**	• Older adult MH outpatient services
Providence St. Peter Chemical Dependency Center **4800 College Street SE** **Lacey, WA 98503**	• Adult outpatient • Youth outpatient • Involuntary Treatment Act (ITA) Juvenile Drug Court

Agency	Services Provided
Northwest Resources II, Inc. **2708 Westmoor Court SW** **Olympia, WA 98502** **235 S. 3rd** **Shelton, WA 98584**	• Adult SUD outpatient • Mason County Drug Court • Intensive SUD case management
SeaMar Community Health Center **409 Custer Way SW, Suite D** **Tumwater, WA 98501**	• Outpatient MH and SUD services • Brief MH treatment and medication
Thurston County Superior Court **2400 Bristol Court** **Olympia WA 98506**	• Drug Court
True North Educational Service District 113 **6005 Tyee Dr. SW** **Tumwater, WA 98512**	• Youth outpatient (co-occurring)
Inpatient and Crisis	
Evaluation and Treatment (E&T) Facility (operated by BHR) **3436 Mary Elder Road NE** **Olympia, WA 98506**	• Crisis resolution services (MH) • ETU services • Crisis stabilization and treatment services (CSTU)
Providence St. Peter's Hospital **413 Lilly Road NE** **Olympia, WA 98506**	• Crisis inpatient (voluntary) services
Thurston County Triage Center **3491 Ferguson Street SW** **Olympia, WA 98506**	• (Coming in 2016) • MH triage center
Information and Referral	
Crisis Clinic **Main Line: 360-586-2800**	• Information and referral services only • SUD and MH

(50) Opiate substitution treatment – program certification by department, department duties – definitions of opiate substitution treatment.

Medication Assisted Treatment (MAT)

Currently, TMBHO has a provider serving the service area with outpatient methadone or Suboxone treatment with wraparound services, including detoxification (up to 180 days), individual and group counseling, acupuncture, HIV education and testing, drug screen urinalysis, and medical evaluation.

(275) Out-of-network services.

When clinically indicated, or when medically necessary services are not available within the TMBHO Network, services may be provided to consumers/enrollees "outside" of the established Network. The issue of providing out-of-network services depends largely on the type of services the consumer needs and the current definitions of "network." For example, with outpatient mental health services, the network is strictly defined as the geographic boundaries of Thurston and Mason Counties. However, for E&T services, the network is more loosely defined to encompass BHO's with contiguous boundaries to TMBHO. For consumers needing SUD residential services, however, the network is defined as the entire state of Washington, understanding that at times appropriate SUD residential services cannot be found within the geographic boundaries of Thurston and Mason counties, or even the west side of the state.

Generally, however, a consumer has the right to "out of network" services when medically necessary services cannot be found within the boundaries of TMBHO, in accordance with 42 CFR 438.206(b)(3). The following are examples of these types of services, and any exceptions:

- A consumer requires a specialty type of mental health treatment (i.e., treatment for an eating disorder) and that service is not provided within TMBHO. A contract (or MOU) is developed with a community mental health agency in another BHO to provide this service. This is an example of an "out of network" service.
- A consumer requires a bed within an evaluation and treatment (E&T) facility. A bed is identified within another BHO which boarders TMBHO. TMBHO has an existing MOU with that BHO. The consumer is placed, but this is not considered an "out of network" service since the BHO was contiguous with TMBHO.
- A consumer requires an SUD residential placement. No beds exist within TMBHO, or even on the west side of Washington. A bed is finally identified in Yakima and the consumer is placed. This is not considered an "out of network" service since within the new BHO structure, any contracted residential provider within Washington is considered "in-network."

Regarding availability of services within a defined network, TMBHO has created a policy and procedure (CI-406) which speaks to providing needed in- and out-of-network services. Policy statements from this policy state:

A. The TMBHO will maintain and monitor a network of behavioral health providers sufficient to provide access to all medically necessary behavioral health services covered in the State Plan, for its entire geographical area. At minimum, TMBHO will ensure provision of:
    1. Access to an intake evaluation by a behavioral health professional (MHP/CDP) for all Medicaid eligible individuals requesting services through:
        a) A phone call,
        b) Walk-in, or
        c) Written request;
    2. Age appropriate, medically necessary behavioral health services identified in the Medicaid State Plan and the 1915(b) Medicaid Waiver; and
    3. A geographic distribution and mix of Network Providers to meet the access and travel standards.

The policy also states that TMBHO will create mechanisms to continuously evaluate the needs of the defined network and work to identify and close any gaps in services. It further states:

E. TMBHO will ensure that if the current contracted provider network becomes unable to provide sufficient covered services in the TMBHO service area, TMBHO will contract with additional, equally qualified providers to furnish the medically necessary behavioral health services, pursuant to the DSHS /PIHP contract.

And:

J. When TMBHO Network Providers are unable to provide medically necessary services with available staff, the provider shall:
    4. Purchase medically necessary services covered under the State Plan and required in the TMBHO/provider contract;
    5. Ensure that any subcontracted services are provided timely when providers are unable to furnish such services within their Organization;
    6. Ensure coordination with the out-of-network provider, with respect to any payment and continuity of care; and
    7. Ensure there is no cost to the consumer/enrollee or that the cost is no greater than if services were furnished within the network.

The TMRSN Procedure on Availability of Services lists the responsibilities of TMBHO as well as its Network Providers. Portions of this procedure state:

B. TMBHO will:
    1. Incorporate available and current DSHS demographic data to establish and maintain an adequate provider network.

2. Review and incorporate any other relevant benchmark data, and/or other sources of information available, to monitor for needed delivery system changes in order to maintain an adequate network of provider services.
3. Review all available data impacting the adequacy of service delivery with the advisory board. Any recommendations from the advisory board, QRT, Ombuds, consumer surveys, or Consumer Council will be incorporated into TMBHO planning activities.
4. Establish service sites in accordance with population distribution in the service area, to include the following travel standards:
    a) In rural areas, service sites are within a 30-minute drive time;
    b) In a large rural geographic area, sites are available within a 90-minute commute time; and
    c) In urban areas, service sites are accessible by public transportation, with the total trip including transfers not to exceed 90 minutes each way.
5. Provide consumer/enrollee information about service availability both in and out of the network and how to access services through the TMBHO Enrollee Benefits Handbook.
6. Purchase behavioral health services through Network Provider contracts that specify the expectations for delivery of State Plan services including second opinions.
7. Monitor contracted providers to assure compliance with the standards and requirements of this policy by:
    a) Reviewing and monitoring Ombud's and QRT findings;
    b) On-site and contract monitoring and auditing activities;
    c) On-site clinical and operational review activities;
    d) Monitoring of complaints and grievances;
    e) Participation with DSHS on licensing reviews;
    f) Reviewing advisory board and other stakeholder input and recommendations; and
    g) Development of a corrective action plan as necessary.

C. Network Providers shall:
1. Furnish all covered behavioral health services pursuant to the TMBHO provider contract.
2. Inform the TMBHO as early as possible of the inability to provide the contracted behavioral health services, and purchase the services from qualified behavioral health providers for as long as is necessary to ensure timely consumer/enrollee access.
3. Ensure that, if there is a need to purchase services outside their provider staff pool, services will be provided by equally qualified individuals at no cost to the consumer / enrollee.

4. Ensure consumers/enrollees are informed about what services are covered and available and how to access them by giving every consumer/enrollee a *TMBHO Enrollee Benefits Booklet* at intake and at any other time information is needed or requested.

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

Thurston Mason Behavioral Health Organization (TMBHO) will continue to maintain Memoranda of Understanding (MOUs) with city and county jails for mentally ill offender (MIO) services. Current MOU's include:

- Thurston County Jail,
- Mason County Jail,
- Olympia City Jail, and
- Juvenile Rehabilitation Administration.

The purpose of these MOU's is for local law enforcement, correction personnel, the Community Service Office (CSO), and Network Providers to coordinate services and expedite and return incarcerated individuals to the community, including enrollment into treatment services where appropriate. MIO services include screening and referral, intake assessments, diversion, crisis intervention, transitional case management, and discharge planning. In addition to direct services, the MIO program provides training and consultation services to correctional staff and law enforcement as well as cross system coordination within the network.

TMBHO has plans to expand jail services in April 2016. The cities of Lacey and Tumwater have requested a Diversion/Re-entry Specialist to assist the mentally ill and substance use disorder misdemeanant population housed at the Nisqually Tribal Jail. The program would be similar to the MIO program already established with the city and county jails, including screening, crisis stabilization, and transitional case management back to the community. TMBHO will collaborate with the identified cities and Nisqually Tribal Authority to develop an implementation plan for a MIO program in the Nisqually Tribal Jail.

Please see the following attachments for examples of existing Agreements and Memorandums of Understanding:

- Attachment 5: Agreement JRA.2004
- Attachment 6: Agreement Mason Jail Services.2014
- Attachment 7: Agreement Thurston Jail MIO MOU.2010

(158) Children's Mental Health Services – children's access to care standards and benefit package.

The Thurston Mason Regional Support Network (TMRSN) currently has capacity to serve 140 children/youth and their families at all times in Wraparound with Intensive Services (WISe). These services are fully compliant with the WISe Manual, the PIHP Draft Contract, and relevant RCWs.

The Research and Data Analysis Division (RDA) of DSHS developed WISe utilization estimates for each region for SFY 2019 (starting July 1, 2018), which is when WISe is required to be fully implemented statewide. The forecast took into account the number of Medicaid children/youth with mental health needs in each region, the severity of needs and functional indicators, and the number of youth at greatest risk for out-of-home placement. RDA's estimate includes a low bound, mid-range, and high bound, with the mid-range being considered the "best estimate." The RDA mid-range estimate for TMRSN is "142," which the current capacity of 140 already approximates.

TMRSN has three (3) separate, but coordinated, WISe programs between two (2) agencies. They include the Catholic Community Services (CCS) WISe Program, Community Youth Services (CYS) Transitional Age Youth WISe Program, and the CYS Multi-systemic Therapy Program.

CCS WISe Program

The CCS WISe Program currently has capacity to serve **100 children/youth** ages birth through 20 years with complex emotional/behavioral health needs, and their families, at all times. The origin of this program goes back to 2007 when TMRSN contracted with CCS to provide high-fidelity wraparound supports to children/youth with complex needs. Concurrent to the CCS contract, TMRSN contracted with Donna Obermeyer, a local parent with lived experience and the Director of Family Alliance for Mental Health, to function as the Wraparound Coordinator, and with the University of Washington's Evidence-Based Practice Institute (UW EBPI) to provide technical assistance, support, and data analysis.

Prior to the conversion to WISe, the fidelity wraparound program closely monitored adherence and outcomes using multiple validated tools, including the Wraparound Fidelity Index (WFI-4), the Strengths and Difficulties Questionnaire (SDQ), and a face-valid, pre-post instrument developed by Eric Bruns, PhD and used by the Maryland Wraparound Project. During that time, the program remained within the adherence range as defined by the National Wraparound Initiative and it produced statistically significant outcomes across many domains, including SDQ Emotional Symptoms, SDQ Conduct Problems, SDQ Hyperactivity, SDQ Total Difficulties, Suicide Attempts, Suicidal Thoughts/Gestures, Property Damage, Theft, School Changes/Disruptions, Suspensions, and Anxiety. Other domains that demonstrated positive change, but did not quite reach statistical significance, included Arrests, Assaults, and Substance Abuse.

The well-established fidelity wraparound program provided a solid foundation when it became necessary to convert to and implement WISe. Because of the rich history with outcome data collected over the past eight (8) years, TMBHO has opted to continue using the same instruments to evaluate the efficacy of the WISe program. TMBHO also chose to continue contracting with Donna Obermeyer as the new WISe Coordinator and with the UW EBPI for technical assistance, program evaluation, and data analysis.

The CCS WISe Program meets (and exceeds) the WISe manual and PIHP contract agency infrastructure and staffing requirements for the 100 slots. They have a current Behavioral Health Agency License through DBHR, with certification to provide the required services, and they have a current contract with TMRSN. All staff have also received the necessary training and credentialing required for the provision of WISe services.

CCS' staffing for this program includes:

A. Ten (10) FTE Care Coordinators/Wraparound Facilitators, all with B.A./B.S. credentials or higher social science degrees;
B. Ten (10) FTE Parent or Youth Partners, all certified peer counselors;
C. Ten (10) FTE WISe Therapists, all masters-level and certified in Managing and Adapting Practices (MAP);
D. Two (2) FTE WISe Clinical Supervisors, all masters-level and certified in Managing and Adapting Practices (MAP);
E. One (1) FTE WISe Parent/Peer Supervisor, parent with lived experience and supervisory experience.

The CCS WISe Program provides the required service array, including intake evaluation, intensive care coordination, intensive services, and 24/7 crisis intervention and stabilization services.

A. **Intensive care coordination** is facilitated by the Care Coordinator and Family/Youth Partner adhering to the National Wraparound Initiative model and ensuring that youth and family voice is at the forefront of services. Families are supported through a four-phase process that includes engagement and development of a Child and Family Team, development of a Cross System Care Plan (CSSP), implementation of the plan and ongoing monitoring of progress (revising as needed), and eventual transition out of formal wraparound with a viable aftercare plan. All Care Coordinators are trained in wraparound facilitation, WISe, and the Managing and Adapting Practices Model; receive weekly WISe supervision; and have access to consultation through Dr. Eric Bruns, co-founder of the National Wraparound Initiative.
B. **Intake evaluations** are completed by the WISe clinicians. The evaluation determines if the child/youth meets access to care standards for Medicaid-funded mental health services and serves as the beginning of the "golden thread" that ensures that

information gleaned from the evaluation is used to support the youth and family in developing meaningful strategies to address their needs and accomplish their goals.

C. **Intensive services** are provided by the WISe clinicians and guided by the goals developed by the Child and Family Team (CFT). The clinician is an integral member of the CFT and ensures that the individualized service plan (ISP is the Medicaid mental health treatment plan) and the Cross System Care Plan are complementary. The ISP is written in a manner that ensures that the functions of the CFT are Medicaid-allowable. The clinician uses the Managing and Adapting Practices (MAP) model to identify evidence-based interventions known to be most effective in addressing the treatment needs identified by the CFT. The clinicians have small caseloads (10) and therefore are available to provide multiple services to each family each week. All WISe clinicians are masters-level clinicians, are trained in WISe and trained and certified in MAP, have weekly supervision, and have access to consultation through Dr. Eric Bruns, co-founder of the National Wraparound Initiative.
D. **24/7 Crisis Intervention and Stabilization Services** are available to all youth/families enrolled in WISe. The CFT (including WISe therapist) work with the family to develop a safety/crisis plan. All members of the team are available to support the family with crises. If intensive, longer-term crisis and stabilization supports are indicated, then a staff from the mobile crisis program is brought into the fold as a child and family team member.

Cross-system collaboration is an essential component of this program. The CCS program has done an outstanding job engaging and partnering with allied systems in the Thurston Mason community. The WISe care coordinators work closely with family members to identify individuals from other systems that are involved in the youth's care and to engage them in the CFT.

CYS Transitional Age Youth WISe Program

The CYS Transitional Age Youth WISe Program has capacity to serve **20 youth** ages 15 through 20 years with complex emotional/behavioral health needs at all times. This WISe program was developed to address the unique needs of the transition age youth (TAY) population, which often includes challenges relating to aging out of federal programs, housing/homelessness, education/occupation, justice involvement, necessary life skills, and lack of parent/caregiver to engagement in more traditional wraparound care planning.

CYS has researched other wraparound programs serving this population and they are receiving consultation from Dr. Eric Bruns on adapting the wraparound/WISe approach to more effectively engage and serve transition age youth in this program.

The CYS TAY WISe Program meets (and exceeds) the WISe manual and PIHP contract agency infrastructure and staffing requirements for the 20 slots. They have a current Behavioral Health

Agency License through DBHR with certification to provide the required services and they have a current contract with TMRSN. All staff have also received the necessary training and credentialing required for the provision of WISe services.

CYS' staffing for this program includes:

A. Two (2) FTE Care Coordinators/Wraparound Facilitators, both with B.A/B.S. credentials or higher in social science degrees;
B. Two (2) FTE Youth Partners, both certified peer counselors;
C. Two (2) FTE WISe Therapists, both masters-level and certified in Managing and Adapting Practices (MAP);
D. One .5 Supervisor dedicated to this program, masters-level and certified in Managing and Adapting Practices (MAP).

The CYS TAY WISe Program provides the required service array, including intake evaluation, intensive care coordination, intensive services, and 24/7 crisis intervention and stabilization services.

A. **Intensive care coordination** is facilitated by the Care Coordinator and Youth Partner adhering to the National Wraparound Initiative model with adaptions made in consultation with Dr. Eric Bruns, co-founder of the National Wraparound Initiative, to better match the unique and developmental needs of the population served. Youth are supported through a four-phase process that includes engagement and development of a Child and Family Team, development of a Cross System Care Plan (CSSP), implementation of the plan and ongoing monitoring of progress (revising as needed), and eventual transition out of formal wraparound with a viable aftercare plan. All Care Coordinators are trained in wraparound facilitation, WISe, and the Managing and Adapting Practices Model; receive weekly WISe supervision; and have access to consultation through Dr. Eric Bruns, co-founder of the National Wraparound Initiative.
B. **Intake evaluations** are completed by the WISe clinicians. The evaluation determines if the child/youth meets access to care standards for Medicaid-funded mental health services and serves as the beginning of the "golden thread" that ensures that information gleaned from the evaluation is used to support the youth (and family when applicable) in developing meaningful strategies to address their needs and accomplish their goals.
C. **Intensive services** are provided by the WISe clinicians and guided by the goals developed by the Child and Family Team (CFT). The clinician is an integral member of the CFT and ensures that the individualized service plan (ISP is the Medicaid mental health treatment plan) and the Cross System Care Plan are complementary. The ISP is written in a manner that ensures that the functions of the CFT are Medicaid-allowable. The clinician uses the Managing and Adapting Practices (MAP) model to identify evidence-based interventions known to be most effective in addressing the treatment needs identified by the CFT. The clinicians have small caseloads (10) and therefore are

available to provide multiple services to each family per week. All WISe clinicians are masters-level clinicians, trained in WISe and trained and certified in MAP, have weekly supervision, and have access to consultation through Dr. Eric Bruns, co-founder of the National Wraparound Initiative.

D. **24/7 Crisis Intervention and Stabilization Services** are available to all youth enrolled in WISe. The CFT (including WISe therapist) work with the family to develop a safety/crisis plan. All members of the team are available to support the family with crises.

Cross-system collaboration is key to this program. CYS routinely participates in social marketing efforts to ensure that allied systems are familiar with how to access the program and to address any barriers. The CCS TAY WISe coordinators work closely with the youth to identify allied providers that can participate on the CFT.

CYS Multi-Systemic Therapy (MST)

The CYS MST Program currently has capacity to serve **20** WISe-eligible youth ages 12 to 18 years with complex emotional/behavioral health needs and their families at all times. The CYS MST Program has been approved as an "enhancement" to the WISe Program because it has been proven highly effective in treating the WISe-eligible population in Thurston and Mason counties. CYS has been providing MST services in this community since January 1, 2013. This program has been closely monitored for fidelity and outcomes during this time. The program has consistently exceeded the adherence threshold and has produced positive outcomes in the following measures: school suspensions, expulsions, degree of school success, suicide attempts, suicidal gestures, assaults, property damage, theft, running away, anxiety, arrests, substance use, SDQ Emotional Symptoms, SDQ Conduct Problems, SDQ Hyperactivity, SDQ Peer Problems, SDQ Prosocial Behavior, and SDQ Total Difficulties.

Due to the rich data already being collected, TMBHO opted to continue using the same instruments to evaluate the efficacy of the MST program as it became a WISe enhancement. TMRSN continued to contract with University of Washington's Evidence-Based Practice Institute for technical assistance, program evaluation, and data analysis. This program also receives weekly supervision and consultation from MST, Inc.

The CYS MST program meets and exceeds the requirements of the WISe Manual and PIHP contract in most categories, with the exception of the training requirements (WISe training was waived because clinicians are certified MST therapists) and with staffing patterns, which was also waived due to the proven effectiveness of the program for this population. CYS has a current Behavioral Health Agency License through DBHR with certification to provide the required services and they have a current contract with TMRSN to provide MST/WISe services. All staff have received the training and credentialing required to be approved as a WISe enhancement program.

CYS' MST staffing includes:

A. Six (6) FTE MST Therapists, all MST trained and credentialed with weekly supervision and weekly consultation.
B. One (1) FTE Clinical Supervisor, MST trained, MST Supervisor Trained, weekly consultation from MST, Inc.

The CYS MST WISe enhancement program provides the required service array, including intake evaluation, intensive care coordination, intensive services, and 24/7 crisis response and stabilization services.

A. **Intake evaluations** and WISe screens are completed by the MST Therapist. The intake evaluation plus the CANS screen determines if the youth meets access to care standards and WISe criteria. This information is combined with the MST intake to begin the "golden thread" process of ensuring that the information gleaned from the evaluation is used to support the youth and family in developing meaningful strategies to address their needs and accomplish their treatment goals.
B. **Intensive care coordination** is accomplished through family and therapists engagement of allied system participants in treatment planning and care coordination. All MST therapists are MST trained and credentialed, receive weekly supervision and weekly consultation.
C. **Intensive services** are provided by the WISe therapists. The MST caseloads range from four to six cases at any time, which allows therapists capacity to provide each youth/family multiple services each week.
D. **24/7 crisis intervention and stabilization services** are available to all youth/families enrolled in MST. The therapist, family, youth, and allied providers develop a crisis/safety plan, which includes access to a CYS MST therapist 24/7, as needed.

Cross-system collaboration is a key element to this program. CYS actively engages and partners with allied systems in the Thurston and Mason community. The CYS MST program closely coordinates with other systems and involves them in treatment as is appropriate.
All three of the Thurston Mason WISe programs are closely monitored by TMRSN and are coordinated by Donna Obermeyer, a parent with lived experience and who serves as the Director of the Family Alliance for Mental Health (Thurston Mason parent network). This approach has proven effective in maintaining continuity across the WISe programs. It also infuses parent/consumer voice at a critical, decision-making level. TMRSN's children's Care Manager and Donna co-chair a bi-monthly WISe Implementation workgroup, which addresses the day-to-day operational needs (access, utilization, data, information systems, quality, etc.) of the three programs.

The *TR vs. Quigley and Teeter* Settlement Agreement requires each region to form a collaborative governance structure for WISe that includes youth, families, and child-serving agencies. The Thurston Mason WISe governance structure is facilitated through Donna Obermeyer, WISe Coordinator. Locally, this is known as the Thurston Mason WISe Steering Committee, which meets quarterly to provide oversight of local WISe implementation. This team includes multiple youth and parents, Tribal members, WISe providers, TMRSN staff, and representatives from education, juvenile justice, child welfare, developmental disabilities, and mental health.

TMRSN, the WISe Coordinator, WISe providers, and the Steering Committee closely monitor the demand for WISe services and the current capacity. If it is determined that additional capacity is needed to meet demand, TMRSN will notify DBHR and request approval to build additional capacity.

6

Staffing and Workforce Analysis and Development Plan

Training

As Thurston County employees, all staff are required to attend numerous county-sponsored trainings. Training topics required as a condition of employment include: Workplace Violence Prevention, Cultural Sensitivity, and Sexual Harassment and Prevention, among others. In addition, personnel working specifically in TMBHO are required to have an annual compliance training in fraud and abuse prevention, and a biennial training in HIPAA and related confidentiality issues (including 42 CFR Part 2 training). In addition, all credentialed staff are required to fulfill their training requirements as mandated through their particular credentialing body. In all cases, this includes a biennial training in law and ethics.

Throughout the year, TMBHO staff are also encouraged to participate in trainings that broaden their overall scope of expertise and help them to deliver services in a current and well-informed manner. In 2015, mental health staff have participated in ASAM trainings, while several SUD staff have participated in trainings on the new DSM-5 and ICD-10 changes. Staff have also participated in conferences, online training, and professional coursework in areas relevant to their assigned duties and specific license.

Personnel

TMBHO has increased its staffing and brought on individuals with expertise in SUD prevention and treatment to be prepared to manage the new benefits in 2016. Please find TMBHO's Organizational Chart for its 2016 BHO attached (Attachment 8: 2016 Organizational Chart).

Ombuds

(175) Mental health Ombuds office.

When TMBHO begins operations in April, 2016, it fully intends on having a fully staffed Consumer Affairs Office ready to serve the needs of both mental health and substance use disorder consumers/enrollees. TMBHO is taking this opportunity to re-imagine Ombuds and Quality Review Team (QRT) services. In the past, these two (2) required functions have operated somewhat independently. While there was some cross-communication, especially in the area of report sharing, no concerted efforts were made to coordinate activities and play a

larger role in the overall quality management structure of the RSN. With the creation of BHOs, it is felt that this is an opportune time to restructure both programs and re-title these as the TMBHO Consumer Affairs Office.

Current Ombuds / QRT Structure

In the past – under the Thurston Mason Regional Support Network structure – the Mental Health Ombuds provided exceptional services to consumers with complaints, concerns, and grievances. She also provided a considerable number of what can be termed as "information and referral" services. This generally meant linking consumers with non-mental health services within the community or assisting mental health consumers with finding additional (non-Medicaid funded) services. She also served as the lead for the Consumer Council, a local group of consumers who meet on a regular basis to review TMRSN written materials such as handbooks, policies and procedures, brochures, Notice of Action / Notice of Determination (NOA/NOD) templates and other materials intended to be read by consumers. The goal of the Council is to ensure that written materials are written in a way that are clearly understandable to all consumers and to offer suggestions to TMRSN staff on how to improve communication to all users of network services.

Currently, the Ombuds is funded as a three-quarter time position. The position is functionally independent, as required by RCW and contract. In calendar year 2014, the TMRSN mental health Ombuds provided the following services:

- Total number of grievances received: 114
- Total number of information / referral contacts: 266
- Total number of Ombuds contacts: 380
- First contact made within 24 hours: 99.17%
- Acknowledgment letter sent within five (5) working days: 80.17%
- Grievances resolved within thirty (30) calendar days: 99.33%

The Quality Review Team (QRT), by contrast, has historically conducted consumer surveys only. This has primarily involved distributing and/or administrating TMRSN-developed surveys to consumers in waiting rooms of community mental health agencies. The results of these surveys were then calculated and a quarterly report generated. The report was then distributed among all RSN staff – including the TMRSN Quality Manager, who used them to support quality improvement initiatives – and leadership from applicable community mental health agencies.

The QRT function is funded currently at as a half-time position. The current QRT representative recently resigned his position (as of July 15, 2015) and therefore the position is vacant as of this writing. With his vacancy, the opportunity to completely restructure the Ombuds/QRT functions has become more of a reality and therefore this position will remain vacant until such

time as this new structure can be realized. In calendar year 2013, the TMRSN QRT conducted 129 interviews within nineteen (19) site visits; in 2014, 81 interviews were conducted at fourteen (14) different sites.

Future TMBHO Ombuds/QRT Structure (Consumer Affairs Office)

One of the primary goals of the Consumer Affairs Office will be to ensure that all consumer-generated grievances are heard, investigated and resolved within the required timeframes (as established by 42 CFR and PIHP Contract). To that end, the TMBHO will add a half-time FTE primary dedicated to substance use disorder grievances. After careful analysis of current mental health Ombuds grievances, and an examination of current SUD consumers, it is felt that increasing Ombuds services by twenty (20) hours per week is sufficient to address these needs.

The Ombuds will continue to record, investigate and resolve grievances as they have historically done. This means that grievances (both mental health and SUD) coming into TMBHO will be recorded by the Ombuds. They will issue an official notification of the grievance and mail it to the consumer within the required five (5) day timeframe. They will then initiate an initial investigation into the grievance. Depending on the nature of the grievance, the resolution will be reviewed and signed off on by a mental health professional (MHP) or chemical dependency professional (CDP). The Ombuds will then ensure that a final resolution is mailed to the consumer and the applicable network agency within the required timeframes. The TMBHO Ombuds will also assist consumers with petitioning for a State Fair Hearing if the consumer is not satisfied with the outcome of the grievance resolution. They will also provide assistance in directing consumers to the appropriate TMBHO staff in matters related to appeals.

The structure of the new Consumer Affairs Office is still evolving. It is anticipated that it will consist of two (2) full time employees and a number of consumer volunteers who will sit on the Consumer Council. The two (2) full time employees will primarily fulfill the requirements of the Ombuds and QRT, but will play a much more expansive role than they previously did within the overall quality management structure. It is anticipated that each of the positions will address grievances as well as be much more involved with direct consumer contact and interviews. It is currently within the job descriptions that all Ombuds / QRT positions must be filled by consumers or persons with lived experience with either mental health or substance use disorders.

The new TMBHO Consumer Affairs Office will have as its centerpiece a vibrant system to hear and address the concerns and grievances of consumers. However, it will also provide the following services:

- Assist consumers with advance directives.
- Assist consumers with information and referral requests for other community-based services.

- Educate consumers and Network Providers on grievance rights of consumers.
- Participate with the TMBHO Quality Manager in monthly meetings with Network Providers to examine trends and possible solutions within prevent grievance categories.
- Initiate consumer surveys, both for one-on-one administration and mailed surveys, to gauge satisfaction in the following areas:
  - Access to care,
  - Customer service,
  - Dignity and respect,
  - Provision of consumer/enrollee rights,
  - Treatment planning,
  - Knowledge and understanding of assigned diagnosis,
  - Understanding of recovery principles and anticipated length of stay, and
  - Overall consumer satisfaction with services.
- Initiate Network Provider interviews and surveys to address community need and gaps in the service array.
- Initiate community partner interviews and surveys to examine how ancillary services are (or could be) beneficial to the consumers that TMBHO serves.
- Lead the Consumer Council for the purpose of reviewing written materials (for ease of understanding and relevance), creating and contributing to a consumer-run / TMBHO-supported website, and identifying strategies to better address service gaps and areas in need of future quality improvement efforts.
- Produce monthly productivity reports that capture all of the efforts of the Consumer Affairs Office. This report would also present outcome and output measures required by TMBHO (i.e., timeliness of grievance resolutions, etc.).

TMBHO will continue to track grievances under its present categories. These categories are comprehensive and can accommodate both mental health and substance use disorders. According to the TMBHO Policy and Procedure Guidelines for Ombuds Services (GL-1001), grievance categories include:

Grievance Type	Definition
Access – Inpatient	Refers to (1) access to inpatient services (denied hospitalization), and/or (2) termination from service. Can be concerned with getting into needed services, or having such services terminated early. Concerns can also be related to length of time it took to get services and whether the service was available when needed.
Access – Outpatient	Refers to (1) access to outpatient services, and/or (2) termination from service. Can be concerned with services being limited, reduced,

Grievance Type	Definition
	eliminated, or services not available at all, as well as the length of time it took to obtain needed services. May also concern eligibility for services.

Grievance Type	Definition
Violation of Confidentiality	A real or received breach of confidentiality. A violation of confidentiality can be a verbal or written infraction. This can include discussing a consumer/enrollee without proper release of information (consumer permission), discussing a consumer/enrollee in public areas loudly enough that others can hear, or releasing confidential information to third parties without written authorization / permission.
Consumer Rights	A real or perceived violation in client (consumer/enrollee) rights as defined by Washington Administrative Code. This category is generally used when the consumer/enrollee states that their "consumer" or "client" rights have been violated.
Dignity and Respect	A real or perceived consumer /enrollee experience where they feel they were **not** treated with dignity and respect. Differs from customer service in level of degree: Generally, customer service is concerned with rudeness or inattention, while dignity and respect is concerned with marginalizing, minimizing or otherwise disrespecting a consumer / enrollee and their experience. This could also include family members who do not feel respected while advocating for family members.
Emergency Services	Concerned with crisis services (i.e., CRS), programs that should provide emergency services (i.e., PACT), E&T, or hospitals. Expressed dissatisfaction with emergency / crisis services.
Financial Services	Generally concerned with a consumer's/enrollee's funds. Can concern payees and pay problems. Concern might involve SSI eligibility, termination or reduction of services due to eligibility, or problems accessing needed funds.
Phone	Refers to the agency's failure to return phone calls, or to provide requested reminder calls.
Physician and Medications	Refers to a consumer's/enrollee's experience with agency physicians, nurses or other medical staff (physical and mental health); experiences with a consumer's/enrollee's medication (dosage, failure to prescribe needed medications, support and education about medications); experiences with agency psychiatrist.

Grievance Type	Definition
Quality & Appropriateness	Refers to the quality and appropriateness of services. Broad category that is concerned with any aspect of the consumer's/enrollee's experience with a Network Provider. Can include a service that is not being provided, or the consumer/enrollee has been placed into inappropriate services. Concerns in this category can also involve case manager or therapist appropriateness and effectiveness.
Service – Coordination	Concerned with the lack of appropriate coordination of services. Refers to the failure of an agency to appropriately coordinate with other service providers (i.e., JRA, CD, Schools, DSHS, DOC, Hospitals.), or with other programs within the same agency.
Service – Not Available	Concerned with the lack of appropriate services being available for the consumer/enrollee. Differs from Quality and Appropriateness in that the service is not part of the agency's overall milieu, whereas in Quality and Appropriateness, the service is offered at the agency, but just not to the specific consumer/enrollee.
Service – Intensity	Concerned with the lack of appropriate service intensity. Generally, this refers to the agency **not** providing the needed level (intensity) of services to the consumer/enrollee. Can be concerned with level of care placement and service package intensity or placement (i.e., therapy only one time monthly).
Transportation	May be concerned with the availability of bus passes, transportation coupons, or otherwise the consumer's/enrollee's inability to arrive at needed services due to transportation issues. Can also be concerned consumers/enrollees who are unable to travel (for diagnostic reasons) and require needed mental health services.

TMBHO also tracks grievance resolutions. The type of resolution is largely dependent on how effectively TMBHO, and the TMBHO Ombuds, work to resolve the issue at the lowest possible level. TMBHO grievance resolution categories include:

Resolution Type	Definition
Appeal	An appeal refers specifically to real or perceived denial of services. A grievance generally would not be resolved by initiating an appeal, although it could happen (if the real issue was a denial of services).
Information, Referral, Assistance	Generally refers to information (e.g., names, phone numbers, addresses) provided to a consumer/enrollee from the community as the result of an inquiry call. Can be facilitated by agency or TMBHO Ombuds.

Resolution Type	Definition
Referral to the QRT	A referral to the Quality Review Team would be made by the TMBHO Ombuds as **part** of an overall resolution. Generally, this is done after a grievance trend has been observed.
Referral to Agency QM	Refers to a resolution where the TMBHO refers the caller to the Network Provider quality management person (the identified person responsible for addressing consumer grievances). For such a resolution, the TMBHO Ombuds and the agency quality management person should communicate that such a referral has been made.
Referral to Ombuds	Refers to a resolution where the Network Provider quality management person refers the consumer to the TMBHO Ombuds. Generally, this occurs when the issue involves another agency, when the agency-provided response is not satisfactory for the consumer, or when the consumer wants to file an appeal or grievance. For the agency to mark this type of resolution, communication between the TMBHO Ombuds and the agency quality management person should occur.
Conciliation with Ombuds Assistance	The most common resolution, this refers to a resolution where the consumer and the Network Provider have resolved the issue amongst themselves. Generally, this involves the agency or Ombuds investigating the issue and arriving at some form of solution for the consumer. Communication between the Ombuds and the Network Provider is common for this resolution. The nature of the solution can vary.
Formal Arbitration / Mediation	Can refer to a semi-formal process whereby both parties develop a solution that is mutually agreed upon. For example, arbitration can occur between the consumer and the Network Provider, and be facilitated by the TMBHO Ombuds. Solutions are not binding, but are arrived at in good faith between all parties. Generally, arbitration is seen as the next level up from conciliation and mediation.
Grievance	Refers to a situation where other possible outcomes (solutions) to an initial problem are not satisfactory to the consumer or their representative. Formal grievances are investigated, tracked, and reported upon by the TMBHO quality manager.
Fair Hearing	Refers to a situation where the outcome of a grievance investigation by the TMBHO is not satisfactory to the consumer. The consumer has the right to request a fair hearing in front of an administrative law judge with the Office of Administrative Hearings. Fair hearings are investigated by DSHS, but the progress is tracked by TMBHO with the Ombuds remaining as support for the grievant.

Resolution Type	Definition
Not Pursued	Refers to a resolution where the consumer does not respond back to the agency or TMBHO, or is unable to be reached. A consumer may call and leave a message, but does not respond when called back by the agency or TMBHO.
Other	Other type of resolution. This category should be rarely used; clear explanatory notes should be provided when this category is used.

One of the guiding principles of the TMBHO Grievance System, under which the Ombuds and QRT system lies, is to resolve all grievances and appeals at the lowest level possible. This means that the system subscribes to the philosophy that the consumer should experience the least amount of stress (trauma) as possible. Consumers, by the very nature of being involved in services, are already experiencing a high degree of stress. They should not be subjected to any undue stress by entering into the legally-sanctioned grievance and appeal processes.

It is for these reasons that the TMBHO Grievance System is organized the way it is. To summarize, this includes:

- All grievances are heard and tracked by the TMBHO Ombuds. The Ombuds conducts initial research and provides possible solutions to for the grievance. A TMBHO mental health professional (MHP) or chemical dependency professional (CDP) reviews and signs all grievance resolutions. This eliminates the need for a “two-tiered” grievance system whereby consumers are forced to engage with multiple systems in order to get their concerns heard. It also allows TMBHO a better opportunity to keep a pulse on the overall system in terms of grievances within the community.
- Consumers are given one (1) primary office (Consumer Affairs Office) in which to lodge concerns, grievances and appeals. This eliminates the need for consumers to “track down” individual agency representatives.
- The Consumer Affairs Office prepares the consumer’s grievances and appeals and works with TMBHO staff, as necessary, to resolve the issues.

7

Financial and Administrative Plan

TMRSN has successfully managed mental health (MH) benefits for indigent and Medicaid enrollees for over twenty (20) years. The Thurston Mason Governing Board and its management staff are well on the way to making the transition to TMBHO. As previously indicated, inter-local joint agreements are in place and the TMBHO management team has developed an actionable plan that will result in the required state of readiness, as expected by its board and DBHR, to provide services April 1, 2016.

TMBHO shares the state legislator's vision of an integrated system of care that provides comprehensive integrated primary and behavioral health care at the right time, in the right amount, and with the intended outcome. While this is the ultimate aim of the state and TMBHO, all evidence indicates that there are significant barriers to overcome to align funding streams, train providers, and engage consumers in creating the forthcoming system. TMBHO is stepping boldly into the future to do its part to create the best system of care for its customers.

As a high level time frame for creating a BHO in Thurston and Mason counties, the following timetable has been developed:

Project	Anticipated Completion
Policy and Procedures	February 1, 2016
Staffing (full staffing)	February 1, 2016
Training (internal)	March 1, 2016
Training (providers / external)	March 1, 2016
Contracts (draft)	February 1, 2016
Contracts (fully funded)	April 1, 2016
MIS (new system)	March 1, 2016

(3) Behavioral health organizations - contracting process.

TMBHO is fully committed and accountable for efficient and effective behavioral health services in the region through state-of -the-art outcome performance measures, statewide standards and for monitoring consumer/enrollee and system outcomes, performance, and reporting of system outcome information. Reimbursement methods will be designed in Network Provider

subcontracts to maximize the use of available resources and performance to meet performance measures for the direct care of people with a behavioral health disorder.

A. TMBHO Contracts will be consistent with the intent expressed in RCW 71.24.015, 71.36.005, 70.96A.010 and 70.96A.011
    1. TMBHO utilizes reimbursement models that incentivizes service providers to report and be in compliance with statewide performance measures and outcomes.
    2. TMBHO subcontracts identify, by exhibit, what the performance measures are and what, if any, the performance based incentives are to each measures. A logic model is utilized to identify the performance measures then identify what the incentives are to be attached to the contract payment.
    3. TMBHO prioritizes and incentivizes community-based treatment (non-clinic) in consumer's/enrollee's home, shelters, etc. (any place but the clinic). The goal is to treat individuals where they are best served in the community.
        i. TMBHO will fund these outpatient services at a higher rate than clinic-based services – which incentivizes out-of-facility treatment, since it is paid at a higher rate than clinic-based services.
        ii. TMBHO data and community input has identified an increased need for psychiatric care in the community. Due to the lack of work force for psychiatric services in the Provider Network, TMBHO will increase the rate of reimbursement for physicians and ARNPs (Advanced Register Nurse Practitioner) and decrease the ratio of psychiatrists to consumers/enrollees, thereby improving access to medical services.
B. TMBHO will utilize reimbursement methods that incentivize improved performance with respect to the consumer/enrollee outcomes established in RCW 43.20A.895 and 71.36.025.
    1. TMBHO has determined in policy that the BHO will have in place reimbursement methods designed to promote community-driven outcome and performance measures that are efficient and effective for monitoring consumer/enrollee and system performance improvement. These methods will be designed so as to maximize the appropriate use of available resources for direct care of people with behavioral health needs. The results of these methods shall be tracked and reported as part of the TMBHO quality improvement plan.
C. TMBHO will utilize reimbursement methods to target specific services that have been identified to fill a gap and are essential to care and performance. Through contracting, TMBHO has identified and has dedicated funding for the following sample of programs that it wants to ensure are made available by service providers:
    1. Multi-systemic Therapy (evidence-base practice [EBP] for children),
    2. Children's crisis response – Homebuilder's type model,

3. Transition age youth services (funding dedicated for the 15 to 24 year-old age group),
4. Intensive case management teams including PACT (Professional Assertive Community Treatment),
5. Mentally Ill Offender services for adults (in jail services and intensive transition services),
6. Mentally Ill Offender services for juveniles (in jail assessment and transition services),
7. Crisis stabilization services (dedicated funding for a licensed ten bed facility),
8. Triage facility (ten beds that are licensed for involuntary treatment; opening date of April 2016),
9. Free-standing evaluation and treatment facility (fifteen beds),
10. A free-standing consumer-run agency providing peer counseling services.

The purpose of this reimbursement model is to ensure that these services are made available and that it is not just up to the discretion of service providers to determine what essential treatment they will provide beyond individual and group treatment. In this fashion, TMBHO assures adequate levels of funding for EBPs that are not necessarily recognized by the Centers for Medicare and Medicaid Services. In this fashion, TMBHO clearly is responding to identified community need and ensuring the availability of services.

D. TMBHO will coordinate with Apple Heath for purposes of case planning, coordination and consumer/enrollee transfers. This will be further defined by DBHR contract requirements but will include, at a minimum, a data sharing agreement and process shared by both the BHOs and Apple Health.

(5) BHOs – access to chemical dependency and mental health professionals.

TMBHO is fully committed to the integration of behavioral health and primary care. Data shows that life expectancy for the population of persons with severe behavioral health needs is substantially less than that of the adult population without chronic/severe behavioral health issues. TMBHO is committed to turn this outcome around by creating a seamless system of care between primary health care and behavioral health care, particularly for those with co-morbid disorders.

There are several ways in which TMBHO promotes clinical integration and access behavioral health services and primary care, as described below.

First, TMBHO has in place a policy that is referenced in every service provider contract regarding care coordination with primary care providers. All service provider agencies and their case managers are required to promote care coordination and access to primary care services

for the population served. Providers are to require case managers to contact primary physicians to coordinate care and if one is not in place, assist the consumer in finding a primary physician.

Secondly, TMBHO has in place several contracts with primary care practice settings to promote access to the services of substance use disorder professionals and mental health professionals for the purpose of integrating such services into primary care settings for individuals with behavioral health and medical comorbidities. The following is a list of existing contracts with arrangements to promote direct integration, already in place:

a) Geriatric behavioral health services provided by Providence St. Peters Hospital;
b) SeaMar, a federally qualified health center (FQHC);
c) Primary care services at the Thurston Mason Evaluation and Treatment Facility.

Providence St. Peters Hospital holds a contract with TMBHO to provide geriatric outpatient mental health care to both Thurston and Mason counties. These services include home bound visitation and linkage to primary care provided by Providence St. Peters Hospital for these individuals.

SeaMar is a federal qualified health center (FQHC) that provides mental health care to Medicaid and low income populations. In addition, they operate their facility as a health clinic for this population. The result is that these consumers can utilize SeaMar as their health home for all areas of care. This past year, SeaMar began expanding and opened a clinic in rural Thurston County (Yelm), providing better access.

Thurston Mason Evaluation and Treatment Facility (E&T) is licensed to provide involuntary evaluation and detention services and required to provide health screenings. In the past, these services were usually provided at the local hospital emergency department where police would bring a referral prior to coming to the E&T. The E&T facility now provides health screens on site along with primary care for those consumers who have co-morbid health conditions. The result is less transportation by consumers between facilities and better coordinated care on site.

Thirdly, TMBHO is developing more integrated contracts with primary care to effectively combine behavioral and primary care services in the same setting. Some of these proposed contracts are:

a) A new FQHC agency (Valley View) paired with a behavioral health provider. TMBHO supported the partnership between Valley View and Behavioral Health Resources, located on the same facility campus, resulting in the ability to create what is essentially a health home with the ability to ensure availability and coordination of primary care and behavioral health services.
b) In Mason County, Mason General Hospital owns all of the health clinics in the county. TMBHO is currently involved with a task force to assist the hospital with behavioral

health services that they do not provide. The initial step will target how to divert and transition behavioral health consumers from using the emergency room for any behavioral health services. Linkages are being created between the hospital and behavioral health clinics to bridge this gap and form a coordinated and cooperative plan for overall health care.

c) TMBHO is now working on building a new triage facility: a ten bed voluntary and involuntary service for initial assessment and jail diversion. These triage services will focus on providing initial health screens and services to reduce the use of the emergency room by police prior to a consumer being accepted into the facility, a problem most other facilities in the state experience. Primary care physicians will be on site to provide health care as necessary.

d) TMBHO has a longstanding history of supporting the community through use of one tenth of one percent funding sales tax to provide "free" health and behavioral health care services for the region. Many individuals with behavioral health issues who require care are reluctant to access mainstream services. The result is a large gap in care, particularly for individuals with low income who may or may not have Medicaid. In this region, TMBHO has helped support access to care by supporting downtown clinics that are open to work with this high-need population. These services include the integration of health and behavioral health care.

TMBHO is currently in contract discussion with Providence St. Peters Hospital regarding the development of a downtown drop-in center for the homeless and street population in Olympia. The plan is to develop a "mall like" approach where multiple service organization will be available, along with primary care and behavioral health care. The intent is to make all services available for a hard-to-reach population that often does not use services until they are in a state of acute need. Many of these consumers will be brought to the facility by the police. The overall hope is to provide an accessible facility that includes an urban drop-in with showers and laundry, along with health care and psychiatric care to initiate a consumer into the first step of recovery.

(37) Payment for treatment — Financial ability of patients.

Certain TMBHO consumers/enrollees will be required to pay some portion of the cost for treatment, depending on their level of income and the third party payers associated with their account. What follows is policy guidance given to providers and the contractual expectations they are held to.

(1) If treatment is provided by an approved treatment program and the patient has not paid or is unable to pay the charge therefore, the program is entitled to any payment (a) received by the patient or to which he or she may be entitled because of the services rendered, and (b) from any public or private source available to the program because of the treatment provided

to the patient.

(2) A patient in a program, or the estate of the patient, or a person obligated to provide for the cost of treatment and having sufficient financial ability, is liable to the program for cost of maintenance and treatment of the patient therein in accordance with rates established.

(3) The secretary shall adopt rules governing financial ability that take into consideration the income, savings, and other personal and real property of the person required to pay, and any support being furnished by him or her to any person he or she is required by law to support.

The Contractor is authorized to and shall determine financial eligibility for patients as follows:

A. All persons applying for services supported by County funds are screened for financial eligibility.
B. Conduct an inquiry regarding each patient's continued financial eligibility no less than once each month and document the evidence of each financial screening in individual patient record.
C. Sliding fee schedules are used in determining the fees for low-income eligible services.
D. Persons who have a gross monthly income (adjusted for family size) that does not exceed the 220% of the Federal Poverty Guideline are eligible to receive services partially supported by funds included in this Contract. The Federal Poverty Guidelines can be found here http://aspe.hhs.gov/poverty/12poverty.shtml

   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.

E. If any service is available free of charge from the Contractor to persons who have the ability to pay, the Contractor shall ensure the County is not charged for Fee Requirements for low-income patients.
F. 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.
G. 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 Service Rate Plan.
   i. Indigent patients are exempt from this fee requirement.
   ii. Interim Services are exempted from this fee requirement.
H. Refer client to Health Plan Finder website for eligibility determination at http://www.wahbexchange.org

8

Utilization Management Plan

(24) Acceptance for approved treatment.

(284) Authorization of services.

Written policies and procedures for utilization management currently exist for mental health disorder services to adhere to 42 CFR 438.210(b)(1). Policies and procedures will be developed to include substance use disorder (SUD) services for both TMBHO and its subcontractors by February 1, 2016. Validation of the policies and procedures will be completed during initial implementation of the contract.

In addition to converting to the Avatar system by enacting signed data sharing agreements with providers, the following information outlines how TMBHO expects to incorporate SUD services into the utilization management system by April 1, 2015. The following is an overview of the mental health disorder authorization process and the proposed substance use disorder authorization process.

Utilization Management: Mental Health Disorder services

Mechanisms to ensure consistent application of review criteria for authorization decisions are described below.

TMBHO will continue to require its mental health providers to provide initial assessments that meet Medicaid and DSHS requirements for determining diagnosis and medical necessity for BHO-funded mental health services. In addition, TMBHO providers will use the LOCUS/CALOCUS tool for determining level of care for its outpatient mental health consumers/enrollees that meet medical necessity and Medicaid eligibility criteria. A credentialed mental health professional from the provider agency completes the LOCUS/CALOCUS score sheet for the consumer/enrollee following the initial assessment and at the time of authorization extension request. The TMBHO LOCUS/CALOCUS Navigators provide a guideline for recommended frequency and intensity of services for each of the levels of care. TMBHO will continue to require its mental health service providers to participate in quarterly inter-rater reliability studies and forward their results to TMBHO for review. TMBHO Care Managers will continue to review those quarterly results with provider leadership to address opportunities for improved reliability ratings within each provider agency and within the BHO as a whole. TMBHO will also continue to be available for consultation when providers have questions related to determining

levels of care or intensity of services for specific consumers / enrollees or when patterns have developed that call for attention.

Utilization Management: Substance Use Disorder (SUD) services

SUD services will be provided to consumers/enrollees for whom they are medically necessary by adhering to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), American Society of Addiction Medicine (ASAM) criteria, and other principles identified by TMBHO. As the Medicaid population is the top priority, TMBHO will allow other non-Medicaid individuals to access services within available resources:

- The individual has an income level no more than 220% of the federal poverty level,
- Is not Medicaid eligible,
- Is uninsured,
- Has insurance but is unable to meet the co-pay or deductible for the services.

Using the standards set forth in the DSM-5, SUD will be measured on a continuum from mild to severe with each substance addressed by a separate disorder. Out of the 11 symptoms, mild substance use disorder will require two to three symptoms, moderate will require four to five, and severe will be classified as six or more.

With the biopsychosocial assessment, and a DSM-5 diagnoses determined, the chemical dependency professional (CDP) or CDP trainee will use the ASAM criteria's six dimensions to place, assess continued stay, and transfer/discharge the consumer/enrollee over five levels of care, which will be the basis for authorizations and utilization reviews.

TMBHO intends to provide an ASAM training in February 2016 for all providers to ensure proficiency in use of the criteria. Ongoing technical assistance from the Care Managers will be available to help providers prepare for the use of the ASAM criteria in authorizations and re-authorizations.

TMBHO will develop a tool, similar to the LOCUS/CALOCUS Navigators, to provide a guideline for recommended frequency and intensity of services for each of the levels of care. TMBHO will develop an inter-rater reliability tool, require its providers to participate in quarterly inter-rater reliability studies, and forward their results to TMBHO for review per 42 CFR 438.210(b)(2)(i). TMBHO will review those quarterly results with provider leadership to address opportunities for improved reliability ratings within each provider agency and within the BHO as a whole. TMBHO will also continue to be available for consultation when providers have questions related to determining levels of care or intensity of services for specific consumers/enrollees or when patterns have developed that call for attention adhering to requirements in 42 CFR 438.210(b)(2)(ii). TMBHO will have trained Care Managers review substance use disorder

authorization requests for services, with appropriately credentialed professionals reviewing denials for services in accordance with requirements set forth in 42 CFR 438.210(b)(3). Policies and procedures will be developed to reflect this process.

In addition to development of the authorization and utilization process, contract language will be inclusive of the following information to adhere to RCW 70.96A.100:

- Every attempt shall be made to ensure a consumer/enrollee is in treatment on a voluntary rather than involuntary basis. A consumer/enrollee shall not be denied treatment solely because he or she has withdrawn from treatment against medical advice on a prior occasion or because of a relapse after earlier treatment. An individualized treatment plan shall be prepared and maintained on a current basis for each consumer/enrollee using, but not limited to, the six dimensions of the ASAM criteria which impact any and all assessment, service planning, and level of care placement decisions. This approach to individualized treatment shall allow for a continuum of coordinated treatment services, so that a consumer/enrollee who leaves a facility or a form of treatment will have available and use other appropriate treatment.

Furthermore, contracts with providers will outline the National Institute on Drug Abuse (NIDA)'s Thirteen Principles of Effective Drug Addiction Treatment (http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment):

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each patient's problems and needs is critical.
2. **Treatment needs to be readily available.** Treatment applicants can be lost if treatment is not immediately available or readily accessible.
3. **Effective treatment attends to multiple needs** of the individual, not just his or her drug use. Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
4. **Treatment needs to be flexible** and to provide ongoing assessments of patient needs, which may change during the course of treatment.
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about three months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.

7. **Medications are an important element of treatment for many patients,** especially when combined with counseling and other behavioral therapies. Methadone and levo-alpha-acetylmethadol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol dependence. Nicotine patches or gum, or an oral medication, such as bupropion, can help persons addicted to nicotine.
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because these disorders often occur in the same individual, patients presenting for one condition should be assessed and treated for the other.
9. **Medical detoxification is only the first stage of addiction treatment** and by itself does little to change long-term drug use. Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.
10. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
11. **Possible drug use during treatment must be monitored continuously.** Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases,** and counseling to help patients modify or change behaviors that place them or others at risk of infection. Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process** and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.

System of Care Guiding Principles (http://www.tapartnership.org/SOC/SOCprinciples.php):

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.

3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

Substance Abuse and Mental Health Services Administration (SAMHSA) Guiding Principles of Trauma-Informed Care (http://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/guiding_principles.html).

1. **Safety** – Throughout the organization, staff and the people they serve feel physically and psychologically safe.
2. **Trustworthiness and transparency** – Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.
3. **Peer support and mutual self-help** – These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
4. **Collaboration and mutuality** – There is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.
5. **Empowerment, voice, and choice** – Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary. The organization aims to strengthen the staff's, clients', and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach. This includes a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.
6. **Cultural, historical, and gender issues** – The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma

Emerging Substance Use Disorder Trends

TMBHO anticipates further utilization of the Thurston/Mason Continuing Education and Training Grant (CETG). These funds are a combination of federal, state, and local resources for education and training opportunities that will increase TMBHO’s capacity to implement evidence-based substance use prevention, treatment, and co-occurring disorder treatment programming. This will provide an opportunity for the TMBHO provider network to stay current on emerging substance use disorder trends.

9

Quality Assurance Plan

(292) Quality assessment and performance improvement program.

TMBHO endorses a vibrant and rigorous quality assurance and performance improvement (QAPI) system. Historically, TMRSN defined its quality management plan as a broad set of activities in the service of quality care to all of its consumers/enrollees; it subscribed to the philosophy that quality management is never just the examination of simple data sets, or the review of a handful of clinical charts. It is not simply imposing outcome measures on the service providers it contracts with, nor is it mandating that evidence-based practices be implemented. A well-developed QAPI system is broad in scope and must, by definition, encompass all aspects of the consumer's/enrollee's experience in the mental health and substance use disorder system.

The primary charter for the TMBHO QAPI system is the annual Quality Assurance and Performance Improvement Plan. This document will be referred to several times throughout this response. The first major section of this annual plan describes the Guiding Principles of the TMBHO QAPI system:

> TMBHO, as a Prepaid Inpatient Health Plan (PIHP), will ensure continued progress toward effective and efficient age- and culturally-competent delivery of behavioral health services and improved consumer/enrollee satisfaction and outcomes. This includes objective measures of progress toward rehabilitation, recovery, and reintegration into the mainstream of social, employment, and educational choices by maintaining an internal and external quality assessment and performance improvement program. The guiding principles of this program include the following:
>
> - Best model for quality care – utilization of evidence-based (EB), research-based, and consensus-based models of care;
> - Services to promote consumers'/enrollees' recovery, resiliency, and tenure in the community;
> - Cost effective, clinically effective, and efficient services;
> - Comprehensive community-based care;
> - Age and cultural congruency;
> - Customer satisfaction;
> - Dignity, hope, and respect for consumers/enrollees and their families;
> - Community and provider collaboration;
> - Services in compliance with all state and federal regulations and standards;

- Ongoing relevant training;
- Effective monitoring of the service delivery system to assure quality; and
- Adherence to the continuous quality assessment and performance improvement program model and work plan.

While the TMBHO QAPI system will strive to meet the mandates of 42 CFR 438.240 and the requirements of the DBHR contracts, it will also reach far beyond those minimum elements in an attempt to make the experience of its consumers/enrollees as useful and meaningful as possible. To that end, the TMBHO QAPI Plan has formulated the following goals and objectives.

1. Establish organizational standards of integrity in delivery of quality services, accurate data collection and reporting, accountability, and compliance with federal and state regulatory requirements;
2. Establish a consistent process for distributing, communicating and implementing any changes or modifications necessary within the organization and provider network;
3. Provide oversight and technical assistance as needed to operationalize the regulatory and contractual requirements;
4. Safeguard the integrity of resources, services and data to prevent, detect and resolve any incidents of intentional or unintentional conflict of interest, fraud or abuse;
5. Address financial and performance expectations and commitments objectively;
6. Establish qualitative and quantitative review mechanisms that allow for objective system review and continuous process and program improvement; and
7. Promote recovery and resiliency through effective mental health service delivery.

The response to this Detailed Plan question will examine the broad categories of activities of the TMBHO QAPI plan. These categories, which represent the actual work of the TMBHO quality management program, include:

- **Clinical Practice**: To include clinical monitoring activities, use of evidence-based practices, and practice guidelines.
- **Utilization Management:** To include the use of the TMBHO level of care system and over/under utilization.
- **Performance Measures:** To include the use of regional and statewide (core) performance measures and incorporation of outcome measures into Network Provider contracts as regular deliverables.
- **Performance / Program Improvement Projects (PIPs):** To include the use of Medicaid-required PIPs, use of PIPs and corrective action plans (CAPs) to improve overall practice and remedy Network Provider deficiencies, and compliance monitoring.
- **Data Collection and Analysis:** To include regular monitoring of key data elements, adherence to state and federal requirements, and use of data analysis as a “tool” to assist with overall clinical improvement within the system.

- **Grievance and Critical Incident Review:** To include regular monitoring and identification of trends and incorporation of lessons learned into the overall quality improvement strategies and work plans.
- **Policy and Procedure:** To include TMBHO development and implementation of policy and procedure to assist Network Providers in operations, the use of protocols as a means of ongoing communication with Network Providers, and policy expectations of Network Providers.
- **Training:** To include regular and ongoing Network Provider training expectations and TMBHO-provided technical assistance.
- **Provider Communication and Networking:** To include regular meetings and information sharing between TMBHO and its Network Providers and dissemination to the TMBHO Advisory Board of quality improvement activities and initiatives.

Clinical Practice

1. Clinical Monitoring Activities: One of the primary activities of the QAPI program is to conduct clinical reviews from a representative sample of service recipients. TMBHO has a created a policy and procedure (QM-618) that outlines how it will implement a regular and ongoing system of clinical reviews. Clinical reviews at TMBHO can consist of "targeted reviews" which examine only one (1) key element of a clinical record (e.g., intakes, bio-psychosocial assessments, treatments plans, etc.). The other type of clinical review is what TMBHO calls a "comprehensive review" wherein the entire episode of care is reviewed. In both types of clinical reviews, TMBHO utilizes a standardized review instrument that has been developed to incorporate Washington Administrative Code (WAC), Revised Code of Washington (RCW), and applicable CFRs. The clinical review instruments also incorporate state and TMBHO contract requirements.

In addition to the various types of clinical chart reviews that TMBHO will conduct under the QAPI system, there are additional reviews in which the organization will engage. One of these includes the operational review, which examines major TMBHO-funded programs and looks at compliance in terms of contract requirements (adherence to the Statement of Work in the contract), clinical practice, and utilization (number served and cost of services per consumer/enrollee). Another type of review that might be conducted by TMBHO involves a specialized review. This type of review primarily examines clinical and/or program records in cases of suspected fraud and abuse, or other types of suspected programmatic irregularities.

TMBHO Policy for clinical chart reviews (QM-618) states that TMBHO will ensure an ongoing, on-site clinical chart review process that includes:

a. A clinical chart review of five percent (5%) of all unduplicated behavioral health charts in a given calendar year using a standardized review instrument. Review instruments may be comprehensive (full-instrument) or targeted (partial) review instruments.
b. Quarterly summaries that identify areas of strength, areas in need of further improvement, and record of compliance according to cited requirements.
c. Instructions for performance improvement plans (PIP's) to address any deficiencies identified in the clinical chart review and that focus on measurable goals and objectives, with clear deliverable due dates and responsible persons identified.
d. Results of ongoing clinical chart reviews will be summarized and provided in report format to the TMBHO Advisory Team, TMBHO Manager, and TMBHO Care Managers on a quarterly basis. Reports will also be provided to DSHS, as requested.

2. Use of Evidence-Based Practices: The TMBHO QAPI system encourages Network Providers to utilize evidence-based practices (EBPs), promising practices, or other research-based clinical interventions in their service delivery array. If an EBP is used, TMBHO will monitor the use of the EBP and assist the providers in coding this intervention in such a way that the encounters can be collected and reported accurately to the State. TMBHO does **not** clinically monitor EBPs for fidelity. Rather, if a Network Provider employs an EBP as part of its overall service delivery model, TMBHO will insist that it has some method of verification (adherence standards) that it is indeed following the EBP to fidelity **before** it will report these encounters to the state as an EBP. In other words, if an agency is claiming to use an EBP, it must attest that it is using this model to fidelity and is employing some method to measure this fidelity. In many cases this means using an outside organization closely aligned with the particular EBP.

Recent trends in Washington State are very much in support of evidence-based practices. In children's mental health, there is a requirement that all Network Providers must incorporate EBPs into their practice, and that this rate of EBP usage increase incrementally each year. The role of the TMBHO QAPI program in EBPs is to ensure that agencies purporting to have EBPs (and therefore, wanting to submit encounters under a particular EBP) do indeed have a method in place to ensure fidelity and can attest to this fact.

3. Practice Guidelines: TMRSN has long used practice guidelines as an aid for mental health practitioners in the mental health arena. For many years this involved the use of the Schizophrenia and High Risk Protocol Practice Guidelines. In 2014, however TMRSN decided to borrow a chapter from other RSN's in the state and adopt a broader concept with regards to practice guidelines. For mental health, TMRSN decided to use a diagnostically-driven menu of practice guidelines to assist clinicians in the field. These guidelines list the most prevalent children and adult diagnoses and link the clinician to the most recent APA

guidelines for treatment and intervention. This electronic system, which allows a clinician to simply click on a link and be directly connected with APA practice guidelines, should be fully operational in late 2015 and available through the TMBHO website.

Since the recent trend to adopt evidence-based practices and mandate that Network Providers implement them, the use and practicality of the practice guidelines has waned. It is felt that as EBPs make a larger presence in overall service delivery, the use of discreet practice guidelines will no longer be as valuable. The newly adopted system of diagnostically-driven practice guidelines should provide a more up-to-date aid for clinicians and offer direct access to what the APA is suggesting as evidence-based practice guidelines.

During the first year of the TMBHO, substance use disorder practice guidelines will **not** be available. There was not enough time to develop a list of prevalent SUD diagnoses and link those with applicable practice guidelines. Many of the TMBHO SUD providers, however, are already linked with an evidence-based practice. This, and the prescriptive nature of the ASAM criteria, provides for ample clinical direction for practitioners in the field for the time being. Practice guidelines for SUD services will be part of the TMBHO QAPI Work Plan for 2016.

Utilization Management

1. TMBHO Level of Care System (Mental Health) and ASAM Criteria Placement (SUD): One of the roles of the TMBHO Quality Management program is to continuously review and monitor utilization within the system. In 2013, TMRSN selected the Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) as its primary level of care system for mental health services. The LOCUS/CALOCUS are research-based functional assessments that help determine appropriate placement among the continuum of care for mental health consumers/enrollees. Part of the development of the LOCUS/CALOCUS involved creating a “Navigator” which provides service levels and intensities. Training in the LOCUS/CALOCUS was provided to each provider in the TMRSN network, and service intensities were included as part of the overall utilization management system. Utilization under each of the LOCUS/CALOCUS levels of care are routinely monitored by the TMBHO Quality Manager.

   For substance use disorders, level of care placement has been determined by the American Society of Addiction Medicine (ASAM) Criteria; however, a consumer’s/enrollee’s stay has historically also been based on programming policies, such as a 30-day residential program. As TMBHO moves to prior authorization for services, ASAM Criteria will be used to place a consumer/enrollee into care and any re-authorizations must be documented with proper clinical justification. Furthermore, TMBHO will develop a tool similar to the “Navigator” as a reference for providers. In order to ensure Network Providers are prepared for this new

process, TMBHO will be offering a free two-day training provided by The Change Company, and purchasing ASAM Criteria books for providers. Additionally, our Care Managers will be available for technical assistance as needed for our providers.

2. Under and Over Utilization: 42 CFR 438.240 (b)(3) requires that QAPI programs have effective mechanisms to monitor under- and over-utilization of services. By using the level of care instruments described above, TMBHO will have an effective means to monitor under- and over-utilization. It is the role of the TMBHO Quality Manager to ensure that utilization is continuously monitored and, when necessary, performance improvement strategies initiated when a Network Provider begins to fall outside of expected utilization norms.

TMBHO has taken a methodical look at over- and under-utilization and has developed policy guidelines (GL-1003) to assist staff in addressing these issues. Below are some operational definitions from the guidelines of over- and under-utilization and some mechanisms to help identify the issue.

Over Utilization Refers to:

- The use of higher cost and more restrictive services, such as crisis and inpatient services, when other more cost-effective and clinically appropriate services could potentially be offered/provided at a lower and less restrictive level of care. An example would be the over use of the emergency room or inpatient hospitalizations for crisis episodes, when regular case management with responsive and timely outpatient appointments may avoid the onset of the crisis.
- The provision of unnecessary services or services in excess of what is medically necessary or clinically appropriate to the needs of the consumer/enrollee. When a consumer/enrollee is in an acute episode, additional and more frequent services may be medically necessary. However, once the consumer/enrollee is stabilized, services should be tailored to meet the consumer's/enrollee's currently demonstrated needs and to promote recovery and independence, regardless of frequency. An example would be the provision of more frequent case management visits, phone calls, or escorts to other community providers, when the consumer/enrollee could be encouraged to manage or assisted to learn to manage more independently using personal or other community resources.
- Billing for unnecessary services or services in excess of what is reasonable and customary, and is provided in accordance with service activity and billing codes.

Under Utilization Refers to:

- The infrequency of consumer/enrollee contacts, including efforts at engagement and outreach, or the insufficiency of timely and appropriate services to meet the consumer's

/ enrollee's needs. This may be a consideration at the onset of treatment, during an acute episode, or when there is an inability to effectively engage a previously involved consumer / enrollee in services over time.

- The lack of sufficient, appropriate and medically necessary services to meet the consumer's/enrollee's needs that may lead to the over-utilization of more restrictive and costly services. This also refers to the inadequate or insufficient provision of services to meet the consumer's/enrollee's relevant and reasonable treatment goals. An example would be face-to-face outpatient visits that are only available and offered less than once per month when the consumer/enrollee may require more frequent visits to be effectively engaged in his or her own treatment.

Performance Measures

1. Regional Performance Measures: RSN's have been familiar with the requirement of Regional Performance Measures for a number of years, as they have been (and will continue to be under the new BHOs) a part of the overall quality management structure of the organization. The requirement for Regional Performance Measures continues under the new PIHP contract (section 8.8.4). TMBHO is very familiar with the structure and overall requirements of Regional Performance Measures and will continue to develop, monitor and report on these under the upcoming BHO structure. In the future, however, substance use disorder services will also be considered when developing the measures. As specified in the new PIHP contract (section 8.8.4.1), areas for consideration will include:

- 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

Currently, TMRSN has three (3) active Regional Performance Measures that it will be retiring with the start of the new contract. Two (2) of these involve service intensity within the

children's mental health system (outpatient and crisis services) and one (1) involves improving consumer/enrollee knowledge and awareness of the TMRSN Grievance System. All three (3) measures have demonstrated considerable improvements over the past five (5) years. Within the coming year, as part of the overall QAPI Work Plan, new Regional Performance Measures will be developed and sent to DBHR for approval. More information concerning TMBHO's Regional Performance Measures can be seen in the TMBHO policy on Regional and Core Performance Measures (QM-612)

2. Core Performance Measures: As a result of the recent legislation on Core Performance Measures (HB1519 and SB5732), the direction of Core Performance Measures is fairly established. The measures are integrated and examine both mental health and substance use disorders. Through its quality management program, TMBHO supports the work of the Core Performance Measures and will initiate performance improvement strategies, as needed, to improve performance in these key areas. TMBHO policy (QM-612) stipulates that TMBHO will:

- Partner with local Network Providers, and the TMBHO Advisory Board, to develop strategies to increase performance for each of the identified Core Performance Measures;
- Develop policies and procedures that support performance improvement;
- Develop monitoring activities that focus on the Core Performance Measures; and,
- Develop strategies that seek to improve performance if quarterly and annual DSHS reports do not meet annual performance targets.

In the next several years TMBHO will be working on four (4) Core Performance Measures. The QAPI program will be incorporating these Core Performance Measures into the overall QAPI Work Plan. It will be the responsibility of the TMBHO Quality Manager to monitor progress of these measures on a quarterly basis, develop any required corrective action plans, and report on progress to all stakeholders. The draft PHIP contract states that the four (4) Core Performance Measures are:

1) Core Performance Measure #1 – Psychiatric Hospitalization Readmission Rate: The proportion of acute psychiatric inpatient stays during the measurement year followed by an acute psychiatric re-admission within 30 days. This measure will be a modified version of the NCQA HEDIS "Plan All-Cause Readmission" metric.
2) Core Performance Measure #2 – Mental Health Treatment Penetration: Percent of adults identified in need of mental health treatment where treatment is received during the measurement year. This measure will be defined by DSHS and required of all RSNs.
3) Core Performance Measure #3 – Substance Use Disorder Treatment Penetration (to be defined at a later date).

4) Core Performance Measure #4 – Substance Use Disorder Treatment Retention (to be defined at a later date).

1. Provider-Based Outcome Measures**:** In addition to the various regional and statewide performance measures that are, and will become, part of TMBHO's and its Network Provider's responsibility to monitor, various other outcome measures will be introduced. There are currently a handful of specialized programs (especially with substance use disorder services and children's mental health) that require specific outcome measures to be reported. In the future, TMBHO will be infusing outcome measures in all of its contracts. This includes core outpatient mental health and substance use disorder services. There are a variety of different outcome measures that can be introduced to Network Providers and become part of their ongoing reporting to TMBHO. By mandating outcome measures, TMBHO can better measure the effectiveness of the services it is purchasing from the network, as well as report with more confidence that consumers/enrollees are receiving the right type of services at the right duration and intensity.

Performance/Program Improvement Plans

A significant part of the TMBHO QAPI program involves researching, creating, monitoring and evaluating various types of performance or program improvement plans (PIPs). In some cases it also involves creating and monitoring corrective action plans (CAPs). This section of the Detailed Plan discusses the different types of PIPs and how TMBHO uses these instruments as a means to improve the overall delivery of services to the consumers/enrollees it serves.

1. CMS/DBHR-Required Performance Improvement Plans (PIPs): A major and ongoing initiative at TMBHO involves the development, monitoring, and reporting on Centers for Medicare and Medicaid Services (CMS) and DBHR required performance improvement plans (PIPs). It should be noted at the outset of this discussion that the term "PIP," used by the state to describe this prescribed, research-oriented scope of work, is very different than how the TMBHO Quality Management system uses the term. The former describes a process strictly outline by CMS protocol, while the latter uses it as a process whereby Network Providers create performance/program improvement plans to improve upon a noted deficiency within their organization (see bullet #2 below).

   Each year, the TMBHO Quality Manager facilitates the annual External Quality Review Organization's (EQRO) audit of TMBHO. This is a comprehensive external review of the RSNs/BHOs and involves many facets of the organization, with a significant portion targeting the review of the BHO's PIPs. TMRSN has historically been required (through contract) to develop and monitor two (2) PIPs – one clinical and one non-clinical. One of the PIPs was required to be a "children's" PIP. These PIPs have historically been developed by Care Managers within the organization. With the advent of the BHO, however, the

requirements for PIPs have changed to include the addition of a third, substance use disorder-related PIP.

TMBHO supports the requirements surrounding PIPs and it will be the responsibility of the TMBHO Quality Manager to ensure that PIPs are created and reported to both DBHR and to the EQRO partners during the annual review. TMBHO policy and procedure (QM-613) outlines this support in the following policy statements:

Thurston Mason Behavioral Health Organization (TMBHO) will:

1) Be engaged in three (3) performance improvement projects (PIPs) at all times, in accordance with federal regulations. Two of the PIPs will focus on improving clinical care, while the other will focus on nonclinical aspects of service delivery. One (1) PIP must be a children's PIP and can be either clinical or non-clinical.
2) Develop each PIP using Centers for Medicare and Medicaid Services (CMS) criteria and protocol. A written project plan with study design, analysis plan, and summary of results will be developed prior to implementing a PIP.
3) Conduct measurements of current performance (pre-intervention) using objective quality indicators.
4) Identify and implement intervention strategies designed to improve quality in the identified PIP areas.
5) Immediately measure and evaluate the results of the intervention, according to the written project plan.
6) Incorporate positive intervention results of the performance improvement project into future policies, program designs, and contract negotiations to ensure increased and/or sustained improvement.
7) Participate in annual program reviews conducted by the Department of Health and Social Services (DSHS) and the External Quality Review Organization (EQRO) to evaluate TMBHO's effectiveness of its PIP's.

2. <u>TMBHO-Required PIPs / Corrective Action Plans (CAPs):</u> After any type of review or audit with Network Providers, where deficits are noted, the primary mechanism to address these issues is through a performance improvement plan (PIP). The PIP process allows providers to develop their own quality improvement strategies to remedy the noted deficiencies. The areas of concern noted in the review are presented to the Network Provider, along with recommendations for improvement. The provider then takes this information and formulates a plan for meeting the requirements that are out of compliance. The plan is then submitted to TMBHO, where it is reviewed and either approved or returned for further clarification.

Engaging providers in the performance improvement plan process is generally the first step in the quality improvement process. It allows for the provider to take "ownership" of the issues and develop their own strategies for improvement that best meet with the values and needs of their organization. There are times, however, when TMBHO must move directly to the second step of quality improvement – the corrective action plan (CAP). These generally involve issues related to fraud and abuse, safety issues, or other compliance issues where the luxury of provider-drive improvement plans are not feasible. With a CAP, the Network Provider is instructed by TMBHO what must be done to remedy an identified issue or concern. It is a much more directive process and can involve direct sanctions for non-compliance (e.g., payback for previously paid services).

TMBHO uses both the PIP and CAP on a fairly regular basis within its QAPI program. TMBHO has a preformatted template it uses for all PIPs; corrective action plans are generally in the form of a letter that directs the provider on the course of action they need to take. In both cases, the process is overseen and monitored by the TMBHO Quality Manager. The process of PIPs is also discussed and affirmed through TMBHO policy and procedure (QM-618), which states that Network Providers will:

> Participate fully in the performance improvement process. This includes developing an internal performance improvement plan that reflects the identified issue(s) from the clinical chart review summary document (or other review process), taking concrete steps to correct identified deficiencies, and communicating all necessary steps to TMBHO, as required. The performance improvement plan will:
>
> a) Describe the identified area of concern, with citations from recent clinical chart reviews;
> b) Outline a plan of correction to be undertaken by the Network Provider, to include expected dates of completion and responsible persons;
> c) Describe how the actions of the performance improvement plan fit into the organization's overall quality improvement plan; and
> d) Describe any technical assistance needed from the TMBHO to ensure timely completion of the performance improvement plan.

Data Collection and Analysis

The TMBHO QAPI system will continue to engage in an aggressive data collection process for the purpose of program and system analysis and improvement. The TMBHO Grievance Plan (AP-1105) discusses the data collection and analysis process within TMBHO. Language in this section states:

> TMBHO will collect data using standardized tools, criteria and reports for the following minimum data set:

a) Clinical chart audits using TMBHO-developed standardized tools of at least five (5) percent of active consumers/enrollees that represent age and cultural diversity that includes:
    i. Compliance with WAC and RCW documentation and practice standards;
    ii. Compliance with EPSDT standards;
    iii. Compliance with access to care and level of care guidelines;
    iv. Compliance with ASAM criteria;
    v. Compliance with clinical practice guidelines; and
    vi. Quality of care to include appropriateness, least restrictive, care coordination and cultural, linguistic and age competency.

b) Operational Reviews that provide:
    i. Detailed information on specific identified programs operating within the TMRSN catchment area. These currently include:
        1. Mentally Ill Offender (MIO) Program
        2. Mentally Ill Juvenile Offender Program (MIJOP)
        3. Community Integration and Outreach Program (CIO)
        4. PACT
        5. PATH
        6. Mason Thurston Wraparound Initiative (MTWI)
    ii. Clinical chart review results;
    iii. Program review results; and
    iv. Utilization review results.

c) Access Reports that provide:
    i. Screening, disposition and referral information;
    ii. Timeframes for request for services to an intake;
    iii. Timeframes from intake evaluation to initiation of routine service;
    iv. Timeframes from request for urgent behavioral health services to provision of services; and
    v. Time from request for emergent behavioral health services to provision of services.

d) Authorization/Service Provision Reports that provide:
    i. Time from initiation of intake evaluation to request for service authorization;
    ii. Time from request for service authorization to authorization decision; and
    iii. Time from service authorization to decision notification.

e) Hospital Admission and Discharge and Seven (7)-Day Post Hospitalization Discharge Reports that provide:

i. Number of TMBHO-funded hospital admissions and lengths of stay in community inpatient hospitals, evaluation and treatment programs, and Western State Hospital; and
ii. Number of days between inpatient discharge and first non-crisis service.

f) Utilization Management Reports that provide:
   i. Number of consumers/enrollees served by age group, number of services and number of service hours, including trends;
   ii. Number of consumers/enrollees served with Medicaid and Non-Medicaid funds;
   iii. Number of consumers/enrollees served by provider, reporting unit (RU) and project code;
   iv. Number of consumers/enrollees needing crisis services and Designated Mental Health Professionals (DMHP) services;
   v. Number of consumers/enrollees receiving services over or under a predetermined amount of service hours (outliers): and
   vi. Community hospitalization, Western State Hospital, evaluation and treatment (E&T) admission reports.
g) Data and Financial Reports that provide:
   i. Data quality monitoring;
   ii. Encounter data validation;
   iii. Monthly error and clean-up;
   iv. Third Party Liability (TPL);
   v. Revenue and expenditures; and
   vi. Average cost per consumer/enrollee.
h) Quality Management Reports that:
   i. Identify and track utilization patterns and trends;
   ii. Identify critical incidents;
   iii. Evaluate effectiveness of programs and service areas;
   iv. Assess internal controls for measuring, reporting, and monitoring a program;
   v. Identify expected outcome measures that validate change over time;
   vi. Identify factors inhibiting satisfactory performance;
   vii. Identify corrective actions and outcomes;
   viii. Identify grievances, to include trends;
   ix. Evaluate consumer/enrollee satisfaction;
   x. Evaluate service provider reports and deliverables;
   xi. Review and validate DSHS published performance indicators; and
   xii. Measure indicators for performance improvement projects.

Data is gathered and measured through a multitude of sources and activities. Mechanisms will be incorporated to assure that a broad sampling of demographic groups, care settings,

and types of services are reviewed over multiple review periods. In addition to the data incorporated by the above activities, other key quality improvement activities include, but are not limited to:

a) Review of advisory board and committee reports;
b) Review of performance and utilization reports;
c) Initiation and review of provider, allied service, stakeholder and community surveys/forums;
d) Administrative audits – this includes compliance with contracts and state and federal requirements;
e) Participation in DSHS BHO certification, Medicaid managed care reviews (EQRO), provider licensing and certification reviews;
f) Intake assessment and concurrent authorization reviews – periodic and by category; and
g) Participation in the DSHS Performance Indicator Workgroup (PIWG/DQ4).

Grievance and Critical Incident Review and Analysis

1. Grievance Review and Analysis: A key component of the TMBHO Grievance System, and an overall tenant of the QAPI system, is the regular and ongoing review and analysis of grievances within TMBHO service delivery system. Both the TMBHO Grievance Policy and Procedure (QM-603) and Annual Grievance Plan (AP-1101) stress the importance of regular analysis of system grievances to include developing performance improvement initiatives with Network Providers based on "lessons learned" from grievances, and sharing of grievance information to all TMBHO stakeholders. Policy language states:

- TMBHO will review concerns, grievances and appeals for the purpose of reporting and quality improvement initiatives in accordance with *TMBHO's Policy QM-601 Quality Assessment and Performance Improvement Program*.
- TMBHO will review the *TMBHO AP-1101 Grievance Plan* and policies at least biannually and implement changes to the grievance system in response to contract changes and changes to the service delivery system in response to recommendations by stakeholders or as a result of concerns and grievances.

The TMBHO Quality Manager generates a monthly report of all concerns, grievances and information / referrals that come into the TMBHO Ombuds. Complaint information collected from Network Providers and reported to TMBHO is also included in this report. Once this report is produced, an analysis of trends is conducted to see if there are any major trends that should be addressed through a quality improvement initiative. Information is then shared to Network Provider quality leads and TMBHO staff. On a quarterly basis, a grievance report is produced for members of the TMBHO Advisory Board. Grievance types and trends are reviewed with members of the board, as are critical incidents.

Periodically, the TMBHO Quality Manager meets with leadership from Network Providers and the TMBHO Ombuds to review that agency's specific grievance trends and develop specific strategies to prevent future occurrence of the grievance type.

2. Critical Incident Review and Analysis: The collection and reporting of critical incidents, as defined by DBHR and supported in TMBHO policy and procedure (QM-606), is the responsibility of the TMBHO Quality Manager. TMBHO policy statements regarding critical incident reporting states:

TMBHO shall monitor the quality of care in the provider network, investigate and track any incidents, events and potential abusive or high-risk incidents, and report them to the Department of Social and Health Services (DSHS) based on designated incident categories.

a) For category one (1) incidents, TMBHO will contact DSHS immediately upon becoming aware of events involving a person who has been served within 365 days of one of the following incidents:
    i. Death or serious injury of patients, consumers/enrollees, 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) crisis stabilization and transition units (CSTU) and triage facilities that accept involuntary consumers/enrollees.
    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 consumer/enrollee.
    iv. Any event involving an individual or staff that has attracted, or that in the professional judgment of the Incident Manager, is likely to attract media attention.
b) For category two (2) incidents, TMBHO will contact DSHS within one (1) working day upon becoming aware of events involving a person of one of the following incidents:
    i. Alleged consumer/enrollee abuse or consumer/enrollee neglect of a serious or emergent nature by an employee, volunteer, licensee, Contractor, or another consumer/enrollee.
    ii. A substantial threat to facility operation or consumer/enrollee 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 consumer/enrollee data in any form that is considered as reportable in accordance with the Health Information Technology for

Economic and Clinical Health (HITECH) Act and that would allow for the unauthorized use of consumer/enrollee personal information. In addition to the standard elements of an incident report, BHOs will document and/or attach: 1) the police report, 2) any equipment that was lost, and 3) specifics of the consumer/enrollee information.

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

Critical incidents are reviewed and analyzed on regular basis. Similar to the TMBHO Grievance System, critical incidents are reviewed in terms of prevalence and trends and are reported out to all TMBHO stakeholders. Periodically, critical incidents are reviewed for the purpose of developing quality improvement initiatives and developing harm reduction strategies.

Policy and Procedure

1. Policy and Procedure Development and Dissemination: The TMBHO QAPI program subscribes to the notion that well-developed policies and procedures are one of the cornerstones of a sound quality management system. They are key mechanism to assist in the translation between state of Washington contractual requirements, Washington State Administrative Code, Revised Code of Washington and CFR. TMBHO has a robust set of policies and procedures. They are designed to not only assist TMBHO staff in performing their job duties, but also to convey expectations from TMBHO the Network Providers. Within each contract, language exists that expressly communicates that TMBHO providers

must adhere to and follow TMBHO policies and procedures, where and when applicable. They are therefore an extremely important tool in both communication and the establishment of expectations.

The TMBHO Quality Manager has the responsibility of ensuring that policies and procedures are kept current, are appropriately disseminated to all Network Providers, and reflect the accurate authority from which the policy has been developed. TMBHO maintains a policy and procedure (QM-614) on the creation and implementation of policies and procedures within TMBHO. Key policy statements from this policy state:

A. The TMBHO Administrator, or Designee, has signatory authority to approve all TMBHO policies and procedures which govern operations and provide technical direction and assistance to Network Providers of the TMBHO behavioral health service delivery system.
B. TMBHO will develop and maintain administrative and operational policies and procedures to assure compliance with federal, state and local laws and regulations, including RCW's, WAC's, and CFR's. TMBHO will incorporate into policy the requirements and provisions of the current Medicaid Prepaid Inpatient Health Plan and the state behavioral health services contracts with the Department of Social and Health Services (DSHS).
C. TMBHO policies will identify any expected standards and outcomes, and will specify processes, data elements, and reporting requirements that may be required to support program operations and compliance objectives. Policies will include where applicable, BHO and Network Provider roles, and the oversight and reporting relationships and responsibilities.

2. Protocols: Protocols are another way in which TMBHO conveys expectations to the Network Provider community. Each year TMBHO issues roughly ten (10) protocols to providers around a variety of issues. Generally speaking, protocols relate to MIS coding changes. However, they can relate to state-level policy changes that require immediate response and attention by providers, or an immediate change or alteration of TMBHO policy. TMBHO has a very specific policy and procedure around protocols, and protocol development (QM-615). Major policy statement from this document state:
    A. The TMBHO Administrator will designate signatory authority to TMBHO identified staff for TMBHO protocols which govern operations and provide technical direction and assistance to contractors of the TMBHO behavioral health service delivery system.
    B. TMBHO will develop protocols, as needed and required, to assure current compliance with federal, state and local laws and regulations, including RCW's, WAC's, and CFR's, and/or to relate process instructions and requirements to the Network Providers.

C. TMBHO protocols will identify any expected standards and outcomes, and will specify processes, data elements and reporting requirements that may be required to support program operations and compliance objectives. Protocols will include, where applicable, BHO and contracted provider roles, and the oversight and reporting relationships and responsibilities.
D. Protocols that change or nullify existing policy and procedure will be documented so that the affected policy and procedure can be updated during the biennial policy review.
E. Protocol requirements will be included in TMBHO monitoring and auditing activities.
F. Protocols may be issued for:
    1) New contract requirements or changes to existing requirements;
    2) Changes to the Data Dictionary, MIS reporting guidelines or other MIS-related documents or requirements;
    3) New policies and procedures, or changes to existing policies and procedures; and/or
    4) Clarification of an existing requirement, policy, program, process, guideline, etc.

Training

1. Network Provider Training (provided by the Network Provider): As one of the major pillars of a sound quality improvement system, training and technical assistance has a prominent place in TMBHO's QAPI system. Each Network Provider is required, through contract, to have a quality improvement (QI) plan. This will also be true of substance use disorder providers under the new BHO. A key component of an agency's QI plan is a description of the regular and ongoing training provided by the agency. These trainings – provided either by agency personnel or outside trainers – can cover a host of different topics. The types of training provided by Network Providers depends on what is mandated by TMBHO through contract, required training as part of an evidence-based practice and the values and needs of the organization.

   Some examples of TMBHO-required training include culturally competent services and violence prevention and assessment (supported through TMBHO Policy QM-609 and QM-611 respectively). With these examples, both mental health and substance use disorder Network Providers are expected to develop, provide, and document that training has occurred with their staff.

   In some instances, the agency must provide training (or purchase training through a third party) to some Network Providers in order to meet the requirements of an evidence-based practice (EBP) that the agency is participating in. Many EBPs have training requirements that must be met in order to comply with fidelity. It is the agency's responsibility to ensure that these trainings occur and that staff are allowed to participate. As part an agency's

attestation that they are operating an EBP to fidelity, they must include assurances that required trainings are taking place.

One example of EBP training that will be forthcoming (and supported in new TMBHO provider contracts) is in the area of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and CBT-Plus. DBHR will be emphasizing TF-CBT and CBT+ in the coming years and will have the expectation that BHOs support training in these areas in order to build capacity. TMBHO supports this initiative and will work with Network Providers to ensure their staff find and receive such training.

2. Network Provider training (provided by TMBHO): In some instances TMBHO will provide training to Network Providers and their staff. Due to the large number of provider agency staff, training to the entire provider community is fairly rare. In most cases training is in the form of "train the trainers" where TMBHO provides training materials (e.g., a PowerPoint presentation) with the expectation that provider network leadership will disseminate the training down to all required staff. Examples of such training include the TMBHO-developed training on HIPAA and compliance (fraud and abuse). Other mechanisms to provide training to staff include the use of TMBHO protocols and TMBHO-developed policies and procedures (see above). In cases where TMBHO is mandating a training to be delivered to all Network Provider staff, an attestation form is used to gather documentation verifying that staff has been trained. The TMBHO Quality Manager is responsible for gathering these attestations as evidence of training and provide them to DBHR and/or EQRO upon request.

   Finally, the bulk of TMBHO provider training occurs in a much less formalized (although still documented) fashion. Technical assistance is oftentimes provided to Network Providers on a case-by-case basis, and is usually the result of a performance improvement plan (PIP) or other identified deficiency within the organization. Examples of TMBHO-initiated technical assistance include treatment planning, following the "Golden Thread," LOCUS/CALOCUS, and developing useful crisis plans. Generally, the TMBHO Quality Manager provides the technical assistance, although it may be another Care Manager within TMBHO who does this. As needed, the Quality Manager may also find third party experts who can provide technical assistance for the agency for an identified issue.

Provider Communication and Networking

TMBHO is dependent upon a well-developed and continuous system of TMBHO / provider networking in order to communicate the quality improvement initiatives and strategies inherent in the TMBHO QAPI system, as discussed above. This document has already outlined several ways in which TMBHO communicates with Network Providers. This includes:

- Policy and procedures,
- Protocols,

- TMBHO Grievance System,
- Clinical and operational reviews, and the subsequent performance improvement plans,
- Data reports and provider report cards,
- Training and technical assistance.

Regular and ongoing Network Provider communication, however, is also part of the TMBHO QAPI system. TMBHO supports regular and ongoing communication in its QAPI plan (AP-1105):

> The TMBHO QAPI plan includes ongoing and consistent meetings between TMBHO staff, Network Providers, TMBHO Ombuds and a QRT member. The purpose of ongoing Quality Manager and Network Provider meetings is to foster a working relationship in order to review administrative and clinical processes, analyze data collected from consumer/enrollee and allied system surveys, review data reports, grievance and complaint findings, performance outcome reports, and any other source of system data brought forth for consideration. During individual meetings with Network Providers, the Quality Manager will ensure the following activities are conducted:
>
> 1) Review and analysis of key contract performance indicators, quality measures and outcomes;
> 2) Review and evaluation of available data to include audit, survey, quarterly, expenditure and revenue, and cost report data to identify trends, address service gaps and need for system improvements;
> 3) Review and evaluation of critical incidents, risk issues, and other areas of concern;
> 4) Review of cross-system and allied provider issues;
> 5) Review of QRT and Ombuds reports, findings and recommendations;
> 6) Make recommendations for system, program and/or policy changes;
> 7) Collaboration and participation in process and/or performance improvement projects; and
> 8) Collaborate on standards of practice, use of effective and efficient best practice models of care, and share ideas for quality improvements to consumer/enrollee-focused care.

In addition to regularly scheduled TMBHO / Network Provider quality improvement meetings, TMBHO has many other opportunities to communicate and network with the provider community. The TMBHO Quality Manager meets one-on-one with Network Provider quality leads on a regular basis. This communication is generally topic-specific and concerns some quality aspect of the provider's operation. In many cases, these meetings are related to developing a performance improvement plan (PIP), but oftentimes these meetings are for the purpose of offering technical assistance.

Finally, TMBHO utilizes its advisory board as a means of communicating QAPI information and ongoing strategies to board members. The QAPI plan, along with the TMBHO bylaws, describe how the QAPI program integrates overall program operations:

> The TMBHO Advisory Board provides oversight of the TMBHO Quality Assessment and Performance Improvement Program. The advisory board functions to review and evaluate the quality, effectiveness and efficiency of systems and services, and evaluate TMBHO's ability to meet the community's behavioral health needs. Key activities of this committee are to:
>
> 1) Identify key outcomes and quality measures;
> 2) Review the TMBHO "dash board" report of selected performance indicators and targets for outcome measures;
> 3) Perform and review community needs assessments and identify essential needs/concerns;
> 4) Review quarterly grievance reports, critical incident reports, and Ombuds and Quality Review Team reports, findings, and recommendations for improvements;
> 5) Review data collected from multiple sources and identify areas for further review and/or improvement;
> 6) Review, evaluate and recommend approval of the TMBHO QAPI Program, and the TMBHO Annual Report;
> 7) Identify potential trainings and education needs; and
> 8) Record and document committee activities, recommendations and actions.

Conclusion

The TMBHO fully intends on having an active and vigorous quality assurance and performance improvement program, as specified through 42 CFR and the DBHR contract. Historically, the QAPI program within the RSN was well-developed and active, meeting all expectations from EQRO onsite reviews. With the advent of the BHO, Thurston and Mason counties are proposing to carry on with this tradition. It is anticipated that the QAPI program will expand to meet all the quality improvement mandates currently offered in mental health.

This response has outlined many of the key facets of the TMBHO QAPI program. In summary, this include a discussion of the following areas:

1. Clinical Practice (reviews)
2. Utilization Management
3. Performance Measures
4. Performance Improvement Plans / Corrective Actions
5. Data Collection and Analysis
6. Grievance System and Critical Incident Analysis
7. Policy and Procedure Development

8. Training
9. Provider Communication and Networking

These nine (9) areas encapsulate the bulk of the activities provided by the TMBHO Quality Manager. This individual – Larry Horne – is a licensed mental health counselor and a child mental health specialist. He holds a CHC certificate and serves as the Compliance Officer for TMBHO. He has eighteen (18) years of experience in the mental health field, and fourteen (14) years of experience in continuous quality improvement. He has worked at the local, state and federal level on various quality improvement initiatives, including the development of CQI programs within both small and large organizations.

(274) Second opinion.

Each consumer/enrollee enrolled in TMBHO services is entitled to a second opinion from a qualified health care professional within the network in accordance with 42 CFR 438.206(b)(3). TMBHO policy and procedure (CI-407) supports obtaining a second option through the following policy statements:

A. TMBHO will ensure that a Medicaid enrolled consumer/enrollee has the right to a second opinion from another equally qualified mental health professional (MHP) and/or chemical dependency professional (CDP) when:
    1. The consumer/enrollee needs more information about the medical necessity of the treatment recommended by TMBHO Network Provider; or
    2. The enrolled consumer believes that TMBHO is not authorizing medically necessary community behavioral health services.

In some instances, TMBHO might need to go “outside” the network to obtain the second opinion. TMBHO also supports out-of-network second opinions through the following policy statements:

- If another TMBHO Network Provider is not available, a second opinion assessment by an equally qualified MHP / CDP within a Network Provider currently under contract with another BHO will be provided by TMBHO at no cost to the consumer/enrollee, on a case by case basis and only with the approval of TMBHO.

Information about second opinions are made readily available to all consumers/enrollees. Procedures for second opinions are available to Network Providers through its policy and procedure on second opinions (CI-407):

A. TMBHO will ensure that:
    1. Provisions for a second opinion are incorporated into all Network Provider contracts.
    2. TMBHO policies and procedures regarding authorization, utilization review and utilization management incorporate the requirements for a second opinion in

accordance with CFR 438.206, WAC 388-865-0344 and the Department of Social and Health Services (DSHS) Prepaid Impatient Health Plan (PIHP) contract.

3. TMBHO consumers/enrollees are notified of their right to a second opinion in the *TMBHO Enrollee Benefit Handbook*, in the Notice of Action (NOA) if denying mental health services, and in the TMBHO authorization decision notices provided to consumers/enrollees.
4. The PIHP Medical Director reviews any decision by the PIHP to deny or not authorize voluntary inpatient services.
5. If the PIHP Medical Director agrees with the decision **not** to authorize voluntary hospitalization, the PIHP will send a NOA to the consumer/enrollee informing them of their right to a second medical opinion and how to access one.
6. Upon request, a second psychiatric medical opinion is provided within three (3) calendar days of request.
7. TMBHO will purchase an out-of-network second opinion assessment, upon request from a consumer/enrollee, or when another provider within the network is **not** available, and on a case-by-case basis.
8. A mechanism to monitor consumer/enrollee access to a second opinion is implemented through:
    a) Review of provider logs and tracking of second opinion requests;
    b) Review of provider treatment documentation;
    c) Review of complaints and grievances;
    d) Review of provider processes, documents and encounter data on denials and second opinion assessments;
    e) Tracking PIHP Medicaid denials and NOA; and
    f) Tracking TMBHO requests for second opinion assessments as a result of TMBHO authorization notices.

B. Network Providers shall ensure that:
1. Enrollees/consumers are informed of their right to a second opinion assessment upon request, and this right is upheld.
2. A second opinion assessment is provided by an equally qualified MHP at no cost to the consumer/enrollee.
3. If another network MHP is not available within 30 days of the request, that an assessment by a qualified out-of-network MHP is requested and coordinated through the TMBHO care management staff.
4. Requests for second opinions are logged and tracked to ensure follow up, and that the second opinion treatment recommendations are incorporated into the individual's service plan.
5. A second opinion assessment shall include:
    a) Information about the medical necessity of the treatment recommended; and

b) An assessment of initial eligibility for outpatient services under the Access to Care Standards criteria; or
c) An assessment of the medical necessity for continuing care or discharge; and
d) The recommended level and scope of treatment services; and
e) The recommended duration of services.

6. All second opinion assessments shall be reviewed with the consumer/enrollee and included in the consumer's/enrollee's decisions about treatment options, when applicable.
7. A copy of the second opinion assessment is provided to the TMBHO care management staff promptly for review.

(277) Timely access.

TMBHO has numerous methods to monitor access to services and the timeliness of service delivery, in compliance with 42 CFR 438.206 (C). TMBHO policy (SD-206) speaks to the furnishing of services and timely access through the following policy statements:

A. The Thurston Mason Regional Support Network (TMBHO) will provide consumers / enrollees timely access to behavioral health services by:
1. Meeting or exceeding the Department of Social and Health (DSHS) standards for timely access to services, taking into account the individual's urgency of need for services;
2. Ensuring that services are offered to consumers/enrollees during hours of operation that are comparable to commercial or Medicaid fee-for-service enrollees;
3. Ensuring covered behavioral health services are available 24 hours per day and seven (7) days per week when medically necessary;
4. Establishing internal monitoring and oversight procedures to assure compliance with timely access;
5. Taking corrective action as needed for provider's failure to comply with access standards.

With regards to operationalizing this policy, TMBHO has developed the following procedures:

A. TMBHO will:
1. Include access standards and expectations in all Network Provider contracts and policies.
2. Ensure that adequate network capacity is available for timely access to behavioral health services within reasonable timeframes and in a manner that meets or exceeds DSHS standards of offering a mutually-agreeable intake within fourteen (14) calendar days of the consumer's/enrollee's request for services.
3. Ensure that adequate network services are available 24 hours per day and seven (7) day per week for crisis telephone services, crisis response services, and on-call care management for individuals needing urgent or emergent care.

4. Authorize outpatient or residential services within fourteen (14) calendar days of request for authorization of services, unless the individual requests an extension.
5. Monitor providers for compliance to timely access through the following activities:
   a) Monitor consumer/enrollee charts for compliance with intake and treatment planning timeframe standards;
   b) Review and monitor consumer/enrollee survey results;
   c) Review consumer/enrollee complaints and grievances;
   d) Review complaints and grievances from community stakeholders or members at large;
   e) Periodic review of provider logs and reports of appointment scheduling and office wait times;
   f) Monitor availability and effectiveness of after hours on-call services by periodic audit and random test calls;
   g) Monitor volume of calls to crisis services and timeliness of response by staff through periodic audit and provider quarterly report;
   h) Assure commitment to access and timeliness standards by monitoring performance indicators and outcome measures with the TMBHO/Provider Quality Assurance (QA/QI) Committee; and
   i) Develop corrective action plans for changes in service delivery as necessary, to assure Medicaid enrollees have timely access to covered behavioral health services.

B. TMBHO Network Providers will:
   1. Comply with the standards of timely access to behavioral health services established by DSHS, through the following:
      a) Provision of an initial screening and availability and offer of a mutually-agreeable initial intake appointment within fourteen (14) calendar days of consumer's / enrollee's request for behavioral health services.
      b) Initiate routine behavioral health services within 28 calendar days from the date of initial request for service. An extension of fourteen (14) additional calendar days is possible if there are extenuating circumstances and the extension is made in the interest of the consumer/enrollee.
      c) Provider must document any reasons for delays, including when a consumer / enrollee declines an appointment offered for an intake (within 14 calendar days) and/or the first routine appointment (within the 28 days).
      d) Complete an individualized treatment plan within 30 calendar days of the intake, unless extenuating circumstances require an extension of fourteen (14) calendar days and it is the consumer's/enrollee's interest.
      e) Monitor access and continuity of care at periodic points during treatment, but at a minimum, update the treatment plan with the consumer/enrollee every 180 days.

f) Contact with inpatient facility staff within three (3) working days of admission to coordinate care and discharge planning with the facilities' team when an consumer/enrollee transitions between outpatient or inpatient care.
g) Ensure that face-to-face outpatient appointments do not exceed seven (7) calendar days from hospital discharge, when transitioning consumers/enrollees from inpatient to outpatient care.
h) Ensure that crisis system services are provided in a timely manner (time from initial call for service to crisis service), according to the following necessity:
    i) For emergent behavioral health services, within two (2) hours of the initial request; and
    ii) For urgent behavioral health services, within 24 hours of initial request.
i) Ensure that office appointment wait times do not exceed one (1) hour.
j) Ensure that appointment scheduling is expedited if consumer's/enrollee's condition warrants.
k) Monitor scheduling and wait times and develop strategies to improve access as necessary.
l) Provide, upon request, reports of timeframes for screening and scheduling intakes, initiation of routine services, and in-office appointment wait times to the TMBHO.
m) Ensure consumer's/enrollee's access to covered medically necessary behavioral health services during regular operating hours, after hours, and 24 hours a day, seven (7) days a week within reasonable response timeframes per above.
n) Ensure consumer/enrollees are assisted to utilize urgent and emergent crisis behavioral health services as condition warrants, and prior to an intake if medically necessary.

The TMBHO MIS supports monitoring of timeliness through its own policy and procedure on BHO operations (IS-816). In part, this policy states:

A. TMRSN will integrate the information system into key components of the TMBHO delivery system to include Utilization, Resource and Quality Management. This will include at minimum:
    1. Processes for access, timely authorization of services and notification to consumers / enrollees;
    2. TMBHO and provider performance and reporting on service utilization and costs;
    3. Development and maintenance of statewide and regional performance standards and measures;
    4. Development of a billing and claims payment system that supports compliance with federal and state standards and requirements;
    5. Fiscal management and resource allocation;
    6. Support of quality assurance and improvement activities and initiatives;

7. Support for TMBHO performance improvement projects (PIPs).

TMBHO has developed several Chrystal Reports on Timeliness that it uses with its Network Providers to help with monitoring. These reports include:

- Length of Time between Request for Service to Intake
- Length of Time between Intake and First Routine Service
- Number of Days Between Discharge from Inpatient Care to First Routine Outpatient
- Service Monitoring by Assigned Level of Care (LOCUS and CALOCUS)

These reports are currently only for the mental health services provided through the TMBHO network; in the future, reports will be built that look at substance use disorder services.

(290) Sub-contractual relationships and delegation.

TMBHO has a comprehensive Delegation Plan that outlines what services can be delegated to our provider network (please see Attachment 9: AP-1103 TMBHO Delegation Plan), and a policy and procedure on sub-contracting (also please see Attachment 9: SD-204 Sub-Contractual Relationships and Delegation). Delegated functions are described in our contracts with Network Providers. Three (3) examples of delegated functions embedded in contracts are included within this Plan.

- Attachment 10: Older Adult.PSPH.2015
- Attachment 11: ProtoCall Services.2015
- Attachment 12: BHR Acute Services.2015

Finally, as described earlier in this document, TMBHO has a comprehensive quality management program. As part of its responsibility to monitor Network Providers and their delegated (contracted) services, a series of administrative, clinical, utilization, and operational reviews take place on a regular basis. The following three (3) attachments demonstrate the variety of review activities that have occurred in the past:

- Attachment 13: Superior Court Felony Drug Court Review
- Attachment 14: Crisis Clinic Review
- Attachment 15: PACT OP Review

(4) Adult Behavioral Health System – Improvement Strategy.

TMBHO is fully committed and accountable for efficient and effective behavioral health services in the region through state-of-the-art outcome performance measures, statewide standards and for monitoring consumer/enrollee and system outcomes, performance, and reporting of consumer/enrollee and system outcome information. Reimbursement methods will be designed in service provider subcontracts to maximize the use of available resources and performance to meet performance measures for the direct care of people with a behavioral

health disorder. TMBHO contracts will be consistent with the intent expressed in RCW 71.24.015, 71.36.005, 70.96A.010 and 70.96A.011. Please see **DPR Item #3** under the Financial and Administrative Plan for more information on TMBHO contracting processes.

10

Grievance System Plan

(296) Grievance system - general requirements.

TMBHO has a robust and active grievance system that has fully met EQRO standards for the five (5) years. No deficiencies or recommendations have been made in this area, either from EQRO or from DBHR.

TMBHO has grounded its grievance system several primary documents. These include:

- *TMBHO Policy QM603 – Grievance System Requirements*
- *TMBHO Annual Plan AP1101 – Grievance Plan*
- *TMBHO Policy QM604 – TMBHO Ombuds Services*
- *TMBHO Guidelines GL1001 – Ombuds Services Guidelines*
- *TMBHO Policy CI415 – Consumer Notification*
- *TMBHO Guidelines GL1007 – TMBHO Notification Guidelines*

TMBHO understands and acknowledges the definitions of "Grievance," "Appeal," and "Action" as presented in 42 CFR 438.4009b:

Grievance: *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level, and access to the state fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the consumer's/enrollee's rights.)

Appeal: *Appeal* means a request for review of an action, as "action" is defined in this section.

Action: *Action* means (in the case of an MCO or PIHP):

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;
5. The failure of an MCO or PIHP to act within the timeframes provided in § 438.408(b); or

6. For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

Grievances (current system)

TMBHO has elected to address all grievances and appeals at the BHO level, as opposed to delegating this responsibility to the community mental health agencies (CMHAs). The BHO believes that in order to truly understand the issues facing consumers/enrollees within CMHAs, it is imperative that it address each consumer/enrollee grievance. In this way, TMBHO understands and documents the type of grievance being reported and is personally responsible for a timely and appropriate resolution and response.

The current grievance system, as it relates to consumer/enrollee complaints and grievances (any expression of dissatisfaction) in the mental health system, is structured such that consumer/enrollee voice is heard immediately and resolution is achieved quickly. When a consumer/enrollee expresses a complaint with a CMHA they are instructed (by the BHO) to seek an immediate resolution. In some cases the provider can make a simple change to the consumer's/enrollee's experience that will immediately resolve the issue. For example, if a waiting room is too hot or cold, a receptionist can simply adjust the thermostat and resolve the complaint. In such cases, where resolution can be immediately achieved, the provider is asked to document the concern on a log which, on a monthly basis, is submitted to the BHO. No other action is needed for such simple concerns.

For more complex grievances, TMBHO has directed CMHA's to provide consumers/enrollees with the number of the TMBHO Ombuds. The Ombuds in TMBHO is a functionally independent employee of Thurston County Public Health and Social Services, yet also works closely and collaboratively with TMBHO. All calls that come into the Ombuds office are logged and then categorized into one of several categories. These include:

- Concerns (non-Medicaid consumers/enrollees),
- Information and Referral,
- Grievances,
- Fair Hearings.

For grievances, the Ombuds officially notifies the consumer/enrollee in writing within five (5) working days from when the grievance is received (see Grievance Acknowledgement form). This letter outlines the nature of the grievance and provides the consumer/enrollee with an explanation of the investigation process to follow. The Ombuds has 30 days to resolve the grievance and communicate the resolution back to (1) the consumer/enrollee, (2) the CMHA, and (3) the BHO. Grievance investigations are initiated by the TMBHO Ombuds and the TMBHO

Quality Manager. The final resolution letter is submitted under the name of the TMBHO Quality Manager, who is also a licensed mental health professional. The resolution letter also explains the consumer's/enrollee's rights in terms of how to file a request for a fair hearing.

In calendar year (CY) 2014, TMBHO documented the following statistics with regards to grievances:

- 114 grievances received;
- 266 information and referral / non-Medicaid consumer/enrollee concerns received;
- One (1) fair hearing was received and adjudicated during CY2014;
- 380 total contacts by the TMBHO Ombuds;
- 99.17% of consumers/enrollees received acknowledgement within required timeframes;
- 99.33% of consumers/enrollees had grievances resolved within 30 working days of receipt.

TMBHO currently tracks grievances under the following categories:

- Access – Outpatient Services
- Consumer Rights
- Dignity and respect
- Transportation
- Housing
- Phone Calls Not Returned
- Quality and Appropriateness
- Service: Coordination
- Residential
- Access – Inpatient Services
- Customer Service
- Emergency Services
- Financial / Administrative Services
- Legal
- Physicians and Medications
- Service: Intensity
- Service: Not Available
- Other

<u>Appeals (current system)</u>

TMBHO has not had any appeals in the past five (5) years. The does not mean that TMBHO has not taken any adverse action that meets the definition of "action" under 42 CFR 438.400(b), only that there has not been a request for a review of such an action. In general, TMBHO works very hard with its CMHAs to eliminate the need for appeals within the system. In cases where a consumer/enrollee is denied a requested service, the consumer/enrollee is notified of their right to an appeal, including the provision for an expedited appeal (please see notification letter examples).

Currently, CMHA's are trained on a regular basis with regards to Medicaid eligibility requirements, as well as the Access to Care Standards (ACS). For all denials of a requested service, the primary reason has been due to Medicaid eligibility. Denials based on clinical necessity generally do not make it to the BHO for approval or denial. Clinicians within the CMHA's are well aware of the ACS, and if the consumer/enrollee does not meet medical necessity he/she is referred to other, more appropriate services within the community. In cases

where a consumer/enrollee who meets the state's definition of a priority population, TMBHO has a process in place for the CMHA to submit an "exception request" whereby state dollars can fund services for an individual who does not meet Access to Care Standards, but could clinically benefit from treatment.

Grievances (future BHO)

TMBHO will have a fully integrated grievance system by April 1, 2016. This includes a full replication of the current grievance system with the ability to record and investigate grievances in both mental health and substance use disorders. Policies and procedures, as well as the Grievance System Plan, have been updated to reflect these changes. Some of changes made to accommodate this expanded grievance system include the following:

- Updating current policies and procedures.
- Updating the Grievance System Plan.
- Requesting a new full-time employee within Thurston County Public Health and Social Services to serve part-time as a SUD Ombuds, and part-time as a member of the Quality Review Team (QRT). The current mental health Ombuds will be expanded to a full-time position as well, and will be functionally in charge of QRT activities.
- The new position will primarily serve as the SUD Ombuds as well as have QRT functions. This move is being made since the current QRT person is resigning from the agency after many years of service. His departure has allowed TMBHO to re-structure its Ombuds/QRT system into a newly developed "Consumer Affairs" department with two (2) full time positons fulfilling these obligations.

For SUD grievances and appeals, an appropriately credentialed CDP will sign off on all investigations and appeal decisions. The TMBHO Grievance Coordinator/Quality Manager will continue to review and approve all mental health grievances and appeal decisions.

(297) Grievance system – action.

TMBHO makes authorization decisions based on a pre-established set of authorization criteria. This decision making process, along with actions it takes when denying, limiting, reducing or suspending any requested or existing authorization, is thoroughly described in TMBHO policy and procedure. CFR definitions are included in the TMBHO Grievance Plan (AP1101).

All TMBHO consumers/enrollees have a choice of providers within the TMBHO network. In BHO terminology, the "network" is defined as those service providers who reside within the Thurston and Mason County boundaries. Since TMBHO contracts and monitors those licensed entities within Thurston and Mason Counties – and not agencies licensed outside of this geographic area – these entities are considered "in-network." In Medicaid parlance, however, a "network" is considered any duly licensed agency within the state of Washington. Duly licensed

means that it is either licensed as a substance use disorder provider or as a licensed community mental health agency (CMHA). Some agencies are dually licensed to provide both substance use disorder and mental health services. With regards to this response, a consumer/enrollee is always free to receive services at any licensed facility within the Thurston and Mason BHO geographic region (TMBHO).

If a service is not available within the BHO network, and it has been determined to be a medically necessary service covered under the Washington State Access to Care Standards or ASAM criteria, TMBHO allows and reimburses for "out of network" services. In such cases TMBHO, or a local Network Provider, makes an appropriate referral to a neighboring BHO to arrange for and reimburse this needed service.

Access to medically appropriate services in relation to the TMBHO Grievance System is thoroughly addressed in the TMBHO Grievance Plan. Specifically:

CONTINUATION OF BENEFITS

A. For Medicaid Enrollees:
    1. While an appeal of an action is under consideration at the TMBHO or OAH level, the TMBHO will continue service benefits for a Medicaid enrollee if:
        a) The appeal is filed in a timely manner (within ten (10) days of receipt of notice) by the Medicaid enrollee or the Network Provider;
        b) The appeal pertains to TMBHO's termination, suspension, or reduction of a previously authorized course of treatment covered by Medicaid;
        c) The covered Medicaid mental health services were ordered and provided by an authorized Network Provider in the TMBHO Network;
        d) The original period covered by the authorization has not expired; and
        e) The enrollee has requested a continuation of benefits.
B. If TMBHO continues or reinstates the Medicaid enrollee's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:
    1. The enrollee withdraws the appeal;
    2. Ten (10) calendar days pass after TMBHO mails the notice of disposition of an appeal or grievance, and the resolution is not in favor of the enrollee, unless the enrollee requests a fair hearing;
    3. The enrollee requests a fair hearing and the decision is not in the enrollee's favor (adverse); or
    4. The current authorization expires or the current authorization service limits are met.
C. Medicaid enrollees who request continuation of benefits will be notified that, if the final resolution of the appeal is adverse to the enrollee (the hearing decision upholds the TMBHO action), TMBHO may request the enrollee to reimburse the cost of the services furnished to the enrollee while the appeal is pending.

D. Reversal of Appeal Resolution – TMBHO and its contracted providers will abide by all administrative (fair) hearing decisions:
    1. If on appeal the TMBHO or the State Administrative Law Judge (ALJ) reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the TMBHO will ensure that the disputed services are provided promptly and as expeditiously as the enrollee's mental health condition requires.
    2. If on appeal the TMBHO or the ALJ reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, TMBHO will pay for those services.

E. For Consumers/Enrollees of State Funded Services:
    1. TMBHO will continue the consumer's/enrollee's medically necessary services within its available resources if:
        a) The consumer's/enrollee's grievance involves the reduction, suspension or termination of currently authorized services;
        b) The services were ordered and determined to be medically necessary by an authorized community mental health agency (Network Provider);
        c) The benefit period covered by the original authorization has not expired; and
        d) The consumer/enrollee requests extension of the service benefit.

A. Reversal of a TMBHO grievance decision – TMBHO and its contracted providers will abide by all administrative hearing decisions:
    1. If the ALJ reverses a TMBHO grievance decision to reduce, suspend or terminate previously authorized services, the TMBHO will provide the disputed services within available resources as expeditiously as the consumer's/enrollee's mental health condition requires.
    2. If the ALJ reverses a TMBHO grievance decision to deny authorization of services, and the consumer/enrollee received the disputed services while the hearing was pending, TMBHO will pay for those services.

All consumers/enrollees who enter into a grievance process and are not satisfied with the resolution have the right to enter into the State Fair Hearing process, as required by 42 CFR 438.56(f)(2). This process is further described in the TMBHO Grievance Plan.

The TMBHO is not considered a "rural" area, therefore mandates of 42 CFR 438.53(b)(ii)(2) do not apply.

(298) Grievance system – service authorization.

TMBHO requires that all service providers within the network document and track requests for service. TMBHO requires that once an enrollee requests service, they are seen for a mental health intake, or substance use disorder assessment, within fourteen (14) calendar days from the request. Once the intake/assessment has been completed, the Network Provider must

submit an authorization request to the authorizing entity (TMBHO). The time from intake/assessment to authorization request decision can be no longer than fourteen (14) calendar days.

TMBHO authorizes all service authorization requests. It employs an electronic authorization process that links the Network Provider with TMBHO. When an authorization for services is sought by a Network Provider, the provider enters in all required authorization information into an "Authorization for Services Request (ASR)" system. This request is then sent on a bi-weekly basis to TMBHO. A qualified Care Manager then reviews the request and all supporting documentation, and makes a decision whether or not to authorize the service request. For mental health services, these requests are reviewed and approved/denied by a mental health professional (MHP); in the future, all requests for substance use disorder services will be reviewed and approved/denied by a chemical dependency professional (CDP).

(299) Grievance system – service authorization process.

TMRSN requires that all authorization decisions to either approve or deny a mental health or substance use disorder service are made by a qualified individual (Care Manager) with applicable experience to make such a decision. For mental health services this means a qualified mental health professional (MHP). For substance use disorder authorizations, this means a chemical dependency professional (CDP).

(300) Grievance system – notice of action.

Currently TMRSN issues a Notice of Determination (NOD) or Notice of Action (NOA) for every request for service that it receives from a community mental health agency (CMHA) agency. Under the new BHO, this will be expanded to include every request for service that it receives from a duly licensed agency providing substance use disorder / co-occurring services.

TMBHO receives authorization requests twice weekly through its CMCH-MIS system. It is a process known as the Authorization Service Request (ASR) process. ASRs are submitted to TMBHO on Monday and Wednesday mornings. Care Managers have fourteen (14) calendar days to make a decision on the requested authorization. During this time frame, a decision must be made on the authorization request and the notices must be prepared and sent out to the consumers/enrollees.

The TMBHO defines a Notice of Determination as a notice sent to the consumer/enrollee that verifies that the requested service has been authorized as submitted. In other words, the requested service (from the CMHA or licensed substance use disorder agency) was authorized with no changes, limitations, or reductions. These letters (NODs) are sent out immediately after the authorization decision has been made (within fourteen (14) calendar days).

In the event that TMBHO must deny, limit or alter an authorization request, a Notice of Action (NOA) is sent to the consumer/enrollee. The same notice is also sent to the Network Provider who has requested the service. A NOA notification is defined by TMBHO as any "adverse" or negative decision made concerning an authorization request. It applies to both initial authorization requests as well as authorization requests for continued (or previously authorized) services.

NOAs are sent out immediately after the authorization decision has been made. The notices include information about how the consumer/enrollee may file an appeal to the decision, as well as how the consumer/enrollee may file for a State Fair Hearing if the appeal decision does not favor the consumer/enrollee. Applicable timeframes and contact information is included on all NOAs.

It is important to note that, historically, TMRSN has not generated many Notices of Action. This is primary due to the fact that TMRSN has spent considerable time training and coaching its Network Providers on authorization requirements, including Access to Care Standards, Medicaid eligibility, state-funded service authorization requirements, and its level of care system. Nearly all denials for Medicaid-funded services are a result of the consumer/enrollee **not** having a Medicaid benefit. However, these are fairly rare since Network Providers are checking eligibility at the time of initial intake and screening.

For clinical issues that might arise during an authorization request period, TMRSN Care Managers have historically notified the Network Provider and discussed these issues prior to issuing an authorization decision. This way, clinical issues can be discussed and any clarifications made. The bottom line has always been to eliminate the need for NOAs whenever possible. The receipt of such notices can create undue stress and anxiety with a consumer/enrollee and it has always been the philosophy of TMRSN to remedy any authorization dilemmas prior to the issuance of a formal Notice of Action. This will continue to be the philosophy moving forward with the new BHO.

(301) Grievance system – notice of action – timeframes – termination, suspension or reduction of services.

The TMBHO will abide by all notification timeframes as established through 42 CFR 431.211 and 42 CFR 431.213. Historically, TMRSN has followed this instruction and has incorporated these timeframes into its policy and procedures and applicable protocols and guidelines. These expectations will be incorporated into the newly formed TMBHO.

As noted previously, all NOAs clearly communicate to consumers/enrollees the right of appeal and the right of a State Fair Hearing. They also communicate the right of the consumer/enrollee

to file a grievance. In addition, it is the policy of TMBHO to ensure that services continue until such time as the appeal or grievance is resolved, thereby ensuring that services are not disrupted during the investigation of the consumer's/enrollee's complaint. Similarly, consumers/enrollees are also notified that they have a right to request an extension on the appeal process if they request this to TMBHO. They also have the right to an "expedited" appeal process as well, so long as a request is submitted to TMBHO requesting the expedited process. These consumer/enrollee rights are explained in the Grievance System Annual Plan, as well as the actual notices themselves.

(302) Grievance system – notice of action – timeframes – denial of payment.

In the event that TMBHO is required to deny an authorization, an immediate notice is sent to both the consumer/enrollee (in the form of a Notice of Action [NOA]), as well as the Network Provider who has requested the service.

(303) Grievance system – notice of action – timeframes – denial of standard authorization.

As discussed in response (302) of this Detailed Plan, in the event that TMBHO is required to deny an authorization, an immediate notice is sent to both the consumer/enrollee (in the form of a Notice of Action [NOA]), as well as the Network Provider who has requested the service.

TMBHO policy and procedure does allow for an extension of the required timeframes if any party needs more time to complete an investigation or if additional information is required. An extension request from any party would be clearly communicated and documented. Specifically, TMBHO policy states:

1. Extension of timeframes: The TMBHO may extend the timeframes by up to fourteen (14) calendar days if:
    a) The consumer/enrollee requests an extension; or
    b) TMBHO shows that there is a need for additional information and how the delay is in the consumer's/enrollee's interest.
2. If the TMBHO extends the prescribed timeframes, the consumer/enrollee will be given written notice as to the reason for the delay.

And:

1. In some instances, TMBHO may need additional time or information. When it is in the consumer's/enrollee's interest, additional time of up to fourteen (14) calendar days may be needed, and TMBHO will notify the consumer/enrollee or representative of the reason for the delay.
2. TMBHO designated staff making Medicaid appeal decisions regarding medical necessity, expedited resolution, and clinical issues will be qualified mental health professionals or chemical dependency professionals with appropriate clinical expertise and who have

not previously been involved in any other level of review or decision–making regarding treatment or the disputed issue(s).

(304) Grievance system – notice of action – timeframes – denial of expedited authorization.

TMBHO makes allowances for expedited appeals when it is felt that an immediate decision is required for situations when the denial, suspension or termination of services could jeopardize the consumer's / enrollee's well-being. The process for an expedited appeal is discussed in TMBHO policy and procedure. In the event of an expedited appeal, the consumer/enrollee will be notified within three (3) business days of the outcome of the appeal.

TMBHO policy language regarding expedited appeals can be found below:

1. An expedited appeal process may be requested if the consumer/enrollee, representative and/or the mental health/substance use disorder care provider believes that a longer resolution time would jeopardize the consumer's/enrollee's ability to maintain or regain maximum functioning. If requested, TMBHO will make an expedited decision within three (3) business days.
2. TMBHO may also choose to expedite an appeal in order to support a consumer's / enrollee's clinical needs. If the TMBHO needs additional time for a decision, the consumer/enrollee and/or representative will be notified of the reason for the delay.
3. Parties to a Medicaid appeal may include the consumer/enrollee and his/her representative, or the legal representative of a deceased enrollee's estate as well as the TMBHO.
4. At the consumer/enrollee and/or representative's request, TMBHO will provide consumers/enrollees and /or representatives with a reasonable opportunity (generally 72 hours) to informally discuss the appeal, present evidence, and allegations of fact or law, in person as well as in writing. TMBHO will inform the consumer/enrollee and/or representative of the limited time available in the case of an expedited resolution.

(305) Grievance system – notice of action – timeframes – untimely authorization.

If a service authorization decision – specifically an appeal – is not decided within the required timeframes, and there has not been a request for an extension by TMBHO, the decision is considered to be a denial (or, an action not in favor of the consumer/enrollee) according to 42 CFR 438.404(c)(5). In such cases, the consumer/enrollee would have the right to file for a State Fair Hearing with the Office of Administrative Hearings.

Timeframes are detailed in the TMBHO Grievance Plan. Specifically:

A. TMBHO Notification Timelines:
    1. For denial of an intake, NOA is mailed within fourteen (14) calendar days of the request;

2. For denial of an inpatient authorization request, as expeditiously as possible, but a verbal notification is made within twelve (12) hours of request, followed up by a written NOA within three (3) business days;
3. For termination, suspension or reduction of previously authorized covered Medicaid behavioral health services, at least ten (10) calendar days before the effective date of the action (exceptions: refer to 42 CFR 431.213 and 431.214);
4. For denial of payment, at the time of any action affecting the payment;
5. For **standard** notice of service authorization decisions that deny or limit services, as expeditiously as the consumer's/enrollee's behavioral health condition requires, and no longer than fourteen (14) calendar days following the receipt of the request for services by the Network Provider;
6. If standard authorization decisions are not reached in accordance with the timeframes established, it constitutes an adverse action and is subject to appeal with OAH.
7. For notice of decisions that may require an extension, up to fourteen (14) additional calendar days may be needed if the consumer/enrollee or the provider requests an extension, or the TMBHO justifies a need for additional information if it is in the consumer's/enrollee's interest. If TMBHO extends the timeframe for a decision, the consumer/enrollee will be notified in writing of the reason for the extension. TMBHO will make the decision as expeditiously as the consumer's/enrollee's behavioral health condition requires, and no later than the date the extension expires.
8. For expedited decisions, TMBHO will make a reasonable effort to provide oral or written notice within three (3) working days.

(306) Grievance system – information to providers and subcontractors.

All providers are educated on the TMBHO Grievance System at the time of initial contracting. Mandates from the PIHP and State Behavioral Health Contract related to grievances are included and carried over to all provider contracts. In the new BHOs, these grievance requirements within the contracts will continue.

At the time of consumers'/enrollees' initial entrance into an agency, providers are required to inform them of the TMBHO grievance process, including the existence of an Ombuds and the scope and type of services provided by the Ombuds. In TMBHO, the Ombuds is a very visible presence. The Ombuds ensures that posters and brochures about the Ombuds program are located at every community mental health agency. With future implementation of the BHOs, the Ombuds will also ensure that these notifications are posted in licensed substance use disorder agencies.

Information requirements are described in the TMBHO Grievance Plan, Ombuds Guidelines, and within the overall policy and procedure on the grievance system.

Within the basic template of the TMRSN contract the following contract language exists related to the grievance system. Similar language will also exist for contracts with all SUD providers when BHOs are implemented in April 2016:

A. GRIEVANCE SYSTEM

a. The Contractor must maintain a concern and grievance system process to address Grievances that complies with the following process and TMRSN's Policy and Procedure.
b. Information about the Consumer's/Enrollee's Rights and the TMRSN Grievance System must be provided to all Enrollees at the time they enter into services or at any time it is requested or needed.
c. General Requirements
    i. An Enrollee/Consumer or duly authorized 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.
        1. If an initial request for a grievance is made orally, a written, signed request for a grievance must be submitted within seven (7) days.
    ii. Contractor shall assist the Enrollee to make contact with the TMRSN Ombuds, who has responsibility for investigating and resolving all grievances.
    iii. The Consumer/Enrollee must be given reasonable assistance in pursuing a grievance or fair hearing.
        1. The Consumer/Enrollee will be provided assistance from the TMRSN in investigating and resolving a grievance. This may require cooperation from the Consumer's/Enrollee's case manager, the Contractor, or any other person of the Consumer's/Enrollee's choice.
    iv. The Consumer/Enrollee shall be provided access to interpreter services and toll-free numbers that have adequate TTU/TTD and interpreter capability.
    v. Contractor shall post the rights in all the identified languages, and provide written materials on filing a grievance in a readily available location within each clinical site.
    vi. The Contractor shall ensure that there is no retaliation against Consumers / Enrollees or staff, who on behalf of the Consumer/Enrollee, files a grievance or fair hearing.
d. Resolution and Notification
    i. Individuals who file a grievance shall be notified:
        1. Of their right to request a fair hearing, and how to do so.
        2. Of their right to continue to receive authorized mental health services during the grievance and fair hearing process.

3. How to make the request.
4. That an individual may be asked to pay for the cost of those services if the hearing decision upholds the original decision.

e. Continuation of Services
    i. During the grievance process, the Contractor must continue the individual's authorized services if all of the following conditions are met:
        1. The grievance involves the termination, suspension, or reduction of a previously authorized course of treatment.
        2. The services were provided by an authorized Network Provider.
        3. The individual requests a continuation of services.
        4. The individual is currently receiving services at the time of the request.

f. Handling of Grievances:
    i. The TMRSN Ombuds will acknowledge receipt of each grievance, received either orally or in writing, within one (1) working day. If acknowledgement is made orally, it must be followed in writing within five (5) working days.
    ii. The TMRSN Ombuds will attempt to provide resolutions at the lowest level. The grievant and/or representative shall have access to individuals at the lowest level such as the individual care provider or other individuals within the Contractor agency.
    iii. The Contractor will work diligently with the TMRSN Ombuds to resolve the Grievance in timely manner. This requires timely response (within five (5) working days) to TMRSN Ombuds' inquiries and requests.
    iv. The Contractor must maintain records of grievances referred to TMRSN and all complaints and concerns that are not referred to TMRSN for resolution. This log must be submitted monthly via the TMRSN Complaint/Grievance report per Section 20. Reports must be submitted even if there are no reportable grievances, complaints or concerns during the month.
    v. The TMRSN Ombuds will retain a log of all grievances and submit this log to the TMRSN Quality Manager on a monthly basis
    vi. The Contractor will abide by all TMRSN, DBHR or OAH decisions following a grievance, appeal or fair hearing.
    vii. The TMRSN Ombuds shall ensure that the individuals who make decisions on grievances are individuals who:
        1. Were not involved in any previous level of review or decision-making; and
        2. 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.

g. Grievance Resolution and Notification: The TMRSN Ombuds will work with the Contractor, Consumer/Enrollee and any other authorized party to resolve each grievance and provide written notice as expeditiously as the Consumer's/Enrollee's mental health condition requires and not more than 30 calendar days from the receipt of the statement of grievance by the TMRSN.
    i. The TMRSN Ombuds may extend the timeframe by up to 14 calendar days if:
        1. The Consumer/Enrollee requests the extension; or
        2. The Ombuds shows (to the satisfaction of TMRSN upon request) that there is a need for additional information and how the delay is in the Consumer's/Enrollee's interest.
    ii. If the TMRSN Ombuds extends the timeframes, the Ombuds must, for any extension, give the Consumer/Enrollee written notice of the reason for the delay.
        1. The written notice of resolution must include the results of the resolution process and the date it was completed.
        2. *For grievances not resolved wholly in favor of the Consumer/Enrollee, the notice must include the right to request a fair hearing and how to do so.*
h. Fair Hearings – This function is only available to Medicaid Funded Enrollees
    i. Enrollees may request a fair hearing conducted by independent state agency in accordance with Chapter 388-02 WAC and provisions of mental health services per Chapter 388-865 WAC.
    ii. The parties to a fair hearing include TMRSN, the Contractor as well as the Enrollee and his or her representative or the legal representative of a deceased Enrollee's estate.
    iii. A Fair Hearing may be requested from the State of Washington Office of Administrative Hearings when:
        1. An Enrollee believes there has been a violation of DSHS rule.
        2. The Contractor or TMRSN does not provide a written response to a grievance within the required timeframes.
        3. An Enrollee receives an adverse ruling by the Contractor, TMRSN or its agent to a grievance.
            a. If the Enrollee elects to request a fair hearing, the request must be filed within 20 calendar days from the date of notice of adverse ruling.
    iv. TMRSN and/or DBHR will notify the Contractor of hearing determinations. The Contractor will be bound by the hearing determination, whether or not the hearing determination upholds the Contractor's decision.

(307) Grievance system – record keeping and reporting.

TMBHO has a rigorous process of continually reviewing and assessing grievance information. It regularly synthesizes grievance information and uses this information to make programmatic changes within the network. Grievance information is reviewed on a daily basis by the TMBHO Quality Manager, who reviews and approves all grievance resolutions. In addition, on a monthly basis, grievance statistics, trends, and resolutions are consolidated into a monthly Grievance Report. Also on a monthly basis, TMBHO meets with its largest providers in a face-to-face meeting to discuss grievance trends, open grievances in need of additional attention, and possible programmatic changes to reduce/eliminate common grievance trends.

With regards to retention of grievance records, TMBHO policy and guidelines clearly records how grievance and appeal information should be kept. Specifically:

A. TMBHO, its contracted providers, and the Ombuds service will retain full records of all concerns, formal grievances, actions, appeals, and fair hearings. These records will be kept in confidential, central files, separate from the consumer/enrollee clinical case records, for six (6) years from completion of the grievance or appeal process. An enrollee/consumer and/or his/her representative will be provided an opportunity to examine the enrollee's/consumer's case file, including medical records and any other documents and records considered during the concern, grievance or appeals process.
B. Upon written request, the enrollee/consumer or the representative may receive written consumer/enrollee information when filing or resolving grievances, appeals, or fair hearings. This will be provided at no cost to the enrollee or representative. For record requests that are needed to determine issues of continuity of care, concerns, or assistance with obtaining state and federal entitlements, records may be requested at a minimum cost to the consumer/enrollee. The TMBHO and/or service providers will not charge for the first 100 pages of copying, and a maximum of ten cents (10¢) per page thereafter.
C. TMBHO will ensure the enrollee/consumer that grievance-related materials will not be disclosed without the enrollee's/consumer's permission, except as necessary to resolve the grievance or appeal, and except to DSHS or OAH if an administrative or fair hearing is requested.
D. Network Providers will each maintain their own *Grievance and Concern Tracking Log* for the purpose of ongoing quality improvement.
E. TMBHO will maintain a master log of grievances and concerns, and will ensure that information from Network Providers and Ombuds services are incorporated into the form. TMBHO will submit semiannual reports to DSHS within 45 days of the close of each reporting period, that include:
    1. The number and nature of actions, fair hearings, grievances and appeals;
    2. The timeframes within which they were disposed of or resolved;
    3. The nature of the decisions; and

4. A summary and analysis of the implications of the data, including what measures will be taken to address undesirable patterns.

(308) Grievance system – appeal.

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

Definitions, as presented in TMBHO's Grievance Plan, include the following:

Action: A TMBHO (PIHP) decision involving a Medicaid enrollee and:

1. The denial or limited authorization of a requested covered Medicaid service, including the type or level of service;
2. The reduction, suspension, or termination of previously authorized covered Medicaid services;
3. An Individualized Treatment Plan wherein the provider and the consumer/enrollee cannot reach agreement and the consumer/enrollee does not receive requested, Medicaid-allowable services;
4. The denial, in whole or in part, of payment for a covered Medicaid service;
5. The failure to provide services in a timely manner, as defined by the state; and
6. The failure of a Prepaid Inpatient Health Plan to act within the timeframes provided in section 42 CFR 438.408(b).

Adverse Action: Any decision or action that is unfavorable to a consumer/enrollee. In the instance of a TMBHO violation of state rules, an RSN funded consumer/enrollee may bypass the RSN/BHO level and file a request for a fair hearing from the OAH when:

1. TMBHO fails to provide Medicaid services in a timely manner, as defined by the state;
2. TMBHO fails to authorize services or process a grievance or Medicaid appeal according to the required timelines; and/or
3. TMBHO fails to act within the timeframes provided in section 42 CFR 438(b) or any successor.

Appeal: A Medicaid enrollee's (or representative's) request for a review by TMBHO of an action, as "action" is defined in this section.

Grievance: A formal expression of dissatisfaction about any matter **other than an action**, as "action" is defined above. The term is also used to refer to the overall system that includes grievances and appeals that are handled at the RSN level, and access to the state fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or

employee, or failure to respect the consumer's/enrollee's rights.) Grievances may be received either orally or in writing.

After the TMBHO is established, a fully integrated grievance system will be in place. This will include the adoption of all definitions inherent in 42 CFR 438.408(b).

(309) Grievance system – authority to file.

All TMBHO consumers/enrollees will have the ability to file a grievance or appeal once the official BHO has been established. Currently, all TMRSN consumers/enrollees have the ability to file grievances and appeals. Once the BHO is established, consumers/enrollees in the heretofore county-operated substance use disorder programs will also have the ability to file grievances and appeals.

Currently, the right of the consumer/enrollee to file a grievance and appeal is communicated in several different ways. This includes the TMRSN handbook, the individual contracts between the RSN and community mental health centers, through Ombuds-produced materials, and when consumers/enrollees are issued Notices of Determination and Notices of Action. The right of consumers/enrollees to file for a State Fair Hearing with the Office of Administrative Hearings (OAH) is also clearly described in these materials, as well as grievance and appeal notifications sent to consumers/enrollees after a grievance/appeal investigation.

(310) Grievance system – timing.

For consumers/enrollees who receive a Notice of Action that is unfavorable, they have the right to file for an appeal. Rules for filing an appeal are included in TMBHO's Grievance System Plan. It is important to note that adverse actions (NOAs) are only issued after a clinical review of the case by either a qualified mental health professional or chemical dependency professional. TMBHO provides twenty (20) days for the consumer/enrollee to file an appeal of the NOA if they so choose.

The NOA includes instructions on how this appeal should be filed. Specific language from the NOA letter is included below:

***IF YOU DON'T AGREE WITH THIS DECISION**, you have the right to a second opinion or an appeal. If you choose to get a second opinion, you must request that your provider arrange an appointment for you within thirty (30) calendar days. If you choose to file an appeal, you have twenty (20) calendar days from the date this notice was mailed to request or file an appeal. If you wish to continue your services during your appeal, you must file your request within ten (10) calendar days of receiving this notice. Your mental health provider or another representative may also file an appeal on your behalf when you ask them in writing. To request or file an*

appeal, you need to contact: ***Mark Meyer****, TMRSN Care Manager, by calling* ***360-867-2561 or 1-800-658-4105*** *or send your appeal to the TMRSN address above.*

If YOU NEED HELP WITH A SECOND OPINION OR FILING AN APPEAL *you may also contact the TMRSN Ombuds Service at* ***360-867-2556****. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process. If you need interpreter services, they will be provided to you. If you are hard of hearing or deaf, or have trouble with speech, please contact TMBHO through the Telecommunication Relay Service at* ***867-2603 or dial 711****. The Relay Service will be able to provide you with the correct phone number.*

As noted above, specific instructions regarding appeals are included in the TMBHO Grievance Plan. Language regarding the consumer's/enrollee's timeframes to file an appeal, along with language about overall timeframes and obligations of TMBHO with appeals and grievances, are presented below:

I. TMBHO NOTIFICATION OF ACTION (NOA) (Medicaid Enrollees)

B. The TMBHO will issue a Notice of Action (NOA) when Medicaid enrollees are denied an intake or TMBHO reduces, suspends or terminates currently authorized and covered medically necessary services.

C. If TMBHO denies or limits an authorization request for covered Medicaid services, TMBHO will issue a NOA only after a clinical review of the service request and determination by a qualified mental health / chemical dependency professional, that medical necessity and/or access to care standards are not met.

D. If TMBHO denies an authorization request for a medically necessary inpatient psychiatric hospitalization, an NOA will be issued only after a medical review by the TMBHO Medical Director, who is a licensed, board-certified psychiatrist.

E. Notice of Action will be sent to the Medicaid enrollee in writing by TMBHO for a denial or "action" as it is defined, and will be in language that is clear and understandable to the enrollee. The Notice of Action will explain the following:

1. The "action," as it is defined, that TMBHO has taken or intends to take;
2. The reason for the intended action;
3. An explanation of the enrollee's (or representative's or Network Provider's acting on behalf of the enrollee) right to request an appeal with the TMBHO/PIHP, and to have access to an administrative or fair hearing, and the procedures for exercising those rights;
4. Definitions of denial, suspension, reduction, and termination as applicable;
5. A statement that the enrollee has twenty (20) days from the date of the Notice of Action to file an appeal with TMBHO;
6. The circumstances under which expedited resolution is available; and
7. The enrollee's right to continue service benefits during the appeal process.

F. TMBHO Notification Timelines:

9. For denial of an intake, the NOA is mailed within fourteen (14) calendar days of the request;
10. For denial of an inpatient authorization request, as expeditiously as possible, but a verbal notification is made within twelve (12) hours of request, followed up by a written NOA within three (3) business days;
11. For termination, suspension or reduction of previously authorized covered Medicaid behavioral health services, at least ten (10) calendar days before the effective date of the action (exceptions: refer to 42 CFR 431.213 and 431.214);
12. For denial of payment, at the time of any action affecting the payment;
13. For **standard** notice of service authorization decisions that deny or limit services, as expeditiously as the enrollee's behavioral health condition requires, and no longer than fourteen (14) calendar days following the receipt of the request for services by the Network Provider;
14. If standard authorization decisions are not reached in accordance with the timeframes established, it constitutes an adverse action and is subject to appeal with OAH.
15. For notice of decisions that may require an extension, up to fourteen (14) additional calendar days may be needed if the enrollee or the provider requests an extension, or the TMBHO justifies a need for additional information if it is in the enrollee's interest. If TMBHO extends the timeframe for a decision, the enrollee will be notified in writing of the reason for the extension. TMBHO will make the decision as expeditiously as the enrollee's behavioral health condition requires, and no later than the date the extension expires.
16. For expedited decisions, TMBHO will make a reasonable effort to provide oral or written notice within three (3) working days.

(311) Grievance system – appeal process – procedures.

The TMBHO appeal process and procedures are clearly documented in the TMBHO Grievance System Plan. Language from the TMBHO policy and procedure (QM603) states:

I. PROCEDURES

A. TMBHO and its contracted Network Providers will:

1. Designate an individual that is responsible for resolution, notification, monitoring, oversight, and updating of their respective grievance system policies and procedures;
2. Assure the designees collaborate with all quality improvement, quality management, and utilization management committees and subcommittees throughout the network for system improvements as a result of grievance system issues. (See also

TMBHO Policy QM-601 Quality Assessment and Performance Improvement Program);

3. Establish a consistent process for informing consumers/enrollees of eligibility decisions and their right to file a grievance or appeal and how to do so;
4. Ensure that, if requested by the consumer/enrollee, current services are continued throughout the appeal process; and
5. Ensure that, if requested by the state-funded consumer/enrollee, previously and currently authorized services are continued throughout the grievance and fair hearing process.

B. Comply with the TMBHO process for documenting any denials and adverse decisions. (See *TMBHO Policy UM-904 Authorization of Services*). Concerns and grievances will be submitted to TMBHO per Section H.2.(See *TMBHO AP-1101 Grievance Plan* for definitions of concern, grievance, and appeal).
C. TMBHO Ombuds shall log and track all concerns, grievances, and appeals using the *TMBHO Grievance Tracking Log*.
D. TMBHO, it's contracted Network Providers, and the Ombuds will maintain confidential separate records of all resolutions and dispositions for a period of six (6) years from completion of the process, as specified in the *TMBHO AP-1101 Grievance Plan*.
E. TMBHO will:
    1. Ensure that the TMBHO Enrollee's Benefits Handbook incorporates the grievance system rights, responsibilities and procedures, and is available and distributed to all Network Providers.
    2. Maintain and update the TMBHO grievance system information on its TMBHO Thurston County website as needed.
    3. Review 100% of intakes that result in an individual not meeting the medical necessity or access to care criteria, and a quarterly sample review of all other level of care service authorization requests to assure consistent application of the *TMBHO GL-1006 Level of Care Guidelines*.
    4. Send timely notices to enrollees/consumers when required, and in accordance with *TMBHO GL-1007 Consumer Notification Guidelines.*
F. Network Providers will:
    1. Ensure that every consumer/enrollee is given a TMBHO Enrollee's Benefits Handbook upon initiation of services, upon request, and at any other time as needed or requested.
    2. Assure that all staff have a working knowledge of the overall grievance system process, and are able to assist enrollees/consumers with initiating a grievance with the provider's designee, the Ombuds or the TMBHO.
    3. Send TMBHO written notices to consumers/enrollees as delegated by TMBHO that inform the consumer/enrollee of their right to request a second opinion or file a grievance if they are not satisfied.

Language from the TMBHO Annual Grievance Plan states:

II. PROCEDURES FOR (CONCERNS), GRIEVANCES, and APPEALS

B. General Requirements:

1. The following applies to all concerns, grievances or appeals:
   a) Consumers/enrollees may have a representative who acts on his or her behalf in filing and pursuing grievances and appeals.
   b) A Network Provider may file a grievance or appeal on behalf of the consumer /enrollee with written consent.
   c) Network Providers must report all concerns and potential grievances to TMBHO within twenty-four hours of receipt, using the established *TMBHO Provider Grievance Notification Form*.
   d) Consumers will be given reasonable assistance in completing forms and taking other procedural steps as needed in pursuing a grievance, an appeal or a fair hearing, including access to the Ombuds service at all levels.
   e) Consumers/enrollees will be provided information about the grievance and appeal rights and process under the TXIX or state-funded programs, including timeframes for filing requests, and that the Ombuds service is available to consumers/enrollees at no cost to assist throughout the entire process.
   f) TMBHO will ensure that Network Providers post Clients' Rights at each site providing treatment services, and in the most prominent languages identified for Washington State.
   g) TMBHO will ensure that consumers/enrollees have access to oral or manual language interpretation services as well as toll-free TTY/TTD services that have adequate interpreter capacity, or other alternate formats as needed and upon request.
   h) TMBHO and its contracted providers will ensure that consumers/enrollees are provided a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.
   i) TMBHO and its contracted providers will ensure that consumers/enrollees may examine their case files, including medical records, documents and records considered before and during the appeal process.
   j) TMBHO will acknowledge receipt of each grievance and appeal received (either orally or in writing) within five (5) business days. This acknowledgement will come in the form of a written letter from the TMBHO Ombuds.
   k) Each consumer/enrollee has the right to have grievances and appeals received in a respectful, helpful manner and to have grievances and appeals investigated and resolved promptly at the lowest possible level of the system, and without retaliation against the individuals.

l) TMBHO will ensure that there is no retaliation or punitive action taken against a consumer/enrollee or a provider who supports a consumer/enrollee's appeal, or supports/requests an expedited resolution of an appeal.
m) TMBHO will ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making.
n) TMBHO will ensure that the individuals that make decisions on appeals regarding medical necessity, expedited resolution, or involving clinical issues are qualified mental health professionals (MHPs) or chemical dependency professional (CDPs) who have the appropriate clinical expertise.

In addition:

C. Network Provider Filing an Appeal for Medicaid Enrollees:
   3. A Medicaid enrollee or representative may file an appeal whenever a Notice of Action (NOA) is received. (See the definition of "action" above.) To start the appeal process, the enrollee or representative may contact the Network Provider, the Ombuds, or TMBHO.
   4. The enrollee has the right to request assistance with an appeal from the Ombuds, the Network Provider or anyone else the enrollee chooses. Interpreter and TTY/TDD services are available at no cost to the enrollee.
   5. If the enrollee wants someone else to assist with an appeal, the enrollee and the authorized representative must send a statement signed and dated by both individuals naming the person that is to act on the enrollee's behalf.
   6. The enrollee, Network Provider, or other representative acting on the enrollee's behalf may file an appeal either orally or in writing by contacting TMBHO. Oral requests establish the earliest possible filing date for an appeal, but a written signed request for an appeal must be submitted within seven (7) calendar days, unless there is a request in writing for an expedited appeal (see Number 9, below).
   7. An appeal must include the name and signature of enrollee, how to reach him or her, the reason for the appeal, and any information that supports the request.
   8. If an enrollee or his/her representative wishes to appeal an action by the TMBHO, he or she must request an appeal within twenty (20) days of the enrollee's receipt of the Notice of Action (NOA) from TMBHO.
   9. If an enrollee wishes to continue currently authorized and covered Medicaid services, and the appeal involves a reduction, suspension or termination of services that the Network Provider believes the enrollee needs, the enrollee or representative must file a request within ten (10) calendar days of receiving the NOA or the intended effective date of the action. If the appeal decision is not in the enrollee's favor, he or she may have to pay for the services received during the appeal.

10. TMBHO will acknowledge receipt of the appeal either orally or in writing within one (1) business day. Any oral notification will be followed up in writing within five (5) business days.
11. An expedited appeal process may be requested if the enrollee, representative and/or the behavioral health care provider believes that a longer resolution time would jeopardize the enrollee's ability to maintain or regain maximum functioning. If requested, TMBHO will make an expedited decision within three (3) business days.
12. TMBHO may also choose to expedite an appeal in order to support an enrollee's clinical needs. If the TMBHO needs additional time for a decision, the enrollee and/or representative will be notified of the reason for the delay.
13. Parties to a Medicaid appeal may include the enrollee and his/her representative, or the legal representative of a deceased enrollee's estate as well as the TMBHO.
14. At the enrollee and/or representative's request, TMBHO will provide enrollees and / or representatives with a reasonable opportunity (generally 72 hours) to informally discuss the appeal, present evidence, and allegations of fact or law, in person as well as in writing. TMBHO will inform the enrollee and/or representative of the limited time available in the case of an expedited resolution.
15. During the appeal process, the enrollee – and anyone else he or she gives permission to – can look at the enrollee's case file, behavioral health records and any other documents and records considered during the appeals process.
16. A qualified TMBHO mental health professional or chemical dependency professional (CDP), who has not been involved in making treatment decisions, will review the appeal and provide a written decision within forty-five (45) days from the date the appeal was started, unless a faster process has been requested.
17. In some instances, TMBHO may need additional time or information. When it is in the enrollee's interest, additional time of up to fourteen (14) calendar days may be needed, and TMBHO will notify the enrollee or representative of the reason for the delay.
18. TMBHO designated staff making Medicaid appeal decisions regarding medical necessity, expedited resolution, and clinical issues will be qualified mental health professionals or chemical dependency professionals with appropriate clinical expertise and who have not previously been involved in any other level of review or decision–making regarding treatment or the disputed issue(s).

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

For individuals who have entered into the appeal process with TMBHO, a timeframe of forty-five (45) days has been established (from the day that TMBHO receives the appeal) per 42 CFR 438.408(b)(2). Language from the TMBHO Grievance Plan states:

1. **Standard disposition:** TMBHO will resolve each grievance, complete each appeal, and provide written notice as expeditiously as the consumer's/enrollee's behavioral health

condition requires, but not more than thirty (30) calendar days from receipt of the grievance or forty-five (45) calendar days from receipt of an appeal.

TMBHO also allows for an extension of these timeframes. In order to extend these timeframes, TMBHO must demonstrate that there is a need for extension and how this is in the best interests of the consumer's/enrollee's request (i.e., additional time is needed to conduct an investigation). An extension may also be allowed upon consumer/enrollee request. If TMBHO requests an extension, policy requires that TMBHO provide a written explanation of the extension and the reasons why. Language from the TMBHO Grievance Plan states:

2. **Extension of timeframes:** The TMBHO may extend the timeframes by up to fourteen (14) calendar days if:
   c) The consumer/enrollee requests an extension; or
   d) TMBHO shows that there is a need for additional information and how the delay is in the consumer's/enrollee's interest.
3. If the TMBHO extends the prescribed timeframes, the consumer/enrollee will be given written notice as to the reason for the delay.

(313) Grievance system – appeal process – format and content of resolution notice.

TMBHO meets the requirements of 42 CFR 438.408(e) through its thorough explanation of Notice of Actions, Disposition and Resolution, and Continuation of Benefits found within the TMBHO Grievance Plan.

Written NOAs explain to consumers/enrollees what their rights are throughout the appeal process, including the right to request a State Fair Hearing if the decision is not wholly in favor of the consumer/enrollee. Similarly, consumers/enrollees are informed of their right to have continuation of services during the appeals process, but that if the final disposition is not in favor of the consumer/enrollee, TMBHO has the right to seek payment for these services:

- Medicaid enrollees who request continuation of benefits will be notified that, if the final resolution of the appeal is adverse to the enrollee (the hearing decision upholds the TMBHO action), TMBHO may request the enrollee to reimburse the cost of the services furnished to the enrollee while the appeal is pending 42 CFR 438.408(e)(2)(iii).

Notification included in the NOA, and related to the appeal process, are included in the TMBHO Grievance Plan, and include:

III. TMBHO NOTIFICATION OF ACTION (NOA) (Medicaid Enrollees)

A. The TMBHO will issue a Notice of Action (NOA) when Medicaid enrollees are denied an intake or TMBHO reduces, suspends or terminates currently authorized and covered medically necessary services.

B. If TMBHO denies or limits an authorization request for covered Medicaid services, TMBHO will issue a NOA only after a clinical review of the service request and determination by a qualified mental health / chemical dependency professional, that medical necessity and/or access to care standards are not met.

C. If TMBHO denies an authorization request for a medically necessary inpatient psychiatric hospitalization, an NOA will be issued only after a medical review by the TMBHO Medical Director, who is a licensed, board-certified psychiatrist.

D. Notice of Action will be sent to the Medicaid enrollee in writing by TMBHO for a denial or "action" as it is defined, and will be in language that is clear and understandable to the enrollee. The Notice of Action will explain the following:

1. The "action," as it is defined, that TMBHO has taken or intends to take;
2. The reason for the intended action;
3. An explanation of the enrollee's (or representative's or Network Provider's acting on behalf of the enrollee) right to request an appeal with the TMBHO/PIHP, and to have access to an administrative or fair hearing, and the procedures for exercising those rights;
4. Definitions of denial, suspension, reduction, and termination as applicable;
5. A statement that the enrollee has twenty (20) days from the date of the Notice of Action to file an appeal with TMBHO;
6. The circumstances under which expedited resolution is available; and
7. The enrollee's right to continue service benefits during the appeal process.

(314) Grievance system – appeal and state fair hearing process – continuation of benefits.

The TMBHO Grievance Plan (AP-1101) and Grievance System policy and procedure (QM-603) explain the continuation of benefits during both a grievance investigation and an appeal review. It is the policy of TMBHO to allow for full continuance of services during an investigation into an appeal or grievance. This is supported though policy language:

I. CONTINUATION OF BENEFITS

A. For Medicaid Enrollees:

2. While an appeal of an action is under consideration at the TMBHO or OAH level, the TMBHO will continue service benefits for a Medicaid enrollee if:
   f) The appeal is filed in a timely manner (within ten (10) days of receipt of notice) by the Medicaid enrollee or the Network Provider;
   g) The appeal pertains to TMBHO's termination, suspension, or reduction of a previously authorized course of treatment covered by Medicaid;
   h) The covered Medicaid behavioral health services were ordered and provided by an authorized Network Provider in the TMBHO network;
   i) The original period covered by the authorization has not expired; and
   j) The enrollee has requested a continuation of benefits.

B. If TMBHO continues or reinstates the Medicaid enrollee's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:
   5. The enrollee withdraws the appeal;
   6. Ten (10) calendar days pass after TMBHO mails the notice of disposition of an appeal or grievance, and the resolution is not in favor of the enrollee, unless the enrollee requests a fair hearing;
   7. The enrollee requests a fair hearing and the decision is not in the enrollee's favor (adverse); or
   8. The current authorization expires or the current authorization service limits are met.

D. Medicaid enrollees who request continuation of benefits will be notified that, if the final resolution of the appeal is adverse to the enrollee (the hearing decision upholds the TMBHO action), TMBHO may request the enrollee to reimburse the cost of the services furnished to the enrollee while the appeal is pending.

E. Reversal of Appeal Resolution – TMBHO and its contracted providers will abide by all administrative (fair) hearing decisions:
   3. If on appeal the TMBHO or the State Administrative Law Judge (ALJ) reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the TMBHO will ensure that the disputed services are provided promptly and as expeditiously as the enrollee's behavioral health condition requires.
   4. If on appeal the TMBHO or the ALJ reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, TMBHO will pay for those services.

F. For Consumers/Enrollees of State Funded Services:
   2. TMBHO will continue the consumer's/enrollee's medically necessary services within its available resources if:
      e) The consumer's/enrollee's grievance involves the reduction, suspension or termination of currently authorized services;
      f) The services were ordered and determined to be medically necessary by an authorized, licensed mental health or chemical dependency agency (Network Provider);
      g) The benefit period covered by the original authorization has not expired; and
      h) The consumer/enrollee requests extension of the service benefit.

D. Reversal of a TMBHO grievance decision – TMBHO and its contracted providers will abide by all administrative hearing decisions:
   3. If the ALJ reverses a TMBHO grievance decision to reduce, suspend or terminate previously authorized services, the TMBHO will provide the disputed services within available resources as expeditiously as the consumer's/enrollee's behavioral health condition requires.

4. If the ALJ reverses a TMBHO grievance decision to deny authorization of services, and the consumer/enrollee received the disputed services while the hearing was pending, TMBHO will pay for those services.

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

If, during the course of a State Fair Hearing, the decision is made to support the consumer / enrollee (in in full or partially), TMBHO will abide by the decision of the ALJ (State Fair Hearing Officer). This is supported in policy and procedure, and is summarized below:

D. Reversal of Appeal Resolution – TMBHO and its contracted providers will abide by all administrative (fair) hearing decisions:
   1. If on appeal the TMBHO or the State Administrative Law Judge (ALJ) reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the TMBHO will ensure that the disputed services are provided promptly and as expeditiously as the consumer's/enrollee's behavioral health condition requires.
   2. If on appeal the TMBHO or the ALJ reverses a decision to deny authorization of services, and the consumer/enrollee received the disputed services while the appeal was pending, TMBHO will pay for those services.

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

If an administrative law judge reverses a TMBHO decision during the course of a State Fair Hearing, TMBHO will pay for any services provided during the course of the hearing and investigation – in accordance with 42 CFR 438.424(b). Language supporting this requirement is found in the TMBHO Grievance Plan:

D. Reversal of Appeal Resolution – TMBHO and its contracted providers will abide by all administrative (fair) hearing decisions:
   1. If on appeal the TMBHO or the State Administrative Law Judge (ALJ) reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the TMBHO will ensure that the disputed services are provided promptly and as expeditiously as the consumer's/enrollee's behavioral health condition requires.
   2. If on appeal the TMBHO or the ALJ reverses a decision to deny authorization of services, and the consumer/enrollee received the disputed services while the appeal was pending, TMBHO will pay for those services.

(317) Grievance system – expedited appeals process – general.

TMBHO has an expedited process in place for expedited appeals when it is believed that not having an expedited process is detrimental for the consumer/enrollee. Appeals are reviewed and decided upon by either a mental health professional (MHP), or a chemical dependency professional (CDP).

The process for expedited appeals are outlined in the TMBHO Grievance Plan:

1. **Expedited disposition (for appeals only):** TMBHO will ensure an expedited review process when the consumer/enrollee, provider, or PIHP determines that taking the time for a standard resolution could seriously jeopardize the consumer's/enrollee's life or health or ability to attain, maintain or regain maximum function. The TMBHO will make a reasonable effort to provide prompt oral notice to the consumer/enrollee, followed by written notice of the decision within three (3) working days. If the request for an expedited resolution is denied, the consumer/enrollee and/or representative will be promptly notified orally, with a written notice to follow within three (3) calendar days of the request. The appeal will then be transferred to the timeframe for a standard resolution as above.
2. For expedited decisions, TMBHO will make a reasonable effort to provide oral or written notice within three (3) working days.

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

TMBHO allows for appeals to be filed either orally or in writing. See language provided in the TMBHO Grievance Plan below:

A. Network Provider Filing an Appeal for Medicaid Enrollees:

1. A Medicaid enrollee or representative may file an appeal whenever a Notice of Action (NOA) is received. (See the definition of "action" above.) To start the appeal process, the enrollee or representative may contact the Network Provider, the Ombuds, or TMBHO.
2. The enrollee has the right to request assistance with an appeal from the Ombuds, the Network Provider or anyone else the enrollee chooses. Interpreter and TTY/TDD services are available at no cost to the enrollee.
3. If the enrollee wants someone else to assist with an appeal, the enrollee and the authorized representative must send a statement signed and dated by both individuals naming the person that is to act on the enrollee's behalf.
4. The enrollee or the Network Provider or other representative, acting on the enrollee's behalf, may file an appeal either orally or in writing by contacting TMBHO. Oral requests establish the earliest possible filing date for an appeal, but a written signed request for an appeal must be submitted within seven (7) calendar days, unless there is a request in writing for an expedited appeal (see Number 9, below).

5. An appeal must include the name and signature of enrollee, how to reach him or her, the reason for the appeal, and any information that supports the request.
6. If an enrollee or his/her representative wishes to appeal an action by the TMBHO, he or she must request an appeal within twenty (20) days of the enrollee's receipt of the Notice of Action (NOA) from TMBHO.
7. If an enrollee wishes to continue currently authorized and covered Medicaid services, and the appeal involves a reduction, suspension or termination of services that the Network Provider believes the enrollee needs, the enrollee or representative must file a request within ten (10) calendar days of receiving the NOA or the intended effective date of the action. If the appeal decision is not in the enrollee's favor, he or she may have to pay for the services received during the appeal.
8. TMBHO will acknowledge receipt of the appeal either orally or in writing within one (1) business day. Any oral notification will be followed up in writing within five (5) business days.
9. An expedited appeal process may be requested if the enrollee, representative and/or the behavioral health care provider believes that a longer resolution time would jeopardize the enrollee's ability to maintain or regain maximum functioning. If requested, TMBHO will make an expedited decision within three (3) business days.

Consumers/enrollees are notified within the allowable number of days, per 42 CFR. This includes:

A. TMBHO Notification Timelines:
    1. For denial of an intake, NOA is mailed within fourteen (14) calendar days of the request;
    2. For denial of an inpatient authorization request, as expeditiously as possible, but a verbal notification is made within twelve (12) hours of request, followed up by a written NOA within three (3) business days;
    3. For termination, suspension or reduction of previously authorized covered Medicaid behavioral health services, at least ten (10) calendar days before the effective date of the action (exceptions: refer to 42 CFR 431.213 and 431.214);
    4. For denial of payment, at the time of any action affecting the payment;
    5. For **standard** notice of service authorization decisions that deny or limit services, as expeditiously as the consumer's/enrollee's behavioral health condition requires, and no longer than fourteen (14) calendar days following the receipt of the request for services by the Network Provider;
    6. If standard authorization decisions are not reached in accordance with the timeframes established, it constitutes an adverse action and is subject to appeal with OAH.

7. For notice of decisions that may require an extension, up to fourteen (14) additional calendar days may be needed if the consumer/enrollee or the provider requests an extension, or the TMBHO justifies a need for additional information if it is in the consumer's/enrollee's interest. If TMBHO extends the timeframe for a decision, the consumer/enrollee will be notified in writing of the reason for the extension. TMBHO will make the decision as expeditiously as the consumer's/enrollee's behavioral health condition requires, and no later than the date the extension expires.
8. For expedited decisions, TMBHO will make a reasonable effort to provide oral or written notice within three (3) working days.

(319) Grievance system – expedited appeals process – procedures.

The TMBHO appeals process allows for consumers/enrollees, or their representatives, to present evidence in support of their request for initial or ongoing services and refute a termination, suspension or limitation of their service. This includes allowing the consumer / enrollee, or their representative, to present allegations of fact or law in person or in writing.

TMBHO discusses how consumers/enrollees may present evidence in the TMBHO Grievance Plan. This includes:

1. Parties to a Medicaid appeal may include the enrollee and his/her representative, or the legal representative of a deceased enrollee's estate as well as the TMBHO.
2. At the consumer/enrollee and/or representative's request, TMBHO will provide consumers/enrollees and /or representatives with a reasonable opportunity (generally 72 hours) to informally discuss the appeal, present evidence, and allegations of fact or law, in person as well as in writing. TMBHO will inform the consumer/enrollee and/or representative of the limited time available in the case of an expedited resolution.
3. During the appeal process, the consumer/enrollee – and anyone else he or she gives permission to – can look at the consumer's/enrollee's case file, behavioral health records and any other documents and records considered during the appeals process.
4. A qualified TMBHO mental health professional or chemical dependency professional (CDP) who has not been involved in making treatment decisions, will review the appeal and provide a written decision within forty-five (45) days from the date the appeal was started, unless a faster process has been requested.
5. In some instances, TMBHO may need additional time or information. When it is in the consumer's/enrollee's interest, additional time of up to fourteen (14) calendar days may be needed, and TMBHO will notify the consumer/enrollee or representative of the reason for the delay.
6. TMBHO designated staff making Medicaid appeal decisions regarding medical necessity, expedited resolution and clinical issues, will be qualified mental health professionals or chemical dependency professionals with appropriate clinical expertise and who have

not previously been involved in any other level of review or decision–making regarding treatment or the disputed issue(s).

(320) Grievance system – expedited appeal process – resolution and notification.

TMBHO is very conscientious of timeframes with both grievances and appeals. In both cases, TMBHO strives to resolve the issues before the required timeframes established by the state and 42 CFR. Special attention is always paid to a consumer's/enrollee's individual needs when conducting a review on an appeal or investigating a grievance.

Much discussion has already been spent on timeframes for Appeals. Timeframes for grievances, however, differ somewhat. For grievances, the following requirements are stipulated under the Grievance Plan:

- If TMBHO receives notification that a consumer/enrollee wishes to file a grievance, the TMBHO Ombuds contacts the consumer/enrollee immediately (within one (1) working day) to officially discuss and open up the grievance.
- An Acknowledgement Letter is sent to the consumer/enrollee within five (5) working days after the date that the grievance was opened.
- TMBHO will investigate the grievance and issue a Resolution Letter within thirty (30) days after the original date of the grievance being opened.
- In some circumstances, an additional fourteen (14) days may be granted if the consumer / enrollee, or his or her representative desires an extension.
- Similarly, TMBHO may also request an additional fourteen (14) days if it needs additional time to investigate the grievance, but only with written notice to the consumer/enrollee explaining the circumstances around the extension.
- The entire grievance process should be wrapped up within ninety (90) days (from opening to resolution). However, TMBHO is very strict on having all grievances resolved within thirty (30) days of initiation.

Fair hearings are seen as the second step in the formal grievance process. If a resolution is not found to be in the consumer's/enrollee's favor the he or she has the right to request a State Fair Hearing. Neither TMBHO nor DBHR has control over the fair hearing process and, therefore, timeframes are not applicable. However, consumers/enrollees are given twenty (20) days to request a fair hearing after the issuance of the Grievance Resolution.

Reference to the grievance and appeal timeframes are cited below – as taken from the TMBHO Grievance Plan:

A. Filing a Grievance for Medicaid and State Funded Consumers:

1. All Medicaid and state funded consumers/enrollees or their family members, or other interested parties, may file a written or oral grievance with the provider, the TMBHO, or the Ombuds service at any time regarding TMBHO funded services.
2. In most cases it is advantageous to the consumer/enrollee if a concern regarding services is addressed immediately, without involvement in the formal, quasi-judicial grievance process. If the issue being reported by the consumer/enrollee is minor (does not involve a violation of WAC, RCW, federal regulation, or other grievance category defined by DSHS) and can be addressed immediately (within five (5) business days) to the consumer's/enrollee's satisfaction, then the issue should not be considered a formal grievance. Rather, in such circumstances, the issue will be considered a "concern," but will still be tracked for quality improvement purposes. However, all concerns that involve a potential violation of WAC, RCW, federal regulation, or other grievance category must be submitted to TMBHO for appropriate disposition.
3. Concerns will be investigated in a timely manner, with notification to the enrollee/consumer, representative or other individual either orally or in writing.
4. Concerns will first be considered at the Network Provider level by individuals that have not previously been involved with the issue of concern. Qualified mental health and/or chemical dependency professionals will review any concerns related to behavioral health treatment.
5. To start a grievance, a consumer/enrollee (and/or his or her representative) may contact their Network Provider, the Ombuds or TMBHO. The consumer/enrollee has the right to initiate a grievance at any level of the system.
6. A grievance may be filed at any time.
7. A provider may file a grievance with the TMBHO on behalf of the consumer / enrollee, with written consent.
8. The consumer/enrollee or representative may file a grievance orally or in writing. In all cases, the grievance will be summarized by TMBHO or the TMBHO Ombuds in writing and sent to the grievant within five (5) business days of receipt of the grievance information.
9. The letter must include the grievant's name, the date that the grievance information originally came to the attention of TMBHO, best-known contact information for the consumer/enrollee, the nature of the grievance, and what the consumer/enrollee or representative is requesting as a resolution to the grievance.
10. If a concern is addressed directly with a Network Provider, the Network Provider must attempt to resolve the issue satisfactorily within five (5) business days. These efforts must be appropriately documented and include the resolution. If, however, a concern cannot be addressed by the Network Provider in a timely manner, it must be immediately forwarded to the TMBHO Ombuds for investigation and resolution.

11. The Network Provider must facilitate the transfer of the concern and/or grievance to the TMBHO Ombuds. This means that the Network Provider cannot simply direct the consumer/enrollee to call the TMBHO Ombuds, but must actually contract the Ombuds to transfer the information.
12. TMBHO will investigate the grievance, including the previous steps taken by the Network Provider to resolve the concern at the lowest possible level. A written decision will be sent to the consumer/enrollee and/or representative within 30 calendar days.
13. Fourteen (14) additional calendar days may be given if the consumer/enrollee or representative requests an extension, or if TMBHO needs more time for additional information and it is in the consumer's/enrollee's interest, the BHO will notify the consumer or representative of the delay.
14. If the consumer/enrollee or representative does not receive a decision about the grievance within the specified timeframes, or the consumer/enrollee disagrees with the decision, he or she may file a request for a fair hearing
15. Consumers/enrollees and representatives have the right to request a fair hearing with the Office of Administrative Hearings (OAH) or through the Health Care Authority (HCA) if the grievance decision is unfavorable through the BHO level. The request must be filed within twenty (20) calendar days of receipt of the written decision from the BHO.
16. The entire grievance process should not exceed 90 (ninety) calendar days from initiation of the grievance.
17. Resolution/follow-up to a grievance will not end if the grievant has left services. Review and follow-up of the grievance, as filed, will proceed to resolution.

With regards to 42 CFR 438.408(d)(2)(ii), consumers/enrollees who are under an expedited appeal process will be notified orally whenever possible. This is also supported by the TMBHO Grievance Plan:

A. Notification of Grievances and Appeals:

1. Consumers/enrollees will be notified of the receipt of a grievance or appeal orally within one (1) business day from receiving the request. If the request is submitted orally, TMBHO will work with the consumer/enrollee to ensure that the request is submitted in a written format. Once the request is received in a written format, with the signature of the consumer/enrollee and/or consumer representative, TMBHO will send an acknowledgement letter to the consumer/enrollee and/or consumer representative within five (5) business days.

(321) Grievance system – expedited appeal process – punitive action.

TMBHO takes the possibility of retribution, or punitive action, against a provider and/or a consumer/enrollee very seriously. All grievances and appeals are reviewed by either a mental

health professional (MSP) or chemical dependency professional (CDP) prior to issuance to ensure that the consumer/enrollee, or agency, is treated fairly and that there is no punitive actions taken.

TMBHO Grievance Plan specifically addresses this item:

I. RETALIATION

A. TMBHO and its contracted providers will ensure that no formal or informal retaliation occurs as a result of an enrollee/consumer or representative filing a concern, grievance, or appeal by:
   1. Ensuring that a multi-level (service provider, TMBHO, Ombuds, State of Washington Administrative Hearing), independent grievance and appeal system is in place;
   2. Providing oversight and follow-up on grievances to determine outcome through a TMBHO established review process; and
   3. A periodic independent sampling of closed or resolved concerns or grievances against a service provider to determine if an enrollee or consumer has been the victim of retaliation.

(322) Grievance system – state fair hearing process – notification of state procedures.

TMBHO will make the dissemination of all grievance system rights to consumers/enrollees mandatory under its contracts with mental health and substance use disorder providers. It currently does this with all mental health Network Providers under the current RSN structure. This practice will continue under the newly formed BHO.

Any consumer/enrollee who is not satisfied with the outcome of an appeal or grievance, or if the decision is not fully favorable, will receive information about their right to request a State Fair Hearing. This information is disseminated on all resolution letters for appeals and grievances. This information is currently supported in the TMBHO Grievance Plan, as well as through existing contracts and resolution letters (please see evidence provided under the attachments for this response).

TMBHO Grievance Plan language that supports 42 CFR 438.10(g)(1) is presented below:

A. Requesting an Administrative (Fair) Hearing Following an Appeal or Grievance Decision:
   1. Following notice of disposition of a grievance or appeal, consumers/enrollees may request a fair hearing that is conducted by an independent state agency in accordance with WAC Chapter 388.526. The parties to the fair hearing include TMBHO as well as the consumer/enrollee and his or her representative.
   2. Medicaid consumers/enrollees have the right to ask for additional consideration and file a request for a fair hearing from the state Office of Administrative Hearings (OAH) or the Washington State Health Care Authority (HCA) if the resolution of a grievance or appeal at the TMBHO level is not favorable or the consumer/enrollee is

not satisfied. The request must be filed within twenty (20) days from the notice of the adverse decision, and the process must be completed within 90 calendar days of the date the grievance or appeal was initially filed, excluding time taken by the consumer/enrollee to file for a fair hearing following receipt of the notice of disposition of the grievance or appeal from TMBHO.

3. All levels of attempted resolution must occur at the TMBHO level prior to filing for a fair hearing, except as stated in Number 4 and 5 below.
4. In some situations, a consumer/enrollee may request a fair hearing before filing an appeal with TMBHO when there has been an alleged violation of state rules. Examples include the failure of TMBHO to authorize services in a timely manner or to process an appeal according to the required timelines. The consumer/enrollee may call the OAH or the Ombuds if he or she wants to ask the OAH to review the appeal.
5. All consumers/enrollees of TMBHO funded services have the right to use HCA's prehearing meeting and/or prehearing conference processes as described in WAC 388-526, when:
   a) The consumer/enrollee believes there has been a violation of DSHS rules;
   b) The TMBHO did not provide a written response within thirty (30) calendar days for a grievance and forty-five (45) days for an appeal, from the date a written request was received; or
   c) The TMBHO, DSHS, or a provider denies services per WAC 388-877 and 388-877A.
6. The OAH is **not** part of DSHS or the TMBHO. Requests for a fair hearing are sent to The Office of Administrative Hearings, P.O. Box 42489, Olympia, WA 98504.
7. All consumers/enrollees of TMBHO funded services have the right to file a request a fair hearing when the resolution of a grievance is not satisfactory at the lower BHO level, or the TMBHO grievance decision was not received with the timeframes specified in Section 3 above.
8. If the decision of the Administrative Law Judge (ALJ), who proceeds at the fair hearing, is not favorable to any party, that party may request a Review of the Initial Order (as specified in WAC 388-526-0560). If a final order has been issued by the ALJ, the party may request a Reconsideration of the Final Order, as specified in WAC 388-526-0605.
9. The final recourse for parties who are not satisfied with the decision of the fair hearing proceedings is the Judicial Review process. This process takes place in Superior Court, and is governed by RCW 34.05.510 through 34.05.598.
10. A provider or other representative may file a fair hearing on behalf of the enrollee / consumer with his or her written consent.

11. Parties to the fair hearing will include the TMBHO/PIHP, as well as the consumer / enrollee and his or her representative, or the representative of a deceased consumer's/enrollee's estate.

(323) Grievance system – state fair hearing – parties.

Allowable parties to the State Fair Hearing process are defined in the TMBHO Grievance Plan. Please see language below:

1. Following notice of disposition of a grievance or appeal, consumer/enrollees may request a fair hearing that is conducted by an independent state agency in accordance with WAC Chapter 388.526. The parties to the fair hearing include TMBHO as well as the consumer/enrollee and his or her representative.

(324) Grievance system – grievance – definition.

The TMBHO grievance system complies with the definitions sited in 42 CFR 438.400 (TMBHO Grievance System Plan). Within this plan the following terms are defined:

Action: A TMBHO (PIHP) decision involving a Medicaid enrollee and:

7. The denial or limited authorization of a requested covered Medicaid service, including the type or level of service;
8. The reduction, suspension, or termination of previously authorized covered Medicaid services;
9. An Individualized Treatment Plan wherein the provider and the consumer/enrollee cannot reach agreement and the consumer/enrollee does not receive requested, Medicaid-allowable services;
10. The denial in whole or in part, of payment for a covered Medicaid service;
11. The failure to provide services in a timely manner, as defined by the state; and
12. The failure of a Prepaid Inpatient Health Plan to act within the timeframes provided in section 42 CFR 438.408(b).

Administrative Hearing: A hearing conducted through the auspices of the State of Washington Office of Administrative Hearings (OAH), in accordance with Washington Administrative Code (WAC) 388-02. The term "fair hearing" is synonymous with "administrative hearing." The OAH decision made by the Hearing Officer must be carried out by the Department of Social and Health Services (DSHS), the TMBHO, and the affiliated Network Providers.

Adverse Action: Any decision or action that is unfavorable to a consumer/enrollee. In the instance of a TMBHO violation of state rules, an RSN funded consumer/enrollee may bypass the RSN level and file a request for a fair hearing from the OAH when:

4. The TMBHO fails to provide Medicaid services in a timely manner, as defined by the state;
5. The TMBHO fails to authorize services or process a grievance or Medicaid appeal according to the required timelines; and/or
6. TMBHO fails to act within the timeframes provided in section 42 CFR 438(b) or any successor.

Appeal: A Medicaid enrollee's (or representative's) request for a review by TMBHO of an action, as "action" is defined in this section.

Concern: An informal oral expression of dissatisfaction with any aspect of a consumer's / enrollee's experience with a Network Provider, TMBHO, or the Ombuds service that is **not** related to the pre-determined grievance definitions established by DSHS. Network Provider concerns should be resolved at the lowest level possible. This means that a concern should be resolved immediately by the person receiving the concern, without any delay or undue hardship for the consumer/enrollee, if at all possible. If a concern cannot be immediately (within 24 hours) resolved by the person accepting the concern, then the issue automatically becomes a grievance (see Grievance section below).

Network Provider: A mental health or substance use disorder agency licensed by the State of Washington Department of Social and Health Services (DSHS) with whom TMBHO contracts (Network Provider) to provide outpatient behavioral health services to enrollees/consumers. The contract between TMBHO and the Network Provider specifies that the Network Provider will abide by all appeals, grievances, and administrative hearing decisions.

Denial: An adverse decision made by TMBHO that requires a Notice of Action (NOA) and includes a decision:

1. Not to offer an intake to a Medicaid enrollee;
2. To deny or limit requested authorization of covered Medicaid behavioral health services based on the PIHP Level of Care Guidelines;
3. To deny requested authorization of a voluntary inpatient psychiatric hospitalization for a Medicaid enrollee; or
4. To deny, in whole or in part, requested payment for a covered Medicaid service.

Enrollee/Consumer: The terms are interchangeable, but may be specified as a "Medicaid enrollee/consumer" enrolled in the Title XIX entitlement program, or a "state funded enrollee/consumer." Medicaid enrollees have access to all levels of concerns, grievance, appeals and fair hearings. A "state funded enrollee/consumer" refers to a consumer enrolled in TMBHO services and funded through the RSN's State Behavioral Health Services Contract with the Department of Social and Health Services (DSHS). A state funded consumer has access to

the concern and grievance processes, as well as access to a State Fair Hearing for a grievance that remains unfavorable to the consumer after an RSN decision. (See Adverse Action above for exceptions).

Fair Hearing: The term "fair hearing" is synonymous with "administrative hearing."

Grievance: A formal expression of dissatisfaction about any matter **other** than an action, as "action" is defined above. The term is also used to refer to the overall system that includes grievances and appeals that are handled at the RSN level and access to the state fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the consumer's/enrollee's rights.) Grievances may be either received orally or in writing.

Department of Social and Health Services (DSHS): DSHS contracts with the TMBHO as a Prepaid Inpatient Health Plan (PIHP) to provide managed Medicaid behavioral health services to Medicaid enrollees, and as a behavioral health organization (BHO) to provide state behavioral health services to consumers/enrollees in Thurston and Mason counties.

Notice of Action: Written notification of the PIHP/TMBHO's decision regarding an "action" regarding the provision of behavioral health services to Medicaid enrollees. The notice must explain the particular action the TMBHO has taken or intends to take, the reason for the action, the enrollee's right to appeal the decision or action, and how to exercise that right and the right to continue benefits until the appeal is resolved.

Ombuds Service: An independent service created by Washington State law to assist consumers / enrollees with concerns, grievances, and appeals regarding public behavioral health services. The TMBHO Ombuds receives and investigates concerns and grievances from TMBHO consumers/enrollees, family members, and other interested parties, and will follow through to see that the concern or grievance is satisfactorily resolved. The Ombuds can also provide information on resources and consumer/enrollee rights, and assist with developing an advance directive.

Reduction: The decision made by TMBHO to decrease a Medicaid enrollee's previously authorized covered Medicaid behavioral health services described in their level of care guidelines. (Note: The Network Provider's decision to decrease or change a covered service in the enrollee's Individualized Service Plan is not a "reduction.")

Suspension: The decision made by TMBHO to temporarily stop a Medicaid enrollee's previously authorized covered Medicaid behavioral health services described in their level of care

guidelines. (Note: The Network Provider's decision to temporarily stop or change a covered service in the enrollee's Individualized Service Plan is not a "suspension.")

Termination: The decision made by TMBHO to stop a Medicaid enrollee's previously authorized covered Medicaid behavioral health service described in their level of care guidelines. (Note: The Network Provider's decision to stop or change a covered service in the enrollee's Individualized Service Plan is not a "termination.")

Timely filing: Filing a Medicaid appeal on or not later than twenty (20) calendar days after receiving a TMBHO Notice of Action of a denial, or within ten (10) calendar days of a notice for a reduction, suspension or termination of previously covered Medicaid services. If a continuation of previously authorized services is requested, the appeal must be filed within ten (10) calendar days of receiving the Notice of Action. (See also Section V for specific filing timelines.)

In addition, the TMBHO utilizes the following definitions for grievance types and grievance resolutions. This list of category and resolution types are subject to change in the coming months as the new Washington State Administrative Code is finalized:

Access:

- Concerns about ability to receive intake appointments, timeliness of referrals and appointments, or other issues with the intake or referral process;
- Inability to access services due to language barriers;
- Denials, terminations, suspensions or reductions of services for non-Medicaid consumers/enrollees;
- (A denial or termination of services for a Medicaid consumer/enrollee is not a grievance, it is an action and the RSN must provide a Notice of Action. Notices of Actions may then be appealed.)

Dignity and Respect: Issues regarding courtesy, tone of voice, language, or other treatment seen as disrespectful

Quality/Appropriateness: Issues regarding poor quality treatment or treatment errors.

Phone Calls Not Returned: May involve calls made to multiple clinicians or supervisors.

Service Intensity, Not available or Coordination of Services: Generally, issues in this category would be actions (disagreement with treatment plan), except for non-Medicaid consumers. May include problems with coordination between providers, peer support services, health care providers, or others involved in the treatment plan.

Participation in Treatment: A grievance might be that an individual's voice and viewpoint is not being included in treatment planning, or a parent is dissatisfied with their level of participation, or that requested other supports are not involved in treatment planning.

Physicians, ARNPs, and Medications: Problems with communication or scheduling issues. Disagreement with medications is an action for Medicaid enrollees and requires providing a Notice of Action. A person may also request a second opinion.

Financial and Administrative Services: Generally deals with payees employed by the CMHA, or incorrect paperwork or billing issues. An individual may not file a grievance regarding eligibility for SSI or regarding private payees.

Residential: Any issue with RSN-related services. These should primarily concern mental health treatment activities, noise, or privacy. An individual may, however, file a grievance with other issues including food, health or safety. These issues should be investigated by the RSN as well as be referred to the Department of Health.

Housing*:* These would include issues involving effectiveness in assisting consumers/enrollees in this area.

Transportation: Issues relating to transportation that are RSN-related.

Emergency Services: These grievances would always involve an additional category to clarify the nature of the problem. Grievances generally relate to services the RSN provides, including crisis lines, E&T centers, hospital alternative programs, or DMHP services. Grievances from RSN-enrolled consumes/enrollees regarding an authorized stay in a community hospital are also accepted.

A person may file a RSN grievance about DMHP services, although the resolution may be limited to providing information and avenues for further recourse. RSNs should be informed of the number of grievances in detainments and note any trends.

Resolution of grievances regarding a community hospital most often include referring a person to the individual hospital grievance procedures. The RSN may, however, decide an issue requires working with the hospital to improve services for RSN consumers/enrollees.

Violation of Confidentiality: Any information regarding a consumer/enrollee that is inappropriately disclosed, including name, diagnosis, treatment, or providers.

Other Rights Violations: Violation of any consumer/enrollee rights that are **not** covered in other categories (such as dignity and respect and confidentiality). These could include issues involving interpreters, cultural differences, or Advance Directives.

Other: A rarely used category for hard to categorize issues.

Resolution Types
Information or Referral: A person's wishes cannot be met by the RSN, but the issue is ended by providing information or referrals. An example would be a person complaining about a rights violation and it is decided there has been no violation of law. Information would be provided about privacy rules.

Conciliation/Mediation: A resolution agreed to mutually.

Not Pursued: Consumer/enrollee requested to end grievance, discontinued participation in grievance process, moved away, was hospitalized, died, etc. A letter of resolution should be sent whenever possible, using discretion and sensitivity.

Other: An RSN resolution decision without mutual agreement. Other hard to categorize resolutions.

(A fair hearing is not a resolution. The grievance resolution letter is sent with its explanation—that is the resolution. The filing of a fair hearing is a separate decision.)

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

The TMBHO Grievance Plan makes it clear that all consumers/enrollees have the right to file a grievance, at any time, for any dissatisfaction experienced in the mental health or substance use disorder provider network system. All providers in the network are required to expressly make this right known to consumers/enrollees at the time of intake. Posters explaining the grievance system and information about the TMBHO Ombuds are also required in all network agencies. In addition, information is given to consumers/enrollees in both the DBHR Handbook and the TMBHO Handbook.

General information about the grievance system (including appeals) is included in the TMBHO Grievance Plan and summarized below:

A. General Requirements:
    1. The following applies to all concerns, grievances or appeals:
        a) Consumers/enrollees may have a representative who acts on his or her behalf in filing and pursuing grievances and appeals.

b) A Network Provider may file a grievance or appeal on behalf of the consumer / enrollee with written consent.
c) Network Providers must report all concerns and potential grievances to TMBHO within twenty-four hours of receipt, using the established *TMBHO Provider Grievance Notification Form*.
d) Consumers/enrollees will be given reasonable assistance in completing forms and taking other procedural steps as needed in pursuing a grievance, an appeal, or a fair hearing, including access to the Ombuds service at all levels.
e) Consumers/enrollees will be provided information about the grievance and appeal rights and process under the TXIX or state funded programs, including timeframes for filing requests, and that the Ombuds service is available to consumers/enrollees at no cost to assist throughout the entire process.
f) TMBHO will ensure that Network Providers post clients' rights at each site providing treatment services, and in the most prominent languages identified for Washington State.
g) TMBHO will ensure that consumers/enrollees have access to oral or manual language interpretation services as well as toll-free TTY/TTD services that have adequate interpreter capacity, or other alternate formats as needed and upon request.
h) TMBHO and its contracted providers will ensure that consumers/enrollees are provided a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.
i) TMBHO and its contracted providers will ensure that consumers/enrollees may examine their case file, including medical records, documents and records considered before and during the appeal process.
j) TMBHO will acknowledge receipt of each grievance and appeal received (either orally or in writing) within five (5) business days. This acknowledgement will come in the form of a written letter from the TMBHO Ombuds.
k) Each consumer/enrollee has the right to have grievances and appeals received in a respectful, helpful manner, and to have grievances and appeals investigated and resolved promptly at the lowest possible level of the system and without retaliation against the individuals.
l) TMBHO will ensure that there is no retaliation or punitive action taken against a consumer/enrollee or a provider who supports a consumer's/enrollee's appeal, or supports/requests an expedited resolution of an appeal.
m) TMBHO will ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making.
n) TMBHO will ensure that the individuals that make decisions on appeals regarding medical necessity, expedited resolution, or involving clinical issues are qualified

mental health professionals (MHPs) or chemical dependency professional (CDPs) who have the appropriate clinical expertise.

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

The TMBHO Grievance Plan outlines the method in which TMBHO addresses all grievances. These rules are also included in the TMBHO Ombuds plan.

With regards to grievance disposition and specific timeframes, the TMBHO Grievance Plan contains the following language:

I. DISPOSITION, RESOLUTION, and NOTIFICATION

A. Notification of Grievances and Appeals:

1. Consumers/enrollees will be notified of the receipt of a grievance or appeal orally within one (1) business day from receiving the request. If the request is submitted orally, TMBHO will work with the consumer/enrollee to ensure that the request is submitted in a written format. Once the request is received in a written format, with the signature of the consumer/enrollee and/or consumer representative, TMBHO will send an acknowledgement letter to the consumer/enrollee and/or his or her representative within five (5) business days.
2. The consumer/enrollee will be notified of the resolution of the grievance or appeal in writing as expeditiously as the consumer's/enrollee's health condition requires, but at least within 30 calendar days for a grievance, and within 45 calendar days for an appeal. Notice will include the date of resolution, unless an extension or expedited decision is requested or indicated.
3. The TMBHO will notify Medicaid enrollees and their representatives of their right to request a fair hearing, as described in WAC 388-526, when the enrollee has received an unfavorable disposition to an appeal filed at the TMBHO level.
4. Consumers/enrollees who file a grievance will be notified:
   a) Of their right to request a fair hearing if they are unsatisfied, and how to do so;
   b) Of their right to request to receive medically necessary services while the hearing is pending;
   c) How to make the request; and
   d) That the individual may be asked to pay for the cost of those services if the hearing decision upholds the original decision.
5. For grievances or appeals not resolved wholly in favor of the consumer/enrollee, notification will include the results of the resolution process and include:
   a) The date the resolution was completed;
   b) The right to request a fair hearing and how to make the request;
   c) The right to request and receive service benefits while the hearing is pending and how to make the request; and

d) Notice that the consumer/enrollee may be asked to pay for the cost of those benefits if the fair hearing decision upholds the TMBHO decision.

6. TMBHO will assure that a written notice meets the language and format requirements of 42 CFR 438.10 (c) (d), including but not limited to, ease of reading and in easily understood English or prevalent non-English language of the consumer / enrollee.

B. Disposition/Resolution:

1. **Standard disposition:** TMBHO will resolve each grievance, complete each appeal, and provide written notice as expeditiously as the consumer's/enrollee's behavioral health condition requires, but not more than thirty (30) calendar days from receipt of the grievance or forty-five (45) calendar days from receipt of an appeal.
2. **Expedited disposition (For Appeals only):** TMBHO will ensure an expedited review process when the consumer/enrollee, provider, or PIHP determines that taking the time for a standard resolution could seriously jeopardize the consumer's/enrollee's life or health or ability to attain, maintain or regain maximum function. The TMBHO will make a reasonable effort to provide prompt oral notice to the consumer / enrollee, followed by written notice of the decision within three (3) working days. If the request for an expedited resolution is denied, the consumer/enrollee and/or representative will be promptly notified orally, with a written notice to follow within three (3) calendar days of the request. The appeal will then be transferred to the timeframe for a standard resolution as above.

11

Tribal communication and Coordination and Communication Plan

(169) BHO – inclusion of tribal authorization – roles and responsibilities

The newly formed Thurston Mason Behavioral Health Organization (TMBHO) will consist of a governing board of three (3) elected officials, County Commissioners, two (2) from Thurston County and one (1) from Mason County. TMBHO maintains an advisory board whose role is to advise the governing board on matters relating to behavioral health services in the service area. The advisory board members will represent the demographic character of the region and TMBHO will maintain a Tribal Coordination Plan for each Tribal Authority identified in the service area (Chehalis Confederated Tribes, Nisqually Tribe, Skokomish Tribe, and Squaxin Island Tribe) in accordance with state policy 7.01 on inclusion of local tribal authorities' representation as a party to the BHO.

TMBHO will coordinate prior to April 01, 2016 with all Tribal Authorities in the service area through the development of:

a) Policy 7.01 Implementation Plans
b) ITA Crisis Coordination Plans
c) American Indian Addendum

TMBHO ensures that Network Provider contracts specifically include non-discrimination language and language requiring that services are provided based on eligibility criteria (e.g., medical necessity and access to care standards). In addition, contracts include tribal relation requirements per the Prepaid Inpatient Health Plan:

- *"In the event the liaison is aware that the Enrollee is a Tribal Member or receiving mental health services from a Tribal or Urban Indian Health Program and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in discharge planning and transition for the Enrollee."*
- *"If an Enrollee is a Tribal Member of a Washington State Federally Recognized Tribe and is referred to or presents for non-crisis services and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in treatment planning and service provision for the Enrollee."*

TMBHO requires each Network Provider to track and log each time a notification has been made to a Tribal Authority for treatment or discharge collaboration with the Tribe. This is monitored through clinical chart audits and administrative contract audits.

In addition, TMBHO will attempt to meet with each individual Tribal Authority in the service area to develop Policy 7.01 implementation plans to ensure that Tribal Authorities and Tribal members understand how to access the TMBHO provider network and behavioral health services.

TMBHO will ensure services are delivered in a culturally competent manner as detailed in *Policy & Procedure QM609 Culturally Competent Services*:

a) Recognize the unique legal and social status of Indian Nations; the Tribes under the Supremacy clause; the Indian Commerce Clause of the United State Constitution; federal treaties, executive orders; Indian Citizens Act of 1924 statutes; state and federal court decisions; and maintain compliance with DSHS American Indian Policy 7.01 or any successor, pursuant to the Centennial Accord between the Washington State Government and the Washington Tribes.
b) Ensure provision of behavioral health services that are responsive and sensitive to age, cultural and developmental differences, and persons with a disability.
c) Ensure access to age and culturally competent behavioral health services and ensure eligible consumers/enrollees receive appropriate levels of care.
d) Develop publicized forums annually to seek and include input about service needs and priorities from community stakeholders, including:
    - Enrollees/consumers;
    - Family members and enrollee/consumer advocates;
    - Culturally diverse communities including consumers/enrollees who have limited English proficiency (LEP);
    - Network Providers;
    - Social service agencies;
    - Organizations representing persons with a disability;
    - Tribal Authorities; and
    - Underserved groups.
e) Develop and implement quality assessment and monitoring activities that assess the degree to which services provided are age, culturally and linguistically appropriate.
f) Ensure direct access to behavioral health specialists that may be available for consultation with clinicians, enrollees/consumers, families and community members upon request and as needed, at no charge to the individual, and in accordance with the special populations to include Tribal Authorities:
g) TMBHO Network Providers shall evaluate and consider a consumer's/enrollee's unique cultural, racial, ethnic, or social background when developing the individualized service plan. If those factors are not relevant to the current episode of care, the Network

Provider shall document that these factors were considered, but are not to be considered at this time.

h) TMBHO Network Providers shall provide an annual cultural competency training for all staff working with consumers/enrollees. This training shall be no less than six (6) hours, be documented and signed by all staff who participate, and shall include (at a minimum) information about working with the following populations:
   - Older adults (geriatric population);
   - Ethnic minorities (using present ethnic minority populations specific to TMBHO, and/or the Network Provider's demographic information);
   - Tribal Authorities;
   - Persons with physical/medical disabilities;
   - Persons with intellectual disabilities;
   - Lesbian/Gay/Bisexual/Transgender (LGBT) population.

SUD ITA services will continue to be accessible by Tribal members using the county-designated (CD) CDP for ITA as needed. Tribal members found to meet criteria for ITA commitment by the CD CDP will have court orders issued through the County District or Superior Court. TMBHO will ensure when developing Policy 7.01 implementation plans that the process for accessing SUD ITA is clear to Tribal members and it will work with any Tribes wanting to develop Tribal SUD ITA services, including a process for honoring Tribal ITA court orders.

Additionally, TMBHO will ensure that federal Substance Abuse Prevention and Treatment block grant and/or state funding is available to pay for clinically appropriate ITA treatment services through coordination with Thurston and Mason Tribes.

12

Behavioral Health Data Consolidation Project Plan

(295) Health information systems.

It is the intention of TMBHO to fully integrate and incorporate mental health and substance use disorder (SUD) service providers, existing and new, into managed care client and service data reporting requirements. As noted below in requested responses, this involves multiple steps. One step is the facilitation of existing SUD service provider's data systems and the transition from reporting client data and service encounters directly to Department of Health and Human Services (DSHS) to submission into the TMBHO client data system. The second step is to transition all electronic health records and existing databases at both mental health and SUD service providers so that they can transmit data directly to TMBHO, or enable them to enter data directly into the TMBHO data system. The third step is to transition the existing TMRSN Management Information System (MIS) system into a new MIS, in coordination with several other behavioral health organizations, that is able to fulfill DSHS client data and reporting requirements.

TMBHO has also identified a new data system to manage client data and reporting requirements. TMBHO is currently proceeding with joining the "Washington State NetSmart (Avatar) Consortium" with several other BHOs implementing the NetSmart (NTST) product called Avatar. This new product will allow TMBHO to (1) share expenses with other BHOs when changes to the data system are necessary, (2) use a proven tool for client data and reporting requirements, and (3) allow service providers who are located in two (2) BHOs to gain efficiencies in only having to manage one reporting system. Also, the new system will allow for further standardization of reporting to DSHS. This will hopefully reduce the perspective by the legislature that they do not trust data from one BHO to be comparable to the data from another BHO.

Additionally, TMBHO has contracted with an MIS consultant to assist with the transition of SUD service providers to move from reporting directly to DSHS to utilizing their existing electronic health records (EHRs) to report in batch files directly to TMBHO, or via direct entry into the TMBHO's MIS. Providers will also be given the option to adopt TMBHO's Avatar product as their EHR. TMBHO will be working with this consultant to help service providers understand the changes in reporting requirements as well as the technical aspect of making the changes.

TMBHO has identified this transition and integration of data requirements as the "TMBHO Behavioral Health Data Consolidation Project." Through this project, TMBHO has identified the DSHS 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. Reporting rules, definitions, and values for new elements will be developed with the RSN/BHO representatives between July 1, 2015 and December 31, 2015, either through the SERI workgroup or the BHDC data group.

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).
   RESPONSE: TMBHO is implementing the NetSmart (NTST) product Avatar to collect all required mental health data elements (both non-Provider One and Provider One). The version of Avatar being implemented will have the ability to collect the new data elements listed. The Avatar software products include processes that allow direct data entry (DDE), electronic data interchange (EDI) with an agency, EDI to the BHO, and external interfaces, including ProviderOne (837) and State CIS submissions. The following table lists key milestones that identify significant delivery dates leading up to the BHO launch:

Description	Date / Status
Software requirement specifications documented	Complete
Vendor specifications review / final changes	Complete
Software programming	In process 1/31/2016
User acceptance testing	2/28/2016
Product finalization (including customized configuration)	3/15/2016
Provider agency training / testing	3/31/2016

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.
      RESPONSE: TMBHO has contracted with an MIS consultant to work with TMBHO to assess and facilitate the transition to ensure all provider agencies in the Thurston Mason network are able to submit client and service data that meets the DSHS/BHO reporting requirements. The two (2) largest agencies already have data exchanges that support

the Avatar product. For the smaller agencies, TMBHO and its MIS consultant will be meeting with them to do an assessment and develop a staff training and technical schedule to make the transition. TMBHO will be training providers on the use of the provider portal and direct data entry requirements.

b. How are you communicating the data reporting requirements?
RESPONSE: TMBHO will be working with its MIS consultant to communicate the data reporting requirements to all service providers. TMBHO has begun meeting with substance use disorder and mental health providers to identify and discuss several cross-functional (administration, finance, IT/IS, allowable encounters, clinical documentation) changes in the reporting system and in the provider and BHO roles. Providers now understand that TARGET will be decommissioned and that data reporting will be conducted through the BHOs beginning April 1, 2016.

With the MIS consultant, TMBHO will continue to hold trainings as part of the go-live process, starting in February 2016, to introduce the managed care requirements.

c. Describe technical assistance or other support you are providing to substance use disorder treatment agencies.
RESPONSE: TMBHO will be holding several meetings with providers, and trainings beginning in February 2016 to bring agencies online. Technical support requirements will be identified with each individual agency, beginning with the November/December meetings. Ongoing support will be provided from within the IT/IS team to the agencies.

d. Describe the IT systems/EHRs used by the provider agencies in your network to collect and submit client and services information.
RESPONSE: The two largest agencies already interface directly with the Avatar system and provide both client and service data. Smaller agencies will be allowed the option of either direct data entry or developing interfaces from the EHR system to Avatar.

3. Document your plan to collect client and services data from the substance use residential providers located throughout the state.
RESPONSE: TMBHO plans to implement contractual arrangements with residential providers outside the region. The contractual requirements would require these out-of-region providers to submit data elements just like any other service provider, which could include direct data entry or submission of supplemental files that are accepted into the system for inclusion with the state data sets that are generated. BHOs in multiple regions are collaborating in order to set up processes that will facilitate the data flow and information across statewide utilization.

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.
   RESPONSE: At this time, the funding source submission requirement has been dropped from the submission requirements.

5. Describe how will you ensure that encounters are submitted within 30 days after the close of the month of service?
   RESPONSE: TMBHO plans to implement contract language requirements with Network Providers that align with DBHR's new requirement that encounters must be submitted within 30 days after the close of the month, which will also include monetary penalties for non-compliance. TMBHO will also ensure our data submission schedule reflects the 30 day submission requirement.

Attachment 1

Attachment 1: Attestations and Responses for Detailed Plan

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	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 73, 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 111, 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 75, Section 7**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 11, Section 3**	
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 15, 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 79, 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 16, 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 16, 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.

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	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 21, 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 77, 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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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 38, Section 4**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 21, 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 53, Section 5**	
51	RCW 70.96A.420	Statewide treatment and operating standards for opiate substitution programs - evaluation and report.	A			
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~~			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 persons.~~	~~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			
72	RCW 71.05.020	Definitions.	A			
73	RCW 71.05.025	Integration with chapter 71.24 RCW - behavioral health organizations.	A			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 persons.	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 22, Section 3**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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**				

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 35, Section 4**	
152	RCW 71.24.015(3 - ~~7~~)	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			
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 58, 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 4, 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 4, 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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
168	RCW 71.24.250	Behavioral health organizations - gifts and grants.	A			
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 157, 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 57, 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 65, Section 6**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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 38, Section 3**	
188	RCW 71.24.850	Regional service areas - report - managed care integration.	A			
189	RCW 71.34	Mental Health Services for Minors				

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 minors.	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			
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
216	RCW 71.34.510	Notice to parents when minor admitted to inpatient treatment without parental consent.	A			
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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 24, Section 3**	
232	RCW 71.34.760	Placement of minor in state evaluation and treatment facility - placement committee - facility to report to committee.	A			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 27, 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			
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 enrollee.	A			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 41, 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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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.				

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	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 42, 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 106, 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 54, 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 108, Section 9**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 45, 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 5, Section 3**	
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 79, 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 52, Section 5**	
288	42 CFR 438.214(a, b, c, & d)	Provider requirements.	A			
289	42 CFR 438.224	Confidentiality.	A			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 111, 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 85, Section 9**	
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 & 3)	Health information systems.	R	Provide a response to the Behavioral Health Data Consolidation Requirements, Exhibit A to the Detailed Plan Request.	**Item (295), page 160, Section 12**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 113, 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 116, 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 118, 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 119, 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 119, 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 120, Section 10**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	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 121, 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 121, 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 122, 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 122, 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 123, 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 127, Section 10**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 128, 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 129, 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 129, Section 10**	
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 131, 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 135, 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 136, Section 10**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 137, 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 139, 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 139, 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 140, 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 140, 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 142, Section 10**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	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 143, 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 145, 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 146, 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 148, 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 148, Section 10**	
325	42 CFR 438.402(b)(3)(i), 42 CFR 438.402(b)(1)(i), 42 CFR 438.402(b)(3)(i)	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 153, Section 10**	

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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 155, 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~~			
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			

Attestation Signature:_____Date:_____

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

Thurston Mason BHO - Amended Detailed Plan Request: Attestations and Responses for Detailed Plan 8/31/15

	A	B	C	D	E	F
1	Authority	Description	(Q)ues(R)esponse	Responses to be Addressed in Detailed Plan	Cross-reference to Detailed Plan	Initial
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			
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:_____

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

Attachment 2

Attachment 2: TMBHO Interlocal Agreement 9-15

Thurston Mason Behavioral Health Organization
INTERLOCAL AGREEMENT

THIS AGREEMENT, made and entered into this _____ day of _____, 2015 by and between **Thurston County**, a political subdivision of the State of Washington, and **Mason County**, a political subdivision of the State of Washington hereinafter collectively referred to as the '**Counties or County,**' under the authority of the Interlocal Cooperation Act, chapter 39.34 RCW, for purposes hereinafter stated.

WHEREAS, RCW 71.24.015 encourages county authorities (as defined in RCW 71.24.025 (3) effective April 1, 2016) to enter into joint operating agreements with other county authorities to form Behavioral Health Organizations; and

WHEREAS, chapters 71.05 and 71.24 RCW allow counties and other entities to establish Behavioral Health Organizations to integrate planning, administration, and service delivery duties assigned to the Counties; and

WHEREAS, the Counties have a mutual interest in forming a Behavioral Health Organization to plan, coordinate and administer mental health and substance use disorder services;

NOW, therefore, in consideration of the mutual promises and covenants contained herein, the Counties agree as follows:

ESTABLISHMENT AND ORGANIZATION OF THE BEHAVIORAL HEALTH ORGANIZATION:

1. PURPOSE

The purpose of this Agreement is to establish a Behavioral Health Organization to carry out the responsibilities of a Behavioral Health Organization as defined in RCW 71.24.300. The Thurston Mason Behavioral Health Organization ("TMBHO") established by the terms of this Agreement is the successor to and is intended to replace the Thurston Mason Regional Support Network, created by Interlocal Agreement between Thurston County and Mason County dated October 21, 1980.

This Agreement between the Counties shall continue uninterrupted, **PROVIDED,** however**,** the Counties agree that each party shall be responsible for prior obligations and liabilities arising out of the operation of programs funded under RCW Chapter 71.24 prior to the effective date of this Agreement, and to defend, indemnify and hold harmless each other participating County from any such prior liability.

2. DURATION OF AGREEMENT

a. This Agreement shall commence upon final approval of the Counties and shall be in force until such time it is terminated by the participating Counties.

b. Any actions taken by the Counties pursuant to this Agreement on or after October 1, 2015, are hereby ratified by the Counties and subject to this Agreement.

3. ORGANIZATION

a. **Governing Board:** TMBHO shall have a Governing Board of three members. One member shall represent Mason County; two members shall represent Thurston County. The Board of County Commissioners for Mason County shall appoint the member for Mason County. The Board of County Commissioners for Thurston County shall appoint the two members for Thurston County. Governing Board members shall serve at the pleasure of the appointing authorities. The respective appointing authorities shall also appoint one alternate member for each County. Alternate members shall have the same authority to attend, participate in, and vote at any meeting of the Governing Board as that County authority's member when the regularly appointed member is absent from the meeting. Each person so appointed shall commence service upon written notification to TMBHO of the name of the appointed member and alternate member.

   I. Except as otherwise provided herein, a simple majority vote by a quorum of the members of the Governing Board shall be required for the Governing Board to take action or exercise any of its powers.

   II. Any decision that would solely or disproportionately affect services in Mason County must receive an affirmative vote by the sitting/appointed Mason County Board member.

b. The TMBHO Governing Board shall provide oversight of the functions of the TMBHO Administrator and the TMBHO Administrative Service Organization operations.

c. The powers of the Governing Board shall be those necessary to transact the business of the TMBHO, including, but not limited to:

   i. Subject to section 3.f herein, hiring, evaluating and terminating the TMBHO Administrator.

   ii. Reviewing, modifying, approving, and adopting policy and procedures developed and presented by the TMBHO Administrator or the Governing Board;

   iii. Reviewing, modifying, approving, and adopting TMBHO budgets and contracts developed and presented by the TMBHO Administrator;

iv. Reviewing, modifying, approving and adopting service delivery plans and operating plans developed and presented by the TMBHO Administrator;

vi. Adopting TMBHO bylaws and approving amendments, alterations or repeals of the TMBHO bylaws. Any such bylaws shall be consistent with this Agreement and shall be binding on each County; and

vii. Taking any necessary or proper steps to exercise the powers of the Governing Board.

d. **Administrator:** Subject to Section 3.f herein, the TMBHO Administrator will be responsible for ensuring compliance with all applicable statutes, rules, regulations, policies, bylaws and contract provisions.

e. **Advisory Board**: There is hereby created a TMBHO Advisory Board consisting of a minimum of nine members. Each County, acting through its Board of County Commissioners, shall appoint two members to the Advisory Board. The remaining Advisory Board members shall be selected by the Governing Board and shall have at minimum:

i. one law enforcement member appointed by a County,

ii. one member for Tribal representation,

iii. a minimum of 51% of the Advisory Board membership are persons, parents or legal guardians of person, with lived experience and/or self-identified as a person in recovery from a behavioral health disorder,

iv. residents of the appointing Counties only.

The composition of the Advisory Board shall be broadly representative of the demographic character of the Counties and the persons served therein. The Advisory Board will meet monthly if there is business to be conducted and may rotate the location of these meetings as approved by the Governing Board. Each County authority shall seek local input in selecting its representatives to the Advisory Board. Members of the Advisory Board shall serve at the pleasure of the County Commissioners. Appointments to the Advisory Board shall be for three-year terms that may be repeated with Board of County Commissioner approval. No employees, managers or other decision makers of subcontractors who have the authority to make policy or fiscal decisions on behalf of the subcontractor shall be on the Advisory Board.

f. **Administrative Services Organization Entity**: The Governing Board shall, at minimum, contract with Thurston County to function as the Administrative Service Organization in the first year of operation. As the Administrative

Service Organization for the TMBHO, Thurston County is responsible for maintaining mental health and substance use disorder services and functions of a BHO as required by chapters 70.96, 70.96A, 71.05, 71.24 RCW and applicable WACs including, but not limited to, the following duties:

i. Management Information System;

ii. Care Management System;

iii. Quality Management System;

iv. Provider Service Network Management;

v. Consumer Service;

vi. Financial Management;

vii. Service Coordination in both Counties; and

viii. Grievance System.

g. **TMBHO Funds:** TMBHO funds shall be deposited with the Thurston County Treasurer who shall be the custodian of such funds. The Thurston County Treasurer may make payments from such funds upon audit by the Thurston County Auditor as provided for in RCW 71.24.100. The Thurston County Treasurer shall establish a special fund to be designated "Operating Fund of Thurston Mason BHO." Interest on investment of TMBHO funds shall accrue for the benefit of said operating fund.

h. **Attorney:** TMBHO may retain the services of an attorney when deemed necessary and approved by the Governing Board.

i. **Applicable Standards**: All services provided under the auspices of this Agreement shall be in accordance with all applicable laws, rules and regulations, including, but not limited to:

a. RCW 39.34: Interlocal Cooperation Act
b. RCW 71.05: Mental Illness
c. RCW 71.24: Community Mental Health Services Act
d. RCW 71.34: Mental Health Services for Minors
e. RCW 70.96: Alcoholism
f. RCW 70.96A: Treatment for Alcoholism, Intoxication and Drug Addiction

4. CONFLICT OF INTEREST

The Governing Board and the BHO Advisory Board shall be free from conflicts of interest and from any appearance of conflicts of interest of personal, professional and fiduciary

interests relating to the TMBHO and the consumers it serves. Members, or their immediate family will have no commitment, investment, obligation, or substantive involvement (financial or otherwise), in any agency contracting with, submitting any proposals to, or is expected to submit any proposals to the BHO. A former Board member may submit proposals to the BHO only following a minimum of one full calendar year after the date of their official departure from either Board.

5. INSURANCE, RISK MANAGEMENT, AND INDEMNIFICATION

a. **Risk reserves**: TMBHO will maintain Risk Reserve Funds as required by the Regional Support Network Medicaid (Pre-paid Inpatient Health Plan) and Non-Medicaid contract with the State of Washington, Department of Social and Health Services. If at any time, the balance of said Risk Reserve Fund goes below that which is required by the DSHS Medicaid and Non-Medicaid contract, the TMBHO shall immediately give notice to each party to this Agreement and shall give monthly notices of the current balance of said Risk Reserve Fund each month thereafter until the balance of said fund meets the TMBHO contacted requirements. Risk Reserve Fund*s* shall only be used as allowed in contract.

b. TMBHO agrees to defend, indemnify, and hold harmless each of the Counties to this Agreement against any and all claims arising out of the acts or omissions of the TMBHO staff members.

   TMBHO additionally agrees to defend, indemnify, and hold harmless each of the Counties to this Agreement against any and all claims brought by TMBHO staff members as a result of their employment, including but not limited to claims for wrongful termination and for violation of employee rights.

c. **Claims based on acts of subcontractors**: This paragraph shall not be construed to create any rights whatsoever in any person or entity not a party to this Agreement. The sole purpose of this paragraph is to allocate contribution among the Counties to this Agreement, in the event of claims brought against TMBHO as a result of the acts or omissions of TMBHO's subcontractors. It is the intent of the Counties to this Agreement that TMBHO is not liable for the acts or omissions of TMBHO's independent contractors. The TMBHO Governing Board shall include in all subcontracts provisions requiring subcontractors to defend, indemnify, and hold harmless TMBHO against any and all claims attributed to the acts or omissions of said subcontractors.

   The TMBHO Governing Board shall also require all subcontractors to maintain policies of general and professional liability insurance with limits of not less than $2,000,000 per occurrence, and $5,000,000 in the aggregate and each such policy shall name the TMBHO, Thurston County, Mason County and the State of Washington as additional insureds.

d. **TMBHO Liability** Policies As an additional level of protection, TMBHO shall, with TMBHO funds, purchase policies of liability insurance as follows to cover against the risk of subcontractor liability:

Governing Board Member's Errors and Omission Insurance: TMBHO shall purchase and maintain a Governing Board members' Errors and Omission Insurance policy with limits of liability of not less than $1,000,000, combined single limit.

Commercial General Liability Insurance: TMBHO shall purchase and maintain a Commercial General Liability policy using Insurance Services Office "Commercial General Liability" policy form CG 00 01, with an edition date prior to 2004, or the exact equivalent. Coverage for an additional insured shall not be limited to its vicarious liability. Defense costs must be paid in addition to limits. Limits shall be no less than $5,000,000 per occurrence for all covered. Thurston County, Mason County and the State of Washington shall be included as additional named insureds on such policy and such policy shall include each County's and/or the State's officials, employees, agents, and volunteers when they are performing an official function for TMBHO as authorized by the TMBHO Governing Board or Administrator. Coverage shall include contractual liability and employer's liability.

Workers' Compensation: TMBHO shall purchase and maintain a state-approved policy form providing statutory benefits as required by law with employer's liability limits no less than $1,000,000 per accident for all covered losses.

Business Auto Coverage: TMBHO shall purchase and maintain an ISO Business Auto policy utilizing Coverage form CA 00 01 including owned, non-owned and hired autos, or the exact equivalent. Limits shall be no less than $1,000,000 per accident, combined single limit. If TMBHO owns no vehicles, this requirement may be satisfied by a non-owned auto endorsement to the general liability policy described above. If TMBHO or TMBHO's employees will use personal autos in any way with the work of TMBHO, TMBHO shall obtain evidence of personal auto liability coverage for each such person.

Excess or Umbrella Liability Insurance (Over Primary): If used to meet limit requirements, any excess or umbrella liability policy shall provide coverage at least as broad as specified for the underlying coverages. Such policy or policies shall include as insureds those covered by the underlying policies, including additional insureds. Coverage shall be "pay on behalf", with defense costs

payable in addition to policy limits. There shall be no cross liability exclusion precluding coverage for claims or suits by one insured against another. Coverage shall be applicable to the Counties for injury to employees of TMBHO, subcontractors or others involved in the Work. The scope of coverage provided is subject to approval of County following receipt of proof of insurance as required herein.

e. **Additional Insurance Stipulations**:

1) TMBHO agrees to endorse third party liability coverage required herein to include as additional insureds the Counties, their officials, employees and agents, and the State of Washington using ISO endorsement CG 20 10 with an edition date prior to 2004. [If this is a construction contract, ISO endorsement 20 37 also is required.] TMBHO also agrees to require all contractors, subcontractors, and anyone else involved in this agreement on behalf of the TMBHO (hereinafter "indemnifying parties") to comply with these provisions.

2) TMBHO agrees to waive rights of recovery against the Counties, their officials, employees and agents, and the State of Washington regardless of the applicability of any insurance proceeds, and to require all indemnifying parties to do likewise.
3) All insurance coverage maintained or procured by TMBHO or required of others by TMBHO pursuant to this agreement shall be endorsed to delete the subrogation condition as to the Counties, their officials, employees and agents, and the State of Washington or must specifically allow the named insured to waive subrogation prior to a loss.
4) All coverage types and limits required are subject to approval, modification and additional requirements by the Counties. TMBHO shall not make any reductions in scope or limits of coverage that may affect the Counties' protection without the Counties' prior written consent.
5) Proof of compliance with these insurance requirements, consisting of endorsements and certificates of insurance shall be delivered to the Counties prior to the execution of this Agreement. If such proof of insurance is not delivered as required, or if such insurance is canceled at any time and no replacement coverage is provided, the Counties have the right, but not the duty, to obtain any insurance it deems necessary to protect their interests. Any premium so paid by the Counties shall be charged to and promptly paid by TMBHO or deducted from sums due TMBHO.
6) It is acknowledged by the parties of this agreement that all insurance coverage required to be provided by TMBHO or indemnifying party, is intended to apply first and on a primary non- contributing basis in relation to any other insurance or self-insurance available to the Counties.
7) TMBHO agrees not to self-insure or to use any self-insured retentions on any portion of the insurance required herein and further agrees that it will not allow any indemnifying party to self- insure its obligations to Counties. If TMBHO's existing coverage includes a self-insured retention, the self-insured retention must be declared to the Counties. The

Counties may review options with the TMBHO, which may include reduction or elimination of the self-insured retention, substitution of other coverage, or other solutions.

8) TMBHO will renew the required coverage annually as long as the Counties, or their employees or agents face an exposure from operations of any type pursuant to this agreement. This obligation applies whether or not the agreement is canceled or terminated for any reason. Termination of this obligation is not effective until the Counties execute a written statement to that effect.
9) The limits of insurance as described above shall be considered as minimum requirements. Should any coverage carried by the TMBHO or a subcontractor of any tier maintain insurance with limits of liability that exceed the required limits or coverage that is broader than as outlined above, those higher limits and broader coverage shall be deemed to apply for the benefit of any person or organization included as an additional insured and those limits shall become the required minimum limits of insurance in all Paragraphs and Sections of this Agreement.

e. **Hold Harmless**: Each party to this Agreement agrees to defend, indemnify and hold harmless the other party to this Agreement, its officers, agents, and employees for any claim, action, including but not limited to actions for misappropriation of funds, and provision of services, judgment, or lien for injury to persons or property damage caused by, resulting from or arising out of the sole negligence of the indemnifying party, its officers, agents or employees.

6. PROPERTY OF TMBHO

a. Disposal of Assets Upon Termination: Assets acquired on or after April 1, 2016, shall be the property of TMBHO, unless otherwise specified by the Governing Board at the time of acquisition of such asset. In the event of termination of this Agreement, all assets of TMBHO, after payment of all claims, obligations, and expenses of TMBHO, shall be distributed to Thurston County and Mason County proportionate to their respective populations.

The Governing Board shall distribute the assets to Thurston County and Mason County within six months after the disposition of the last pending claim by TMBHO.

b. **Contingent Liabilities:** Upon termination, the Governing Board shall complete and dissolve the business affairs of TMBHO. If liabilities of TMBHO at the time of termination exceed assets, each party shall pay its share of any additional amounts necessary for final disposition of all claims, as determined according to the contribution and indemnification principles established in this Agreement and after determining the appropriate share of third Counties, if any, including but not limited to, contractors of TMBHO and the State.

7. LOCAL ACCESS TO SERVICES

TMBHO shall assure an integrated system of care for persons in need of publically funded behavioral health care services. TMBHO shall assure local access and a sufficient network of outpatient community behavioral health services. The TMBHO shall have at least one licensed mental health center and one licensed chemical dependency service agency within each County and shall ensure adequate funding for personnel to provide seven day a week/ 24 hours per day crisis response in each County.

8. NONDISCRIMINATION

TMBHO, its assignees, delegates or subcontractors shall not discriminate against any person in the performance of any of its obligations hereunder on the basis of race, color, creed, ethnicity, religion, national origin, age, sex, marital status, veteran status, sexual orientation or the presence of any disability. Implementation of this provision shall be consistent with RCW 49.60.400.

9. FINANCING AND BUDGET

TMBHO shall be financed from State, Federal and local funds legally available for the provision of behavioral health services. The Governing Board shall establish and maintain such funds and accounts as may be required by good accounting practices and the State Budget Accounting Reporting System.

10. WITHDRAWAL

Any party hereto shall have the right to withdraw from this Agreement at any time, **PROVIDED** that the remaining County to this Agreement shall have received written notification of the other party's intention to withdraw at least 120 days prior to the proposed effective date of such withdrawal; and **PROVIDED FURTHER**, that such notification is received at least 120 days prior to the expiration of the current fiscal year period.

11. TERMINATION OF THE AGREEMENT

This Agreement may be terminated at any time by the unanimous written consent of all of the Counties. Upon termination, this Agreement and the TMBHO shall continue for the purpose of disposing of all claims, distribution of assets, and all other functions necessary to complete responsibilities of the TMBHO.

12. AMENDMENTS

This Agreement may be amended at any time by the written approval of the Counties.

13. PROHIBITION AGAINST ASSIGNMENT

The obligations and duties of the Counties under this Agreement shall not be assigned, delegated, or subcontracted to any other person, firm or entity without the prior express written consent of the Counties.

14. CHOICE OF LAW, JURISDICTION AND VENUE

a. This Contract has been and shall be construed as having been made and delivered within the State of Washington, and it is agreed by each party hereto that this Contract shall be governed by the laws of the State of Washington, both as to its interpretation and performance.

b. Any action at law, suit in equity, or judicial proceeding arising out of this Contract shall be instituted and maintained only in any of the courts of competent jurisdiction in Thurston County.

15. SEVERABILITY

a. If a court of competent jurisdiction holds any part, term or provision of this Contract to be illegal, or invalid in whole or in part, the validity of the remaining provisions shall not be affected, and the parties' rights and obligations shall be construed and enforced as if the Contract did not contain the particular provision held to be invalid.

b. If any provision of this Contract is in direct conflict with any statutory provision of the State of Washington, that provision which may conflict shall be deemed inoperative and null and void insofar as it may conflict, and shall be deemed modified to conform to such statutory provision.

16. COUNTERPARTS

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. This Agreement shall be effective upon its execution by the two named Counties.

17. FILING OF AGREEMENT

A copy of this Agreement shall be filed with the County Auditor of Thurston County or,

alternatively, listed by subject on a public agency's web site or other electronically retrievable public source, as required by RCW 39.34.040.

18. ENTIRE AGREEMENT:

The Counties agree that this Agreement is the complete expression of its terms and conditions. Any oral or written representations or understandings not incorporated in this Agreement are specifically excluded.

IN WITNESS WHEREOF, the Counties have executed this Agreement by authorized officials thereof on the _____ day of _____, 2015

Thurston County Board of Commissioners	**Mason County Board of Commissioners**
_____ Cathy Wolfe, Chair of Board Date:_____	_____ Randy Neatherlin, Chair of Board Date_____
Sandra Romero, Commissioner Date:_____	Tim Sheldon, Commissioner Date:_____
_____ Bud Blake, Vice Chair Date: _____	_____ Terri Jeffreys, Commissioner Date:_____
Approved as to form: Jon Tunheim, Prosecuting Attorney _____ By: Scott Cushing Deputy Prosecuting Attorney	Approved as to form: , Prosecuting Attorney _____ By: Deputy Prosecuting Attorney

Attachment 3

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

Policies and Procedures

THURSTON MASON
BEHAVIORAL HEALTH ORGANIZATION
Policy and Procedure Manual

TITLE:	Care Coordination with Primary Care Providers and Emergency Rooms			**POLICY:**	CM-506
SECTION:	Care Management	**WAC:**	388-877 (A; B)		
EFFECTIVE:	October 01, 2005	**RCW:**			
REVISIONS:	05/23/06; 12/15/10; 04/01/16	**CFR:**	42 Part 438 (208)		
APPROVED:		***DATE:***			

I. PURPOSE

To ensure coordination of care for Thurston Mason Behavioral Health Organization (TMBHO) enrollees/consumers between Primary Care Providers (PCPs), emergency room services and Network Providers, in order to address complex needs that may negatively impact the consumer's progress toward recovery.

II. POLICY

A. TMBHO understands that physical disorders can impede progress toward behavioral health (behavioral health) treatment goals, and may complicate an individual's ability to adhere to medical treatment plans. TMBHO will ensure the coordination of an enrollee's/consumer's physical and behavioral health care by:

1. Contracting with Network Providers to communicate and coordinate with consumers' primary care providers and with emergency room services.
2. Assuring that if a consumer does not have a primary care provider, Network Providers and TMBHO Care Managers will make referrals and support access to a primary care provider.
3. If the consumer has a primary care provider, documenting the name and the date of the last physical.
4. Collaborating with the local community health clinics and other available providers to assure that consumers have access to physical care as needed.

III. PROCEDURES

A. Network Providers shall assure that case managers assist consumers with communication and coordination of care with Primary Care Providers.

B. Providers shall assure that consumer's medical issues and need for medical care are addressed at intake and at any treatment juncture that the issues arise. The case manager and the consumer will develop a treatment plan to include the appropriate

use of medical and emergency care services, with the goal of supporting the consumer in overcoming barriers and progressing toward recovery.

C. Provider case managers shall collaborate with PCPs to develop or modify the consumer's medical treatment plan to effectively identify and address behavioral health symptoms that may complicate the consumer's recovery.

D. Providers shall ensure that appropriate release(s) of information are obtained from consumers for other healthcare providers, in compliance with HIPAA rules and regulations.

E. Providers shall collaborate with the consumer's PCP to exchange information relating to past, present and current treatment interventions, so involved providers have a comprehensive case overview of the individual. Consumer information exchanged may include:

1. Medical History and Physical (H&P);
2. Demographic Information;
3. Assessments;
4. Treatment Plan;
5. Progress Notes;
6. Diagnosis;
7. Pharmacology; and
8. Social Assessments.

F. Provider case managers should collaborate with the Primary Care Physician to update information when there is a change in the treatment plan or general condition of the consumer.

G. TMBHO Care Managers will assist consumers by making referrals to appropriate community or Medicaid providers and by providing assistance in completing the application if needed.

H. For enrollees/consumers that are stabilized and in recovery, providers may transfer the management of medications and prescriptive authority to the enrollee's PCP in accordance with standard medical protocol, in a manner that does not leave the enrollee without medication or medical management. Providers shall continue to be available to the enrollee's PCP for telephone consultation on psychotropic medication management as needed. Enrollees shall be provided with support during the transition that includes education and information about their medication and the reason for the transfer. TMBHO Care Managers may be consulted to assist with coordination of care.

I. Other points of coordination with PCPs include:

1. TMBHO's contracted Network Provider's psychiatric medical staff provides consultation and support to community PCPs that may have concerns regarding psychotropic medications and/or behavioral health issues for TMBHO enrolled consumers. Entities such as Healthy Option Plan physicians, PCPs at nursing homes, and other community based physicians providing services to TMBHO consumers have access to this service.
2. With the support of TMBHO, Network Provider clinical staff provides outreach to a consumer's primary care provider to facilitate care coordination as requested by either party.
3. A Network Provider clinical staff coordinates enrollees in participating in specialized medical services in the community as needed. For instance, TMBHO clients are encouraged to participate in Hospice and Grief and Bereavement Services, when appropriate. This is an important part of treating the whole person.
4. PCPs that work with or refer to TMBHO through EPSDT to provide services to children are included in the individual service plan as part of our interdisciplinary team approach to treatment.
5. In accordance with the TMBHO's service contract with Network Providers, in all instances of care where a client also requests involvement of their PCP in the treatment, the Network Provider will comply.

J. Key points of coordination with emergency rooms include:

1. Provider case managers and/or provider's crisis staff shall respond to requests and collaborate with emergency room staff and the enrollee/consumer, to identify the reasons the individual requests emergency care, and if any less restrictive, less costly and more appropriate interventions are available. TMBHO Care Manager(s) may assist/consult with the emergency room staff to identify resources, remove barriers and problem solve.
2. Contracted providers and crisis service (E&T) have 24 hours a day, seven days a week access to TMBHO client's BHO enrollment status and crisis plans to assist the client's individualized care when presenting to the ER.
3. Enrollees may choose to have Advanced Directives available to emergency rooms to assist the crisis service staff as necessary.
4. Behavioral health services provided in emergency rooms are available to divert a client from inpatient psychiatric care or to help support a client's compliance with appropriate medical care.
5. All regional ERs have access to the TMBHO hospital liaison/Care Manager to coordinate placement, diversion or follow up service needed to assist TMBHO enrollees and un-enrolled persons presenting at the ER.

6. Designated Mental Health Professionals (DMHPs) are able to refer individuals to inpatient care and to hospital diversion services, including the E&T Crisis Stabilization and Transitional Unit (CSTU) and Fairfax, Two Rivers Landing, and Kitsap E&T for children when appropriate.
7. Admission to inpatient/E&T care from the ER is coordinated for all referrals requiring voluntary admission through 24/7 direct access with the TMBHO Care Manager, the Evaluation and Treatment Unit (ETU) of the E&T, and community inpatient psychiatric providers. An inpatient certification specialist works with the ER to coordinate care and all placement issues.
8. Network Providers are required by contract with TMBHO to respond to requests from the emergency room staff to provide supportive services to TMBHO enrollees when requested to do so by the ER staff, family member, client, advance directive.
9. TMBHO Care Managers maintain primary contact with the local emergency rooms and coordinate referrals to contracted Network Providers to ensure that there is appropriate access for behavioral health services.
10. Staff from the E&T crisis, inpatient and triage units meet regularly with emergency room physicians and crisis services staff to ensure coordination of care.

K. Monitoring:

1. TMBHO will include these provisions in the Network Provider medical charts reviews.
2. Any failure to comply with these provisions may result in corrective actions by the provider.

THURSTON MASON
BEHAVIORAL HEALTH ORGANIZATION
Policy and Procedure Manual

TITLE:	Coordination and Continuity of Care	**POLICY:**	CM-502
SECTION:	Care Management	**WAC:**	388-877(A; B)
EFFECTIVE:	June 01, 2004	**RCW:**	70.02 (050)
REVISIONS:	11/28/06; 12/15/10; 04/01/16	**CFR:**	42 Part 438.208 (b) (1)(2)(3)(4); (c)(1)(2)(3)(4); and 45 Parts 160 Subparts A & E; 162; 164(4)
APPROVED:		***DATE:***	

I. PURPOSE

To ensure that Thurston Mason Behavioral Health Organization (TMBHO) and it's contracted providers coordinate the delivery of Medicaid mental health / substance use disorder (behavioral health) services and provide continuity of care with other community services and providers.

II. DEFINITIONS

Collaborative/Coordinated Services: The services from one service provider are planned in concert with another agency or care provider. Care plans are complimentary between agencies. Ideally, there is one care plan per family that is shared amongst the providers of services to the family.

Enrollees with special health care needs: means the TMBHO enrollees and service recipients within the TMBHO service delivery network. In this context, this includes a population defined by CMS to include:

1. SSI beneficiaries of all ages;
2. Adults 65 years of age and older;
3. The following groups of children (foster children, children in adoption support, blind children, disabled children and children on Title V); and
4. Children with multiple needs who meet the Medicaid early and periodic screening, diagnosis and treatment program (EPSDT) requirements.

Medical Necessity: A term for describing a requested service which is reasonably calculated to prevent the worsening of conditions that endanger life, 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 equally effective, more conservative, or substantially less costly course of treatment available or suitable for the recipient requesting service. Course of treatment may include only observation or when appropriate, no treatment at all.

Behavioral Health Care Provider (BHCP): The professional with primary responsibility for implementing an individualized plan for outpatient behavioral health services and/or community psychiatric inpatient care to be provided to the service recipient.

Primary Care: TMBHO determines how this term is used in the service area, but is often defined as care within a Managed Care Organization or a Health Plan, but can also be construed to refer to the Primary Care Physician (PCP) the enrollee/consumer is assigned to..

Primary Behavioral Health Care: In this service area and in this context, it refers to the services and care delivered to the enrollee/consumer by their primary treating behavioral health clinician or case manager within the TMBHO or its provider network.

III. POLICY

B. TMBHO and contracted providers shall ensure that the behavioral health service delivery system protocols incorporate the coordination and integration of services across all systems of care, to include but not be limited to:

1. Populations with special health care needs;
2. Native American/Native Alaskan children;
3. Children served by DSHS Juvenile Rehabilitation Administration;
4. Children served by Children's Administration;
5. Adults and older adults served by DSHS Aging and Adult Services Administration;
6. Adults transitioning out of the criminal justice system;
7. Enrollees/consumers being discharged to another system of care;
8. Enrollees transitioning between levels of care and/or care providers;
9. Individuals transitioning to or from outpatient and inpatient services;
10. Individuals integrating back into the community; and
11. Individuals dually enrolled in allied systems.

C. TMBHO and contracted providers will assure that care coordination activities are provided for at least the following:

1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT);
2. High risk consumers;
3. Frequent users of crisis services, the emergency room and inpatient services;
4. Primary care and emergency room care utilized by consumers;
5. Inpatient and community care; and
6. Special populations to include:

a) Children;

b) Geriatric;

c) Ethnic minorities; and

d) Persons with disabilities in addition to mental illness.

D. Network Providers shall:

1. Assure coordination and continuity of care in the delivery of behavioral health services;
2. Implement a mechanism to identify enrollees/consumers with other special health care needs or involvement in other systems; and
3. Implement procedures that address the identification, assessment, and treatment planning for coordination of care, and a mechanism for direct access to specialists as warranted.

IV. PROCEDURES

A. TMBHO will:

1. Collaborate with DSHS, the Division of Developmental Disability (DDD), Division of Child and Family Services (DCFS), Aging and Disability Services Administration (ADSA), Home and Community Services (H&CS), Juvenile Rehabilitation Administration (JRA), Alcohol and Substance Abuse, Vocational Rehabilitation (DVR), city and county jails and correctional facilities, school and educational districts, local Native American Tribes, Healthy Option Plans and physical health care providers, and other identified providers or agencies to coordinate with other systems of care and identify persons with special behavioral health care needs that are eligible for behavioral health services.
2. Establish community reintegration protocols that effectively promote recovery and resiliency, and rapid and successful reintegration of consumers back into the community from long-term placements from a psychiatric hospital or facility.
3. Establish working agreements with Western State Hospital, Providence St Peter Hospital, and any other inpatient facilities where TMBHO enrollees/consumers may obtain services.
4. Comply with the Inter-RSN Transfer Agreement when transferring consumers between counties or providers in a different service area.
5. Include coordination of care requirements in provider contracts.
6. Include information about cross-system linkages in TMBHO marketing and education material.

7. Assure compliance with cross system care requirements and protocols through monitoring and oversight of provider services (see also *TMBHO AP-1105 QAPI Program Plan*).

B. Network Providers shall:

1. Coordinate when asked, with the Healthy Options program to better serve Medicaid enrollees with behavioral health needs.
2. Assess all consumers at screening and at intake, to identify any other conditions that may require a more specialized course of treatment or regular care monitoring.
3. Assure that credentialed behavioral health professionals are making assessments of the consumer's special health care needs.
4. Assure that a coordinated individualized treatment plan is implemented in accordance with WAC 388-877(A; B).
    a) To include consumer participation;
    b) In consultation with any specialists caring for the enrollee/consumer as needed;
    c) In consultation with any other specialties (e.g. DDD, Geriatric, etc.) as needed, to develop an appropriate course of treatment or regular care monitoring;
    d) Within 30 days of Intake and updated at least every 180 days; and
    e) In accordance with any applicable quality assurance and utilization review standards.
5. Incorporate mechanisms to identify, assess and coordinate consumer's special health care needs in their procedural manuals, orientation and training curriculum, and clinical practice guidelines.
6. Assure that the process for identification, coordination and integration of care is documented on standard forms in each consumer's behavioral health chart.
7. Assure that each consumer has an ongoing source of behavioral health primary care appropriate to his or her needs, and a person formally designated as primarily responsible for coordinating the health care services furnished to the consumer.
8. Assign clinical staff to coordinate care and discharge planning with facility staff, for consumers being admitted to or discharged from a psychiatric facility.
9. Minimize the number of days from hospital discharge to first face-to-face outpatient appointment, and assure that consumers are seen within seven (7) days of discharge.

10. Implement services or projects as identified and directed by the TMBHO.
11. Coordinate services to the consumer with any other plans, agencies or individuals who may also be serving the consumer, to prevent a duplication of services and to optimize service integration in meeting the enrollee's/consumer's needs.
12. Assure that agency staff is aware of and follow the provisions of RCW 70.02.050 regarding disclosure of health information.
13. Assure that appropriate informed consents are obtained from the enrollee/consumer or his or her designee when necessary, prior to contact with other entities, and that in the process of coordinating care the consumer's privacy is protected in accordance with the privacy requirements in 45 CFR, parts 160 and 164, subparts A and E, to the extent they are applicable.

THURSTON MASON
BEHAVIORAL HEALTH ORGANIZATION
Policy and Procedure Manual

TITLE:	Allied Systems Coordination			**POLICY:**	SD-220
SECTION:	Service Delivery	**WAC:**	388-877 (A;B)		
EFFECTIVE:	October 12, 2005	**RCW:**			
REVISIONS:	8/15/07; 12/15/10; 04/01/16	**CFR:**	42 Part 438 (208)		
APPROVED:		***DATE:***			

I. PURPOSE

To ensure that Thurston Mason Behavioral Health Organization (TMBHO) has formal plans and processes in place for coordination and integration of services with each allied system that mutually serves clients within the Thurston Mason mental health / substance use disorder (behavioral health) service delivery system.

II. POLICY

E. TMBHO will include the participation of enrollees/consumers, families and advocates in the development and review of allied systems procedures and working plans to assure responsiveness to consumer voice, choice, and other relevant consumer oriented issues.

F. TMBHO will develop written allied system coordination plans for each of the programs identified in the Prepaid Inpatient Health Plan Contract (PIHP) between the Department of Social and Health Services (DSHS) and TMBHO. Programs will be added/dropped as needed per contract requirements.

G. Each allied system coordination plan will contain, at a minimum, the following:

1. Clarification of roles and responsibilities of allied systems in serving persons mutually served;
    a) For children this includes EPSDT coordination for any child serving agency, including a process for participation by the agency in the development of cross-system Individual Service Plan when indicated under EPSDT;
2. Processes for sharing of information related to eligibility, access, and authorization;
3. Identification of needed local resources, including initiatives to address those needs;

4. Process for facilitation of community reintegration from out-of-home placements (e.g., State hospitals, CLIP, Juvenile Rehabilitation Administration facilities, foster care, skilled nursing facilities, acute inpatient settings) for consumers of all ages;
5. A process to address disputes related to service or payment responsibility; and
6. A process to evaluate cross-system coordination and integration of services.

III. PROCEDURES

A. TMBHO Administrator will assign a TMBHO Care Manager to work with the Provider Network Coordinator on the development Allied Plans and coordination of any written agreements or Memorandum of Understanding (MOU) that support each Allied System Plan.

B. The TMBHO Care Manager will be responsible for working collaboratively with the designated liaison(s) from each allied system to identify any concerns and to assure that mutual clients are provided with the most appropriate care and continuous services without interruption.

C. TMBHO will monitor the coordination plans to evaluate processes for effectiveness and efficiency of coordination and integration of service delivery.

D. TMBHO will review the coordination plans at least annually, update plans as required, and identify and address additional allied systems of care as needed.

E. TMBHO will review and update policies, plans and agreements as needed to maintain compliance with requirements of federal or state legislation or DSHS contracts.

F. Per contract, Network Providers will adhere to TMBHO's Allied System Plan, Agreements, or MOU's and will work collaboratively with all identified Allied Systems.

THURSTON MASON
BEHAVIORAL HEALTH ORGANIZATION
Policy and Procedure Manual

TITLE:	Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	**POLICY:**	CM-504
SECTION:	Care Management	**WAC:**	388-877 (A; B)
EFFECTIVE:	January 21, 2005	**RCW:**	
REVISIONS:	12/13/06; 12/15/10; 01/01/14; 04/01/16	**CFR:**	42 CFR Part 441 Subpart B.
APPROVED:		***DATE:***	

I. PURPOSE

To ensure that Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are available to all Medicaid enrollees ages birth (0) through 20 years throughout the TMBHO provider network, and to ensure that they are administered in a consistent, contractually compliant, age and culturally appropriate manner.

II. POLICY

H. TMBHO will ensure that Network Providers coordinate EPSDT assessment and early intervention in accordance with the Pre-paid Inpatient Health Plan (PIHP) contract, or any successor.

I. TMBHO will incorporate the following requirements into its care management, network management, and quality management activities:

1. Identification of a Children's Care Manager to assure communication between behavioral health providers and physicians, juvenile justice, K-12 education, child welfare staff and foster care to reduce fragmentation and duplication of efforts among systems serving children and to control costs.
2. Provision of intake evaluations for EPSDT-eligible children by qualified Child Mental Health Specialists for children/youth ages birth through seventeen (17) years and/or by a Mental Health Professional (MHP) for Medicaid enrollees' ages eighteen (18) through 20 years.
3. Provision of mental health / substance use disorder (behavioral health) services to EPSDT children in a culturally and age appropriate manner that involves family members, when appropriate.
4. Communication between Network Providers and medical providers regarding the coordination of EPSDT services.
5. Assignment of appropriate Level of Care (LOC) for EPSDT children/youth.

6. Provision of an Individual Service Team (IST) for all appropriate EPSDT Level of Care multi-system children/youth that develops cross-system treatment goals.
7. Monitoring of EPSDT services at both the Network Provider and TMBHO level.

III. PROCEDURES

A. TMBHO will designate a Children's Care Manager to provide resource management services and provide monitoring of the TMBHO EPSDT program implemented through the provider network.

B. The TMBHO EPSDT Care Manager will:

1. Be a Child Mental Health Specialist, or be supervised by a Child Mental Health Specialist;
2. Function as the point of contact for EPSDT-related issues within the provider network;
3. Be responsible for placing EPSDT issues on the agenda of TMBHO committees, and the TMBHO Advisory Board agenda, when appropriate; and
4. Be responsible for coordinating with community interagency councils, state agencies and divisions, as appropriate.

C. All Medicaid enrollees under the age of 21 shall receive a comprehensive EPSDT intake assessment, upon request for public behavioral health services.

D. The intake and EPSDT Behavioral Health Assessment will be:

1. Conducted by a qualified Child Mental Health Specialist for Medicaid enrollees ages birth through seventeen (17) and/or by a qualified MHP for Medicaid enrollees ages eighteen (18) through 20 years, within fourteen (14) calendar days of the request for services. If the assessment does not occur within the required fourteen (14) calendar days, the Network Provider describes in the clinical record:
    a) The problems or issues encountered that precluded the assessment from being conducted;
    b) Remedial actions to be taken; and
    c) Specific timelines for the completion of the comprehensive evaluation.
2. Structured in a culturally and age appropriate manner involving families, when appropriate.
3. Given priority over self-referred Medicaid individuals when a referral is made by the enrollee's primary medical provider for an EPSDT evaluation and for EPSDT services.

E. The EPSDT intake assessment shall include:

1. Medical history and identification of the enrollee's current primary care physician (PCP)/primary medical provider;
2. The child's/youth's current condition/presenting need (physical and/or mental);
3. A developmental and psychosocial assessment identifying the child/youth's cultural and developmental strengths and needs;
4. Identification of the family's strengths and needs;
5. Identification of the child's/youth's academic/learning needs;
6. A chemical dependency assessment, if applicable;
7. A multi-axial diagnostic assessment, including identification of substance abuse/addiction diagnoses (Axis I) and chronic and disabling medical conditions (Axis III);
8. Completion of the "Other Systems/EPSDT Indicators Involved" section of the Demographic Forms identifying all systems in which the client is currently involved. When there are no other systems involved, "none" is checked;
9. Signatures allowing the exchange of necessary information between the Network Provider and the medical provider, and between the Network Provider and all other systems and providers currently involved in the child's/youth's care; and
10. Completion of the entire TMBHO intake packet, which includes EPSDT markers.

F. EPSDT Physical Screenings conducted by the medical care provider includes:

1. A comprehensive health and development history, updated at each screening examination;
2. A comprehensive physical examination performed at each screening examination;
3. Vision and hearing testing;
4. Appropriate laboratory tests, including blood lead level testing;
5. Immunizations appropriate to age and health status; and
6. Maintaining records of the child's/youth's developmental progress, significant physical findings, and any treatments or referrals.

G. At intake, the provider's Child Mental Health Specialist will complete the *Healthy Kids EPSDT Referral for Mental Health/Substance Abuse Assessment* form, Sections I & IV for all Medicaid enrollees ages birth (0) through 20 years. Documentation in

Section IV shall include the date of the intake, diagnosis, and level of care assignment.

H. Communication between medical providers and the Network Provider:

1. When the Medicaid enrollee is referred for EPSDT services by a physician, ARNP, Physician Assistant, public health nurse or TMBHO, the Network Provider will reply using a TMBHO-approved response letter and a copy of the completed *Healthy Kids EPSDT Referral for Mental Health/Substance Abuse Assessment* form.
2. When behavioral health services are requested **without** an EPSDT referral, the provider sends a copy of the completed *Healthy Kids EPSDT Referral for Mental Health/Substance Abuse Assessment* and a TMBHO-approved formal written notice to the enrollee's medical care provider. The notice requests that the primary medical provider either:
    a) Provide documentation that a Healthy Child screening has been provided in the past twelve (12) months; or
    b) Completes a Healthy Child screening and provide documentation to the Network Provider that this has occurred.
3. Copies of the letters and the completed Healthy Kids document are placed in the client record. The Network Provider also ensures that EPSDT referrals are "flagged" in the Management Information System (MIS) system.
4. When the enrollee does **not** identify a medical care provider, the Network Provider provides a copy of the EPSDT rights contained in the DSHS Benefits booklet to the enrollee and provides the following:
    a) The contact information to assist with the selection of a medical provider (1-800-562-3022, or http://hrsa.dshs.wa.gov/HealthyOptions/index.html;
    b) Documentation of the referral to a medical care provider and a copy of the completed Healthy Kids form for the client record; and
    c) A of a copy of the Healthy Kids form to the client/family to be given to the chosen medical provider.

I. Service Authorization:

1. EPSDT "multi-system" children/youth are defined as those involved with one or more of the following systems, in addition to behavioral health:
    a) Children's Administration;
    b) Division of Developmental Disabilities;
    c) Juvenile Rehabilitation Administration/Department of Corrections;
    d) Receiving special education services; and/or

e) A chronic and disabling medical condition.

2. Level of Care will be determined at the time of the behavioral health intake, and using the Children and Adolescent Level of Care Utilization System (CALOCUS).

J. Individual Service Team (IST):

1. An IST is established for all Medicaid "multi-system" children/youth assigned to LOC "3" or greater services.
2. The IST includes the Network Provider case manager/therapist, representatives from all systems involved, parent(s)/guardian(s) as appropriate, and the youth (if age 13 or older). Identification and contact information for each IST member is documented on a TMBHO-approved form and placed in the client record. This form is dynamic, allowing for revisions, as appropriate.
3. Once appropriate authorization is obtained, the Network Provider facilitates communication with potential IST members by sending a TMBHO-approved letter requesting their participation on the IST and in collaborative treatment planning. A copy of the written request is placed in the client record.
4. Within 30 days of the first routine outpatient service, the IST convenes (in person or via phone, fax, or email) and develops cross-system treatment goals to augment the collaborative treatment planning process and to ensure that efforts are documented.
5. If the client or guardian (if under age 13 years) does not consent to communication between systems, this is documented in the client record.
6. Unsuccessful efforts to engage representatives from other systems in the collaborative treatment planning process is documented in the client record, and the TMBHO Children's Care Manager is notified so this issue may be resolved.
7. The Individual Service Plan for all LOC "3" or greater EPSDT children/youth will:
    a) Identify all systems involved;
    b) Address the overall needs of the child and family including, when appropriate:
        i) Age/development;
        ii) Culture/ethnicity;
        iii) Residential status;
        iv) Family issues;
        v) Social/emotional needs; and

vi) Medical needs; and

c) Clearly identify which system is responsible for each identified need;

d) Include at least one (1) cross-system goal for each identified system unless the youth/family refuses collaborative treatment planning. EPSDT goals are marked for easy identification; and

e) Includes cross-system goals that are complimentary to existing goals of other systems (e.g., Individual Education Plan and Individual Service & Safety Plan).

K. Documentation:

1. All EPSDT efforts are documented in an easily identifiable manner for monitoring purposes. This includes addressing all ongoing EPSDT services in progress notes/phone logs and identifying these services using the EPSDT Contact checkbox.

L. EPSDT Cross System Coordination:

1. To effectively promote and facilitate coordination of care for EPSDT children/youth, the TMBHO maintains updated working agreements with the following allied systems providers:

    a) Children's Administration;

    b) Juvenile Rehabilitation (JRA);

    c) Department of Corrections (DOC);

    d) Local school districts;

    e) Division of Developmental Disabilities (DDD); and

    f) Chemical dependency and substance abuse service providers.

M. EPSDT Reporting:

1. TMBHO submits reports to the Department of Social and Health Services (DSHS), upon request, including the following:

    a) Number of EPSDT unduplicated children referred;

    b) Level of service each child/youth is assigned;

    c) Behavioral health service utilization associated for each child; and

    d) Behavioral health expenditures associated for each child.

N. Policy and Program Monitoring:

1. To ensure compliance with the TMBHO contract and this policy, the Network Provider will:

    a) Develop an EPSDT Policy and Procedure and review it annually;

b) Conduct annual reviews of a representative sample of LOC "3" or greater EPSDT charts as part of its internal continuous quality improvement program to verify that:

   i. EPSDT clients are identified;

   ii. EPSDT clients have the appropriate Level of Care assignment; and

   iii. Attempts are made and documented to include other appropriate systems in service planning.

2. TMBHO monitoring of EPSDT services will include:

   a) Annual TMBHO Provider Administrative Review;

   b) Annual clinical chart review of a representative sample;

   c) TMBHO Care Management supervision and oversight;

   d) Annual review of allied system agreements;

   e) Annual review of the EPSDT policy and procedure;

   f) Ongoing review of complaints and grievances related to EPSDT compliance; and

   g) Annual provider surveys.

Attachment 4

Attachment 4: TMBHO Service Matrix

Substance Use Disorder

Mental Health

LEVEL OF CARE/INTENSITY OF SERVICES

	ASAM .05 Early Intervention	ASAM 1 Outpatient	ASAM 2.1 Intensive Outpatient	ASAM 3.1-3.5 Residential	Recovery Support Services	Community Support and/or LOC A (intake only)	LOC 1 and/or Intensity Level for Ancillary	LOC 2 and/or Intensity Level for Ancillary	LOC 3 and/or Intensity Level for Ancillary	LOC 4 and/or Intensity Level for Ancillary	Crisis/ Inpatient
ADULTS (26 and older)	•Crisis Clinic •Public Health/ Social Services (trainings/ community events)	•Alternatives •Family Education & Support Services •Northwest Resources •Pierce County Alliance Drug Court •Providence St. Peter's CDC •SeaMar Community Health **BHR-PPW Harvest Program** **Evergreen Treatment Services: OST** **Partial Hospitalization/Day Treatment**		Northwest Resources Intensive Case Management Residential services Withdrawal management PPW Residential services	Northwest Resources Housing Case Management Recovery Housing (coordinate with day treatment)	•Intake Only •Crisis Clinic •Family Alliance for Mental Health •Olympia Free Clinic—MHAP •Housing Authority of TC •PATH	•**BHR**: Core outpatient services •**SeaMar**: Core outpatient services •**Providence St. Peter's**: Older adult program **Capital Recovery Center:** Peer Support/Day Support **BHR:** Community integration and outreach (CIO) (includes MIO) **Partial Hospitalization/Day Treatment** **Permanent Supportive Housing** **BHR:** PACT **BHR:** Comm Stabilization/Transition Unit **PSPH:** IOP Program (ancillary)				**BHR Operated ETU** (18 and up) Mobile Crisis Team **Community hospital** (18 and up)
TRANSITIONAL AGE (15-25)	•Crisis Clinic •Public Health/ Social Services (trainings/ community events)	•ESD 113 True North •Providence St. Peter's CDC		Residential services Withdrawal management	ESD 113 True North Recovery oriented systems of care	• Intake Only •Crisis Clinic •Family Alliance for Mental Health	•**BHR:** Core outpatient services •**SeaMar**: Core outpatient services **CYS:** Multisystemic Therapy **CYS/CCS:** Wise Program **Community Youth Services (CYS) and Catholic Community Services (CCS):** TAY program **Thurston County Public Health & Social Services:** Nurse Family Partnership **Community Youth Services (CYS):** MIJOP **Catholic Community Services (CCS):** Wraparound program (typically non-TXIX youth)				**CCS:** Children's Crisis (mobile crisis team) **CLIP (Children's Long Term Inpatient)** (0-18 yrs)
CHILDREN/YOUTH (0-14)	•Crisis Clinic •Public Health/ Social Services (trainings/ community events)	•ESD 113 True North •Providence St. Peter's CDC		Residential services Withdrawal management	ESD 113 True North Recovery oriented systems of care	•Intake Only •Crisis Clinic •Family Alliance for Mental Health	•**BHR:** Core outpatient services •**SeaMar**: Core outpatient services **Community Youth Services (CYS):** Multisystemic therapy **CYS/CCS:** WISe program **Thurston County Public Health & Social Services:** Nurse Family Partnership **Community Youth Services (CYS):** MIJOP **Catholic Community Services (CCS):** Wraparound program (typically non-TXIX youth)				

KEY				
No formal assessment for LOC	Formal assessment for level of care	Service and provider pending	Ancillary Service Intake completed with no CA/LOCUS determination	Crisis/Inpatient Services
	Formal assessment for LOC—expanding services		Ancillary Service—expanding services	

Attachment 5

Attachment 5: Agreement JRA.2004

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
JUVENILE REHABILITATION ADMINISTRATION
14th & Jefferson • PO Box 45720 • Olympia, Washington 98504-5720
Telephone (360) 902-8499 • FAX (360) 902-8108

January 28, 2005

Sherri McDonald, Director
Thurston County Public Health &
Social Services Department
412 Lilly Road
Olympia, WA 98506-5132

Dear Sherri:

Enclosed please find the final signed Thurston-Mason Regional Support Network and Juvenile Rehabilitation Administration agreement. As noted in the faxed copy sent to you last month, while Assistant Secretary Tim Brown's, Assistant Secretary Cheryl Stephani's, and Mental Health Division's Director Karl Brimner's names appear on the agreement, it is not necessary for them to sign it. They are satisfied that the Regional Support Network and corresponding JRA region have signed and they are in full support of this intra-agency agreement.

Thank you.

Sincerely,

Rebecca Kelly, MSW
Mental Health Program Administrator
Juvenile Rehabilitation Administration

JUVENILE REHABILITATION ADMINISTRATION
AND
THURSTON/MASON REGIONAL SUPPORT NETWORK

TRANSITION AGREEMENT
Effective: July 01, 2004

I. Purpose: Why should we have a statewide transition agreement?

The purpose of this agreement is to identify and standardize minimum transition protocols for mentally ill or seriously emotionally disturbed youth transitioning from residential facilities in the Juvenile Rehabilitation Administration (JRA) to their home communities or JRA state and contracted community facilities in order to provide timely access to and enrollment in community mental health services for these youth and their families. Early notification of youth with mental illness re-entering local communities to Regional Support Networks (RSNs) and its community mental health treatment providers is one intervention in meeting the goal of engaging and motivating youth and families to participate in the mental health continuum-of-care. While this agreement outlines only minimum transition standards, the hope of JRA staff, RSN staff, mental health treatment providers, and family advocates involved in drafting this agreement is to build strong, cohesive relationships between all stakeholders in order to help youth with mental illness better manage their illnesses, achieve their personal goals, and live, work and participate in their communities.

II. Mental Health Target Population: Who will JRA refer to RSNs and Community Mental Health Treatment Providers?

JRA will refer any Medicaid eligible youth that meet any one of the following criteria to RSNs and/or community mental health treatment providers and will provide documentation of the condition:

A. Any youth who has a current DSM-IV Axis I "A" list diagnosis or a "B" list diagnosis with additional concerns, consistent with the approved Access to Care Standards.
B. Any youth with a current prescription of psychotropic medication that has been prescribed because of a mental illness or serious emotional disturbance listed in the Access to Care Standards "A" diagnostic list;
C. Any youth who has exhibited suicidal behavior or who has had an acute psychiatric hospitalization in the past six months.

JRA acknowledges that the RSN will screen every Medicaid eligible referral listed in A, B, and C above for eligibility for mental health services who resides in the catchment area. JRA screens every youth for Medicaid eligibility and begins the application process

for medical coupons. Those youth screened who do not meet eligibility requirements for medical coupons will be referred to local community resources. The RSN will assist in developing a list of private providers and community resources at JRA's request.

III. Referral Process: Responsibilities and Duties

JRA staff will be responsible for the following:

A. Institutional staff will establish a referral packet for each youth appearing to meet the mental health population listed in item II. The referral packet will contain a cover letter (Attachment A), a Release of Information/Authorization form signed by the youth (Attachment C) and a referral checklist (Attachment D) with available relevant documents. The referral packet will be sent to the appropriate JRA Regional Mental Health Treatment Coordinator.
B. The Regional Mental Health Treatment Coordinator or designee will forward the referral packet **30-45 days** prior to the youth transitioning to the home community or JRA state/contracted community facility to the designated RSN and/or community mental health treatment provider. (Attachment E)
C. All JRA staff will be available to communicate with youth, families, and community mental health providers to facilitate comfortable transitions for all.

RSN staff and/or Community Mental Health Treatment Providers will be responsible to:

A. Screen all referrals and when indicated, schedule an intake appointment and psychiatric appointment (if necessary) for youth referred within 10 days of receiving the referral.
B. Communicate reception of the referral packet and date of intake appointment and psychiatric appointment (if necessary) with designated JRA staff by mail (Attachment B) and/or email or telephone call. (Attachment E) Communication will occur within **10 days** of the RSN/provider receiving the referral packet from JRA.
C. Ensure the intake is scheduled to occur within **5 days** of the youth transitioning into the home community from a JRA residential facility.
D. Ensure psychiatric appointment is scheduled to occur within **30 days** of the youth transitioning into the home community from a JRA residential facility.
E. Perform intake assessments on significantly complex transition cases at the residential facility when possible.
F. Be available to communicate with youth, families, and JRA residential and parole staff to facilitate comfortable transitions for all.

RSN and JRA staff recognize that circumstances arise which may create barriers to fulfilling the above outlined responsibilities and achieving a smooth transition. Therefore, JRA and RSN staff agree to work creatively and collaboratively to transition these youth into their communities in these difficult circumstances. JRA and the RSNs may contact the Mental Health Program Administrators for both JRA and MHD for additional assistance.

IV. Quality Assurance: What do I do if the process is not working?

Participants in this process are encouraged to communicate openly, honestly, and often with each other to resolve challenges that arise through transitioning a complex population. However, participants can contact Bronwyn Vincent, Program Administrator, Lead for Children's Mental Health Services, for the Mental Health Division at (360) 902-0822 or Rebecca Kelly, Mental Health Program Administrator for the Juvenile Rehabilitation Administration at (360) 902-7752 should issues or complications arise.

Signed and dated in accordance:

Sherri McDonald

Sherri McDonald, Director

Thurston County Public Health &
Social Services Department

Corinne Mason

~~David Charles, Acting~~ JRA Region 6 Administrator Corinne Mason,

Karl Brimner, Director, MHD

Tim Brown, Assistant Secretary, MHD

Cheryl Stephani, Assistant Secretary, JRA

Attachment 6

Attachment 6: Agreement Mason Jail Services.2014

MENTALLY ILL OFFENDER AGREEMENT

Between

Thurston County Department: Thurston Mason RSN

and

Mason County Correctional Facility

This Agreement is entered into in duplicate originals between Thurston County, a municipal corporation, hereinafter "Thurston Mason RSN", the Mason County Correctional Facility, hereinafter, "the Jail".

WHEREAS, Thurston Mason RSN and the Thurston Mason RSN Mental Health Advisory Board have recognized the need for a cross system coordination with Mason County Correctional Facility; and

WHEREAS, mental health systems coordination between Mason County Correctional Facility staff and any Subcontractors to the Jail and mental health staff is a high priority for the Thurston County Board of County Commissioners,

In consideration of the mutual benefits and covenants contained herein, the parties agree as follows:

1. DURATION

1.1. This Agreement is effective upon the date of signatures of the parties to this Agreement and will continue until revised or terminated in accordance with the termination provisions of this Agreement.

1.2. Parties agree to meet no less than at least annually to review the terms of the Agreement.

2. TARGET POPULATION

2.1. Mentally ill offenders (MIO) confined in the Jail who may or may not be enrolled in community mental health services but who meet priority populations as defined in RCW 71.24.

3. AUTHORITY

3.1. The Agreement supports the provision of services in accordance with ESSB 6090, §204, sub§1(h), Department of Social and Health Services (DSHS), Mental Health Program, and the DSHS/Thurston Mason RSN Service Provider Contracts.

4. SERVICES TO BE PROVIDED BY THURSTON MASON RSN

4.1. A mental health Network Provider, contracted by the Thurston Mason RSN, will provide those services as set forth in this Agreement for mentally ill offenders.

4.2. Objective

4.2.1. To decrease the number and duration of inappropriate incarcerations of persons with mental illness and facilitate access to available community services for this population per the Agreement among Thurston Mason RSN and Jail.

4.2.2. Coordinate with local law enforcement and Jail personnel, Community Service Office(s) (CSOs) and Thurston Mason RSN Network Providers to expedite and facilitate return of incarcerated individuals to the community.

4.2.3. Identify and divert, when possible, mentally ill individuals who could be better served in a less-restricted, more appropriate setting.

4.2.4. Assess individuals placed in the Jail, to determine whether they have an acute or chronic mental illness.

4.2.5. Facilitate prompt reinstatement and speedy eligibility determinations for persons likely to be eligible for medical assistance and/or federal benefits upon release from confinement.

4.2.6. Provide early intervention and linkage to community mental health services for mentally ill individuals.

4.2.7. Provide short-term crisis intervention and brief treatment services to inmates who are in an acute state.

4.2.8. Identify training and consultation needs of Jail employees, court staff, and law enforcement regarding issues related to the mentally ill and the mentally ill offender.

4.2.9. This program shall not supplant existing jail funded services.

4.3. Screening

4.3.1. Screen individuals for MIO services who have been identified as having a mental health diagnosis or a person in need of mental health services.

4.3.2. Look up eligibility and enrollment information to identify any prior or current benefit, enrollment status and history, and/or treatment in the mental health system.

4.4. Access

4.4.1. Access to MIO screening/services may come from referrals from, but not be limited to:

4.4.1.1. Jail or correctional staff;

4.4.1.2. Court (mental health or any court) or court liaison;

4.4.1.3. Self-referrals, including family of confined individual;

4.4.1.4. Thurston Mason RSN Care Manager or other staff;

4.4.1.5. Individuals that have been arrested and are at risk of being jailed, are currently Jailed, or are nearing release from Jail may receive MIO screening/services.

5. PROGRAM COMPONENTS

5.1. Identification/Referral

5.1.1. An individual who is identified and screened in for referral to MIO services will be referred for the most appropriate services to expedite and facilitate their return to the community.

5.1.2. Individuals identified as Thurston Mason RSN enrolled clients, or previously enrolled and/or who are likely to be eligible for Medicaid services, will be referred to the most recent outpatient Case Manager of Record for collaboration/coordination of discharge planning and transition into outpatient services upon release.

5.1.3. For individuals currently enrolled with a contracted Thurston Mason RSN Network Provider, the Network Provider will:

5.1.3.1. Complete the MIO Short Form provided by the Thurston Mason RSN;

5.1.3.2. Notify the current Case Manager of Record of the incarceration;

5.1.3.3. Coordinate case management services with the outpatient provider;

5.1.3.4. Explore possible diversion alternatives with the case manager;

5.1.3.5. Function as or collaborate with the court liaison; and

5.1.3.6. Whenever possible, provide the case manager with advance notification of release so an appointment can be schedule prior to release, and services (including medication management) can be reinstated.

5.1.4. For individuals not previously enrolled, but who meet the priority populations definition, Service Provider will:

5.1.4.1. Complete an MIS Short Form for all individuals seen face-to-face. Information gathered from the face-to-face interview and through a review of available records will be used to determine if the individual should be referred for an intake assessment.

5.2. Intake Assessments

5.2.1. Network Provider will complete an intake assessment on site, to determine if the individual meets the medical necessity and Access to Care Standards (ACS) criteria for outpatient services.

5.2.2. If the individual meets the medical necessity and ACS criteria, but has not applied for SSI in the past, an application for Medical Assistance and SSI/SSDI must be expedited and the application process facilitated prior to release.

5.2.3. Network Provider shall accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24. Network Provider shall conduct mental health intake assessments for these persons and when appropriate provide transitions services prior to their release from Jail.

5.3. Diversion

5.3.1. When possible, diversion options will be explored. Network Provider will facilitate diversion with: the prosecution counsel, defense counsel, and mental health court and case managers. Network Provider may recommend to the court that the individual be diverted to a less-restrictive, more appropriate alternative to incarceration provided the following conditions are met;

5.3.2. Individual meets medical necessity for treatment of an acute or chronic mental illness; and

5.3.3. Alternative resources have been identified that more appropriately address the individual's needs, including modification of the offending behavior; and

5.3.4. The alternative plan reasonably supports the safety of the individual.

5.4. Crisis Intervention Services

5.4.1. Network Provider will respond to in-house requests for crisis counseling as resources are available. Crisis interventions will be brief in nature, and will emphasize safety.

5.4.2. Crisis Resolution Services/Designated Mental Health Professionals (DMHPs) will be involved when indicated.

5.5. Transitional Case Management and Discharge Planning

5.5.1. Network Provider shall identify and provide transition services to persons with mental illness to expedite their assignment to Medicaid benefits and facilitate their enrollment into mental health services if appropriate.

5.5.2. Network Provider will assist individuals with, referrals, early intervention and linkages to community resources and services, including initiating applications for public funding when appropriate.

5.5.3. Network Provider will attempt to provide face to face discharge planning to include development of a written plan to address safety to self, other and property, housing needs, reinforcement of behavioral goals and strategies to improve mental health functioning and prevent future offenses.

5.5.4. Network Provider will provide cross system coordination to facilitate the individual's discharge from confinement, and provide post-release assistance with follow up to the application process, accessing community resources, and other systems as needed.

5.6. Training/Consultation/Cross System Coordination

5.6.1. Network Provider will work with Jail staff to identify possible training needs and provide training as resources are available

5.6.2. Network Provider will be available for a cross system/agency meeting called by Thurston Mason RSN to exchange information regarding MIO services.

5.6.3. Network Provider will make available regularly scheduled times to meet with law enforcement, courts and detention staff to enhance the quality and efficacy of services, and to notify of any staff shortages that may effect work completion or result in a wait list for MIO services.

6. SERVICES TO BE PROVIDED BY THE JAIL

6.1. Provide office space, telephone, reception duties, voice messaging service, fax machine, computer, and printer, use of copier and paper supply, work space, desks, chairs.

6.2. Provide psychiatric services through on-site Jail health provider.

7. REIMBURSEMENT

7.1. The Jail agrees to reimburse Thurston Mason RSN a total of $320 per month for the services set out in sections 4 and 5.

7.2. On a quarterly basis, the Thurston Mason RSN shall submit to the Jail an invoice for payment. Payment shall be made to the Thurston Mason RSN within 30 days from the date of the billing.

8. PARTIES AGREE TO

8.1. Designate a lead staff person to be responsible for cross systems coordination;

8.2. Facilitate cross systems communications regarding gaps or needed system improvements;

8.3. Facilitate training for cross systems staff related to access to services;

8.4. Review Agreements annually to identify system needs and/or changes; and

8.5. Facilitate Jail Staff training.

9. CONFIDENTIALITY

9.1. The parties shall use Personal Information and other information gained by reason of this service only for the purpose of the services outlined in this Agreement. Thurston Mason RSN, the Jail and

the Network Provider shall not disclose, transfer, or sell any such information to any other party, except as provided by law or, in the case of Personal Information, without the prior written consent of the person to whom the Personal Information pertains. The parties shall maintain the confidentiality of all Personal Health Information and other information gained by reason of this Agreement and shall return or certify the destruction of such information if requested in writing by the party to this Agreement that provided the information.

9.2. The Thurston Mason RSN, the Jail, and the Network Provider 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.

9.3. The Thurston Mason RSN, the Jail, and the Network Provider shall comply with all confidentiality requirements of the Health Insurance Portability and Accountability Act (42 CFR Sections 160 - 164).

10. DISPUTE RESOLUTION PROCESS

10.1. When a dispute/compliance issue arises concerning the terms of this Agreement the parties agree to the following process to address the dispute:

10.1.1. The Jail Clinical Coordinator and the Network Provider MIO program director shall meet in an attempt to resolve the dispute through informal means.

10.2. If the party that raised the initial issue is not satisfied, the party shall provide the other two parties with a written summary of the area(s) of dispute/noncompliance within five (5) days of the above meeting. The RSN Administrator shall then contact the Mason County Sheriff, Public Health Director, and Chief Administrative Officer for Thurston County to establish a date and time when these parties shall meet to discuss and resolve the issue. Resolutions at this level shall be documented and forwarded to all parties involved in the dispute resolution process.

11. EVALUATION/MONITORING

11.1. All parties to this Agreement agree to meet and evaluate this Agreement annually based on the execution date.

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

IN WITNESSETH WHEREOF the parties hereto have caused this Agreement to be executed this 24th day of FEBRUARY, 2015.

MASON COUNTY **BOARD OF COUNTY COMMISSIONERS**

12-15-14

~~Chief~~ Lieutenant Cindy Kasten

Authorized Signature (if applicable)

Authorized Signature (if applicable)

THURSTON COUNTY WASHINGTON

Cathy Wolfe
Chair

Bud Blake
Vice-Chair

Sandra Romero
Commissioner

Attest:

LaBonita S. Bowmar
LABONITA BOWMAR, Clerk of the Board

Attachment 7

Attachment 7: Agreement Thurston Jail MIO MOU.2010

MEMORANDUM OF UNDERSTANDING: THURSTON COUNTY JAIL SERVICES

Between

Thurston County Department: Thurston Mason RSN, and

Behavioral Health Resources, and

Thurston County Correctional Facility

This Memorandum of Understanding is entered into in triplicate originals between Thurston County, a municipal corporation, hereinafter "Thurston Mason RSN", the Thurston County Correctional Facility, hereinafter, "the Jail," and Behavioral Health Resources, hereinafter, "BHR," as Subcontractor to Thurston County.

WHEREAS, Thurston Mason RSN and the Thurston Mason RSN Mental Health Advisory Board have recognized the need for a cross system coordination with Thurston County Correctional Facility; and

WHEREAS, mental health systems coordination between Thurston County Correctional Facility staff and any Subcontractors to the jail and mental health staff is a high priority for the Thurston County Board of County Commissioners,

In consideration of the mutual benefits and covenants contained herein, the parties agree as follows:

1. Duration

1.1. This MOU is effective upon the date of signatures of the parties to this MOU and will continue until revised or terminated in accordance with the termination provisions of this MOU.

1.2. Parties agree to meet no less than at least annually to review the terms of the MOU.

2. Target Population

2.1. Mentally ill offenders (MIO) confined in the Jail who may or may not be enrolled in community mental health services but who meet priority populations as defined in RCW 71.24.

3. Authority

3.1. The MOU supports the provision of services in accordance with ESSB 6090, §204, sub§1(h), Department of Social and Health Services (DSHS), Mental Health Program, and the DSHS/Thurston Mason RSN Service Provider Contracts.

4. Services to be provided by Behavioral Health Resources

4.1. Objective

4.1.1. To decrease the number of incarcerations of persons with mental illness and facilitate access to available community services for this population per the MOU among Thurston Mason RSN, BHR, and the Jail.

4.1.2. Coordinate with local law enforcement and Jail personnel, Community Service Office(s) (CSOs) and Thurston Mason RSN Network Providers to expedite and facilitate return of incarcerated individuals to the community.

4.1.3. Assess individuals placed in the Jail, to determine whether they have an acute or chronic mental illness.

4.1.4. Facilitate prompt reinstatement and speedy eligibility determinations for persons likely to be eligible for medical assistance and/or federal benefits upon release from confinement.

4.1.5. Provide early intervention and linkage to community mental health services for mentally ill individuals.

4.1.6. Provide short-term crisis intervention and brief treatment services to inmates who are in an acute state. The provision these services will include initial request for crisis services (KITES) by inmate population.

4.1.7. Identify training and consultation needs of jail employees, court staff, and law enforcement regarding issues related to the mentally ill and the mentally ill offender.

4.2. Screening

4.2.1. Screen individuals for MIO services who have been identified as having a mental health diagnosis or a person in need of mental health services.

4.2.2. Look up enrollment status and history, and/or treatment in the mental health system within Thurston and Mason Counties.

4.3. Access

4.3.1. Access to MIO screening/services may come from referrals from, but not be limited to:

4.3.2. Jail or correctional staff

4.3.3. Court (mental health or any court) or court liaison

4.3.4. Self-referrals, including family of confined individual

4.3.5. Thurston Mason RSN Care Manager or other staff

4.3.6. Individuals that have been arrested and are at risk of being jailed, are currently jailed, or are nearing release from jail may receive MIO screening/services

5. Program Components

5.1. Identification/Referral

5.1.1. An individual who is identified and screened in for referral to MIO services will be referred for the most appropriate services to expedite and facilitate their return to the community.

5.1.2. Individuals identified as Thurston Mason RSN enrolled clients who have not lost their benefits due to incarceration will be referred back to their current Case Manager of Record for discharge planning and transitioning back into outpatient services upon release. Individuals who do not have benefits will be referred to the transitional case manager upon release.

5.1.3. BHR will participate in the Thurston Mason RSN approved protocol for cross-referencing jail bookings to the Thurston Mason RSN Management Information System (MIS) to verify enrollment status.

5.1.4. For individuals currently enrolled with a contracted Thurston Mason RSN Provider, the Service Provider will:

5.1.4.1. Complete the MIO Short Form provided by the Thurston Mason RSN;

5.1.4.2. Notify the current Case Manager of Record of the incarceration;

5.1.4.3. Coordinate case management services with the outpatient provider;

5.1.4.4. Collaborate with the court diversion specialist; and

5.1.4.5. Whenever possible, provide the case manager with advance notification of release so an appointment can be schedule prior to release, and services (including medication management) can be reinstated.

5.1.5. For individuals not previously enrolled, but who meet the priority populations definition, Service Provider will:

5.1.5.1. Complete an MIS Short Form for all individuals seen face-to-face. Information gathered from the face-to-face interview and through a review of available records will be used to determine if the individual should be referred for an intake assessment performed by the MIO staff.

5.2. Intake Assessments

5.2.1. Service Provider will complete an intake assessment on site, to determine if the individual meets the medical necessity and Access to Care Standards (ACS) criteria for outpatient services.

5.2.2. If the individual meets the medical necessity and ACS criteria, but has not applied for SSI in the past, an application for Medical Assistance and

SSI/SSDI must be expedited and the application process facilitated prior to release.

5.2.3. BHR shall accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24. BHR shall conduct mental health intake assessments for these persons and when appropriate provide transitions services prior to their release from jail.

5.3. Diversion

5.3.1. When possible, diversion options will be explored

5.3.2. Individual meets medical necessity for treatment of an acute or chronic mental illness; and

5.3.3. Alternative resources have been identified that more appropriately address the individual's needs, including modification of the offending behavior; and

5.3.4. The alternative plan reasonably supports the safety of the individual and the community.

5.4. Crisis Intervention Services

5.4.1. BHR will respond to in-house requests for crisis counseling as resources are available. Crisis interventions will be brief in nature, and will emphasize safety.

5.4.2. Crisis Resolution Services/Designated Mental Health Professionals (DMHPs) will be involved when indicated.

5.5. Transitional Case Management and Discharge Planning

5.5.1. BHR shall identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.

5.5.2. BHR will assist individuals with, referrals, early intervention and linkages to community resources and services, including initiating applications for public funding when appropriate.

5.5.3. BHR will attempt to provide face to face discharge planning to include development of a written plan to address safety to self, other and property, housing needs, reinforcement of behavioral goals and strategies to improve mental health functioning and prevent future offenses.

5.5.4. BHR will provide cross system coordination to facilitate the individual's discharge from confinement, and provide post-release assistance with follow up to the application process, accessing community resources, and other systems as needed.

5.6. Training/Consultation/Cross System Coordination

5.6.1. BHR will work with Jail staff to identify possible training needs and provide training as resources are available

5.6.2. BHR will be available for a cross system/agency meeting called by Thurston Mason RSN to exchange information regarding MIO services.

5.6.3. BHR will make available regularly scheduled times to meet with law enforcement, courts and detention staff to enhance the quality and efficacy of services, and to notify of any staff shortages that may effect work completion or result in a wait list for MIO services.

6. Services to be provided by Jail and Sheriff's Office

6.1. The county or local jail has primary responsibility for direct mental health services and medications for individuals while they are in jail. Services provided with this funding are intended to facilitate safe transition into community services. To that end, the funding provided through the provider contract shall supplement, and not supplant, local or other funding or in-kind resources being used for these purposes that were in effect in April 2005.

6.2. Provide office space, telephone, reception duties, voice messaging service, fax machine, computer, and printer, use of copier and paper supply, work space, desks, chairs.

6.3. Provide psychiatric services through on-site jail health provider.

6.4. Provide initial clinical triage of clients requiring screening for priority status..

7. Parties agree to

7.1. Designate a lead staff person to be responsible for cross systems coordination;

7.2. Facilitate cross systems communications regarding gaps or needed system improvements;

7.3. Facilitate training for cross systems staff related to access to services;

7.4. Review MOUs annually to identify system needs and/or changes; and

7.5. Facilitate Jail Staff training.

8. Confidentiality

8.1. The parties shall use Personal Information and other information gained by reason of this service only for the purpose of the services outlined in this MOU. . Thurston Mason RSN, Jail and BHR shall not disclose, transfer, or sell any such information to any other party, except as provided by law or, in the case of Personal Information, without the prior written consent of the person to whom the Personal Information pertains. The parties shall maintain the confidentiality of all Personal Health Information and other information

gained by reason of this MOU and shall return or certify the destruction of such information if requested in writing by the party to this MOU that provided the information.

8.2. The Thurston Mason RSN, the Jail, and BHR 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.

8.3. The Thurston Mason RSN, the Jail, and BHR shall comply with all confidentiality requirements of the Health Insurance Portability and Accountability Act (42 CFR Sections 160 -164).

9. Records

9.1. Mental health records generated by BHR staff are the property of BHR. Mental health charts will remain housed in the jail facilities until BHR requests them.

10. Dispute Resolution Process

10.1. When a dispute/compliance issue arises concerning the terms of this MOU the parties agree to the following process to address the dispute:

10.1.1. The Jail Clinical Coordinator and the BHR MIO program director shall meet in an attempt to resolve the dispute through informal means.

10.1.2. If the informal meeting process does not result in resolution, the Jail Clinical Coordinator will contact the BHR MIO program director, the Chief of Corrections at the Jail, and the BHR CEO for the purpose of official verbal notification of possible dispute to establish a date and time when these parties shall meet to attempt to resolve the issues. Resolutions at this level shall be documented and forwarded to the Thurston Mason RSN Administrator.

10.2. If the party that raised the initial issue is not satisfied, the party shall provide the other two parties with a written summary of the area(s) of dispute/noncompliance within five (5) days of the above meeting. The RSN Administrator shall then contact the Thurston County Sheriff, Public Health Director, and Chief Administrative Officer for Thurston County to establish a date and time when these parties shall meet to discuss and resolve the issue. Resolutions at this level shall be documented and forwarded to all parties involved in the dispute resolution process.

11. Evaluation/Monitoring

11.1. All parties to this MOU agree to meet and evaluate this MOU annually based on the execution date.

IN WITNESS WHEREOF, the parties hereto have caused this Memorandum of Understanding to be executed by the dates and signature herein under affixed. The persons signing this MOU on behalf of the parties represent that each has authority to execute this MOU on behalf of the party entering into this MOU.

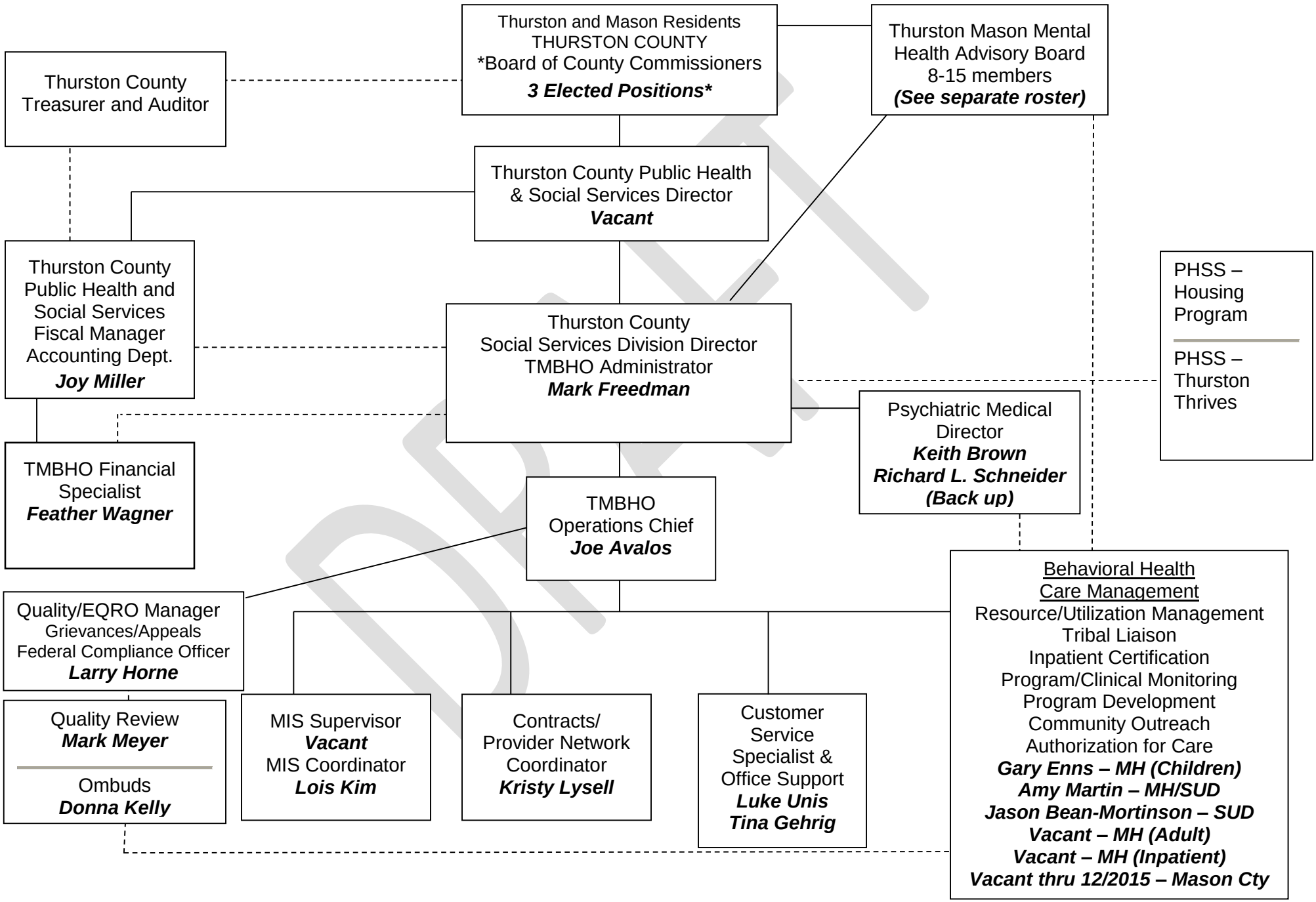
Thurston County Correctional Facility	**Thurston Mason RSN**	**Behavioral Health Resources**
Daniel D Kimball	Sherri McDonald	
Authorized Signature	*Authorized Signature*	*Authorized Signature*
DANIEL D. KIMBALL	Sherri McDonald	John P. Masterson
Printed Name	*Printed Name*	*Printed Name*
SHERIFF	Director, TCPHSS	CEO
Title	*Title*	*Title*
02/05/10	3-25-10	3/23/10
Date	*Date*	*Date*

Attachment 8

Attachment 8: 2016 Organizational Chart

Thurston Mason Behavioral Health Organization

2016 ORGANIZATIONAL FLOW CHART



Attachment 9

Attachment 9: TMBHO Delegation Plan and Sub-Contractual Relationships

THURSTON MASON BEHAVIORAL HEALTH ORGANIZATION
Policy and Procedure Manual

TITLE:	Delegation Plan	**PLAN:**	AP-1103
SECTION:	Annual Plans	**SUPPORTS POLICY:**	SD-204
EFFECTIVE:	September 01, 2006	**WAC:**	388-865; 388-877 (A; B)
PLAN YEAR:	2016	**CFR:**	42 Part 438 (12; 214; 230; 608); 42 Part 455 and 42 Part 1000-1008

I. PURPOSE

To define the mechanism and process by which Thurston Mason Behavioral Health Organization (TMBHO) delegate's authority to qualified entities to perform contractual functions required of TMBHO in the Prepaid Inpatient Health Plan (PIHP) and Behavioral Health State Contracts (BHSC).

II. DEFINITIONS

Delegation: A formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed correctly.

Credentialing: A formal process designed to ensure that all potential service provider agencies meet contractual requirements and all clinical practitioners are appropriately trained and licensed, and are not included on the excluded provider list, as evidenced by primary source verification.

Recredentialing: A formal process designed to ensure that all contracted service provider agencies and clinical practitioners are currently licensed, certified and insured and are not on the exclusion list, as evidenced by primary source verification, do not have outstanding quality of care issues and continue to meet the standards expected through periodic evaluation of performance of delegated functions.

Quality Management: A formal process for continuous quality improvement in the delivery of culturally competent mental health services (WAC 388-865-0280).

Utilization Management: A formal process used to ensure appropriate and efficient use of behavioral health care resources, and includes authorization, pre-authorization or pre-certification, concurrent and retrospective reviews. This function is performed by appropriately trained, qualified clinical personnel who reference valid clinical criteria (e.g. Level of Care Guidelines) for authorization or denial and monitoring of services, (WAC 388-865-0320).

III. GUIDING PRINCIPLES

A. TMBHO will assume the legal responsibility for performance of all mental health / substance use disorder (behavioral health) related services under the terms of the PIHP and BHSC with the Department of Social and Health Services (DSHS).

B. TMBHO retains the responsibility for ensuring that applicable standards of Federal and State statutes, regulations, and WAC are met, even when it delegates allowable functions to Network Providers or other professional agencies.

C. To the extent that it is clinically sound and cost effective, TMBHO will delegate specific functions through written subcontracting agreements.

D. TMBHO will not delegate the following PIHP/BHO functions:

1. Credentialing/recredentialing of Network Providers
    a) TMBHO will work with DSHS to monitor Mental Health Professionals (MHP) and Mental Health Specialists (MHS) credentials (See *TMBHO SD230 Credentialing of Mental Health Professionals-Specialists*).
2. Care Management functions to include:
    a) Level of Care guidelines
    b) Authorization standards and clinical criteria
    c) Utilization review
    d) Development of practice guidelines
    e) Coordination with Children's Long-term Inpatient Program (CLIP) Administration
    f) Allied System Coordination Plans
    g) Home and Community Placements from Western State Hospital
3. Utilization Management to include:
    a) Authorization of routine outpatient services
    b) Authorization and claims processing of community inpatient services
    c) Authorization of length of stay and monitoring of discharge criteria
    d) Monitoring of authorization timeline requirements
    e) Resource Management
4. Quality Assurance and Performance Improvement to include:
    a) Monitoring and auditing activities
    b) Management of consumer complaints, grievances, appeals/fair hearings process and notification guidelines
    c) Service and encounter verification
    d) Core and Regional Performance Measures
    e) Performance Improvement Projects (PIPs)
        i) TMBHO shall have three (3) PIPs at all times while under contract with DSHS, which shall include two (2) clinical and one (1) non-clinical PIP. In addition, one (1) of the three (3) PIPs must be a children's PIP and one (1) must be specific to substance use disorder treatment.
    f) Performance evaluations – clinical, program, contract, financial, etc.
    g) Quality review activities
    h) Practice Guidelines
    i) Evidence/Research Based Practices

5. Management Information System to include:
    a) Monitoring of changes to Service Encounter Reporting Guidelines and Data Dictionary, and ensuring implementation
    b) Data quality monitoring and correction
    c) Monthly Data Certification of batch submissions
    d) Data security, confidentiality and maintenance of hardware
    e) Maintenance of Business Continuity and Disaster Recovery Plan
6. TMBHO consumer notification requirements and notice release (Notice of Determination and Notice of Action)

E. Prior to delegation of any functions or services by TMBHO, a pre-assessment (Network Provider Credentialing) evaluation process will be implemented.

F. TMBHO will develop and implement an ongoing monitoring process to evaluate the performance of any functions delegated by or under contract with TMBHO.

IV. PROCEDURE

A. TMBHO will maintain operational policies, procedures, guidelines and monitoring activities to ensure the performance of services under PIHP/BHO contracts.

B. Prior to contracting for delegated functions TMBHO will implement the following pre-assessment evaluation activities to ensure delivery of the most efficient, cost effective and quality services:

1. Evaluation of TMBHO resources and staff availability to perform the function;
2. Analysis of the cost/benefit of performing function by staff or outside entity;
3. If function is to be delegated, initiate competitive application process, when applicable, to include at minimum a Request for Qualification (RFQ) or Request for Proposal (RFP);
4. Credentialing of the prospective Network Provider;
5. Review of qualifications or proposal to determine capacity/ability to perform delegated function.

C. Prior to any formal delegation of responsibility or authority to a subcontractor, TMBHO will:

1. Develop a written contract consistent with the requirements of 42 CFR 438.230, to include:
    a) Name, address, and telephone number of the subcontractor;
    b) A detailed description of the services, activities, duties and reporting responsibilities being delegated under the proposed subcontracting arrangements;
    c) Compensation arrangement;
    d) Monitoring plan; and
    e) Terms for revoking delegation or imposing corrective actions or other sanctions if the subcontractor's performance is inadequate.
2. Schedule an on-site visit to review clinical site for accessibility, documentation of primary source verification, and policies and procedures.

3. Verify the intended subcontractor is not excluded, disqualified, or debarred from participating in any Federal Assistance Program or that it does not operate any physician incentive plans.
4. Ensure the subcontractor performs pre-hire and annual background checks on all employees, volunteers, interns, or any persons who will work with any persons under the contract with the BHO.

D. TMBHO will monitor the functions delegated to contracted network providers, professional services contractors, and/or independent staff through continuous quality improvement activities, and when necessary, make appropriate recommendations for improvement, and/or impose performance improvement plans and/or corrective actions as needed. Monitoring activities will include, but not be limited to the following:

1. TMBHO Provider Network Coordinator will monitor the initial Credentialing Application process, contracting and periodic recredentialing process to ensure that current TMBHO subcontract language and provider performance complies with requirements of the DSHS PIHP and BHSCs;
2. TMBHO Quality Manager will provide direction and oversight of the continuous quality improvement process to include annual auditing and monitoring activities for all clinical and program requirements, performance measures, and the grievance processes, including any functions delegated to subcontractors;
3. TMBHO Information Technology Specialist will monitor all MIS functions, provide oversight of all data collection and auditing activities, and monitor and track database support services and reporting guidelines, including any functions delegated to IT subcontractors;
4. TMBHO Care Managers will monitor and provide oversight of any delegated Utilization Management (UM) functions and implement performance improvement plans and/or corrective actions as needed.

E. TMBHO will notify DSHS of observations and information indicating that providers may not be in compliance with licensing or certification requirements.

F. TMBHO will revoke delegation of a contracted provider if:

1. DSHS notifies the TMBHO of a provider's failure to attain or maintain licensure or certification, if applicable;
2. Provider is unable to adequately meet the terms of the contracted services;
3. TMBHO determines that it is more effective and efficient to perform the function within the available BHO staff resources;
4. TMBHO or the Network Provider end contract obligations in accordance with the General Terms and Conditions of the TMBHO contract.

G. TMBHO will delegate the following functions to subcontractors:

1. State Plan Mental health services for adults and children;
2. Outpatient and residential substance use disorder treatment services;
3. Crisis Services and DMHP functions;
4. Outpatient mental health treatment services;
5. Free Standing Evaluation and Treatment services;

6. Monitoring Least Restrictive Alternative (LRA) and Conditional Release (CR) orders;
7. Utilization Management limited to inpatient certification and pre-authorization of admission;
8. Information technology support for data collection/submission and software/server management support;
9. Grievance System response at provider level;
10. Monitoring of fidelity for two (2) children's evidence based practices;
11. Psychiatric Medical Director for consultation, utilization review activities, and concurrent review of inpatient denials;
12. Ombuds services; and
13. Quality Review Team surveying.

V. TMBHO DELEGATION PLANS 2016:

Table to be updated 01/01/16

Delegated Functions to Contracted Providers/Professional Services		
Network Provider	**Delegated Function(s)**	**Relevant Plan/Policy(s)**
Behavioral Health Resources 3857 Martin Way E. Olympia, WA 98506 (360) 704-7170	• Intake Assessments and provision of State Plan services to adults and children; • Individual and practitioner credentialing/recredentialing; • Residential Services; • Crisis Information & Referral; • Mentally Ill Offender and Mentally Ill Juvenile Offender programs; • Older Adult Day Support Services; • Children's Mental Health Crisis services.	• TMBHO Mental Health Outpatient Contract # 0911-62-2 with Attachments; • TMBHO PATH Program Contract #0911-62-3; • TMBHO Policy and Procedure Manual; • TMBHO Data Dictionary; • TMBHO Reporting Guidelines.
Providence St Peter Hospital Older Adult Program 413 Lilly Rd NE Olympia, WA 98506 (360) 493-7060	• Intake Assessments and provision of State Plan services to adults, age 60 and older; • Individual and practitioner credentialing/recredentialing.	• TMBHO Older Adult Program Contract # 0911-2010-9; • TMBHO Policy and Procedure Manual; • TMBHO Data Dictionary; • TMBHO Reporting Guidelines.
Sea Mar Community Health Center 409 Custer Way, Ste D Tumwater, WA 98501 (360) 704-7590	• Intake Assessments and provision of State Plan services to adults; • Individual and practitioner credentialing/recredentialing.	• TMBHO Federally Qualified Health Center (FQHC) Program Contract # 0911-3082-4; • TMBHO Policy and Procedure Manual; • TMBHO Data Dictionary; • TMBHO Reporting Guidelines.
Behavioral Health Resources Acute Psychiatric Services Evaluation and Treatment Center 3436 Mary Elder Rd NE Olympia, WA 98506 (360) 528-2590	• Free Standing Evaluation and Treatment services; • Involuntary and Voluntary Inpatient services; • Stabilization services; • Crisis services;	• TMBHO Evaluation and Treatment Program Contract # 0911-62-1; • TMBHO Policy and Procedure Manual; • TMBHO Data Dictionary;

	• DMHP services; • Individual and practitioner credentialing/recredentialing.	• TMBHO Reporting Guidelines .
Subcontractors	**Delegated Function(s)**	**Relevant Plan/Policy(s)**
Capital Clubhouse 618 7th Ave SE Olympia, WA 98501 (360) 357-2582	• Consumer run clubhouse with facility and community based pre-vocational opportunities, support groups, peer support and socialization programs for members	• TMBHO Mental Health Clubhouse Program Contract # 0911-64-0; • TMBHO Policy and Procedure Manual; • TMBHO Data Dictionary; • TMBHO Reporting Guidelines.
NAMI 4305 Lacey Blvd SE #5 Lacey, WA 98503 (360) 493-6021	• Mental Health Advocacy for consumers and family members; • Community Education; • Mental Health Support Groups.	• TMBHO Professional Services Contract with National Alliance on Mental Illness July 1, 2010 to June 30, 2011.
Jet Computer Support 1001 Cooper Point Rd SW Ste 140-215 Olympia, WA 98502 (360) 491-3061	• Submit encounter and data to DSHS in accordance with requirements; • Investigate, correct and resubmit rejected data and encounters within 30 days; • Submit certification and batch submission to DSHS; • Implement required data changes w/in 150 days, including test batches; • Assist RSN with implementation of Business Continuity & Disaster Recovery Plans, including backup process, reinstitution of MIS and recovery/restoration of data/system files; • Ensure security processes align with data security requirements; • CMHC/MIS System database management/support.	• TMBHO Professional Services Contract with Jet Computer Support July 1, 2010 to June 30, 2011; • TMBHO Policy and Procedure Manual – Section 8 Information System; • TMBHO Data Dictionary; • TMBHO Reporting Guidelines.
ProtoCall 621 SW Alder, Ste 400 Portland, OR 97205 (800) 435-2197	• Utilization Management limited to 24/7 response to inpatient authorization requests, certification of medical necessity, and pre-authorization for initial inpatient admission.	• TMBHO Professional Services Contract with ProtoCall Services, Inc July 1, 2010 to June 30, 2011
Dr. Richard L. Schneider 3609 South 19th St Tacoma, WA 98405 (253) 725-6056	• Psychiatric consultation; • Review of inpatient denials; • Consultation and assistance with utilization management and review, quality assurance and improvement, and clinical practice guidelines.	• TMBHO Professional Services Contracts: ○ Richard L. Schneider, MD Mar 15, 2007 – until terminated; ○ Keith M. Brown, MD Jan 01, 2011 – Dec 31, 2012 • GL-1006 Level of Care Guidelines; • AP-1106 Utilization Management Plan; • AP-1105 Quality Management Plans; • Policy CM-501 Care Management Program; • Policy CM-505 Management of High Risk Consumers; • GL-1005 Clinical Practice Guidelines.
Dr. Keith M. Brown Psychiatric Medical Director 15121 NE 177th Dr Woodinville, WA 98072 (425) 488-9023		

Functionally Independent Staff	Delegated Function(s)	Relevant Plan/Policy(s)
Donna Kelly TMBHO Ombuds 412 Lilly Rd NE Olympia, WA 98506 (360) 867-2556	• Assist consumers and family members with information and referral; • Assistance with complaints, grievances, appeals and Fair Hearings; • Advocacy and support for Consumer Rights.	• Policy QM-604 Ombuds Services; • GL-1001 Ombuds Guidelines; • Policy QM-603 Grievance System Requirements; • AP-1101Grievance Plan; • Policy QM-610 Client Rights and Responsibilities.
Dan Downey TMBHO Quality Review Team 412 Lilly Rd NE Olympia, WA 98506 (360) 867-2555	• Consumer surveys; • Advocacy for Consumer Rights.	• Policy QM-605 Quality Review Team; • GL-1002 QRT Guidelines; • AP-1105 Quality Management Plan; • Policy QM-610 Clients Rights and Responsibilities.

THURSTON MASON
BEHAVIORAL HEALTH ORGANIZATION
Policy and Procedure Manual

TITLE:	Subcontractual Relationships and Delegation			**POLICY:**	SD-204
SECTION:	Service Delivery	**WAC:**	388-865 (0225; 0280); 388-877 (0335)		
EFFECTIVE:	September 22, 2004	**RCW:**			
REVISIONS:	8/15/07; 12/01/10; 01/01/14; 04/01/16	**CFR:**	42 Part 438 (214; 230 (a)(1)(2)- (b)(1)(2)(3)(4); 608); 42 Part 455 and 42 Part 1000-1008		
APPROVED:		***DATE:***			

I. PURPOSE

To identify the responsibilities and provisions under contractual and subcontractual agreements within the Thurston Mason Behavioral Health Organization (TMBHO), and to provide policies, procedures, protocols, and plans when any required functions are delegated to subcontractors by TMBHO.

II. POLICY

A. TMBHO will ensure that:

1. There is no discrimination with respect to:
    a) The participation, reimbursement, or indemnification of any Network Provider that is acting within the scope of its license or certification under applicable State law solely upon the basis of that license or certification; and
    b) Particular Network Providers who serve high risk enrollees or specialize in mental health conditions that require costly treatment.
2. Written notice is provided to individual Network Providers or to groups of Network Providers as to the reason for TMBHO's decision if they are not selected for the TMBHO authorized Network Provider.
3. All subcontracts with Network Providers are in compliance with 42 CFR 438.214, and will be required to hold the necessary licenses, certifications and/or permits as required by law to perform the services under contract.
4. All subcontracts will meet the requirements under the "subcontracting" section as defined in the Department of Social and Health Services (DSHS) Prepaid Inpatient Health Plan (PIHP) and Behavioral Health State Contract (BHSC). Additional requirements will be followed in regards to Network Providers subcontracted to provide direct mental health / substance use disorder (behavioral health) services.
5. All subcontracts with TMBHO will be in writing and will specify all duties, reports, and responsibilities to be performed or delegated. Subcontracts will be submitted to the DSHS in accordance with the PIHP and BHSC.
6. All subcontracts will require compliance with State and Federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), the Americans with Disabilities Act, and any other State or Federal mandates and any successors.

7. Any subcontract does not terminate the legal responsibility of TMBHO to perform the terms of the written agreement(s) with DSHS. TMBHO will retain all fiscal and program responsibility for the performance of work set forth in PIHP and BHSC.
8. Oversight and accountability are provided, and that the functions and responsibilities performed by or delegated to any subcontractor are monitored on an ongoing basis, including the completion of annual reviews, including contractual and program.
9. The following functions will **not** be delegated to a subcontracted Network Provider, but will be performed by a TMBHO Mental Health Professional (MHP):
    a) Care Management functions focused on:
        i) Timely Access;
        ii) Referrals;
        iii) Care Coordination oversight;
        iv) Utilization Review and Management;
        v) Resource Management;
        vi) Risk Management; and
        vii) Quality Improvement.
    b) Allied System Coordination.
    c) Preparation of TMBHO notices of eligibility.
    d) Monitoring and reporting activities for individuals determined to be primarily served by Developmental Disabilities Administration.

B. Delegated Functions:

1. Prior to any delegation of responsibility or authority to a subcontractor, TMBHO will implement a formal delegation plan, consistent with the requirements of 42 CFR 438.230, to evaluate the subcontractor's ability to perform delegated activities.
2. Before execution of any subcontract, and/or prior to delegation of the specified function, TMBHO will submit its delegation plan to DSHS for approval. The delegation plan will include the following:
    a) An evaluation of the subcontractor's ability to perform delegated activities;
    b) A detailed description of the proposed subcontracting arrangements, including:
        i) Name, address, and telephone number of the subcontractor(s);
        ii) Specific contracted services;
        iii) Compensation arrangement; and
        iv) Monitoring plan; and
    c) A copy of the existing or draft subcontract that specifies the activities and reporting responsibilities delegated and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is not adequate.
3. TMBHO will revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to perform the delegated functions according to specified standards and terms of the subcontract.

C. Contract Termination:

1. TMBHO will notify DSHS at least 30 days prior to termination of any direct service subcontracts prior to any public announcement.
2. TMBHO will ensure that if either TMBHO or the subcontractor terminates a subcontract in less than 30 days, TMBHO will notify DSHS as soon as possible and prior to a public announcement.
3. If a Network Provider contract is terminated, TMBHO will collaborate with the Network Provider to develop and submit a transition plan to DSHS for enrollees and services that includes at least:
    a) Notification to Ombuds services;
    b) Crisis services plan;
    c) Client notification plan;
    d) Plan for provision of uninterrupted services; and
    e) Any information released to the media.

D. Annual Review:

1. TMBHO will perform a formal annual performance review of direct providers of behavioral health services to include contractual requirements, compliance with WAC and RCW standards, **and** at minimum:
    a) Quality Clinical Care
    b) Program Integrity;
    c) Timely access;
    d) Referrals for Healthy Child screens for EPSDT;
    e) Pursuit of third party revenue;
    f) Quality Assessment and Performance Improvement Projects (PIPs);
    g) Intake Evaluations, Individual Treatment Plans, Discharge Planning; and
    h) Practice Guidelines.

E. Excluded Providers:

1. TMBHO will comply with 42-U.S.C. section 1369u-2, and will **not** knowingly employ a director, officer, partner or person with a beneficial ownership of any amount of TMBHO's equity, reserve or operational funds. This includes an employee, contractor or consultant who is significant or material to the provision of services under the DSHS contract(s), which has been or is affiliated with someone who has been debarred, suspended or otherwise excluded by any federal agency.
2. TMBHO will not employ or subcontract with any entity that is debarred, suspended, proposed for debarment, and declared ineligible or voluntarily excluded from participating in Federal or State health care contracts by any Federal department or agency.
3. TMBHO contracted providers shall not employ nor subcontract with any person or Community Mental Health Agency (Network Provider) that is excluded from participation in federal health care programs under either 42 U.S.C. section 1320a-7

(1128A Social Security Act) or debarred or suspended in accordance with the TMBHO Contract General Terms and Conditions.

4. TMBHO will monitor, on a monthly basis, TMBHO and subcontractor employees, board members, volunteers, and interns, contracted Network Providers, and any other individual or entity with five percent (5%) or more ownership or control interest that would benefit from funds received under the PIHP, BHSC, or any other federally funded grant or contract. (See also *Excluded Provider Monitoring Process*)

F. Provider Credentialing:

1. TMBHO will only subcontract with Network Providers and/or Agencies that are currently licensed and/or certified by DSHS under WAC 388-877(A; B).
2. TMBHO will ensure that subcontractors adhere to program integrity requirements including mandatory compliance with state and federal fraud and abuse requirements (See *TMBHO AP1102 Compliance Plan).*
3. TMBHO requires subcontracted providers to submit to a credentialing process prior to the delegation of functions specified in written contract, and thereafter at least biennially as part of the annual review and documentation. (See *TMBHO Policy SD-216 Provider Credentialing)*
    a) If a subcontract is awarded based on a Request for Proposal (RFP), then the credentialing process is bypassed for that year. The credentialing process is only applied to subcontractors whose contracts will be renewed without a formal RFP process.
4. TMBHO will monitor provider credentials at least annually, or as often as current law requires, assuring Network Providers are in good standing and demonstrating the ability to provide the subcontracted services.
5. TMBHO requires upon hire and annually a criminal history background check through the Washington State Patrol and a background search through the Office of Inspector General for all employees, interns and volunteers of the TMBHO and contracted providers.
6. DSHS retains the authority to verify and issue MHP and Mental Health Specialist (MHS) credentials to individual Providers. TMBHO will work with DSHS to monitor individual provider credentials, as needed per *TMBHO Policy SD-230 Credentialing of Mental Health Professionals-Specialists*.
7. TMBHO will maintain the function of credentialing all Designated Mental Health Professionals (DMHPs) in the TMBHO Provider Network (see also *TMBHO Policy SD-231 DMHP*).

G. Contract Termination:

1. TMBHO may rescind, cancel or terminate a subcontract or any delegated functions with a provider if:
    a) The provider fails to attain or maintain licensure or certification needed to provide contracted services;
    b) The provider is in noncompliance with Federal or State laws; and/or
    c) The provider fails to comply with the provisions of the contractual agreement, including any delegated functions.

2. TMBHO may terminate a contract in accordance with the Termination Section of the TMBHO Contract on General Terms and Conditions or Professional Service Agreement, whichever written agreement the subcontractor is under.

III. PROCEDURES

A. TMBHO will develop a formal Delegation Plan for any functions that it delegates, that includes the provisions of the DSHS PIHP and BHSC, and submit the plan to DSHS for approval as required.

B. TMBHO will submit subcontracts and amendments to DSHS in accordance to the PIHP and BHSC requirements. In the event that the contract performance period does not encompass a full report period TMBHO will provide a report for the partial period. Copies will be provided in word processing format and submitted to the DSHS deliverable site.

C. As a condition of contracting with TMBHO, network providers will be required to:

1. Hold and keep current all necessary licenses, certifications, and/or permits as required by law for the performance of the services to be performed under the subcontract;
2. Adhere to the Americans with Disabilities Act;
3. Comply with all state and federal program integrity requirements regarding fraud and abuse, monitoring for excluded providers, and ensuring reimbursement requests are in compliance with Centers for Medicaid & Medicare.
4. Implement and comply with the Mental Health Advance Directive statutes;
5. Cooperate with Quality Review Activities and provide access to their facilities, personnel and records;
6. Participate in DSHS offered training on the implementation of Evidence-Based Practices and Promising Practices;
7. Provide enrollees access to translated information and interpreter services as described in *TMBHO Policy CI-401 General Information Requirements;*
8. Notify TMBHO in the event of a change in status of any required license or certification, including probationary status;
9. Participate in training when requested or mandated by TMBHO and/or DSHS;
10. Comply with State and Federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH) Act, and DSHS-CIS and TMBHO MIS Data Dictionary;
11. Correct any areas of deficiencies in the subcontractor's performance that are identified by TMBHO or DSHS as part of a subcontractor review;
12. Put forth best efforts to provide written or oral notification no later than 15 working days after termination of an individual Mental Health Care Professional (MHCP), to enrollees currently open for services that received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the Network Provider;
13. Comply with TMBHO's policy and procedures for access standards, utilization of the Access to Care Standards and LOCUS/CALOCUS.
14. Implement a grievance process that complies with 42 CFR 438.400 and the TMBHO Grievance Policy, or any successors;

15. Pursue and report all Third Party Revenue related to services provided under the subcontract in accordance with Medicaid being the payer of last resort; and
16. Use the DSHS provided *Integrated Co-Occurring Disorder Screening and Assessment Tool (or any successors)* and provide required training on the instrument to all staff responsible for using the tool.

D. TMBHO will ensure that:

1. Any formally delegated functions will be monitored by the TMBHO for consistent application of the functional and operational criteria specified, and for compliance with the written agreement.
2. Ongoing monitoring and an annual formal review of subcontractors will be conducted by TMBHO that identifies any deficiencies in performance or areas of concern. Monitoring activities will include, but are not limited to:
    a) Clinical chart audits;
    b) On-site documentation audits;
    c) Administrative audits;
    d) Financial/Fiscal Reviews;
    e) Data system reports/audits;
    f) DSHS licensing reviews;
    g) Reports of grievances/complaints;
    h) Quarterly reports and other contract deliverables; and
    i) Other quality and utilization management activities.
3. Results of monitoring activities will be reviewed with the TMBHO/Provider Quality Management Committee, and any deficiencies or areas of concern will be identified, and recommendations, corrective actions or quality improvements will be initiated.
4. Any adverse findings are communicated in writing to the Network Provider through a Performance Improvement Plan or Corrective Action for resolution.
5. A clear process is defined to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.
6. The authority to perform the delegated function(s) shall be revoked with the contract expiration date, unless renewed by authorized signature and mutual agreement.

Attachment 10

Attachment 10: Older Adult.PSPH.2015

Thurston Mason Regional Support Network
Contract on General Terms and Conditions

These General Terms and Conditions are entered into in duplicate originals between Thurston County by and through Thurston Mason Regional Support Network, hereinafter "TMRSN" and Providence Health & Services – WA d/b/a Providence St. Peter Hospital hereinafter "CONTRACTOR." These General Terms and Conditions govern work to be performed under any TMRSN Program Contract between the parties, and supersede and replace any previously executed general terms and conditions as of the start date below.

Thurston Mason RSN Contact:		Kristy Lysell, Provider Network Coordinator	
Address:	412 Lilly Road NE Olympia WA 98506		
Contact Information:	**Phone:** 360.867.2560	**Email:** lysellk@co.thurston.wa.us	
Contractor:	Providence Health & Services – WA d/b/a Providence St. Peter Hospital	**Contact:**	Sue Beall, Manager
Address:	413 Lilly Road NE Olympia WA 98506		
Contact Information:	**Phone:** 360.493.7809	**Email:** Beall.sue@providence.org	

The term of this Contract on General Terms and Conditions shall start and end on the following dates, unless terminated sooner as provided herein.

Contract Start Date: January 01, 2012	**Contract End Date: June 30, 2017**

By their signatures below, the parties hereto agree to these General Terms and Conditions. FURTHER, THE PARTIES HEREBY SPECIFICALLY ACKNOWLEDGE THAT BY SIGNING THESE GENERAL TERMS AND CONDITIONS THE PARTIES HAVE MUTUALLY NEGOTIATED THE WAIVER PROVISION SET OUT IN SECTION 20.2 The individual signing below warrants that he/she has the authority to execute these General Terms and Conditions on behalf of the CONTRACTOR.

Contractor Signature:	**Printed Name and Tile:**	**Date:**
Thurston County Signature:	**Printed Name and Title:** Sherri McDonald, Director	**Date:**
Approved as to Form:	**Jon Tunheim Prosecuting Attorney:** By: Catherine Galvin, Deputy Prosecuting Attorney	

Table of Contents

1. DEFINITIONS – The words and phrases listed below, as used in this Contract, shall each have the following definitions:

1.1. **CFR** means Code of Federal Regulations. All references in this Contract to CFR chapters or sections shall include any successor, amended, or replacement regulation. The CFR may be accessed at http://www.gpoaccess.gov/cfr/index.html

1.2. **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.

1.3. **Contract** means this Thurston Mason Regional Support Network Contract on General Terms and Conditions and Program Contracts Statement of Work, including any exhibits and other documents attached or incorporated by reference.

1.4. **CONTRACTOR** means the CONTRACTOR named above, its employees, agents and Subcontractors performing services pursuant to this Contract.

1.5. **Debarment** means an action taken by a federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

1.6. **DSHS or the department or the Department** means the Department of Social and Health Services of the State of Washington and its Secretary, officers, employees, and authorized agents.

1.7. **General Terms and Conditions** means the contractual provisions contained within this Thurston Mason Regional Support Network Contract on General Terms and Conditions, which govern the contractual relationship between TMRSN and the CONTRACTOR, under the Program Contracts subsidiary to and incorporating therein by reference this Thurston Mason Regional Support Network Contract on General Terms and Conditions

1.8. **Personal Information** means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers, and any financial identifiers.

1.9. **Program Contract** means a written contract between TMRSN and the CONTRACTOR including a statement of work to be performed by the CONTRACTOR and payment to be made by TMRSN.

1.10. **RCW** means the Revised Code of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended, or replacement statute. The RCW may be accessed at http://apps.leg.**wa.gov/rcw.**

1.11. **RSN** means the Regional Support Network designated by the county authority, group of county authorities or nonprofit entity recognized by the secretary of DSHS, and has authority to establish and operate a community mental health program.

1.12. **Shall** indicates that which is mandatory.

1.13. **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 Contract.

1.14. **Subcontractor** means any person, partnership, corporation, association or organization, not in the employment of TMRSN or the CONTRACTOR, who is performing any part of this Contract under separate contract with the CONTRACTOR. The term "subcontractor(s)" mean subcontractor(s) in any tier.

1.15. **Subrecipient** means any person, government department, agency, or establishment that receives federal financial assistance through the State to carry out a program for which it is accountable through an agreement, contract, subcontract, or award.

1.16. **TMRSN** means Thurston Mason Regional Support Network.

1.17. **USC** means United States Code. All references to USC chapters or sections in this Contract shall include any successor, amended, or replacement statute. The USC may be accessed at http://www.gpoaccess.gov/uscode/

1.18. **WAC** means the Washington Administrative Code. All references to WAC chapters or sections in this Contract shall include any successor, amended, or replacement regulation. The WAC may be accessed at http://apps.leg.wa.gov/wac.

2. RECAPTURE PROVISIONS

2.1. In the event that the CONTRACTOR fails to comply with any of the terms and conditions of this Contract and that failure results in an overpayment, or CONTRACTOR fails to expend funds under this Contract in accordance with state and federal laws and/or provisions of this Contract, TMRSN reserves the right to recapture funds in an amount equivalent to the overpayment or extent of the noncompliance. Such right of recapture shall exist for a period not to exceed three (3) years following Contract termination or Contract completion. Repayment by the CONTRACTOR of funds under this recapture provision shall occur within 30 calendar days of demand. If repayment is not made within the specified time frame, TMRSN may secure repayment, plus interest, if any, utilizing available remedies.

3. COMPLIANCE WITH APPLICABLE LAW & TMRSN PRACTICES

3.1. The CONTRACTOR shall comply with all applicable local, State, and federal laws, rules, regulations, and ordinances, including but not limited to nondiscrimination laws, rules, and regulations, all as now existing or as later adopted or amended. The CONTRACTOR shall also comply with Title XIX and Title XXI of the Social Security Act and Title 42 of the CFR regardless of whether a specific citation is identified in various sections of this Contract.

3.2. The CONTRACTOR shall comply with applicable federal, State and local professional and facility licensing and accreditation requirements/standards that apply to services performed under this Contract regardless of whether a specific citation is identified in various sections of this Contract.

3.3. The CONTRACTOR shall comply with these General Terms and Conditions, the Program Contract Statement of Work, Exhibits, Attachments, TMRSN and/or the Department Reporting Guidelines, TMRSN Data Dictionary, TMRSN Policies and Procedures, TMRSN Protocols, TMRSN and/or the Department required forms and policies, and any other documents attached hereto or incorporated herein by reference.

3.4. 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 all applicable regulations contained in 45 CFR parts 160, 162, 164 issued by the U.S. Department of Health and Human Services, as either have been amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), Title XIII of Division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5). The CONTRACTOR shall enter into a Business Associate Addendum with TMRSN if TMRSN determines that the CONTRACTOR will be acting as a Business Associate as defined under HIPAA.

3.5. The CONTRACTOR shall have policies, procedures, and practices that ensure a drug free workplace.

3.6. The CONTRACTOR shall comply with the Americans with Disabilities Act. The CONTRACTOR shall provide reasonable accommodations for individuals with disabilities in accordance with the Americans with Disabilities Act for all covered services and will assure that physical and communication barriers will not inhibit individuals with disabilities from obtaining covered services.

4. DEBARMENT CERTIFICATION

4.1. The CONTRACTOR, by signature to this General Terms and Conditions, certifies that the CONTRACTOR is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Contract by any Federal department or agency. The CONTRACTOR also agrees to include the above requirement in all Subcontracts entered into.

4.2. The CONTRACTOR shall ensure that it neither employs any person nor contracts with any person or entity excluded from participation in federal health care programs under either 42 U.S.C.§1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Contract.

5. PROFESSIONAL CREDENTIALING

5.1. The CONTRACTOR must have a formal agency process to credential Mental Health Professionals and Mental Health Specialists, per WAC 388-865-0150, and written policies and procedures that require ongoing monitoring of individual provider credentials.

5.2. The CONTRACTOR shall require a criminal history background check through the Washington State Patrol for all employees, including contracted employees, interns, and volunteers. The CONTRACTOR will also require a similar criminal history background check of all Subcontractors.

6. PHYSICIAN INCENTIVE PLANS

6.1. The CONTRACTOR shall not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) contract with any Subcontractor operating such a plan.

7. EXCLUDED PROVIDERS

7.1. The CONTRACTOR is prohibited from paying with funds received under this Contract 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)).

7.2. The CONTRACTOR shall screen potential employees through the OIG Excluded Provider Database prior to employment. If the individual is determined to be an excluded individual, the CONTRACTOR may not hire that individual to provide services under this Contract.

7.3. The CONTRACTOR shall monitor employees and individuals at a minimum of once a year through the OIG Excluded Provider Database. If an employee is found to be on the excluded provider list, the CONTRACTOR must notify TMRSN within five (5) business days. The CONTRACTOR will immediately terminate any employment, contractual, and control relationships with an excluded individual and entity that it discovers.

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

7.5. 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)).