Meeting Date: July 27, 2020
Agenda Item No: ____

<table>
<tr><td colspan="2"><u>Kitsap County Board of Commissioners</u></td></tr>
<tr><td colspan="2">Office/Department: Human Services
Staff Contact:
Stephanie Lewis, SBH-ASO Administrator, 337-4422
Doug Washburn, Human Services Director, 337-4526

Agenda Item Title: Revenue Contract KC-068-20 Amendment C, between Kitsap County and Washington State Health Care Authority, Division of Behavioral Health and Recovery, to provide additional funding and updates contract exhibits.</td></tr>
<tr><td colspan="2">Recommended Action: Move that the Board execute Contract KC-068-20, Amendment C, with Washington State Health Care Authority, Division of Behavioral Health and Recovery.</td></tr>
<tr><td>Summary:</td><td>This revenue contract amendment with Washington State Health Care Authority (HCA), Division of Behavioral Health and Recovery, increases funding by $5,090,503. This changes the contract balance from $4,836,406 to $9,926,909. The overall contract term remains unchanged from January 1, 2020 to December 31, 2020.

This amendment: 1) Updates requirements and provides editorial changes to Contract to ensure clarity of Contract Expectations, 2) Revises C.F.R, RCW and WAC references, 3) Replaces Exhibit A-2 With Exhibit A-3: Non-Medicaid Funding Allocation, 4) Removes Exhibit C: Reporting Requirements, 5) Replaces Exhibit E with Exhibit E-1: Crisis System Reporting Requirements, 6) Replaces Exhibit G with Exhibit G-1: Behavioral Health Services, 7) Replaces Exhibit H with Exhibit H-1: Peer Bridger Program, 8) Replaces Exhibit I with Exhibit I-1: Mental Health Block Grant Plan, 9) Replaces Exhibit J with Exhibit J-1: Substance Abuse Block Grant Plan, 10) Replaces Exhibit L with Exhibit L-1: Service Area Matrix, 11) Replaces Exhibit P with Exhibit P-1: Federal Award Identification for Subrecipients, 12) Replaces Exhibit R with Exhibit R-1: Semi-Annual Trueblood Misdemeanor Diversion Fund, 13) Adds Exhibit S: Criminal Justic Treatment Account, 14) Adds Exhibit T: Community Behavioral Health Expenditure, and 14) Adds Exhibit U: Grievance, Adverse Authorization Determination and Appeals.

Kitsap County is the administrative entity for the SBHASO, which contracts with HCA to provide public behavioral health services in Kitsap, Jefferson, and Clallam Counties. The state and block grant funding in this contract is prioritized to pay for crisis services, inpatient services and residential services. Funds that remain after those priorities are met are to be used to provide outpatient services to the non-Medicaid population.</td></tr>
<tr><td>Attachments:</td><td>1. Contract Review Sheet
2. KC-068-20-C [HCA Contract Number K4162-3]
3. Exhibit E-1: Crisis System Quarterly Report
4. Exhibit H-1: Peer Bridger Monthly Report
5. Exhibit I-1: Mental Health Block Grant Plan
6. Exhibit J-1: Substance Abuse Block Grant Plan</td></tr>
</table>

	7. Exhibit S: CJTA Quarterly Progress Report 8. Exhibit T: Community Behavioral Health Enhancement Funds Expenditures 9. Exhibit U: Grievance, Adverse Authorization Determinate and Appeals

Fiscal Impact for this Specific Action	
Expenditure required for this specific action:	$5,090,503
Related Revenue for this specific action:	$5,090,503
Cost Savings for this specific action:	NA
Net Fiscal Impact:	100% Grant Funded
Source of Funds:	WA State Health Care Authority

Fiscal Impact for Total Project – NA

<u>Fiscal Impact (DAS) Review</u>

Office/Departmental Review & Coordination		
Office/Department	**Elected Official/Department Director**	
Human Services	Doug Washburn	

Contract Information			
Contract Number	**Date Original Contract or Amendment Approved**	**Amount of Original Contract Amendment**	**Total Amount of Amended Contract**
KC-068-20	12/14/2019		$3,693,490
KC-068-20-A	05/13/2020	$196,911	$3,890,401
KC-068-20-B	Pending	$946,005	$4,836,406
KC-068-20-C	Pending	$5,090,503	$9,926,909

Kitsap County
CONTRACT REVIEW SHEET
(Chapter 3.56 KCC)

A. CONTRACT INFORMATION

1. Contractor: Washington State Health Care Authority, Division of Behavioral Health and Recovery
2. Purpose: To provide additional funding and update contract exhibits
3. Contract Amount: $5,090,503 — Disburse [ ] Receive [X]
4. Contract Term: January 1, 2020 to December 31, 2020
5. Contract Administrator: Stephanie Lewis — Phone: 337-4422

Approved: Richard VanCleave **Date** 6/30/2020

B. AUDITOR – ACCOUNTING INFORMATION

1. Contract Control Number: KC-068-20-C
2. Fund Name: SBHASO Non-Medicaid
3. Payment from-Revenue to CC/Account Nbr: 1971.3340.0460,3330.93958,3330.93959
4. **Encumbered By:** Dave Schureman **Date** 6/30/2020

C. AUDITOR'S ACCOUNTING – GRANTS REVIEW
Signature required only if contract is grant funded

1. [X] Approved [ ] Not Approved

Reviewer Dave Schureman **Date** 6/30/2020

2. Comments: amendment

D. ADMINISTRATIVE SERVICES DEPARTMENT – RISK MANAGER REVIEW

1. [X] Approved [ ] Not Approved

Reviewer Anastasia Johnson **Date** 6/30/2020

2. Comments: Amendment Only

E. ADMINISTRATIVE SERVICES DEPARTMENT – BUDGET MANAGER REVIEW
Signature required only if contract is for $50,000 or more, OR it will be signed by board of commissioners (regardless of dollar amount)

1. [X] Approved [ ] Not Approved

Reviewer Aimée Campbell **Date** 07/01/2020

2. Comments:

G. PROSECUTING ATTORNEY

1. [X] Approved as to Form [ ] Not Approved as to Form

Reviewer Alan L. Miles **Date** 2020-06-30

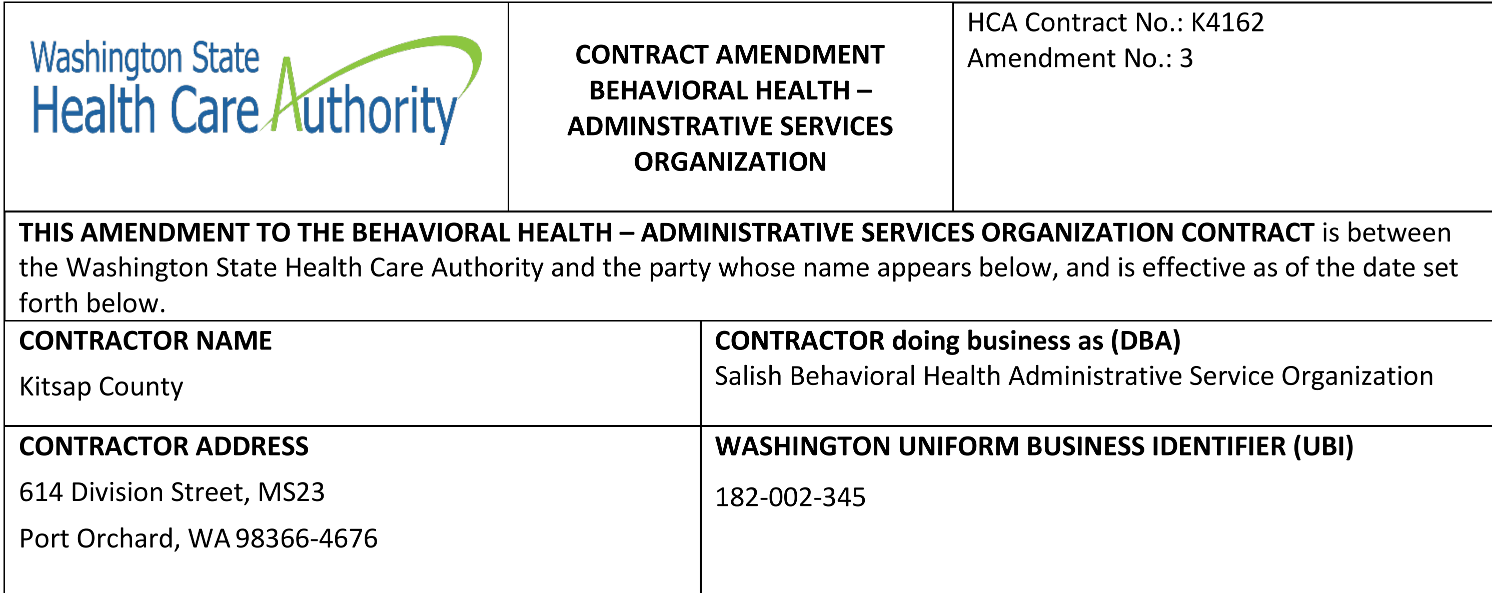
2. Comments:

H. CERTIFICATION BY CONTRACT ADMINISTRATOR: THIS CONTRACT IS READY FOR CONSIDERATION BY THE AUTHORIZED CONTRACT SIGNER.
(For contract signing authority, see KCC 3.56.075)

Contract Administrator: **Stephanie Lewis** **Date** **6/29/2020**

Date Approved by Authorized Contract Signer: **Date**

RETURN SIGNED ORIGINALS TO: Melynda Phelps @ MS-23, X3534



Washington State Health Care Authority	**CONTRACT AMENDMENT BEHAVIORAL HEALTH – ADMINSTRATIVE SERVICES ORGANIZATION**	HCA Contract No.: K4162 Amendment No.: 3

THIS AMENDMENT TO THE BEHAVIORAL HEALTH – ADMINISTRATIVE SERVICES ORGANIZATION CONTRACT is between the Washington State Health Care Authority and the party whose name appears below, and is effective as of the date set forth below.

CONTRACTOR NAME	**CONTRACTOR doing business as (DBA)**
Kitsap County	Salish Behavioral Health Administrative Service Organization
CONTRACTOR ADDRESS 614 Division Street, MS23 Port Orchard, WA 98366-4676	**WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)** 182-002-345

WHEREAS, HCA and Contractor previously entered into a Contract for behavioral health services, and;

WHEREAS, HCA and Contractor wish to amend the Contract to: 1) update requirements and provide editorial changes to the BH-ASO Contract to ensure clarity of contract expectations; 2) revisions to C.F.R., RCW, and WAC references; 3) update Exhibit A, Non-Medicaid Funding Allocation; 2) remove Exhibit C, Reporting Requirements; 3) revise Exhibit E, Crisis System Reporting; 4) revise Exhibit G, Behavioral Health Services; 5) revise Exhibit H, Peer Bridger Program; 6) revise Exhibit I, Mental Health Block Grant Project Plan; 7) revise Exhibit J, Substance Abuse Block Grant Project Plan; 8) revise Exhibit L, Service Area Matrix; 9) revise Exhibit P, Federal Award Identification for Subrecipients; 10)revise Exhibit R, Semi-Annual Trueblood Misdemeanor Diversion Fund; 11) add Exhibit S, Criminal Justice Treatment Account; 12) add Exhibit T, Community Behavioral Health Expenditure; and 13) add Exhibit U, Grievance, Adverse Authorization Determination.

NOW THEREFORE, the parties agree the Contract is amended as follows:

1. The total maximum consideration for this Contract is increased by $5,090,503.00 from $4,836,406.00 to $9,926,909.00.

2. Section 1, Definitions, a new subsection 1.1 Access, is added as follows:

   1.1 Access

   "Access" means the timely use of services to achieve optimal outcomes, as evidenced by the Contractor's successful demonstration and reporting outcome information for the availability and timeliness defined in this Contract.

   All remaining subsections are subsequently renumbered and internal references updated accordingly.

3. Section 1, Definitions, 1.11 American Indian/Alaska Native (AI/AN), is amended to read as follows:

   1.11 American Indian/Alaska Native (AI/AN)

   "American Indian/Alaska Native (AI/AN)" means any individual defined at 25 U.S.C. § 1603(13), § 1603(28), or § 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a Tribe or resides in an urban center and meets one or more of the following criteria:

1.11.1 Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is descendant, in the first or second degree, of any such member;

1.11.2 Is an Eskimo or Aleut or other Alaska Native;

1.11.3 Is considered by the Secretary of the Interior to be an Indian for any purpose; or

1.11.4 Is determined to be an Indian under regulations issued by the Secretary.

The term AI/AN also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

4. Section 1, Definitions, 1.16 Assessment Substance Use Disorder, is amended to read as follows:

1.16 Assessment Substance Use Disorder

"Assessment Substance Use Disorder" means the activities conducted to evaluate an Individual to determine if the Individual has a Substance Use Disorder (SUD) and determine placement in accordance with the ASAM Criteria.

5. Section 1, Definitions, 1.20 Behavioral Health Administrative Services Organization (BH- ASO), is amended to read as follows:

1.20 Behavioral Health Administrative Services Organization (BH- ASO)

"Behavioral Health Administrative Services Organization (BH-ASO)" means an entity selected by HCA to administer behavioral health programs, including Crisis Services and Ombuds for Individuals in a defined Regional Service Area (RSA), regardless of an Individual's ability to pay, including Medicaid eligible members.

6. Section 1, Definitions, 1.23 Behavioral Health Supplemental Transaction, is amended to read as follows:

1.23 Behavioral Health Supplemental Transaction

"Behavioral Health Supplemental Transaction" means non-encounter data submissions to the BHDS as outlined in the Behavioral Health Data System Guide. These transactions include supplemental data, including additional demographic and social determinate data, as well as service episode and outcome data necessary for federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant reporting and other state reporting needs.

7. Section 1, Definitions, 1.26 Business Associate Agreement (BAA), is amended to read as follows:

1.26 Business Associate Agreement (BAA)

"Business Associate Agreement (BAA)" means an agreement under the federal Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), between a HIPAA covered entity HIPAA business associate. The agreement protects Personal Health Information (PHI) in accordance with HIPAA guidelines.

8. Section 1, Definitions, 1.29 Certified Substance Use Disorder Professional (SUDP), is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

9. Section 1, Definitions, a new subsection 1.34 Co-responder, is added as follows:

1.34 Co-responder

"Co-responder" means teams consisting of law enforcement officer(s) and behavioral health professional(s) to engage with individuals experiencing behavioral health crises that does not rise to the level of need for incarceration.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

10. Section 1, Definitions, 1.47 Criminal Justice Treatment Account (CJTA), is amended to read as follows:

1.47 Criminal Justice Treatment Account (CJTA)

"Criminal Justice Treatment Account (CJTA)" means an account created by the state for expenditure on: a) SUD treatment and treatment support services for offenders with a SUD that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; b) the provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program (RCW 71.24.580).

11. Section 1, Definitions, 1.49 Crisis Services (Behavioral Health), is amended to read as follows:

1.49 Crisis Services (Behavioral Health)

"Crisis Services (Behavioral Health)" means providing evaluation and short term treatment and other services to Individuals with an emergent mental health condition or are intoxicated or incapacitated due to substance use and when there is an immediate threat to the Individual's health or safety.

12. Section 1, Definitions, a new subsection 1.50 Cultural Humility, is added as follows:

1.50 Cultural Humility

"Cultural Humility" means the continuous application in professional practice of self-reflection and self-critique, learning from patients, and partnership building, with an awareness of the limited ability to understand the patient's worldview, culture(s), and communities.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

13. Section 1, Definitions, a new subsection 1.51 Culturally Appropriate Care, is added as follows:

1.51 Culturally Appropriate Care

"Culturally Appropriate Care" means health care services provided with Cultural Humility and an understanding of the patient's culture and community, and informed by Historical Trauma and the resulting cycle of Adverse Childhood Experiences (ACEs).

All remaining subsections are subsequently renumbered and internal references updated accordingly.

14. Section 1, Definitions, 1.54 Department of Children, Youth, and Families (DCYF), is amended to read as follows:

1.54 Department of Children, Youth, and Families (DCYF)

"Department of Children, Youth, and Families (DCYF)" means the Washington State agency responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.

15. Section 1, Definitions, a new subsection1.65 Encounter Data Reporting Guide, is added as follows:

1.65 Encounter Data Reporting Guide

"Encounter Data Reporting Guide" means the published guide to assist contracted entities in the standard electronic encounter data reporting process required by HCA.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

16. Section 1, Definitions, 1.67 Evaluation and Treatment, is amended to read as follows:

1.67 Evaluation and Treatment

"Evaluation and Treatment (E&T)" means services provided for Individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self-due to the onset or exacerbation of a psychiatric disorder. Services are provided in freestanding inpatient residential (non-hospital/non-Institution for Mental Disease (IMD) facilities) licensed and certified by DOH to provide medically necessary evaluation and treatment to the Individual who would otherwise meet hospital admission criteria.

17. Section 1, Definitions, a new 1.74 Fee-for Service Medicaid (FFS) Program, is added as follows:

1.74 Fee-for Service Medicaid (FFS) Program

"Fee-for-Service Medical (FFS) Program" means the state Medicaid program, which pays for services furnished to Medicaid patients in accordance with the Medicaid State Plan's fee-for-service methodology.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

18. Section 1, Definitions, a new subsection 1.86 Health Disparities, is added as follows:

1.86 Health Disparities

"Health Disparities" are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

19. Section 1, Definitions, a new subsection 1.87 Historical Trauma, is added as follows:

1.87 Historical Trauma

"Historical Trauma" means situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

20. Section 1, Definitions, a new subsection 1.90 Indian Health Service, is added as follows:

1.90 Indian Health Service

"Indian Health Service (IHS)" means the federal agency in the Department of Health and Human Services, including contracted Tribal health programs, entrusted with the responsibility to assist eligible AI/ANs with health care services.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

21. Section 1, Definitions, 1.93 Inpatient/Residential Substance Use Treatment Services, is amended to read as follows:

1.93 Inpatient/Residential Substance Use Treatment Services

“Inpatient/Residential Substance Use Treatment Services” means rehabilitative services, including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward Individuals who are harmfully affected by the use of mood-altering chemicals or have been diagnosed with a SUD. Techniques have a goal of abstinence (assisting in their Recovery) for Individuals with SUDs. Provided in certified residential treatment facilities with sixteen (16) beds or less. Excludes room and board. Residential treatment services require additional program-specific certification by DOH, and include:

1.93.1 Intensive inpatient services;

1.93.2 Recovery house treatment services;

1.93.3 Long-term residential treatment services; and

1.93.3 Youth residential services.

22. Section 1, Definitions, 1.102 Less Restrictive Alternative (LRA) Treatment, is amended to read as follows:

1.102 Less Restrictive Alternative (LRA) Treatment

“Less Restrictive Alternative (LRA) Treatment” means a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.05.585.

23. Section 1, Definitions, 1.108 Medically Necessary Services, is amended to read as follows:

1.108 Medically Necessary Services

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

24. Section 1, Definitions, 1.113 Mental Health Block Grant (MHBG), is amended to read as follows:

1.113 Mental Health Block Grant (MHBG)

"Mental Health Block Grant (MHBG)" means those funds granted by the Secretary of the Department of Health and Human Services (DHHS), through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), to states to establish or expand an organized community-based system for providing mental health services for adults with Serious Mental Illness (SMI) and children who are seriously emotionally disturbed (SED).

25. Section 1, Definitions, a new subsection 1.119 Non-Tribal Health Care Provider, is added as follows:

1.119 Non-Tribal Health Care Provider

"Non-Tribal Indian Health Care Provider" means an Indian Health Care Provider that is not operated by a Tribe, including the Indian Health Service and an Urban Indian Health Program.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

26. Section 1, Definitions, 1.120 Notice of Action (NOA), is amended to read as follows:

1.120 Notice of Action (NOA)

"Notice of Action (NOA)" means a written notice that must be provided to Individuals to inform them that a requested Contracted Service was denied or received only a limited authorization based on medical necessity.

27. Section 1, Definitions, 1.122 Opioid Dependency/HIV Services Outreach, is amended to read as follows:

1.122 Opioid Dependency/HIV Services Outreach

"Opioid Dependency/HIV Services" means the provision of outreach and referral services to special populations to include opioid use disorder, Injecting Drug Users (IDU), HIV or Hepatitis C-positive individuals.

28. Section 1, Definitions, 1.123 Opioid Substitution Treatment, is amended to read as follows:

1.123 Opioid Substitution Treatment

"Opioid Substitution Treatment" means assessment and treatment to opioid dependent patients. Services include prescribing and dispensing of an approved medication, as specified in 21 C.F.R. Part 291, for opioid substitution services in accordance with WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 1).

29. Section 1, Definitions, 1.129 Peer Support, is amended to read as follows:

1.129 Peer Support

"Peer Support" means behavioral health services provided by peer counselors to Individuals under the consultation, facilitation, or supervision of a Behavioral Health Professional, including Mental Health or SUD Professional.

30. Section 1, Definitions, a new subsection 1.135 Promising Practice, is added as follows:

1.135 Promising Practice

“Promising Practice” means a practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the evidence-based or research-based criteria that may include the use of a program that is evidence-based for outcomes, including practices that may be focused on groups for whom evidence-based or research-based criteria have not yet been developed.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

31. Section 1, Definitions, a new subsection 1.136 Protocols for Coordination with Tribes and non-Tribal IHCPs, is added as follows:

1.136 Protocols for Coordination with Tribes and non-Tribal IHCPs

“Protocols for Coordination with Tribes and non-Tribal IHCPs” means the protocols that HCA and a Tribe or non-Tribal IHCP develop and agree on, with input from the Contractor, for the coordination of crisis services (including involuntary commitment assessment), care coordination, and discharge and transition planning. See Subsection 16.6, Development of Protocols for Coordination with Tribes and non-Tribal IHCPs.

32. Section 1, Definitions, 1.29 Certified Substance Use Disorder Professional (SUDP), is renamed and moved to 1.164, as follows:

1.164 Substance Use Disorder Professional (SUDP)

“Substance Use Disorder Professional (SUDP)” means an individual who is certified according to RCW 18.205.020 and the certification requirements of WAC 246-811-030 to provide SUD services.

33. Section 1, Definitions, 1.165 Substance Use Disorder Professional Trainee (SUDPT), is amended to read as follows:

1.165 Substance Use Disorder Professional Trainee (SUDPT)

“Substance Use Disorder Professional Trainee (SUDPT)” means an individual working toward the education and experience requirements for certification as a SUDP and who has been credentialed as a SUDPT.

34. Section 1, Definitions, a new subsection 1.173 Tribal Organization, is added as follows:

1.173 Tribal Organization

"Tribal Organization" means the recognized governing body of any Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by one or more federally recognized Tribes or whose governing body is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

35. Section 1, Definitions, a new subsection 1.174 Tribe, is added as follows:

1.174 Tribe

"Tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

36. Section 1, Definitions, a new subsection 1.117 Urban Indian Health Program (UIHP), is added as follows:

1.117 Urban Indian Health Program (UIHP)

"Urban Indian Health Program (UIHP)" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, that is operating a facility delivering health care.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

37. Section 1, Definitions, 1.179 Waiting List, is amended to read as follows:

1.179 Waiting List

“Waiting List” means a list of Individuals who qualify for SABG-funded services for whom services have not been scheduled due to lack of capacity.

38. Section 2, General Terms and Conditions, Subsection 2.3 Billing Limitations, is amended to read as follows:

2.3 Billing Limitation

2.3.1 HCA shall pay the Contractor only for services provided in accordance with this Contract.

39. Section 2, General Terms and Conditions, Subsection 2.4 Compliance with Applicable Law, is amended to read as follows:

2.4 Compliance with Applicable Law

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

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

2.4.1 Title XIX and Title XXI of the Social Security Act.

2.4.2 Title VI of the Civil Rights Act of 1964.

2.4.3 Title IX of the Education Amendments of 1972, regarding any education programs and activities.

2.4.4 The Age Discrimination Act of 1975.

2.4.5 The Rehabilitation Act of 1973.

2.4.6 The Budget Deficit Reduction Act of 2005.

2.4.7 The Washington Medicaid False Claims Act and Federal False Claims Act (FCA).

2.4.8 The Health Insurance Portability and Accountability Act (HIPAA).

2.4.9 The American Recovery and Reinvestment Act (ARRA).

2.4.10 The Patient Protection and Affordable Care Act (PPACA or ACA).

2.4.11 The Health Care and Education Reconciliation Act.

2.4.12 The Mental Health Parity and Addiction Equity Act (MHPAEA) and final rule.

2.4.13 21 C.F.R. Food and Drugs, Chapter 1 Subchapter C – Drugs – General.

2.4.14 42 C.F.R. Subchapter A, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.

2.4.15 42 C.F.R. Subchapter A, Part 8 – Certification of Opioid Treatment Programs.

2.4.16 45 C.F.R. Part 96 Block Grants.

2.4.17 45 C.F.R. § 96.126 Capacity of Treatment for Intravenous Substance Abusers who Receive Services under Block Grant funding.

2.4.18 Chapter 70.02 RCW Medical Records – Health Care Information Access and Disclosure.

2.4.19 Chapter 71.05 RCW Mental Illness.

2.4.20 Chapter 71.24 RCW Community Mental Health Services Act.

2.4.21 Chapter 71.34 RCW Mental Health Services for Minors.

2.4.22 Chapter 246-341 WAC.

2.4.23 Chapter 43.20A RCW Department of Social and Health Services.

2.4.24 Senate Bill 6312 (Chapter 225. Laws of 2014) State Purchasing of Mental Health and Chemical Dependency Treatment Services.

2.4.25 All federal and State professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including but not limited to:

2.4.25.1 All applicable standards, orders, or requirements issued under Section 508 of the Clean Water Act (33 U.S.C. § 1368), Section 306 of the Clean Air Act (42 U.S.C. § 7606), Executive Order 11738, and Environmental Protection Agency (EPA) Regulations (40 C.F.R. Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to HCA, DHHS, and the EPA.

2.4.25.2 Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.

2.4.25.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

2.4.25.4 Those specified in Title 18 RCW for professional licensing.

2.4.26 Industrial Insurance – Title 51 RCW.

2.4.27 Reporting of abuse as required by RCW 26.44.030.

2.4.28 Federal Drug and Alcohol Confidentiality Laws in 42 C.F.R. Part 2.

2.4.29 Equal Employment Opportunity (EEO) Provisions.

2.4.30 Copeland Anti-Kickback Act.

2.4.31 Davis-Bacon Act.

2.4.32 Byrd Anti-Lobbying Amendment.

2.4.33 All federal and State nondiscrimination laws and Regulations.

2.4.34 Americans with Disabilities Act (ADA): The Contractor shall make reasonable accommodation for Individuals with disabilities, in accord with the ADA, for all Contracted Services and shall assure physical and communication barriers shall not inhibit Individuals with disabilities from obtaining Contracted Services.

2.4.35 Any other requirements associated with the receipt of federal funds.

2.4.36 Any services provided to an Individual enrolled in Medicaid are subject to applicable Medicaid rules.

40. Section 2,General Terms and Conditions, Subsection 2.7 Debarment Certification, subsection 2.7.3 is amended to read as follows:

2.7.3 The Contractor shall immediately notify HCA if, during the term of this Contract, the Contractor becomes debarred. HCA may immediately terminate this Contract by providing Contractor written notice in accord with Subsection 2.39 of this Contract if the Contractor becomes debarred during the term hereof

41. Section 2, General Terms and Conditions, Subsection 2.13 Insolvency, subsection 2.13.2 is amended to read as follows:

2.13.2 The Contractor shall, in accordance with RCW 48.44.055, provide for the Continuity of Care for Individuals and shall provide Crisis Services and ITA services in accordance with Chapters 71.05 and 71.34.

42. Section 2, General Terms and Conditions, Subsection 2.14 Inspection, subsection 2.14.1 is amended to read as follows:

2.14.1 The Contractor and its Subcontractors shall cooperate with all audits and investigations performed by duly authorized representatives of the state of Washington, HCA and Washington State Medicaid Fraud Control Division (MFCD), as well as the federal DHHS, auditors from the federal Government Accountability Office, federal Office of the Inspector General (OIG) and federal Office of Management and Budget (OMB).

43. Section 2, General Terms and Conditions, Subsection 2.18 Notification of Organizational Changes, is amended to read as follows:

2.18 Notification of Organizational Changes

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

44. Section 2, General Terms and Conditions, Subsection 2.24 Health and Safety, is amended to read as follows:

2.24 Health and Safety

The Contractor shall perform any and all of its obligations under this Contract in a manner that does not compromise the health and safety of any HCA Individual with whom the Contractor has contact.

45. Section 2, General Terms and Conditions, Subsection 2.25 Indemnification and Hold Harmless, a new subsection 2.25.3 is added as follows:

2.25.3 In accordance with RCW 71.05.026 and RCW 71.24.370, the Contractor will have no claim for declaratory relief, injunctive relief, or judicial review under chapter 34.05 RCW, or civil liability against the state, state agencies, state officials, or state employees for actions or inactions performed pursuant to the administration of chapter 71.05 RCW and chapter 71.24 RCW with regards to:

2.25.3.1 The allocation of federal or state funds;

2.25.3.2 The use of state hospital beds; or

2.25.3.3 Financial responsibility for the provision of inpatient mental health care.

46. Section 2, General Terms and Conditions, Subsection 2.32 Solvency, subsection 2.32.4 is amended to read as follows:

2.32.4 In the RSAs where HCA has authorized reserves, the Contractor shall notify HCA within ten (10) Business Days after the end of any month in which the Contractor's reserves reaches a level representing two (2) or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Contract or which may otherwise materially affect the relationship of the parties under this Contract.

47. Section 2, General Terms and Conditions, Subsection 2.33 Surety Bond, is amended to read as follows:

2.33 Surety Bond

In RSAs where HCA approved use of a surety bond, the Contractor shall furnish to HCA a surety bond in the amount of $1,000,000.00, or in an amount equal to the total minimum balance per region, found in the Region Reserve table, whichever is greater. The surety bond shall be provided to HCA within thirty (30) calendar days of the effective date, in a form satisfactory to HCA. The Contractor shall maintain the surety bond in effect until expiration or termination of the Contract. Any change or extension of time of this Contract shall in no way release the Contractor or any of its sureties from any of their obligations under the bond. Such bond shall contain a waiver of notice of any changes to this Contract. The Contractor shall notify its sureties and any bonding organizations of changes to this Contract.

No payment shall be made to the Contractor until this surety bond is in place and reviewed by HCA. The surety bond shall be issued by a licensed insurance company authorized to do business in the state of

Washington and made payable to the HCA. The Contract number and dates of performance shall be specified in the surety bond. In the event that HCA exercises an option to extend the Contract for any additional period(s), Contractor shall extend the validity and enforcement of the surety bond for said periods.

An amount up to the full amount of the surety bond may also be applied to Contractor's liability for any administrative costs and/or excess costs incurred by HCA in obtaining similar products and services to replace those terminated as a result of Contractor's default. HCA may seek other remedies in addition to this stated liability.

48. Section 2, General Terms and Conditions, a new Subsection 2.34 Reserves is added as follows:

2.34 Reserves

2.34.1 In RSAs where HCA has authorized reserves, the Contractor shall maintain a reserve, within the levels specified in the table found in this Section, for non-Medicaid services within the region. The funds must be deposited into a designated reserve account and may only drop below the allocated amount in the event the cost of providing psychiatric inpatient services or crisis services exceeds the revenue the Contractor receives. The Contractor may also use the allocated reserve funds that are in excess of the minimum required reserve level to ensure a smooth transition to integrated managed care. This includes maintaining existing levels of regional BH crisis and diversion programs, and other required BH-ASO services, and to stabilize the crisis services system.

BH-ASO	Residents	Percent	Allocation
2020 Adopters			
Great Rivers	288,420	28%	$719,342
Thurston-Mason	350,780	34%	$874,872
Salish	378,010	37%	$942,786
All other Regions			
Greater Columbia	720,000	12%	$1,468,293
King	2,154,000	37%	$5,370,943
North Central	256,000	4%	$638,393
North Sound	1,229,000	21%	$3,065,156
Pierce	859,000	15%	$2,143,190
Spokane	596,000	10%	$1,486,293

2.34.2 If the Contractor spends a portion of these funds, and the reserve balance drops below the allocated reserve amount, the Contractor must replenish the reserve account within one year, or at the end of the state fiscal year in which the funds were spent, whichever is longer. If HCA determines the reserves are outside the allocation found in the table in this Section, HCA may require a corrective action plan.

2.34.3 All expenditures of reserve funds shall be documented and included on Exhibit B, Non-Medicaid Monthly Expenditure Report.

2.34.4 If the Contractor terminates this Contract for any reason or will not enter into any subsequent contracts, HCA shall require that all remaining reserves and fund balances be spent within a reasonable timeframe determined by HCA. Funds will be deducted from the monthly payments made by HCA to the Contractor until all reserves and fund balances are spent. Any funds not spent for the provision of services under this Contract shall be returned to HCA within sixty (60) calendar days of the last day of this Contract is in effect.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

49. Section 2, General Terms and Conditions, Subsection 2.35 Conflict of Interest Safeguards, is amended to read as follows:

2.35 Conflict of Interest Safeguards

The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public Contracting (42 C.F.R. § 438.58).

50. Section 2, General Terms and Conditions, Subsection 2.38 Termination for Convenience, is amended to read as follows:

2.38 Termination for Convenience

Notwithstanding any other provision of this Contract, the HCA may, by giving thirty (30) calendar days written notice, beginning on the second day after the mailing, terminate this Contract in whole or in part when it is in the best interest of HCA, as determined by HCA in its sole discretion. If this Contract is so terminated, HCA shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination.

If the Contractor terminates this Contract for convenience, the Contractor is required to provide no less than six (6) months advance notice in writing to HCA.

51. Section 2, General Terms and Conditions, Subsection 2.42 Administrative Simplification, subsection 2.42.2 is amended to read as follows:

2.42.2 The Contractor must follow National Correct Coding Initiative (NCCI) policies to control improper coding, unless otherwise directed by the HCA. Any Contractor requested exceptions to NCCI policies must be approved by HCA. The Contractor must incorporate compatible NCCI methodologies in its payment systems for processing claims. The NCCI editing should occur in addition to current procedure code review and editing by the Contractor's claims payment systems.

52. Section 3, Material and Information Requirements, Subsection 3.1 Media Materials and Publications, is amended to read as follows:

3.1 Media Materials and Publications

3.1.1 Media materials and publications developed with state funds shall be submitted to the HCA for written approval prior to publication. HCA must be cited as the funding source in news releases, publications, and advertising messages created with or about HCA funding. The funding source shall be cited as: The Washington State Health Care Authority. The HCA logo may also be used in place of the above citation.

3.1.2 Materials described in 3.1.1 but not paid for by funds provided under this Contract must be submitted to HCA for prior approval.

3.1.3 The Contractor is encouraged but is not required to submit the following items to HCA for approval:

3.1.3.1 News coverage resulting from interviews with reporters including online news coverage;

3.1.3.2 Pre-scheduled posts on electronic / social media sites;

3.1.3.3 When a statewide media message developed by HCA is localized; and

3.1.3.4 When SAMHSA-sponsored media campaign are localized.

3.1.4 Materials for Crisis Services

3.1.4.1 The Contractor shall develop and implement a plan that educates and informs community stakeholders to include: residents of the RSA, Health Care Providers, First Responders, the criminal justice community, educational systems, Tribes, and faith-based organizations.

3.1.4.2 After the initial Contract period, provide an update by March 31 on a two (2) year cycle as determined by HCA.

3.1.4.3 Publicize the regional crisis system services and facilitate awareness of the existence of the Behavioral Health Crisis Services for all stakeholders.

53. Section 3, Material and Information Requirements, Subsection 3.3 Equal Access for Individuals with Communication Barriers, is amended to read as follows:

3.3 Equal Access for Individuals with Communication Barriers

The Contractor shall assure equal access for all Individuals when oral or written language creates a barrier to such access.

3.3.1 Oral Information:

3.3.1.1 The Contractor shall assure interpreter services are provided free of charge for Individuals with a preferred language other than English. This includes the provision of interpreters for Individuals who are Deaf, DeafBlind, or Hard of Hearing. This includes oral interpretation Sign Language (SL), and the use of Auxiliary Aids and Services as defined in this Contract (42 C.F.R. § 438.10(d)(4)). Interpreter services shall be provided for all interactions between such Individuals and the Contractor or any of its providers including, but not limited to:

3.3.1.1.1 Customer service;

3.3.1.1.2 All appointments with any provider for any covered service; and

3.3.1.1.3 All steps necessary to file Grievances and Appeals.

3.3.2 Written Information:

3.3.2.1 The Contractor shall provide all generally available and Individual-specific written materials in a language and format which may be understood by each Individual in each of the prevalent languages that are spoken by 5 percent or more of the population of the RSA based on information obtained from HCA.

3.3.2.2 For Individuals whose preferred language has not been translated as required in this Section, the Contractor may meet the requirement of this Section by doing any one of the following:

3.3.2.2.1 Translating the material into the Individual's preferred reading language;

3.3.2.2.2 Providing the material in an audio format in the Individual's preferred language;

3.3.2.2.3 Having an interpreter read the material to the Individual in the Individual's preferred language;

3.3.2.2.4 Providing the material in another alternative medium or format acceptable to the Individual. The Contractor shall document the Individual's acceptance of the material in an alternative medium or format; or

3.3.2.2.5 Providing the material in English, if the Contractor documents the Individual's preference for receiving material in English.

3.3.3 The Contractor shall ensure that all written information provided to Individuals is accurate, is not misleading, is comprehensible to its intended audience, is designed to provide the greatest degree of understanding, is written at the sixth (6th) grade reading level, and fulfills other requirements of the Contract as may be applicable to the materials.

3.3.4 HCA may make exceptions to the sixth (6th) grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth (6th) grade reading level or the Individual's needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth (6th) grade reading level must be in writing.

3.3.5 Educational materials about topics or other information used by the Contractor for health promotion efforts must be submitted to HCA, but do not require HCA approval as long as they do not specifically mention the Contracted Services.

3.3.6 Educational materials that are not developed by the Contractor or by the Contractor's Subcontractors are not required to meet the sixth (6th) grade reading level requirement and do not require HCA approval.

3.3.7 For Individual-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved materials in final form.

3.3.8 Interpreter services for Individuals in crisis over-the-telephone

3.3.8.1 The Contractor will submit claims to HCA under a billing National Provider Identifier (NPI), or an Alternative Provider Identifier (API) for reimbursement through the ProviderOne Medicaid Management Information System for interpretation provided over-the-phone to Individuals in crisis. Reimbursable Services must meet the following criteria:

3.3.8.1.1 The Individuals must be Medicaid eligible on the date the service took place;

3.3.8.1.2 The Individual received a Medicaid covered service by a servicing provider that has a Core Provider Agreement with HCA;

3.3.8.1.3 The Interpretation requests must be for urgent same day events, necessary to assist Individuals determined to be in crisis;

3.3.8.1.4 Services must be provided by a qualified interpreter as described by Section 1557 of the Affordable Care Act; and

3.3.8.1.5 The claim must be submitted to HCA within ninety (90) calendar days of the date of service.

3.3.8.2 The Contractor will facilitate payment to interpreters for the over-the-phone interpretation provided in accordance with HCA Interpreter Services Billing Guides, and the below criteria:

3.3.8.2.1 Reimbursement is per minute and shall not exceed the over-the-phone interpreter rates negotiated in the Language Access Provider (LAP) contract. A copy of the current agreement may be found on the Office of Financial Management (OFM) website.

3.3.8.2.2 Administrative activities including but not limited to scheduling or reminder calls are not reimbursable.

3.3.8.2.3 Scheduled events, or appointments scheduled more than 24-hours in advance, are not reimbursable through this process and must use the HCA Interpreter Services program.

3.3.8.3 HCA is not responsible for any unpaid service claims made by the interpreter or the Interpreter Agency.

54. Section 4, Service Area and Individual Eligibility, Subsection 4.3 Eligibility, is amended to read as follows:

4.3 Eligibility

4.3.1 All Individuals in the Contractor's RSA regardless of insurance status, ability to pay, county of residence, or level of income are eligible to receive medically necessary Behavioral Health Crisis Services, and services related to the administration of the Involuntary Treatment Act and Involuntary Commitment Act (Chapters 71.05 and 71.34 RCW).

4.3.2 The Contractor shall also prioritize the use of funds for the provision of non-crisis behavioral health services including crisis stabilization and voluntary Behavioral Health admissions for Individuals in the Contractor's RSA who are not eligible for Medicaid and meet the medical necessity and financial eligibility criteria described herein.

4.3.3 To be eligible for any GFS non-crisis Behavioral Health service under this Contract, an Individual must meet the financial eligibility criteria and the clinical or program eligibility criteria for the GFS service:

4.3.3.1 Individuals who do not qualify for Medicaid and have income up to 220 percent of the federal poverty level meet the financial eligibility for all of the GFS services.

4.3.3.2 For services in which medical necessity criteria applies, all services must be medically necessary.

4.3.3.3 As defined in this Contract, certain populations have priority to receive services.

4.3.4 The Contractor shall ensure that FBG funds are used only for services to Individuals who are not enrolled in Medicaid, or for services that are not covered by Medicaid, as outlined in Section 18, Federal Block Grants (FBG).

4.3.5 Meeting the eligibility requirements under this Contract does not guarantee the Individual will receive a non-crisis behavioral health service. Services other than Behavioral Health Crisis Services and ITA-related services are contingent upon Available Resources as managed by the Contractor.

4.3.6 Eligibility functions may be done by the Contractor or delegated to providers. If delegated to providers, the Contractor shall monitor the providers' use of such protocols and ensure appropriate compliance in determining eligibility.

4.3.6.1 The Contractor shall develop eligibility data collection protocols for providers to follow to ensure that the provider checks the Individual's Medicaid eligibility prior to providing a service and captures sufficient demographic, financial, and other information to support eligibility decisions and reporting requirements.

4.3.6.2 At HCA's direction, the Contractor shall participate with the regional IMC MCOs in a regional initiative to develop and implement consistent protocols to determine clinical or program eligibility for the non-crisis Behavioral Health services.

4.3.6.3 The Contractor shall participate in developing protocols for Individuals with frequent eligibility changes. The protocols will address, at a minimum, coordination with the AH-IMC MCOs, Tribes, HCA Regional Tribal Liaisons, and referrals, reconciliations, and potential transfer of GFS/FBG funds to promote Continuity of Care for the Individual. Any reconciliation will occur at a frequency determined by HCA, but no less than semiannually, with potential for up to monthly reconciliations in the last quarter of the allocation year.

55. Section 5, Payment and Sanctions, Subsection 5.1 Funding, is amended to read as follows:

55.1 Funding

55.1.1 The funds under this Contract are dependent upon HCA's receipt of continued state and federal funding. If HCA does not receive continued state and federal funding, HCA may terminate this Contract in accordance with this Contract's General Terms and Conditions.

55.1.2 HCA will provide the Contractor with its budget of State-Only, proviso, and FBG funds prior to the beginning of the state fiscal year as identified in Exhibit A. As regions integrate, the Contractor's budget will be based upon available funding for the RSA. At HCA's discretion, the Contractor's budget of GFS and proviso funds may be amended as described in subsection 5.1.7.

55.1.3 A maximum of 10 percent of available funds paid to the Contractor may be used for administrative costs, taxes and other fees per RCW 71.24.330. A maximum of 5 percent of State-Only and proviso funds paid to the Contractor may be used for direct service support costs. The Contractor shall not use FBG funds for administrative costs or direct service support costs. Administrative and direct service support costs must be reported on the Exhibit B, Non-Medicaid Expenditure Report.

55.1.4 HCA will pay the allocation of State-Only and proviso funds, including the administrative portion, to the Contractor in equal monthly installments at the beginning of each calendar month.

55.1.5 HCA will pay the Contractor FBG funds monthly based upon receipt of the Forms A-19.

55.1.6 The Contractor shall send Exhibit B, Non-Medicaid Expenditure Report to the HCA Contract Manager no later than thirty (30) calendar days after the last day of the quarter. The expenditures reported shall represent the payments made for services under this contract during the quarter being reported. The 10 percent administrative load identified in this Section will be included on the report.

55.1.7 HCA will perform a reconciliation of the Contractor's expenditure reports to its budget. Based upon the results of the reconciliation, at HCA's discretion, the allocation and distribution of GFS and proviso funds may be re-evaluated and unspent funds may be reallocated retrospectively. If the expenditures reported by the Contractor on the expenditure report exceed the Contractor's budget identified in Exhibit A, HCA will not reimburse the Contractor for the amount that exceeds the budget.

55.1.8 For all services, the Contractor must determine whether the Individual receiving services is eligible for Medicaid or has other insurance coverage.

55.1.8.1 For Individuals eligible for Medicaid or other insurance, the Contractor must submit the claim for services to the appropriate party within twelve (12) months from the calendar month in which the services were provided to the eligible Individual.

55.1.8.2 If a claim was incorrectly billed Contractor has an additional year to correct the claim WAC 182-502-0150.

55.1.8.3 For those Individuals who are not eligible for Medicaid coverage, or are unable to pay co-pays or deductibles, the Contractor may offer a sliding fee schedule in accordance with this Contract.

55.1.9 For FBG services, the Contractor shall comply with the utilization funding agreement guidelines within the State's most recent FBG plan. The Contractor agrees to comply with Title V, Section 1913 of the Public Health Services Act [42 U.S.C. 300x-1 et seq.]. The Contractor shall not use FBG funds for the following:

55.1.9.1 The Contractor's administrative costs associated with salaries and benefits at the Contractor's organization level.

55.1.9.2 Inpatient mental health services.

55.1.9.3 Construction and/or renovation.

55.1.9.4 Capital assets or the accumulation of operating reserve accounts.

55.1.9.5 Equipment costs over $5,000.

55.1.9.6 Cash payments to Individuals.

55.1.10 Unless otherwise obligated, funds allocated under this Contract that are not expended by the end of the applicable state fiscal year may be used or carried forward to the subsequent state fiscal year. Unspent allocations shall be reported to HCA at the end of the applicable state fiscal year, as specified in this Contract. In order to expend these funds the Contractor shall submit a plan to HCA for approval.

55.1.11 The Contractor shall ensure that all funds provided pursuant to this Contract, (other than the 10 percent allowed for administration and 5 percent for direct service supports) including interest earned, are to be used to provide services as described in this Contract.

56. Section 5, Payment and Sanctions, Subsection 5.2 Inpatient Psychiatric Stays Outside the State Hospital System, is amended to read as follows:

56.1 Inpatient Psychiatric Stays Outside the State Hospital System

HCA will pay professional fees on a fee-for-service basis directly to the hospital for inpatient psychiatric stays that are authorized by the Contractor. The inpatient hospital claim(s) will be paid by the Contractor. The Contractor shall reimburse HCA within thirty (30) calendar days from the receipt of the inpatient claims to pay the applicable costs.

57. Section 5, Payment and Sanctions, Subsection 5.2 Inpatient Psychiatric Stays Outside the State Hospital System, subsection 5.3.4 is amended to read as follows:

5.3.4 Additional Remuneration Prohibited

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

5.3.4.2 The Contractor must reduce the amount paid to providers by any sliding fee schedule amounts collected from Individuals in accordance with this Contract.

58. Section 5, Payment and Sanctions, Subsection 5.5 Sanctions, subsection 5.5.1 is amended to read as follows:

5.5.1 Initiate remedial action if it is determined that any of the following situations exist:

5.5.1.1 The Contractor has failed to perform any of the Contracted Services.

5.5.1.2 The Contractor has failed to develop, produce, and/or deliver to HCA any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described in this Contract.

5.5.1.3 The Contractor has failed to perform any Administrative Function required under this Contract.

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

59. Section 6, Access to Care and Provider Network, Subsection 6.1 Network Capacity, subsection 6.1.3 is amended to read as follows:

6.1.3 The Contractor must submit a network of contracted service providers adequate to serve the population in the Contractor's RSA annually by November 1. If the Contractor fails to provide evidence of or HCA is unable to validate contracts with a sufficient number of providers, HCA may terminate this Contract. The network must have sufficient capacity to serve the RSA and include, at a minimum:

6.1.3.1 24/7/365 Telephone Crisis Intervention;

6.1.3.2 Designated Crisis Responder (DCR);

6.1.3.3 Evaluation and treatment (E&T) and Secure Withdrawal Management and Stabilization capacity to serve the RSA's non-Medicaid population;

6.1.3.4 Psychiatric inpatient beds to serve the RSA's non-Medicaid population, including direct contracts with community hospitals at a rate no greater than that outlined in the HCA FFS schedule;

6.1.3.5 Staff to provide mobile crisis outreach in the RSA.

60. Section 6, Access to Care and Provider Network, Subsection 6.2 Priority Population Considerations, is amended to read as follows:

6.2 Priority Population Considerations

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

6.2.1.1 The expected utilization of services, the characteristics and health care needs of the population, the number and types of providers (training, experience and specialization) able to furnish services, and the geographic location of providers and Individuals (including distance, travel time, means of transportation ordinarily used by Individuals, and whether the location is ADA accessible) for all Contractor funded behavioral health programs and services based on Available Resources.

6.2.1.2 The anticipated needs of priority populations identified in this Contract.

6.2.2 The Contractor and its Subcontractors shall:

6.2.2.1 Ensure that all services and activities provided under this Contract shall be designed and delivered in a manner sensitive to the needs of the diverse population; and

6.2.2.2 Initiate actions to develop or improve access, retention, and cultural relevance of treatment, relapse prevention or other appropriate services, for ethnic minorities and other diverse populations in need of services under this Contract as identified in their needs assessment.

61. Section 6, Access to Care and Provider Network, Subsection 6.3 Hours of Operation for Network Providers, is amended to read as follows:

6.3 Hours of Operation for Network Providers

The Contractor shall require that providers offer hours of operation for Individuals that are no less than the hours of operation offered to any other Individual.

62. Section 6, Access to Care and Provider Network, Subsection 6.4 Customer Service, is amended to read as follows:

6.4 Customer Service

The Contractor shall have a single toll-free number for Individuals to call regarding services, at its expense, which shall be a separate and distinct number from the Contractor's regional crisis toll free telephone

number(s). The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8:00 a.m. to 5:00 p.m. Pacific Time, or alternative hours as agreed to by HCA, Monday through Friday, year round and shall provide customer service on all dates recognized as work days for state employees. The Contractor shall report to HCA by December 1 of each year its scheduled non-Business Days for the upcoming calendar year.

6.4.1 The Contractor must notify HCA five (5) Business Days in advance of any non-scheduled closure during scheduled Business Days, except in the case when advance notification is not possible due to emergency conditions.

6.4.2 The Contractor and its Individual customer service centers, if any, shall comply with the following performance standards:

6.4.2.1 Telephone abandonment rate – performance standard is 5 percent or less.

6.4.2.2 Telephone response time – performance standard is at least 90 percent of calls are answered within thirty (30) seconds.

6.4.3 The Contractor shall staff its call center with a sufficient number of trained customer service representatives to answer the phones. Staff shall be able to access information regarding eligibility requirements and benefits; GFS/FBG services; refer for behavioral health services; and resolve Grievances and triage Appeals.

6.4.4 The Contractor shall develop and maintain customer service policies and procedures that address the following:

6.4.4.1 Information on Contracted Services including where and how to access them;

6.4.4.2 Authorization requirements; and

6.4.4.3 Requirements for responding promptly to family members and supporting links to other service systems such as Medicaid services administered by the AH-IMC MCO, First Responders, criminal justice system, Tribal governments, IHCPs, and social services.

6.4.5 Providing Individuals with access to qualified clinicians without placing the Individual on hold. The clinician shall assess the crisis and warm transfer the call to a DCR, call 911, refer the Individual for services or to his or her provider, or resolve the crisis.

6.4.6 The Contractor shall train customer service representatives on GFS/FBG policies and procedures.

63. Section 6, Access to Care and Provider Network, Subsection 6.5 Priority Populations and Waiting Lists, is amended to read as follows:

6.5 Priority Populations and Waiting Lists

6.5.1 For SABG services:

6.5.1.1 SABG services shall be provided in the following priority order to:

6.5.1.1.1 Pregnant Individuals injecting drugs.

6.5.1.1.2 Pregnant Individuals with SUD.

6.5.1.1.3 Women with dependent children.

6.5.1.1.4 Individuals who are injecting drugs or substances.

6.5.1.2 The following are additional priority populations for SABG services, in no particular order:

6.5.1.2.1 Postpartum women up to one (1) year, regardless of pregnancy outcome).

6.5.1.2.2 Individuals transitioning from residential care to outpatient care.

6.5.1.2.3 Youth.

6.5.1.2.4 Offenders.

6.5.2 The Contractor will implement protocols for maintaining Waiting Lists and providing Interim Services for members of SABG priority populations, who are eligible but for whom SUD treatment services are not available due to limitations in provider capacity or Available Resources.

64. Section 6, Access to Care and Provider Network, Subsection 6.6 Access to SABG Services, is amended to read as follows:

6.6 Access to SABG Services

6.6.1 The Contractor shall, within Available Resources, ensure that SABG services are not denied to any eligible Individuals regardless of:

6.6.1.1 The Individual's drug(s) of choice.

6.6.1.2 The fact that an Individual is taking FDA approved medically-prescribed medications.

6.6.1.3 The fact that an Individual is using over-the-counter nicotine cessation medications or actively participating in a nicotine replacement therapy regimen.

6.6.2 The Contractor shall, as required by the SABG Block Grant, ensure Interim Services are provided for Pregnant and Post-partum Women and Individuals Using Intravenous Drugs (IUID).

6.6.2.1 Interim Services shall be made available within forty-eight (48) hours of seeking treatment. The Contractor shall document the provision of Interim Services. Interim Services shall include, at a minimum:

6.6.2.1.1 Counseling on the effects of alcohol and drug use on the fetus for pregnant women.

6.6.2.1.2 Referral for prenatal care.

6.6.2.1.3 Human immunodeficiency virus (HIV) and tuberculosis (TB) education.

6.6.2.2 TB treatment services if necessary IUID.

6.6.2.3 Admission to treatment services for the intravenous drug user shall be provided within fourteen (14) calendar days after the Individual makes the request, regardless of funding source.

6.6.2.4 If there is no treatment capacity within fourteen (14) calendar days of the initial Individual request, offer or refer the Individual to Interim Services within forty-eight (48) hours of the initial request for treatment services.

6.6.3 A pregnant Individual who is unable to access residential treatment due to lack of capacity and is in need of withdrawal management, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within 24 hours.

6.6.4 Capacity Management (42 U.S.C. 300-23 and 42 U.S.C. 300X 27)

6.6.4.1 The Contractor must notify HCA, in writing, when its network of SABG providers is at 90 percent capacity.

6.6.4.2 On a quarterly basis, submit Exhibit D, SABG Capacity Management Form on the last day of the month following the close of the quarter.

6.6.4.3 The Capacity Management Form must identify PPW and IUID providers receiving SABG funds, who are at 90 percent capacity, and what action was taken to address capacity.

6.6.5 Tuberculosis Screening, Testing and Referral (42 U.S.C. 300x-24(a) and 45 C.F.R. § 96.127)

6.6.5.1 The Contractor must directly or through arrangement with other public entities, make tuberculosis services available to each Individual receiving SABG-funded SUD treatment. The services must include tuberculosis counseling, testing, and provide for or refer Individuals with tuberculosis for appropriate medical evaluation and treatment.

6.6.5.2 When an Individual is denied admission to the tuberculosis program because of the lack of capacity, the Contractor will refer the Individual to another provider of tuberculosis services.

6.6.5.3 The Contractor must conduct case management activities to ensure the Individual receives tuberculosis services.

6.6.6 Outreach to Individuals Using Intravenous Drugs (IUID)

6.6.6.1 The Contractor shall ensure that Opioid Dependency Outreach is provided to IUID. (45 C.F.R. § 96.126)(e)).

65. Section 7, Quality Assessment and Performance Improvement, Subsection 7.1 Quality Management Program, is amended to read as follows:

7.1 Quality Management Program

7.1.1 The Contractor shall ensure its Quality Management (QM) program addresses the following elements:

7.1.1.1 GFS/FBG requirements according to this Contract and meets Crisis Services Performance Measures, described in this Contract and Exhibit F, Federal Block Grant Annual Progress Report. It shall be the obligation of the Contractor to remain current with all GFS/FBG requirements;

7.1.1.2 Goals and interventions to improve the quality of care received;

7.1.1.3 Service to culturally and linguistically diverse Individuals;

7.1.1.4 Inclusion of Individual voice and experiences. This may include feedback and grievance data from the Ombuds;

7.1.1.5 Inclusion of provider voice and experience, which may include feedback through involvement in Contractor committees, provider complaints, and provider appeals; and

7.1.1.6 Involvement of Contractor's Behavioral Health Medical Director in the QM program.

7.1.2 The Contractor shall participate in a Community Behavioral Health Advisory Board (BHAB) and attend meetings as required by established bylaws.

66. Section 7, Quality Assessment and Performance Improvement, Subsection 7.2 Quality Review Activities, is amended to read as follows:

7.2 Quality Review Activities

7.2.1 The Contractor shall submit to annual compliance monitoring reviews by HCA. The monitoring review process and examination shall be implemented and conducted by HCA or its agent using standards established by HCA. Results are used to identify and correct problems and to improve care and services to Individuals served by this Contract.

7.2.2 If the Contractor has had an accreditation review or visit by the National Committee for Quality Assurance (NCQA) or another accrediting body, the Contractor shall provide the complete report from that organization to HCA. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with the HCA compliance monitoring review as needed to reduce duplicated work for both the Contractor and the state.

7.2.3 The HCA, Office of the State Auditor, or any of their duly-authorized representatives, may conduct announced and unannounced:

7.2.3.1 Surveys, audits, and reviews of compliance with licensing and certification requirements and the terms of this Contract.

7.2.3.2 Audits regarding the quality, appropriateness, and timeliness of behavioral health services provided under this Contract.

7.2.3.3 Audits and inspections of financial records.

7.2.4 The Contractor shall participate with HCA in Quality Review activities. Participation will include at a minimum:

7.2.4.1 The submission of requested materials necessary for an HCA initiated review within thirty (30) calendar days of the request.

7.2.4.2 The completion of site visit protocols provided by HCA.

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

7.2.5 The Contractor shall notify HCA immediately when any entity other than the State Auditor gives notice of an audit related to any activity contained in this Contract.

67. Section 7, Quality Assessment and Performance Improvement, Subsection 7.3 Performance-Measurement and Crisis System Reporting, is amended to read as follows:

7.3 Performance-Measurement and Crisis System Reporting

7.3.1 At HCA's discretion, individual performance measures will be linked to potential payment adjustments.

7.3.2 The Contractor shall comply with the reporting and data submissions requirements as directed by HCA.

7.3.3 For each RSA, the Contractor shall provide crisis system reports to include Exhibit E, Crisis System quarterly reports due by the last day of the month following each quarter and Exhibit E, Crisis System annual reports due by January 31 for the previous calendar year. The Contractor must use HCA provided Exhibit E reporting template for the quarterly reports and submit the reports to HCA at hcabhaso@hca.wa.gov.

68. Section 7, Quality Assessment and Performance Improvement, Subsection 7.4 Critical Incident Reporting, subsection 7.4.2 is amended to read as follows:

7.4.2 Individual Critical Incident Reporting

7.4.2.1 The Contractor shall submit an Individual Critical Incident report for the following incidents that occur:

7.4.2.1.1 To an Individual receiving BH-ASO funded services, and occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider.

7.4.2.1.1.1 Abuse, neglect, or sexual/financial exploitation; and

7.4.2.1.1.2 Death.

7.4.2.1.2 By an Individual receiving BH-ASO funded services, with a behavioral health diagnosis, or history of behavioral health treatment within the previous 365 days. Acts allegedly committed, to include:

7.4.2.1.2.1 Homicide or attempted homicide;

7.4.2.1.2.2 Arson;

7.4.2.1.2.3 Assault or action resulting in serious bodily harm which has the potential to cause prolonged disability or death;

7.4.2.1.2.4. Kidnapping; and

7.4.2.1.25 Sexual assault.

7.4.2.1.3 Unauthorized leave from a behavioral health facility during an involuntary detention, when funded by the BH-ASO

7.4.2.1.4 Any event involving an Individual that has attracted or is likely to attract media coverage, when funded by the BH-ASO. (Contractor shall include the link to the source of the media, as available).

7.4.2.2 The Contractor shall report critical incidents within one (1) Business Day of becoming aware of the incident and shall report incidents that have occurred within the last thirty (30) calendar days, with the exception of incidents that have resulted in or are likely to attract media coverage. Media related incidents should be reported to HCA as soon as possible, not to exceed one (1) Business Day.

7.4.2.2.1 The Contractor shall enter the initial report, follow-up, and actions taken into the HCA Incident Reporting System https://fortress.wa.gov/hca/ics/, using the report template within the system.

7.4.2.2.2 If the system is unavailable the Contractor shall report Critical Incidents to HCABHASO@hca.wa.gov.

7.4.2.2.2.1 HCA may ask for additional information as required for further research and reporting. The Contractor shall provide information within three (3) business days of HCA's request.

69. Section 7, Quality Assessment and Performance Improvement, Subsection 7.6 Health Information Systems, is amended to read as follows:

7.6 Health Information Systems

The Contractor shall establish and maintain, and shall require Subcontractors to maintain, a health information system that complies with the requirements of the Office of the Chief Information Officer (OCIO) Security Standard 141.10, and the Data, Security and Confidentiality Exhibit, and provides the information necessary to meet the Contractor's obligations under this Contract. OCIO Security Standards are available at: https://ocio.wa.gov.

The Contractor shall have in place mechanisms to verify the health information received from Subcontractors. The Contractor shall:

7.6.1 Collect, analyze, integrate, and report data. The system must provide information on areas including, but not limited to utilization, and fund availability by service type and fund source.

7.6.2 Ensure data received from providers is accurate and complete by:

7.6.2.1 Verifying the accuracy and timeliness of reported data;

7.6.2.2 Screening the data for completeness, logic and consistency; and

7.6.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.

7.6.3 Make all collected data available to HCA upon request, to the extent permitted by the HIPAA Privacy Rule (45 C.F.R. Part 160 and Subparts A and E of Part 164 and RCW 70.02.005).

7.6.4 Establish and maintain protocols to support timely and accurate data exchange with any Subcontractor that will perform any delegated functions under the Contract. Adding information to the portal shall not be a barrier to providing a necessary Crisis Service.

7.6.5 Establish and maintain web-based portals with appropriate security features that allow referrals, requests for prior authorizations, claims/encounters submission, and claims/encounters status updates.

7.6.6 Have information systems that enable paperless submission, automated processing, and status updates for prior authorization and other utilization management related requests.

7.6.7 Maintain behavioral health content on a website that meets the following minimum requirements.

7.6.7.1 Public and secure access via multi-level portals for providing web-based training, standard reporting, and data access for the effective management and evaluation of the performance of the Contract and the service delivery system as described under this Contract.

7.6.7.2 The Contractor shall organize the website to allow for easy access of information by Individuals, family members, network providers, stakeholders and the public in compliance with the ADA. The Contractor shall include on its website, at a minimum, the following information or links:

7.6.7.2.1 Hours of operations;

7.6.7.2.2 How to access information on Contracted Services and toll-free crisis telephone numbers;

7.6.7.2.3 Telecommunications device for the deaf/text telephone numbers;

7.6.7.2.4 Information on the right to choose a qualified behavioral health service provider, including IHCPs, when available and medically necessary; and

7.6.7.2.5 An overview of the range of behavioral health services being provided.

70. Section 7, Quality Assessment and Performance Improvement, Subsection 7.7 Required Reporting for Behavioral Health Services, is amended to read as follows:

7.7 Required Reporting for Behavioral Health Services

7.7.1 The Contractor’s disclosure of individually identifiable information is authorized by law. This includes 42 C.F.R. § 2.53, authorizing disclosure of an Individual’s records for purposes of Medicaid evaluation.

7.7.2 The Contractor must comply with behavioral health reporting requirements, including SERI. Beginning October 1, 2020, the Contractor must begin reporting of Behavioral Health Supplemental Transactions using the BHDS. The first report must include data going back to January 1, 2020. A test batch must be sent no later than September 1, 2020. Reporting includes

encounters and Behavioral Health Supplemental Transactions documenting services paid for by the Contractor and delivered to Individuals during a specified reporting period.

7.7.2.1 The Contractor shall request technical assistance from HCA as needed. HCA will respond within two to three business days of a request for technical assistance by the Contractor. The Contractor is responsible for providing technical assistance as needed to Subcontractors and Providers.

7.7.3 Behavioral Health Supplemental Transaction Data Submission and Error Correction

7.7.3.1 The Contractor must submit Behavioral Health Supplemental Transactions about Individuals to the BHDS within thirty (30) calendar days of collection or receipt from subcontracted providers.

7.7.3.2 Upon receipt of data submitted, the BHDS generates error reports. The Contractor must have documented policies and procedures to assure that data submitted and rejected due to errors are corrected and resubmitted within thirty (30) calendar days.

7.7.3.3 The Contractor must implement changes documented in any updated version of the BHDS Guide within one hundred twenty (120) calendar days from the date published.

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

7.7.3.4 The Contractor must send at least one test batch of data containing the required changes. The test batch must be received no later than fifteen (15) calendar days prior to the implementation date.

7.7.3.4.1 The test batch must include one hundred (100) transactions that include information effected by the change.

7.7.3.4.2 The processed test batch must result in at least 80 percent successfully posted transactions or an additional test batch is required.

7.7.3.5 The Contractor must respond to requests from HCA for behavioral health information not previously reported in a timeframe determined by HCA that will allow for a timely response to inquiries from CMS, SAMHSA, the legislature, and other parties.

7.7.4 The Contractor shall continue to report to HCA data related to ITA investigations and detentions under Chapter 71.05 and 71.34 RCW within 24 hours.

7.7.5 The following are the required reporting from BHDS Guide:

7.7.5.1 For each RSA, the Contractor must collect and report to HCA all applicable transactions described in the most recent BHDS guide. The BHDS guide describes the content of the transactions, and requirements for frequency and timeliness of reporting.

7.7.5.2 All reporting must be done via a flat file in the format and with the acceptable data values prescribed in the BHDS guide.

7.7.5.3 Throughout the BHDS Guide, the term BH-ASO means the same as the Contractor.

7.7.5.4 The transactions identified in the BHDS Guide as “DCR Investigation” and “ITA Hearing” must be submitted by the BH-ASO in accordance with RCW 71.05.740. The BH-ASO is also responsible for making any needed correction of this data within five (5) business days from the date of notification of the error.

71. Section 7, Quality Assessment and Performance Improvement, a new Subsection 7.8 Encounter Data is added as follows:

7.8 Encounter Data

The Contractor shall submit and maintain accurate, timely and complete data. The Contractor shall comply with the following:

7.8.1 Designate a person dedicated to work collaboratively with HCA on quality control and review of encounter data submitted to HCA.

7.8.2 Submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA. The Contractor shall submit encounter data using assigned program identifiers. The data shall adhere to the following data quality standards:

7.8.2.1 Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter. The Contractor shall submit to HCA, without alteration, omission, or splitting, all available claim data in its entirety from the provider’s original claim submission to the Contractor;

7.8.2.2 Submitted encounters and encounter records must pass all HCA ProviderOne system edits with a disposition of accept as listed in the Encounter Data Reporting Guide or sent out in communications from HCA to the Contractor; and

7.8.2.3 Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.

7.8.2.4 The data quality standards listed within this Contract and incorporated by reference into this Contract. The Contractor shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with HCA’s data quality standards as defined and subsequently amended.

7.8.3 HCA shall perform encounter data quality reviews to ensure receipt of complete and accurate encounter data for program administration and rate setting.

7.8.4 The Contractor must certify the accuracy and completeness of all data concurrently with each file upload. The certification must affirm that:

7.8.4.1 The Contractor has reported to HCA for the month of (indicate month and year) all paid claims for all claim types; and

7.8.4.2 The Contractor has reviewed the claims data for the month of submission;

7.8.4.3 The Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer is the individual certifying the submission.

7.8.4.3.1 The individual certifying must attest that based on the best knowledge, information, and belief as of the date indicated, all information submitted to HCA in the submission is accurate, complete, truthful, and no material fact has been omitted from the submission.

7.8.4.3.2 The certification must indicate if the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the encounter data submission.

7.8.5 HCA collects and uses this data for many reasons such as: Audits, investigations, identifications of improper payments and other program integrity activities, federal reporting, rate setting and risk adjustment, service verification, quality improvement program, utilization patterns and access to care; HCA hospital rate setting; pharmacy rebates, and research studies.

7.8.6 Additional detail can be found in the Encounter Data Reporting Guide and SERI Guide published by HCA and incorporated by reference into this Contract.

7.8.6.1 HCA may change the Encounter Data Reporting Guide and SERI Guide with ninety (90) calendar days' written notice to the Contractor.

7.8.6.2 The Encounter Data Reporting Guide and SERI Guide may be changed with less than ninety (90) calendar days' notice by mutual agreement of the Contractor and HCA.

7.8.6.3 The Contractor shall, upon receipt of such notice from HCA, provide notice of changes to subcontractors.

7.8.7 The Contractor shall ensure that final reporting of encounters for services provided under this Contract shall occur no more than ninety (90) calendar days after the end of each fiscal year of this Contract.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

72. Section 8, Policies and Procedures, is amended to read as follows:

8.1 Policies and Procedures Requirements

8.1.1 The Contractor shall develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of this Contract.

8.1.2 The Contractor shall submit policies and procedures to HCA for review upon request by HCA and any time there is a new policy and procedure or there is a substantive change to an existing policy and procedure.

8.1.3 The Contractor shall provide all relevant policies and procedures to its providers and Subcontractors, including but not limited to: billing, critical incidents, and other reporting requirements.

8.1.4 The Contractor's policies and procedures shall:

8.1.4.1 Direct and guide the Contractor's employees, Subcontractors, and any non-contracted providers' compliance with all applicable federal, state, and contractual requirements.

8.1.4.2 Comply with the Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's Regional Service Area.

8.1.4.3 Fully articulate the requirements.

8.1.4.4 Have an effective training plan related to the requirements and maintain records of the number of staff participating in training, including evidence of assessment of participant knowledge and satisfaction with the training.

8.1.4.5 Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

73. Section 9, Subcontracts, Subsection 9.3 Required Provisions, is amended to read as follows:

9.3 Required Provisions

9.3.1 Subcontracts shall be in writing, and available to HCA upon request. All Subcontracts shall contain the following provisions in addition to applicable provisions contained in this Contract:

9.3.1.1 Identification of the parties of the Subcontract and their legal basis for operation in the state of Washington.

9.3.1.2 The process for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

9.3.1.3 Procedures and specific criteria for terminating the Subcontract.

9.3.1.4 Identification of the services to be performed by the Subcontractor and which of those services may be subcontracted by the Subcontractor. If the Contractor allows the Subcontractor to further subcontract, all Subcontractor requirements contained in this Contract must be propagated downward into any other lower tiered Subcontracts (45 C.F.R. § 92.35).

9.3.1.5 Reimbursement rates and procedures for services provided under the Subcontract, including the use of the Contractor's own fee schedule for all services provided, other than for psychiatric inpatient services provided in a community hospital.

9.3.1.6 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.

9.3.1.7 Reasonable access to facilities, and financial and medical records for duly authorized representatives of HCA or DOH for audit purposes and immediate access for Medicaid Fraud investigators.

9.3.1.8 The requirement to submit complete and accurate reports and data required under the Contract, including encounter data that complies with HCA SERI Guide, HCA Encounter Data Reporting Guide (EDRG), and Behavioral Health Supplemental Transactions that complies with the BHDS Guide, to the Contractor. The Contractor shall ensure that all Subcontractors required to report encounter and Behavioral Health Supplemental Transactions data have the capacity to submit all HCA required data to enable the Contractor to meet the requirements under the Contract.

9.3.1.9 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved Program Integrity policies and procedures.

9.3.1.10 The requirement to refer potential allegations of Fraud to HCA and as described in Section 12 of this Contract.

9.3.1.11 A requirement to comply with the applicable state and federal statutes, rules and Regulations as set forth in this Contract.

9.3.1.12 A requirement to comply with any term or condition of this Contract that is applicable to the services to be performed under the Subcontract.

9.3.2 The Contractor shall provide the following information regarding the Grievance and Appeal System for GFS/FBG funded Contracted Services to all Subcontractors:

9.3.2.1 The toll-free numbers to file oral Grievances and Appeals

9.3.2.2 The availability of assistance in filing a Grievance or Appeal.

9.3.2.3 The Individual's right to file Grievances and Appeals and their requirements and timeframes for filing.

9.3.2.4 The Individual's right to an Administrative Hearing, how to obtain an Administrative Hearing and representation rules at an Administrative Hearing.

9.3.3 The Contractor may not delegate its responsibility to contract with a provider network. This does not prohibit a contracted, licensed provider from subcontracting with other appropriately licensed providers so long as the subcontracting provisions of this Contract are met.

9.3.4 The responsibilities found in the Quality Management Section in this Contract may not be delegated to a contracted network Behavioral Health Agency.

9.3.5 HCA may place limits on delegating financial risk to any Subcontractor in any amount, and is subject to review and approval by HCA.

74. Section 9, Subcontracts, Subsection 9.4 Management of Subcontracts, is amended to read as follows:

9.4 Management of Subcontracts

9.4.1 The Contractor shall evaluate any prospective Subcontractor's ability to perform the activities for which that Subcontractor is contracting, including the Subcontractor's ability to perform delegated activities described in the Subcontracting document.

9.4.2 FBG funds may not be used to pay for services provided prior to the execution of Subcontracts, or to pay in advance of service delivery.

9.4.3 The Contractor shall not provide GFS or FBG funds to a county, unless a county is a licensed service provider and is providing direct services.

75. Section 9, Subcontracts, Subsection 9.5 Provider Subcontracts, is amended to read as follows:

9.5 Provider Subcontracts

The Contractor's Subcontracts shall contain the following provisions:

9.5.1 A statement that Subcontractors receiving GFS or FBG funds shall cooperate with the Contractor or HCA-sponsored Quality Improvement (QI) activities.

9.5.2 A means to keep records necessary to adequately document services provided to Individuals for all delegated activities including QI, Utilization Management, and Individual Rights and Protections.

9.5.3 For providers, a requirement to provide discharge planning services which shall, at a minimum:

9.5.3.1 Coordinate a community-based discharge plan for each Individual served under this Contract beginning at intake. Discharge planning shall apply to all Individuals regardless of length of stay or whether they complete treatment.

9.5.3.2 Coordinate exchange of assessment, admission, treatment progress, and continuing care information with the referring entity. Contact with the referral agency shall be made within the first week of residential treatment.

9.5.3.3 Establish referral relationships with assessment entities, outpatient providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of entities making referrals in treatment activities;

9.5.3.4 Coordinate, as needed, with DBHR prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including the DCYF, and the DSHS Economic Services Administration including Community Service Offices (CSOs), Tribal governments and non-Tribal IHCPs.

9.5.3.5 Coordinate services to financially-eligible Individuals who are in need of medical services.

9.5.4 A requirement that residential treatment providers ensure that priority admission is given to the populations identified in this contract.

9.5.5 Requirements for information and data sharing to support Care Coordination consistent with this Contract.

9.5.6 A requirement to implement a Grievance Process that complies with WAC 182-538C-110 and as described in the Grievance and Appeal System Section of this Contract.

9.5.7 A requirement that termination of a Subcontract shall not be grounds for an Appeal, Administrative Hearing, or a Grievance for the Individual if similar services are immediately available in the service area.

9.5.8 Requirements for how Individuals will be informed of their right to a Grievance or Appeal in the case of:

9.5.8.1 Denial or termination of service related to medical necessity determinations.

9.5.8.2 Failure to act upon a request for services with reasonable promptness.

9.5.9. A requirement that the Subcontractor shall comply with Chapter 71.32 RCW (Mental Health Advance Directives).

9.5.10 A requirement to provide Individuals access to translated information and interpreter services as described in the Materials and Information Section of this Contract.

9.5.11 A requirement for adherence to established protocols for determining eligibility for services consistent with this Contract.

9.5.12 A requirement to use the Integrated Co-Occurring Disorder Screening Tool (GAIN-SS found at https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/gain-ss). The Contractor shall include requirements for training staff that will be using the tool(s) to address the screening and assessment process, the tool and quadrant placement as well as requirements for corrective action if the process is not implemented and maintained throughout the Contract's period of performance.

9.5.13 A requirement for subcontracted staff to participate in training when requested by HCA. Exceptions must be in writing and include a plan for how the required information shall be provided to them.

9.5.14 A requirement to conduct criminal background checks and maintain related policies and procedures and personnel files consistent with requirements in Chapter 43.43 RCW and, Chapter 246-341 WAC.

9.5.15 Requirements for nondiscrimination in employment and Individual services.

9.5.16 Protocols for screening for Debarment and suspension of certification.

9.5.17 Requirements to identify funding sources consistent with the Payments and Sanctions Section of this Contract, FBG reporting requirements and the rules for payer responsibility found in the table "How do providers identify the correct payer" within the Apple Health Mental Health Services Billing Guide.

9.5.18 A requirement to participate in the peer review process when requested by HCA. (42 U.S.C. § 300x-53(a) and 45 C.F.R. § 96.136). The MHBG and SABG Block Grant requires an annual peer review by individuals with expertise in the field of drug abuse treatment (for SABG) and individuals with expertise in the field of mental health treatment consisting (for MHBG). At least 5 percent of treatment providers will be reviewed.

9.5.19 The Contractor shall ensure that the Charitable Choice Requirements of 42 C.F.R. Part 54 are followed and that Faith-Based Organizations (FBO) are provided opportunities to compete with SUD providers for funding.

9.5.20 If the Contractor Subcontracts with FBOs, the Contractor shall require the FBO to meet the requirements of 42 C.F.R. Part 54 as follows:

9.5.20.1 Individuals requesting or receiving SUD services shall be provided with a choice of SUD treatment providers.

9.5.20.2 The FBO shall facilitate a referral to an alternative provider within a reasonable time frame when requested by the recipient of services.

9.5.20.3 The FBO shall report to the Contractor all referrals made to alternative providers.

9.5.20.4 The FBO shall provide Individuals with a notice of their rights.

9.5.20.5 The FBO provides Individuals with a summary of services that includes any religious activities.

9.5.20.6 Funds received from the FBO must be segregated in a manner consistent with federal Regulations.

9.5.20.7 No funds may be expended for religious activities.

9.5.21 A requirement that the Subcontractor shall respond with all available records in a timely manner to law enforcement inquiries regarding an Individual's eligibility to possess a firearm under RCW 9.41.040(2)(C)(iv)

9.5.21.1 The Contractor shall report new commitment data within 24 hours. Commitment information under this Section does not need to be re-sent if it is already in the possession of HCA. The Contractor and HCA shall be immune from liability related to the sharing of commitment information under this Section (RCW 71.05.740).

9.5.22 Delegated activities are documented and agreed upon between Contractor and Subcontractor. The document must include:

9.5.22.1 Assigned responsibilities.

9.5.22.2 Delegated activities.

9.5.22.3 A mechanism for evaluation.

9.5.22.4 Corrective action policy and procedure.

9.5.23 A requirement that information about Individuals, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and Regulations.

9.5.24 The Subcontractor agrees to hold harmless HCA and its employees, and all Individuals served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which

may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors.

9.5.25 A ninety (90) calendar day termination notice provision.

9.5.26 A specific provision for termination with short notice when a Subcontractor is excluded from participation in the Medicaid program.

9.5.27 The Subcontractor agrees to comply with the appointment wait time standards of this Contract. The Subcontract must provide for regular monitoring of timely access and corrective action if the Subcontractor fails to comply with the appointment wait time standards.

9.5.28 A provision for ongoing monitoring and compliance review when the Contractor identifies deficiencies or areas requiring improvement and provide for corrective action.

9.5.28.1 The Contractor shall ensure that Subcontractors have complied with data submission requirements established by HCA for all services funded under the Contract.

9.5.28.2 The Contractor shall ensure that the Subcontractor updates Individual funding information when the funding source changes.

9.5.28.3 The Contractor shall maintain written or electronic records of all Subcontractor monitoring activities and make them available to HCA upon request.

9.5.29 A statement that Subcontractors shall comply with all applicable required audits including authority to conduct a Facility inspection, and the federal OMB Super Circular, 2 C.F.R. § 200.501 and 45 C.F.R. § 75.501 audits.

9.5.29.1 The Contractor shall submit a copy of the OMB audit performed by the State Auditor to the HCA Contact identified on page one of the Contract within ninety (90) calendar days of receipt by the Contractor of the completed audit.

9.5.29.1.1 If a Subcontractor is subject to OMB Super Circular audit, the Contractor shall require a copy of the completed Single Audit and ensure corrective action is taken for any audit finding, per OMB Super Circular requirements.

9.5.29.1.2 If a Subcontractor is not subject to OMB Super Circular, the Contractor shall perform sub-recipient monitoring in compliance with federal requirements.

9.5.30 The Contractor shall document and confirm in writing all single-case agreements with providers. The agreement shall include:

9.5.30.1 The description of the services;

9.5.30.2 The authorization period for the services, including the begin date and the end date for approved services;

9.5.30.3 The rate of reimbursement for the service or reference to the Contractor’s fee schedule or other documents that define payment; and

9.5.30.4 Any other specifics of the negotiated rate.

9.5.31 The Contractor must supply documentation to the Subcontractor no later than five (5) Business Days following the signing of the agreement. Updates to the unique contract, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).

9.5.32 The Contractor shall maintain a record of the single-case agreements for a period of six (6) years.

76. Section 9, Subcontracts, Subsection 9.6 Federal Block Grant (FBG) Subcontracts and Subcontract Monitoring, is amended to read as follows:

9.6 Federal Block Grant (FBG) Subcontracts and Subcontract Monitoring

9.6.1 All activities and services performed in accordance with this Contract, which are not performed directly by the Contractor, must be subcontracted according to the terms set forth by the Community BHAB-approved MHBG project plan or SABG project plan.

9.6.2 FBG funds may not be used to pay for services provided prior to the execution of Subcontracts, or to pay in advance of service delivery. All Subcontracts and amendments must be in writing and executed by both parties prior to any services being provided.

9.6.3 FBG FFS, set rate, performance-based, Cost Reimbursement, and lump sum Subcontracts shall be based on reasonable costs.

9.6.4 The Contractor shall retain, on site, all Subcontracts. Upon request by HCA, the Contractor will immediately make available any and all copies, versions, and amendments of Subcontracts.

9.6.5 The Contractor shall submit to HCA Certification in writing that the Subcontractor meets all requirements under the Contract and that the Subcontract contains all required language under the Contract, including any data security, confidentiality, and/or Business Associate language as appropriate.

9.6.6 The Contractor shall ensure that its Subcontractors receive an independent audit if the Subcontractor expends a total of $750,000 or more in federal awards from any and/or all sources in any state fiscal year. The Contractor shall require all Subcontractors submit to the Contractor the data collection form and reporting package specified in 2 C.F.R. Part 200, Subpart F, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor within ten (10) business days of audit reports being completed and received by Subcontractors. The Contractor shall follow up with any corrective actions for all Subcontractor audit findings in accordance with 2 C.F.R. Part 200, Subpart F. The Contractor shall retain documentation of all Subcontractor monitoring activities; and, upon request by HCA, shall immediately make all audits and/or monitoring documentation available to HCA.

9.6.7 The Contractor shall conduct and/or make arrangements for an annual fiscal review of each Subcontractor receiving FBG funds regardless of reimbursement methodology (e.g., through fee-for-service, set rate, performance-based or cost reimbursement Subcontracts), and shall provide HCA with documentation of these annual fiscal reviews upon request. The annual fiscal review shall ensure that:

9.6.7.1 Expenditures are accounted for by revenue source

9.6.7.2 No expenditures were made for items identified in the Payment and Sanctions Section of this Contract.

9.6.7.3 Expenditures are made only for the purposes stated in this Contract, and for services that were actually provided.

77. Section 9, Subcontracts, a new Subsection 9.7 Subcontracts with Indian Health Care Providers is added as follows:

9.7 Subcontracts with Indian Health Care Providers

9.7.1 The Contractor shall coordinate with and pay all IHCPs enrolled with the HCA who provide a service to an Individual under this Contract regardless of the IHCP's decision whether to subcontract.

9.7.2 If, at any time during the term of this Contract, an IHCP submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such IHCP's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the IHCP. The Contractor will offer and negotiate contracts in good faith to all IHCPs, including any tribal care coordination or related services. To be offered in good faith, a Contractor must offer contract terms comparable to terms that it offers to a similarly-situated non-IHCP provider, except for terms that would not be applicable to an IHCP, such as by virtue of the types of services that an IHCP provides. The Contractor will provide verification of such offers on request for the state to verify compliance with this provision.

9.7.2.1 The subcontract must reference the IHCP's ability to submit complaints to the HCA for resolution and for the HCA to facilitate resolution directly with the Contractor.

9.7.3 Any subcontracts with IHCP must be consistent with the laws and regulations that are applicable to the IHCP.

9.7.4 In the event that the Contractor and the IHCP fail to reach an agreement on a subcontract within ninety (90) calendar days from the date of the IHCP's written request, the IHCP may request HCA assistance in facilitating resolution. Executive leadership of the Contractor must attend this meeting in person and be permitted to have legal counsel present.

9.7.5 The Contractor will include reference in any contract between the Contractor and the IHCP to the Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's Regional Service Area.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

78. Section 9, Subcontracts, Subsection 9.9 Provider Education, is amended to read as follows:

9.9 Provider Education

9.9.1 The Contractor shall inform GFS and FBG providers in writing regarding these requirements:

9.9.1.1 Contracted Services for Individuals served under this Contract.

9.9.1.2 Coordination of care requirements.

9.9.1.3 HCA and the Contractor's policies and procedures as related to this Contract.

9.9.1.4 Data interpretation.

9.9.1.5 Practice guidelines as described in the provisions of this Contract.

9.9.1.6 Requirements for Utilization Management (UM) decision making, procedure coding, and submitting claims for GFS and FBG funded services.

9.9.1.7 Care management staff who can assist in care transitions and care management activity.

9.9.1.8 Program Integrity requirements.

9.9.1.9 Ensure Contractor sponsored Certified Peer Counselor trainings are offered in accordance with DBHR policies. Policy requirements include the use of DBHR approved curriculum, trainers, testers and applicants.

9.9.1.10 The Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's Regional Service Area.

79. Section 9, Subcontracts, Subsection 9.11 Coordination of Benefits (DOB) and Subrogation of Rights of Third Party Liability, is amended to read as follows:

9.11 Coordination of Benefits (DOB) and Subrogation of Rights of Third Party Liability

9.11.1 Coordination of Benefits:

9.11.1.1 The services and benefits available under this Contract shall be secondary to any other coverage.

9.11.1.2 Nothing in this Section negates any of the Contractor's responsibilities under this Contract. The Contractor shall:

9.11.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable COB rules in WAC 284-51.

9.11.1.2.2 Attempt to recover any third-party resources available to Individuals and make all records pertaining to COB collections for Individuals available for audit and review.

9.11.1.2.3 Pay claims for Contracted Services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed.

9.11.1.2.4 Coordinate with out-of-network providers with respect to payment to ensure the cost to Individuals is no greater than it would be if the services were furnished within the network.

9.11.1.2.5 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

9.11.1.2.6 Ensure subcontracts require the pursuit and reporting of all third party revenue related to services provided under this agreement, including pursuit of FFS Medicaid funds provided for AI/AN Individuals who did not opt into managed care.

80. Section 9, Subcontracts, Subsection 9.14 Provider Credentialing, is amended to read as follows:

9.14 Provider Credentialing

9.14.1 The Contractor shall collaborate with HCA to establish uniform provider credentialing policies and procedures to contribute to reducing provider burden. The Contractor's policies and procedures shall follow the State's requirements, which are in accordance with standards defined by the NCQA, related to the credentialing and re-credentialing of Health Care Professionals who have signed contracts or participation agreements with the Contractor (Chapter 246-12 WAC). Credentialing processes support administrative simplification efforts through OneHealthPort's credentialing portal.

9.14.2 Beginning January 1, 2021, the Contractor shall implement credentialing and recredentialing processes consistent with HCA requirements described below. The Contractor's policies and procedures shall ensure compliance with requirements described in this Section.

9.14.2.1 The Contractor shall verify that all Subcontractors meet the licensure and certification requirements as established by state and federal statute, administrative code, or as directed in this Contract.

9.14.2.2 The Contractor's behavioral health medical director shall have direct responsibility for and participation in the credentialing program.

9.14.2.3 The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.

9.14.2.4 The Contractor may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.

9.14.2.5 The Contractor's credentialing and recredentialing program shall include:

9.14.2.5.1 Identification of the type of providers credentialed and recredentialed, including mental health and SUD providers.

9.14.2.5.2 Specification of the verification sources used to make credentialing and recredentialing decisions, including any evidence of provider sanctions.

9.14.2.5.3 Use and dissemination of the Washington Provider Application (WPA).

9.14.2.5.4 A process for provisional credentialing that affirms that:

9.14.2.5.4.1 The practitioner may not be held in a provisional status for more than sixty (60) calendar days; and

9.14.2.5.4.2 The provisional status will only be granted one time and only for providers applying for credentialing the first time.

9.14.2.5.4.3 Provisional credentialing shall include an assessment of:

9.14.2.5.4.3.1 Primary source verification of a current, valid license to practice;

9.14.2.5.4.3.2 Primary source verification of the past five (5) years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Databank query; and

9.14.2.5.4.3.3 A current signed application with attestation.

9.14.2.5.5 Prohibition against employment or contracting with providers excluded from participation in federal health care programs under federal law as verified through List of Excluded Individuals and Entities (LEIE).

9.14.2.5.6 A detailed description of the Contractor's process for delegation of credentialing and recredentialing to Subcontractors, if applicable.

9.14.2.5.7 Verification of provider compliance with all Program Integrity requirements in this Contract.

9.14.2.6 The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials shall include communication of the provider's rights to:

9.14.2.6.1 Review materials.

9.14.2.6.2 Correct incorrect or erroneous information.

9.14.2.6.3 Be informed of their credentialing status.

9.14.2.7 The Contractor's process for notifying providers within fifteen (15) calendar days of the credentialing committee's decision.

9.14.2.8 An appeal process for providers for quality reasons and reporting of quality issues to the appropriate authority and in accord with the Program Integrity requirements of this Contract.

9.14.2.9 The Contractor's process to ensure confidentiality.

9.14.2.10 The Contractor's process to ensure information provided to Individuals by the BH-ASO in accordance with the Information Requirements for Individuals subsection of this Contract are consistent with credentialing file content, including education, training, certification and specialty designation.

9.14.2.11 The Contractor's process for recredentialing providers, at minimum every thirty-six (36) months, through information verified from primary sources, unless otherwise indicated.

9.14.2.12 The Contractor's process to ensure that offices of Health Care Professionals meet office site standards established by the Contractor, allowing for on-site review for quality concerns.

9.14.2.13 The Contractor's system for monitoring sanctions, limitations on licensure, complaints and quality issues or information from identified adverse events and provide evidence of action, as appropriate based on defined methods or criteria.

9.14.2.14 The Contractor's process and criteria for assessing and reassessing organizational providers in which the Contractor:

9.14.2.14.1 Confirms that the provider is in good standing with state and federal regulatory bodies (e.g., verification of state licensure);

9.14.2.14.2 Confirms that the provider has been reviewed and approved by an accrediting body within the previous thirty-six (36) months; or

9.14.2.14.3 If the provider is not accredited within the last thirty-six (36) months, conducts an onsite quality assessment and verification of a process to ensure the organizational provider credentials its providers, which addresses review of providers operating under the license of a licensed or certified agency.

9.14.2.15 The criteria used by the Contractor to credential and recredential practitioners shall include:

9.14.2.15.1 Evidence of a current valid license or certification to practice;

9.14.2.15.2 A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate if applicable;

9.14.2.15.3 Evidence of appropriate education and training;

9.14.2.15.4 Board certification if applicable;

9.14.2.15.5 Evaluation of work history;

9.14.2.15.6 A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider; and

9.14.2.15.7 A signed, dated attestation statement from the provider that addresses:

9.14.2.15.7.1 The lack of present illegal drug use;

9.14.2.15.7.2 A history of loss of license and criminal or felony convictions;

9.14.2.15.7.3 A history of loss or limitation of privileges or disciplinary activity;

9.14.2.15.7.4 Current malpractice coverage;

9.14.2.15.7.5 Any reason(s) for inability to perform the essential functions of the position with or without accommodation; and

9.14.2.15.7.6 Accuracy and completeness of the application.

9.14.2.15.8 Verification that DCRs are authorized as such by the county authorities.

9.14.2.15.9 Verification of the: NPI, the provider's enrollment as a Washington Medicaid provider, and the Social Security Administration's death master file.

81. Section 10, Individual Rights and Protections, Subsection 10.2 Ombuds, is amended to read as follows:

10.2 Ombuds

10.2.1 The Contractor shall provide a regional behavioral health Ombuds with lived experience as described in Chapter 71.24 RCW. Contracting for Ombuds services shall include the following provisions:

10.2.1.1 Separation of personnel functions (e.g., hiring, salary and benefits determination, supervision, accountability and performance evaluations).

10.2.1.2 Independent decision making to include all activities, findings, recommendations and reports.

10.2.1.3 Is responsive to the age and demographic character of the region and assists and advocates for Individuals with resolving Grievances at the lowest possible level.

10.2.1.4 Independent from Contracted Services providers.

10.2.1.5 Receives Individual, family member, and other interested party Grievances.

10.2.1.6 Is accessible to Individuals, including a toll-free, independent phone line for access.

10.2.1.7 Is able to access service sites and records relating to the Individual with appropriate releases so that it can reach out to Individuals, and provide assistance with the Grievance process.

10.2.1.8 Receive training and adheres to confidentiality consistent with this Contract and Chapters 71.05, 71.24, and 70.02 RCW.

10.2.1.9 Participates in state trainings as required.

10.2.1.10 Continue to be available to advocate and assist the Individual through the Grievance and Appeal System and Administrative Hearing processes, including participating in face to face meetings with Behavioral Health agency representatives at the Individual's request.

10.2.1.11 Involve other persons, at the Individual's request.

10.2.1.12 Coordinates and collaborates with allied systems' advocacy and Ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared Individuals.

10.2.1.13 Prepare reports and formalized recommendations at least biannually to the Community BHAB, and in the state-approved format to the HCA.

82. Section 10, Individual Rights and Protections, Subsection 10.6 Individual Charges for Contracted Services, is amended to read as follows:

10.6 Individual Charges for Contracted Services

10.6.1 Under no circumstances shall the Contractor deny the provision of Crisis Services, ITA services, or SUD involuntary commitment services, to an Individual due to the Individual's ability to pay or type of health care coverage, including the FFS Medicaid Program.

10.6.2 Providers may develop and implement a sliding fee schedule for Individuals that takes into consideration an Individual's circumstances and ability to pay. If the provider selects to develop a fee schedule, the fee schedule must be reviewed and approved by the Contractor. Providers that offer a fee schedule must comply with the requirements in Subsection 9.12.

83. Section 11, Utilization Management Program and Authorization of Services, Subsection 11.1 Utilization Management Requirements, is amended to read as follows:

11.1 Utilization Management Requirements

11.1.1 The Contractor's Behavioral Health Medical Director will provide guidance, leadership and oversight of the Contractor's Utilization Management (UM) program for Contracted Services used by Individuals. The following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the Behavioral Health Medical Director to oversee:

11.1.1.1 Processes for evaluation and referral to services.

11.1.1.2 Review of consistent application of criteria for provision of services within Available Resources and review of related Grievances.

11.1.1.3 Review of assessment and treatment services against clinical practice standards. Clinical practice standards include, but are not limited to evidenced-based practice guidelines, culturally appropriate services, discharge planning guidelines, and activities such as coordination of care.

11.1.1.4 Monitor for over-utilization and under-utilization of services, including Crisis Services.

11.1.1.5 Ensure that resource management and UM activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary behavioral health services.

11.1.2 The Contractor shall develop and implement UM protocols for all services and supports funded solely or in part through GFS or FBG funds. The UM protocols shall comply with the following provisions:

11.1.2.1 The Contractor must have policies and procedures that establish a standardized methodology for determining when GFS and FBG resources are available for the provision of behavioral health services. The processes and methodology shall include the following components:

11.1.2.1.1 An aggregate of spending across GFS and FBG fund sources under the Contract.

11.1.2.1.2 For any case-specific review decisions, the Contractor shall maintain UM criteria when making authorization, continued stay and discharge determinations. The UM criteria shall address GFS and SABG priority population requirements.

11.1.2.1.3 The Contractor shall use ASAM criteria to make medical necessity decisions for SUD services.

11.1.2.1.4 A plan to address under- or over-utilization patterns with providers to avoid unspent funds or gaps in service at the end of a Contract period due to limits in Available Resources.

11.1.2.1.5 Education and technical assistance to address issues related to quality of care, medical necessity, timely and accurate claims submission or aligning service utilization with allocated funds to avoid disruption in service or unspent funds at the end of a Contract year.

11.1.2.1.6 Corrective action with providers, as necessary, to address issues with compliance with state and federal Regulations or ongoing issues with patterns of service utilization.

11.1.2.1.7 A process to make payment denials and adjustments when patterns of utilization deviate from state, federal or Contract requirements (e.g., single source funding).

11.1.2.2 The Contractor shall monitor provider discharge planning to ensure providers meet requirements for discharge planning defined in this Contract.

11.1.3 The Contractor shall educate UM staff in the application of UM protocols including the criteria used in making UM decisions. UM protocols shall address the cultural needs of diverse populations.

11.1.4 The Contractor shall ensure that all UM staff making service authorization decisions have been trained in working with the specific area of service which they are authorizing and managing.

11.1.5 The Contractor’s policies and procedures related to UM shall comply with, and require the compliance of Subcontractors with delegated authority for UM requirements described in this Section.

11.1.6 Authorization reviews shall be conducted by state licensed Behavioral Health Professionals with experience working with the populations and/or settings under review.

11.1.6.1 The Contractor shall have UM staff with experience and expertise in working with Individuals of all ages with a SUD and who are receiving medication-assisted treatment.

11.1.7 Actions including any decision to authorize a service in an amount, duration or scope that is less than requested shall be conducted by:

11.1.7.1 A physician board-certified or board-eligible in Psychiatry or Child and Adolescent Psychiatry;

11.1.7.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry; or

11.1.7.3 A licensed, doctoral level clinical psychologist.

11.1.8 The Contractor shall ensure that any behavioral health clinical peer reviewer who is subcontracted or works in a service center other than the Contractor's Washington State service center shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center. This includes participation in initial orientation and at least annual training on Washington State specific benefits, protocols and initiatives.

11.1.9 The Contractor shall ensure that any behavioral health Actions must be peer-to-peer, that is, the credential of the licensed clinician making the decision to authorize service in an amount, duration or scope that is less than requested must be at least equal to that of the recommending clinician. In addition:

11.1.9.1 A physician board-certified or board-eligible in Psychiatry must determine all inpatient level of care Actions for psychiatric treatment.

11.1.9.2 A physician board-certified or board-eligible in Addiction Medicine, or a subspecialty in Addiction Psychiatry, must determine all inpatient level of care Actions (denials) for SUD treatment.

11.1.10 The Contractor shall not structure compensation to individuals or entities that conduct UM activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Individual.

11.1.11 The Contractor shall maintain written job descriptions of all Contractor UM staff. Contractor staff that review denials of care based on medical necessity shall have job descriptions that describe required education, training or professional experience in medical or clinical practice and evidence of a current, non-restricted license, including HIPAA training compliance.

11.1.12 The Contractor shall have a sufficient number of behavioral health clinical reviewers available to conduct denial and appeal reviews or to provide clinical consultation on complex case review and other treatment needs.

11.1.13 The Contractor shall not penalize or threaten a provider or facility with a reduction in future payment or termination of Participating Provider or participating facility status because the provider or facility disputes the Contractor's determination with respect to coverage or payment for health care services.

84. Section 11, Utilization Management Program and Authorization of Services, Subsection 11.3 Authorization of Services, is amended to read as follows:

11.3 Authorization of Services

11.3.1 The Contractor shall provide education and ongoing guidance and training to Individuals and providers about its UM protocols and UM criteria, including ASAM Criteria for SUD services for admission, continued stay, and discharge criteria.

11.3.2 The Contractor shall have in effect mechanisms to ensure consistent application of UM review criteria for authorization decisions.

11.3.2.1 The Contractor shall have mechanisms for at least annual assessment of interrater reliability of all clinical professionals and non-clinical staff involved in UM determinations.

11.3.3 The Contractor shall consult with the requesting provider when appropriate, prior to issuing an authorization determination.

85. Section 11, Utilization Management Program and Authorization of Services, Subsection 11.4 Timeframes for Authorization Decisions, is amended to read as follows:

11.4 Timeframes for Authorization Decisions

11.4.1 The Contractor is required to acknowledge receipt of a standard authorization request for behavioral health inpatient services within two (2) hours and provide a decision within twelve (12) hours of receipt of the request.

11.4.2 The Contractor shall provide for the following timeframes for authorization decisions and notices:

11.4.2.1 For denial of payment that may result in payment liability for the Individual, at the time of any Action or Adverse Authorization Determination affecting the claim.

11.4.2.2 For termination, suspension, or reduction of previously authorized Contracted Services, ten (10) calendar days prior to such termination, suspension, or reduction, unless the criteria stated in 42 C.F.R. §§ 431.213 and 431.214 are met.

11.4.2.3 Standard authorizations for planned or elective service determinations: The authorization decisions are to be made and notices of Adverse Authorization Determinations are to be provided as expeditiously as the Individual's condition requires. The Contractor must make a decision to approve, deny, or request additional information from the provider within five (5) calendar days of the original receipt of the request. If additional information is required and requested, the Contractor must give the provider five (5) calendar days to submit the information and then approve or deny the request within four (4) calendar days of the receipt of the additional information.

11.4.2.3.1 An extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances:

11.4.2.3.1.1 The Individual or the provider requests the extension; or

11.4.2.3.1.2 The Contractor justifies and documents a need for additional information and how the extension is in the Individual's interest.

11.4.2.3.2 If the Contractor extends the timeframe past fourteen (14) calendar days of the receipt of the request for service:

11.4.2.3.2.1 The Contractor shall provide the Individual written notice within three (3) Business Days of the Contractor's decision to extend the timeframe. The notice shall include the reason for the decision to extend the timeframe and inform the Individual of the right to file a Grievance if he or she disagrees with that decision.

11.4.2.3.2.2 The Contractor shall issue and carry out its determination as expeditiously as the Individual's condition requires, and no later than the date the extension expires.

11.4.2.4 Expedited Authorization Decisions: For timeframes for authorization decisions not described in inpatient authorizations or standard authorizations, or cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the Individual's life or health, or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Individual's condition requires.

11.4.2.4.1 The Contractor will make the decision within two (2) calendar days if the information provided is sufficient; or request additional information within one (1) calendar day, if the information provided is not sufficient to approve or deny the request. The Contractor must give the provider two (2) calendar days to submit the requested information and then approve or deny the request within two (2) calendar days.

11.4.2.4.2 The Contractor may extend the expedited time period by up to ten (10) calendar days under the following circumstances:

11.4.2.4.2.1 The Individual requests the extension; or

11.4.2.4.2.2 The Contractor justifies and documents a need for additional information and how the extension is in the Individual's interest.

11.4.2.5 Concurrent Review Authorizations: The Contractor must make its determination within one (1) Business Day of receipt of the request for authorization.

11.4.2.5.1 Requests to extend concurrent care review authorization determinations may be extended to within three (3) Business Days of the request of the authorization, if the Contractor has made at least one (1) attempt to obtain needed clinical information within the initial one (1) Business Day after the request for authorization of additional days or services.

11.4.2.5.2 Notification of the Concurrent Review determination shall be made within one (1) Business Day of the Contractor's decision.

11.4.2.5.3 Expedited Appeal timeframes apply to Concurrent Review requests.

11.4.2.6 For post-service authorizations, the Contractor shall make its determination within thirty (30) calendar days of receipt of the authorization request.

11.4.2.6.1 The Contractor shall notify the Individual, the requesting provider, and the facility in writing within three (3) Business Days of the Contractor's determination.

11.4.2.6.2 Standard Appeal timeframes apply to post-service denials.

11.4.2.6.3 When post-service authorizations are approved they become effective the date the service was first administered.

86. Section 11, Utilization Management Program and Authorization of Services, Subsection 11.5 Notification of Coverage and Authorization Determinations, subsection 11.5.1, is amended to read as follows:

11.5.1 For all authorization determinations the Contractor shall notify the Individual, the requesting facility, and ordering provider in writing. The Contractor must notify all parties, other than the Individual, in advance whether notification will be provided by mail, fax, or other means.

11.5.1.1 For an authorization determination involving an expedited authorization request, the Contractor must notify the Individual in writing of the decision. The Contractor may initially provide notice orally to the Individual or the requesting provider. The Contractor shall send the written notice within one business day of the decision.

11.5.1.2 Provide notice at least ten (10) calendar days before the effective date of Action or Adverse Authorization Determination when the decision is a termination, suspension or reduction of previously authorized Contracted Services.

11.5.1.3 The Contractor shall notify the requesting provider and give the individual written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice to the Individual and provider shall explain the following:

11.5.1.3.1 The decision the Contractor has taken or intends to take.

11.5.1.3.2 The reasons for the decision, in easily understood language including citation to any Contractor guidelines, protocols, or other criteria that were used to make the decision, and how to access the guidelines, protocols or other criteria.

11.5.1.3.3 A statement of whether the Individual has any liability for payment.

11.5.1.3.4 Information regarding whether and how the Individual may Appeal the decision.

11.5.1.3.5 The Individual's right to receive the Contractor's assistance in filing an Appeal and how to request it, including access to services for Individuals with communication barriers or disabilities.

87. Section 11, Utilization Management Program and Authorization of Services, Subsection 11.6 Alien Emergency Medical, is amended to read as follows:

11.6 Alien Emergency Medical

11.6.1 The Contractor shall serve as the point of contact for inpatient community psychiatric admissions for undocumented aliens to support HCA Alien Emergency Medical (AEM) Program.

11.6.1.1 The Contractor shall establish if the Individual is an undocumented alien, possibly qualifying for the AEM program, and instruct the requesting hospital to assist the Individual in submitting an AEM eligibility request.

11.6.1.2 The Contractor shall receive the admission notification for ITA admissions and make medical necessity determinations for voluntary psychiatric admissions.

11.6.1.3 The Contractor shall assure staff are trained and qualified in HCA's ProviderOne system to complete the direct data entry prior authorization request screen, completing all required fields and record the clinical information required through the ProviderOne provider portal within five (5) business days of the discharge. The required data and clinical information includes, but not limited to:

11.6.1.3.1 The Individual's name and date of birth;

11.6.1.3.2 The hospital to which the admission occurred;

11.6.1.3.3 If the admission is an ITA or voluntary;

11.6.1.3.4 The diagnosis code;

11.6.1.3.5 The date of admission;

11.6.1.3.6 The date of discharge;

11.6.1.3.7 The number of covered days, with dates as indicated;

11.6.1.3.8 The number of denied dates, with dates as indicated; and

11.6.1.3.9 For voluntary admissions, a brief statement as to how the stay met medical necessity criteria.

11.6.1.4 If the information has not been submitted completely, the Contractor has five (5) business days to respond to inquiries for the designated HCA staff to obtain the information necessary to support completion on the prior authorization request record.

88. Section 12, Program Integrity, Subsection 12.4 Referring of Allegations of Potential Fraud and Invoking Provider Payment Suspensions, is amended to read as follows:

12.4 Referring of Allegations of Potential Fraud and Invoking Provider Payment Suspensions

The Contractor shall establish policies and procedures for referring all identified allegations of potential Fraud to HCA, as well as for provider payment suspensions. When HCA notifies the Contractor that a credible Allegation of Fraud exists, the Contractor shall follow the provisions for payment suspension contained in this Section.

12.4.1 When the Contractor has concluded that an allegation of potential Fraud exists, the Contractor shall make a Fraud referral to HCA within five (5) Business Days of the determination. The referral

must be emailed to HCA at ProgramIntegrity@hca.wa.gov. The Contractor shall report using the WA Fraud Referral Form.

12.4.2 When HCA determines the Contractor's referral of potential Fraud is a credible Allegation of Fraud, HCA shall notify the Contractor's compliance officers.

12.4.2.1 To suspend provider payments, in full, in part, or if a good cause exception exists to not suspend.

12.4.2.1.1 Unless otherwise notified by HCA to suspend payment, the Contractor shall not suspend payment of any provider(s) identified in the referral.

12.4.2.2 Whether HCA or appropriate law enforcement agency, accepts or declines the referral.

12.4.2.2.1 If HCA or appropriate law enforcement agency accepts the referral, the Contractor must "stand-down" and follow the requirements in the Investigation subsection of this Section.

12.4.2.2.1.1 If HCA or appropriate law enforcement agency decline to investigate the potential Fraud referral, the Contractor may proceed with its own investigation and comply with the reporting requirements contained in Section 12.

12.4.3 Upon receipt of payment suspension notification from HCA, the Contractor shall send notice of the decision to suspend program payments to the provider within five (5) calendar days of HCA's notification to suspend payment, unless an appropriate law enforcement agency requests a temporary withhold of notice.

12.4.4 The notice of payment suspension must include or address all of the following:

12.4.4.1 State that payments are being suspended in accordance with this provision;

12.4.4.2 Set forth the general allegations identified by HCA. The notice should not disclose any specific information concerning an ongoing investigation;

12.4.4.3 State that the suspension is for a temporary period and cite suspension will be lifted when notified by HCA that it is no longer in place;

12.4.4.4 Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

12.4.4.5 Where applicable and appropriate, inform the provider of any Appeal rights available to this provider, along with the provider's right to submit written evidence for consideration by the Contractor.

12.4.5 All suspension of payment actions under this Section will be temporary and will not continue after either of the following:

12.4.5.1 The Contractor is notified by HCA or appropriate law enforcement agency that there is insufficient evidence of Fraud by the provider; or

12.4.5.2 The Contractor is notified by HCA or appropriate law enforcement agency that the legal proceedings related to the provider's alleged Fraud are completed.

12.4.6 The Contractor must document in writing the termination of a payment suspension and issue a notice of the termination to the provider. A copy must be sent to HCA at ProgramIntegrity@hca.wa.gov.

12.4.7 HCA may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible Allegation of Fraud if any of the following are applicable:

12.4.7.1 A law enforcement agency has specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

12.4.7.2 Other available remedies are available to the Contractor, after HCA approves the remedies as more effective or timely to protect Medicaid funds.

12.4.7.3 HCA determines, based upon the submission of written evidence by the Contractor, individual or entity that is the subject of the payment suspension, there is no longer a credible Allegation of Fraud and that the suspension should be removed. HCA shall review evidence submitted by the Contractor or provider. The Contractor may include a recommendation to HCA. HCA shall direct the Contractor to continue, reduce, or remove the payment suspension within thirty (30) calendar days of having received the evidence.

12.4.7.4 Individual’s access to items or services would be jeopardized by a payment suspension because of either of the following:

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

12.4.7.4.2 The individual or entity serves a large number of Individuals within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.

12.4.7.5 A law enforcement agency declines to certify that a matter continues to be under investigation.

12.4.7.6 HCA determines that payment suspension is not in the best interests of the Medicaid program.

12.4.8 The Contractor shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

12.4.8.1 Details of payment suspensions that were imposed in whole or in part; and

12.4.8.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.

12.4.9 If the Contractor fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible Allegation of Fraud without good cause, and HCA directed the

Contractor to suspend payments, HCA may impose sanctions in accordance with the Sanctions Subsection of this Contract.

12.4.10 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery belongs exclusively to the state of Washington and the Contractor and any involved subcontractor have no claim to any portion of this recovery.

12.4.11 Furthermore, the Contractor is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the state of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the Contractor or subcontractor has or may have against any entity or individual that directly or indirectly receives funds under this Contract including, but not limited to, any Health Care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, Medical Equipment, or other health care related products or services.

12.4.12 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

12.4.13 For the purposes of this Section, “subrogation” means the right of any state of Washington government entity or local law enforcement to stand in the place of a Contractor or Individual in the collection against a third party.

89. Section 12, Program Integrity, Subsection 12.5 Reporting, is amended to read as follows:

12.5 Reporting

12.5.1 The Contractor shall submit to HCA a report of any recoveries made or overpayments identified by the Contractor during the course of their claims review/analysis. The report must be submitted to HCA at ProgramIntegrity@hca.wa.gov.

12.5.2 The Contractor is responsible for investigating Individual Fraud, waste and abuse. If the Contractor suspects Client Fraud:

12.5.2.1 The Contractor shall notify and submit all associated information of any alleged or investigated cases in which the Contractor believes there is a serious likelihood of Fraud by an Individual to the HCA Office of Medicaid Eligibility and Policy (OMEP) by any of the following:

12.5.2.1.1 Sending an email to WAHeligibilityfraud@hca.wa.gov;

12.5.2.1.2 Calling OMEP at 360-725-0934 and leaving a detailed message;

12.5.2.1.3 Mailing a written referral to:

Health Care Authority
Attn: OMEP
P.O. Box 45534
Olympia, WA 98504-5534

12.5.2.1.4 Faxing the written complaint to Washington Apple Health Eligibility Fraud at 360-725-1158.

12.5.3 The Contractor shall notify and submit all associated information of any alleged or investigated cases in which the Contractor believes there is a serious likelihood of provider Fraud by an individual or group using the WA Fraud Referral Form within five (5) Business Days from the date of determining an allegation of potential Fraud exists.

12.5.4 The Contractor shall submit to HCA on occurrence a list of terminations report including providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related Program Integrity termination. The Contractor shall send the report electronically to HCA at ProgramIntegrity@hca.wa.gov with subject “Program Integrity list of Terminations Report.” The report must include all of the following:

12.5.4.1 Individual provider/entities’ name;

12.5.4.2 Individual provider/entities’ NPI number;

12.5.4.3 Source of termination;

12.5.4.4 Nature of the termination; and

12.5.4.5 Legal action against the individual/entities.

90. Section 12, Program Integrity, Subsection 12.7 On Site Inspections, subsection 12.7.3 is amended to read as follows:

12.7.3 The Contractor must provide access to its premises and the records requested to any state or federal agency or entity, including, but not limited to: HCA, U.S. Department of Health and Human Services (HHS), OIG, Office of the Comptroller of the Treasury, whether the visitation is announced or unannounced.

91. Section 13, Grievance and Appeal System, Subsection 13.8 Recording and Reporting Grievances Adverse Authorization Determinations, and Appeals, subsection 13.8.2 is amended to read as follows:

13.8.2 The Contractor shall provide separate reports to HCA, quarterly using Exhibit U, Grievance, Adverse Authorization Determination, and Appeals reporting template due the 15th of the month following the quarter.

92. Section 14, Care Management and Coordination, Subsection 14.1 Care Coordination Requirements, is amended to read as follows:

14.1 Care Coordination Requirements

14.1.1 The Contractor shall develop and implement protocols that promote coordination, continuity, and quality of care that address the following:

14.1.1.1 Access to crisis safety plan and coordination information for Individuals in crisis.

14.1.1.2 Use of GFS/FBG funds to care for Individuals in alternative settings such as homeless shelters, permanent supported housing, nursing homes or group homes.

14.1.1.3 Strategies to reduce unnecessary crisis system utilization as defined in the Crisis System Section of this Contract.

14.1.1.4 Care transitions and sharing of information among jails, prisons, hospitals, residential treatment centers, withdrawal management and sobering centers, homeless shelters and service providers for Individuals with complex behavioral health and medical needs.

14.1.1.5 Continuity of Care for Individuals in an active course of treatment for an acute or chronic behavioral health condition, including preserving Individual-provider relationships through transitions.

14.1.2 The Contractor will provide Care Coordination to Individuals who are named on the HCA Referral List, also known as the “high utilizer list,” in the Trueblood, et al., v. Department of Social and Health Services Settlement Agreement. HCA will provide the HCA Referral List to the Contractor monthly. The Contractor will support connecting Individuals with behavioral health needs and current or prior criminal justice involvement receive Care Coordination. The Contractor will report semi-annually, using Exhibit R, Semi-Annual Trueblood Misdemeanor Diversion Fund Report Template. Reports must be submitted to HCA by January 31, for the reporting period of July through December of the previous year, and by July 31, for the reporting period of January through June of the current year.

93. Section 14, Care Management and Coordination, Subsection 14.2 Coordination with External Entities, is amended to read as follows:

14.2 Coordination with External Entities

14.2.1 The Contractor shall coordinate with External Entities including, but not limited to:

14.2.1.1 BH-ASOs for transfers between regions;

14.2.1.2 Family Youth System Partner Roundtable (FYSPRT);

14.2.1.3 Apple Health Managed Care Organizations to facilitate enrollment of Individuals who are eligible for Medicaid;

14.2.1.4 Tribal entities regarding tribal members who access the crisis system;

14.2.1.5 Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHC);

14.2.1.6 The Criminal Justice system (courts, jails, law enforcement, public defenders, Department of Corrections, juvenile justice system);

14.2.1.7 DSHS and other state agencies;

14.2.1.8 State and federal agencies and local partners that manage access to housing;

14.2.1.9 Education systems, to assist in planning for local school district threat assessment process;

14.2.1.10 Accountable Community of Health (ACH); and

14.2.1.11 First Responders.

14.2.2 The Contractor shall coordinate the transfer of Individual information, including initial assessments and care plans, with MCO's, other BH-ASOs, and Tribes and non-Tribal IHCPs, as needed when an Individual moves between regions or gains or loses Medicaid eligibility, to reduce duplication of services and unnecessary delays in service provision.

14.2.3 The Contractor shall participate in disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by HCA, county, or local public health jurisdiction. The Contractor shall attend state-sponsored training and participate in emergency/disaster preparedness planning when requested by HCA, the county or local public health jurisdiction, and Tribes in the region and provide Disaster Outreach and post-Disaster Outreach in the event of a disaster/emergency.

94. Section 14, Care Management and Coordination, Subsection 14.4 Care Coordination and Continuity of Care: State Hospitals and Community Hospital and Evaluation and Treatment 90/180 Civil Commitment Facilities, is amended to read as follows:

14.4 Care Coordination and Continuity of Care: State Hospitals and Community Hospital and Evaluation and Treatment 90/180 Civil Commitment Facilities

14.4.1 Utilization of State Hospital Beds

14.4.1.1 The Contractor will be assigned Individuals for discharge planning purposes in accordance with agency assignment process within each RSA in which the Contractor operates.

14.4.1.1.1 If the Contractor disagrees with the Individual assignment, it must request a reassignment within thirty (30) calendar days of admission. If a request to change the assignment is made within thirty (30) calendar days of admission and the request is granted, the reassignment will be retroactive to the date of admission.

14.4.1.1.2 If the Contractor's request is received by HCA after the thirtieth day of admission and is granted, the effective date of the reassignment will be based on the date HCA receives the reassignment request form.

14.4.1.2 The Contractor will be responsible for coordinating discharge for the Individuals assigned and, until discharged.

14.4.1.2.1 The Contractor may not enter into any agreement or make other arrangements for use of State Hospital beds outside of this Contract.

14.4.2 Admission and Discharge Planning for State Hospital and Community 90/180 Civil Commitment Facilities

14.4.2.1 The Contractor shall meet the requirements of the State Hospital MOU or Working Agreement.

14.4.2.2 The Contractor shall ensure Individuals are medically cleared, if possible, prior to admission to a State Psychiatric Hospital or 90/180 Community Civil Commitment facility.

14.4.2.3 The Contractor shall use best efforts to divert admissions and expedite discharges by using alternative community resources and mental health services, within Available Resources.

14.4.3 The Contractor shall work with the discharge team to identify potential placement options and resolve barriers to placement, to ensure that Individuals will be discharged back to the community after the physician/treatment team determines the Individual is ready for discharge.

14.4.4 The Contractor shall provide the following services for American Indian/Alaska Native Individuals in the FFS Medicaid Program who have opted out of Medicaid managed care, in coordination with the Individual's IHCP, if applicable:

14.4.4.1 Crisis services and related coordination of care;

14.4.4.2 Involuntary commitment evaluation services; and

14.4.4.3 Services related to inpatient discharge and transitions of care.

14.4.4.4 Assistance in identifying services and resources for Individuals with voluntary admission.

14.4.5 The Contractor or Subcontractor shall monitor Individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 to ensure compliance with LRA requirements.

14.4.6 The Contractor shall offer behavioral health services to Individuals who are ineligible for Medicaid to ensure compliance with LRA requirements.

14.4.7 The Contractor shall respond to requests for participation, implementation, and monitoring of Individuals receiving services on conditional release consistent with RCW 71.05.340. The Contractor or Subcontractor shall provide behavioral health services to Individuals who are ineligible for Medicaid to ensure compliance with conditional release requirements (RCW 10.77.150 and RCW 71.05.340).

14.4.8 Non-Medicaid Conditional Release Individuals in transitional status in Pierce or Spokane County will transfer back to the region they resided prior to entering the State Hospital upon completion of transitional care. Individuals residing in the Contractor's RSA prior to admission, and discharging to another RSA, will do so according to the agreement established between the receiving RSA and the Contractor. The Agreements shall include:

14.4.8.1 Specific roles and responsibilities of the parties related to transitions between the community and the State Hospital.

14.4.8.2 Collaborative discharge planning and coordination with cross-system partners such as residential facilities, community mental health or SUD providers, etc.

14.4.8.3 Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's Service Area.

14.4.8.4 When Individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the Contractor shall:

14.4.8.4.1 Coordinate with DSHS Aging and Long Term Services Administration (ALTSA) Home and Community Services (HCS) and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the HCA website.

14.4.8.4.2 Coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement when the Individual meets access to care criteria.

14.4.8.4.3 Coordinate with Tribal governments and/or IHCPs for AI/AN Individuals, when the Contractor has knowledge that the Individual is AI/AN and receives health care services from a Tribe and/or IHCP in Washington State.

14.4.9 Peer Bridger Program

14.4.9.1 The Contractor shall develop and implement a Peer Bridger program staffed by at least one or more Peer Bridger(s) based on FTE allocation table in Exhibit A in each region and in collaboration with the MCOs in the region to facilitate and increase the number of State Hospital discharges and promote continuity of services when an Individual returns to the community. Services shall be delivered equitably to Individuals assigned to the MCOs and the Contractor. BH-ASO regions may begin utilizing Peer Bridgers for local psychiatric inpatient discharges. The program shall follow Peer Bridger program standards found in Peer Bridger, Exhibit H.

14.4.9.2 The Contractor shall ensure that the Peer Bridger is allowed to attend treatment activities with the Individual during the one hundred twenty (120) day period following discharge if requested by the Individual. Examples of activities include but are not limited to: intake evaluations, prescriber appointments, treatment planning, etc. This may be extended on a case-by-case basis.

14.4.9.3 Data reporting: For each region, the Contractor shall submit the Peer Bridger monthly report to HCA, using a current version of the Exhibit H, Peer Bridger report template provided to the Contractor. The monthly report shall include: discharges and community placements, efforts to discharge and place Individuals, service encounters using the Rehabilitation Case Management Services and entering the state/stop date in the Peer Bridger Program ID within BHDS. The report is due by the 15th of the month following the month being reported.

95. Section 14, Care Management and Coordination, Subsection 14.5 Care Coordination: Filing of an Unavailable Detention Facilities Report, is amended to read as follows:

14.5 Care Coordination: Filing of an Unavailable Detention Facilities Report

14.5.1 The Contractor shall ensure its DCRs report to HCA when it is determined an Individual meets detention criteria under RCW 71.05.150, 71.05.153, 71.34.700 or 71.34.710 and there are no beds available at the Evaluation and Treatment Facility, Secure Withdrawal Management and Stabilization facility, psychiatric unit, or under a single bed certification, and the DCR was not able to arrange for a less restrictive alternative for the Individual.

14.5.2 When the DCR determines an Individual meets detention criteria, the investigation has been completed and when no bed is available, the DCR shall submit an Unavailable Detention Facilities report to HCA within 24 hours. The report shall include the following:

14.5.2.1 The date and time the investigation was completed;

14.5.2.2 A list of facilities that refused to admit the Individual;

14.5.2.3 Information sufficient to identify the Individual, including name and age or date of birth; and;

14.5.2.4 Other reporting elements deemed necessary or supportive by HCA.

14.5.3 When a DCR submits a No Bed Report due to the lack of an involuntary treatment bed, a face-to-face re-assessment is conducted each day by the DCR or Mental Health Professional (MHP) employed by the crisis provider to verify that the person continues to require involuntary treatment. If a bed is still not available, the DCR sends a new Unavailable Detention Facilities Report (No Bed Report) to HCA and the DCR or MHP works to develop a safety plan to help the person meet their health and safety needs. The DCR continues to work to find an involuntary treatment bed.

14.5.4 The Contractor must attempt to engage the Individual in appropriate services for which the Individual is eligible and report back within seven (7) business days to HCA. The Contractor may contact the Individual's MCO to ensure services are provided.

14.5.5 The Contractor shall implement a plan to provide evaluation and treatment services to the Individual, which may include the development of LRAs to involuntary treatment, or relapse prevention programs reasonably calculated to reduce demand for evaluation and treatment.

14.5.6 HCA may initiate corrective action to ensure an adequate plan is implemented. An adequate plan may include development of LRAs to Involuntary Commitment, such as crisis triage, crisis diversion, voluntary treatment, or relapse prevention programs reasonably calculated to reduce demand for evaluation and treatment.

96. Section 14, Care Management and Coordination, Subsection 14.6 Care Coordination and Continuity of Care: Evaluation and Treatment (E&T) Facilities, is amended to read as follows:

14.6 Care Coordination and Continuity of Care: Evaluation and Treatment (E&T) Facilities

14.6.1 E&T Discharge Planners shall be provided within the identified resources in Exhibit A. HCA shall pay the Contractor upon receipt and acceptance by HCA of verification that an E&T Discharge Planner position has been fully staffed by an individual whose sole function is the E&T Discharge Planner role, as described in this Contract.

14.6.2 Each E&T location shall have a designated E&T Discharge Planner. The E&T Discharge Planner shall develop and coordinate discharge plans that are: complex, multi system, mixed funding, and specific to Individuals that would otherwise be transferred to a state hospital. The plan shall track the Individual's progress upon discharge for no less than thirty (30) calendar days after discharge from the E&T Facility.

14.6.3 The Contractor shall submit to HCA the E&T Discharge Planner's reports that track the total number of all discharges from their E&T location and differentiate between those that were deemed complex and those that were deemed standard. The report is due the 15th of the month following the month being reported using the template provided by HCA.

97. Section 15, General Requirements and Benefits, Subsection 15.1 Special Provisions Regarding Behavioral Health Benefits, subsection 15.1.8 is amended to read as follows:

15.1.8 In addition to the managerial staff, the Contractor shall have a sufficient number of qualified operational staff to meet its responsibilities under the Contract.

15.1.8.1 The Contractor shall have a sufficient number of staff available 24 hours a day, seven (7) days a week, and sufficient DCRs to respond to requests for SUD Involuntary Commitment services and Mental Health ITA services. Crisis triage staff shall have training in crisis triage and management for Individuals of all ages and behavioral health conditions, including SMI, SUDs, and co-occurring disorders.

15.1.8.2 The Contractor shall have access to a physician, psychiatrist, physician assistant or ARNP with prescriptive authority 24 hours a day, seven (7) days a week, to address specialized needs of callers experiencing crisis, and to provide assistance with crisis triage, referral, and resolution.

15.1.8.3 The Contractor shall have a sufficient number of behavioral health clinical peer reviewers available to conduct Appeal reviews or to provide clinical consultation on complex cases, treatment plan issues, and other treatment needs.

15.1.8.3.1 Clinical peer reviewers may be subcontracted and can be located outside of Washington State but shall be subject to the same supervisory oversight and quality monitoring as staff located in Washington State.

15.1.8.4 The Contractor shall ensure that staffing is sufficient to support behavioral health data analytics and behavioral health data systems, including FBG reporting requirements, to oversee all data interfaces and support the behavioral health specific reporting requirements under the Contract.

15.1.8.5 The Contractor shall ensure adequate staffing to perform the following functions: administrative services, member services, Grievances and Appeals, claims, encounter and Behavioral Health Supplemental Transactions data processing, data analysts, and financial reporting analysts.

15.1.8.6 The Contractor shall develop and maintain a human resources and staffing plan that describe how the Contractor will maintain adequate staffing.

15.1.8.7 Develop and implement staff training plans that address how all staff will be trained on the requirements of this Contract.

15.1.8.8 Develop and implement provider education, training and performance management, including SABG outreach requirements related to pregnant Individuals with intravenous drug use, pregnant Individuals with a SUD, and other Individuals with intravenous drug use.

15.1.9 The Contractor shall ensure development and implementation of training programs for network providers that deliver, coordinate, or oversee behavioral health services to Individuals.

98. Section 15, General Requirements and Benefits, Subsection 15.2 Scope of Services, is amended to read as follows:

15.2 Scope of Services

15.2.1 The Contractor may limit the provision of Contracted Services to Participating Providers and services provided by IHCPs except Crisis Services specifically provided in this Contract.

15.2.2 Outside the Service Areas:

15.2.2.1 The Contractor is only responsible for telephone crisis intervention and triage services for Individuals who are temporarily outside the Service Area.

15.2.2.2 The Contractor is not responsible for coverage of any services when an Individual is outside the United States of America and its territories and possessions.

99. Section 15, General Requirements and Benefits, Subsection 15.3 General Description of Contracted Services, is amended to read as follows:

15.3 General Description of Contracted Services

15.3.1 The Contractor shall prioritize state funds for Crisis Services, evaluation and treatment services for Individuals ineligible for Medicaid, and services related to the administration of Chapters 71.05 and 71.34 RCW. Available Resources shall then be used for voluntary inpatient, crisis stabilization services and services for the priority populations defined in this Contract (refer to Scope of Services-Crisis System for additional Crisis and ITA services requirements).

15.3.2 The Contractor must expend FBG funds in accordance with the optional and required service details as specified in the Block Grant Project Plan Templates.

15.3.3 The Contractor shall establish and apply medical necessity criteria for the provision or denial of the following services:

15.3.3.1 Assessment.

15.3.3.2 Brief Intervention.

15.3.3.3 Brief Outpatient Treatment.

15.3.3.4 Case Management.

15.3.3.5 Day Support.

15.3.3.6 Engagement and Referral.

15.3.3.7 Evidenced Based/Wraparound Services.

15.3.3.8 Interim Services.

15.3.3.9 Opioid Dependency/HIV Services Outreach.

15.3.3.10 E&T Services provided at Community Hospitals or E&T facilities.

15.3.3.11 Family Treatment.

15.3.3.12 Group Therapy.

15.3.3.13 High Intensity Treatment.

15.3.3.14 Individual Therapy.

15.3.3.15 Inpatient Psychiatric Services.

15.3.3.16 Intake Evaluation.

15.3.3.17 Intensive Outpatient Treatment – SUD.

15.3.3.18 Intensive Inpatient Residential Treatment Services – SUD.

15.3.3.19 Long Term Care Residential – SUD.

15.3.3.20 Medication Management.

15.3.3.21 Medication Monitoring.

15.3.3.22 Mental Health Residential.

15.3.3.23 Opioid Treatment Programs (OTPs)/Medication Assisted Treatment (MAT)

15.3.3.24 Outpatient Treatment.

15.3.3.25 Peer Support.

15.3.3.26 Psychological Assessment.

15.3.3.27 Recovery House Residential Treatment – SUD.

15.3.3.28 Rehabilitation Case Management.

15.3.3.29 Special Population Evaluation.

15.3.3.30 TB Counseling, Screening, Testing and Referral.

15.3.3.31 Therapeutic Psychoeducation.

15.3.3.32 Urinalysis/Screening Test.

15.3.3.33 TB Screening/Skin Test.

15.3.3.34 Withdrawal Management – Acute.

15.3.3.35 Withdrawal Management – Sub-Acute.

15.3.4 The Contractor shall develop and apply criteria and to determine the provision for or denial of following services to which medical necessity does not apply:

15.3.4.1 Alcohol/Drug Information School.

15.3.4.2 Childcare.

15.3.4.3 Community Outreach – SABG priority populations PPW and IUID.

15.3.4.4 Continuing Education and Training.

15.3.4.5 PPW Housing Support Services.

15.3.4.6 Recovery Support Services.

15.3.4.7 Sobering Services.

15.3.4.8 Therapeutic Interventions for Children.

15.3.4.9 Transportation.

15.3.5 Pharmaceutical Products:

15.3.5.1 Prescription drug products may be provided within Available Resources based on medical necessity. Coverage to be determined by HCA FFS formulary.

100. Section 16, Scope of Services- Crisis System, Subsection 16.1 Crisis System General Requirements, is amended to read as follows:

16.1 Crisis System General Requirements

16.1.1 The Contractor shall develop and maintain a regional behavioral health crisis system and provide services that meet the following requirements:

16.1.1.1 Crisis Services will be available to all Individuals who present with a need for Crisis Services in the Contractor's Service Area, as defined in this Contract.

16.1.1.2 Crisis Services shall be provided in accordance with WAC 246-341-0900 to -0915.

16.1.1.3 ITA services include all services and Administrative Functions required for the evaluation of involuntary detention or involuntary treatment of Individuals in accordance with Chapter 71.05 RCW, RCW 71.24.300 and Chapter 71.34 RCW. Requirements include payment for all services ordered by the court for Individuals ineligible for Medicaid, and costs related to court processes and Transportation. Crisis Services become ITA Services when a DCR determines an Individual must be evaluated for involuntary treatment. ITA services continue until the end of the Involuntary Commitment and may be outpatient or inpatient.

16.1.2 Crisis Services shall be delivered as follows:

16.1.2.1 Stabilize Individuals as quickly as possible and assist them in returning to a level of functioning that no longer qualifies them for Crisis Services. Stabilization Services will be provided in accordance with WAC 246-341-0915.

16.1.2.2 Provide solution-focused, person-centered and Recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, institutionalization or out of home placement.

16.1.2.3 Coordinate closely with the regional MCOs, community court system, First Responders, criminal justice system, inpatient/residential service providers, Tribal governments, IHCPs, and outpatient behavioral health providers to operate a seamless crisis system and acute care system that is connected to the full continuum of health services and

inclusive of processes to improve access to timely and appropriate treatment for Individuals with current or prior criminal justice involvement.

16.1.2.4 Engage the Individual in the development and implementation of crisis prevention plans to reduce unnecessary crisis system utilization and maintain the Individual's stability.

16.1.2.5 Develop and implement strategies to assess and improve the crisis system over time.

101. Section 16, Scope of Services- Crisis System, Subsection 16.2 Crisis System Staffing Requirements, is amended to read as follows:

16.2 Crisis System Staffing Requirements

16.2.1 The Contractor shall comply with staffing requirements in accordance with Chapter 246-341 WAC. Each staff member working with an Individual receiving Crisis Services must:

16.2.1.1 Be supervised by a Mental Health Professional or licensed by DOH.

16.2.1.2 Receive annual violence prevention training on the safety and violence prevention topics described in RCW 49.19.030. The staff member's personnel record must document the training.

16.2.1.3 Have the ability to consult with one of the following (who has at least one (1) years' experience in the direct treatment of Individuals who have a mental or emotional disorder):

16.2.1.3.1 A psychiatrist;

16.2.1.3.2 A physician;

16.2.1.3.3 Physician assistant; or

16.2.1.3.4 An ARNP.

16.2.2 The Contractor shall comply with DCR qualification requirements in accordance with Chapters 71.05 and 71.34 RCW and be licensed by the DOH under WAC 246-341-0900 to -0915. The provider shall incorporate the statewide DCR Protocols, listed on the HCA website, into the practice of their DCRs.

16.2.3 The Contractor shall have clinicians available 24 hours a day, seven (7) days a week who have expertise in Behavioral Health issues pertaining to children and families.

16.2.4 The Contractor shall make available at least one SUDP with experience conducting Behavioral Health crisis support for consultation by phone or on site during regular Business Hours.

16.2.5 The Contractor shall make available at least one CPC with experience conducting behavioral health crisis support for consultation by phone or on site during regular Business Hours.

16.2.6 The Contractor shall establish policies and procedures for crisis and ITA services that implement the following requirements:

16.2.6.1 No DCR or crisis worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's ITA, unless a second trained individual accompanies them.

16.2.6.2 The clinical team supervisor, on-call supervisor, or the individual professional, shall determine the need for a second individual to accompany them based on a risk assessment for potential violence.

16.2.6.3 The second individual who responds may be a First Responder, a Mental Health Professional, a SUDP, or a mental health provider who has received training required in RCW 49.19.030.

16.2.6.4 No retaliation shall be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.

16.2.6.5 The Contractor shall have a plan to provide training, mental health staff back-up, information sharing, and communication for crisis staff who respond to private homes or other private locations.

16.2.6.6 Every DCR dispatched on a crisis visit shall have prompt access to information about an Individual's history of dangerousness or potential dangerousness documented in crisis plans or commitment records and is available without unduly delaying a crisis response.

16.2.6.7 The Contractor or Subcontractor shall provide a wireless telephone or comparable device to every DCR or crisis worker, who participates in home visits to provide Crisis Services.

102. Section 16, Scope of Services- Crisis System, Subsection 16.3 Crisis System Operational Requirements, is amended to read as follows:

16.3 Crisis System Operational Requirements

16.3.1 Crisis Services shall be available 24 hours a day, seven (7) days a week.

16.3.1.1 Mobile crisis outreach shall respond within two (2) hours of the referral to an emergent crisis and within 24 hours for referral to an urgent crisis.

16.3.2 The Contractor shall provide a toll free line that is available 24 hours a day, seven days a week, to provide crisis intervention and triage services, including screening and referral to a network of providers and community resources.

16.3.2.1 The toll-free crisis line shall be a separate number from the Contractor's customer service line.

16.3.3 Individuals shall be able to access Crisis Services without full completion of Intake Evaluations and/or other screening and assessment processes. Telephone crisis support services will be provided in accordance with WAC 246-341-0905 and crisis outreach services will be provided in accordance with WAC 246-341-0910.

16.3.4 The Contractor shall establish registration processes for non-Medicaid Individuals utilizing Crisis Services to maintain demographic and clinical information, and establish a medical record/tracking system to manage their crisis care, referrals, and utilization.

16.3.5 The Contractor shall establish protocols for providing information about and referral to other available services and resources for Individuals who do not meet criteria for Medicaid or GFS/FBG services (e.g., homeless shelters, domestic violence programs, Alcoholics Anonymous). Protocols shall align with the Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's Regional Service Area.

16.3.6 The Contractor shall ensure that Crisis Service providers document calls, services, and outcomes. The Contractor shall comply with record content and documentation requirements in accordance with WAC 246-341-0900 to -0915.

103. Section 16, Scope of Services- Crisis System, Subsection 16.4 Crisis System Services, is amended to read as follows:

16.4 Crisis System Services

16.4.1 The Contractor shall make the following services available to all Individuals in the Contractor's RSAs, in accordance with the specified requirements:

16.4.1.1 Crisis Triage and Intervention to determine the urgency of the needs and identify the supports and services necessary to meet those needs. Dispatch mobile crisis or connect the Individual to services. For Individuals enrolled with a MCO, assist in connecting the Individual with current or prior service providers. For Individuals who are AI/AN, assist in connecting the Individual to services available from a Tribal government or IHCP. Crisis Services may be provided prior to completion of an Intake Evaluation. Services shall be provided by or under the supervision of a Mental Health Professional. The Contractor must provide 24-hour a day, seven (7) day a week crisis mental health services to Individuals who are within the Contractor's RSAs and report they are experiencing a crisis. There must be sufficient staff available, including a DCR, to respond to requests for Crisis Services.

16.4.1.2 Behavioral Health ITA Services shall be provided in accordance with WAC 246-341-0810. Services include investigation and evaluation activities, management of the court case findings and legal proceedings in order to ensure the due process rights of the Individuals who are detained for involuntary treatment. The Contractor shall reimburse the county for court costs associated with ITA and shall provide for evaluation and treatment services as ordered by the court for Individuals who are not eligible for Medicaid, including Individuals detained by a DCR as described in Subsection 16.7 of this Contract. Under no circumstance shall the Contractor deny the provision of Crisis Services, Behavioral Health ITA Services, E&T, or Secure Withdrawal Management and Stabilization services, to a consumer due to the consumer's ability to pay.

16.4.1.3 Services provided in Involuntary Treatment facilities such as Evaluation and Treatment Facilities and Secure Withdrawal Management and Stabilization facility, licensed and certified by DOH. These facilities must have adequate staff to provide a safe and secure environment for the staff, patients and the community. The facilities will provide evaluation and treatment such as to provide positive results and limit the duration of involuntary treatment until the person can be discharged back to their home community to continue their treatment without the loss of their civil liberties. The treatment shall be evidence based practices to include Pharmacological services,

psycho-social classes, withdrawal management as needed, discharge planning, and warm handoff to secondary treatment including any less restrictive alternative care ordered by the court.

16.4.2 The Contractor shall provide the following services to Individuals who meet eligibility requirements defined in this Contract but who do not qualify for Medicaid, when medically necessary, and based on Available Resources:

16.4.2.1 Crisis Stabilization Services, includes short-term assistance with life skills training and understanding of medication effects and follow up services. Services are provided in the person's own home, or another home-like setting, or a setting which provides safety for the Individual experiencing a behavioral health crisis.

16.4.2.2 SUD Crisis Services including short term stabilization, a general assessment of the Individual's condition, an interview for therapeutic purposes, and arranging transportation home or to an approved Facility for intoxicated or incapacitated Individuals on the streets or in other public places. Services may be provided by telephone, in person, in a Facility or in the field. Services may or may not lead to ongoing treatment.

16.4.2.3 Secure Withdrawal Management and Stabilization Services provided in a Facility licensed and certified by DOH to provide involuntary evaluation and treatment services to Individuals detained by the DCR for SUD ITA. Appropriate care for Individuals with a history of SUD who have been found to meet criteria for involuntary treatment includes: evaluation and assessment, provided by a SUDP; acute or subacute withdrawal management services; SUD treatment; and discharge assistance provided by SUDPs, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to LRA as appropriate for the Individual in accordance with WAC 246-341-1104. This is an involuntary treatment which does not require authorization.

16.4.2.4 Peer-to-Peer Warm Line Services are available to callers with routine concerns who could benefit from or who request to speak to a peer for support and help de-escalating emerging crises. Warm line staff may be peer volunteers who provide emotional support, comfort, and information to callers living with a mental illness.

104. Section 16, Scope of Services- Crisis System, Subsection 16.5 Coordination with External Entities, is amended to read as follows:

16.5 Coordination with External Entities

16.5.1 The Contractor shall collaborate with HCA and MCOs operating in the RSA to develop and implement strategies to coordinate care with community behavioral health providers for Individuals with a history of frequent crisis system utilization. Coordination of care strategies will seek to reduce utilization of Crisis Services.

16.5.2 The Contractor shall collaborate with HCA MCOs operating in the RSA to establish protocols related to the provision of behavioral health Crisis Services and Ombuds services by the Contractor to the MCOs' Medicaid Enrollees. The protocols shall, at a minimum, address the following:

16.5.2.1 Payment by the MCOs to the Contractor for Crisis Services arranged for or delivered by the Contractor or the Contractor's provider network to Individuals enrolled in the MCOs' plan.

16.5.2.1.1 If the Contractor is paid on a FFS basis and delivers Crisis Services through a network of crisis providers, it shall reimburse its providers within fourteen (14) calendar days of receipt of reimbursement from the MCO.

16.5.2.1.2 Any sub-capitation arrangement with HCA MCOs or the Contractor's providers shall be reviewed and approved by HCA.

16.5.2.2 The Contractor shall submit claims and/or encounters for Crisis Services consistent with the provisions of this Contract. Claims and encounter submission timeliness requirements apply regardless of whether the Contractor directly provides services, acts as a third party administrator for a network of crisis providers, or is paid on a capitation or a FFS basis.

16.5.2.3 The Contractor shall establish information systems to support data exchange consistent with the requirements in this Contract including, but not limited to: eligibility interfaces, exchange of claims and encounter data, administrative data such as PRISM, critical incidents, sharing of care and crisis plans, and MHAD necessary to coordinate service delivery in accordance with applicable privacy laws, HIPAA Regulations and 42 C.F.R. Part 2.

16.5.2.4 The Contractor shall notify an MCO within one Business Day when a MCO's Enrollee interacts with the crisis system.

16.5.3 The Contractor shall, in partnership with the MCOs operating in the RSA, develop protocols to engage and collaborate with First Responders and other partners within the criminal justice system to coordinate the discharge and transition of incarcerated adults and TAY with SMI for the continuation of prescribed medications and other Behavioral Health services prior to re-entry to the community.

16.5.4 BH-ASOs shall require that Mobile Crisis Services coordinate with co-responders within their region.

105. Section 16, Scope of Service – Crisis System, Subsection 16.6 Tribal Coordination for Crisis and Involuntary Commitment Evaluation Services is renamed as "Development of Protocols for Coordination with Tribes and non-Tribal IHCPs." All internal references are updated accordingly.

106. Section 16, Scope of Services- Crisis System, Subsection 16.6 Development of Protocols for Coordination with Tribes and non-Tribal IHCPs, is amended to read as follows:

16.6 Development of Protocols for Coordination with Tribes and non-Tribal IHCPs

16.6.1 The Contractor shall participate in meetings with Tribes and non-Tribal, facilitated by HCA, to develop the Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's Regional Service Area. Until these protocols are completed and agreed upon for each Tribe or non-Tribal IHCP, the Contractor shall use the most recent annual plan for providing crisis and ITA evaluation on Tribal Lands that was agreed upon by the Contractor and the Tribe.

16.6.2 Beginning July 1, 2020, HCA in partnership with the Contractor through the convened meetings will develop and revise protocols for the coordination of crisis services (including involuntary commitment assessment), care coordination, and discharge and transition planning as part of HCA's government-to-government relationship with each of the Tribes under chapter 43.376 RCW and various federal requirements and as part of HCA's meet-and-confer relationship with each non-Tribal IHCP under HCA policy. These protocols will include a procedure and timeframe for evaluating the protocols' efficacy and reviewing or modifying the protocols to the satisfaction of all parties. These protocols may be jointly developed with more than one Tribe and/or non-Tribal IHCPs in a Regional Service Area. With respect to crisis and involuntary commitment assessment services, these protocols will include at a minimum a description of the procedures or processes for:

16.6.2.1 Designated Crisis Responders to access Tribal lands to provide services, including crisis response and involuntary commitment assessment;

16.6.2.2 Providing services on Tribal lands in the evening, holidays, or weekends if different than during business hours;

16.6.2.3 Notifying Tribal authorities when crisis services are provided on Tribal land, especially on weekends or holidays or after business hours, including who is notified and timeframes for the notification;

16.6.2.4 How Designated Crisis Responders will coordinate with Tribal mental health and/or substance use disorder providers and others identified in the protocols, including coordination and debriefing with any Tribal mental health or substance use disorder providers after a crisis service has been provided;

16.6.2.5 When a Designated Crisis Responder determines whether to detain or not for involuntary commitment; and

16.6.2.6 If ITA evaluations cannot be conducted on Tribal land, how and by whom Individuals will be transported to non-Tribal lands for involuntary commitment assessment and detention and/or to a licensed Evaluation and Treatment Facility.

16.6.3 HCA will provide the Contractor a copy of each set of Protocols applicable to the Contractor's Regional Service Area as soon as they are agreed upon by the Tribe or non-Tribal IHCP.

107. Section 16, Scope of Services- Crisis System, Subsection 16.7 Tribal Designated Crisis Responders, is amended to read as follows:

16.7 Tribal Designated Crisis Responders

16.7.1 Upon the Contractors authority to designate DCR's, and upon request, the Contractor must assist and designate at least one person from each Tribe within the Contractor's RSA as a Tribal Designated Crisis Responder, subject to the following requirements:

16.7.1.1 The potential Tribal DCR must meet all the requirements as a Designated Crisis Responder in accordance with RCW 71.05.020, 71.24.025 and 71.34.020;

16.7.1.2 The request for designation of a potential Tribal DCR person must be made in writing to the Contractor from the Tribal Authority;

16.7.1.3 If the Contractor's RSA includes multiple Tribes, and upon written request from all the affected Tribes, Tribes may elect to share Tribal DCRs;

16.7.1.4 The decision-making authority of the DCR must be independent of the Contractor's administration and the Tribal Authority.

16.7.2 The Contractor will enable any Tribal DCR to shadow with and receive on-the-job training from a DCR employed by a DCR provider agency that is contracted with the Contractor.

16.7.3 The Contractor must actively engage and include Tribal DCRs in the regional work on Crisis Services collaborative groups, trainings, and policy impacts within their RSA and as provided to other crisis and DCR service providers.

16.7.4 In the event the Contractor and Tribal Authority are unable to reach agreement on a methodology to designate a Tribal DCRs, including hiring, funding and operational processes, written documentation must be provided to HCA's office of Tribal Affairs and must be submitted to HCABHASO@hca.wa.gov.

16.7.4.1 Documentation must include names of those participating in the planning discussions from both parties and barriers or issues that remain unresolved.

16.7.4.2 HCA will work with both parties to attempt to resolve issues and provide technical assistance where needed. This may include a facilitated executive level meeting between both parties.

108. Section 17, Juvenile Drug Court and Criminal Justice Treatment Account, Subsection 17.1 Juvenile Drug Court, is amended to read as follows:

17.1 Juvenile Drug Court

17.1.1 In RSAs where funding is provided, the Contractor shall support Individuals involved with a region's Juvenile Drug Court (JDC) and provide the following services:

17.1.1.1 A SUD assessment.

17.1.1.2 SUD and mental health treatment and counseling as appropriate which may include Evidence-Based Practices such as Functional Family Therapy and Aggression Replacement Training.

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

17.1.1.4 Track attendance and completion of activities, offer incentives for compliance and impose sanctions for lack of compliance.

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

109. Section 17, Juvenile Drug Court and Criminal Justice Treatment Account, Subsection 17.2 Criminal Justice Treatment Account (CJTA), is amended to read as follows:

17.2 Criminal Justice Treatment Account (CJTA)

In RSAs where funding is provided, the Contractor shall be responsible for treatment and Recovery Support Services using specific eligibility and funding requirements for CJTA in accordance with RCW 71.24.580 and RCW 2.30.030. Services provided through CJTA appropriation must be clearly documented and reported in accordance with subsection 9.3.1.8.

17.2.1 The Contractor shall implement any CJTA plans developed by the local CJTA panel and approved by the CJTA Panel established in RCW 71.24.580(5)(b).

17.2.2 CJTA Funding Guidelines:

17.2.2.1 In accordance with RCW 2.30.040, if CJTA funds provided support for, or associated services by a Therapeutic Court, then the county is required to provide a dollar-for-dollar participation match for services to Individuals who are receiving services under the supervision of a Therapeutic Court.

17.2.2.2 No more than 10 percent of the total CJTA funds can be used for the following treatment support services combined:

17.2.2.2.1 Transportation; and

17.2.2.2.2 Child Care Services.

17.2.3 HCA retains the right to request progress reports or updates on innovative projects funded under this subsection. The Contractor shall dedicate a minimum 30 percent of the CJTA funds for innovative projects that meet any or all of the following conditions:

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

17.2.3.2 An approach utilizing either traditional or best practices to treat significantly underserved and marginalized population(s) and populations who are disproportionately affected by involvement in the criminal justice system, or

17.2.3.3 A regional project conducted in partnership with at least one other entity serving the RSA service area such as, the AH-IMC MCOs operating in the RSA or the ACH.

17.2.4 Services that can be provided using CJTA funds are:

17.2.4.1 Brief Intervention (any level, assessment not required);

17.2.4.2 Acute Withdrawal Management (ASAM Level 3.2WM);

17.2.4.3 Sub-Acute Withdrawal Management (ASAM Level 3.2WM);

17.2.4.4 Outpatient Treatment (ASAM Level 1);

17.2.4.5 Intensive Outpatient Treatment (ASAM Level 2.1);

17.2.4.6 Opioid Treatment Program (ASAM Level 1);

17.2.4.7 Case Management (ASAM Level 1.2);

17.2.4.8 Intensive Inpatient Residential Treatment (ASAM Level 3.5);

17.2.4.9 Long-term Care Residential Treatment (ASAM Level 3.3);

17.2.4.10 Recovery House Residential Treatment (ASAM Level 3.1);

17.2.4.11 Assessment (to include Assessments done while in jail);

17.2.4.12 Interim Services;

17.2.4.13 Community Outreach;

17.2.4.14 Involuntary Commitment Investigations and Treatment;

17.2.4.15 Room and Board (Residential Treatment Only);

17.2.4.16 Transportation;

17.2.4.17 Childcare Services;

17.2.4.18 Urinalysis;

17.2.4.19 Treatment in the jail:

17.2.4.19.1 CJTA funding used for this purpose may not supplant any locally funded programs within a city, county or tribal jail.

17.2.4.19.2 The Contractor may not use more than 30 percent of their total annual allocation for providing treatment services in jail:

17.2.4.19.2.1 The Contractor may request an exception to this funding limit within their strategic plan submitted per subsection 17.2.5 of this Contract.

17.2.4.19.3 SUD treatment service provided in jail may include, but is not necessarily limited to the following:

17.2.4.19.3.1 Engaging Individuals in SUD treatment;

17.2.4.19.3.2 Referral to SUD services;

17.2.4.19.3.3 Administration of Medications for the treatment of SUDs, including Opioid Use Disorder, to include the following:

17.2.4.19.3.3.1 Screening for medications for SUDs;

17.2.4.19.3.3.2 Cost of medications for SUDs; and

17.2.4.19.3.3.3 Administration of medications for SUDs.

17.2.4.19.4 Coordinating care;

17.2.4.19.5 Continuity of Care; and

17.2.4.19.6 Transition planning.

17.2.4.20 Employment services and job training;

17.2.4.21 Relapse prevention;

17.2.4.22 Family/marriage education;

17.2.4.23 Peer-to-peer services, mentoring and coaching;

17.2.4.24 Self-help and support groups;

17.2.4.25 Housing support services (rent and/or deposits);

17.2.4.26 Life skills;

17.2.4.27 Spiritual and faith-based support;

17.2.4.28 Education; and

17.2.4.29 Parent education and child development.

17.2.5 Beginning July 31, 2021, the CJTA Biennial Plan is due every two years on July 31.

17.2.5.1 The BH-ASO must coordinate with the local legislative authority for the county or counties in its RSA in order to facilitate the planning requirement as described in RCW 71.24.580(6). The CJTA Biennial Plan shall:

17.2.5.1.1 Describe in detail how SUD treatment and support services will be delivered within the region;

17.2.5.1.2 Address the CJTA Account Match Requirement from subsection 17.2.2.1 of this Contract;

17.2.5.1.3 Include details on special projects such as best practices/treatment strategies, significant underserved population(s), or regional endeavors, including the following:

17.2.5.1.3.1 Describe the project and how it will be consistent with the strategic plan;

17.2.5.1.3.2 Describe how the project will enhance treatment services for eligible Individuals identified in RCW 71.24.580(1)(a) - (b);

17.2.5.1.3.3 Indicate the number of Individuals who were served using innovative funds;

17.2.5.1.3.4 Detail the original goals and objectives of the project.

17.2.5.1.4 If applicable, the CJTA Biennial Plan will indicate a plan of action for meeting the requirements in subsection 17.3 of this Contract.

17.2.6 Completed plans must be submitted to HCA and the CJTA Panel established in RCW 71.24.580(5)(b), for review and approval. Once approved, the Contractor must implement its plan as written.

17.2.7 State Appropriation Recoupment

17.2.7.1 Per 71.24.582, HCA authority shall monitor and review, on an annual basis, expenditures related to CJTA appropriations.

17.2.7.2 HCA will help recoup and redistribute underspent or overspent funds on an annual basis to ensure per RCW 71.24.582, any remaining unspent CJTA appropriations will be returned to HCA at the end of the State Fiscal biennium.

110. Section 17, Juvenile Drug Court and Criminal Justice Treatment Account, Subsection 17.3 Medications for Opioid Use Disorder in Therapeutic Courts, is amended to read as follows:

17.3 Medications for Opioid Use Disorder in Therapeutic Courts

17.3.1 Per RCW 71.24.580, “If a region or county uses Criminal Justice Treatment Account funds to support a therapeutic court, the therapeutic court must allow the use of all medications approved by the federal FDA for the treatment of opioid use disorder as deemed medically appropriate for a participant by a medical professional. If appropriate medication-assisted treatment resources are not available or accessible within the jurisdiction, the HCA's designee for assistance must assist the court with acquiring the resource.”

17.3.1.1 The Contractor, under the provisions of this contractual agreement, will abide by the following guidelines related to CJTA and Therapeutic Courts:

17.3.1.1.1 The Contractor will only subcontract with Therapeutic Courts that have policy and procedures allowing Participants at any point in their course of treatment to seek FDA-approved medication for any SUD and ensuring the agency will provide or facilitate the induction of any prescribed FDA approved medications for any SUD.

17.3.1.1.2 The Contractor will only subcontract with Therapeutic Court programs that work with licensed SUD behavioral health treatment agencies that have policy and procedures in place ensuring they will not deny services to Individuals who are prescribed any of the Federal Drug Administration (FDA) approved medications to treat all SUDs.

17.3.1.1.3 The Contractor may not subcontract with a Therapeutic Court program that is known to have policies and procedures in place that mandate titration of any prescribed FDA approved medications to treat any SUD, as a condition of participants being admitted into the program, continuing in the program, or graduating from the program, with the understanding that decisions concerning medication adjustment are made solely between the participant and their prescribing provider.

17.3.1.1.4 The Contractor must notify the HCA if it discovers that a CJTA funded Therapeutic program is practicing any of the following:

17.3.1.1.4.1 Requiring discontinuation, titration, or alteration of their medication regimen as a precluding factor in admittance into a Therapeutic Court program;

17.3.1.1.4.2 Requiring participants already in the program to discontinue medication regimen in order to comply with program requirements;

17.3.1.1.4.3 Requiring discontinuation, titration, or alteration of their medication regimen as a necessary component of meeting program requirements for graduation from a Therapeutic Court program.

17.3.1.1.5 All decisions regarding an Individual's amenability and appropriateness for medications will be made by the Individual in concert with a medical professional.

17.3.2 The Contractor will submit a quarterly CJTA Quarterly Progress Report within forty-five (45) calendar days of the state fiscal quarter end using the reporting template, Exhibit S, CJTA Quarterly Progress Report. CJTA Quarterly Progress Report must include the following program elements:

17.3.2.1 Number of Individuals served under CJTA funding for that time period;

17.3.2.2 Barriers to providing services to the criminal justice population;

17.3.2.3 Strategies to overcome the identified barriers;

17.3.2.4 Training and technical assistance needs;

17.3.2.5 Success stories or narratives from Individuals receiving CJTA services; and

17.3.2.6 If a Therapeutic Court provides CJTA funded services: the number of admissions of Individuals into the program who were either already on medications for opioid use disorder, referred to a prescriber of medications for opioid use disorder, or were provided information regarding medications for opioid use disorder.

111. Section 18, Federal Block Grants (FBG), Subsection 18.1 Federal Block Grant Requirements, is amended to read as follows:

18.1 Federal Block Grant Requirements

18.1.1 In each RSA, the Contractor shall collect information from key stakeholders and community partners, to include Tribal partners and other IHCPs, to develop the regional MHBG and SABG Project Plans. The plans shall be submitted to and approved by the regional BHAB. The Contractor shall send its board-approved Project Plans to HCA annually by July 15 for approval prior to submitting the first A-19 invoice. Plans shall be on the most recent templates. The current MHBG Project plan template is identified in Exhibit I, and the SABG Project Plan template is in Exhibit J. HCA shall review the proposed plans and notify the Contractor of the date of approval, or if not approved, the date revisions are due. HCA shall not process payment for FBG services until HCA has approved the project plans. Any changes to the Project Plans must be submitted to HCA for review and approval prior to implementation.

18.1.2 The Contractor shall provide, or subcontract for services, according to the approved regional MHBG and the regional SABG project plans.

18.1.3 The Contractor shall provide MHBG services to promote Recovery for an adult with a SMI and resiliency for SED children in accordance with federal and state requirements. SABG funds shall be used to provide services to priority populations.

18.1.4 The Contractor shall ensure that FBG funds are used only for services to Individuals who are not enrolled in Medicaid or for services that are not covered by Medicaid as described below:

Benefits	Services	Use MHBG or SABG Funds	Use Medicaid
Individual is not a Medicaid recipient	Any Allowable Type	Yes	No
Individual is a Medicaid recipient	Allowed under Medicaid	No	Yes
Individual is a Medicaid recipient	Not Allowed under Medicaid	Yes	No

18.1.5 Upon request by HCA, the Contractor shall attend or send a representative to the Washington State Behavioral Health Advisory Committee meetings to discuss priorities for future FBG supported services.

18.1.6 FBG requires annual peer reviews by individuals with expertise in the field of mental health treatment (for MHBG) and by individuals with expertise in the field of drug abuse treatment (for SABG) consisting of at least 5 percent of treatment providers. The Contractor and Subcontractors shall participate in a peer review process when requested by HCA (42 U.S.C. 300x-53(a) and45 C.F.R. § 96.136, MHBG Service Provisions).

18.1.7 The Contractor shall submit regional MHBG and SABG Final Reports, annually, by August 1 of each year, for services provided in the prior state fiscal year. Reports must be provided on the current templates. See Exhibit F, Federal Block Grant Annual Progress Report.

18.1.8 Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . . in full accordance with U.S. statutory . . . .requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under the Federal Drug Administration (FDA)-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned substance under federal law.

112. Section 19, Jail Transition Services, Subsection 19.1 Jail Transition Services Requirements, is amended to read as follows:

19.1 Jail Transition Services Requirements

19.1.1 Jail Transition Services are to be provided within the identified resources in Exhibit A.

19.1.2 The Contractor shall coordinate with local and Tribal law enforcement, courts and jail personnel to meet the needs of Individuals detained in city, county, tribal, and regional jails.

19.1.3 The Contractor must identify and provide transition services to persons with mental illness and/or co-occurring disorders to expedite and facilitate their return to the community.

19.1.4 The Contractor shall accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in Chapter 71.24 RCW. The Contractor must conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.

19.1.5 The Contractor shall assist Individuals with mental illness in completing and submitting an application for medical assistance prior to release from jail.

19.1.6 The Contractor shall assist Individuals with mental illness and/or co-occurring disorders with the coordination of the re-activation of Medicaid benefits if those benefits were suspended while the Individual was incarcerated, which may involve coordinating the submission of prior-authorization with the managed care organizations, or the FFS Medicaid Program.

19.1.7 Pre-release services shall include:

19.1.7.1 Mental health and SUD screening for Individuals who display behavior consistent with a need for such screening who submit a Health Kite requesting services, or have been referred by jail staff, or officers of the court.

19.1.7.2 Mental health intake assessments for persons identified during the mental health screening as a member of apriority population.

19.1.7.3 Facilitation of expedited medical and financial eligibility determination with the goal of immediate access to benefits upon release from incarceration.

19.1.7.4 Other prudent pre-release and pre-trial case management and transition planning.

19.1.7.5 Direct mental health or SUD services to Individuals who are in jails that have no mental health staff working in the jail providing services.

19.1.7.6 Post-release outreach to ensure follow-up for mental health and other services (e.g. SUD) to stabilize Individuals in the community.

19.1.8 If the Contractor has provided the jail services in this Section the Contractor may also use the Jail Coordination Services funds, if sufficient, to facilitate any of the following:

19.1.8.1 Identify recently booked Individuals that are eligible for Medicaid or had their Medicaid benefits suspended for purposes of establishing Continuity of Care upon release.

19.1.8.2 Develop individual alternative service plans (alternative to the jail) for submission to the courts. Plans will incorporate evidence-based risk assessment screening tools.

19.1.8.3 Inter-local Agreements with juvenile detention facilities.

19.1.8.4 Provide up to a seven (7) day supply of medications for the treatment of mental health symptoms following the release from jail.

19.1.8.5 Training to local law enforcement and jail services personnel regarding de-escalation, crisis intervention, and similar training topics.

113. Section 20, Dedicated Marijuana Account (DMA), Subsection 20.1 DMA expenditure requirements, is amended to read as follows:

20.1 DMA expenditure requirements

20.1.1 DMA funds are to be provided within the identified resources in Exhibit A.

20.1.2 DMA funds shall be used to fund SUD treatment services for youth living at or below 220 percent of the federal poverty level, without insurance coverage or who are seeking services independent of their parent/guardian;

20.1.3 DMA funds may be used for development, implementation, maintenance, and evaluation of programs that support intervention, treatment, and Recovery Support Services for middle school and high school aged students.

20.1.4 All new programs and services must direct at least 85 percent of funding to evidence-based or research-based programs and practices that produce objectively measurable results, and are expected to be cost beneficial.

20.1.5 Up to 15 percent of the funds appropriated for new programs and new services may be used to provide support to proven and tested practices, emerging best practices, or promising practices.

114. Section 21, Family Youth System Partner Roundtable (FYSPRT), Subsection 21.1 General Requirements, is amended to read as follows:

21.1 General Requirements

21.1.1 FYSPRT support shall be provided within the identified resources in Exhibit A and reported in accordance with this Section.

21.1.2 Work completed under this Section of the Contract will be in alignment with the FYSPRT manual.

21.1.3 Consistent with the FYSPRT manual, the Contractor will continue to develop, promote and support each Regional FYSPRT by providing administrative and staff support for the performance of work as defined in this Section, including but not limited to: community Outreach and Engagement efforts to publicize the work of the FYSPRTs and recruit members; fiscal management; arranging meeting space; and other administrative supports necessary for the operation of the Regional FYSPRT.

21.1.4 Consistent with the FYSPRT manual the Contractor shall:

21.1.4.1 Include youth, family, and system partner representation in all aspects of the development, promotion, support, implementation, and evaluation of the Regional FYSPRT;

21.1.4.2 Engage Federally Recognized Tribes, IHCPs, and Indian Organizations to promote, participate in, and aid in the continued development of the Regional FYSPRT and show dates and type of outreach in progress reports;

21.1.4.3 Engage with youth, families, and system partners to build and maintain a Regional FYSPRT membership that will include:

21.1.4.3.1 At least 51 percent Youth and family membership (if not at 51 percent, note this in the quarterly report and identify strategies being utilized to become compliant);

21.1.4.3.2 Representatives from Family and Youth Run Organizations and other relevant stakeholder groups within the region;

21.1.4.3.3 Key administrators connected to the WISe implementation;

21.1.4.3.4 Community System Partners and Community Members, such as:

21.1.4.3.4.1 Suggested Participants listed in the FYSPRT Manual;

21.1.4.3.4.2 Behavioral Health Provider(s) including WISe Care Coordinators, WISe Family Partners, WISe Youth Partners, WISe Therapists, etc.;

21.1.4.3.4.3 The Department of Children, Youth, and Families (including child welfare and juvenile rehabilitation);

21.1.4.3.4.4 Developmental Disabilities Administration;

21.1.4.3.4.5 Education/Local Education Agency, Educational Service Districts;

21.1.4.3.4.6 Faith Community Leaders;

21.1.4.3.4.7 Federally Recognized Tribes or Tribal Governments;

21.1.4.3.4.8 Foster Care Provider(s);

21.1.4.3.4.9 Local Juvenile Justice;

21.1.4.3.4.10 Law enforcement;

21.1.4.3.4.11 Managed Care Organizations;

21.1.4.3.4.12 Regional Advocacy Groups;

21.1.4.3.4.13 Physical health care/public health;

21.1.4.3.4.14 Recognized American Indian Organizations;

21.1.4.3.4.15 Urban Indian organizations and IHCPs; and

21.1.4.3.4.16 Interested community stakeholders.

21.1.5 Convene Regional FYSPRT meetings at a minimum of once per month. Meeting materials must be made publicly available on the Contractor's website prior to the meeting. The meetings shall:

21.1.5.1 Follow the Regional FYSPRT Meeting protocol found in the FYSPRT Manual;

21.1.5.2 Be open to the public and publicized;

21.1.5.3 Provide for and publicize a process for obtaining travel and support (such as childcare assistance/reimbursement) to attend meetings; and

21.1.5.4 Be planned and facilitated by the Regional Tri-Leads, with input from all Tri-Leads, in the development of meeting agendas, identification of issues for follow up and other items.

21.1.5.5 Include a review of the WISe Quarterly Behavioral Health Assessment Solutions (BHAS) reports at one meeting per quarter to identify the strengths and needs of the RSA. Include in the progress report a plan to address the need(s) as a meeting agenda item, Annual Work Plan goal or other method. If applicable to the RSA, other regional data reports can be reviewed to fulfill this requirement for two of the four quarters.

21.1.5.6 Once per Contract period, provide an update at the Regional FYSPRT meeting on the Contract deliverables connected to the Regional FYSPRT (for example, tribal engagement).

21.1.6 Continue to implement the five (5) year strategic plan created by the Regional FYSPRT and update as needed based on the results of the following:

21.1.6.1 The annual needs assessment completed between July 1 and September 30 and submitted to HCA by October 10;

21.1.6.2 FYSPRT meetings and evaluations;

21.1.6.3 Between October 1 and December 31 develop and begin implementing an Annual Work Plan using the Strategic Plan and the results of the annual needs assessment. The Annual Work Plan shall be submitted by January 10. As part of the Annual Work Plan, identify at least three (3) priority areas of focus and include for each priority:

21.1.6.3.1 Goals;

21.1.6.3.2 Action steps;

21.1.6.3.3 Those assigned; and

21.1.6.3.4 Timeline for completion.

21.1.6.4 No later than June 30, complete goals and action steps as outlined in the Work Plan. Submit quarterly reports that identifies progress on goals and action steps, including barriers found and plans to address barriers.

21.1.6.5 Funding identified in Exhibit A to support performance work statement items and travel and meeting support, can also be budgeted to support projects outlined in the Five (5) Year Strategic Plan or the Annual Work Plan.

21.1.7 Maintain Regional FYSPRT webpages that include:

21.1.7.1 Point of contact, name, email, phone number, and mailing address;

21.1.7.2 Regional agendas and meeting notes;

21.1.7.3 Dates, locations, and times of past and upcoming Regional meetings (including information on travel reimbursement, child care, and other meeting supports);

21.1.7.4 A Regional Charter;

21.1.7.5 Policies and procedures (may also be addressed in the Regional FYSPRT Charter);

21.1.7.6 Results of the needs assessment and a strategic plan framework;

21.1.7.7 The Five (5) Year Strategic Plan;

21.1.7.8 The Annual Work Plan, when developed; and

21.1.7.9 Links to relevant regional/statewide resources and information.

21.1.8 Participate in State-level activities, to include:

21.1.8.1 Identifies Regional Tri-Leads to participate as members of the Statewide FYSPRT;

21.1.8.2 Provide travel support for all Regional Tri-Leads to attend the Statewide FYSPRT meetings in-person with the requirement that at least two of the three Tri-Leads attend each Statewide FYSPRT meeting, and ensures that no Tri-Lead attends fewer than one Statewide meeting each year;

21.1.8.3 Supports Regional FYSPRT members to attend FYSPRT-related training and technical assistance meetings or events, as requested by HCA;

21.1.8.4 Supports Regional FYSPRT Youth Tri-Lead(s) to attend youth run organization or program events and activities as determined by regional needs or as requested by HCA;

21.1.8.5 Supports Regional FYSPRT Family Tri-Lead(s) to participate as members of the Washington Behavioral Health Statewide Family Network's activities, trainings, or meetings a minimum of once per quarter and attend other family run organization or program events and activities as determined by regional needs or requested by HCA and within available resources; and

21.1.8.6 Identify Regional Tri-Leads and FYSPRT members to participate on subgroups of the Statewide FYSPRT.

21.1.9 At a minimum utilize the FYSPRT Evaluation Tool and FYSPRT Evaluation – Narrative Team Effectiveness Questionnaire, (found in the FYSPRT Manual) to evaluate the effectiveness of the Regional meetings on at least a quarterly basis and submit a summary to HCA. Identify how the information gathered from the evaluation tools have informed future meetings.

21.1.10 The Contractor shall not be obligated to reimburse costs in excess of the difference between its reasonable costs to administer this program and the total available payments.

21.1.11 Reporting. On a quarterly basis, the Contractor shall submit the following:

21.1.11.1 A report summarizing the progress or completion of Performance Work Statement items, identifying any barriers and plans for next steps.

21.1.11.2 Submit the Five (5) Year Strategic Plan in any quarter in which updates have been made.

21.1.11.3 Sign-in sheets, showing percentage of youth and family in attendance, and meeting notes.

21.1.11.4 Updated membership roster identifying the percentage of youth and family membership.

21.1.11.5 A link to the required Regional FYSPRT webpage materials in accordance with the Performance Work Statement item found in this Contract.

21.1.11.6 Tri-Lead attendance at statewide FYSPRT meetings.

21.1.11.7 Member travel and meeting support. Documentation shall include the date of travel, name of participant, the purpose of the expense, and the amount paid. Documentation shall be submitted with the invoice in alignment with Contractor policies and shall be billed quarterly on the A-19.

21.1.11.8 Reports and A-19s are due by the 10th of the month of January, April, July and October and must be submitted to HCA HCABHASO@hca.wa.gov.

115. Section 22, Community Behavioral Enhancement (CBHE) Funds, Subsection 22.1 CBHE Communication Plan Requirements, is amended to read as follows:

22.1 CBHE Communication Plan Requirements

22.1.1 The CHBE funding is intended to increase funding for Behavioral Health services provided by licensed and certified community Behavioral Health agencies. The Contractor must follow the previously submitted CBHE Communication Plan ("Communication Plan") that outlines how the portion of the funding received will strengthen the Behavioral Health community and assist in recruitment and retention.

22.1.2 The Communication Plan must include the following:

22.1.2.1 Outline of how the portion of the funding received will strengthen the Behavioral Health provider community workforce.

22.1.2.2 How the Contractor will increase provider capacity, including staff retention and service delivery.

22.1.2.3 The Communication Plan must meet the intention of Engrossed Substitute House Bill 1109; Chapter 415, Laws of 2019.

22.1.2.4 Timeframes for implementation of all planned enhancement activities.

22.1.3 The Contractor will take the following steps to ensure that providers are receiving the appropriate amount of enhancement funds:

22.1.3.1 Develop a provider Communication Plan.

22.1.3.2 In accordance with you Communication Plan, notify providers about how the Enhancement funds will be utilized in your region.

22.1.3.3 Operationalize your plan to deploy FY 2020- 2021 enhancement funds.

22.1.3.4 Conduct quarterly reviews to ensure that funds are being dispersed to providers as outlined in your Communication Plan.

22.1.3.5 Contractor will notify HCA of any changes to the provider Communication Plan within ten (10) business days of the changes. Submit updated Communication Plans to HCABHASO@hca.wa.gov.

22.1.4 The Contractor will submit a completed CBHE Quarterly Expenditure report using the CBHE Quarterly Expenditure reporting template (Exhibit T).

22.1.4.1 The Exhibit T, CBHE Quarterly Expenditure report must be submitted to HCABHASO@hca.wa.gov by the last day of the month following the end of each quarterly reporting period. The 2020 fiscal reports are due by: July 10 (January-March) for Calendar Year 2020 only; July 31 (April-June); October 31 (July-September); and January 31 (October-December).

116. Section 23, Behavioral Health Advisory Board (BHAB), Subsection 23.1 Advisory Board Requirements, is amended to read as follows:

23.1 Advisory Board Requirements

23.1.1 The Contractor shall maintain a Community BHAB in each RSA that is broadly representative of the demographic character of the region. The composition of the BHAB and length of terms shall be provided to HCA upon request and meet the requirements in this Section.

23.1.2 BHAB Membership Requirements:

23.1.2.1 Be representative of the geographic and demographic mix of service population;

23.1.2.2 Have at least 51 percent of the membership be persons with lived experience, parents or legal guardians of persons with lived experience and/or self-identified as a person in Recovery from a behavioral health disorder;

23.1.2.3 Law Enforcement representation;

23.1.2.4 County representation;

23.1.2.5 No more than four elected officials;

23.1.2.6 No employees, managers or other decision makers of subcontracted agencies who have the authority to make policy or fiscal decisions on behalf of the subcontractor; and

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

23.1.3 The BHAB will:

23.1.3.1 Solicit and use the input of Individuals with mental health and/or SUD to improve behavioral health services delivery in the region;

23.1.3.2 Solicit and use the input of Individuals with mental health and/or SUD to improve behavioral health services delivery in the region;

23.1.3.3 Approve the annual SABG and MHBG expenditure plan for the region and provide annual documentation of the approval to HCA by July 15 of each year. The expenditure plan format will be provided by HCA and the approved plans are to be submitted by the Contractor to HCA at HCABHASO@hca.wa.gov.

117. Section 24, Crisis Triage/Stabilization Centers and Increasing Psychiatric Residential Treatment Beds, Subsection 24.1 General Requirements, is amended to read as follows:

24.1 General Requirements

24.1.1 For Contractors that received a one-time start-up cost payment for either a Crisis Triage/Stabilization Center or to increase psychiatric residential treatment beds for Individuals transitioning from psychiatric inpatient settings the Contractor shall continue submitting quarterly reports to HCA at HCABHASO@hca.wa.gov , using the Crisis Triage/Stabilization and Increasing Psychiatric Bed Capacity reporting template (Exhibit N) provided by HCA. Reports are due thirty (30) calendar days after the end of the SFY quarter.

118. Section 25, Business Continuity and Disaster Recovery, Is amended to read as follows:

25 BUSINESS CONTINUITY AND DIASTER RECOVERY

25.1 General Requirement

25.1.1 The Contractor shall have a primary and back-up system for electronic submission of data requested by HCA. The system shall include the use of the Inter-Governmental Network (IGN) Information Systems Services Division (ISSD) approved secured virtual private network (VPN) or other ISSD-approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on HCA approval.

25.1.2 The Contractor shall create and maintain a business continuity and disaster recovery plan that insures timely reinstitution of the Individual information system following total loss of the primary system or a substantial loss of functionality. The plan shall include the following:

25.1.2.1 A mission or scope statement.

25.1.2.2 Information services disaster recovery person (s).

25.1.2.3 Provisions for back up of key personnel, emergency procedures, and emergency telephone numbers.

25.1.2.4 Procedures for effective communication, applications inventory and business recovery priorities, and hardware and software vendor lists.

25.1.2.5 Documentation of updated system and operations and a process for frequent back up of systems and data.

25.1.2.6 Off-site storage of system and data backups and ability to recover data and systems from back-up files.

25.1.2.7 Designated recovery options.

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

25.1.3 The Contractor must submit an annual certification statement indicating there is a business continuity disaster plan in place for both the Contractor and Subcontractors. The certification must be submitted by January 1 of each Contract year. The certification must indicate the plan is up to date, the system and data backup and recovery procedures have been tested, and copies of the Contractor and Subcontractor plans are available for HCA to review and audit.

119. Exhibit A-3 Non-Medicaid Funding Allocation, is effective July 1, 2020 through December 31, 2020 and supersedes and replaces Exhibit A-2 Non-Medicaid Funding Allocation and is attached hereto and incorporated herein.

120. Exhibit C, Reporting Requirements is deleted in its entirety. The language was incorporated into Section 8.1. Policies and Procedures.

121. Exhibit E-1, Crisis System Reporting, replaces Exhibit E in its entirety, and is attached hereto and incorporated herein.

122. Exhibit G-1, Behavioral Health Services replaces Exhibit G in its entirety, and is attached hereto and incorporated herein.

123. Exhibit H-1, Peer Bridger Program replaces Exhibit H in its entirety, and is attached hereto and incorporated herein.

124. Exhibit I-1, Mental Health Block Grant Project Plan replaces Exhibit I in its entirety, and is attached as a separate document to this Amendment.

125. Exhibit J-1, Substance Abuse Block Grant Project Plan replaces Exhibit J in its entirety, and is attached as a separate document to this Amendment.

126. Exhibit L-1, Service Area Matrix replaces Exhibit L in its entirety, and is attached hereto and incorporated herein.

127. Exhibit P-2, Federal Award Identification for Subrecipients, replaces Exhibit P-1 in its entirety, and is attached hereto and incorporated herein.

128. Exhibit R-1, Semi-Annual Trueblood Misdemeanor Diversion Fund replaces Exhibit R in its entirety, and is attached hereto and incorporated herein.

129. A new Exhibit S, Criminal Justice Treatment Account is attached as a separate document to this Amendment, and incorporated herein.

130. A new Exhibit T, Community Behavioral Health Expenditure fund is attached as a separate document to this Amendment, and incorporated herein.

131. A new Exhibit U, Grievance, Adverse Authorization Determination, and Appeals is attached as a separate document to this Amendment, and incorporated herein.

132. This Amendment will be effective July 1, 2020 (“Effective Date”).

133. All capitalized terms not otherwise defined herein have the meaning ascribed to them in the Contract.

134. All other terms and conditions of the Contract remain unchanged and in full force and effect.

The parties signing below warrant that they have read and understand this Amendment and have authority to execute the Amendment. This Amendment will be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

Exhibit A-3: Non-Medicaid Funding Allocation
Salish BH-ASO

This Exhibit addresses Non-Medicaid funds in the Salish RSA for the provision of crisis services and non-crisis behavioral health services for July 1, 2020, through December 31, 2020, of state fiscal year (SFY) 2021.

MHBG and SABG funds will be administered by the BH-ASO in accordance with the plans developed locally for each grant. Bock grant funding is shown for the full SFY 2021, and spending in January-June 2021 is also counted out of these totals.

Line items such as Dedicated Marijuana Account (DMA), Criminal Justice Treatment Account (CJTA), Jail Services, 5480 – ITA Non-Medicaid, Detention Decision Review, Ombuds, and the Behavioral Health Advisory Board are allocated to the BH-ASO. GF-S, Program for Assertive Community Treatment (PACT), and Assisted Outpatient Treatment (AOT) provisos are allocated between the BH-ASO and MCOs on an 80/20 basis.

Table 1: Salish RSA July-December 2020 GF-S Funding

Fund Source	Monthly	Total 6 Months
Flexible GF-S	$317,401	$1,904,406
PACT	$11,583	$69,498
Assisted Outpatient Tx	$5,147	$30,882
Flexible GF-S (ASO)	$16,443	$98,658
Jail Services	$9,561	$57,366
ITA - Non-Medicaid funding	$13,605	$81,630
Detention Decision Review	$2,291	$13,746
Crisis Triage/Stabilization	$42,205	$253,230
Long-Term Civil Commitment Court Costs	$537	$3,222
Trueblood Misdemeanor Diversion	$10,940	$65,640
DMA	$18,880	$113,280
CJTA	$21,817	$130,902
CJTA Therapeutic Drug Court	$18,975	$113,850
CJTA State Drug Court	$17,573	$105,438
Secure Detox	$8,466	$50,796
Behavioral Health Advisory Board	$3,333	$19,998
Ombuds	$3,750	$22,500
Discharge Planners	One-Time payment	$71,529
BH Service Enhancements	One-Time payment	$109,956
Total	**$522,507**	**$3,316,527**

Table 2: Salish RSA FY 2021 Grant Funding (12 months)

Fund Source	Total FY2020
MHBG (Full Year SFY2021)	$329,354
Peer Bridger (Full Year SFY2021)	$160,000
FYSPRT (Full Year SFY2021)	$75,000
SABG (Full Year SFY2021)	$1,209,622

Explanations

All proviso dollars are GF-S funds. Outlined below, are explanations of the provisos and dedicated accounts applicable **to all regions that receive the specific proviso**:

- **Juvenile Drug Court:** Funding to provide alcohol and drug treatment services to juvenile offenders who are under the supervision of a juvenile drug court.

- **State Drug Court:** Funding to provide alcohol and drug treatment services to offenders who are under the supervision of a drug court.

- **Jail Services:** Funding to provide mental health services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate access to programs that offer mental health service upon mentally ill offenders' release from confinement. This includes efforts to expedite applications for new or re- instated Medicaid benefits.

- **WA - Program for Assertive Community Treatment (WA - PACT)/Additional PACT:** Funds received per the budget proviso for development and initial operation of high-intensity programs for active community treatment WA- PACT teams.

- **1109 PACT Startup:** Funding to ensure the productive startup of services while maintaining fidelity to the PACT model. These funds are provided for provider startup expenses.

- **Detention Decision Review:** Funds that support the cost of reviewing a DCR's decision whether to detain or not detain an individual under the State's involuntary commitment statutes.

- **Criminal Justice Treatment Account (CJTA):** Funds received, through a designated account in the State treasury, for expenditure on: a) SUD treatment and treatment support services for offenders with an addition of a SUD that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; b: the provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program.

- **CJTA Therapeutic Drug Court:** Funding to set up of new therapeutic courts for cities or counties or for the expansion of services being provided to an already existing therapeutic court that engages in evidence-based practices, to include medication assisted treatment in jail settings pursuant to RCW 71.24.580.

- **Assisted Outpatient Treatment:** Funds received to support Assisted Outpatient Treatment (AOT). AOT is an order for Less Restrictive Alternative Treatment for up to ninety days from the date of judgment and does not include inpatient treatment.

- **Dedicated Marijuana Account (DMA):** Funding to provide a) outpatient and residential SUD treatment for youth and children; b) PPW case management, housing supports and residential treatment program; c) contracts for specialized fetal alcohol services; d) youth drug courts; and e) programs that support intervention, treatment, and recovery support services for middle school and high school aged students. All new program services must direct at least eighty-five percent of funding to evidence-based on research-based programs and practices.

- **ITA Non-Medicaid – Mobile Crisis (5480 Proviso):** Funding that began in 2013, to provide additional local mental health services to reduce the need for hospitalization under the Involuntary Treatment Act in accordance with regional plans approved by DBHR.

- **Secure Detoxification:** Funding for implementation of new requirements of RCW 71.05,

RCW 71.34 and RCW 71.24 effective April 1, 2018, such as evaluation and treatment by a SUDP, acute and subacute detoxification services, and discharge assistance provided by a SUDP in accordance with this Contract.

- **Crisis Triage/Stabilization and Step-Down Transitional Residential:** Funding originally allocated under SSB 5883 2017, Section 204(e) and Section 204(r) for operational costs and services provided within these facilities.

- **Behavioral Health Enhancements (one-time payment):** Funding for the implementation of regional enhancement plans originally funded under ESSB 6032 and continued in ESHB 1109.SL Section 215(23).

- **Discharge Planners (one-time payment):** These are funds received for a position solely responsible for discharge planning.

- **Trueblood Misdemeanor Diversion Funds:** These are funds for non-Medicaid costs associated with serving individuals in crisis triage, outpatient restoration, Forensic PATH, Forensic HARPS, or other programs that divert individuals with behavioral health disorders from the criminal justice system.

- **Ombuds:** Specific General Fund allocation to support a regional ombuds.

- **Behavioral Health Advisory Board (BHAB):** Specific General Fund allocation to support a regional BHAB.

Outlined below are explanation for provisos applicable to specific regions:

- **ITA 180 Day Commitment Hearings:** Funding to conduct 180 day commitment hearings.

- **Assisted Outpatient Treatment (AOT) Pilot:** Funding for pilot programs in Pierce and Yakima counties to implement AOT.

- **Spokane: Acute Care Diversion:** Funding to implement services to reduce the utilization and census at Eastern State Hospital.

- **MH Enhancement – Mt Carmel (Alliance):** Funding for the Alliance E&T in Stevens County.

- **MH Enhancement-Telecare:** Funding for the Telecare E&T in King County.

- **Crisis Stabilization Support (one-time payment):** Funds provided specifically for subcontract arrangements with Pioneer Human Services and Compass Health, to provide crisis stabilization services for non-Medicaid individuals in Whatcom County.

- **Island County Crisis Stabilization:** These funds must be used for crisis stabilization services that are not reimbursable under Medicaid provided in a crisis stabilization center in Island County. Administrative expenses are limited to 5% for these funds.

- **Long-Term Civil Commitment Beds:** This funding is for court costs and transportation costs related to the provision of long-term inpatient care beds as defined in RCW 71.24.025 through community hospitals or freestanding evaluation and treatment centers.

EXHIBIT C

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Exhibit E-1

Crisis System Reporting

Quarterly Reporting

Crisis System quarterly reports must be submitted by the last day of the month following each quarter and must include the following reported for each month of the quarter:

1. **Crisis Calls**
   a) Total number of crisis calls received
   b) Total number of crisis calls answered
   c) Average answer time of all crisis calls (seconds)
   d) Percentage of crisis calls answered live within 30 seconds
   e) Percentage of crisis calls abandoned

2. **Mobile Crisis Team**

   a) Total number of face to face crisis contacts

3. **Designated Crisis Responder (DCR)**

   a) Total number of ITA investigations
   b) Total number of ITA investigations resulting in a referral to outpatient treatment
   c) Total number of ITA investigations resulting in a referral to voluntary inpatient treatment
   d) Total number of ITA investigations resulting in detention under ITA

Annual Reporting

Crisis System annual reports must be submitted by January 31st for the previous calendar year and must include:

1. A summary and analysis about each regions crisis system, to include information from the quarterly crisis system reports, callers funding sources (Medicaid, non-Medicaid, other) and caller demographics including age, gender, and ethnicity.

2. A summary of crisis system coordination activities with external entities, including successes and challenges. External entities addressed in the summary must include but are not limited to regional Managed Care Organizations (MCOs), community behavioral health providers, First Responders, partners within the criminal justice system, and Tribal entities.

3. A summary of how Individuals crisis prevention plans are used to inform DCRs dispatched on crisis visits, reduce unnecessary crisis system utilization and maintain the

Individual's stability. Include in the summary an analysis of the consistency of use and effectiveness of the crisis prevention plans.

4. Provide a summary of the development, implementation, and outcomes of activities and strategies used to improve the crisis system. To include:

   - An overview and analysis of available information and data about the disposition of crisis calls.
   - Coordination of referrals to provider agencies or MCOs for case management, awareness of frequent crisis line callers and reduction of law enforcement involvement with the crisis system.
   - A description of how crisis system data is used throughout the year, including the use of information from community partners about the crisis system effectiveness.
   - Any systemic changes to the crisis system planned in the upcoming year as a result of the information and data.

Exhibit G-1

Behavioral Health Services

Status	Service	Medicaid	MHBG	SABG	GFS	Drug Court
Required for Medicaid Enrollees	Brief Intervention (Any Level, Assessment not Required)	x	X	x	x	x
Required for Medicaid Enrollees	Acute Withdrawal Management (ASAM Level 3.2WM)	x		x	x	x
Required for Medicaid Enrollees	Sub-Acute Withdrawal Management (ASAM Level 3.2WM)	x		x	x	x
Required	Secure Withdrawal Management	x		x	x	x
Required for Medicaid Enrollees	Intensive Home-Based Services (SMI/SED)	X	X		X	
Required for Medicaid Enrollees	Outpatient Treatment (ASAM Level 1) or SMI/SED	x	X	x	x	x
Required for Medicaid Enrollees	Intensive Outpatient Treatment (ASAM Level 2.1) or SMI/SED	x	X	x	x	x
Required for Medicaid Enrollees	Brief Outpatient Treatment (ASAM Level 1) or SMI/SED	x	X	x	x	x
May be provided or arranged for Medicaid Enrollees when available as a treatment option	Opioid Treatment Program (ASAM Level 1)	x		x	x	x
Required for Medicaid Enrollees	Case Management (ASAM Level 1, 2) or SMI/SED	x	X	x	x	x
Required for Medicaid Enrollees	Intensive Inpatient Residential Treatment (ASAM Level 3.5)	x		x	x	x
Required for Medicaid Enrollees	Long-term Care Residential Treatment (ASAM Level 3.3)	x		x	x	x
Required for Medicaid Enrollees	Residential Treatment (Recovery House ASAM Level 3.1) or for SMI/SED	x	X	x	x	x
Required for Medicaid Enrollees	Assessment	x	X	x	x	x

Optional	Engagement and Referral		X	x	x	
Optional	Alcohol/Drug Information School				x	
Required if delivering SABG Services	Opioid Dependency Outreach			x	x	
Required if delivering SABG Services to PPW/IUID	Interim Services		X	x	x	x
Optional	Community Outreach			x	x	x
Optional	Crisis Services		X	x	x	
Optional	Sobering Services			x	x	
Required	Involuntary Commitment Investigations and Treatment	*	X	x	x	x
Required for Medicaid Enrollees	Room and Board		X	x	x	x
Priority to meet SABG 5% PPW Set-Aside	Therapeutic Interventions for Children		X	x	x	
Optional	Transportation		X	x	x	x
Optional	Childcare Services		X	x	x	x
Priority to meet SABG 5% PPW Set-Aside	PPW Housing Support Services			x	x	
Optional	Family Hardship				x	
Optional	Recovery Support Services			x	x	
Required if receiving SABG or MHBG funds	Continuing Education/ Workforce Development		X	x	x	
Optional	Medication Services not covered by insurance or Medicaid (SMI/SED)		X		X	
Optional	Assisted Living Services (SMI/SED)		X		X	
Optional	Assertive Community Treatment	X	X		X	

*Involuntary Residential Treatment may be paid for with Medicaid funds if service is delivered in a Non-IMD Setting.

Exhibit H-1
Peer Bridger Program

1) Peer Bridger Program Overview

The Peer Bridger Program is intended to serve those who are currently at Western State Hospital (WSH), Eastern State Hospital (ESH) or community hospitals with inpatient mental health beds, and have had a lengthy hospitalization or a history of frequent, multiple hospitalizations. Participation in the program is voluntary. The Peer Bridgers will attempt to engage Individuals in planning their discharge. Hospital staff and the IMC/BH-ASO Hospital Liaisons will help the Peer Bridgers identify potential participants.

The Peer Bridger will transition from spending time on social support and begin offering assistance with independent living skills, coping skills and community adjustment skills. The hand-off between the Peer Bridger and the community behavioral health provider who is providing mental health services will be gradual and based on the Individual's needs and their person-centered plan. The anticipated duration of in-community Peer Bridger services is one hundred twenty days with extensions granted by the BH-ASO on a case-by-case basis.

The Peer Bridger is not a case manager, discharge planner or a crisis worker. However, the Peer Bridger can bring the Individual's perspective into the provision of those services.

2) Peer Bridger Program Duties

a) The Peer Bridger will work with six to twelve (6-12) program Individuals. Prior to hospital discharge the majority of the work will be inside the state or local psychiatric hospitals or Evaluation and Treatment facilities. Post-discharge activities will be in the community. Peer Bridgers shall routinely engage and interact with potential program participants.

   i) The Contractor shall contract with an agency licensed as a Community Behavioral Agency by DOH to provide recovery support services.

   ii) After being recruited, and prior to beginning hospital related activities, the Peer Bridger or Peer Bridger team will:

      (1) Participate in statewide Peer Bridger Orientation and training.

      (2) Participate in statewide Peer Bridger Orientation and training.

      (3) Participate in orientation at WSH or ESH and any specialized training required by state hospitals.

      (4) Complete required non-disclosure, Acknowledgement of Health Care Screening for Contractors and other required forms.

b) The same Peer Bridger shall work directly with Individuals and potential Individuals and follow the Individuals into the community setting to ensure consistency with the “bridging” process. After discharge, the time spent between the community and the inpatient setting shall be adjusted to respond to Individuals in the hospital and Individuals in the community. In conjunction with the MCO/BH-ASO Hospital Liaisons and State Hospital Peer Bridger Liaison (identified during orientation), the Peer Bridger will work to engage potential Individuals. These Individuals may:

   i) Have been on the hospital “referred for active discharge planning”; or

   ii) Be individuals with multiple state hospitalizations or involuntary hospitalizations; or

   iii) Be individuals with hospital stays of over one year; or

   iv) Be individuals whom hospital staff and/or the Hospital Liaison have been unable to engage in their own discharge planning; or

   v) Be individuals who require additional assistance to discharge and/or need support in the community.

c) Examples of Peer Bridger engagement activities may include:

   i) Interacting with potential participants.

   ii) Developing a trusting relationship with participants.

   iii) Promoting a sense of self-direction and self-advocacy.

   iv) Sharing their experiences in recovery.

   v) Helping motivate through sharing the strengths and challenges of their own illness.

   vi) Considering the Individual’s medical issues and helping them develop wellness plans they can pursue in accordance with their physician recommendations.

   vii) Helping the Individual plan how they will successfully manage their life in the community.

   viii) Educating Individuals about resources in their home community.

   ix) Join with the Individual (when requested by the Individual) in treatment team meetings if there are no safety concerns. Help to convey the Individual’s perspectives and assist the Individual with understanding the process.

d) The Peer Bridger shall support the Individual in discharge planning to include the following:

   i) Function as a member of the Individual’s hospital discharge planning efforts.

   ii) Identify Individual-perceived barriers to discharge, assist the Individual with working through barriers and assure the Individual that they will be supported throughout the process.

iii) Coordinating in conjunction with discharge planning efforts for the Individual to travel back to his or her community.

iv) The Peer Bridgers shall conduct routine weekly hospital-based engagement groups for any individual willing to participate.

e) Peer Bridger team duties:

i) Participate in monthly statewide Peer Bridger Program administrative support conference calls.

ii) Participate in biannual Peer Bridger Training events scheduled by HCA.

iii) Ensure that Peer Bridgers Complete Tracking logs on a monthly basis and submit logs to HCA via secured email

f) Community-based post-discharge activities will include:

i) The frequency and duration of community based Peer Bridger services will be determined by the Individual's needs, the service level required to help the individual stay safely in the community and caseload prioritization. Peer Bridger services will be decreased when the Individual is receiving behavioral health treatment and peer services from a behavioral health agency or when the Individual no longer wants the Peer Bridger's support. The Peer Bridger shall facilitate a "warm hand-off'' to the behavioral health agency chosen by the Individual. Warm hand-off activities may include:

(1) Being present and supportive during the Individual's first appointment and during the intake evaluation, primary provider or prescriber appointments, etc.

(2) Helping the Individual complete any necessary paperwork for receiving BH services.

(3) Supporting the Individual's self-advocacy in the development of their own community treatment plan and treatment activities.

ii) The Peer Bridger may assist the Individual in developing a crisis plan with the Individual's behavioral health service agency. The Peer Bridger may be identified as a non-crisis resource in the plan.

iii) The Peer Bridger shall:

(1) Attempt to connect the Individual with natural support resources and the local recovery community and attend meetings as allowed.

(2) Help the Individual develop skills to facilitate trust-based relationships, develop strategies for maintaining wellness and develop skills to support relationships.

(3) Assist the Individual in developing a life structure, including skills for daily living such as visits to coffee shops, use of local transportation, opening a bank account, work effectively with a payee if needed, understand benefits, budget planning, shopping and meal preparation, access leisure activities, find a church or faith home, attain and maintain housing, etc.

(4) Help the Individual develop skills to schedule, track and attend appointments with providers.

(5) Help the Individual develop skills for self-advocacy so that the Individual can better define his or her treatment plan and communicate clearly with professionals such as psychiatric prescribers, primary care doctors, etc. The Peer Bridger should also help Individuals prepare for appointments and identify questions or comments the Individual might have for the provider.

(6) Explore supported employment that addresses the following:

(a) Employment goals and how they relate to recovery.

(b) The availability of additional training and education to help the Individual become employable.

(c) The array of employment programs and supported employment opportunities available within the region.

g) Peer Bridgers should demonstrate that recovery is possible and model the ten components of recovery as defined in the SAMHSA Consensus Statement on Mental Health Recovery (http://store.samhsa.gov/shin/content/SMA05-4129/SMA05-4129.pdf). Peer Bridgers shall:

i) Participate in hospital and IMC/BH-ASO Peer Bridger trainings.

ii) Coordinate activities with the MCO/BH-ASO Hospital liaison.

iii) Participate in monthly, statewide Peer Bridger Program support conference calls.

iv) Attend and participate in quarterly Peer Bridger team coordination meetings at both ESH and WSH and trainings or conferences as directed by HCA.

v) Complete Tracking logs on a monthly basis and submit logs to The Contractor.

vi) Meet the documentation requirements of the state hospital and their employer.

h) The Peer Bridger team, including Peer Bridger Supervisor will:

i) Participate in monthly, statewide Peer Bridger Program administrative support conference calls.

ii) Participate in bi-annual Peer Bridger Training events scheduled by DBHR.

iii) Ensure that Peer Bridgers Complete tracking logs on a monthly basis and submit logs to DBHR via secured or encrypted emails.

iv) Coordinate and communicate Peer Bridger team schedules for participating at the hospital with Peer Bridger coordinator.

i) The Peer Bridger Job Description must contain the following elements:

i) Required Qualifications

(1) Lived experience of mental health recovery and the willingness to share his/her own experiences.

(2) Ability to work flexible hours.

(3) Valid Washington Driver's license or the ability to travel via public transportation.

(4) Ability to meet timely documentation requirements.

(5) Ability to work in a cooperative and collaborative manner as a team member with Hospital staff, MCO/BH-ASO staff, and program Individuals.

(6) Strong written and verbal communication skills.

(7) General office and computer experience.

(8) Washington Certified Peer Specialist with at least two years' experience working as a peer.

(9) Dress professionally and appropriately.

ii) Desired Qualifications

(1) Ability and experience working with people from diverse cultures.

(2) Experience with state hospital system.

(3) Ability to form trusting and reciprocal relationships.

Exhibit I-1

Mental Health Block Grant Project Plan

Attached as a separate Excel document

Exhibit J-1

Substance Abuse Block Grant Project Plan

Attached as a separate Excel document

Exhibit L-1
Service Area Matrix
Effective July 1, 2020

County	BH-ASO
ADAMS	Spokane
ASOTIN	Greater Columbia
BENTON	Greater Columbia
CHELAN	NCWA - Beacon Health Options
CLALLAM	Salish
CLARK	SWWA - Beacon Health Options
COLUMBIA	Greater Columbia
COWLITZ	Great Rivers
DOUGLAS	NCWA - Beacon Health Options
FERRY	Spokane
FRANKLIN	Greater Columbia
GARFIELD	Greater Columbia
GRANT	NCWA - Beacon Health Options
GRAYS HARBOR	Great Rivers
ISLAND	North Sound
JEFFERSON	Salish
KING	King
KITSAP	Salish
KITTITAS	Greater Columbia
KLICKITAT	SWWA – Beacon Health Options
LEWIS	Great Rivers
LINCOLN	Spokane
MASON	Thurston-Mason
OKANOGAN	NCWA – Beacon Health Options
PACIFIC	Great Rivers
PEND OREILLE	Spokane
PIERCE	Pierce – Beacon Health Options
SAN JUAN	North Sound
SKAGIT	North Sound
SKAMANIA	SWWA – Beacon Health Options
SNOHOMISH	North Sound
SPOKANE	Spokane
STEVENS	Spokane
THURSTON	Thurston-Mason
WAHKIAKUM	Great Rivers
WALLA WALLA	Greater Columbia
WHATCOM	North Sound
WHITMAN	Greater Columbia
YAKIMA	Greater Columbia

Exhibit P-2

Federal Award Identification for Subrecipients

July – December 2020

Federal Award Identification for Subrecipients (reference 2 CFR 200.331)
Substance Abuse Block Grant

(i) Subrecipient name (which must match the name associated with its unique entity identifier);	Kitsap County DBA Salish Behavioral Health Administrative Service Organization
(ii) Subrecipient's unique entity identifier; (DUNS)	07-185-5191
(iii) Federal Award Identification Number (FAIN);	B08TI010056
(iv) Federal Award Date (see §200.39 Federal award date);	6/4/2019
(v) Subaward Period of Performance Start and End Date;	1/1/2020 – 12/31/2020
(vi) Amount of Federal Funds Obligated by this action;	$1,209,622
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	$1,698,976
(viii) Total Amount of the Federal Award;	$76,172,934
(ix) Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);	**Block Grant for Prevention and Treatment of Substance Abuse**
(x) Name of Federal awarding agency, pass-through entity, and contact information for awarding official,	Department of Health and Human Services Substance Abuse and Mental Health Services Administration Washington State HCA Michael Langer, Assistant Director DBHR PO Box 45330 Olympia, WA 98504-5330 Michael.langer@hca.wa.gov
(xi) CFDA Number and Name; the pass-through entity must identify the dollar amount made available under each Federal award and the CFDA number at time of disbursement;	93.959
(xii) Identification of whether the award is R&D; and	☐ Yes ☒ No
(xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per §200.414 Indirect (F&A) costs).	5%

Federal Award Identification for Subrecipients (reference 2 CFR 200.331)
Mental Health Block Grant

(i) Subrecipient name (which must match the name associated with its unique entity identifier);	Kitsap County DBA Salish Behavioral Health Administrative Service Organization
(ii) Subrecipient's unique entity identifier; (DUNS)	07-185-5191
(iii) Federal Award Identification Number (FAIN);	B09SM010056
(iv) Federal Award Date (see §200.39 Federal award date);	7/18/2019
(v) Subaward Period of Performance Start and End Date;	1/1/2020 – 12/31/2020
(vi) Amount of Federal Funds Obligated by this action;	$489,354
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	$1,698,976
(viii) Total Amount of the Federal Award;	$32,638,787
(ix) Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA);	**Block Grant for Community Mental Health**
(x) Name of Federal awarding agency, pass-through entity, and contact information for awarding official,	Department of Health and Human Services Substance Abuse and Mental Health Services Administration Washington State HCA Michael Langer, Assistant Director DBHR PO Box 45330 Olympia, WA 98504-5330 Michael.langer@hca.wa.gov
(xi) CFDA Number and Name; the pass-through entity must identify the dollar amount made available under each Federal award and the CFDA number at time of disbursement;	93.958
(xii) Identification of whether the award is R&D; and	☐ Yes ☒ No
(xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per §200.414 Indirect (F&A) costs).	5%

Exhibit R-1
Semi-Annual Trueblood Misdemeanor Diversion Funds Report

1. As per the contract deliverable, the Contractor will provide a report on the number of individuals served with the Trueblood Misdemeanor Diversion Funds resources.
2. Please complete the matrix and identify the number of individuals served with the Trueblood Misdemeanor Diversion Funds for each of the categories.
3. Reports are due January 31, for the reporting period of July through December of the previous year, and by July 31, for the reporting period of January through June of the current year. Please send your report to: HCABHASO@hca.wa.gov.

	Number of unique individuals served during SFY 20 with Misdemeanor Diversion funding
Crisis Services	
Freestanding Evaluation and Treatment (E&T)	
Mental Health Residential Treatment	
Room and Board in a Residential Setting	
Psychiatrist Inpatient Treatment - Facility Fee	
ITA Commitment Services	
ITA Judicial Administrative, 90, & 180 Day Commitment Hearings	
Program for Active Community Treatment (PACT)	
Outpatient Mental Health Treatment	
Supported Employment	
Respite Care	
Rehab Case Management	
Transportation (MH)	
Interpreter Services	
Ombuds	
Other	

Exhibit S

Criminal Justice Treatment Account Quarterly Progress Report

Attached as a separate PDF document

Exhibit T

Community Behavioral Health Enhancement Funds

Quarterly Report

Attached as a separate Excel document

Exhibit U

Grievance, Adverse Authorization Determination, and Appeals

Attached as a separate Excel document

BH - ASO: Crisis System Quarterly Report Template					
BH ASO:					
BH-ASO Contact Person:					
BH-ASO Contact Person Phone Number:					
BH-ASO Contact Person Email:					
Reporting Period (quarter/year):					
Date of Report Submission:					
Exhibit E.	Metric / Information	Month 1	Month 2	Month 3	**Quarter Total**
Crisis Calls					
1a	Total number of crisis calls received				
1b	Total number of crisis calls answered				
1c	Average answer time of all crisis calls (seconds)				
1d	Percentage of crisis calls abandoned				
1e	Percentage of crisis calls answered live within 30 seconds				
Mobile Crisis Team					
2a	Total number of face to face crisis contacts				
Designated Crisis Responder					
3a	Total number of DCR events				
3b	Total number of DCR events resulting in a referral to outpatient treatment				
3c	Total number of DCR events resulting in a referral to voluntary inpatient treatment				
3d	Total number of DCR events resulting in detention under ITA				

Peer Bridger Participant Log													
Peer Bridger Name:			Organization:				PB Email address:						
Status	Last Name	First Name	Provider 1 Client ID	Region the individual is from:	Date of Birth	Contact Date	Which State Hospital?	Ward	Referred by?	On the D/C list Y or N	Projected D/C Date	D/C Placement type (please specify if other) Independent Housing Adult Family Home Assisted Living Adult residential treat Family member home Skilled Nursing Facility Other - please explain	

dger Participant Log													
r Name:											Discharge from PB project		
Last Name	First Name	If 'Other' please specify	Actual D/C Date	Service Participant Goals: Develop Self-Advocacy s Natural Supports Promote Socialization Develop a wellness plan Meaningful activities (E Connect to community Connect to OP Peer Sup Other - please explain i	If 'Other' please specify	Engagement with Community BH Agency Date	Community BH Agency Name	Warm handoff to Peer Specialist at CBH Agency Date	Did the participant meet their goal? (Y or N)	Date	Reason	NOTES:	

Peer Bridger Activity Log						
Peer Bridger Name:		**Organization:**			**PB Email address:**	
[##/##/####] **Date:**	**Activity**	**If 'Other' please specify**	**Amount of time spent in activity (Time in hour - 1 (hr) or .5 (hr) - Numbers only please)**			

- Independent Housing
- Adult Family Home
- Assisted Living
- Adult residential treatment facility
- Family member home
- Skilled Nursing Facility
- Other - please explain in next column

- Develop Self-Advocacy skills
- Natural Supports
- Promote Socialization
- Develop a wellness plan/activities
- Meaningful activities (Employment, school, volunteering, recre
- Connect to community resources (library, self-help center)
- Connect to OP Peer Support
- Other - please explain in next column

- Activities
- Meeting with BHO Hospital Liaison
- Meeting with local peer
- Researching community resources
- Meeting with Treatment team
- Agency training
- In-Person State Hosp Meetings
- Monthly Peer Bridger administrative call
- Peer related training
- State Hosp related training
- Meeting with Hosp Peer or Community Links
- WRAP training
- Collateral activities on behalf of an individual
- Paperwork
- Groups
- Supervision
- Travel
- Housing related activities
- Other - Please explain in next column

Introduction

Washington State provides Combined Federal Block Grant service through BH-ASOs. Contracts with BH-ASOs support flexibility to meet the needs of populations based on local planning efforts and goals as identified in this Project Plan. The goal of the MHBG Project Plan is to ensure effective services are provided across populations with measurable outcomes.

This Plan is for July 1, 2020 – June 30, 2021. All Mental Health Block Grant funds contractually allocated for services provided, but not expended for services actually provided by June 30, 2021, may not be used or carried forward.

Please complete both sections (Section 1- Proposed Plan Narratives and Section 2 – Proposed Project Summaries and Expenditures) in this document and submit electronically to HCA for approval prior to submitting your first A-19 invoice.

Contact the person identified above if there are any questions:

Danny Highley, Behavioral Health Program Manager
Danny.highley@hca.wa.gov

MHBG Final Reports are due by August 1.

DO NOT MODIFY OR DELETE ANY PARTS OF THIS TEMPLATE.

Instructions:
• Provide a detailed description for each anticipated range of services. There is no word limit. Each cell will automatically expand.
• Only complete Categories/Subcategories that align with local plans. There is no requirement to provide services in each Category.
• Insert Planned Expenditure Amounts for each category under the column heading "Proposed Total Expenditure Amount." The Grand Total at bottom of that column must equal total MHBG Allocation.
• Insert the number of Adults with SMI** and Children with SED** projected to be served.
• "Outcomes and Performance Indicators" – Provide planned outcomes that are measurable and define what indicators will be used to support progress towards outcomes.

**SMI/SED Definitions - For MHBG planning and reporting, SAMHSA has clarified the definitions of SED and SMI: Children with SED refers to persons from birth to age 18 and adults with SMI refers to persons age 18 and over: (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g. most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Revision date 3/26/2020

Region:	
Current Date:	
Total MHBG Allocation:	
Contact Person:	
Phone Number:	
Email:	

Section 1
Proposed Plan Narratives

Needs Assessment	Describe what strengths, needs, and gaps were identified through a need's assessment of the geographic area of the region. To the extent available, include age, race/ethnicity, gender, and language barriers.
	Begin writing here *:*
Cultural Competence *	Provide a narrative summarizing how cultural competence overall, is incorporated within proposed projects. Identify what anticipated efforts will be taken to measure progress.
	Begin writing here *:*
Children's Services	Describe how integrated system of care will be provided for children with SED with multiple needs, including: social services, educational services, juvenile services, and substance use disorder services.
	Begin writing here *:*

Public Comment/Local/ BH Advisory Board Involvement	Describe how integrated system of care will be provided for children with SED with multiple needs, including: social services, educational services, juvenile services, and substance use disorder services.
	Begin writing here *:*
Outreach Services	Provide a description of how outreach services will target individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.
	Begin writing here *:*
Staff Training	Describe the plan to ensure training is available for mental health providers and to providers of emergency mental health services and how this plan will be implemented.
	Begin writing here *:*
Program Compliance	Provide a description of the strategies that will be used for monitoring program compliance with all MHBG requirements.
	Begin writing here *:*

Cost Sharing (optional)	Provide a description of the policies and procedures established for cost-sharing, to include how individuals will be identified as eligible, how cost-sharing will be calculated, and how funding for cost-sharing will managed and monitored.
	Begin writing here *:*

Section 2
Proposed Project Summaries and Expenditures

Category/Subcategory	Provide a plan of action for each supported activity	Proposed #Children with SED	Proposed #Adults with SMI	Proposed Total Expenditure Amount
Prevention & Wellness – Activities that enhance the ability of persons diagnosed with SMI or SED, including their families, to effectively decrease their need for intensive mental health services:				$100,000.00
Screening, Brief Intervention and Referral to Treatment	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Brief Motivational Interviews	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Parent Training	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Facilitated Referrals	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Relapse Prevention/ Wellness Recovery Support	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Warm Line: Please note that ALL costs that directly serve persons with SMI/SED and their families must be tracked.	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00

Outcomes and Performance Indicators:

Engagement Services – Activities associated with providing evaluations, assessments, and outreach to assist persons diagnosed with SMI or SED, including their families, to engage in mental health services:				$100,000.00
Assessment	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Specialized Evaluations (Psychological and Neurological)	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Service Planning (including crisis planning)	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Educational Programs	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Outreach	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Outcomes and Performance Indicators:				

Outpatient Services – Outpatient therapy services for persons diagnosed with SMI or SED, including services to help their families to appropriately support them.				$100,000.00
Individual Evidenced-Based Therapies	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Group Therapy	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Family Therapy	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Multi-Family Counseling Therapy	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Consultation to Caregivers	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Outcomes and Performance Indicators:				

Medication Services – Necessary healthcare medications, and related laboratory services, not covered by insurance or Medicaid for persons diagnosed with SMI or SED to increase their ability to remain stable in the community.				$100,000.00
Medication Management	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Pharmacotherapy	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Laboratory Services	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Outcomes and Performance Indicators:				

Community Support (Rehabilitative) – Community-based programs that enhance independent functioning for persons diagnosed with SMI or SED, including services to assist their families to care for them.				$100,000.00
Parent/Caregiver Support	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Skill Building (social, daily living, cognitive)	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Case Management	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Continuing Care	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Behavior Management	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Supported Employment	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Permanent Supported Housing	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Recovery Housing	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Therapeutic Mentoring	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Traditional Healing Services	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00

Outcomes and Performance Indicators:

Recovery Support Services – Support services that focus on improving the ability of persons diagnosed with SMI or SED to live a self-direct life, and strive to reach their full potential.				$100,000.00
Peer Support	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Recovery Support Coaching	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Recovery Support Center Services	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Supports for Self-Directed Care	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Outcomes and Performance Indicators:				

Other Supports (Habilitative) – Unique direct services for persons diagnosed with SMI or SED, including services to assist their families to continue caring for them.				$100,000.00
Personal Care	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Respite	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Support Education	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Transportation	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Assisted Living Services	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Trained Behavioral Health Interpreters	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Interactive communication Technology Devices	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Outcomes and Performance Indicators:				

Intensive Support Services – Intensive therapeutic coordinated and structured support services to help stabilize and support persons diagnosed with SMI or SED.				$100,000.00
Assertive Community Treatment	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Intensive Home-Based Services	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Multi-Systemic Therapy	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Intensive Case Management	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Outcomes and Performance Indicators:				

Out of Home Residential Services – Out of home stabilization and/or residential services in a safe and stable environment for persons diagnosed with SMI or SED.				$100,000.00
Crisis Residential/Stabilization	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Adult Mental Health Residential	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Children's Residential Mental Health Services	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Therapeutic Foster Care	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Outcomes and Performance Indicators:				

Acute Intensive Services – Acute intensive services requiring immediate intervention for persons diagnosed with SMI or SED.				$100,000.00
Mobile Crisis	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Peer-Based Crisis Services	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Urgent Care	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
23 Hour Observation Bed	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
24/7 Crisis Hotline Services	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Outcomes and Performance Indicators:				
Non-Direct Activities – any activity necessary to plan, carry out, and evaluate this MHBG plan, including Staff/provider training, travel and per diem for peer reviewers, logistics cost for conferences regarding MHBG services and requirements, and conducting needs assessments.				$100,000.00
Workforce Development/Conferences	*Begin writing here:*	1	1	Enter budget allocation to this proposed activity $0.00
Grand Total				**$1,100,000.00**

Introduction

Washington State provides Substance Abuse Block Grant service delivery through BH-ASOs. Contracts with BH-ASOs support flexibility to meet the needs of populations based on local planning efforts and goals as identified in this Project Plan. The goal of the Substance Abuse Block Grant is to ensure effective services are provided across populations with measurable outcomes and performance indicators.

This Plan is for July 1, 2020 – June 30, 2021. All Substance Abuse Block Grant funds contractually allocated for services provided, but not expended for services actually provided by June 30, 2021, may not be used or carried forward.

Please complete both sections (Section 1- Proposed Plan Narratives and Section 2 – Proposed Project Summaries and Expenditures) in this document and submit electronically to HCA for approval prior to submitting your first A-19 invoice.

Contact the Person identified below if there are any questions:

Jenn Chancellor, Behavioral Health Program Manager
Jenn.chancellor@hca.wa.gov

SABG Final Reports are due annually on August 1.

DO NOT MODIFY OR DELETE ANY PARTS OF THIS TEMPLATE.
Instructions:
• Provide a detailed description for each anticipated range of services. There is no word limit. Each cell will automatically expand.
• Only complete Categories/Subcategories that align with local plans. There is no requirement to provide services in each Category.
• Insert Planned Expenditure Amounts for each category under column heading “Proposed Expenditure Amount.” The “Grand Total” at bottom of that column must equal total contract amount. The “Grand Total” will automatically calculate off of the amounts entered into each “Proposed Total Expenditure Amount” text box.
• Federal Requirement – A minimum of 10% of funding must be expended to maintain, develop or enhance services for Pregnant, Postpartum Women and Women with Dependent Children (PPW). Provide the number of PPW expected to be served.
• “Outcomes and Performance Indicators” – Provide planned outcomes that are measurable and define what indicators will be used to support progress towards outcomes.
• Tab or use your curser to enter information into each text box.
• Use your curser to enter amounts into “Proposed Total Expenditure Amount.” You do not need to enter a “$” – it will automatically add the symbol when you move to the next text box.

Revision Date 03/26/2020

Region:	
Current Date:	
Total SABG Allocation:	
Contact Person:	
Phone Number:	
Email:	

Section 1
Proposed Plan Narratives

Needs Assessment (required)	Describe what strengths, needs, and gaps were identified through a need's assessment of the geographic area of the region. To the extent available, include age, race/ethnicity, gender, and language barriers. ***Begin writing here*** *:*
Cultural Competence (required)	Provide a narrative summarizing how cultural competence overall, is incorporated within proposed projects. Identify what anticipated efforts will be taken to measure progress. ***Begin writing here*** *:*
Continuing Education for Staff (required)	Describe how continuing education for employees of treatment facilities is expected to be implemented. ***Begin writing here*** *:*
Charitable Choice (required)	Provide a description of how faith-based organizations will be incorporated into your network and how referrals will be tracked. ***Begin writing here*** *:*
Coordination of Services (required)	Provide a description of how treatment services are coordinated with the provision of other appropriate services including health, social, correctional and criminal justice, education, vocational rehabilitation and employment services. ***Begin writing here*** *:*
Public Comment/Local Board /BH Advisory Board Involvement (required)	Describe how you facilitated public comment from any person, behavioral health association, individuals in recovery, families, and local boards in the development of this SABG Plan. ***Begin writing here*** *:*

Program Compliance (required)	Provide a description of the strategies that will be used for monitoring program compliance with all SABG requirements.
	Begin writing here *:*

Recovery Support Services (optional)	Provide a description of how and what recovery support services will be made available to individuals in SUD treatment and their families.
	Begin writing here *:*

Cost Sharing (optional)	Provide a description of the policies and procedures established for cost-sharing, to include how individuals will be identified as eligible, how cost-sharing will be calculated, and how funding for cost-sharing will be managed and monitored.
	Begin writing here *:*

Section 2 Proposed Project Summaries and Expenditures The * indicates a required component of the Proposed Project Summary and must be completed				
Category/Subcategory	Provide a plan of action for each supported activity	Proposed # PPW to be served	Outcomes and Performance Indicators	Proposed Total Expenditure Amount
Prevention & Wellness – Preventive services, such as drug use prevention and early intervention, are critical components of wellness:				$0.00
*PPW Outreach (required)	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Outreach to Individuals Using Intravenous Drugs (IUID)	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Brief Intervention	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Drug Screening	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
*Tuberculosis Screening (required)	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Engagement Services – Assessment/admission screening related to SUD to determine appropriateness of admission and levels of care. Education Services may include information and referral services regarding available resources, information and training concerning availability of services and other supports. Educational programs can include parent training, impact of alcohol and drug problems, anxiety symptoms and management, and stress management and reduction. Education services may be made available to individuals, groups, organizations, and the community in general. This is different than staff training. Treatment services must meet the criteria as set forth in Chapter 246-341 WAC.				$0.00
Assessment	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
*Engagement and Referral (required)	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
*Interim Services (required)	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Educational Programs	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Outpatient Services – Services provided in a non-residential SUD treatment facility. Outpatient treatment services must meet the criteria as set forth in Chapter 246-341 WAC.				$0.00
Individual Therapy	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Group Therapy	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00

Family Therapy	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Multi-Family Counseling Therapy	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Medication Assisted Therapy (MAT) - Opioid Substitution Treatment	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Community Support (Rehabilitative) – Consist of support and treatment services focused on enhancing independent functioning.				$0.00
Case Management	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Recovery Housing	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Supported Employment	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Other Support (Habilitative) – Structured services provided in segments of less than 24 hours using a multi -disciplinary team approach to develop treatment plans that vary in intensity of services and the frequency and duration of services based on the needs of the client.				$0.00
PPW Housing Support Services	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Supported Education	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Housing Assistance	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Spiritual/Faith-Based Support	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Intensive Support Services – Services that are therapeutically intensive, coordinated and structured group-oriented. Services stabilize acute crisis and clinical conditions, utilizing recovery principles to help return individuals to less intensive outpatient, case management, and/or other recovery based services.				$0.00
*Therapeutic Intervention Services for Children (required)	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Sobering Services	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Out of Home Residential Services – 24 hour a day, live-in setting that is either housed in or affiliated with a permanent facility. A defining characteristic is that they serve individuals who need safe and stable living environments in order to develop their recovery skills. Treatment services must meet the criteria as set forth in Chapter 246-341 WAC.				$0.00

Sub-acute Withdrawal Management	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Crisis Services Residential/ Stabilization	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Intensive Inpatient Residential Treatment	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Long Term Residential Treatment	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Recovery House Residential Treatment	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Involuntary Commitment	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Acute Intensive Services -24-hour emergency services that provide access to a clinician. The range of emergency services available may include but are not limited to direct contact with clinician, medication evaluation, and hospitalization. Services must meet the criteria as set forth in Chapter 246-341 WAC.				$0.00
Acute Withdrawal Management	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Recovery Supports –A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery emphasizes the value of health, home, purpose, and community to support recovery.				$0.00
*Interim Services (required)	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
*Transportation for PPW (required)	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
Transportation	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
*Childcare Services (required)	*Begin writing here:*	0	*Begin writing here:*	Enter budget allocation to this proposed activity $0.00
*Other SABG activities (required) – any activity necessary to plan, carry out, and evaluate this SABG plan, including Continued Education/training, logistics cost for conferences regarding SABG services and requirements, capacity management infrastructure, and conducting needs assessments.				$0.00
Begin writing here:				
Grand Total				**$0.00**

CRIMINAL JUSTICE TREATMENT ACCOUNT

QUARTERLY PROGRESS REPORT

Please respond to each question and submit to: tony.walton@hca.wa.gov and HCABHASO@hca.wa.gov

Report Quarter

☐**1st State Fiscal Quarter (July 1st-Sept 30th)** ☐**2nd State Fiscal Quarter (Oct 1st-Dec 31st)**

☐**3rd State Fiscal Quarter (Jan 1st- March 31st)** ☐**4th State Fiscal Quarter (Apr 1st- June 30th)**

Name of Region completing Report:

Please enter your status for each item, if item is incomplete please list your plan of correction (POC) including actions to be taken and target date for completion.

1. Contractor ensured all CJTA-funded services were reported through Provider 1 Operating System and Supplemental Transaction?
   ☐Yes ☐No
   If no, please enter POC.

2. Contractor has made attempts to expand access to Recovery Support Services for the intended population?
   ☐Yes ☐No
   If no, please enter POC.

3. Does the Contractor use CJTA funding to provide services for individual in a Therapeutic Court Program?
   ☐Yes ☐No
   If Yes, please indicate the number of individuals who were admitted into the program during this quarter who are receiving medication assisted treatment or medications for opioid use disorder:

   If Yes, please indicate what medications the individuals admitted into the program during this quarter are receiving (e.g. Buprenorphine, Methadone, Naltexone):

4. Is there any indication that the Therapeutic Court programs benefitting from CJTA are denying access to, or requiring titration from, any medications for opioid use disorder?
   ☐Yes ☐No
   Please enter any additional comments here:

5. CJTA funding used in the local, county, city, or tribal jail?
   ☐Yes ☐No
   If Yes, please indicate any barriers to providing treatment services and transitioning individuals into the community:

6. List any other significant accomplishments.

7. List any training or technical assistance needs.

8. Summarize any barrier(s) encountered and plans to overcome the barrier(s) with timeline.

9. Please include any other comments you would like to convey to the HCA Contract Manager:

   Completed By:
   Date:

Instructions for Completing this Workbook

This template is to report data on provider payments funded with Community Behavioral Health Enhancement Funds (CBHEF) appropriated originally under ESSB 6032 Sec. 213 (5)(pp) and continued under HB 1109, Sec. 215(23).

Provider payments reported on this workbook should be limited to payment increases funded with CBHEF Medicaid (MCO) and Non-Medicaid (ASO) dollars.

Please complete the following two sheets:

1.) **Expenditures:** This sheet is for reporting provider payment increases in dollar amounts delineated by the payment mechanism used. Providers in more than one region should be listed under each. *Please see the image at right for how to add additional rows for additional providers as needed.*

Columns F through K: Identify the payment mechanism used for increased payments. These include the three listed in the proviso and three [BLANK] columns. Additional mechanisms should be added on the Payment_Mechanism_Detail sheet, and the headers on the Expenditures sheet will then automatically be updated.

2.) **Payment_Mechanism_Detail**: On this sheet, please answer each question regarding each payment mechanism used. If additional mechanisms were used, please identify them using one of the three [BLANK] headers. If more than three additional payment mechanisms were used please contact Marcus Ehrlander or

Excerpted Proviso language

Twenty percent of the general fund—state appropriation amounts for each regional service area must be used to increase their nonmedicaid funding and the remainder must be used to increase medicaid rates above FY 2018 levels. Effective January 2020, the medicaid funding is intended to increase rates for behavioral health services provided by licensed and certified community behavioral health agencies as defined by the department of health.

...

The authority must require the managed care organizations to provide a report on their implementation of this funding. The authority must submit a report to the legislature by December 1, 2020, summarizing how this funding was used and provide information for future options of increasing behavioral health provider rates through directed payments. The report must identify different mechanisms for implementing directed payment for behavioral health providers including but not limited to minimum fee schedules, across the board percentage increases, and value-based payments. The report must provide a description of each of the mechanisms considered, the timeline that would be required for implementing the mechanism, and whether and how the mechanism is expected to have a differential impact on different providers. The report must also summarize the information provided by managed care organizations in implementing the funding provided under this section. HB 1109, Sec. 215(23)

Inserting rows for additional providers ***Step 1***

Inserting rows for additional providers: ***Step 2***

Health Care Authority | Division of Behavioral Health & Recovery
Calendar Year 2020 Community Behavioral Health Enhancement Funds (CBHEF) Expenditures

Entity Name:
Reporting Period:
Submitted by:

PLEASE COMPLETE CI

Funds Expended by Mechanism *(click links to add)*

PROVIDERS	Fee Schedules	Sub-capitated Rates	Value-based Purchasing	[BLANK 1]	[BLANK 2]	[BLANK 3]	Total Expended	Notes
Great Rivers	$0	$0	$0	$0	$0	$0	$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
	↑ INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) ↑						DRAG DOWN FORMULA FOR NEW LINES	
Greater Columbia	$0	$0	$0	$0	$0	$0	$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
	↑ INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) ↑						DRAG DOWN FORMULA FOR NEW LINES	
King	$0	$0	$0	$0	$0	$0	$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
	↑ INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) ↑						DRAG DOWN FORMULA FOR NEW LINES	

R3	North Central								
		$0	$0	$0	$0	$0	$0	$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	

INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) DRAG DOWN FORMULA FOR NEW LINES

R4	North Sound								
		$0	$0	$0	$0	$0	$0	$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	

INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) DRAG DOWN FORMULA FOR NEW LINES

R5	Pierce								
		$0	$0	$0	$0	$0	$0	$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	

INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) DRAG DOWN FORMULA FOR NEW LINES

R6	Salish								
		$0	$0	$0	$0	$0	$0	$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	
								$0	

INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) DRAG DOWN FORMULA FOR NEW LINES

R7 Southwest	$0	$0	$0	$0	$0	$0	$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	

INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) DRAG DOWN FORMULA FOR NEW LINES

R8 Spokane	$0	$0	$0	$0	$0	$0	$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	

INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) DRAG DOWN FORMULA FOR NEW LINES

R9 Thurston Mason	$0	$0	$0	$0	$0	$0	$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	
							$0	

INSERT ROWS ABOVE THIS ROW (**NOT FROM THIS ROW**) DRAG DOWN FORMULA FOR NEW LINES

$ -	$ -	$ -	$ -	$ -	$ -	$ -

Expand or collapse by clicking the **+ and - symbols at far left.**

Insert additional rows as needed, but please be sure to drag down the SUM() formula in the "Total Expended" column.

Additional Notes

Certification

I have reviewed this report and certify that to the best of my knowledge it is both complete and accurate.

Signature ____________ Date ____________

Organization ____________

Payment Mechanism Detail

This sheet is for providing narrative details on each mechanism implemented to disburse funds as specified in the proviso

		Fee Schedules	Sub-capitated Rates	Value-based Purchasing	[BLANK 1]	[BLANK 2]	[BLANK 3]
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*						
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*						
3	*When was this mechanism implemented?*						
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*						
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*						
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*						

Please identify additional mechanisms here and they will appear on the "Expenditures" sheet. If more than three additional columns are needed please contact HCA.

Delegated Entity	Reporting Period 1, 2, 3, 4	Individual ID	Individual Last Name	Individual First Name	Individual Middle Initial	Individual Birthdate (MM/DD/YYYY)	Provider/ Practitioner Agency Name	Servicing Provider/ Practitioner Last Name	Servicing Provider/ Practitioner First Name	Servicing Provider/ Practitioner Specialty	Servicing Provider/ Practitioner NPI	Type/Level 1. Grievance 2. Adverse Authorization Determination 3. Appeal 4. State Hearing 5. Board of Appeals	Expedited (X if Yes)	Clinical/ Medical Necessity (X if Yes)

Primary Category	Subcategory	Reason	Resolution No more than 30 characters	Date Received (MM/DD/YYYY)	Date Resolved (MM/DD/YYYY)	Date written notice sent to individual and practitioner (MM/DD/YYYY)	Unique BH-ASO record identifier

Washington State Health Care Authority
BH-ASO Narrative Report-- Outlining Trends and Plans for Improvement

BH-ASO Name:	0
Contact Name:	0
Contact Number:	0
Reporting Period:	0

Please provide narrative to the questions below:

1. What are the overall trends in grievances, adverse authorization determinations, and appeals during this reporting period?
Please include specific age groups and trends or patterns in regards to specific categories and/or types of services.
Describe mental health and substance use trends together or separately.

2. Compared to previous reporting periods, describe changes in numbers of Adverse Authorization Determinations, grievances, appeals, and administrative hearings.
a) Are there any significant increases or decreases?

b) If the number of grievances is below 10, or the number of appeals is below 3:
please add an explanation as to how/why and the efforts you have made in training providers/individuals in the grievance and appeal system.
Describe concerns you have with under- and/or over- reporting and the steps you are taking to correct the issue.

3. Additional Comments (optional)

Health Care Authority (HCA)
Grievance and Appeal System Reporting
BH-ASO Quarterly Reporting
Grievance
Field Descriptions

Note: All fields must be populated when applicable or left blank, unless otherwise indicated.

Grievance Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
Column A:	**Delegated Entity** Enter Name of Delegated Entity: Full name of delegated entity Blank = No delegated entity	Identifies the organization's delegated entity that receives and takes action on the grievances. The organization is responsible to integrate the delegated entity's data into the organization's data. There should be no separate data submission for the delegated entities. If no delegated entity leave blank.
Column B:	**Reporting Period** Enter Reporting Quarter as a numerical indicator: 1 = First Quarter 2 = Second Quarter 3 = Third Quarter 4 = Fourth Quarter	Indicates the reporting period the initial grievance is received. Reporting format: 1, 2, 3, or 4. Calendar Quarter: Quarter in which Grievances, Adverse Authorization Determinations, and Appeals were received by the BH-ASO.
Column C:	**Individual ID**	Enter the BH-ASO's ID of the Individual.
Column D:	**Individual Last Name**	Input the name of the person associated with the ID provided in Column C: Individual ID.
Column E:	**Individual First Name**	
Column F:	**Individual Middle Initial**	
Column G:	**Individual Birthdate** Enter the person's birthdate as MM/DD/YYYY Example: 12/01/1985	Input with the birthdate associated with ID and name provided in Columns C through F.
Column H:	**Provider/Practitioner Agency Name**	Identifies the facility or clinic the servicing provider/practitioner is associated with, if associated with the grievance.
Column I:	**Servicing Provider/Practitioner Last Name**	Identifies the servicing provider as the source of an individual's grievance.
Column J:	**Servicing Provider/Practitioner First Name**	
Column K:	**Servicing Provider/Practitioner Specialty**	Identifies type or specialty of servicing provider/practitioner. Should be no more than thirty (30) characters. Examples: Certified Peer Counselor, Crisis Service Provider, Designated Crisis Responder, SUD Provider, etc.
Column L:	**Servicing Provider/Practitioner NPI** Example: 1112345678	Identifies the Servicing Provider/Practitioner's National Provider Identification number (NPI).
Column M:	**Type** Enter Type as a numerical indicator: 1 = Grievance	Specifies the category for the data submitted. This column must be populated for all records.

Grievance Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
Column N:	**Expedited** Enter code as an alpha indicator: X = Yes Blank = Not expedited	Identifies urgency of the grievance. Reporting format: "X" if yes leave blank if no.
Column O:	**Clinical / Medical Necessity** Enter code as an alpha indicator: X = Clinical Blank = Non-clinical	Reporting format: "X" if the grievance is regarding a clinical issue. Leave blank if no.
Column P:	**Primary Category**	Describes what the grievance is about. This key descriptive column must be populated for all records.
	Enter Primary Category as:	
	Access BH-ASO Billing/Claims Coverage and Services Eligibility Quality of Care (QOC) Quality of Service (QOS) Referral/Authorization Written materials	
Column Q:	**Subcategory** Enter Subcategory as:	Provides additional detail of the primary category in Column S. (NOTE: "Other" category should be used sparingly and must include specific information related to the grievance.) This key descriptive column must be populated for all records. Locate Primary Grievance Category Below then select Subcategory to the left:
	Ability to contact BH-ASO	Access
	ADA	
	Co-occurring/Behavioral health	
	Crisis Services	
	Cultural Considerations	
	Distance	
	Housing	
	Mental Health	
	No provider available	
	Other (list specific issue)	
	Provider hours	
	Provider not responsive	
	Substance Use Disorder treatment services	
	Telephone wait time	
	Transportation	
	Wait time	
	Balance Owed	Billing/Claims
	Copay	
	Cost Sharing	
	Misapplied payment	
	Other Health Insurance	
	Other (list specific issue)	
	Price of Service	
	Mental Health - inpatient	Coverage and Services
	Mental Health - outpatient	
	Other (list specific issue)	
	Service not covered	
	Substance Use Disorder - inpatient/residential	
	Substance Use Disorder - outpatient	

Grievance Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
	Not eligible	Eligibility/Membership
	Other (list specific issue)	
	Other Health Insurance	
	Amount of time spent	Quality of Care
	Clinical Skills	
	Diagnosis	
	Other (list specific issue)	
	Treatment delay	
	Treatment plan	
	Confidentiality	Quality of Service
	Dignity and Respect	
	Office/site appearance	
	Other (list specific issue)	
	Responsiveness to requests	
	Staff attitude	
	Non Participating Provider	Referral/Authorization
	Other (list specific issue)	
	Referral/Authorization not allowed	
	Want more visits than allowed	
	Confidentiality	BH-ASO Service
	Coordination of Services	
	Dignity and Respect	
	Other (list specific issue)	
	Plan Service	
	Staff attitude	
	Did not receive, or materials were delayed	Written materials
	Do not understand materials	
	Other (list specific issue)	
Column R:	**Reason** Who is the grievance about? BH-ASO Crisis Provider Health Care Authority (HCA) Inpatient Provider Not Applicable (N/A) Other (list specific issue) Outpatient Provider Residential Provider	Describes who the grievance is about. This key descriptive column must be populated for all records.

Grievance Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
Column S:	**Resolution** Enter Resolution as: In Process Information/Referral Misfiled with ASO - redirected Other Outreach and Coordination Provider Education Reviewed and no action needed Staff Training Withdrawn by Individual	Describes the outcome of the grievance. This key descriptive column must be populated for all records. In the instance that a grievance is identified as in process (not resolved) during a reporting period it will need to be reported on the following quarterly report with resolution.
Column T:	**Date Received** Enter Date Received as MM/DD/YYYY: Example: 12/01/1985	Documents the date the grievance was received. Reporting format: MM/DD/YYYY. This column must be populated for all records.
Column U:	**Date Resolved** Enter Date Resolved as MM/DD/YYYY: Example: 12/01/1985 12/31/2999 = Still in process	Identifies the date a grievance was responded to. In the instance that a grievance is identified as in process (not resolved) during a reporting period it will need to be reported on the following quarterly report with the date of resolution identified. Reporting format: MM/DD/YYYY, if still in process use 12/31/2999.
Column V:	**Date written notice** Enter Date written notice sent to individual and servicing provider as MM/DD/YYYY: Example: 12/01/1985 12/31/2999 = Not applicable	Identifies the Date written notification sent to individual and servicing provider. Required for clinical grievances. Reporting format: MM/DD/YYYY, if not applicable use 12/31/2999.
Column W:	Unique BH-ASO record identifier (optional)	The purpose of the unique record identifier is to track updates to initial record submissions.

Note: All fields must be populated when applicable or left blank, unless otherwise indicated.

Adverse Authorization Determination Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
Column A:	**Delegated Entity** Enter Name of Delegated Entity: Full name of delegated entity Blank = No delegated entity	Identifies the organization's delegated entity that receives and takes action on the adverse authorization determinations. The organization is responsible to integrate the delegated entity's data into the organization's data. There should be no separate data submission for the delegated entities. If no delegated entity leave blank.
Column B:	**Reporting Period** Enter Reporting Quarter as a numerical indicator: 1 = First Quarter 2 = Second Quarter 3 = Third Quarter 4 = Fourth Quarter	Indicates the reporting period the initial adverse authorization determination is received. Reporting format: 1, 2, 3, or 4. Calendar Quarter: Quarter in which Grievances, Adverse Authorization Determinations, and Appeals were received by the BH-ASO.
Column C:	**Individual ID**	Enter the BH-ASO's ID of the Individual.
Column D:	**Individual Last Name**	Input the name of the person associated with the ID provided in Column C: Individual ID.
Column E:	**Individual First Name**	
Column F:	**Individual Middle Initial**	
Column G:	**Individual Birthdate** Enter the person's birthdate as MM/DD/YYYY Example: 12/01/1985	Input with the birthdate associated with ID and name provided in Columns C through F.
Column H:	**Provider/Practitioner Agency Name**	Identifies the facility or clinic the servicing provider/practitioner is associated with.
Column I:	**Servicing Provider/Practitioner Last Name**	Identifies the servicing provider.
Column J:	**Servicing Provider/Practitioner First Name**	
Column K:	**Servicing Provider/Practitioner Specialty**	Identifies type or specialty of servicing provider/practitioner. Should be no more than thirty (30) characters. Examples: Certified Peer Counselor, Crisis Service Provider, Designated Crisis Responder, SUD Provider, etc. This key descriptive column must be populated for all records.
Column L:	**Servicing Provider/Practitioner NPI** Example: 1112345678	Identifies the Servicing Provider/Practitioner's National Provider Identification number (NPI).
Column M:	**Type** Enter Type as a numerical indicator: 2 = Adverse Authorization Determination	Specifies the category for the data submitted. This column must be populated for all records.
Column N:	**Expedited** Enter code as an alpha indicator: X = Yes Blank = Not expedited	Identifies urgency of the adverse authorization determination. Reporting format: "X" if yes leave blank if no.

Adverse Authorization Determination Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
Column O:	**Clinical / Medical Necessity** Enter code as an alpha indicator: X = Action Blank = Adverse Authorization Determination excluding Action	Reporting format: "X" if the denial is an Action, and leave blank if this is an Adverse Authorization Determination (not an Action).
Column P:	**Primary Category** Enter Primary Category as: Mental Health - Inpatient Mental Health - Outpatient Substance Use Disorder - Inpatient/Residential Substance Use Disorder - Outpatient	Describes the "what" or the catalyst for the Adverse Authorization Determination. This key descriptive column must be populated for all records.
Column Q:	**Subcategory** Enter Subcategory as: Denial in part of authorization request Denial in whole of authorization request	Provides additional detail of the primary category in Column S. This key descriptive column must be populated for all records.
Column R:	**Reason** Enter Reason as: Failure to act within authorization decision timeframe Exceeds authorization on file Medical necessity No available resources No referral/authorization on file Non Participating Provider Not contracted service Not meeting criteria for service other than medical necessity	Describes the "why" the Adverse Authorization Determination occurred. This key descriptive column must be populated for all records.
Column S:	**Resolution** Leave blank. Does not apply to Actions and Adverse Authorization Determinations.	This column is N/A for this data element.
Column T:	**Date Received** Enter Date Received as MM/DD/YYYY: Example: 12/01/1985	Documents the date the authorization request was received (for Adverse Authorization Determinations). Reporting format: MM/DD/YYYY. This column must be populated for all records. Note that for Adverse Authorization Determinations related to concurrent review requests, it is acceptable to use the date the pertinent information was submitted by the provider in order for the BH-ASO to evaluate the need for continued stay.
Column U:	**Date Resolved** Enter Date Resolved as MM/DD/YYYY: Example: 12/01/1985 12/31/2999 = In process	Identifies the date an Adverse Authorization Determination. Reporting format: MM/DD/YYYY.
Column V:	**Date written notice** Enter Date written notice sent to individual and servicing provider as MM/DD/YYYY: Example: 12/01/1985 12/31/2999 = Not applicable	Identifies the Date written notification sent to individual and servicing provider. Reporting format: MM/DD/YYYY
Column W:	Unique BH-ASO record identifier (optional)	The purpose of the unique record identifier is to track updates to initial record submissions.

Health Care Authority (HCA)
Grievance and Appeal System Reporting
BH-ASO Quarterly Reporting
Appeal Field Descriptions

Note: All fields must be populated when applicable or left blank, unless otherwise indicated.

Appeal Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
Column A:	**Delegated Entity** Enter Name of Delegated Entity: Full name of delegated entity Blank = No delegated entity	Identifies the organization's delegated entity that receives and takes action on the appeals. The organization is responsible to integrate the delegated entity's data into the organization's data. There should be no separate data submission for the delegated entities. If no delegated entity leave blank.
Column B:	**Reporting Period** Enter Reporting Quarter as a numerical indicator: 1 = First Quarter 2 = Second Quarter 3 = Third Quarter 4 = Fourth Quarter	Indicates the reporting period the initial appeal request is received. Reporting format: 1, 2, 3, or 4. Calendar Quarter: Quarter in which Grievances, Adverse Authorization Determinations, and Appeals were received by the BH-ASO.
Column C:	**Individual ID**	Enter the BH-ASO's ID of the Individual.
Column D:	**Individual Last Name**	Input the name of the person associated with the ID provided in Column C: Individual ID.
Column E:	**Individual First Name**	
Column F:	**Individual Middle Initial**	
Column G:	**Individual Birthdate** Enter the person's birthdate as MM/DD/YYYY Example: 12/01/1985	Input with the birthdate associated with ID and name provided in Columns C through F.
Column H:	**Provider/Practitioner Agency Name**	Identifies the facility or clinic the servicing provider/practitioner is associated with.
Column I:	**Servicing Provider/Practitioner Last Name**	Identifies the servicing provider associated with the appeal.
Column J:	**Servicing Provider/Practitioner First Name**	
Column K:	**Servicing Provider/Practitioner Specialty**	Identifies type or specialty of servicing practitioner. Should be no more than thirty (30) characters. Examples: Certified Peer Counselor, Crisis Service Provider, Designated Crisis Responder, SUD Provider, etc. This key descriptive column must be populated for all records.
Column L:	**Servicing Provider/Practitioner NPI** Example: 1112345678	Identifies the individual Practitioner National Provider Identification number (NPI).
Column M:	**Type** Enter Type as a numerical indicator: 3 = Appeal	Specifies the category for the data submitted. This column must be populated for all records.
Column N:	**Expedited** Enter code as an alpha indicator: X = Yes Blank = Not expedited	Identifies urgency of the appeal. Reporting format: "X" if yes leave blank if no.
Column O:	**Clinical / Medical Necessity** Not applicable. Leave blank.	Not applicable. Leave blank.

Appeal Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
Column P:	**Primary Category** Enter Primary Category as: Mental Health - Inpatient Mental Health - Outpatient Substance Use Disorder - Inpatient/Residential Substance Use Disorder - Outpatient	Describes the "what" or the catalyst for the appeal. This key descriptive column must be populated for all records.
Column Q:	**Subcategory** Leave blank. Not applicable.	Leave blank. Not applicable.
Column R:	**Reason** Enter Reason as: Exceeds authorization on file Medical necessity No funding available No authorization on file Not meeting criteria for service (not medical necessity) Other (list specific issue)	Describes the reason why the BH-ASO made the appeal determination. This key descriptive column must be populated for all records.
Column S:	**Resolution** Enter the status of the appeal as: In Process Overturned Partial Upheld Upheld Withdrawn by Individual	Describes the outcome of the appeal. This key descriptive column must be populated for all records.
Column T:	**Date Received** Enter Date Received as MM/DD/YYYY: Example: 12/01/1985	Document the date the appeal request was received. Reporting format: MM/DD/YYYY. This column must be populated for all records.
Column U:	**Date Resolved** Enter Date Resolved as MM/DD/YYYY: Example: 12/01/1985 12/31/2999 = Still in process	Identifies the date an appeal determination is made. In the instance that an appeal is identified as in process (not resolved) during a reporting period it will need to be reported on the following quarterly report with the date of resolution identified. Reporting format: MM/DD/YYYY, if still in process use 12/31/2999.
Column V:	**Date written notice** Enter Date written notice sent to individual and servicing provider as MM/DD/YYYY: Example: 12/01/1985 12/31/2999 = Not applicable	Identifies the Date written notification sent to individual and servicing provider. Reporting format: MM/DD/YYYY, if not applicable use 12/31/2999.
Column W:	**Unique BH-ASO record identifier (optional)**	The purpose of the unique record identifier is to track updates to initial record submissions.

Health Care Authority (HCA)
Grievance and Appeal System Reporting
BH-ASO Quarterly Reporting
State Hearing / Board of Appeals
Field Descriptions

Note: All fields must be populated when applicable or left blank, unless otherwise indicated.

State Hearing Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
Column A:	**Delegated Entity** Enter Name of Delegated Entity: Full name of delegated entity Blank = No delegated entity	Identifies the organization's delegated entity that receives and takes action. The organization is responsible to integrate the delegated entity's data into the organization's data. There should be no separate data submission for the delegated entities. If no delegated entity or not applicable leave blank.
Column B:	**Reporting Period** Enter Reporting Quarter as a numerical indicator: 1 = First Quarter 2 = Second Quarter 3 = Third Quarter 4 = Fourth Quarter	Indicates the reporting period the State Hearing or Board of Appeals request is received. Reporting format: 1,2,3, or 4. Calendar Quarter: Quarter in which Grievances, Adverse Authorization Determinations, and Appeals were received by the BH-ASO.
Column C:	**Individual ID**	Enter the BH-ASO's ID of the Individual.
Column D:	**Individual Last Name**	Input the name of the person associated with the ID provided in Column C: Individual ID.
Column E:	**Individual First Name**	
Column F:	**Individual Middle Initial**	
Column G:	**Individual Birthdate** Enter the person's birthdate as MM/DD/YYYY Example: 12/01/1985	Input with the birthdate associated with ID and name provided in Columns C through F.
Column H:	**Provider/Practitioner Agency Name**	Identifies the facility or clinic the servicing provider/practitioner is associated with.
Column I:	**Servicing Provider/Practitioner Last Name**	Identifies the servicing provider.
Column J:	**Servicing Provider/Practitioner First Name**	
Column K:	**Servicing Provider/Practitioner Specialty**	Identifies type or specialty of servicing practitioner. Should be no more than thirty (30) characters. Examples: Certified Peer Counselor, Crisis Service Provider, Designated Crisis Responder, SUD Provider, etc. This key descriptive column must be populated for all records.
Column L:	**Servicing Provider/Practitioner NPI** Example: 1112345678	Identifies the individual Practitioner National Provider Identification number (NPI).

State Hearing Reporting Data Elements with description		
Excel Column	Data Element	Data Element Description
Column M:	**Type** Enter Type code as a numerical indicator: 4 = State Hearing 5 = Board of Appeals	Specifies the category for the data submitted. This column must be populated for all records.
Column N:	**Expedited** Not applicable. Leave blank.	Not applicable. Leave blank.
Column O:	**Clinical / Medical Necessity** Not applicable. Leave blank.	Not applicable. Leave blank.
Column P:	**Primary Category** Enter Primary Category as: Mental Health - Inpatient Mental Health - Outpatient Substance Use Disorder - Inpatient Substance Use Disorder - Outpatient	Describes the “what” or the catalyst for the State Hearing or Board of Appeals. This key descriptive column must be populated for all records.
Column Q:	**Subcategory** Not applicable. Leave blank.	Not applicable. Leave blank.
Column R:	**REASON** Not applicable. Leave blank.	Not applicable. Leave blank.
Column S:	**Resolution** Enter Resolution as: Dismissed In process Overturned Upheld Withdrawn by Individual	Describes the outcome of the State Hearing or Board of Appeals determination. This key descriptive column must be populated for all records.
Column T:	**Date Received** Enter Date Received as MM/DD/YYYY: Example: 12/01/1985	Documents the date the State Hearing or Board of Appeals request was received. Reporting format: MM/DD/YYYY. This column must be populated for all records.
Column U:	**Date Resolved** Enter Date Resolved as MM/DD/YYYY: Example: 12/01/1985 12/31/2999 = Still in process	Identifies the date an State Hearing or Board of Appeals determination is made. In the instance that a State Hearing or Board of Appeals is identified as in process (not resolved) during a reporting period it will need to be reported on the following quarterly report with the date of resolution identified.
Column V:	**Date written notice** Enter Date written notice sent to enrollee and practitioner as MM/DD/YYYY: Example: 12/01/1985 12/31/2999 = Not applicable	Identifies the Date written notification sent to enrollee and practitioner. Reporting format: MM/DD/YYYY, if not applicable use 12/31/2999.
Column W:	Unique BH-ASO record identifier (optional)	The purpose of the unique record identifier is to track updates to initial record submissions.