Washington State Health Care Authority	**WASHINGTON BEHAVIORAL HEALTH – ADMINISTRATIVE SERVICES ORGANIZATION CONTRACT**	HCA Contract Number: K4949

This Contract is made by and between the Washington State Health Care Authority ("HCA") and the party whose name appears below ("Contractor").

CONTRACTOR NAME North Sound Behavioral Health Organization		CONTRACTOR doing business as (DBA)
CONTRACTOR ADDRESS 301 Valley Mall Way, Suite 110 Mount Vernon, WA 98273		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) 603-583-336
CONTRACTOR CONTACT Margaret Rojas Contracts Manager	CONTRACTOR TELEPHONE (360) 416-7013	CONTRACTOR E-MAIL ADDRESS Margaret_rojas@nsbhaso.org

HCA CONTACT NAME AND TITLE Ruth Leonard, Section Supervisor	HCA CONTACT ADDRESS 626 8th Avenue SE Olympia, WA 98504	
HCA CONTACT TELEPHONE (360) 725-1487	HCA CONTACT FAX N/A	HCA CONTACT E-MAIL ADDRESS ruth.leonard@hca.wa.gov
IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF **THIS CONTRACT**? No		CFDA NUMBER(S) 93.958; 93.959
CONTRACT START DATE Date of Execution (DOE) Services Start Date: January 1, 2021	**CONTRACT END DATE** December 31, 2022	**MAXIMUM CONTRACT AMOUNT** **$13,867,349.00**

EXHIBITS. The following Exhibits are attached and are incorporated into this Contract by reference:

☒ Exhibits: Exhibit A, Non-Medicaid Funding Allocation; Exhibit B, SUD Service; Exhibit C, RSA Spend Down; Exhibit D, Service Area Matrix; Exhibit E, Data Use, Security, Confidentiality; Exhibit F, Federal Award Identification for Subrecipients; and Exhibit G, Peer Bridger Program.

The terms and conditions of this Contract are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise regarding the subject matter of this Contract, between the parties. The parties signing below represent they have read and understand this Contract, and have the authority to execute this Contract. This Contract shall be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE Joe Valentine, Executive Director	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE Annette Schuffenhauer, Chief Legal Officer	DATE SIGNED

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1 DEFINITIONS

The words and phrases in this section shall have the following meanings for purposes of this Contract. In addition, in any subcontracts and in any other documents that relate to this Contract, the Contractor shall use the following definitions and any other definitions that appear in this Contract.

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.

1.2 Accountable Community of Health (ACH)

"Accountable Community of Health (ACH)" means a regionally governed, public-private collaborative that is tailored by the region to achieve healthy communities and a Healthier Washington. ACHs convene multiple sectors and communities to coordinate systems that influence health, public health, the health care delivery providers, and systems that influence social determinations of health.

1.3 Action

"Action" means the denial or limited authorization of a Contracted Service based on medical necessity.

1.4 Acute Withdrawal Management

"Acute Withdrawal Management" means services provided to an Individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner. Medically monitored withdrawal management provides medical care and physician supervision for withdrawal from alcohol or other drugs.

1.5 Administrative Function

"Administrative Function" means any obligation other than the actual provision of behavioral health services.

1.6 Administrative Hearing

"Administrative Hearing" means an adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by Chapter 34.05 RCW and the Agency's hearings rules found in Chapter 182-526 WAC and other applicable laws.

1.7 Advance Directive

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care relating to the provision of health care when an Individual is incapacitated.

1.8 Adverse Authorization Determination

"Adverse Authorization Determination" means the denial or limited authorization of a requested Contracted Services for reasons of medical necessity (Action) or any other reason such as lack of Available Resources.

1.9 Alcohol/Drug Information School (ADIS)

"Alcohol/Drug Information School (ADIS)" means a program that provides information regarding the use and abuse of alcohol/drugs in a structured educational setting. ADIS must meet the certification standards in WAC 246-341. (The service as described satisfies the level of intensity in ASAM Level 0.5).

1.10 Allegation of Fraud

"Allegation of Fraud" means an unproved assertion: an assertion, especially relating to wrongdoing or misconduct on the part of the Individual.

An Allegation of Fraud is an allegation, from any source, including but not limited to the following:

1.10.1 Fraud hotline complaints;

1.10.2 Claims data mining; and

1.10.3 Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

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.

1.12 American Society of Addiction Medicine (ASAM)

"American Society of Addiction Medicine (ASAM)" means a professional medical society dedicated to increasing access and improving the quality of addiction treatment.

1.13 American Society of Addiction Medicine (ASAM) Criteria

"American Society of Addiction Medicine (ASAM) Criteria" are a comprehensive set of guidelines for determining placement, continued stay and transfer or discharge of Individuals with addiction conditions.

1.14 Appeal

"Appeal" means a request for review of an Action.

1.15 Appeal Process

"Appeal Process" means the Contractor's procedures for reviewing an Action.

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.

1.17 Auxiliary Aids and Services

"Auxiliary Aids and Services" means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the benefits, programs or activities conducted by the Contractor. Auxiliary Aids and Services includes:

1.17.1 Qualified interpreters onsite or through video remote interpreting (VRI), note takers, real-time computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons, videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments;

1.17.2 Qualified readers, taped texts, audio recordings, Brailled materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments;

1.17.3 Acquisition or modification of equipment or devices; and

1.17.4 Other similar services and actions.

1.18 Available Resources

"Available Resources" means funds appropriated for the purpose of providing behavioral health programs. This includes federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated by the Legislature.

1.19 Behavioral Health

"Behavioral Health" means mental health and SUD conditions and related services.

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.

1.21 Behavioral Health Data Systems (BHDS)

"Behavioral Health Data System (BHDS)" means the data system that retains non-encounter data submissions called Behavioral Health Supplemental Transactions.

1.22 Behavioral Health Medical Director

"Behavioral Health Medical Director" means a physician licensed in Washington State to practice medicine, oversee operations, set policies, and help to make informed medical/behavioral health decisions.

1.23 Behavioral Health Professional

"Behavioral Health Professional" means a licensed physician board certified or board eligible in Psychiatry or Child and Adolescent Psychiatry, Addiction Medicine or Addiction Psychiatry, licensed doctoral level psychologist, Psychiatric Advanced Registered Nurse Practitioner (ARNP) or a licensed pharmacist.

1.24 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.

1.25 Breach

"Breach" means the acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of PHI, with the exclusions and exceptions listed in 45 C.F.R. § 164.402.

1.26 Brief Intervention for SUD

"Brief Intervention for SUD" means a time limited, structured behavioral intervention using techniques such as evidence-based motivational interviewing, and referral to treatment services when indicated. Services may be provided at sites exterior to treatment facilities such as hospitals, medical clinics, schools or other non-traditional settings.

1.27 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.

1.28 Business Day

"Business Day" means Monday through Friday, 8:00 am to 5:00 pm Pacific Time, except for holidays observed by the state of Washington.

1.29 Care Coordination

"Care Coordination" means an Individual's healthcare needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the Individual and the Individual's caregivers, and works with the Individual to ensure the Individual receives the most appropriate treatment, while ensuring that care is not duplicated.

1.30 Certified Peer Counselor (CPC)

"Certified Peer Counselor (CPC)" means Individuals who: have self-identified as a consumer of behavioral health services; have received specialized training provided/contracted by HCA, Division of Behavioral Health and Recovery (DBHR); have passed a written/oral test, which includes both written and oral components of the training; have passed a Washington State background check; have been certified by DBHR; and are a registered Agency Affiliated Counselor with the Department of Health (DOH).

1.31 Childcare Services

"Childcare Services" means the provision of child care services to children of parents in treatment in order to complete the parent's plan for treatment services. Childcare Services must be provided by licensed childcare providers.

1.32 Child and Family Team (CFT)

"Child and Family Team (CFT)" means a group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family's care plan, address unmet needs, and work toward the family's vision and team mission.

1.33 Children's Long Term Inpatient Program (CLIP)

"Children's Long Term Inpatient Program (CLIP)" is a medically based treatment approach, available to all Washington State residents, ages 5 to 18 years of age, providing 24 hour psychiatric treatment in a highly structured setting designed to assess, treat, and stabilize youth diagnosed with psychiatric and behavioral disorders.

1.34 Children's Long Term Inpatient Programs Administration (CLIP Administration)

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

1.35 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.

1.36 Code of Federal Regulations (C.F.R.)

"Code of Federal Regulations (C.F.R.)" means the codification of the general and permanent rules and Regulations, sometimes called administrative law, published in the Federal Register by the executive departments and agencies of the federal government of the United States.

1.37 Community Behavioral Health Advisory (CBHA) Board

"Community Behavioral Health Advisory (CBHA) Board" means an advisory board representative of the demographic characteristics of the RSA in accordance with WAC 182-538C-0252.

1.38 Community Health Workers (CHW)

"Community Health Workers (CHW)" means individuals who serve as a liaison and advocate between social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHW include Community Health Representatives (CHR) in the Indian Health Service funded, tribally contracted program.

1.39 Community Mental Health Agency (CMHA)

"Community Mental Health Agency (CMHA)" means a behavioral health agency that is licensed by the state of Washington, and certified to provide mental health services.

1.40 Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or State law. Confidential Information includes, but is not limited to, personal information.

1.41 Continuity of Care

"Continuity of Care" means the provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one (1) setting as the Individual transitions between: Facility to home; Facility to Facility; providers or service areas; managed care Contractors; and Medicaid fee-for-service and managed care arrangements.

1.42 Contract

"Contract" means this entire written agreement between HCA and the Contractor, including any exhibits, documents, and materials incorporated by reference.

1.43 Contractor

"Contractor" means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, officers, directors, partners, employees, and/or agents.

1.44 Continuing Education and Training

"Continuing Education and Training" means activities to support educational programs, training projects, or other professional development programs.

1.45 Contracted Services

"Contracted Services" means services that are to be provided by the Contractor under the terms of this Contract within Available Resources.

1.46 Cost Reimbursement

"Cost Reimbursement" means the Subcontractor is reimbursed for actual costs up to the maximum consideration allowed in this Contract.

1.47 Cost Sharing

"Cost Sharing" means the costs an Individual pays for services not covered by the BH-ASO. Block grant funds may be used to cover health insurance deductibles, coinsurance, and copayments to assist eligible Individuals in meeting their cost-sharing responsibilities.

1.48 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).

1.49 Crisis

"Crisis" means a behavioral health crisis, defined as a turning point, or a time, a stage, or an event, whose outcome includes a distinct possibility of an undesirable outcome.

1.50 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.

1.51 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.

1.52 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).

1.53 Day Support

"Day Support" means an intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Individuals to promote improved functioning or a restoration to a previous higher level of functioning.

1.54 Debarment

"Debarment" means an action taken by a federal official to exclude a person or business entity from participating in transactions involving certain federal funds.

1.55 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.

1.56 Department of Health (DOH)

"Department of Health (DOH)" means the Washington State agency responsible for the licensing and certification of health service providers.

1.57 Department of Social and Health Services (DSHS)

"Department of Social and Health Services (DSHS)" means the Washington State agency responsible for providing a broad array of health care and social services.

1.58 Designated Crisis Responder (DCR)

"Designated Crisis Responder (DCR)" means a person designated by the county or other authority authorized in rule, to perform the civil commitment duties described in Chapters 71.05 RCW and 71.34 RCW.

1.59 Disaster Outreach

"Disaster Outreach" means contacting persons in their place of residence or other settings to provide support, education, information and referral to resources in the event of a disaster.

1.60 Direct Service Support Costs

"Direct Service Support Costs" are BH-ASO level costs incurred to provide services and activities to Individuals, as defined in the instructions in the Non-Medicaid Expenditure Report template.

1.61 Director

"Director" means the Director of HCA. In his or her sole discretion, the Director may designate a representative to act on the Director's behalf. Any designation may include the representative's authority to hear, consider, review, and/or determine any matter.

1.62 Division of Behavioral Health and Recovery (DBHR)

"Division of Behavioral Health and Recovery" or "DBHR" means the HCA behavioral health division.

1.63 Emergency Medical Condition

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual or, with respect to a pregnant

woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.64 Emergency Services

"Emergency Services" means inpatient and outpatient Contracted Services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition.

1.65 Emergent Care

"Emergent Care" means services that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.153.

1.66 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.

1.67 Encrypt

"Encrypt" means to encipher or encode electronic data using software that generates a minimum key length of one hundred twenty-eight (128) bits.

1.68 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.

1.69 Evaluation and Treatment Facility

"Evaluation and Treatment Facility" means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a behavioral health disorder and who are at risk of harm or are gravely disabled, and which is licensed or certified as such by DOH. (RCW 71.05.020)

1.70 Evidence-Based Practices

"Evidence-Based Practices" means a program or practice that has been tested where the weight of the evidence from review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.

1.71 External Entities (EE)

"External Entities (EE)" means organizations that serve eligible Individuals and includes DSHS, DOH, Local Health Jurisdictions (LHJ), community-based service providers and services/programs defined in this Contract.

1.72 Facility

"Facility" means but is not limited to: a hospital, an inpatient rehabilitation center, Long-Term and Acute Care (LTAC) center, skilled nursing facility, and nursing home.

1.73 Family Treatment

"Family Treatment" means behavioral health counseling provided by or under the supervision of a Mental Health Professional for the direct benefit of an Individual. Service is provided with family members and/or other relevant persons in attendance as active participants.

1.74 Federally Qualified Health Center (FQHC)

"Federally Qualified Health Center (FQHC)" means a community-based organization that provides comprehensive primary care and preventive care, including health, dental, and behavioral health services to people of all ages, regardless of their ability to pay or health insurance status.

1.75 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.

1.76 First Responders

"First Responders" means police, sheriff, fire, emergency, medical and hospital emergency rooms, and 911 call centers.

1.77 Fraud

"Fraud" means an intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

1.78 General Fund State/Federal Block Grants (GFS/FBG)

"General Fund State/Federal Block Grants (GFS/FBGs)" means the services provided by the Contractor under this Contract and funded by Federal Block Grants or General Fund State (GFS).

1.79 Global Appraisal of Individual Needs Shorter Screener (GAIN-SS)

"Global Appraisal of Individual Needs Shorter Screener (GAIN-SS)" means the integrated, comprehensive screening for behavioral health conditions.

1.80 Grievance

"Grievance" means an expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Individual's rights regardless of whether remedial action is requested. Grievance includes an Individual's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

1.81 Grievance and Appeal System

"Grievance and Appeal System" means the overall system that includes Grievances and Appeals handled by the Contractor and access to the Administrative Hearing system.

1.82 Grievance Process

"Grievance Process" means the procedure for addressing Individuals' Grievances (42 C.F.R. § 438.400(b)).

1.83 Guideline

"Guideline" means a set of statements used to determine a course of action. A guideline streamlines utilization management decision-making processes according to a set routine or sound evidence-based clinical practice.

1.84 Hardened Password

"Hardened Password" prior to July 1, 2019 means a string of at least eight (8) characters containing at least one (1) alphabetic character, at least one (1) number, and at least one (1) special character such as an asterisk, ampersand, or exclamation point.

1.85 Health Care Authority (HCA)

"Health Care Authority (HCA)" means the Washington State Health Care Authority, any division, Section, office, unit or other entity of HCA or any of the officers or other officials lawfully representing HCA.

1.86 Health Care Professional

"Health Care Professional" means a physician or any of the following acting within his or her scope of practice; an applied behavior analyst, certified registered dietician, naturopath, podiatrist, optometrist, optician, osteopath, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered

or practical nurse (including nurse practitioner or clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed midwife, licensed clinical social worker, licensed mental health counselor, licensed marriage and family therapist, registered respiratory therapist, pharmacist, and certified respiratory therapy technician.

1.87 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.

1.88 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.

1.89 Independent Peer Review

"Independent Peer Review" means to assess the quality, appropriateness, and efficacy of treatment services provided to Individuals under the program involved.

1.90 Indian Health Care Providers (IHCP)

"Indian Health Care Provider (IHCP)" means the Indian Health Service and/or any Tribe, Tribal organization, or Urban Indian Health Program (UIHP) that provides Medicaid-reimbursable services.

1.91 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.

1.92 Individual

"Individual" means any person in the RSA regardless of income, ability to pay, insurance status or county of residence. With respect to non-Crisis Services, "Individual" means a person who has applied for, is eligible for, or who has received GFS/FBG services through this Contract.

1.93 Individuals with Intellectual or Developmental Disability (I/DD)

"Individuals with Intellectual or Developmental Disability (I/DD)" means people with a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.

1.94 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:

1.94.1 Intensive inpatient services;

1.94.2 Recovery house treatment services;

1.94.3 Long-term residential treatment services; and

1.94.4 Youth residential services.

1.95 Institute for Mental Disease (IMD)

"Institute for Mental Disease (IMD)" means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

1.96 Intake Evaluation

"Intake Evaluation" means an evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except Crisis Services, Stabilization Services, and free-standing evaluation and treatment.

1.97 Interim Services

"Interim Services" means services to Individuals who are currently waiting to enter a treatment program to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease.

1.98 Intensive Inpatient Residential Services

"Intensive Inpatient Residential Services" means a concentrated program of SUD treatment, individual and group counseling, education, and related activities including room and board in a 24-hour-a-day supervised Facility in accordance with Chapter 246-341 WAC (The service as described satisfies the level of intensity in ASAM Level 3.5).

1.99 Intensive Outpatient SUD Treatment

"Intensive Outpatient SUD Treatment" means services provided in a non-residential intensive patient centered outpatient program for treatment of SUD (The service as described satisfies the level of intensity in ASAM Level 2.1).

1.100 Involuntary Treatment Act (ITA)

"Involuntary Treatment Act (ITA)" are state laws that allow for individuals to be committed by court order to a Facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to one hundred twenty (120) hours, but, if necessary, individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days of inpatient involuntary treatment or outpatient involuntary treatment (RCW 71.05.180, RCW 71.05.230 and RCW 71.05.290).

1.101 Involuntary Treatment Act Services

"Involuntary Treatment Act Services" includes all services and Administrative Functions required for the evaluation and treatment of individuals civilly committed under the ITA in accordance with chapters 71.05 and 71.34 RCW, and RCW 71.24.300.

1.102 Juvenile Drug Court

"Juvenile Drug Court" means a specific juvenile court docket, dedicated to a heightened and intensified emphasis on therapy and accountability, as described by the U.S. Department of Justice, Bureau of Justice Assistance in the monograph, Juvenile Drug Courts: Strategies in Practice, March 2003.

1.103 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.

1.104 List of Excluded Individuals/Entities (LEIE)

"List of Excluded Individuals/Entities (LEIE)" means an Office of Inspector General's List of Excluded Individuals/Entities and provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

1.105 Lump Sum

"Lump Sum" means the Subcontractor is reimbursed a negotiated amount for completion of requirements under the Subcontract.

1.106 Managed Care

"Managed Care" means a prepaid, comprehensive system of medical and behavioral health care delivery including preventive, primary, specialty, and ancillary health services.

1.107 Managed Care Organization (MCO)

"Managed Care Organization (MCO)" means an organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA Enrollees under HCA managed care programs.

1.108 Materials

"Materials" means any promotional activity or communication with an Individual that is intended to "brand" a Contractor's name or organization.

Materials include written, oral, in-person (telephonic or face-to-face) or electronic methods of communication, including email, text messaging, and social media (i.e. Facebook, Instagram, and Twitter).

1.109 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.

1.110 Medication Assisted Treatment (MAT)

"Medication Assisted Treatment (MAT)" means the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUDs.

1.111 Medication Management

"Medication Management" means the prescribing and/or administering and reviewing of medications and their side effects.

1.112 Medication Monitoring

"Medication Monitoring" means face-to-face, one-on-one cueing, observing, and encouraging an Individual to take medications as prescribed.

1.113 Mental Health Advance Directive

"Mental Health Advance Directive" means a written document in which the Individual makes a declaration of instructions, or preferences, or appoints an agent to make decisions on behalf of the Individual regarding the Individual's mental health treatment that is consistent with Chapter 71.32 RCW.

1.114 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).

1.115 Mental Health Parity

"Mental Health Parity" means the Washington state Office of the Insurance Commissioner rules for behavioral health parity, inclusive of mental health and SUD benefits that apply to this Contract (WAC 284-43-7000 through 284-43-7080).

1.116 Mental Health Professional

"Mental Health Professional" means:

1.116.1 A psychiatrist, psychologist, psychiatric nurse, psychiatric nurse practitioner, physician assistant supervised by a psychiatrist, or social worker as defined in RCW 71.05.020;

1.116.2 A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such persons shall have, in addition, at least two (2) years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional;

1.116.3 A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;

1.116.4 A person who is licensed by DOH as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;

1.116.5 A person who has an approved exception to perform the duties of a Mental Health Professional; or

1.116.6 A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional.

1.117 National Committee for Quality Assurance (NCQA)

"National Committee for Quality Assurance (NCQA)" means an independent nonprofit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs and accreditation.

1.118 National Correct Coding Initiative (NCCI)

"National Correct Coding Initiative (NCCI)" means CMS-developed coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies, and edits.

1.119 Network Adequacy

"Network Adequacy" means a network of providers for the Contractor that is sufficient in numbers and types of providers/facilities to ensure that all services are accessible to Individuals in this Contract and within Available Resources.

1.120 Non-Participating Provider

"Non-Participating Provider" means a person, Health Care Provider, practitioner, Facility, or entity acting within their scope of practice and licensure that does not have a provider service agreement with the Contractor but provides services to Individuals.

1.121 Non-Tribal Indian 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.

1.122 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.

1.123 Office of Inspector General (OIG)

"Office of Inspector General (OIG)" means the Office of Inspector General within the United States Department of Health and Human Services (DHHS).

1.124 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.

1.125 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).

1.126 Opioid Treatment Program (OTP)

"Opioid Treatment Program (OTP)" means a designated program that dispenses approved medication as specified in 21 C.F.R. Part 291 for opioid treatment in accordance with WAC 246-341-0100.

1.127 Outreach and Engagement

"Outreach and Engagement" means identification of hard-to-reach Individuals with a possible SUD and/or Severe Mental Illness (SMI) and engagement of these Individuals in assessment and ongoing treatment services as necessary.

1.128 Overpayment

"Overpayment" means any payment from HCA to the Contractor in excess of that to which the Contractor is entitled by law, rule, or this Contract, including amounts in dispute. Overpayment can also mean a payment from the Contractor to a Provider or Subcontractor to which the Provider or Subcontractor is not legally entitled. RCW 41.05A.010.

1.129 Participating Provider

"Participating Provider" means a person, Health Care Provider, practitioner, or entity, acting within their scope of practice and licensure, with a written agreement with the Contractor to provide services to Individuals under the terms of this Contract.

1.130 Peer Bridger

"Peer Bridger" means a trained Peer Support specialist who offers Peer Support services to participants in state hospitals and inpatient mental health facilities prior to discharge and after their return to their communities. The Peer Bridger must be an employee of a behavioral health agency licensed by DOH that provides Recovery services.

1.131 Peer Support Services

"Peer Support Services" means behavioral health services provided by Certified Peer Counselors. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Individuals actively participate in decision-making and the operation of the programmatic supports.

1.132 Personal Information

"Personal Information" means information identifiable to any person including, but not limited to: information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.

1.133 Predictive Risk Intelligence System (PRISM)

"Predictive Risk Intelligence System (PRISM)" means a DSHS-secure web-based predictive modeling and clinical decision support tool. It provides a unified view of medical, behavioral health, and long-term care service data that is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next twelve (12) months based on the patient's disease profile and pharmacy utilization.

1.134 Pregnant and Post-Partum Women (PPW)

"Pregnant and Post-Partum Women and Women with Dependent Children (PPW)" means: (i) women who are pregnant; (ii) women who are postpartum during the first year after pregnancy completion regardless of the outcome of the pregnancy or placement of children; or (iii) women who are parenting children, including those attempting to gain custody of children supervised by DCYF.

1.135 Pregnant, Post-Partum or Parenting (PPW) Women's Housing Support Services

"Pregnant, Post-Partum or Parenting (PPW) Women's Housing Support Services" means the costs incurred to provide support services to PPW individuals with children under the age of six (6) in a transitional residential housing program designed exclusively for this population.

1.136 Prior Authorization

"Prior Authorization" means the requirement that a provider must request, on behalf of an Individual and when required by HCA or the HCA's designee's, approval to provide a health care service before the Individual receives the health care service.

1.137 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.

1.138 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, Protocols for Coordination with Tribes and non-Tribal IHCPs.

1.139 Provider

"Provider" means an individual medical or Behavioral Health Professional, Health Care Professional, hospital, skilled nursing facility, other Facility, or organization, pharmacy, program,

equipment and supply vendor, or other entity that provides care or bills for health care services or products.

1.140 ProviderOne

"ProviderOne" means the HCA's Medicaid Management Information Payment Processing System, or any superseding platform as may be designated by HCA.

1.141 Psychological Assessment

"Psychological Assessment" means all psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist.

1.142 Recovery

"Recovery" means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

1.143 Recovery House Residential Treatment

"Recovery House Residential Treatment" means a program of care and treatment with social, vocational, and recreational activities designed to aid individuals diagnosed with SUD in the adjustment to abstinence (assisting in their Recovery) and to aid in job training, reentry to employment, or other types of community activities, excluding Room and Board in a 24-hour-a-day supervised Facility in accordance with WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 3.1).

1.144 Recovery Support Services

"Recovery Support Services" means a broad range of non-clinical services that assist individuals and families to initiate, stabilize, and maintain long-term Recovery from behavioral health disorders including mental illness and substance use disorders.

1.145 Regional Service Area (RSA)

"Regional Service Area (RSA)" means a single county or multi-county grouping formed for the purpose of health care purchasing.

1.146 Regulation

"Regulation" means any federal, State, or local Regulation or ordinance.

1.147 Rehabilitation Case Management

"Rehabilitation Case Management" means a range of activities by the outpatient CMHA's liaison conducted in or with a Facility for the direct benefit of an Individual in the public mental health system.

1.148 Resilience

"Resilience" means the capacity of individuals to recover from adversity, trauma, tragedy, threats, or other stresses or behavioral health challenges, and to live productive lives.

1.149 Revised Code of Washington (RCW)

"Revised Code of Washington (RCW)" means the laws of the state of Washington.

1.150 Room and Board

"Room and Board" means provision for services in a 24-hour-a-day setting consistent with the requirements for Residential Treatment Facility Licensing through DOH (Chapter 246-337 WAC).

1.151 Secure Withdrawal Management Facility

"Secure Withdrawal Management Facility" means a facility operated by either a public or private agency as defined in RCW 71.05.020 that provides evaluation and treatment to individuals detained for SUD ITA. This service does not include cost of room and board.

1.152 Secured Area

"Secured Area" means an area such as a building, room, or locked storage container to which only authorized representatives of the entity possessing Confidential Information have access.

1.153 Security Incident

"Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.154 Serious Emotionally Disturbed (SED)

"Serious Emotionally Disturbed (SED)" means children from birth up to age eighteen (18) who have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

1.155 Serious Mental Illness (SMI)

"Serious Mental Illness (SMI)" means persons age eighteen (18) and over who currently, or at any time during the past year, have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders (DSM) that has resulted in functional impairment which substantially limits one (1) or more major life activities such as employment, school, social relationships, etc.

1.156 Service Encounter Reporting Instructions (SERI)

"Service Encounter Reporting Instructions (SERI)" means the guide published by HCA to provide assistance to contracted entities for reporting behavioral health service encounters.

1.157 Single Case Agreement

"Single Case Agreement" means a written agreement between the Contractor and a non-Participating Provider to deliver services to an Individual.

1.158 Sobering Services

"Sobering Services" means short-term (less than twenty-four (24) consecutive hours) emergency shelter, screening, and referral services to persons who are intoxicated or in active withdrawal.

1.159 Special Population Evaluation

"Special Population Evaluation" means an evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods.

1.160 Stabilization Services

"Stabilization Services" means services provided to Individuals who are experiencing a mental health or substance use crisis. These services are provided in the person's home, or another home-like setting, or a setting which provides safety for the individual and the Mental Health Professional. Stabilization Services may be provided prior to an Intake Evaluation for behavioral health services.

1.161 Sub-Acute Withdrawal Management (Detoxification)

"Sub-Acute Withdrawal Management (Detoxification)" means services provided to an Individual to assist in the withdrawal from a psychoactive substance in a safe and effective manner. Sub-Acute is nonmedical detoxification/withdrawal management or patient self-administration of withdrawal medications ordered by a physician, provided in a home-like environment.

1.162 Subcontract

"Subcontract" means any separate agreement or contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Contract.

1.163 Substance Abuse Block Grant (SABG)

"Substance Abuse Block Grant (SABG)" means the Federal Substance Abuse Block Grant Program) authorized by Section 1921 of Title XIX, Part B, Subpart II and III of the Public Health Service Act.

1.164 Substance Use Disorder (SUD)

"Substance Use Disorder (SUD)" means a problematic pattern of use of alcohol and/or drugs that causes a clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school or home.

1.165 Substance Use Disorder Outpatient Treatment

"Substance Use Disorder Outpatient Treatment" means services provided in a non-residential SUD treatment Facility. Outpatient treatment services must meet the criteria in Chapter 246-341 WAC (The service as described satisfies the level of intensity in ASAM Level 1).

1.166 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.

1.167 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.

1.168 Therapeutic Interventions for Children

"Therapeutic Interventions for Children" means services promoting the health and welfare of children that include: developmental assessment using recognized, standardized instruments; play therapy; behavioral modification; individual counseling; self-esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior.

1.169 Therapeutic Psychoeducation

"Therapeutic Psychoeducation" means informational and experiential services designed to aid Individuals, their family members (e.g., spouse, parents, siblings) and others identified by the Individuals as a primary support in the management of psychiatric conditions.

1.170 Tracking

"Tracking" means a record keeping system that identifies when the sender begins delivery of Confidential Information to the authorized and intended recipient, and when the sender receives confirmation of delivery from the authorized and intended recipient of Confidential Information.

1.171 Transitional Age Youth (TAY)

"Transition Age Youth (TAY)" means an individual between the ages of fifteen (15) and twenty-five (25) years who present unique service challenges because they are too old for pediatric services but are often not ready or eligible for adult services.

1.172 Transport

"Transport" means the movement of Confidential Information from one entity to another or within an entity that places the Confidential Information outside of a Secured Area or system (such as a local area network), and is accomplished other than via a Trusted System.

1.173 Transportation

"Transportation" means the transport of individuals to and from behavioral health treatment facilities.

1.174 Tribal Land

"Tribal Land" means any territory within the state of Washington over which a Tribe has legal jurisdiction, including any lands held in trust for the Tribe by the federal government.

1.175 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.

1.176 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.

1.177 Trusted Systems

"Trusted System(s)" means the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; (2) United States Postal Service ("USPS") first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail; (3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.

1.178 Unique User ID

"Unique User ID" means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase, or other mechanism authenticates a user to an information system.

1.179 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.

1.180 Validation

“Validation” means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, and free from bias and in accord with standards for data collection and analysis.

1.181 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.

1.182 Washington Administrative Code (WAC)

“Washington Administrative Code (WAC)” means the rules adopted by state agencies to implement legislation.

1.183 Washington Apple Health – Fully Integrated Managed Care (AH-FIMC)

“Washington Apple Health – Fully Integrated Managed Care (AH-FIMC)” means the program under which a MCO provides GFS services and Medicaid-funded physical and behavioral health services. This program is also referred to as “Washington Apple Health – Integrated Managed Care (AH-IMC)” or “Integrated Managed Care (IMC)”.

1.184 Wraparound with Intensive Services (WISe)

“Wraparound with Intensive Services (WISe)” means a range of services that are individualized, intensive, coordinated, comprehensive, culturally competent, and provided in the home and community. The WISe Program is for Individuals up to age 21 who are experiencing mental health symptoms that are causing severe disruptions in behavior and/or interfering with their functioning in family, school, or with peers requiring: a) the involvement of the mental health system and other child-serving systems and supports; b) intensive care collaboration; and c) ongoing intervention to stabilize the youth and family in order to prevent more restrictive or institutional placement.

1.185 Youth

“Youth” means, in general terms, a person from age 13 through 17. Specific programs may assign a different age range for Youth. Early Periodic Screening Diagnosis and Treatment (EPSDT) defines youth as an Individual up to age 21.

2 GENERAL TERMS AND CONDITIONS

2.1 Amendment

Except as described below, an amendment to this Contract shall require the approval of both HCA and the Contractor. The following shall guide the amendment process:

2.1.1 Any amendment shall be in writing and shall be signed by the Contractor's authorized officer and an authorized representative of HCA. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

2.1.2 HCA reserves the right to issue unilateral amendments which provide corrective or clarifying information.

2.1.3 The Contractor shall submit all feedback or questions to HCA at contracts@hca.wa.gov or other email address as expressly stated.

2.1.4 The Contractor shall submit written feedback within the expressed deadline provided to the Contractor upon receipt of any amendments. HCA is not obligated to accept Contractor feedback after the written deadline provided by HCA.

2.1.5 The Contractor shall return all signed amendments within the written deadline provided by HCA contracts administration.

2.2 Loss of Program Authorization

Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which authority has been withdrawn, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. HCA must adjust Exhibit A to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If HCA paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work must be returned to HCA. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

2.3 Report Deliverable Templates

2.3.1 Templates for all reports that the Contractor is required to submit to HCA are hereby incorporated by reference into this Contract. HCA may update the templates from time to time, and any such updated templates will also be incorporated by reference into this Contract. The report templates are located at:

https://www.hca.wa.gov/billers-providers-partners/programs-and-services/model-managed-care-contracts.The Contractor may email HCA at any time to confirm the most recent version of any template to HCABHASO@hca.wa.gov.

2.3.1.1 Report templates include:

2.3.1.1.1 Community Behavioral Health Enhancement (CBHE) Funds Quarterly Report

2.3.1.1.2 Criminal Justice Treatment Account (CJTA) Quarterly Progress Report

2.3.1.1.3 Crisis Reporting Metrics and Reporting

2.3.1.1.4 Crisis Triage/Stabilization and Increasing Psychiatric Bed Capacity report

2.3.1.1.5 Data Shared with External Entities Report

2.3.1.1.6 Federal Block Grant Annual Progress Report

2.3.1.1.7 Grievance, Adverse Authorization Determination, and Appeals

2.3.1.1.8 Juvenile Court Treatment Program Reporting

2.3.1.1.9 Mental Health Block Grant (MHBG) Project Plan

2.3.1.1.10 Non-Medicaid Expenditure Report

2.3.1.1.11 Peer Bridger Program

2.3.1.1.12 Semi-Annual Trueblood Misdemeanor Diversion Fund Report

2.3.1.1.13 Substance Abuse Block Grant (SABG) Capacity Management Form

2.3.1.1.14 Substance Abuse Block Grant (SABG) Project Plan

2.4 Assignment

The Contractor shall not assign this Contract to a third party without the prior written consent of HCA.

2.5 Billing Limitations

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

2.6 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:

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

2.6.2 Title VI of the Civil Rights Act of 1964.

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

2.6.4 The Age Discrimination Act of 1975.

2.6.5 The Rehabilitation Act of 1973.

2.6.6 The Budget Deficit Reduction Act of 2005.

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

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

2.6.9 The American Recovery and Reinvestment Act (ARRA).

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

2.6.11 The Health Care and Education Reconciliation Act (HCERA).

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

2.6.13 21 C.F.R. Food and Drugs, Chapter 1 Subchapter C – Drugs – General.

2.6.14 42 C.F.R. Subchapter A, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.

2.6.15 42 C.F.R. Subchapter A, Part 8 – Certification of Opioid Treatment Programs.

2.6.16 45 C.F.R. Part 96 Block Grants.

2.6.17 45 C.F.R. § 96.126 Capacity of Treatment for Intravenous Substance Abusers who Receive Services under Block Grant funding.

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

2.6.19 Chapter 71.05 RCW Mental Illness.

2.6.20 Chapter 71.24 RCW Community Mental Health Services Act (CMHSA).

2.6.21 Chapter 71.34 RCW Mental Health Services for Minors.

2.6.22 Chapter 246-341 WAC.

2.6.23 Chapter 43.20A RCW Department of Social and Health Services (DSHS).

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

2.6.25 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:

2.6.25.1 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.

2.6.25.2 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.

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

2.6.25.4 Those specified in Title 18 RCW for professional licensing.

2.6.26 Industrial Insurance – Title 51 RCW.

2.6.27 Reporting of abuse as required by RCW 26.44.030.

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

2.6.29 Equal Employment Opportunity (EEO) Provisions.

2.6.30 Copeland Anti-Kickback Act.

2.6.31 Davis-Bacon Act.

2.6.32 Byrd Anti-Lobbying Amendment.

2.6.33 All federal and State nondiscrimination laws and Regulations.

2.6.34 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.

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

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

2.7 Covenant Against Contingent Fees

The Contractor certifies that no person or selling agent has been employed or retained to solicit or secure this Contract for a commission, percentage, brokerage or contingent fee, excepting bona fide employees or bona fide established agents maintained by the Contractor for the purpose of securing business. HCA shall have the right, in the event of breach of this clause by the Contractor, to terminate this Contract or, in its discretion, to deduct from amounts due the Contractor under the Contract recover by other means the full amount of any such commission, percentage, brokerage or contingent fee.

2.8 Data Use, Security, and Confidentiality

Exhibit E, Data Use, Security, and Confidentiality, sets out Contractor's obligations for compliance with Data security and confidentiality terms.

2.9 Debarment Certification

2.9.1 The Contractor, by signature to this Contract, certifies that the Contractor is not presently debarred, suspended, proposed for Debarment, declared ineligible or voluntarily excluded in any Washington State or federal department or agency from participating in transactions (debarred).

2.9.2 The Contractor agrees to include the above requirement in any and all Subcontracts into which it enters concerning the performance of services hereunder, and also agrees that it shall not employ debarred individuals or Subcontract with any debarred providers, persons, or entities.

2.9.3 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 2.41 of this Contract if the Contractor becomes debarred during the term hereof.

2.10 Defense of Legal Actions

Each party to this Contract shall advise the other as to matters that come to its attention with respect to potential substantial legal actions involving allegations that may give rise to a claim for indemnification from the other. Each party shall fully cooperate with the other in the defense of

any action arising out of matters related to this Contract by providing without additional fee all reasonably available information relating to such actions and by providing necessary testimony.

2.11 Disputes

When a dispute arises over an issue that pertains in any way to this Contract (other than overpayments, as described below), the parties agree to the following process to address the dispute:

2.11.1 The Contractor shall request a dispute resolution conference with the Agency Director. The request for a dispute resolution conference must be in writing and shall clearly state all of the following:

2.11.1.1 The disputed issue(s).

2.11.1.2 An explanation of the positions of the parties.

2.11.1.3 Any additional facts necessary to explain completely and accurately the nature of the dispute.

2.11.2 Requests for a dispute resolution conference must be mailed to the Director, Washington State HCA, P.O. Box 45502, Olympia, WA 98504-5502. Any such requests must be received by the Director within thirty (30) calendar days after the Contractor receives notice of the disputed issue(s).

2.11.2.1 The Director, in his or her sole discretion, shall determine a time for the parties to present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's discretion. The Director shall provide written notice of the time, format, and location of the conference. The conference is informal in nature and is not governed in any way by the Administrative Procedure Act, chapter 34.05 RCW.

2.11.2.2 The Director shall consider all of the information provided at the conference and shall issue a written decision on the disputed issue(s) within thirty (30) calendar days after the conclusion of the conference. However, the Director retains the option of taking up to an additional sixty (60) calendar days to consider the disputed issue(s) or taking additional steps to attempt to resolve them. If the Director determines, in his or her sole discretion, that an additional period of up to sixty (60) calendar days is needed for review, he or she shall notify the Contractor, in writing, of the delay and the anticipated completion date before the initial thirty-day period expires.

2.11.2.3 The Director, at his or her sole discretion, may appoint a designee to represent him or her at the dispute conference. If the Director does appoint a designee to represent him or her at the dispute conference, the Director shall retain all final decision-making authority regarding the disputed issue(s). Under no circumstances shall the Director's designee have any authority to issue a final decision on the disputed issue(s).

2.11.3 The parties hereby agree that this dispute process shall precede any judicial or quasi-judicial proceeding and is the sole administrative remedy under this Contract.

2.11.4 Disputes regarding overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Section.

2.12 Force Majeure

If the Contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of a major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, such nonperformance shall not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to provide, directly or indirectly, alternative and, to the extent practicable, comparable performance. Nothing in this Section shall be construed to prevent HCA from terminating this Contract for reasons other than for default during the period of events set forth above, or for default, if such default occurred prior to such event.

2.13 Governing Law and Venue

This Contract shall be construed and interpreted in accordance with the laws of the state of Washington and the venue of any action brought hereunder shall be in Superior Court for Thurston County. In the event that an action is removed to U.S. District Court, venue shall be in the Western District of Washington in Tacoma.

2.14 Independent Contractor

The parties intend that an independent Contractor relationship shall be created by this Contract. The Contractor and its employees or agents performing under this Contract are not employees or agents of the HCA or the State of Washington. The Contractor, its employees, or agents performing under this Contract shall not hold himself/herself out as, nor claim to be, an officer or employee of the HCA or the state of Washington by reason hereof, nor shall the Contractor, its employees, or agent make any claim of right, privilege or benefit that would accrue to such employee.

The Contractor acknowledges and certifies that neither HCA nor the state of Washington are guarantors of any obligations or debts of the Contractor.

2.15 Insolvency

If the Contractor becomes insolvent during the term of this Contract:

2.15.1 The state of Washington and Individuals shall not be, in any manner, liable for the debts and obligations of the Contractor.

2.15.2 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.

2.15.3 The Contractor shall cover continuation of services to Individuals for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

2.15.4 The above obligations shall survive the termination of this contract.

2.16 Inspection

2.16.1 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 (GAO), federal Office of the Inspector General (OIG) and federal Office of Management and Budget (OMB).

2.16.2 The Contractor and its Subcontractors shall provide access to their facilities and the records documenting the performance of this Contract, for purpose of audits, investigations, and for the identification and recovery of overpayments within thirty (30) calendar days, and access to its facilities and the records pertinent to this Contract to monitor and evaluate performance under this Contract, including, but not limited to, claims payment and the quality, cost, use, health and safety and timeliness of services, provider Network Adequacy, including panel capacity or willingness to accept new patients, and assessment of the Contractor's capacity to bear the potential financial losses.

2.16.3 The Contractor and its Subcontractors shall provide immediate access to facilities and records pertinent to this Contract for state or federal Fraud investigators.

2.17 Insurance

The Contractor shall at all times comply with the following insurance requirements:

2.17.1 Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. The state of Washington, HCA, its elected and appointed officials, agents, and employees shall be named as additional insured's expressly for, and limited to, Contractor's services provided under this Contract.

2.17.2 Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000.

2.17.3 Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and Regulations. The state of Washington and HCA shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and Regulations.

2.17.4 Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.

2.17.5 Subcontractors: The Contractor shall ensure that all Subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for Subcontractors, to HCA if requested.

2.17.6 Separation of Insured's: All insurance Commercial General Liability policies shall contain a "separation of insured's" provision.

2.17.7 Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the state of Washington, with a "Best's Reports'' rating of A-, Class VII or better. Any exception must be approved by HCA. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.

2.17.8 Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accord with the Notices Section of the General Terms and Conditions, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

2.17.9 Material Changes: The Contractor shall give HCA, in accord with the Notices Section of the General Terms and Conditions, forty-five (45) calendar days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give HCA ten (10) calendar days advance notice of cancellation.

2.17.10 General: By requiring insurance, the state of Washington and HCA do not represent that the coverage and limits specified shall be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and HCA in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.

2.17.11 The Contractor may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers and Evidence of Coverage Provisions of this Section if self-insured. In the event the Contractor is self-insured, the Contractor must send to HCA by the third Wednesday of January in each Contract

year, a signed written document, which certifies that the Contractor is self-insured, carries coverage adequate to meet the requirements of this Section, shall treat HCA as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA.

2.17.12 Privacy Breach Response Coverage: For the term of this Contract and three (3) years following its termination, the Contractor shall maintain insurance to cover costs incurred in connection with a Security Incident, privacy Breach, or potential compromise of data including:

2.17.12.1 Computer forensics assistance to assess the impact of a data Breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach notification laws (45. C.F.R. Part 164, Subpart D; RCW 42.56.590, RCW 19.255.010; and WAC 284-04-625).

2.17.12.2 Notification and call center services for Individuals affected by a Security Incident or privacy Breach.

2.17.12.3 Breach resolution and mitigation services for Individuals affected by a Security Incident or privacy Breach including fraud prevention, credit monitoring and identity theft assistance.

2.17.12.4 Regulatory defense, fines and penalties from any claim in the form of a regulatory proceeding resulting from a violation of any applicable privacy or security law(s) or regulation(s).

2.18 Records

2.18.1 The Contractor and its Subcontractors shall maintain all financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.

2.18.2 All records and reports relating to this Contract shall be retained by the Contractor and its Subcontractors for a minimum of ten (10) years after final payment is made under this Contract. When an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of ten (10) years following resolution of such action.

2.18.3 The Contractor acknowledges the HCA is subject to the Public Records Act (Chapter 42.56 RCW). This Contract shall be a “public record” as defined in Chapter 42.56 RCW. Any documents submitted to HCA by the Contractor may also be construed as “public records” and therefore subject to public disclosure.

2.19 Mergers and Acquisitions

If the Contractor is involved in an acquisition of assets or merger with another HCA Contractor after the effective date of this Contract, HCA reserves the right, to the extent permitted by law, to require that each Contractor maintain its separate business lines for the remainder of the Contract period. The Contractor does not have an automatic right to a continuation of the Contract after any such acquisition of assets or merger.

2.20 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.

2.21 Order of Precedence

In the interpretation of this Contract and incorporated documents, the various terms and conditions shall be construed as much as possible to be complementary. In the event that such interpretation is not possible the following order of precedence shall apply:

2.21.1 Federal statutes and Regulations applicable to the services provided under this Contract.

2.21.2 State of Washington statutes and Regulations concerning the operation of HCA programs participating in this Contract.

2.21.3 Applicable state of Washington statutes and Regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers.

2.21.4 General Terms and Conditions of this Contract.

2.21.5 Any other term and condition of this Contract and exhibits.

2.21.6 Any other material incorporated herein by reference.

2.22 Severability

If any term or condition of this Contract is held invalid by any court of competent jurisdiction, and if all Appeals have been exhausted, such invalidity shall not affect the validity of the other terms or conditions of this Contract.

2.23 Survivability

The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: Fraud, Overpayment, Indemnification and Hold

Harmless, Inspection, Maintenance of Records, and Data Use, Security, and Confidentiality. After termination of this Contract, the Contractor remains obligated to:

2.23.1 Submit reports required in this Contract.

2.23.2 Provide access to records required in accord with the Inspection provisions of this Section.

2.23.3 Provide the administrative services associated with Contracted Services (e.g., claims processing, Individual Appeals) provided to Individuals prior to the effective date of termination under the terms of this Contract.

2.23.4 Repay any Overpayments that:

2.23.4.1 Pertain to services provided at any time during the term of this Contract; and

2.23.4.2 Are identified through an HCA audit or other HCA administrative review at any time on or before ten (10) years from the date of the termination of this Contract; or

2.23.4.3 Are identified through a Fraud investigation conducted by the MFCD or other law enforcement entity, based on the timeframes provided by federal or State law.

2.24 Waiver

Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Contract. Only the Director of the HCA or his or her designee has the authority to waive any term or condition of this Contract on behalf of HCA.

2.25 Contractor Certification Regarding Ethics

The Contractor certifies that the Contractor is now, and shall remain, in compliance with Chapter 42.52 RCW, Ethics in Public Service, throughout the term of this Contract.

2.26 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.

2.27 Indemnification and Hold Harmless

2.27.1 HCA and the Contractor shall each be responsible for their own acts and omissions, and the acts and omissions of their agents and employees. Each party to this Contract shall defend, indemnify, protect and hold harmless the other party, or any of the other party's agents, from and against any loss and all claims, settlements, judgments, costs,

penalties, and expenses, including attorney fees, arising from any willful misconduct, or dishonest, fraudulent, reckless, unlawful, or negligent act or omission of the first party, or agents of the first party, while performing under the terms of this Contract except to the extent that such losses result from the willful misconduct, or dishonest, fraudulent, reckless, unlawful or negligent act or omission on the part of the second party.

2.27.2 The Contractor shall indemnify and hold harmless HCA from any claims by Participating Providers related to the provision of services to Individuals according to the terms of this Contract; this obligation shall not apply to any services that were unpaid due to non-payment of installment moneys by HCA. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees.

2.27.3 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:

2.27.3.1 The allocation of federal or state funds;

2.27.3.2 The use of state hospital beds; or

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

2.28 Industrial Insurance Coverage

The Contractor shall comply with the provisions of Title 51 RCW, Industrial Insurance. If the Contractor fails to provide industrial insurance coverage or fails to pay premiums or penalties on behalf of its employees, as may be required by law, HCA may collect from the Contractor the full amount payable to the Industrial Insurance accident fund. HCA may deduct the amount owed by the Contractor to the accident fund from the amount payable to the Contractor by HCA under this Contract, and transmit the deducted amount to the Department of Labor and Industries, (L&I) Division of Insurance Services. This provision does not waive any of L&I's rights to collect from the Contractor.

2.29 No Federal or State Endorsement

The award of this Contract does not indicate an endorsement of the Contractor by the federal government, or the state of Washington. No federal or state funds have been used for lobbying purposes in connection with this Contract.

2.30 Notices

Whenever one party is required to give notice to the other under this Contract, it shall be deemed given if mailed by United States Postal Services, registered or certified mail, return receipt requested, postage prepaid and addressed as follows:

2.30.1 In the case of notice to the Contractor, notice will be sent to:

Margaret Rojas, Contracts Manager
North Sound Behavioral Health Organization
301 Valley Mall Way, Suite 110
Mount Vernon, WA 98273

2.30.2 In the case of notice to HCA, send notice to:

HCA Contract Administrator
Division of Legal Services/Contracts Office
P.O. Box 42702
Olympia, WA 98504-2702

2.30.3 Notices shall be effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage.

2.30.4 Either party may at any time change its address for notification purposes by mailing a notice in accord with this Section, stating the change and setting for the new address, which shall be effective on the tenth (10th) day following the effective date of such notice unless a later date is specified.

2.31 Notice of Overpayment

2.31.1 A Notice of Overpayment to the Contractor will be issued if HCA determines an Overpayment has been made. RCW 41.05A.170.

2.31.2 The Contractor may contest a Notice of Overpayment by requesting an adjudicative proceeding. The request for an adjudicative proceeding must:

2.31.2.1 Comply with all of the instructions contained in the Notice of Overpayment;

2.31.2.2 Be received by HCA within twenty-eight (28) calendar days of service receipt of the Notice of Overpayment by the Contractor;

2.31.2.3 Be sent to HCA by certified mail (return receipt), to the location specified in the Notice of Overpayment;

2.31.2.4 Include a statement and supporting documentation as to why the Contractor thinks the Notice of Overpayment is incorrect; and

2.31.2.5 Include a copy of the Notice of Overpayment.

2.31.3 If the Contractor submits a timely and complete request for an adjudicative proceeding, then the Office of Administrative Hearings will schedule the proceeding. The Contractor may be offered a pre-hearing or alternative dispute resolution conference in an attempt to resolve the dispute prior to the adjudicative proceeding. The adjudicative proceeding will be governed by the administrative procedure act, Chapter 34.05 RCW, and Chapter 182-526 WAC.

2.31.4 If HCA does not receive a request for an adjudicative proceeding within twenty-eight (28) calendar days of service of a Notice of Overpayment, then the Contractor will be responsible for repaying the amount specified in the Notice of Overpayment. This amount will be considered a final debt to HCA from the Contractor. HCA may charge the Contractor interest and any costs associated with the collection of the debt. HCA may collect an Overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; withholding the amount of the debt from any future payment to the Contractor under this Contract; or any other collection action available to HCA to satisfy the overpayment debt.

2.31.5 Nothing in this Agreement limits HCA's ability to recover overpayments under applicable law.

2.32 Proprietary Data or Trade Secrets

2.32.1 Except as required by law, Regulation, or court order, data identified by the Contractor as proprietary trade secret information shall be kept strictly confidential, unless the Contractor provides prior written consent of disclosure to specific parties. Any release or disclosure of data shall include the Contractor's interpretation.

2.32.2 The Contractor shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. If HCA anticipates releasing data that is identified as proprietary or trade secrets, HCA will notify the Contractor upon receipt of any request under the Public Records Act (Chapter 42.56 RCW) or otherwise for data or Claims Data identified by the Contractor as proprietary trade secret information and will not release any such information until five (5) Business Days after it has notified the Contractor of the receipt of such request. If the Contractor files legal proceedings within the aforementioned five (5) Business Day period in an attempt to prevent disclosure of the data, HCA agrees not to disclose the information unless it is ordered to do so by a court, the Contractor dismisses its lawsuit, or the Contractor agrees that the data may be released.

2.32.3 Nothing in this Section shall prevent HCA from filing its own lawsuit or joining any other lawsuit in an attempt to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will promptly notify the Contractor of the filing of any such lawsuit.

2.33 Ownership of Material

HCA recognizes that nothing in this Contract shall give HCA ownership rights to the systems developed or acquired by the Contractor during the performance of this Contract. The Contractor recognizes that nothing in this Contract shall give the Contractor ownership rights to the systems developed or acquired by HCA during the performance of this Contract.

2.34 Solvency

2.34.1 The Contractor understands and agrees that it is required to make some advance payments under this Contract prior to reimbursement from the state, and that the amount of such payments may vary on a month to month basis.

2.34.2 The Contractor understands and agrees that it must remain solvent at all times during the term of this Contract, including any extensions to the term, and that the failure to remain solvent at all times is grounds for immediate termination by default.

2.34.3 The Contractor agrees that HCA at any time may access any information related to the Contractor's financial condition, and upon HCA's request, the Contractor shall furnish to HCA all such financial information and documentation they have concerning their current financial condition. This shall also include the production of financial information that may be held by a third party agent of the Contractor; the Contractor hereby agrees to sign any necessary authorization to allow for the distribution of such information to HCA.

2.34.4 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.

2.35 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.

2.36 Reserves

2.36.1 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%	$1,796,025
King	2,153,700	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

2.36.2 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.

2.36.3 All expenditures of reserve funds shall be documented and included on the Non-Medicaid Monthly Expenditure Report.

2.36.4 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.

2.37 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).

2.38 Reservation of Rights and Remedies

A material default or breach in this Contract will cause irreparable injury to HCA. In the event of any claim for default or breach of this Contract, no provision in this Contract shall be construed, expressly or by implication, as a waiver by the State of Washington to any existing or future right or remedy available by law. Failure of the State of Washington to insist upon the strict performance of any term or condition of this Contract or to exercise or delay the exercise of any right or remedy provided in this Contract or by law, or the acceptance of (or payment for) materials, equipment or services, shall not release Contractor from any responsibilities or obligations imposed by this Contract or by law, and shall not be deemed a waiver of any right of the State of Washington to insist upon the strict performance of this Contract. In addition to any other remedies that may be available for default or breach of this Contract, in equity or otherwise, HCA may seek injunctive relief against any threatened or actual breach of this Contract without the necessity of proving actual damages. HCA reserves the right to recover any or all administrative costs incurred in the performance of this Contract during or as a result of any threatened or actual breach.

2.39 Termination by Default

2.39.1 **Termination by Contractor**. The Contractor may terminate this Contract whenever HCA defaults in performance of the Contract and fails to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after proper receipt from the Contractor of a written notice specifying the full nature of the default. For purposes of this Section, “default” means failure of HCA to meet one or more material obligations of this Contract. In the event it is determined that HCA was not in default, HCA may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction.

2.39.2 **Termination by HCA**. HCA may terminate this Contract whenever HCA determines the Contractor has defaulted in performance of the Contract and has failed to cure the default within a reasonable period of as set by HCA, based on the nature of the default and how such default impacts possible Individuals. For purposes of this Section, “default” means failure of Contractor to meet one or more material obligations of this Contract; this may minimally include the following:

2.39.2.1 The Contractor did not fully and accurately make any disclosure as required

by the HCA.

2.39.2.2 The Contractor failed to timely submit accurate information as required by the HCA.

2.39.2.3 One of the Contractor's owners failed to timely submit accurate information as required by the HCA.

2.39.2.4 The Contractor's agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the Contractor, failed to timely submit accurate information as required by the HCA.

2.39.2.5 One of the Contractor's owners/administrators did not cooperate with any screening methods as required by the HCA.

2.39.2.6 One of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years.

2.39.2.7 The Contractor has been terminated under title XVIII of the Social Security Act, or under any states' Medicaid or CHIP program.

2.39.2.8 One of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by HCA within thirty (30) days of a HCA request.

2.39.2.9 The Contractor failed to permit access to one of the Contractor's locations for site visits.

2.39.2.10 The Contractor has falsified any information provided on its application.

2.40 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.

2.41 Terminations: Pre-termination Processes

2.41.1 Either party to the Contract shall give the other party to the Contract written notice, as described in the Notices Section of the General Terms and Conditions of this Contract, of its intent to terminate this Contract and the reason for termination.

2.41.2 If either party disagrees with the other party's decision to terminate this Contract, that party will have the right to a dispute resolution as described in the Disputes Section of this Contract.

2.42 Termination Due to Funding

In the event funding from any state, federal, or other source is withdrawn, reduced, or limited in any way after the date this Contract is signed and prior to the termination date, HCA may, in whole or in part, suspend or terminate this Contract upon fifteen (15) calendar days' prior written notice to Contractor or upon the effective date of withdrawn or reduced funding, whichever occurs earlier. At HCA's sole discretion the Contract may be renegotiated under the revised funding conditions. If this Contract is so terminated or suspended, HCA shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date.

2.43 Termination - Information on Outstanding Claims

In the event this Contract is terminated, the Contractor shall provide HCA, within ninety (90) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims or bills for Contracted Services to Individuals. Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions Section of this Contract.

2.44 Administrative Simplification

The Contractor shall comply with the requirements of RCW 70.14.155 and Chapter 48.165 RCW.

2.44.1 To maximize understanding, communication, and administrative economy among all Contractors, their Subcontractors, governmental entities, and Individuals, Contractor shall use and follow the most recent updated versions of:

2.44.1.1 Current Procedural Terminology (CPT).

2.44.1.2 International Classification of Diseases (ICD).

2.44.1.3 Healthcare Common Procedure Coding System (HCPCS).

2.44.1.4 The Diagnostic and Statistical Manual of Mental Disorders.

2.44.1.5 National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard D.O.

2.44.1.6 Medi-Span® Master Drug Data Base or other nationally recognized drug data base with approval by HCA.

2.44.2 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.

2.44.3 In lieu of the most recent versions, Contractor may request an exception. HCA's consent thereto will not be unreasonably withheld.

2.44.4 Contractor may set its own conversion factor(s), including special code-specific or group-specific conversion factors, as it deems appropriate.

3 MATERIALS AND INFORMATION REQUIREMENTS

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 subsection 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.

3.2 Information Requirements for Individuals

3.2.1 Upon an Individual's request, the Contractor shall provide all relevant licensure, certification and accreditation status and information for any contracted provider.

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 (6^{th}) 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.

4 SERVICE AREA AND INDIVIDUAL ELIGIBILITY

4.1 Service Areas

The Contractor's policies and procedures related to eligibility shall ensure compliance with the requirements described in this Section. The Contractor's RSAs are described in Exhibit D, Service Area Matrix.

4.2 Service Area Changes

4.2.1 The Contractor must offer services to all Individuals within the boundaries of the RSA covered by this Contract.

4.2.2 The Contractor may not decrease its service areas or its level of participation in any service area except during Contract renewal.

4.2.3 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's RSA, HCA shall alter the service area zip code numbers or the boundaries of the service areas with input from the Contractor.

4.2.4 HCA shall determine, in its sole judgment, which zip codes fall within each service area.

4.2.5 HCA will use the Individual's residential zip code to determine whether an Individual resides within a service area.

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 ITA 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 19, 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 AH-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.

5 PAYMENT AND SANCTIONS

5.1 Funding

5.1.1 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.

5.1.2 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.

5.1.3 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 Non-Medicaid Expenditure Report.

5.1.4 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.

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

5.1.6 The Contractor shall send the Non-Medicaid Expenditure Report to the Finance Department (hcarevenue&expenditures@hca.wa.gov) no later than forty-five (45) 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.

5.1.7 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.

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

5.1.8.1 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.

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

5.1.8.3 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.

5.1.9 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:

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

5.1.9.2 Inpatient mental health services.

5.1.9.3 Construction and/or renovation.

5.1.9.4 Capital assets or the accumulation of operating reserve accounts.

5.1.9.5 Equipment costs over $5,000.

5.1.9.6 Cash payments to Individuals.

5.1.10 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.

5.1.11 The Contractor shall ensure that all funds provided pursuant to this Contract, (other than the 10 percent allowed for administration 5 percent for direct service supports and up to 1.75 percent for B&O tax for actual expenditures paid directly to government entities specifically for B&O taxes) including interest earned, are to be used to provide services as described in this Contract. Direct service supports and B&O tax expense allowances are up to the percentage indicated and not a percentage of GFS funding as is calculated for administrative costs.

5.2 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.

5.3 Non-Compliance

5.3.1 Failure to Maintain Reporting Requirements

In the event the Contractor fails to maintain its reporting obligations under this Contract, HCA reserves the right to withhold reimbursements to the Contractor until the obligations are met.

5.3.2 Recovery of Costs Claimed in Error

If HCA reimburses the Contractor for expenditures under this Contract which HCA later finds were claimed in error or were not allowable costs under the terms of the Contract, HCA shall recover those costs and the Contractor shall fully cooperate with the recovery.

5.3.3 Stop Placement:

DOH or HCA may stop the placement of an Individual in a treatment Facility immediately upon finding that the Contractor or a Subcontractor is not in substantial compliance, with provisions of this Contract or any WAC related to SUD treatment as determined by DOH. The treatment Facility will be notified of this decision in writing.

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.

5.4 Overpayments or Underpayments

5.4.1 If, at HCA's sole discretion, HCA determines as a result of data errors or inadequacies, policy changes beyond the control of the Contractor, or other causes, there are material errors or omissions in the allocation of GFS/FBG funds, HCA may make prospective and/or retrospective modifications to the funding allocations.

5.5 Sanctions

If the Contractor fails to meet one or more of its obligation under the terms of this Contract or other applicable law, HCA may:

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.

5.5.2 Impose any of the following remedial actions:

5.5.2.1 Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to HCA within thirty (30) calendar days of notification. HCA may accept the plan, require modifications or reject the plan. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Contract. HCA may extend or reduce the time allowed for corrective action depending upon the nature of the situation. Corrective action plans shall include:

5.5.2.1.1 A brief description of the situation requiring corrective action.

5.5.2.1.2 The specific actions to be taken to remedy the situation.

5.5.2.1.3 A timetable for completion of the action(s).

5.5.2.1.4 Identification of individuals responsible for implementation of the plan.

5.5.2.2 Withhold up to 5 percent of the next payment and each payment thereafter if the Contractor fails to submit, gain HCA approval of or implement the requested corrective action plan within agreed upon timeframes. The amount of withhold will be based on the severity of the situation as detailed in this Section. HCA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

5.5.2.3 Increase withholdings identified in this Section by up to an additional 3 percent for each successive month during which the corrective action plan has not been submitted or implemented.

5.5.3 Deny any incentive payment to which the Contractor might otherwise have been entitled under this Contract.

5.5.4 Terminate for Default as described in the General Terms and Conditions.

5.6 Mental Health Payer

The Contractor shall follow the rules for payer of responsibility set forth in the table labelled “How do providers identify the correct payer?” in the Apple Health Mental Health Services Billing Guide.

6 ACCESS TO CARE AND PROVIDER NETWORK

6.1 Network Capacity

6.1.1 The Contractor shall maintain and monitor an appropriate and adequate provider network, supported by written agreements, sufficient to provide all Contracted Services under this Contract.

6.1.1.1 The Contractor may provide Contracted Services through Non-Participating Providers, at a cost to the individual that is no greater than if the Contracted Services were provided by Participating Providers, if its network of Participating Providers is insufficient to meet the Behavioral Health needs of Individuals in a manner consistent with this Contract.

6.1.1.2 This provision shall not be construed to require the Contractor to cover such services without authorization.

6.1.1.3 To the extent necessary to provide non-crisis Behavioral Health services covered under this Contract, the Contractor may offer contracts to providers in other RSAs in the state of Washington and to providers in bordering states.

6.1.1.4 The Contractor may not contract for Crisis Services (SUD or Mental Health) or ITA-related services out of Washington State.

6.1.2 For non-crisis behavioral health services funded by GFS:

6.1.2.1 The Contractor shall provide non-crisis Behavioral Health services funded by GFS, within Available Resources, to Individuals who meet financial eligibility standards in this Contract and meet one of the following criteria:

6.1.2.1.1 Are uninsured;

6.1.2.1.2 Have insurance, but are unable to pay the co-pay or deductible for services;

6.1.2.1.3 Are using excessive Crisis Services due to inability to access non-crisis behavioral health services; and

6.1.2.1.4 Have more than five (5) visits over six (6) months to the emergency department, withdrawal management facility, or a sobering center due to a SUD.

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.

6.1.4 The Contractor shall notify HCA ninety (90) calendar days prior to terminating any of its Subcontracts or entering into new Subcontracts with entities that provide direct services, including Crisis Services providers. This notification shall occur prior to any public announcement of this change, and should include:

6.1.4.1 The reason for termination;

6.1.4.2 The Contractor's plan for notification of necessary stakeholders of the change in network; and

6.1.4.3 How the Contractor will ensure network adequacy with the loss of the subcontractor.

6.1.5 If a Subcontract is terminated or a site closure occurs in less than the ninety (90) calendar days, the Contractor shall notify HCA as soon as possible.

6.1.5.1 When a Subcontract is terminated or a site closes unexpectedly, the Contractor shall submit additional information to HCA in writing within seven (7) calendar days that includes:

6.1.5.1.1 Notification to Ombuds services and Individuals;

6.1.5.1.2 A provision for uninterrupted services; and

6.1.5.1.3 Any information released to the media.

6.1.5.2 HCA reserves the right to impose sanctions, in accordance with the Sanctions subsection of this Contract, if the Contractor was notified by the terminating provider in a timely manner and does not comply with the notification requirements of this Section.

6.1.5.2.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor shall provide documentation of the date of notification along with the notice of loss of a terminating provider.

6.1.5.3 Provider network information will be reviewed by HCA for:

6.1.5.3.1 Completeness and accuracy;

6.1.5.3.2 Removal of providers who no longer contract with the Contractor; and

6.1.5.3.3 The effect the change(s) in the provider network will have on the Contractor's compliance with the network requirements of this Section.

6.1.6 The Contractor shall meet the following requirements when developing its network:

6.1.6.1 Only licensed or certified Behavioral Health Providers shall provide behavioral health services. Licensed or certified Behavioral Health Providers include, but are not limited to: Health Care Professionals, licensed agencies or clinics, or professionals operating under an agency affiliated license.

6.1.6.2 Within Available Resources, establish and maintain contracts with office-based opioid treatment providers that have obtained a waiver under the Drug Addiction Treatment Act of 2000 to practice medication-assisted opioid addiction therapy.

6.1.6.3 Assist the State in expanding community-based alternatives for crisis stabilization, such as mobile crisis outreach or crisis residential and respite beds.

6.1.6.4 Assist the State in expanding community-based, Recovery-oriented services, use of Certified Peer Counselors and Research- and Evidence-Based Practices.

6.1.7 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network for Crisis Services, HCA reserves the right to immediately terminate this Contract.

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.

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.

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.

6.5 Priority Populations and Waiting Lists

The Contractor shall comply with the following requirements:

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.

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, ensure Interim Services are provided for PPW 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 the SABG Capacity Management report 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)).

7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

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 the Federal Block Grant Annual Progress Report template. 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.

7.1.3 The Contractor's Behavioral Health Medical Director participates in the HCA or MCO meetings and policy development on emerging technologies for the treatment of behavioral health conditions and related decisions. The Contractor shall also have a Child or Adolescent Psychiatrist available for consultation related to the treatment of behavioral health conditions in children and youth.

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 concerning the line of business applicable to this Contract 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 to the site applicable to this Contract 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.

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 quarterly and annual reports. Reports must be submitted to HCA at hcabhaso@hca.wa.gov..

7.3.3.1 The quarterly report is due by the last day of the month following each quarter. The Contractor must use the HCA provided Crisis System Quarterly Report template.

7.3.3.2 The annual report is due by January 31 for the previous calendar year. The report must include:

7.3.3.2.1 A summary and analysis about each region's 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.

7.3.3.2.2 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.

7.3.3.2.3 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.

7.3.3.2.4 Provide a summary of the development, implementation, and outcomes of activities and strategies used to improve the crisis system. To include:

7.3.3.2.4.1 An overview and analysis of available information and data about the disposition of crisis calls.

7.3.3.2.4.2 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.

7.3.3.2.4.3 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.

7.3.3.2.4.4 Any systemic changes to the crisis system planned in the upcoming year as a result of the information and data.

7.4 Critical Incident Reporting

The Contractor shall communicate with the appropriate MCO when the Contractor becomes aware of an incident for a Medicaid Enrollee.

7.4.1 The Contractor shall establish a Critical Incident Management System consistent with all applicable laws and shall include policies and procedures for identification of incidents, reporting protocols and oversight responsibilities. The Contractor shall

designate a Critical Incident Manager responsible for administering the Incident Management System and ensuring compliance with the requirements of this Section.

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

7.4.2.1.2.5 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.

7.4.3 Population Based Reporting

7.4.3.1 The Contractor shall submit a semi-annual report of all Critical Incidents tracked for Individuals receiving BH-ASO funded services during the previous six (6) months. The report shall include an analysis of the following incidents:

7.4.3.1.1 Incidents reported through the HCA Incident Reporting System;

7.4.3.1.2 Incidents posing a credible threat to an Individual's safety;

7.4.3.1.3 Suicide and attempted suicide; and

7.4.3.1.4 Poisoning/overdoses unintentional or intention unknown.

7.4.3.2 The following shall be addressed in the analysis:

7.4.3.2.1 How the incident reporting program has been structured and operationalized;

7.4.3.2.2 The number and types of critical incidents and comparisons over time;

7.4.3.2.3 Trends found in the population (i.e. regional differences, demographic groups, vulnerable populations, other as defined by Contractor);

7.4.3.2.4 Actions taken by the Contractor to reduce incidents based on the analysis, and other actions taken and why;

7.4.3.2.5 The Contractor's evaluation of how effective their critical incident reporting program has been over the reporting period and changes that will be made, as needed.

7.4.3.3 The report shall be submitted as a Word document and is due no later than

the last Business Day of January and July for the prior six (6) month period. The January report shall reflect incidents that occurred July through December and the July report shall reflect incidents that occurred January through June.

7.4.3.4 The Contractor shall also include a data file of all Critical Incidents from which the analysis is made using a template provided by HCA.

7.5 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:

7.5.1 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.

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

7.5.2.1 Verifying the accuracy and timeliness of reported data;

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

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

7.5.3 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).

7.5.4 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.

7.5.5 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.

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

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

7.5.7.1 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.

7.5.7.2 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:

7.5.7.2.1 Hours of operations;

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

7.5.7.2.3 Telecommunications device for the deaf/text telephone numbers;

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

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

7.6 Required Reporting for Behavioral Health Services

7.6.1 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.

7.6.2 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.

7.6.2.1 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.

7.6.3 Behavioral Health Supplemental Transaction Data Submission and Error Correction

7.6.3.1 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.

7.6.3.2 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.

7.6.3.3 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.

7.6.3.3.1 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.

7.6.3.4 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.

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

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

7.6.3.5 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.

7.6.4 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.

7.6.5 The following are the required reporting from BHDS Guide:

7.6.5.1 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.

7.6.5.2 All reporting must be done via a flat file in the format and with the

acceptable data values prescribed in the BHDS guide.

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

7.6.5.4 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.

7.7 Encounter Data

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

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

7.7.2 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:

7.7.2.1 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;

7.7.2.2 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

7.7.2.3 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.

7.7.2.4 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.

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

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

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

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

7.7.4.3 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.

7.7.4.3.1 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.

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

7.7.5 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.

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

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

7.7.6.2 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.

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

7.7.7 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.

7.8 Technical Assistance

The Contractor may request technical assistance for any matter pertaining to this Contract by contacting HCA.

8 POLICIES AND PROCEDURES

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.

9 SUBCONTRACTS

9.1 Contractor Remains Legally Responsible

9.1.1 No Subcontract shall terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions or responsibilities it delegates to any Subcontractor.

9.2 Provider Nondiscrimination

9.2.1 The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold, however, the Contractor is free to establish criteria and/or standards for providers' inclusion in a network of providers based on their specialties.

9.2.2 If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

9.2.3 The Contractor's policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

9.2.4 Consistent with the Contractor's responsibilities to Individuals, this Section does not:

9.2.4.1 Require the Contractor to contract with providers beyond the number necessary to meet the behavioral health requirements under the Contract.

9.2.4.2 Preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty.

9.2.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs.

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. Behavioral Health Supplemental Transactions related to services provided to Individuals must be submitted within thirty (30) calendar days from the date of service or event.

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.

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.

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 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 (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.

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 an annual 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. The certification must be submitted to HCABHASO@hca.wa.gov by January 31.

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 FFS, 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.

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 IHCPs 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's 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.

9.8 Health Care Provider Subcontracts Delegating Administrative Functions

9.8.1 Subcontracts that delegate Administrative Functions under the terms of this Contract shall include the following additional provisions:

9.8.1.1 Clear descriptions of any Administrative Functions delegated by the Contractor in the Subcontract.

9.8.1.2 Provisions for revoking delegation or imposing sanctions if the Subcontractor's performance is inadequate.

9.8.2 A Subcontractor providing Administrative Functions has established a conflict of interest policy that:

9.8.2.1 Requires screening of employees upon hire and board members at the time of initial appointment, and annually thereafter, for conflicts of interests related to performance of services under the Subcontract.

9.8.2.2 Prohibits employees and/or board members from participating in actions which could impact or give the appearance of impacting a personal interest or the interest of any corporate, partnership or association in which the employee or board member is directly or indirectly involved.

9.8.2.3 Prohibits access to information regarding proprietary information for other providers including, but not limited to: reimbursement rates, for any Subcontractor that provides behavioral health services and administrative services under the Contract.

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

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

9.9.1.7 Program Integrity requirements.

9.9.1.8 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.

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

9.10 Provider Payment Standards

9.10.1 The Contractor shall meet the timeliness of payment standards as specified in this Section. To be compliant with payment standards the Contractor shall pay or deny, and shall require Subcontractors to pay or deny, 95 percent of clean claims and

encounters within thirty (30) calendar days of receipt, 95 percent of all claims within sixty (60) calendar days of receipt and 99 percent of claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

9.10.1.1 A claim is a bill for services, a line item of service, or all services for one (1) Individual within a bill.

9.10.1.2 A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

9.10.1.3 The date of receipt is the date the Contractor receives the claim or encounter from the provider.

9.10.1.4 The date of payment is the date of the check or other form of payment.

9.10.2 The Contractor shall update its claims and encounter system to support hardcopy and electronic submission of claims, adjustment claims, encounters, payments and bills for all Contracted Services types for which claims submission is required.

9.11 Coordination of Benefits (COB) 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.

9.12 Sliding Fee Schedule

9.12.1 Subcontracted 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.

9.12.2 In developing sliding fee schedules, providers must comply with the following:

9.12.2.1 Put the sliding fee schedule in writing that is non-discriminatory;

9.12.2.2 Include language in the sliding fee schedule that no Individual shall be denied services due to inability to pay;

9.12.2.3 Provide signage and information to Individuals to educate them on the sliding fee schedule;

9.12.2.4 Protect Individual's privacy in assessing fees;

9.12.2.5 Maintain records to account for each Individual's visit and any charges incurred;

9.12.2.6 Charge Individuals at or below 100 percent of Federal Poverty Level (FPL) a nominal fee or no fee at all;

9.12.2.7 Develop at least three (3) incremental amounts on the sliding fee scale for Individuals between 101 to 220 percent FPL.

9.13 Cost Sharing Assistance

9.13.1 The Contractor may use block grant funds to help Individuals satisfy cost-sharing requirements for SABG-authorized SUD services or MHBG-authorized mental health services. The Contractor must ensure that:

9.13.1.1 The provider is a recipient of block grant funds;

9.13.1.2 Cost-sharing is for a block grant authorized service;

9.13.1.3 Payments are in accordance with SABG or MHBG laws and regulations;

9.13.1.4 Cost-sharing payments are made directly to the provider of the service; and

9.13.1.5 A report is provided to HCA upon request that identifies:

9.13.1.5.1 The number of Individuals provided cost-sharing assistance;

9.13.1.5.2 The total dollars paid out for cost-sharing; and

9.13.1.5.3 Providers who received cost-sharing funds.

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 work towards creation and implementation of 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 including completion of implementation and a fully credentialed provider network by December 31, 2021.

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.

10 INDIVIDUAL RIGHTS AND PROTECTIONS

10.1 General Requirements

10.1.1 The Contractor shall comply with any applicable federal and state laws that pertain to Individual rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to Individuals.

10.1.2 The Contractor and its Subcontractors shall guarantee that each Individual has the following rights:

10.1.2.1 To information regarding the Individual's behavioral health status.

10.1.2.2 To receive all information regarding behavioral health treatment options including any alternative or self-administered treatment, in a culturally-competent manner.

10.1.2.3 To receive information about the risks, benefits, and consequences of behavioral health treatment (including the option of no treatment).

10.1.2.4 To participate in decisions regarding his or her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions.

10.1.2.5 To be treated with respect and with due consideration for his or her dignity and privacy.

10.1.2.6 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

10.1.2.7 To request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. Part 164.

10.1.2.8 To be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the Contractor treats the Individual.

10.1.3 The Contractor shall require a criminal history background check through the Washington State Patrol for employees and volunteers of the Contractor who may have unsupervised access to children, people with developmental disabilities or vulnerable adults, in accordance with Chapter 388-06 WAC.

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.

10.3 Cultural Considerations

10.3.1 The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

10.3.2 At a minimum, the Contractor shall:

10.3.2.1 Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing bases. (CLAS Standard 4);

10.3.2.2 Offer language assistance to Individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. (CLAS Standard 5);

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

10.3.2.4 Ensure the competence of Individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. (CLAS Standard 7);

10.3.2.5 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. (CLAS Standard 8);

10.3.2.6 Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations. (CLAS Standard 9);

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

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

10.4 Mental Health Advance Directive (MHAD)

10.4.1 The Contractor shall maintain a written Mental Health Advance Directive (MHAD) policy and procedure that respects an Individual's Advance Directive. Policy and procedures must comply with Chapter 71.32 RCW.

10.4.2 The Contractor shall inform all Individuals seeking mental health services and Individuals with a history of frequent crisis system utilization of their right to a MHAD and shall provide technical assistance to those who express an interest in developing and maintaining a MHAD.

10.4.3 The Contractor shall maintain current copies of any MHAD in the Individual's records.

10.4.4 The Contractor shall inform Individuals that complaints concerning noncompliance with a MHAD should be referred to the Department of Health.

10.5 Individual Choice of Behavioral Health Provider

10.5.1 An Individual may maintain existing behavioral health provider relationships when funding is available and when the Contracted Services are medically necessary. Individuals are not guaranteed a choice of Behavioral Health providers for Contracted Services.

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.

10.7 Individual Self-Determination

10.7.1 The Contractor shall ensure that all providers:

10.7.1.1 Obtain informed consent prior to treatment from Individuals, or persons authorized to consent on behalf of an Individual, as described in RCW 7.70.065;

10.7.1.2 Comply with the provisions of the Natural Death Act (Chapter 70.122 RCW) and state rules concerning Advance Directives (WAC 182-501-0125); and,

10.7.1.3 When appropriate, inform Individuals of their right to make anatomical gifts (Chapter 68.64 RCW).

11 UTILIZATION MANAGEMENT (UM) PROGRAM AND AUTHORIZATION OF SERVICES

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 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 take into account the greater and particular needs of diverse populations, as reflected in Health Disparities, risk factors (such as ACEs for Individuals of any age), Historical Trauma, and the need for Culturally Appropriate Care

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 and the needs and clinical risk factors of diverse populations.

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.

11.2 Medical Necessity Determination

The Contractor shall collect all information necessary to make medical necessity determinations. The Contractor shall determine which Contracted Services are medically necessary according to the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity shall be final, except as specifically provided in Section 13 of this Contract.

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.

11.4 Timeframes for Authorization Decisions

11.4.1 The Contractor is required to acknowledge receipt of an 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.

11.5 Notification of Coverage and Authorization Determinations

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 For all authorization decisions, the notice shall be mailed as expeditiously as the Individual's health condition requires and within three (3) Business Days of the Contractor's decision.

11.5.1.3 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.

11.5.1.4 The Contractor shall notify the Individual, the requesting provider if applicable, and ordering provider in writing 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. This includes Adverse Authorization Determinations that occur due to lack of Available Resources, Medicaid payer responsibility, and out of RSA requests. The notice to the Individual and provider shall explain the following:

11.5.1.4.1 The decision the Contractor has taken or intends to take, and effective date if applicable.

11.5.1.4.2 The specific factual basis 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.

11.5.1.4.3 Sufficient detail to enable the Individual to learn why the Contractor's determination was made, be able to prepare an appropriate response, and, if issuing an Action, determine what additional or different information might be provided to appeal the Contractor's determination.

11.5.1.4.4 If applicable, the notice must include information about alternative covered services/treatment that may be seen as a viable treatment option in lieu of denied services.

11.5.1.4.5 The Individual's and provider's right to request and receive free of charge a copy of the rule, guideline, protocol or other criterion that was the basis for the decision, as well as reasonable access to and copies of all documents, records, and other information relevant to the Adverse Authorization Determination.

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

11.5.1.4.7 A toll-free telephone number to call if the Individual is billed for services.

11.5.1.4.8 Information regarding whether and how the Individual may Appeal the decision, including any deadlines applicable to the process.

11.5.1.4.9 The circumstances under which expedited resolution is available and how to request it.

11.5.1.4.10 The Individual's right to receive the Contractor's or regional Ombuds' assistance in filing a Grievance or an Appeal and how to request it.

11.5.1.4.11 The Individual's right to equal access to services for Individuals with communication barriers and disabilities

11.5.1.4.12 When the reason for the Adverse Authorization Determination is that the Individual has Medicaid coverage for the requested service, the notice must redirect to the appropriate payer.

11.5.2 The Contractor shall provide notification in accordance with the timeframes described in this Section except in the following circumstances:

11.5.2.1 The Individual dies;

11.5.2.2 The Contractor has a signed statement from the Individual requesting service termination or giving information that makes the Individual ineligible and requiring termination or reduction of services (where the Individual understands that termination, reduction, or suspension of services is the result of supplying this information);

11.5.2.3 The Individual is admitted to a Facility where he or she is ineligible for services.

11.5.2.4 The Individual's address is unknown and there is no forwarding address.

11.5.2.5 The Individual has moved out of the Contractor's service area.

11.5.2.6 The Individual requests a change in the level of care.

11.5.3 Untimely Service Authorization Decisions: When the Contractor does not reach service authorization decisions within the timeframes for either standard or expedited service authorizations it is considered a denial and thus, an Adverse Authorization Determination and must follow notification requirements.

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.

12 PROGRAM INTEGRITY

12.1 General Requirements

12.1.1 The Contractor shall have and comply with policies and procedures that guide and require the Contractor and the Contractor's officers, employees, agents, and Subcontractors to comply with Program Integrity requirements.

12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts.

12.2 Information on Persons Convicted of Crimes

12.2.1 The Contractor must include in its written agreements with all Subcontractors and providers requirements that the Subcontractor/provider investigate and disclose to HCA immediately upon becoming aware of any person in their employment who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act since the inception of those programs.

12.3 Fraud, Waste and Abuse

12.3.1 The Contractor's Fraud, Waste and Abuse program shall have:

12.3.1.1 A process to inform officers, employees, agents and Subcontractors about the False Claims Act.

12.3.1.2 Administrative procedures to detect and prevent Fraud, waste and abuse, and a mandatory compliance plan.

12.3.1.3 Standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards.

12.3.1.4 The designation of a compliance officer and a compliance committee that is accountable to senior management.

12.3.1.5 Training for all affected parties.

12.3.1.6 Effective lines of communication between the compliance officer and the Contractor's staff and Subcontractors.

12.3.1.7 Enforcement of standards through well-publicized disciplinary policies.

12.3.1.8 Provision for internal monitoring and auditing of the Contractor and providers.

12.3.1.9 Provision for prompt response to detected violations, and for development of corrective action initiatives.

12.3.1.10 Provision of detailed information to employees and Subcontractors regarding Fraud and abuse policies and procedures and the False Claims Act

and the Washington false claims statutes, Chapter 74.66 RCW and RCW 74.09.210.

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 HotTips@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.

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.

12.6 Records Requests

12.6.1 Upon request, the Contractor and the Contractor's Subcontractors shall allow HCA or any authorized state or federal agency or authorized representative, access to all records pertaining to this Contract, including computerized data stored by the Contractor or Subcontractor. The Contractor and its Subcontractors shall provide and furnish the records at no cost to the requesting agency.

12.7 On-Site Inspections

12.7.1 The Contractor and its Subcontractors must provide any record or data pertaining to this Contract including, but not limited to:

12.7.1.1 Medical records;

12.7.1.2 Billing records;

12.7.1.3 Financial records;

12.7.1.4 Any record related to services rendered, quality, appropriateness, and timeliness of service; and

12.7.1.5 Any record relevant to an administrative, civil or criminal investigation or prosecution.

12.7.2 Upon request, the Contractor or Subcontractor shall assist in such review, including the provision of complete copies of records.

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**.**

13 GRIEVANCE AND APPEAL SYSTEM

13.1 General Requirements

The Contractor shall have a Grievance and Appeal System that includes a Grievance Process, an Appeal Process, and access to the Administrative Hearing process for Contracted Services (WAC 182-538C-110).

NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

13.1.1 The Contractor shall have policies and procedures addressing the Grievance and Appeal System, which comply with the requirements of this Contract. HCA must approve, in writing, all Grievance and Appeal System policies and procedures and related notices to Individuals regarding the Grievance and Appeal System.

13.1.2 The Contractor shall give Individuals any reasonable assistance necessary in completing forms and other procedural steps for Grievances and Appeals.

13.1.3 The Contractor shall acknowledge receipt of each Grievance, either orally or in writing, within two (2) Business Days.

13.1.4 The Contractor shall acknowledge in writing, the receipt of each Appeal. The Contractor shall provide the written notice to both the Individual and requesting provider within three (3) calendar days of receipt of the Appeal.

13.1.5 The Contractor shall ensure that decision makers on Grievances and Appeals were not involved in previous levels of review or decision-making.

13.1.6 Decisions regarding Grievances and Appeals shall be made by Health Care Professionals with clinical expertise in treating the Individual's condition or disease if any of the following apply:

13.1.6.1 The Individual is appealing an Action.

13.1.6.2 The Grievance or Appeal involves any clinical issues.

13.1.7 With respect to any decisions described in subsection 13.1.6, the Contractor shall ensure that the Health Care Professional making such decisions:

13.1.7.1 Has clinical expertise in treating the Individual's condition or disease that is age appropriate (e.g., a board certified Child and Adolescent Psychiatrist for a child Individual).

13.1.7.2 A physician board-certified or board-eligible in Psychiatry or Child or Adolescent Psychiatry if the Grievance or Appeal is related to inpatient level of care denials for psychiatric treatment.

13.1.7.3 A physician board-certified or board-eligible in Addiction Medicine or a Sub-specialty in Addiction Psychiatry if the Grievance or Appeal is related to

inpatient level of care denials for SUD treatment.

13.1.7.4 Are one or more of the following, as appropriate, if a clinical Grievance or Appeal is not related to inpatient level of care denials for psychiatric or SUD treatment:

13.1.7.4.1 Physicians board-certified or board-eligible in Psychiatry, Addiction Medicine or Addiction Psychiatry;

13.1.7.4.2 Licensed, doctoral level clinical psychologists; or

13.1.7.4.3 Pharmacists.

13.2 Grievance Process

The following requirements are specific to the Grievance Process:

13.2.1 Only an Individual or the Individual's authorized representative may file a Grievance with the Contractor. A provider may not file a Grievance on behalf of an Individual unless the provider is acting on behalf of the Individual and with the Individual's written consent.

13.2.1.1 The Contractor shall request the Individual's written consent should a provider Appeal on behalf of an Individual without the Individual's written consent.

13.2.2 The Contractor shall accept, document, record, and process Grievances forwarded by HCA.

13.2.3 The Contractor shall provide a written response to HCA within three (3) Business Days to any constituent Grievance. For the purpose of this subsection, "constituent Grievance" means a complaint or request for information from any elected official or agency director or designee.

13.2.4 The Contractor shall assist the Individual with all Grievance and Appeal processes, and provide information about the availability of Ombuds services to assist the Individual.

13.2.5 The Contractor shall cooperate with any representative authorized in writing by the Individual.

13.2.6 The Contractor shall consider all information submitted by the Individual or his/her authorized representative.

13.2.7 The Contractor shall investigate and resolve all Grievances whether received orally or in writing. The Contractor shall not require an Individual or his/her authorized representative to provide written follow up for a Grievance or Appeal the Contractor received orally.

13.2.8 The Contractor shall complete the disposition of a Grievance and notice to the affected parties as expeditiously as the Individual's health condition requires, but no later than forty-five (45) calendar days from receipt of the Grievance.

13.2.9 The notification may be made orally or in writing for Grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

13.2.10 Individuals do not have the right to an Administrative Hearing in regard to the disposition of a Grievance.

13.3 Appeal Process

The following requirements are specific to the Appeal Process:

13.3.1 An Individual, the Individual's authorized representative, or a provider acting on behalf of the Individual and with the Individual's written consent, may Appeal a Contractor Action.

13.3.1.1 If a provider has requested an Appeal on behalf of an Individual, but without the Individual's written consent, the Contractor shall not dismiss the Appeal without first attempting to contact the Individual within five (5) calendar days of the provider's request, informing the Individual that an Appeal has been made on the Individual's behalf, and then asking if the Individual would like to continue the Appeal.

If the Individual wants to continue the Appeal, the Contractor shall obtain from the Individual a written consent for the Appeal. If the Individual does not wish to continue the Appeal, the Contractor shall formally dismiss the Appeal, in writing, with appropriate Appeal rights and by delivering a copy of the dismissal to the provider as well as the Individual.

13.3.1.2 For expedited Appeals, the Contractor may bypass the requirement for the Individual's written consent and obtain the Individual's oral consent. The Individual's oral consent shall be documented in the Contractor's records.

13.3.2 If HCA receives a request to Appeal an Action of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the Individual with information that a provider filed an Appeal.

13.3.3 For Appeals of standard service authorization decisions, an Individual, or a provider acting on behalf of the Individual, must file an Appeal, either orally or in writing, within sixty (60) calendar days of the date on the Contractor's Notice of Action. This also applies to an Individual's request for an expedited Appeal.

13.3.4 Oral inquiries seeking to Appeal an Action shall be treated as Appeals and be confirmed in writing, unless the Individual or provider requests an expedited resolution. The Appeal acknowledgement letter sent by the Contractor to an Individual shall serve as written confirmation of an Appeal filed orally by an Individual.

13.3.5 The Appeal process shall provide the Individual a reasonable opportunity to present evidence, and allegations of fact or law in writing. The Contractor shall inform the Individual of the limited time available for this in the case of expedited resolution.

13.3.6 The Appeal process shall provide the Individual and the Individual's representative opportunity, before and during the Appeals process, to examine the Individual's case file, including medical records, and any other documents and records considered during the Appeal process.

13.3.7 The Appeal process shall include as parties to the Appeal, the Individual and the Individual's authorized representative, or the legal representative of the deceased Individual's estate.

13.3.8 In any Appeal of an Action by a Subcontractor, the Contractor or its Subcontractor shall apply the Contractor's own standards, protocols, or other criteria that pertain to authorizing specific services.

13.3.9 The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Individual's health condition requires, within the following timeframes:

13.3.9.1 For standard resolution of Appeals and for Appeals for termination, suspension or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the Appeal, unless the Contractor notifies the Individual that an extension is necessary to complete the Appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for Appeal.

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

13.3.9.3 For expedited resolution of Appeals or Appeals of behavioral health drug authorization decisions, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the Appeal.

13.3.10 The Contractor shall provide notice of resolution of the Appeal in a language and format which is easily understood by the Individual. The notice of the resolution of the Appeal shall:

13.3.10.1 Be in writing and sent to the Individual and the requesting provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

13.3.10.2 Include the date completed and reasons for the determination.

13.3.10.3 Include a written statement of the reasons for the decision, including how the requesting provider or Individual may obtain the review or decision-making criteria.

13.3.10.4 For Appeals not resolved wholly in favor of the Individual:

13.3.10.4.1 Include information on the Individual's right to request an Administrative Hearing and how to do so.

13.4 Expedited Appeals Process

13.4.1 The Contractor shall establish and maintain an expedited Appeal review process for Appeals when the Contractor determines or a provider indicates that taking the time for a standard resolution could seriously jeopardize the Individual's life or health or ability to attain, maintain, or regain maximum function.

13.4.2 The Individual may submit an expedited Appeal either orally or in writing. No additional Individual follow-up is required.

13.4.3 The Contractor shall make a decision on the Individual's request for expedited Appeal and provide written notice, as expeditiously as the Individual's health condition requires, no later than three (3) calendar days after the Contractor receives the Appeal. The Contractor shall also make reasonable efforts to provide oral notice.

13.4.4 The Contractor may extend the timeframes by up to fourteen (14) calendar days if the Individual requests the extension; or the Contractor shows there is a need for additional information and how the delay is in the Individual's interest.

13.4.5 For any extension not requested by an Individual, the Contractor must give the Individual written notice of the reason for the extension.

13.4.6 The Contractor shall ensure that punitive Action is not taken against a provider who requests an expedited resolution or supports an Individual's Appeal.

13.4.7 If the Contractor denies a request for expedited resolution of an Appeal, it shall transfer the Appeal to the timeframe for standard resolution and make reasonable efforts to give the Individual prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of denial.

13.5 Administrative Hearing

13.5.1 Only the Individual or the Individual's authorized representative may request an Administrative Hearing. A provider may not request an Administrative Hearing on behalf of an Individual.

13.5.2 If an Individual does not agree with the Contractor's resolution of an Appeal, the Individual may file a request for an Administrative Hearing within one hundred and twenty (120) calendar days of the date of notice of the resolution of the Appeal. The Contractor will not be obligated to continue services pending the results of the Administrative Hearing.

13.5.3 If the Individual requests an Administrative Hearing, the Contractor shall provide to HCA and the Individual, upon request, and within three (3) Business Days, all Contractor-held documentation related to the Appeal, including, but not limited to:

transcript(s), records, or written decision(s) from participating providers or delegated entities.

13.5.4 The Contractor is an independent party and is responsible for its own representation in any Administrative Hearing, Board of Appeals, and subsequent judicial proceedings.

13.5.5 The Contractor's Behavioral Health Medical Director or designee shall review all cases where an Administrative Hearing is requested and any related Appeals.

13.5.6 The Individual must exhaust all levels of resolution and Appeal within the Contractor's Grievance and Appeal System prior to filing a request for an Administrative Hearing with HCA.

13.5.7 The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision.

13.5.8 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.

13.5.9 The Administrative Hearings process shall include as parties to the Administrative Hearing, the Contractor, the Individual and the Individual's authorized representative, or the legal representative of the deceased Individual's estate and HCA.

13.6 Petition for Review

Any party may Appeal the initial order from the Administrative Hearing to HCA Board of Appeals in accordance with Chapter 182-526 WAC. Notice of this right shall be included in the Initial Order from the Administrative Hearing.

13.7 Effect of Reversed Resolutions of Appeals and Administrative Hearings

If the Contractor's decision not to provide Contracted Services is reversed, either through a final order of the Washington State Office of Administrative Hearings or the HCA Board of Appeals, the Contractor shall provide the disputed services promptly, and as expeditiously as the Individual's health condition requires.

13.8 Recording and Reporting Grievances, Adverse Authorization Determinations, and Appeals

The Contractor shall maintain records of all Grievances, Adverse Authorization Determinations including Actions, and Appeals.

13.8.1 The records shall include Grievances, Adverse Authorization Determinations including Actions, and Appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of these activities.

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

13.8.3 The Contractor is responsible for maintenance of records for and reporting of these activities handled by delegated entities.

13.8.4 Reports that do not meet the Grievance and Appeal System reporting requirements shall be returned to the Contractor for correction. Corrected reports will be resubmitted to HCA within thirty (30) calendar days.

13.8.5 The report medium shall be specified by HCA.

13.8.6 Reporting of Grievances shall include all expressions of Individual dissatisfaction not related to an Action. All Grievances are to be recorded and counted whether the Grievance is remedied by the Contractor immediately or through its Grievance and quality of care service procedures.

13.9 Grievance and Appeal System Terminations

When Available Resources are exhausted, any Appeals or Administrative Hearings related to a request for authorization of a non-Crisis Contracted Service will be terminated since non-Crisis Services cannot be authorized without funding regardless of medical necessity.

14 CARE MANAGEMENT AND COORDINATION

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 the 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.

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;

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, a Tribe or Indian Health Service facility in the region, 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.

14.3 Care Coordination and Continuity of Care: Children and Youth in the Behavioral Health System

14.3.1 The Contractor shall collaborate with child/TAY serving systems, as follows:

14.3.1.1 Convene the regional Children's Long Term Inpatient Program (CLIP) Committee unless an alternative organization is approved by HCA using the guidelines provided by HCA.

14.3.1.2 If requested by a WISe provider, CLIP facility, or other program in the behavioral health system served by the Contractor.

14.3.1.3 Refer potentially CLIP-eligible children to the regional CLIP Committee and CLIP Administration.

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 ~~A~~greements 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 G.

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. The Contractor shall: .

14.4.9.3.1 Submit to HCA the Peer Bridger Monthly Report by the 15th of the month following the month being reported, for each region, on the template provided by HCA;

14.4.9.3.2 When reporting service encounters, use the Rehabilitation Case Management Services code for services within inpatient settings or other appropriate outpatient modalities ensuring no duplication of services occur; and

14.4.9.3.3 When reporting Behavioral Health Supplemental Transactions into BHDS, ensure the “Program ID – 42” start/stop date is recorded.

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;

14.5.2.4 The identity of the responsible BH-ASO and MCO, if applicable; and

14.5.2.5 The county in which the person met detention criteria; and

14.5.2.6 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) calendar 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.

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.

15 GENERAL REQUIREMENTS AND BENEFITS

15.1 Special Provisions Regarding Behavioral Health Benefits

For each RSA, the Contractor's administration of behavioral health benefits shall comply with the following:

15.1.1 The location of the telephone crisis intervention and triage services (call center staff) is within Washington or within two hundred (200) miles of the Contractor's Service Area unless approved by HCA.

15.1.2 Call center staff located in another state must receive sufficient training to ensure adequate knowledge of the Contractor's operating policies and procedures and Washington's behavioral health service delivery system including, but not limited to, regional network and community resources, practice patterns, culture, and other relevant factors (e.g. state and federal laws).

15.1.3 A Behavioral Health Professional licensed in Washington shall be available on-call 24 hours a day, seven (7) days a week, to provide training and consultation to BH-ASO contracted telephone crisis intervention and triage service providers located in another state.

15.1.4 The same staffing requirements as defined in this Contract and the same performance metrics apply regardless of the location of call center operations.

15.1.5 Data management and reporting, claims and financial management may be located out of Washington State. If claims are administered in another location, provider relations staff shall have access to the claims payment and reporting platform during Pacific Time Business Hours.

15.1.6 The Contractor shall designate employees who fulfill the following Behavioral Health roles:

15.1.6.1 A Behavioral Health Medical Director. Upon approval from HCA, the Behavioral Health Medical Director may be a subcontracted position.

15.1.6.2 A Clinical Director.

15.1.6.3 A Crisis Triage Administrator.

15.1.6.4 A Utilization/Care Management Administrator.

15.1.6.5 A Network Development Administrator.

15.1.6.6 A Provider Relations Administrator.

15.1.6.7 A Children's Specialist.

15.1.6.8 An Addictions Specialist.

15.1.7 In addition, the Contractor shall have a sufficient number of qualified operational staff to meet its responsibilities under the Contract, to include:

15.1.7.1 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.

15.1.7.2 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.

15.1.7.3 Staffing 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.

15.1.7.4 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.

15.1.7.5 The Contractor shall maintain current organizational charts and upon request will provide organizational charts to HCA that identifies what positions are responsible for the roles and responsibilities under the Contract

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

15.1.7.7 The Contractor shall ensure development and implementation of training programs for network providers that deliver, coordinate, or oversee behavioral health services to Individuals, to include SABG outreach requirements related to pregnant Individuals with intravenous drug use, pregnant Individuals with a SUD, and other Individuals with intravenous drug use.

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.

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.

16 SCOPE OF SERVICES- CRISIS SYSTEM

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.

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 include 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.

16.2 Crisis System Staffing Requirements

16.2.1 The Contractor shall ensure Provider compliance with staffing requirements in accordance with Chapter 246-341 WAC. Each staff member working directly with an Individual receiving Crisis Services must receive:

16.2.1.1 Clinical supervision from a Mental Health Professional;

16.2.1.2 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 Staff access to consultation with one of the following professionals (who has at least one 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 who has prescriptive authority.

16.2.2 The Contractor shall ensure compliance with DCR qualification requirements in accordance with Chapters 71.05 and 71.34 RCW and WAC 246-341-0900 to -0915. The Contractor shall ensure providers incorporate the statewide DCR Protocols, listed on the HCA website, into the practice of their DCRs.

16.2.3 The Contractor shall ensure Providers 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 ensure Providers make available at least one SUDP with experience providing Behavioral Health crisis support for consultation by phone or on site during regular Business Hours.

16.2.5 The Contractor shall ensure Providers make available at least one CPC with experience providing behavioral health crisis support for consultation by phone or on site during regular Business Hours.

16.2.6 The Contractor shall ensure Providers of crisis and ITA services establish policies and procedures 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 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.

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 (7) 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.

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.

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, must be 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.

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 The Contractor shall require that Mobile Crisis Services coordinate with co-responders within their region.

16.6 Protocols for Coordination with Tribes and non-Tribal IHCPs

16.6.1 The Contractor shall participate in meetings with Tribes and non-Tribal IHCPs, facilitated by HCA, to develop the Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Contractor's Regional Service Area.

16.6.2 The Contractor will comply with the Protocols for Coordination with Tribes and Non-Tribal IHCPs applicable to the Contractor's Regional Service Area(s) when they are completed and agreed upon for each Tribe or non-Tribal IHCP. Until these protocols are completed and agreed upon, 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.

16.6.3 The Contractor, in partnership with HCA, will participate in HCA convened meetings to 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:

16.6.3.1 DCRs access to Tribal lands to provide services, including crisis response and involuntary commitment assessment;

16.6.3.2 Providing services on Tribal lands in the evening, holidays, or weekends if different than during business hours;

16.6.3.3 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;

16.6.3.4 How DCRs will coordinate with Tribal mental health and/or SUD providers and others identified in the protocols, including coordination and debriefing with any Tribal mental health or SUD providers after a crisis service has been provided;

16.6.3.5 When a DCR determines whether to detain or not for involuntary commitment; and

16.6.3.6 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.

16.6.4 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.

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 DCR, subject to the following requirements:

16.7.1.1 The potential Tribal DCR must meet all the requirements as a DCR 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; and

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

17 JUVENILE COURT TREATMENT PROGRAM

17.1 Juvenile Court Treatment Program Requirements

17.1.1 In RSAs where funding is provided, the Contractor shall support Individuals involved with a region's Juvenile Drug Court (JDC), or other juvenile court treatment program to 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.

17.1.2 The Contractor will submit a quarterly Juvenile Court Treatment Program Report within forty-five (45) calendar days of the state fiscal quarter end using the Juvenile Court Treatment Program reporting template. The Report must capture the following program elements for each reporting period:

17.1.2.1 Program Capacity;

17.1.2.2 Number of individuals enrolled;

17.1.2.3 Number of individuals who were successfully or unsuccessfully discharged;

17.1.2.4 Treatment activities provided through funding under this Section; and

17.1.2.5 A brief narrative that summarizes activities and accomplishments.

18 CRIMINAL JUSTICE TREATMENT ACCOUNT (CJTA)

18.1 CJTA Funding Guidelines

18.1.1 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.

18.1.2 The Contractor shall implement any CJTA plans developed by the local CJTA panel established under RCW 71.24.580(6) and approved by the CJTA Panel in accordance with RCW 71.24.580(5)(b).

18.1.3 In accordance with RCW 2.30.040, counties are required to provide a dollar-for-dollar participation match for CJTA funded services for Individuals who are under the supervision of a therapeutic court.

18.1.4 No more than 10 percent of the total CJTA funds can be used for the following treatment support services combined:

18.1.4.1 Transportation; and

18.1.4.2 Child Care Services.

18.1.5 Moneys allocated under this Section shall be used to supplement, not supplant, other federal, state, and local funds used for SUD treatment per RCW 71.24.580.8.

18.1.6 The Contractor shall dedicate a minimum 30 percent of the CJTA funds for innovative projects that meet any or all of the following conditions:

18.1.6.1 An acknowledged evidence or research based best practice (or treatment strategy) that can be documented in published research, or

18.1.6.2 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

18.1.6.3 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.

18.1.7 HCA retains the right to request progress reports or updates on innovative projects funded under this subsection.

18.2 Allowable Expenditures under CJTA

18.2.1 Services that can be provided using CJTA funds are:

18.2.1.1 Brief Intervention (any level, assessment not required);

18.2.1.2 Acute Withdrawal Management (ASAM Level 3.2WM);

18.2.1.3 Sub-Acute Withdrawal Management (ASAM Level 3.2WM);

18.2.1.4 Outpatient Treatment (ASAM Level 1);

18.2.1.5 Intensive Outpatient Treatment (ASAM Level 2.1);

18.2.1.6 Opioid Treatment Program (ASAM Level 1);

18.2.1.7 Case Management (ASAM Level 1.2);

18.2.1.8 Intensive Inpatient Residential Treatment (ASAM Level 3.5);

18.2.1.9 Long-term Care Residential Treatment (ASAM Level 3.3);

18.2.1.10 Recovery House Residential Treatment (ASAM Level 3.1);

18.2.1.11 Assessment (to include Assessments done while in jail);

18.2.1.12 Interim Services;

18.2.1.13 Community Outreach;

18.2.1.14 Involuntary Commitment Investigations and Treatment;

18.2.1.15 Room and Board (Residential Treatment Only);

18.2.1.16 Transportation;

18.2.1.17 Childcare Services;

18.2.1.18 Urinalysis;

18.2.1.19 Treatment in the jail:

18.2.1.19.1 The Contractor may not use more than 30 percent of their total annual allocation for providing treatment services in jail.

18.2.1.19.1.1 The Contractor may request an exception to this funding limit within their strategic plan submitted per subsection 18.3.1 of this Contract.

18.2.1.19.2 SUD treatment services provided in jail may include, but are not limited to the following:

18.2.1.19.2.1 Engaging Individuals in SUD treatment;

18.2.1.19.2.2 Referral to SUD services;

18.2.1.19.2.3 Administration of Medications for the treatment of SUDs, including Opioid Use Disorder, to include the following:

18.2.1.19.2.3.1 Screening for medications for SUDs;

18.2.1.19.2.3.2 Cost of medications for SUDs; and

18.2.1.19.2.3.3 Administration of medications for SUDs.

18.2.1.19.3 Coordinating care;

18.2.1.19.4 Continuity of Care; and

18.2.1.19.5 Transition planning.

18.2.1.20 Employment services and job training;

18.2.1.21 Relapse prevention;

18.2.1.22 Family/marriage education;

18.2.1.23 Peer-to-peer services, mentoring and coaching;

18.2.1.24 Self-help and support groups;

18.2.1.25 Housing support services (rent and/or deposits);

18.2.1.26 Life skills;

18.2.1.27 Spiritual and faith-based support;

18.2.1.28 Education; and

18.2.1.29 Parent education and child development.

18.3 CJTA Strategic Plan

18.3.1 Beginning October 1, 2021, the CJTA Biennial Plan is due every two years on October 1.

18.3.1.1 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:

18.3.1.1.1 Describe in detail how SUD treatment and support services will be delivered within the region;

18.3.1.1.2 Address the CJTA Account Match Requirement from subsection 18.1.3 of this Contract;

18.3.1.1.3 Include details on innovative projects as referenced in subsection 18.1.6, including the following:

18.3.1.1.3.1 Describe the project and how it will be consistent with the strategic plan;

18.3.1.1.3.2 Describe how the project will enhance treatment services for eligible Individuals identified in RCW 71.24.580(1)(a) - (b);

18.3.1.1.3.3 Describe how the project will incorporate best practices and treatment strategies while addressing underserved populations;

18.3.1.1.3.4 Indicate the number of Individuals who were served using innovative funds; and

18.3.1.1.3.5 Detail the original goals and objectives of the project.

18.3.1.2 If applicable, the CJTA Biennial Plan will indicate a plan of action for meeting the requirements in subsection 18.6 of this Contract.

18.3.1.3 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.

18.4 State Appropriation Recoupment

18.4.1 In accordance with RCW 71.24.580(11), HCA shall monitor and review, on an annual basis, expenditures related to CJTA appropriations.

18.4.2 HCA will help recoup and redistribute underspent or overspent funds on an annual basis to ensure accordance with RCW 71.24.580(11), any remaining unspent CJTA appropriations will be returned to HCA at the end of the State Fiscal biennium.

18.5 Medications for Opioid Use Disorder in Therapeutic Courts

18.5.1 Per RCW 71.24.580(9), “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.”

18.5.2 The Contractor, under the provisions of this contractual agreement, will abide by the following guidelines related to CJTA and therapeutic courts:

18.5.2.1 The Contractor will only subcontract with therapeutic courts that have policy and procedures allowing Individuals 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.

18.5.2.2 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.

18.5.2.3 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.

18.5.2.4 The Contractor must notify the HCA if it discovers that a CJTA funded therapeutic court program is practicing any of the following:

18.5.2.4.1 Requiring discontinuation, titration, or alteration of their medication regimen as a precluding factor in admittance into a therapeutic court program;

18.5.2.4.2 Requiring participants already in the program to discontinue medication regimen in order to comply with program requirements; and

18.5.2.4.3 Requiring discontinuation, titration, or alteration of their medication regimen as a necessary component of meeting program requirements for graduation from a therapeutic court program.

18.5.2.5 All decisions regarding an Individual's amenability and appropriateness for medications will be made by the Individual in concert with a medical professional.

18.6 CJTA Quarterly Progress Report

18.6.1 The Contractor will submit a CJTA Quarterly Progress Report within forty-five (45) calendar days of the state fiscal quarter end using the reporting template, CJTA Quarterly Progress Report. CJTA Quarterly Progress Report must include the following program elements:

18.6.1.1 Number of Individuals served under CJTA funding for that time period;

18.6.1.2 Barriers to providing services to the criminal justice population;

18.6.1.3 Strategies to overcome the identified barriers;

18.6.1.4 Training and technical assistance needs;

18.6.1.5 Success stories or narratives from Individuals receiving CJTA services; and

18.6.1.6 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.

18.6.2 State Fiscal Quarter due dates for CJTA quarterly reports

18.6.2.1 July through September 2020 (SFY 2021/Quarter 1) due November 16, 2020; October through December 2020 (SFY 2021/Quarter 2) due February 15, 2021; January through March 2021 (SFY 2021/Quarter 3) due May 17, 2021; and April through June 2021 (SFY 2021/Quarter 4) due August 16, 2021.

19 FEDERAL BLOCK GRANTS (FBG)

19.1 Federal Block Grant Requirements

19.1.1 In each RSA, the Contractor shall collect information from key stakeholders and community partners, including Tribal partners and other IHCPs, to develop the regional MHBG and SABG Project Plans. The project plans shall be approved by the regional BHAB. The Contractor shall provide annual documentation that the BHAB has approved the project plans. The Contractor must submit the proposed SABG and MHBG project plans for HCA's approval using the current MHBG and SABG project plan templates provided by HCA. Project plans must be submitted annually by July 15.. 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.

19.1.2 The Contractor shall provide, or subcontract for services, according to the approved regional MHBG and the regional SABG project plans.

19.1.3 The Contractor shall provide MHBG services to promote Recovery for adults with a SMI and resiliency for children with Severe Emotional Disturbance (SED) in accordance with federal and state requirements. SABG funds shall be used to provide services to priority populations.

19.1.4 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

19.1.5 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.

19.1.6 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) and 45 C.F.R. § 96.136, MHBG Service Provisions).

19.1.7 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 submitted using the current Federal Block Grant Annual Progress Report template.

19.1.8 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.

20 JAIL TRANSITION SERVICES

20.1 Jail Transition Services Requirements

20.1.1 Jail Transition Services are to be provided within the identified resources in Exhibit A.

20.1.2 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.

20.1.3 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.

20.1.4 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.

20.1.5 The Contractor shall assist Individuals with mental illness in completing and submitting an application for medical assistance prior to release from jail.

20.1.6 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.

20.1.7 Pre-release services shall include:

20.1.7.1 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.

20.1.7.2 Mental health intake assessments for persons identified during the mental health screening as a member of apriority population.

20.1.7.3 Facilitation of expedited medical and financial eligibility determination with the goal of immediate access to benefits upon release from incarceration.

20.1.7.4 Other prudent pre-release and pre-trial case management and transition planning.

20.1.7.5 Direct mental health or SUD services to Individuals who are in jails that have no mental health staff working in the jail providing services.

20.1.7.6 Post-release outreach to ensure follow-up for mental health and other

services (e.g. SUD) to stabilize Individuals in the community.

20.1.8 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:

20.1.8.1 Identify recently booked Individuals that are eligible for Medicaid or had their Medicaid benefits suspended for purposes of establishing Continuity of Care upon release.

20.1.8.2 Develop individual alternative service plans (alternative to the jail) for submission to the courts. Plans will incorporate evidence-based risk assessment screening tools.

20.1.8.3 Inter-local Agreements with juvenile detention facilities.

20.1.8.4 Provide up to a seven (7) day supply of medications for the treatment of mental health symptoms following the release from jail.

20.1.8.5 Training to local law enforcement and jail services personnel regarding de-escalation, crisis intervention, and similar training topics.

21 DEDICATED MARIJUANA ACCOUNT (DMA)

21.1 DMA expenditure requirements

21.1.1 DMA funds are to be provided within the identified resources in Exhibit A.

21.1.2 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.

21.1.3 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.

21.1.4 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.

21.1.5 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.

22 FAMILY YOUTH SYSTEM PARTNER ROUNDTABLE (FYSPRT)

22.1 General Requirements

22.1.1 FYSPRT support shall be provided within the identified resources in Exhibit A and reported in accordance with this Section.

22.1.2 Work completed under this Section of the Contract will be in alignment with the FYSPRT manual.

22.1.3 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.

22.1.4 Consistent with the FYSPRT manual the Contractor shall:

22.1.4.1 Include youth, family, and system partner representation in all aspects of the development, promotion, support, implementation, and evaluation of the Regional FYSPRT;

22.1.4.2 Actively engage 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;

22.1.4.3 Engage with youth, families, and system partners to build and maintain a Regional FYSPRT membership that will include:

22.1.4.3.1 At least 51 percent families and youth with lived experience (if not at 51 percent, note this in the quarterly report and identify strategies being utilized to become compliant);

22.1.4.3.2 Representatives from Family and Youth Run Organizations and other relevant stakeholder groups within the region;

22.1.4.3.3 Key administrators connected to the WISe quality and service delivery; and

22.1.4.3.4 Community System Partners and Community Members as identified in the FYSPRT Manual.

22.1.5 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:

22.1.5.1 Follow the Regional FYSPRT Meeting protocol found in the FYSPRT Manual;

22.1.5.2 Be open to the public and publicized;

22.1.5.3 Provide for and publicize a process for obtaining travel and support (such as childcare assistance/reimbursement) to attend meetings;

22.1.5.4 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;

22.1.5.5 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; and

22.1.5.6 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).

22.1.6 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:

22.1.6.1 The annual needs assessment completed between July 1 and September 30 and submitted to HCA by October 10;

22.1.6.2 FYSPRT meetings and evaluations;

22.1.6.3 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 annually to HCA by January 10. As part of the Annual Work Plan, identify at least three (3) priority areas of focus and include for each priority:

22.1.6.3.1 Goals;

22.1.6.3.2 Action steps;

22.1.6.3.3 Those assigned; and

22.1.6.3.4 Timeline for completion.

22.1.6.4 No later than June 30, complete goals and action steps as outlined in the Work Plan. Submit the updated Annual work plan that identifies progress on goals and action steps, including barriers found and plans to address barriers to HCA by July 10; and

22.1.6.5 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.

22.1.7 Maintain Regional FYSPRT webpages that include:

22.1.7.1 Point of contact, name, email, phone number, and mailing address;

22.1.7.2 Regional agendas and meeting notes;

22.1.7.3 Dates, locations, and times of past and upcoming Regional meetings (including information on travel reimbursement, child care, and other meeting supports);

22.1.7.4 A Regional Charter;

22.1.7.5 Policies and procedures (may also be addressed in the Regional FYSPRT Charter);

22.1.7.6 Results of the needs assessment;

22.1.7.7 The Five (5) Year Strategic Plan;

22.1.7.8 The Annual Work Plan, when developed; and

22.1.7.9 Links to relevant regional/statewide resources and information.

22.1.8 Participate in State-level activities, to include:

22.1.8.1 Identify Regional Tri-Leads to participate as members of the Statewide FYSPRT;

22.1.8.2 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;

22.1.8.3 Supports Regional FYSPRT members to attend FYSPRT-related training and technical assistance meetings or events, as requested by HCA;

22.1.8.4 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;

22.1.8.5 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

22.1.8.6 Identify Regional Tri-Leads and FYSPRT members to participate on subgroups of the Statewide FYSPRT.

22.1.9 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 with the quarterly report. Include how the information gathered from the evaluation tools have informed future meetings.

22.1.10 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.

22.1.11 Reporting. On a quarterly basis, the Contractor shall submit the following:

22.1.11.1 A report summarizing the progress or completion of Performance Work Statement items, identifying any barriers and plans for next steps;

22.1.11.2 Submit the Five (5) Year Strategic Plan in any quarter in which updates have been made;

22.1.11.3 Sign-in sheets, showing percentage of youth and family in attendance, and meeting notes;

22.1.11.4 Updated membership roster identifying the percentage of youth and family membership;

22.1.11.5 A link to the required Regional FYSPRT webpage materials in accordance with the Performance Work Statement item found in this Contract;

22.1.11.6 Tri-Lead attendance at statewide FYSPRT meetings;

22.1.11.7 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; and

22.1.11.8 Reports and A-19s are due by the 10th of the month of January, April, July and October and must be submitted to HCA at HCABHASO@hca.wa.gov.

23 COMMUNITY BEHAVIORAL HEALTH ENHANCEMENT (CBHE) FUNDS

23.1 CBHE Communication Plan Requirements

23.1.1 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.

23.1.2 The Communication Plan must include the following:

23.1.2.1 Outline of how the portion of the funding received will strengthen the Behavioral Health provider community workforce.

23.1.2.2 How the Contractor will increase provider capacity, including staff retention and service delivery.

23.1.2.3 The Communication Plan must meet the intention of Engrossed Substitute House Bill 1109; Chapter 415, Laws of 2019.

23.1.2.4 Timeframes for implementation of all planned enhancement activities.

23.1.3 The Contractor will take the following steps to ensure that providers are receiving the appropriate amount of enhancement funds:

23.1.3.1 Develop a provider Communication Plan.

23.1.3.2 In accordance with you Communication Plan, notify providers about how the Enhancement funds will be utilized in your region.

23.1.3.3 Operationalize your plan to deploy FY 2020- 2021 enhancement funds.

23.1.3.4 Conduct quarterly reviews to ensure that funds are being dispersed to providers as outlined in your Communication Plan.

23.1.3.5 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.

23.1.4 The Contractor will submit a completed CBHE Quarterly Expenditure report using the CBHE Quarterly Expenditure reporting template.

23.1.4.1 The 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 2021 fiscal reports are due by: April 30 (January-March)A; July 31 (April-June); October 31 (July-September); and January 31 (October-December).

24 BEHAVIORAL HEALTH ADVISORY BOARD (BHAB)

24.1 BHAB Requirements

24.1.1 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.

24.1.2 BHAB Membership Requirements:

24.1.2.1 Be representative of the geographic and demographic mix of service population;

24.1.2.2 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;

24.1.2.3 Law Enforcement representation;

24.1.2.4 County representation;

24.1.2.5 No more than four elected officials;

24.1.2.6 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

24.1.2.7 Three year term limit, multiple terms may be served, based on rules set by the BHAB.

24.1.3 The BHAB will:

24.1.3.1 Solicit and use the input of Individuals with mental health and/or SUD to improve behavioral health services delivery in the region;

24.1.3.2 Provide quality improvement feedback to key stakeholders and other interested parties defined by HCA. The Contractor shall document the activities and provide to HCA upon request; and

24.1.3.3 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.

25 CRISIS TRIAGE/STABILIZATION CENTERS AND INCREASING PSYCHIATRIC RESIDENTIAL TREATMENT BEDS

25.1 General Requirements

25.1.1 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 provided by HCA. Reports are due thirty (30) calendar days after the end of the SFY quarter.

26 BUSINESS CONTINUITY AND DISASTER RECOVERY

26.1 General Requirements

26.1.1 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.

26.1.2 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:

26.1.2.1 A mission or scope statement.

26.1.2.2 Information services disaster recovery person (s).

26.1.2.3 Provisions for back up of key personnel, emergency procedures, and emergency telephone numbers.

26.1.2.4 Procedures for effective communication, applications inventory and business recovery priorities, and hardware and software vendor lists.

26.1.2.5 Documentation of updated system and operations and a process for frequent back up of systems and data.

26.1.2.6 Off-site storage of system and data backups and ability to recover data and systems from back-up files.

26.1.2.7 Designated recovery options.

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

26.1.3 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 31 of each Contract year to HCABHASO@hca.wa.gov. 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.

Exhibit A: Non-Medicaid Funding Allocation
North Sound BH-ASO

This Exhibit addresses Non-Medicaid funds in the North Sound RSA for the provision of crisis services and non-crisis behavioral health services for January 1, 2021, through June 30, 2021, 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 July-December 2020 is also counted out of these totals.

Table 1: North Sound RSA January-June 2021 GF-S Funding

Fund Source	Monthly	Total 6 Months
Flexible GF-S	$1,074,947	$6,449,682
PACT	$23,166	$138,996
Assisted Outpatient Tx	$19,737	$118,422
1109 PACT	$19,477	$116,862
Flexible GF-S (ASO)	$60,620	$363,720
Jail Services	$30,380	$182,280
ITA - Non-Medicaid funding	$22,865	$137,190
Detention Decision Review	$8,958	$53,748
Long-Term Civil Commitment Court Costs	$402	$2,412
Trueblood Misdemeanor Diversion	$18,662	$111,972
Island County Crisis Stabilization	$13,750	$82,500
Juvenile Drug Court	$11,650	$69,900
DMA	$48,441	$290,646
Secure Detox	$28,913	$173,478
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	$496,044
Crisis Stabliz Support	One-Time payment	$250,000
Total	**$1,389,051**	**$9,151,879**

Table 2: North Sound RSA FY 2021 Grant Funding (12 months)

Fund Source	Total FY2021
MHBG (Full Year SFY2021)	$1,111,032
Peer Bridger (Full Year SFY2021)	$240,000
FYSPRT (Full Year SFY2021)	$75,000
SABG (Full Year SFY2021)	$3,289,438

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. See Schedule A.

- **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. See Schedule B.

- **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 B

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

Status	Service	Medicaid	MHBG	SABG	GFS	Drug Court
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 C
RSA Spenddown Liability

Overview

Spenddown liability is the amount of medical expenses an Individual must pay before Limited Casualty Program/Medically Needy Program (LCP/MNP) coverage begins. When the Individual has paid medical expenses equal to or greater than a predetermined spenddown amount, the provider can submit a claim for the outstanding amount.

Both state and block grant funds may be used to spenddown qualifying medical expenses (such as voluntary and involuntary inpatient, crisis stabilization and crisis residential stays) incurred. HCA designates and approves the Contractor as a Public Program as described in WAC 182-519-0110(9). Qualified expenses paid by the Contractor shall be used to reduce an Individual's spenddown liability.

For more information about Spenddown see the Provider One Billing and Resource Guide: https://www.hca.wa.gov/assets/billers-and-providers/providerone-billing-and-resource-guide.pdf

Procedure

Individuals must meet financial eligibility, and incur medical expenses in the amount of spenddown liability determined by DSHS staff before coverage is made active in Provider One. An Individual must not have insurance coverage for services used to meet the spenddown liability. DSHS staff enter medical expenses into ACES when documentation for them is received. Once the expenses equal or exceed the spenddown amount, ACES sends a notice to Provider One to open the eligibility segment for the appropriate base period.

RESPONSIBLE DEPARTMENT	ACTIVITY
Facility and BH-ASO UM clinician	**1. Identification and authorization** (a) Facility representative seeks authorization for services within required timeframes and identifies spenddown amount. (b) UM clinician confirms eligibility criteria for funding and service, provides authorization for service and confirms payment of spenddown amount to facility representative (units or dollar amount). (c) UM clinician updates BH-ASO director.
Facility	**2. Report of spenddown, confirmation and payment** (a) Facility reports the Individual's incurred costs that count toward the spenddown amount and confirm submission with UM Clinician and Director. (b) Facility confirms Medicaid assignment after spenddown processing. (c) Facility submits invoices for payment of the agreed spenddown amount to the BH-ASO Director monthly. Fax documentation of incurred medical expenses to the statewide fax number 1-888-338-7410. Providers with authorization from the client may call 1-877-501-2233 to inquire about status and/or request urgent processing. If urgent medical need is required, processing occurs within two business days or less. Regular processing is completed with 2 business days.
BH-ASO Director	**3. Review invoice and submit for payment.**
BH-ASO Finance	**4. Tracking and Reporting** (a) Track spenddown amounts by Individual and facility (b) Report expenses on the Non-Medicaid Expenditure Report indicating the total amount spent.

Exhibit D
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 E
DATA USE, SECURITY AND CONFIDENTIALITY

1 Definitions

The definitions below apply to this Exhibit:

1.1 **"Authorized User"** means an individual or individuals with an authorized business need to access HCA's Confidential Information under this Contract.

1.2 **"Breach"** means the unauthorized acquisition, access, use, or disclosure of Data shared under this Contract that compromises the security, confidentiality or integrity of the Data.

1.3 **"Business Associate"** means a Business Associate as defined in 45 CFR 160.103, who performs or assists in the performance of an activity for or on behalf of HCA, a Covered Entity that involves the use or disclosure of protected health information (PHI). Any reference to Business Associate in this DSA includes Business Associate's employees, agents, officers, Subcontractors, third party contractors, volunteers, or directors.

1.4 **Business Associate Agreement"** means the HIPAA Compliance section of this Exhibit and includes the Business Associate provisions required by the U.S. Department of Health and Human Services, Office for Civil Rights.

1.5 **"Covered Entity"** means HCA, which is a Covered Entity as defined in 45 C.F.R. § 160.103, in its conduct of covered functions by tis health care components.

1.6 **"Data"** means the information that is disclosed or exchanged as described by this Contract. For purposes of this Exhibit, Data means the same as "Confidential Information."

1.7 **"Designated Record Set"** means a group of records maintained by or for a Covered Entity, that is: the medical and billing records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or Used in whole or part by or for the Covered Entity to make decisions about Individuals.

1.8 **"Disclosure"** means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

1.9 **"Electronic Protected Health Information (ePHI)"** means Protected Health Information that is transmitted by electronic media or maintained as described in the definition of electronic media at 45 C.F.R. § 160.103.

1.10 **"Hardened Password"** after July 1, 2019 means a string of characters containing at least three of the following character classes: upper case letters; lower case letters; numerals; and special characters, such as an asterisk, ampersand or exclamation point.

1.10.1 Passwords for external authentication must be a minimum of 10 characters long.

1.10.2 Passwords for internal authentication must be a minimum of 8 characters long.

1.10.3 Passwords used for system service or service accounts must be a minimum of 20 characters long.

1.11 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended, together with its implementing regulations, including the Privacy Rule, Breach Notification Rule, and Security Rule. The Privacy Rule is located at 45 C.F.R. Part 160 and Subparts A and E of 45 C.F.R. Part 164. The Breach Notification Rule is located in Subpart D of 45 C.F.R. Part 164. The Security Rule is located in 45 C.F.R. Part 160 and Subparts A and C of 45 C.F.R. Part 164.

1.12 **"HIPAA Rules"** means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and Part 164.

1.13 **"Medicare Data Use Requirements"** refers to the four documents attached and incorporated into this Exhibit as Schedules 1, 2, 3, and 4 that set out the terms and conditions Contractor must agree to for the access to and use of Medicare Data for the Individuals who are dually eligible in the Medicare and Medicaid programs.

1.14 **"Minimum Necessary"** means the least amount of PHI necessary to accomplish the purpose for which the PHI is needed.

1.15 **"Portable/Removable Media"** means any Data storage device that can be detached or removed from a computer and transported, including but not limited to: optical media (e.g. CDs, DVDs); USB drives; or flash media (e.g. CompactFlash, SD, MMC).

1.16 **"Portable/Removable Devices"** means any small computing device that can be transported, including but not limited to: handhelds/PDAs/Smartphones; Ultramobile PC's, flash memory devices (e.g. USB flash drives, personal media players); and laptops/notebook/tablet computers. If used to store Confidential Information, devices should be Federal Information Processing Standards (FIPS) Level 2 compliant.

1.17 **"PRISM"** means the DSHS secure, web-based clinical decision support tool that shows administrative data for each Medicaid Client and is organized to identify care coordination opportunities.

1.18 **"Protected Health Information"** or "PHI" has the same meaning as in HIPAA except that it in this Contract the term includes information only relating to individuals.

1.19 **"ProviderOne"** means the Medicaid Management Information System, which is the State's Medicaid payment system managed by HCA.

1.20 **"Security Incident"** means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

1.21 **"Tracking"** means a record keeping system that identifies when the sender begins delivery of Confidential Information to the authorized and intended recipient, and when the sender receives confirmation of delivery from the authorized and intended recipient of Confidential Information.

1.22 **"Transmitting"** means the transferring of data electronically, such as via email, SFTP, web-services, AWS Snowball, etc.

1.23 **"Transport"** means the movement of Confidential Information from one entity to another, or within an entity, that: places the Confidential Information outside of a Secured Area or system (such as a local area network); and is accomplished other than via a Trusted System.

1.24 **"Trusted System(s)"** means the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; (2) United States Postal Service ("USPS") first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail; (3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.

1.25 **"U.S.C."** means the United States Code. All references in this Exhibit to U.S.C. chapters or sections will include any successor, amended, or replacement statute. The U.S.C. may be accessed at http://uscode.house.gov/

1.26 **"Unique User ID"** means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase, or other mechanism, authenticates a user to an information system.

1.27 **"Use"** includes the sharing, employment, application, utilization, examination, or analysis, of Data.

2 Data Classification

2.1 The State classifies data into categories based on the sensitivity of the data pursuant to the Security policy and standards promulgated by the Office of the state of Washington Chief Information Officer. (See Section 4 of this Exhibit, Data Security, of Securing IT Assets Standards No. 141.10 in the State Technology Manual at https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets.)

The Data that is the subject of this Contract is classified as Category 4 – Confidential Information Requiring Special Handling. Category 4 Data is information that is specifically protected from disclosure and for which:

2.1.1 Especially strict handling requirements are dictated, such as by statutes, regulations, or agreements;

2.1.2 Serious consequences could arise from unauthorized disclosure, such as threats to health and safety, or legal sanctions.

3 PRISM Access

3.1 Purpose. To provide Contractor, and subcontractors, with access to pertinent Individual-level Medicaid and Medicare Data via look-up access to the online PRISM application and to provider Contractor staff and Subcontractor staff who have a need to know Individual-level Data in order to coordinate care, improve quality, and manage services for Individuals, with selected quality improvement provider feedback reports.

3.2 Justification. The Data being accessed is necessary for Contractor to provide care coordination, quality improvement, and case management services for Individuals.

3.3 PRISM Data Constraints

3.3.1 The Data contained in PRISM is owned and belongs to DSHS and HCA.

3.3.2 The Data shared may only be used for care coordination and quality improvement purposes, and no other purposes.

3.4 System Access. Contractor may request access for specific Authorized Users with a need-to-know to view Data in the PRISM System under this Contract.

3.4.1 Contractor Contract Manager, or their designee, must complete and sign the PRISM Access Request Form, Schedule 5, for each proposed Authorized User. The completed form must be sent to prism.admin@dshs.wa.gov with a copy to hcamcprograms@hca.wa.gov. HCA and DSHS will only accept requests from the Contractor Contract Manager or their designee.

3.4.2 Contractor must access the system through SecureAccessWashington (SAW) or through another method of secure access approved by HCA and DSHS.

3.4.3 HCA and DSHS will grant the appropriate access permissions to Contractor employees or Subcontractor employees.

3.4.4 HCA and DSHS **do not** allow shared User IDs and passwords for use with Confidential Information or to access systems that contain Confidential Information. Contractor must ensure that only Authorized Users access and use the systems and do not allow employees, agents, or Subcontractors who are not authorized to borrow a User ID or password to access any systems.

3.4.5 Contractor will notify the prism.admin@dshs.wa.gov with a copy to hcamcprograms@hca.wa.gov within five (5) business days whenever an Authorized User who has access to the Data is no longer employed or contracted by the Contractor, or whenever an Authorized User's duties change such that the user no longer requires access to the Data.

3.4.6 Contractor's access to the system may be continuously tracked and monitored. HCA and DSHS reserve the right at any time to terminate the Data access for an individual, conduct audits of systems access and use, and to investigate possible violations of this Exhibit, federal, or state laws and regulations governing access to Protected Health Information.

4 Constraints on Use of Data

4.1 This Contract does not constitute a release of the Data for the Contractor's discretionary use. Contractor must use the Data received or accessed under this Contract only to carry out the purpose of this Contract. Any ad hoc analyses or other use or reporting of the Data is not permitted without HCA's prior written consent.

4.2 Data shared under this Contract includes data protected by 42 C.F.R. Part 2. In accordance with 42 C.F.R. § 2.32, this Data has been disclosed from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit Receiving Party from making any further disclosure of the Data that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Party 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (42 C.F.R. § 2.31). The federal rules restrict any use of the SUD Data to investigate or prosecute with regard to a crime any patient wth a substance use disorder, except as provided at 42 C.F.R. § 2.12(c)(5) and § 2.65.

4.2.1 The information received under subsection 7.7 of the Contract is also protected by federal law, including 42 C.F.R. Part 2, Subpart D, § 2.53, which requires HCA and their Subcontractors to:

4.2.1.1 Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under 42 C.F.R. § 2.16;

4.2.1.2 Retain records in compliance with applicable federal, state, and local record retention laws; and

4.2.1.3 Comply with the limitations on disclosure and Use in 42 C.F.R. Part 2, Subpart D, § 2.53(d).

4.3 Any disclosure of Data contrary to this Contract is unauthorized and is subject to penalties identified in law.

4.4 The Contractor must comply with the *Minimum Necessary Standard*, which means that Contractor will use the least amount of PHI necessary to accomplish the Purpose of this Contract.

4.4.1 Contractor must identify:

4.4.2 Those persons or classes of persons in its workforce who need access to PHI to carry out their duties; and

4.4.3 For each such person or class of persons, the category or categories of PHI to which access is needed and any conditions appropriate to such access.

4.4.4 Contractor must implement policies and procedures that limit the PHI disclosed to such persons or classes of persons to the amount reasonably necessary to achieve the purpose of the disclosure, in accordance with this Contract.

4.5 For all Data, including claims data, that is individually identifiable, shared outside of Contractor's system for research or data analytics not conducted on behalf of the Contractor, Contractor must provide HCA with 30 calendar days' advance notice and opportunity for review and advisement to ensure alignment and coordination between Contractor and HCA data governance initiatives. Contractor will provide notice to HCAData@hca.wa.gov and hcamcprograms@hca.wa.gov. Notice will include:

4.5.1 The party/ies the Data will be shared with;

4.5.2 The purpose of the sharing; and

4.5.3 A description of the types of Data involved, including specific data elements to be shared.

4.6 Contractor must provide a report by the 15th of each month of all Data, individually identifiable and de-identified, regarding Individuals, including claims data, shared with external entities, including but not limited to Subcontractors and researchers, to HCA via hcabhaso@hca.wa.gov on the supplied template, Data Shared with External Entities Report.

5 Security of Data

5.1 Data Protection

5.1.1 The Contractor must protect and maintain all Confidential Information gained by reason of this Contract, information that is defined as confidential under state or federal law or regulation, or Data that HCA has identified as confidential, against unauthorized use, access, disclosure, modification or loss. This duty requires the Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:

5.1.1.1 Allowing access only to staff that have an authorized business requirement to view the Confidential Information.

5.1.1.2 Physically securing any computers, documents, or other media containing the Confidential Information.

5.2 Data Security Standards

5.2.1 Contractor must comply with the Data Security Requirements set out in this section and the Washington OCIO Security Standard, 141.10, which will include any successor, amended, or replacement regulation (https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets.) The Security Standard 141.10 is hereby incorporated by reference into this Contract.

5.2.2 Data Transmitting

5.2.2.1 When transmitting Data electronically, including via email, the Data must be encrypted using NIST 800-series approved algorithms (http://csrc.nist.gov/publications/PubsSPs.html). This includes transmission over the public internet.

5.2.2.2 When transmitting Data via paper documents, the Contractor must use a Trusted System.

5.2.3 Protection of Data. The Contractor agrees to store and protect Data as described.

5.2.3.1 Data at Rest:

5.2.3.1.1 Data will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data. Access to the Data will be restricted to Authorized Users through the use of access control lists, a Unique User ID, and a Hardened Password, or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Systems that contain or provide access to Confidential Information must be located in an area that is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

5.2.3.2 Data stored on Portable/Removable Media or Devices

5.2.3.2.1 Confidential Information provided by HCA on Removable Media will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the Data.

5.2.3.2.2 HCA's Data must not be stored by the Contractor on Portable Devices or Media unless specifically authorized within the Contract. If so authorized, the Contractor must protect the Data by:

a. Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;

b. Controlling access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics;

c. Keeping devices in locked storage when not in use;

d. Using check-in/check-out procedures when devices are shared;

e. Maintaining an inventory of devices; and

f. Ensuring that when being transported outside of a Secured Area, all devices containing Data are under the physical control of an Authorized User.

5.2.3.3 Paper Documents. Any paper records containing Confidential Information must be protected by storing the records in a Secured Area that is accessible only to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

5.2.4 Data Segregation

5.2.4.1 HCA Data received under this Contract must be segregated or otherwise distinguishable from non-HCA Data. This is to ensure that when no longer needed by the Contractor, all of HCA's Data can be identified for return or destruction. It also aids in determining whether HCA's Data has or may have been compromised in the event of a security breach.

5.2.4.2 HCA's Data must be kept in one of the following ways:

5.2.4.2.1 On media (e.g. hard disk, optical disc, tape, etc.) which contains only HCA Data;

5.2.4.2.2 In a logical container on electronic media, such as a partition or folder dedicated to HCA's Data;

5.2.4.2.3 In a database that contains only HCA Data;

5.2.4.2.4 Within a database – HCA data must be distinguishable from non-HCA Data by the value of a specific field or fields within database records;

5.2.4.2.5 Physically segregated from non-HCA Data in a drawer, folder, or other container when stored as physical paper documents.

5.2.4.3 When it is not feasible or practical to segregate HCA's Data from non-HCA data, both HCA's Data and the non-HCA data with which it is commingled must be protected as described in this Exhibit.

5.3 Data Disposition

5.3.1 Upon request by HCA, at the end of the Contract term, or when no longer needed, Confidential Information/Data must be returned to HCA or disposed of as set out below, except as required to be maintained for compliance or accounting purposes.

5.3.2 Media are to be destroyed using a method documented within NIST 800-88 (http://csrc.nist.gov/publications/PubsSPs.html).

5.3.3 For Data stored on network disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in Section 5.2.3, above. Destruction of the Data as outlined in this section of this Exhibit may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

6 Data Confidentiality and Non-Disclosure

6.1 Data Confidentiality.

6.1.1 The Contractor will not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Contract for any purpose that is not directly connected with the purpose of this Contract, except:

6.1.1.1 as provided by law; or

6.1.1.2 with the prior written consent of the person or personal representative of the person who is the subject of the Confidential Information.

6.2 Non-Disclosure of Data

6.2.1 The Contractor will ensure that all employees or Subcontractors who will have access to the Data described in this Contract (including both employees who will use the Data and IT support staff) are instructed and aware of the use restrictions and protection requirements of this Exhibit before gaining access to the Data identified herein. The Contractor will ensure that any new employee is made aware of the use restrictions and protection requirements of this Exhibit before they gain access to the Data.

6.2.2 The Contractor will ensure that each employee or Subcontractor who will access the Data signs a non-disclosure of confidential information agreement regarding confidentiality and non-disclosure requirements of Data under this Contract. The Contractor must retain the signed copy of employee non-disclosure agreement in each employee's personnel file for a minimum of six years from the date the employee's access to the Data ends. The Contractor will make this documentation available to HCA upon request.

6.3 Penalties for Unauthorized Disclosure of Data

6.3.1 The Contractor must comply with all applicable federal and state laws and regulations concerning collection, use, and disclosure of Personal Information and PHI. Violation of these laws may result in criminal or civil penalties or fines.

6.3.2 The Contractor accepts full responsibility and liability for any noncompliance with applicable laws or this Contract by itself, its employees, and its Subcontractors.

7 Data Shared with Subcontractors

If Data access is to be provided to a Subcontractor under this Contract, the Contractor must include all of the Data security terms, conditions and requirements set forth in this Exhibit in any such Subcontract. However, no subcontract will terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any subcontractor. Contractor must provide an attestation by January 31, each year that all Subcontractor meet, or continue to meet, the terms, conditions, and requirements in this Exhibit.

8 Data Breach Notification

8.1 The Breach or potential compromise of Data must be reported to the HCA Privacy Officer at **PrivacyOfficer@hca.wa.gov** and to the BH-ASO Contract Manager at **hcabhaso@hca.wa.gov** within five (5) business days of discovery. If the Contractor does not have full details, it will report what information it has, and provide full details within fifteen (15) business days of discovery. To the extent possible, these reports must include the following:

8.1.1 The identification of each non-Medicaid Individual whose PHI has been or may have been improperly accessed, acquired, used, or disclosed;

8.1.2 The nature of the unauthorized use or disclosure, including a brief description of what happened, the date of the event(s), and the date of discovery;

8.1.3 A description of the types of PHI involved;

8.1.4 The investigative and remedial actions the Contractor or its Subcontractor took or will take to prevent and mitigate harmful effects, and protect against recurrence;

8.1.5 Any details necessary for a determination of the potential harm to Individuals whose PHI is believed to have been used or disclosed and the steps those Individuals should take to protect themselves; and

8.1.6 Any other information HCA reasonably requests.

8.2 The Contractor must take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or HCA including but not limited to 45 C.F.R. Part 164, Subpart D; RCW 42.56.590; RCW 19.255.010; or WAC 284-04-625.

8.3 The Contractor must notify HCA in writing, as described in 8.a above, within two (2) business days of determining notification must be sent to non-Medicaid Individuals.

8.4 At HCA's request, the Contractor will provide draft Individual notification to HCA at least five (5) business days prior to notification, and allow HCA an opportunity to review and comment on the notifications.

8.5 At HCA's request, the Contractor will coordinate its investigation and notifications with HCA and the Office of the state of Washington Chief Information Officer (OCIO), as applicable.

9 HIPAA Compliance

This section of the Exhibit is the Business Associate Agreement (BAA) required by HIPAA. The Contractor is a "Business Associate" of HCA as defined in the HIPAA Rules.

9.1 HIPAA Point of Contact. The point of contact for the Contractor for all required HIPAA-related reporting and notification communications from this Section and all required Data Breach Notification from Section 8, is:

HCA Privacy Officer
Washington State Health Care Authority
626 8th Avenue SE
PO Box 42704
Olympia, WA 98504-2704
Telephone: (360) 725-2108
Email: PrivacyOfficer@hca.wa.gov

9.2 Compliance. Contractor must perform all Contract duties, activities, and tasks in compliance with HIPAA, the HIPAA Rules, and all attendant regulations as promulgated by the U.S. Department of Health and Human Services, Office for Civil Rights, as applicable.

9.3 Use and Disclosure of PHI. Contractor is limited to the following permitted and required uses or disclosures of PHI:

9.3.1 Duty to Protect PHI. Contractor must protect PHI from, and will use appropriate safeguards, and comply with Subpart C of 45 C.F.R. Part 164, Security Standards for the Protection of Electronic Protect Health Information, with respect to ePHI, to prevent unauthorized Use or disclosure of PHI for as long as the PHI is within Contractor's possession and control, even after the termination or expiration of this Contract.

9.3.2 Minimum Necessary Standard. Contractor will apply the HIPAA Minimum Necessary standard to any Use or disclosure of PHI necessary to achieve the purposes of this Contractor. See 45 C.F.R. § 164.514(d)(2) through (d)(5).

9.3.3 Disclosure as Part of the Provision of Services. Contractor will only Use or disclose PHI as necessary to perform the services specified in this Contract or as required by law, and will not Use or disclose such PHI in any manner that would violate Subpart E of 45 C.F.R. Part 164, Privacy of Individually Identifiable Health Information, if done by Covered Entity, except for the specific Uses and disclosures set forth below.

9.3.4 Use for Proper Management and Administration. Contractor may Use PHI for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor.

9.3.5 Disclosure for Proper Management and Administration. Contractor may disclosure PHI for the proper management and administration of Contractor, subject to HCA approval, or to carry out the legal responsibilities of the Contractor, provided the disclosures are required by law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Contractor of any instances of which it is aware in which the confidentiality of the information has been Breached.

9.3.6 Impermissible Use or Disclosure of PHI. Contractor must report to the HIPAA Point of Contact, in writing, all Uses or disclosures of PHI not provided for by this Contract within five (5) business days of becoming aware of the unauthorized Use or disclosure of PHI, including Breaches of unsecured PHI as required at 45 C.F.R. § 164.410, Notification by a Business Associate, as well as any Security Incident of which Contractor becomes aware. Upon request by HCA, Contractor will mitigate, to the extent practicable, any harmful effect resulting from the impermissible Use or disclosure.

9.3.7 Failure to Cure. If HCA learns of a pattern or practice of the Contractor that constitutes a violation of Contractor's obligations under the term of this Exhibit and reasonable steps by the Contractor do not end the violation, HCA may terminate this Contract, if feasible. In addition, if Contractor learns of a pattern or practice of its Subcontractor(s) that constitutes a violation of Contractor's obligations under the terms of their contract and reasonable steps by the Contractor do not end the violation, Contractor must terminate the Subcontract, if feasible.

9.3.8 Termination for Cause. Contractor authorizes immediate termination of this Contract by HCA, if HCA determines Contractor has violated a material term of this Business Associate Agreement. HCA may, at its sole option, offer Contractor an opportunity to cure a violation of this Business Associate Agreement before exercising a termination for cause.

9.3.9 Consent to Audit. Contractor must give reasonable access to PHI, its internal practices, records, books, documents, electronic data, and/or all other business information received from, or created, received by Contractor on behalf of HCA, to the Secretary of the United States Department of Health and Human Services (DHHS) and/or to HCA for use in determining compliance with HIPAA privacy requirements.

9.3.10 Obligations of Business Associate upon Expiration or Termination. Upon expiration or termination of this Contract for any reason, with respect to PHI received from HCA, or created, maintained, or received by Contractor, or any Subcontractors, on behalf of HCA, Contractor must:

9.3.10.1 Retain only that PHI which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;

9.3.10.2 Return to HCA or destroy the remaining PHI that the Contractor or any Subcontractors still maintain in any form;

9.3.10.3 Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164, Security Standards for Protection of Electronic Protected Health Information, with respect to ePHI to prevent Use or disclosure of the PHI, other than as provided for in this Section, for as long as Contractor or any Subcontractor retains PHI;

9.3.10.4 Not Use or disclose the PHI retained by Contractor or any Subcontractors other than for the purposes for which such PHI was retained and subject to the same conditions section out in Section 9.3, Use and Disclosure of PHI, that applied prior to termination; and

9.3.10.5 Return to HCA or destroy the PHI retained by Contractor, or any Subcontractors, when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities.

9.3.11 Survival. The obligations of Contractor under this Section will survive the termination or expiration of the Contract.

9.4 Individual Rights.

9.4.1 Accounting of Disclosures.

9.4.1.1 Contractor will document all disclosures, except those disclosures that are exempt under 45 C.F.R. § 164.528, of PHI and information related to such disclosures.

9.4.1.2 Within ten (10) business days of a request from HCA, Contractor will make available to HCA the information in Contractor's possession that is necessary for HCA to respond in a timely manner to a request for an accounting of disclosures of PHI by the Contractor. See 45 C.F.R. §§ 164.504(e)(2)(ii)(G) and 164.528(b)(1).

9.4.1.3 At the request of HCA or in response to a request made directly to the Contractor by an Individual, Contractor will respond, in a timely manner and in accordance with HIPAA and the HIPAA Rules, to requests by Individuals for an accounting of disclosures of PHI.

9.4.1.4 Contractor record keeping procedures will be sufficient to respond to a request for an accounting under this section for the six (6) years prior to the date on which the accounting was requested.

9.4.2 Access.

9.4.2.1 Contractor will make available PHI that it holds that is part of a Designated Record Set when requested by HCA or the Individual as necessary to satisfy HCA's obligations under 45 C.F.R. § 164.524, Access of Individuals to Protected Health Information.

9.4.2.2 When the request is made by the Individual to the Contractor or if HCA ask the Contractor to respond to a request, the Contractor must comply with requirements in 45 C.F.R. § 164.524, Access of Individuals to Protected Health Information, on form, time and manner of access. When the request is made by HCA, the Contractor will provide the records to HCA within ten (10) business days.

9.4.3 Amendment.

9.4.3.1 If HCA amends, in whole or in part, a record or PHI contained in an Individual's Designated Record Set and HCA has previously provided the PHI or record that is the subject of the amendment to Contractor, then HCA will inform Contractor of the amendment pursuant to 45 C.F.R. § 164.526(c)(3), Amendment of Protected Health Information.

9.4.3.2 Contractor will make any amendments to PHI in a Designated Record Set as directed by HCA or as necessary to satisfy HCA's obligations under 45 C.F.R. § 164.526, Amendment of Protected Health Information.

9.5 Subcontracts and other Third Party Agreements. In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii), 164.504(e)(1)(i), and 164.308(b)(2), Contractor must ensure that any agents, Subcontractors, independent contractors, or other third parties that create, receive, maintain, or transmit PHI on Contractor's behalf, enter into a written contract that contains the same terms, restrictions, requirements, and conditions as the HIPAA compliance provisions in this Contract with respect to such PHI. The same provisions must also be included in any contracts by a Contractor's Subcontractor with its own business associates as required by 45 C.F.R. §§ 164.314(a)(2)(b) and 164.504(e)(5).

9.6 Obligations. To the extent the Contractor is to carry out one or more of HCA's obligation(s) under Subpart E of 45 C.F.R. Part 164, Privacy of Individually Identifiable Health Information, Contractor must comply with all requirements that would apply to HCA in the performance of such obligation(s).

9.7 Liability. Within ten (10) business days, Contractor must notify the HIPAA Point of Contact of any complaint, enforcement or compliance action initiated by the Office for Civil Rights based on an allegation of violation of the HIPAA Rules and must inform HCA of the outcome of that action. Contractor bears all responsibility for any penalties, fines or sanctions imposed against the Contractor for violations of the HIPAA Rules and for any imposed against its Subcontractors or agents for which it is found liable.

9.8 Miscellaneous Provisions.

9.8.1 Regulatory References. A reference in this Contract to a section in the HIPAA Rules means the section as in effect or amended.

9.8.2 Interpretation. Any ambiguity in this Exhibit will be interpreted to permit compliance with the HIPAA Rules.

10 Inspection

HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Individuals collected, used, or acquired by Contractor during the terms of this Contract. All HCA representatives conducting onsite audits of Contractor agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

11 Indemnification

The Contractor must indemnify and hold HCA and its employees harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Individuals.

Medicare Data Use Requirements Documents

Schedule 1: Washington State Approval Letter and Data Use Agreement (DUA) #21628

Schedule 2: Medicare Attachment A to DUA

Schedule 3 Information Exchange Agreement for Disclosure of Medicare Part D Data

Schedule 4 Medicare Part D – Conflict of Interest Attestation

Schedule 5 PRISM Access Request Form

SCHEDULE 1
WASHINGTON STATE APPROVAL LETTER
DATA USE AGREEMENT

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop N1-24-08
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Cathie Ott
State of Washington
Health Care Authority
626 8th Avenue SE
Olympia, Washington 98504

Dear Ms. Ott:

Enclosed is a copy of the signed Data Use Agreement (DUA) and the Information Exchange Agreement that the Centers for Medicare & Medicaid Services (CMS) have entered into with your organization for the CMS/Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) program entitled, "Part D - Care Coordination for Beneficiaries Who are Dually Eligible in the Medicare/Medicaid Programs." Please refer to DUA number 21628 when addressing inquiries of any nature concerning this agreement.

I have also enclosed the CMS DUA Guidelines which outlines your responsibilities in terms of safeguarding the confidentiality of CMS data. This approval is based on the understanding that personnel within your organization and any subcontracting organization's personnel will comply with all requirements of this Agreement into which you have entered. It is your responsibility to provide a copy of this agreement and CMS DUA Guidelines to the individuals listed below for your organization and/or any subcontracting organization. Please emphasize the importance of complying with this agreement. Note that this approval only applies to this request for the study mentioned above. Any additional purpose will have to be reviewed and approved by CMS.

Please note that any organization requesting CMS data that has an EXPIRED CMS DUA will not receive authorization to obtain any new data until their expired DUA has been resolved. The retention date stipulates the timeframe in which the information can be used. If your DUA is about to expire, and your project is still in need of the CMS data, you will need to request an extension date on the DUA. However, if your study is complete and the data is no longer required, you must contact CMS and request that the DUA be closed by providing written certification that you have destroyed the CMS data. More information regarding the resolution of expired DUAs can be found at the following CMS website: www.cms.hhs.gov/PrivProtectedData/ under "DUA Extensions or Destruction of CMS Data."

If you have any questions about this DUA or the use of the CMS data, you may contact me at (410) 786-7185. If you have questions regarding the Care Coordination Program, please contact Karyn Anderson, Part D Care Coordination program official, at (410) 786-6696.

Sincerely,

Cheryl Sample

Cheryl Sample
Division of Information Security & Privacy Management
Enterprise Architecture and Strategy Group
Office of Information Services
Centers for Medicare & Medicaid Services

Enclosures

Cc:
Karyn Anderson, CMS, FCHCO

Centers for Medicare & Medicaid Services (CMS)
Data Use Agreement (DUA) Guidelines

1. Requestor agrees to notify CMS if their project is completed sooner than the expiration date specified in the DUA.

2. Requestor agrees that any data provided by CMS will not be physically moved or electronically transmitted in any way from the site indicated in the DUA without expressed written authorization from CMS. If location needs to be modified, the DUA should be updated to include the new location.

3. Upon completion of the project and/or expiration of the DUA, the data must be destroyed and a statement certifying this action sent to CMS. The Requestor agrees that no data, copies, or parts thereof, shall be retained when the file(s) are destroyed, unless CMS has authorized in writing such retention or said file(s). Further details are explained below:

   Destroy data and submit a completed Certificate of Destruction (form may be downloaded at: http://www.cms.hhs.gov/PrivProtectedData/Downloads/certificationofdestruction.pdf.) The Requestor should forward this information to:

   Director, Division of Information Security & Privacy Management
   Enterprise Architecture and Strategy Group
   Office of Information Services
   Centers for Medicare & Medicaid Services
   7500 Security Boulevard
   Mailstop: N1-24-08
   Baltimore, Maryland 21244-1850

4. If the project is still active and the DUA has expired, a one (1) year extension may be granted. The extension will only be approved if the data will continue to be used for the original project purpose and the expiration date has occurred within the past year; otherwise, a new DUA must be negotiated. The letter requesting an extension should be directed to the name and address in item 3a above.

5. Please visit our new website, Privacy Protected Data Request: Policies and Procedures at: http://www.cms.hhs.gov/PrivProtectedData/.

DATA USE AGREEMENT

DUA # 21628

(AGREEMENT FOR USE OF CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DATA CONTAINING INDIVIDUAL IDENTIFIERS)

CMS agrees to provide the User with data that reside in a CMS Privacy Act System of Records as identified in this Agreement. In exchange, the User agrees to pay any applicable fees; the User agrees to use the data only for purposes that support the User's study, research or project referenced in this Agreement, which has been determined by CMS to provide assistance to CMS in monitoring, managing and improving the Medicare and Medicaid programs or the services provided to beneficiaries; and the User agrees to ensure the integrity, security, and confidentiality of the data by complying with the terms of this Agreement and applicable law, including the Privacy Act and the Health Insurance Portability and Accountability Act. In order to secure data that reside in a CMS Privacy Act System of Records; in order to ensure the integrity, security, and confidentiality of information maintained by the CMS; and to permit appropriate disclosure and use of such data as permitted by law, CMS and Health Care Authority, Washington State (Requestor) enter into this agreement to comply with the following specific paragraphs.

1. This Agreement is by and between the Centers for Medicare & Medicaid Services (CMS), a component of the U.S. Department of Health and Human Services (HHS), and Health Care Authority, Washington State (Requestor), hereinafter termed "User."

2. This Agreement addresses the conditions under which CMS will disclose and the User will obtain, use, reuse and disclose the CMS data file(s) specified in section 5 and/or any derivative file(s) that contain direct individual identifiers or elements that can be used in concert with other information to identify individuals. This Agreement supersedes any and all agreements between the parties with respect to the use of data from the files specified in section 5 and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to any grant award or other prior communication from the Department of Health and Human Services or any of its components with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by the CMS point-of-contact or the CMS signatory to this Agreement shown in section 20.

3. The parties mutually agree that CMS retains all ownership rights to the data file(s) referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by CMS.

4. The User represents, and in furnishing the data file(s) specified in section 5 CMS relies upon such representation, that such data file(s) will be used solely for the following purpose(s).

Name of Study/Project
Care Coordination

CMS Contract No. *(If applicable)*
CMS Agreement No 2011-13

The User represents further that the facts and statements made in any study or research protocol or project plan submitted to CMS for each purpose are complete and accurate. Further, the User represents that said study protocol(s) or project plans, that have been approved by CMS or other appropriate entity as CMS may determine, represent the total use(s) to which the data file(s) specified in section 5 will be put.

The User agrees not to disclose, use or reuse the data covered by this agreement except as specified in an Attachment to this Agreement or except as CMS shall authorize in writing or as otherwise required by law, sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement. The User affirms that the requested data is the minimum necessary to achieve the purposes stated in this section. The User agrees that, within the User organization and the organizations of its agents, access to the data covered by this Agreement shall be limited to the minimum amount of data and minimum number of individuals necessary to achieve the purpose stated in this section (i.e., individual's access to the data will be on a need-to-know basis).

5. The following CMS data file(s) is/are covered under this Agreement.

File	Years(s)	System of Record
~~Part D Files~~	~~2006~~	~~System No. 09-70-0571~~
Part D Files	2007	System No. 09-70-0571
Part D Files	2008	System No. 09-70-0571
Part D Files	2009	System No. 09-70-0571
Part D Files	2010	System No. 09-70-0571
Part D Files	2011	System No. 09-70-0571

6. The parties mutually agree that the aforesaid files(s) (and/or any derivative file(s)), including those files that directly identify individuals or that directly identify bidding firms and/or such firms' proprietary, confidential or specific bidding information, and those files that can be used in concert with other information to identify individuals, may be retained by the User until 07/31/2016, hereinafter known as the "Retention Date." The User agrees to notify CMS within 30 days of the completion of the purpose specified in section 4 if the purpose is completed before the aforementioned retention date. Upon such notice or retention date, whichever occurs sooner, the User agrees to destroy such data. The User agrees to destroy and send written certification of the destruction of the files to CMS within 30 days. The User agrees not to retain CMS files or any parts thereof, after the aforementioned file(s) are destroyed unless the appropriate Systems Manager or the person designated in section 20 of this Agreement grants written authorization. The User acknowledges that the date is not contingent upon action by CMS.

   The Agreement may be terminated by either party at any time for any reason upon 30 days written notice. Upon notice of termination by User, CMS will cease releasing data from the file(s) to the User under this Agreement and will notify the User to destroy such data file(s). Sections 3, 4, 6, 8, 9, 10, 11, 13, 14 and 15 shall survive termination of this Agreement.

7. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it.The safeguards shall provide a level and scope of security that is not less than the level and scope of security requirements established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems **(http://www.whitehouse.gov/omb/circulars/a130/a130.html)** as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" **(http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf);** and, Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" **(http://csrc.nist.gov/publications/nistpubs/800-53-Rev2/sp800-53-rev2-final.pdf)**. The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, bidder identifiable or deducible information derived from the file(s) specified in section 5 is prohibited. Further, the User agrees that the data must not be physically moved, transmitted or disclosed in any way from or by the site indicated in section 17 without written approval from CMS unless such movement, transmission or disclosure is required by a law.

8. The User agrees to grant access to the data to the authorized representatives of CMS or DHHS Office of the Inspector General at the site indicated in section 17 for the purpose of inspecting to confirm compliance with the terms of this agreement.

9. The User agrees not to disclose direct findings, listings, or information derived from the file(s) specified in section 5, with or without direct identifiers, if such findings, listings, or information can, by themselves or in combination with other data, be used to deduce an individual's identity. Examples of such data elements include, but are not limited to geographic location, age if > 89, sex, diagnosis and procedure, admission/discharge date(s), or date of death.

   The User agrees that any use of CMS data in the creation of any document (manuscript, table, chart, study, report, etc.) concerning the purpose specified in section 4 (regardless of whether the report or other writing expressly refers to such purpose, to CMS, or to the files specified in section 5 or any data derived from such files) must adhere to CMS' current cell size suppression policy. **This policy stipulates that no cell (e.g. admittances, discharges, patients, services) 10 or less may be displayed.** Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell 10 or less. By signing this Agreement you hereby agree to abide by these rules and, therefore, will not be required to submit any written documents for CMS review. If you are unsure if you meet the above criteria, you may submit your written products for CMS review. CMS agrees to make a determination about approval and to notify the user within 4 to 6 weeks after receipt of findings. CMS may withhold approval for publication only if it determines that the format in which data are presented may result in identification of individual beneficiaries.

10. The User agrees that, absent express written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement to do so, the User shall not attempt to link records included in the file(s) specified in section 5 to any other individually identifiable source of information. This includes attempts to link the data to other CMS data file(s). A protocol that includes the linkage of specific files that has been approved in accordance with section 4 constitutes express authorization from CMS to link files as described in the protocol.

11. The User understands and agrees that they may not reuse original or derivative data file(s) without prior written approval from the appropriate System Manager or the person designated in section 20 of this Agreement.

12. The parties mutually agree that the following specified Attachments are part of this Agreement:

    CMS Agreement No 2011-13

13. The User agrees that in the event CMS determines or has a reasonable belief that the User has made or may have made a use, reuse or disclosure of the aforesaid file(s) that is not authorized by this Agreement or another written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement, CMS, at its sole discretion, may require the User to: (a) promptly investigate and report to CMS the User's determinations regarding any alleged or actual unauthorized use, reuse or disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by CMS, submit a formal response to an allegation of unauthorized use, reuse or disclosure; (d) if requested by CMS, submit a corrective action plan with steps designed to prevent any future unauthorized uses, reuses or disclosures; and (e) if requested by CMS, return data files to CMS or destroy the data files it received from CMS under this agreement. The User understands that as a result of CMS's determination or reasonable belief that unauthorized uses, reuses or disclosures have taken place, CMS may refuse to release further CMS data to the User for a period of time to be determined by CMS.

    The User agrees to report any breach of personally identifiable information (PII) from the CMS data file(s), loss of these data or disclosure to any unauthorized persons to the CMS Action Desk by telephone at (410) 786-2580 or by e-mail notification at **cms_it_service_desk@cms.hhs.gov** within one hour and to cooperate fully in the federal security incident process. While CMS retains all ownership rights to the data file(s), as outlined above, the User shall bear the cost and liability for any breaches of PII from the data file(s) while they are entrusted to the User. Furthermore, if CMS determines that the risk of harm requires notification of affected individual persons of the security breach and/or other remedies, the User agrees to carry out these remedies without cost to CMS.

14. The User hereby acknowledges that criminal penalties under §1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), including a fine not exceeding $10,000 or imprisonment not exceeding 5 years, or both, may apply to disclosures of information that are covered by § 1106 and that are not authorized by regulation or by Federal law. The User further acknowledges that criminal penalties under the Privacy Act (5 U.S.C. § 552a(i) (3)) may apply if it is determined that the Requestor or Custodian, or any individual employed or affiliated therewith, knowingly and willfully obtained the file(s) under false pretenses. Any person found to have violated sec. (i)(3) of the Privacy Act shall be guilty of a misdemeanor and fined not more than $5,000. Finally, the User acknowledges that criminal penalties may be imposed under 18 U.S.C. § 641 if it is determined that the User, or any individual employed or affiliated therewith, has taken or converted to his own use data file(s), or received the file(s) knowing that they were stolen or converted. Under such circumstances, they shall be fined under Title 18 or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $1,000, they shall be fined under Title 18 or imprisoned not more than 1 year, or both.

15. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement and acknowledges having received notice of potential criminal or administrative penalties for violation of the terms of the Agreement.

16. On behalf of the User the undersigned individual hereby attests that he or she is authorized to legally bind the User to the terms this Agreement and agrees to all the terms specified herein.

Name and Title of User *(typed or printed)*		
Cathie Ott		
Company/Organization		
Health Care Authority		
Street Address		
626 8th Ave		
City	State	ZIP Code
Olympia	WA	98504-5502
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
360-725-2116	ottcl@hca.wa.gov	
Signature		Date
Cathie Ott		7/12/2011

17. The parties mutually agree that the following named individual is designated as Custodian of the file(s) on behalf of the User and will be the person responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify CMS within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

    The Custodian hereby acknowledges his/her appointment as Custodian of the aforesaid file(s) on behalf of the User, and agrees to comply with all of the provisions of this Agreement on behalf of the User.

Name of Custodian *(typed or printed)*		
Cathie Ott		
Company/Organization		
Health Care Authority		
Street Address		
626 8th Avenue		
City	State	ZIP Code
Olympia	WA	98504-5502
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
360-725-2116	ottcl@hca.wa.gov	
Signature		Date
Cathie Ott		7/12/2011

18. The disclosure provision(s) that allows the discretionary release of CMS data for the purpose(s) stated in section 4 follow(s). (To be completed by CMS staff.) _____

19. On behalf of _____ the undersigned individual hereby acknowledges that the aforesaid Federal agency sponsors or otherwise supports the User's request for and use of CMS data, agrees to support CMS in ensuring that the User maintains and uses CMS's data in accordance with the terms of this Agreement, and agrees further to make no statement to the User concerning the interpretation of the terms of this Agreement and to refer all questions of such interpretation or compliance with the terms of this Agreement to the CMS official named in section 20 (or to his or her successor).

Typed or Printed Name	Title of Federal Representative
Signature	Date
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*

20. The parties mutually agree that the following named individual will be designated as point-of-contact for the Agreement on behalf of CMS.

On behalf of CMS the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

Name of CMS Representative *(typed or printed)* Karyn Kai Anderson			
Title/Component Medicare-Medicaid Coordination Office			
Street Address 7500 Security Blvd.			Mail Stop 53-13-23
City Baltimore	State MD	ZIP Code 21244	
Office Telephone *(Include Area Code)* 410-786-6696		E-Mail Address *(If applicable)* Karyn.Anderson@CMS.hhs.gov	
A. Signature of CMS Representative			Date 7/22/11
B. Concur/Nonconcur — Signature of CMS System Manager or Business Owner			Date 7/22/11
Concur/Nonconcur — Signature of CMS System Manager or Business Owner			Date
Concur/Nonconcur — Signature of CMS System Manager or Business Owner			Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0734

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for Care Coordination for Dual Eligibles. If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: 21628. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* David Mancuso, PhD		
Task / Role of this individual in this project Senior Research Supervisor	Company / Organization Department of Social and Health Services	
Street Address 14th and Jefferson, OB-2, MS: 45204		
City Olympia	State WA	ZIP Code 98504
Office Telephone *(Include Area Code)* (360) 902-7557	E-Mail Address *(If applicable)* MancuDC@dshs.wa.gov	
Signature of Individual	Date 8/2/2011	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0734. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: Reports Clearance Officer, Baltimore, Maryland 21244-1850.

The Centers for Medicare and Medicaid Services
Data Agreement & Data Shipping Tracking System

dua edit - dua: 21628

Session Summary: **DUA: 21628**

Main Information:

DUA #:	21628		
Study Name:	CARE COORDINATION FOR BENEFICIARIES WHO ARE DUALLY ELIGIBLE IN THE MEDICARE/MEDICAID PROGRAMS		
Category:	11 - STATES		
Encryption:	I - IDENTIFIABLE		
Authorization:	PA03-ST - STATE AGENCY RU		
Privacy Board Approval Date:			
DUA Effective Date:	08/02/2011	DUA Expiration Date:	07/13/2016
Extension:	0	Extension Date:	
DESY Access:	No	DESY Expiration Date:	
Reuse:	No	Reuse Information:	NUL
DSAF Access:	No	CMS Data Center Access:	No
Foreign Tape:	No		
Bene Notification:	N - NOT APPLICABLE		
Contract/Grant No.:	CMS/STATE IEA AGREEMENT #2011-13		
Part D Approval Date:	07/22/2011		
CMS Contact Name:	KARYN ANDERSON		
Federal Project Officer:			

Data Descriptions:

#1 Data Description: PDE - PRESCRIPTION DRUG EVENT DATA
From Year: 2007 To Year: 2011

IDR Custodians:

Requestor:

Address ID: 20120 Contact Info: CATHIE OTT
STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8TH AVENUE SE
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-725-2116
Email: ottcl@hca.wa.gov
Last Modified: 2011-08-02 14:47:24

Custodians:

#1 Address ID: 20120 Contact Info: CATHIE OTT
STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8TH AVENUE SE
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-725-2116
Email: ottcl@hca.wa.gov
Last Modified: 2011-08-02 14:47:24

#2 Address ID: 18110 Contact Info: DAVID MANCUSO
WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND DISABILITY SERVICES
ADMINISTRATION
14TH &JEFFERSON STREET
PO BOX 45204
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-902-7557
Email: mancudc@dshs.wa.gov
Last Modified: 2011-08-04 16:01:09

Subcontractors:

None

Recipients:

#1 Address ID: 20120 Contact Info: CATHIE OTT
STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8TH AVENUE SE
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-725-2116
Email: ottcl@hca.wa.gov
Last Modified: 2011-08-02 14:47:24

#2 Address ID: 18110 Contact Info: DAVID MANCUSO
WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND DISABILITY SERVICES ADMINISTRATION
14TH &JEFFERSON STREET
PO BOX 45204
OLYMPIA, WA 98504
UNITED STATES OF AMERICA
Phone: 360-902-7557
Email: mancudc@dshs.wa.gov
Last Modified: 2011-08-04 16:01:09

DESY Users:

Comments:

Timestamp: Thu Aug 04 17:24:26 EDT 2011 User Name: CHERYL SAMPLE
Text: added David Mancuso as addtional data custodian.

Timestamp: Tue Aug 02 14:51:36 EDT 2011 User Name: CHERYL SAMPLE
Text: WA approved by PDE business owner for use of PDE data (IEA lists data elements--27) for care coordination program under direction of Sharon Donovan and Kai Anderson,CMS/ FCHCO/Duals Office program officials. OIS/EDG to process data feed.

History:

Timestamp: Thu Aug 04 17:24:21 EDT 2011 User Name: CHERYL SAMPLE
Type of Change: RECIPIENT HAS BEEN ADDED

Timestamp: Thu Aug 04 17:24:21 EDT 2011 User Name: CHERYL SAMPLE
Type of Change: CUSTODIAN HAS BEEN ADDED

Submit Cancel

SCHEDULE 2

MEDICARE ATTACHMENT A

SCHEDULE 2: MEDICARE ATTACHMENT A

This Attachment supplements the Data Use Agreement between the Centers for Medicare & Medicaid Services ("CMS") and the Users. To the extent that the provisions of this Attachment are inconsistent with any terms in the Data Use Agreement, this Attachment modifies and overrides the Data Use Agreement.

USE OF THE INFORMATION

A-1. Users are defined as the State Medicaid Agencies and downstream entities that are Health Insurance Portability and Accountability Act (HIPAA) Covered Entities that are given individually identifiable data to carry out care coordination and quality improvement work, as well as the business associates of such entities and any sub-contractor Business Associates of such entities.

Users may include providers and care coordination organizations that wish to use individually identifiable data about beneficiaries of the Medicare and Medicaid programs (Medicare-Medicaid enrollees) to provide care coordination and quality improvement programs on behalf of the State Medicaid Agency and/or one or more HIPAA Covered Entity providers. Such work would need to be done subject to a HIPAA business associate agreement with that State Medicaid Agency and/or those HIPAA Covered Entity providers.

The Users must use any individually identifiable information that they receive under 1.a. to further the delivery of seamless, coordinated care for individuals who are Medicare-Medicaid enrollees to promote better care, better health, and lower growth in expenditures.

A-2. Subject to the limitations described below, users may reuse original or derivative data from the files specified in Section 5 of the Data Use Agreement, with or without direct identifiers, without prior written authorization from CMS, for clinical treatment, case management and care coordination, and quality improvement activities. Information derived from the files specified in Section 5 of the Data Use Agreement may be shared and used within the legal confines of the Users authority in a manner consistent with this section to improve care integration. When using or disclosing protected health information (PHI) or personally identifiable information (PII), obtained under the Data Use Agreement, Users must make "reasonable efforts to limit" the information that is used or disclosed to the "minimum necessary" to accomplish the intended purpose of the use or disclosure. Users shall limit disclosure of information to that which CMS would be permitted to disclose under the established Privacy Act "routine uses," which are categories of disclosures or uses permitted by CMS's system of records notice available at www.cms.hhs.gov/privacy, as well as other permitted disclosures found in the Privacy Act at 5 U.S.C. §552a(b)(1) through (b)(12).

A-3. Nothing in the Data Use Agreement, including but not limited to Section 9, governs the use and/or disclosure of any information that is obtained independent of the Data Use Agreement, regardless of whether the information was also obtained or could also be derived from the files specified in Section 5 of the Data Use Agreement.

A-4. Users are expressly authorized to undertake further investigation into events and individuals related to the files specified in Section 5 in a manner consistent with Section 1.b. This includes, but is not limited to, reviewing other records, interviewing individuals, and attempting to link the files specified in Section 5 to other files.

POTENTIAL PENALTIES

A-5. Users acknowledge having received notice of potential criminal or administrative penalties for violation of the terms of the Data Use Agreement and this attachment.

_____

For: [Name of Downstream Entity]

_____

Washington State Health Care Authority
For: State Medicaid Agency

SCHEDULE 3

INFORMATION EXCHANGE AGREEMENT FOR DISCLOSURE OF MEDICARE PART D DATA

SCHEDULE 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Privacy Act of 1974

INFORMATION EXCHANGE AGREEMENT
BETWEEN
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
THE PARTICIPATING STATE MEDICAID AGENCY
FOR
DISCLOSURE OF MEDICARE PART D DATA

CMS Computer Matching Agreement Number 2011-13

WASHINGTON STATE

INFORMATION EXCHANGE AGREEMENT

INFORMATION EXCHANGE AGREEMENT
BETWEEN
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
THE PARTICIPATING STATE MEDICAID AGENCY
FOR
DISCLOSURE OF MEDICARE PART D DATA
CMS AGREEMENT No. 2011-13

I. PURPOSE, LEGAL AUTHORITY, AND DEFINITIONS

A. Purpose

This Information Exchange Agreement (lEA) establishes the terms, conditions, safeguards, and procedures under which the Centers for Medicare & Medicaid Services(CMS) will disclose Medicare Part D prescription drug event (PDE) data to the State Medicaid Agency for the State of Washington ("the Participating State"). Under this Agreement, PDE data that are maintained by CMS and subject to the requirements of the Privacy Act will be disclosed exclusively for use in care coordination for beneficiaries who are dually eligible for both the Medicare and Medicaid programs ("dual eligible beneficiaries”). The criteria for considering a purpose to be "care coordination" is that the specific uses of the data (e.g., analysis, monitoring, or feedback) support interventions at the individual dual eligible beneficiary level that have the potential to improve the care of dual eligible beneficiaries.

This Agreement describes the Medicare Part D PDE data elements that CMS agrees to provide, the timeframes within which the data or access will be provided, the approved uses of the data, the approved downstream disclosures of the data (if applicable), and the CMS reporting requirements. Certain protections for the data that are required under the terms of this lEA are reinforced in the Data Use Agreement (DUA) Form CMS-R-0235.

B. Legal Authority

The legal authority for CMS’s disclosure of information to the State Medicaid agency is provided by the Privacy Act of 1974 (5 U.S.C. § S52a), as amended, section 1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), and the regulations and guidance promulgated there under. The release of Part D data by CMS to a State is also governed by 42 CFR 423.505. CMS data will be released to the State Medicaid Agency pursuant to the routine use as set forth in the system notice.

Disclosures under this agreement do not constitute a matching program as defined by the Privacy Act, *5* U.S.C. § 552a (a)(8}, but are made in accordance with applicable requirements and other relevant provisions of the Privacy Act, *5* U.S.C. § 552a. The purpose of the disclosures described herein is not for (1) establishing or verifying initial or continuing entitlement or eligibility of individuals or entities (be they applicants for, recipients of, participants in, or providers of services) with respect to Federal benefit programs, (2) verifying compliance with statutory and regulatory requirements of such programs, or (3) recouping payments or delinquent debts under such Federal benefit programs.

This Agreement supports the responsibilities of the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office") as established by the Patient Protection and Affordable Care Act (Affordable Care Act) Section 2602, which specifically include providing States with the tools necessary to develop programs to align Medicare and Medicaid benefits for dual eligible beneficiaries.

C. Definitions

1. "BI" means Business Intelligence (BI) tool.

2. "Care coordination" means uses of the data (e.g., analysis, monitoring, or feedback) to support interventions at the individual dual eligible beneficiary level that have the potential to improve the care of dual eligible beneficiaries.

3. "CMS" means the Centers for Medicare & Medicaid Services.

4. "Custodian" or "custodian agent" means a designated employee of the State Medicaid Agency who is responsible for protecting the confidentiality of data disclosed in accordance with this agreement.

5. "Downstream user" means any entity (e.g., treating provider or contractor) that has been approved by CMS to receive PDE data that was provided to the State Medicaid Agency under this Agreement for care coordination purposes.

6. "DUA" means the CMS Data Use Agreement which accompanies this lEA.

7. "Dual eligible beneficiary" means an individual who is concomitantly enrolled in Medicare and has been determined to be eligible for full benefits under the Participating State's Medicaid program.

8. "Medicare-Medicaid Coordination Office" or "MMCO" means the Federal Coordinated Health Care Office.

9. "HIP AA" means the Health Insurance Portability and Accountability Act.

10. "Medicaid" means the Medicaid program established under Title XIX of the Social Security Act.

11. "Medicare" means the health insurance p1·ogram established under Title XVIII of the Social Security Act.

12. "PDE data" means Medicare Part D Prescription Drug Event data that are reported to CMS by Part D prescription drug plan sponsors and maintained by CMS.

13. "State Medicaid Agency" means the Medicaid Agency for the State of Washington.

14. "Treating provider" is a clinician who is currently responsible for care provision and/or care coordination for dual eligible beneficiaries.

II. RESPONSIBILITIES OF CMS AND STATE MEDICAID AGENCY

Under the terms of this Agreement, CMS will provide to the State Medicaid agency certain Medicare PDE data maintained by CMS. PDE data will only be shared for dual eligible beneficiaries who are eligible to receive full Medicaid benefits in the Participating State; PDE data for this population will be made available to the Participating State whether or not the prescription was filled in the Participating State. Financial data and internal plan and pharmacy prescription identification numbers will be excluded as indicated in MMCOCMCS Informational Bulletin of May 11, 2011.

CMS will provide to the State Medicaid Agency the tools necessary to develop, implement, and monitor care coordination programs to better align and improve the delivery of Medicare and Medicaid benefits for dual eligible beneficiaries. In accordance with the stipulations described throughout both this Agreement and the DUA, this data sharing Agreement will permit State Medicaid Agencies to use and disclose Medicare Part D data solely for CMS approved purposes.

Once CMS approves the State Medicaid Agency's PDE data requests, the State or its custodian should fill out the attached "Approved Uses and Downstream Users. (Please see Attachment 1). CMS will provide the State with access to Medicare Part D PDE data that may include a one-time file of historical data as well as subsequent PDE data updated on a monthly basis. The State Medicaid Agency or its custodian represents further that the facts and statements made in any data use proposal submitted to CMS using Attachment l are complete and accurate. Further, the State Medicaid Agency or its custodian represents that said data uses listed in Attachment 1, and as approved by CMS, represent the total use(s) to which the PDE data will be applied.

The PDE data disclosed under this lEA will be used by State Medicaid Agency employees and approved downstream users solely for the uses and purposes identified above. All downstream users that will receive, view or access these data must hold a valid and current state data use agreement with the State Medicaid Agency. The state

data use agreement must comply with all the terms and conditions of this IEA and the applicable CMS DUA. The State Medicaid Agency must obtain prior CMS approval in the form of an additional DUA Addendum before sharing these data with any additional downstream user. These data may not be used for any purposes that are not indicated in this agreement, such as research, fraud detection, or· payment (e.g., calculating risk adjustment factors).

In exchange for the data provided under this Agreement, every six months the State Medicaid Agency agrees to brief CMS on whether and how the data are being used and the results of its care coordination activities. Among these results will be findings on potential best practices for care coordination, quality improvement, and cost savings. In addition, the State Medicaid Agency will provide directly to CMS any written reports based on these results, which may be used or disseminated by CMS at its discretion. Upon request by CMS at any time, the State Medicaid Agency will also provide CMS with any additional updates as requested. Finally, if requested by CMS, and if the CMS use of the data complies with the Privacy Act and is otherwise permitted by law, the State Medicaid Agency will provide to CMS all linked Medicare/Medicaid data that have been made possible by this data sharing Agreement.

III. DESCRIPTION OF THE DATA TO BE DISCLOSED

Each Information Exchange Agreement for protected data must describe the records which will be matched and exchanged, including a sample of data elements that will be used, the approximate number of records that will be matched, and the projected starting and completion dates of the program.

A. Systems of Records

CMS data that will be released to the State Medicaid Agency are maintained in the following database: Medicare Integrated Data Repository (IDR), System No. 09-70-0571 was published at 71 Fed. Reg. 74915 (December 13, 2006). Data maintained in this system will be released pursuant to routine use number 2 as set forth in the system notice. (A copy of the system notice is given as Attachment 2).

B. Projected Starting and Completion Dates

The Agreement shall remain in effect for· a period not to exceed 5 years; however, within 3 months prior to the expiration of this Agreement, without additional review, CMS may renew this Agreement for not more than 5 additional years.

C. Number of Records Involved and Operational Time Factors

1. CMS PDE records in 2010 contained approximately 336 million individual Medicare PDE records for dual eligible beneficiaries. Medicare records disclosed to the Participating State under this agreement will include approved PDE data elements for approved timeframes for all dual eligible beneficiaries residing in the Participating State.

2. The total full benefit dual eligible beneficiary population of all States in 2010 includes approximately 7 million individua1s. Each Participating State's records file will contain records representing that State's approved PDE data elements for approved time frames for its full benefit dual eligible beneficiaries.

IV. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The State Medicaid Agency will only use the data disclosed under this agreement for the care coordination activities described herein, and will assure that any downstream users with whom it is approved to share these data limit their use to care coordination activities as approved by CMS. In the event these care coordination activities terminate, the State Medicaid Agency will be required to return to CMS or destroy the data files and any derivative data files.

V. PROCEDURES FOR SECURITY

A. CMS and the State Medicaid Agency agree to safeguard the Medicare PDE data as follows:

1. CMS and the State Medicaid Agency will comply with all Federal laws, guidance, and policies for all automated information systems security. For computerized records, safeguards have been established in accordance with the Privacy Act of 1974, as amended, the Computer Security Act of 1987, OMB Circular A-130, revised, Information Resource Management Circular No. 10, HHS Automated Information Systems Security Program, CMS's "IT Systems Security Policies, Standards, and Guidelines Handbook," and other CMS systems security policies. In accordance with the Privacy Act, each automated information system must ensure a level of security commensurate with the level of sensitivity of the data, risk, and magnitude of the harm that may result from the loss, misuse, disclosure, or modification of the information contained in the system.

2. CMS and the State Medicaid Agency will limit access to the data and any derivative files to authorized employees and officials who need them to perform their official duties in connection with the uses and disclosures authorized under this Agreement. Further, all personnel who will have access to the data and any derivative files will be advised of the confidential nature of the information, the safeguards required to protect the records, and the civil and criminal sanctions for non-compliance contained in applicable Federal laws.

3. The State Medicaid Agency will only disclose the data and any derivative files with downstream users after it receives explicit prior approval from CMS. If a disclosure is approved, State Medicaid Agency will place limitations on the downstream user's reuse or redisclosure of the data as a condition of the release of the data. Such limitations are to include a provision barring reuse or redisclosure absent CMS written prior approval.

4. The State Medicaid Agency agrees to limit approved data users to employees of the State Medicaid Agency or users who have a signed data use agreement with the State Medicaid Agency. If data provided under this Agreement are to be shared with a contractor or any other downstream users, the state data use agreement with those users must include all of the data security provisions within this Agreement, and the attachments or exhibits to this Agreement. If any contractor or any other downstream user cannot protect the data as articulated within this Agreement and the attachments or exhibits to this Agreement, then the CMS contact must be notified in writing, data-sharing with that user must be terminated immediately, and data must be destroyed or returned to the State Medicaid Agency. Access to the Medicare PDE data protected by this Agreement will be controlled by the State Medicaid Agency staff who will issue authentication credentials (e.g., a unique user ID and complex password) to authorized downstream users. Contractor or other downstream users will notify State Medicaid Agency staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the contractor or other downstream user, and whenever a user's duties change such that the user no longer requires access to perform work for this Agreement.

5. The records provided and any records created by the project will be stored in an area that is physically safe from access by unauthorized persons during duty hours as well as non-duty hours or when not in use.

6. The records provided, and any records created by the match, will be processed under the immediate supervision and control of authorized personnel, to protect the confidentiality of the records in such a way that unauthorized persons cannot retrieve any such records by means of computer, remote terminal, or other means.

7. The records provided and records created by the project will be transported under appropriate safeguards in compliance with Section 7 of the DUA. This includes encrypting any data that will be in transit outside the State Medicaid Agency's internal network, for example, during transit over the public Internet.

8. CMS may make onsite inspections, with or without advance notice, and may make other provisions to ensure that the State Medicaid Agency and any downstream users are maintaining adequate safeguards.

B. The Participating State agency shall report any breach, inappropriate use of data, or security incident of which it becomes aware to CMS within one hour. CMS will take actions in response to any data breach, inappropriate use of data, or security incident in accordance with CMS Breach Notification Procedures, as defined in Memorandum ISP~ 2007-007 entitled, "Departmental Response to the Office of Management and Budget (OMB) Memorandum (M) 07-16," Safeguarding Against and Responding to the Breach of Personally Identifiable Information, and the HIPAA Security Rule.

VI. RECORDS USAGE, DUPLICATION AND REDISCLOSURE RESTRICTIONS

The State Medicaid Agency agrees to the following limitations on the access to, and disclosure and use of, the electronic files and information provided by CMS:

A. That the files provided by CMS as part of this Agreement will remain the property of CMS and will be returned or destroyed as soon as the use, as stipulated by Section I.A of this Agreement, of the data by the State Medicaid Agency is completed.

B. That the data supplied by CMS will be used only as provided in this Agreement.

C. That the files provided by CMS will not be used to extract information concerning the individuals therein for any purpose not specified in this Agreement.

D. That the files provided by CMS will only be duplicated, disseminated, and accessed within the State Medicaid Agency or with CMS-approved downstream users per the conditions stipulated in this Agreement. The PDE data provided by CMS will only be disclosed outside the State Medicaid Agency if there is signed DUA with each downstream user, and CMS has approved the disclosure per Section II of this Agreement. Otherwise, CMS shall not give such permission unless the redisclosure is required by law.

E. That the files will not be used to investigate fraud and that the files will not be matched to any files that are used for purposes of fraud detection.

VII. REIMBURSEMENT AND REPORTING

No funds will be exchanged under this Information Exchange Agreement for any work to be performed by the Participating State to carry out the requirements of this lEA. CMS will provide data to the State Medicaid Agency at no cost.

VIII. APPROVAL AND DURATION OF AGREEMENT

A. This Agreement is effective upon approval by CMS and the State Medicaid Agency signatories and remains in effect indefinitely or until it is amended or superseded by a new Agreement. This Agreement may be amended at any time through a written modification that is signed by both parties.

B. Either party may unilaterally terminate this Agreement upon written notice to the other party, in which case the termination shall generally be effective 30 days after the date of the notice or at a later date specified in the notice, but in no instance shall such a termination be effective prior to the return or destruction of all data that were supplied to the State Medicaid Agency and to downstream entities in accordance with Section IV of this Agreement.

C. CMS may immediately and unilaterally terminate this Agreement if CMS determines that there have been unauthorized uses or redisclosures of the data by

the State Medicaid Agency or downstream users, a violation of the security requirements of the data, or a violation of, or a failure to follow, any of the terms of this Agreement. In such cases, termination shall be effective in 24 hours from the time and date of such determination; any and all data that were supplied to the State Medicaid Agency are to be destroyed or returned to CMS within 24 hours of the determination, per Section IV of this agreement, and; the State Medicaid Agency will be subject to any or all applicable penalties in accordance with applicable law.

D. CMS may make a unilateral suspension of this Agreement if it suspects that the State Medicaid Agency has breached the terms for privacy and security of data until such time as CMS makes a definite determination regarding a breach.

E. CMS may unilaterally terminate this Agreement if there is no evidence that the State Medicaid Agency has used the data for care coordination purposes within nine (9) months of receiving it.

IX. PERSONS TO CONTACT

A. The CMS program and policy contact:

Karyn Kai Anderson, Ph.D., M.P.H.
Federal Coordinated Health Care Office
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: S3-13-23
Baltimore, MD 21244-1850
(410) 786-6696
E-Mail: Karyn.Anderson@cms.hhs.gov

B. The CMS contact for Privacy issues:

Walter Stone
CMS Privacy Officer
Division of Privacy Compliance
Enterprise Architecture & Strategy Group
Office of Information Services
Mail-stop: Nl-24-08
7500 Security Boulevard
Baltimore Md. 21244-1850
Phone: (410) 786-5357
Fax: (410) 786-5636
Email: Walter.Stone@cms.gov

C. The contact person for the State Medicaid Agency can be found on the State's signature page.

D. The contact person for the Custodian can be found on the Custodian signature page.

X. APPROVALS

A. Centers for Medicare & Medicaid Services Program Official

The authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved by (Signature of Authorized CMS Program Official)

[Signature on File]
Sharon Donovan
Group Director
Program Alignment Group
Federal Coordinated Health Care Office
Centers for Medicare & Medicaid Services

B Centers for Medicare & Medicaid Services Approving Official

The authorized approving official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved by (Signature of Authorized CMS Approving Official)

[Signature on File]
Tony Trenkle
Chief Information Officer & Director
Office of Information Services
Centers for Medicare & Medicaid Services

C. Participating State Program Official

The authorized Participating State program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no ve1·bal agreements of any kind shall be binding or· recognized, and hereby commits their respective organization to the terms of this Agreement.

NAME OF PARTICIPATING STATE MEDICAID AGENCY

State of Washington

Health Care Authority

Approved By (Signature of Authorized State Approving Official)

[Signature on File]
Doug Porter
Director
Health Care Authority

PERSONS TO CONTACT

The Health Care Authority for Approval Issues:

Doug Porter
Director
Health Care Authority
Post Office Box 45502
626 8th Avenue, SE
Olympia, WA 98504-5502
Office: (360) 725-1863
Facsimile: (360) 586-9551
E-Mail: PORTEJD@hca.wa.gov

D. State Agency Custodian Official

The authorized State Agency Custodial official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

NAME OF PARTICIPATING STATE MEDICAID AGENCY

State of Washington

Health Care Authority

Approved By (Signature of Authorized State Custodian Official)

[Signature on File]
Cathie Ott
Deputy Chief Information Officer
Health Care Authority

PERSONS TO CONTACT

The Health Care Authority for Data Custodian issues contact:

Cathie Ott

Deputy Chief Information Officer
Health Care Authority
Post Office Box 45564
626 8th Avenue, SE
Olympia, WA 98504-5564
Office: (360) 725-2116
Facsimile: (360) 586-9551
E-Mail: OTTCL@hca.wa.gov

Attachments:

1) Approved Uses and Downstream Users
2) System Notice-- CMS No. 09-70-0571--Medicare Integrated Data Repository

Attachment 1 -Approved Uses and Downstream Users

Planned Use or Disclosure of PDE Data	**Purpose (i.e., how the Planned Use supports goals of care coordination)**	**Data User category**	**Name of Downstream User (if applicable)**	**Approved ? (for CMS use only)**
Development of predictive risk indicators – ie risk of future hospital admission, nursing home placement, future medical expenditures, etc.	Analysis of high opportunity conditions and individuals for targeting or specific care coordination/ support strategies	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted analysts	
Development of web-based clinical decision support tool, PRISM (Predictive Risk Intelligence System) integrating risk factors and available data for care coordinators and management of health care and related services	To enable care coordinators to easily view integrated patient data and effectively implement care coordination	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted care coordination organizations/ individuals	
Patient summaries provided by care coordinators to patients, families and treating health providers, such as medication lists; health risk summaries	To implement care coordination, care plans and treatment alternatives	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted care coordination organizations/individuals; Patients, Families, Treating health providers	
Program Administration – Model development and analysis including quality and performance incentive alternatives; sub-population profiles (utilization, costs, outcomes, access); development of performance measures, clinical guidelines, performance feedback reports; program monitoring and evaluation including client and provider surveys	For care coordination program and model development, implementation, analysis, monitoring and feedback Analysis and monitoring through profiling of utilization, costs, outcomes and access of the dual population for care coordination program development and modeling of program, qualify and performance incentive alternatives	State Medicaid Agency staff and other downstream users	CMS; Other state agencies; Sub-contracted analysts	

Attachment 2 - System Notice

CMS No. 09-70-0571--Medicare Integrated Data Repository

SYSTEM NO. 09-70-0571

SYSTEM NAME:

"Medicare Integrated Data Repository (IDR), HHS/CMS/OIS"

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive Data

SYSTEM LOCATION:

The Centers for Medicare & Medicaid Services (CMS) Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244-1850.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

This system maintains information on individuals age 65 or over who have been, or currently are, entitled to health insurance (Medicare) benefits under Title XVIII of the Social Security Act (the Act) or under provisions of the Railroad Retirement Act; individuals under age 65 who have been, or currently are, entitled to such benefits on the basis of having been entitled for not less than 24 months to disability benefits under Title II of the Act or under the Railroad Retirement Act; individuals who have been, or currently are, entitled to such benefits because they have End-Stage Renal Disease (ESRD); individuals age 64 and 8 months or over who are likely to become entitled to health insurance (Medicare) benefits upon attaining age 65, and individuals under age 65 who have at least 21 months of disability benefits who are likely to become entitled to Medicare upon the 25th month or entitlement to such benefits and those populations that are dually eligible for both Medicare and Medicaid (Title XIX of the Act). Additionally, this system will maintain information on Medicare beneficiaries Parts A, B, C, and D and physicians, providers, employer plans, Medicaid recipients and Medicare secondary payers.

CATEGORIES OF RECORDS IN THE SYSTEM:

Information maintained in the system include, but are not limited to: standard data for identification such as health insurance claim number, social security number, gender, race/ethnicity, date of birth, geographic location, Medicare enrollment and entitlement information, MSP data necessary for appropriate

Medicare claim payment, hospice election, MA plan elections and enrollment, End Stage Renal Disease (ESRD) entitlement, historic and current listing of residences, and Medicare eligibility and Managed Care institutional status. Additionally, this system will maintain identifying information on physicians, providers, employer plans, Medicaid recipients and Medicare secondary payers.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Authority for the collection of data maintained in this system is given under §§ 226, 226A, 1811, 1818, 1818A, 1831, 1833(a) (1) (A), 1836, 1837, 1838, 1843, 1866, 1874a, 1875, 1876, 1881, and 1902(a) (6) of the Social Security Act (the Act). The following are the corresponding sections from Title 42 of the United States Code (U.S.C.): 426,426-1, 1395c, 1395i-2, 1395i-2a, 1395j, 1395l(a)(1)(A), 1395o, 1395p, 1395q, 1395v, 1395cc, 1395kk-l, 13951l, 1395mm, 1395n·, 1396a(a)(6), and§ 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of2003 (MMA) (Public Law 108M 113), which established the Medicare Part D program.

PURPOSE(S) OF THE SYSTEM:

The primary purpose of this system is to establish an enterprise resource that will provide one integrated view of all CMS data to administer the Medicare and Medicaid programs. Information retrieved from this system of records will also be disclosed to: (1) support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, consultant or CMS grantee; (2) assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) support providers and suppliers of services for administration of Title XVIII; (4) assist third parties where the · contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (5) assist Medicare Advantage Plans and Part D Prescription Drug Plans; (6) support Quality Improvement Organizations (QIO); (7) assist other insurers for processing individual insurance claims; (8) facilitate research on the quality and effectiveness of care provided, as well as payment related projects; (9) support litigation involving the agency; and (10) combat fraud, waste, and abuse in certain health benefits programs.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OR USERS AND THE PURPOSES OF SUCH USES:

The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a "routine use." The proposed routine uses in this system meet the compatibility requirement of the Privacy Act. We are proposing to

establish the following routine use disclosures of information maintained in the system:

1. To support agency contractors, consultants or grantees who have been engaged by the agency to assist in the performance of a service related to this system and who need to have access to the records in order to perform the activity.

2. To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent to:

    a. contribute to the accuracy of CMS' proper payment of Medicare benefits,

    b. enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, and/or

    c. assist Federal/state Medicaid programs within the state.

3. To support providers and suppliers of services directly or through fiscal intermediaries or carriers for the administration of Title XVIII of the Act.

4. To assist third party contact in situations where the party to be contacted has, or is expected to have information relating to the individual's capacity to manage his or her affairs or to his or her eligibility for, or an entitlement to, benefits under the Medicare program and;

    a. the individual is unable to provide the information being sought (an individual is considered to be unable to provide certain types of information when any of the following conditions exists: the individual is confined, to a mental institution, a court of competent jurisdiction has appointed a guardian to manage the affairs of that individual, a court of competent jurisdiction has declared the individual to be mentally incompetent, or the individual's attending physician has certified that the individual is not sufficiently mentally competent to manage his or her own affairs or to provide the information being sought, the individual cannot read or write, cannot afford the cost of obtaining the information, a language barrier exist, or the custodian of the information will not, as a matter of policy, provide it to the individual), or

    b. the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns one or more of the following: the individual's entitlement to benefits under the Medicare program, the amount of reimbursement, and in cases in which the evidence is being reviewed as a result of suspected fraud,

waste, and abuse, program integrity, quality appraisal, or evaluation and measurement of activities.

5. To assist Medicare Advantage Plans, Part D Prescription Drug Plans and their Prescription Drug Event submitters, providing protection against medical expenses of their enrollees without the beneficiary's authorization, and having knowledge of the occurrence of any event affecting (a) an individual's right to any such benefit or payment, or (b) the initial right to any such benefit or payment, for the purpose of coordination of benefits with the Medicare program and implementation of the Medicare Secondary Payer provision at 42 U.S.C. 1395y (b).

   Information to be disclosed shall be limited to Medicare entitlement, enrollment and utilization data necessary to perform that specific function. In order to receive the information, they must agree to:

   a. certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a Third Party Administrator;

   b. utilize the information solely for the purpose of processing the individual's enrollment or insurance claim; and

   c. safeguard the confidentiality of the data and prevent unauthorized access.

6. To support Quality Improvement Organizations (QIO) in connection with review of claims, or in connection with studies or other review activities conducted pursuant to Part B of Title XI of the Act, and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans. As established by the Part D Program, QIOs will conduct reviews of prescription drug events data, or in connection with studies or other review activities conducted pursuant to Part D of Title XVIII of the Act.

7. To assist other insurers, underwriters, third party administrators (TPAs), self-insurers, group health plans, employers, health maintenance organizations, health and welfare benefit funds, Federal agencies, a state or local government or political subdivision of either (when the organization has assumed the role of an insurer, underwriter, or third party administrator, or in the case of a state that assumes the liabilities of an insolvent insurers pool or fund), multiple employers trusts, no-fault medical, automobile insurers, workers' compensation carriers plans, liability insurers, and other groups providing protection against medical expenses who are primary payers to Medicare in accordance with 42

U.S.C. 1395y(b), or any entity having knowledge of the occurrence of any event affecting;

a. an individual's right to any such benefit or payment, or

b. the initial or continued right to any such benefit or payment.(for example, a State Medicaid Agency, State Workers' Compensation Board, or Department of Motor Vehicles) for the pu1pose of coordination of benefits with the Medicare program and implementation of the MSP provisions at 42 U.S.C. 1395 y(b). The information CMS may disclose will be:

- Beneficiary Name
- Beneficiary Address
- Beneficiary Health Insurance Claim Number
- Beneficiary Social Security Number
- Beneficiary Gender
- Beneficiary Date of Birth
- Amount of Medicare Conditional Payment
- Provider Name and Number
- Physician Name and Number
- Supplier Name and Number
- Dates of Service
- Nature of Service
- Diagnosis

To administer the MSP provision at 42 U.S.C. 1395 y (b) (2), (3), and (4) more effectively, CMS would receive (to the extent that it is available) and may disclose the following types of information from insurers, underwriters, third party administrator, self-insurers, etc.:

- Subscriber Name and Address
- Subscriber Date of Birth
- Subscriber Social Security number
- Dependent Name
- Dependent Date of Birth
- Dependent Social Security Number
- Dependent Relationship to Subscriber
- Insurer/Underwriter/TPA Name and Address
- Insurer/Underwriter/TPA Group Number
- Insurer/Underwriter/Group Name
- Prescription Drug Coverage
- Policy Number

- Effective Date of Coverage
- Employer Name, Employer Identification Number (EIN) and Address
- Employment Status
- Amounts of Payment

To administer the MSP provision at 42 U.S.C. 1395y(b) (1) more effectively for entities such as Workers' Compensation carriers or boards, liability insurers, no-fault and automobile medical policies or plans, CMS would receive (to the extent that it is available) and may disclose the following information:

- Beneficiary's Name and Address
- Beneficiary's Date of Birth
- Beneficiary's Social Security number
- Name of insured
- Insurer Name and Address
- Type of coverage; automobile medical, no-fault, liability payment, or workers' compensation settlement
- Insured's Policy Number
- Effective Date of Coverage
- Date of accident, injury or illness
- Amount of payment under liability, no-fault, or· automobile medical policies, plans, and workers' compensation settlements
- Employer Name and Address (Workers' Compensation Only)
- Name of insured could be the driver of the car, a business, the beneficiary (i.e., the name of the individual or entity which carries the insurance policy or plan).

In order to receive this information the entity must agree to the following conditions; to utilize the information solely for the purpose of coordination of benefits with the Medicare program and other third party payer in accordance with Title 42 U .S.C. *1395* y (b); to safeguard the confidentiality of the data and to prevent unauthorized access to it; and, to prohibit the use of beneficiary-specific data for the purposes other than for the coordination of benefits among third party payers and the Medicare program. This agreement would allow the entities to use the information to determine cases where they or other third party payers have primary responsibility for payment. Examples of prohibited uses would include but are not limited to; creation of a mailing list, sale or transfer of data.

To administer the MSP provisions more effectively, CMS may receive or disclose the following types of information from or to entities

including insurers, underwriters, TPAs, and self-insured plans, concerning potentially affected individuals:

- Subscriber HICN
- Dependent Name
- Funding arrangements of employer group health plans, for example, contributory or non-contributory plan, self-insured, re-insured, HMO, TPA insurance
- Claims payment information, for example, the amount paid, the date of payment, the name of the insurers or payer
- Dates of employment including termination date, if appropriate
- Number of full and/or part-time employees in the current and preceding calendar years
- Employment status of subscriber, for example, full or part time or self-employed

8. To assist an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.

9. To support the Department of Justice (DOJ), court or adjudicatory body when: the agency or any component thereof, or any employee of the agency in his or her official capacity, or any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or the United States Government, is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

10. To support a CMS contractor (including, but not necessarily limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, dete1o, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such program.

11. To support another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in

part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such programs.

E. Additional Provisions Affecting Routine Use Disclosures

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation "Standards for Privacy of Individually Identifiable Health Information" (45 CFR Parts 160 and 164, Subparts A and E) *65* Fed. Reg. 82462 (12-28-00), as modified at 67 Fed. Reg. 53,182 (8-14-2002). Disclosures of such PHI that are otherwise authorized by these routine uses may only be made if, and as, permitted or required by the "Standards for Privacy of Individually Identifiable Health Information."

In addition, our policy will be to prohibit release even of data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual `can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that, because of the small size, use this information to deduce the identity of the beneficiary).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

All records are stored electronically.

RETRIEVABILITY:

All Medicare records are accessible by HICN, SSN, and unique provider identification number.

SAFEGUARDS:

CMS has safeguards in place for authorized users and monitors such users to ensure against unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information

security and data privacy. These laws and regulations may apply but are not limited to: the Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A-130, Management of Federal Resources, Appendix III, and Security of Federal Automated Information Resources also apply. Federal, HHS, and CMS policies and standards include but are not limited to: all pertinent National Institute of Standards and Technology publications; the HHS Information Systems Program Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

Records are maintained for a period of 6 years and 3 months. All claims-related records are encompassed by the document preservation order and will be retained until notification is received from DOJ.

SYSTEM MANAGER AND ADDRESS:

Director, Division of Business Analysis & Analysis, Enterprise Databases Group, Office of Information Services, CMS, Room Nl-14-08, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the system manager who will require the system name, HICN, address, date of birth, and gender, and for verification purposes, the subject individual's name (woman's maiden name, if applicable), and SSN. Furnishing the SSN is voluntary, but it may make searching for a record easier and prevent delay.

RECORD ACCESS PROCEDURE:

For purpose of access, use the same procedures outlined in Notification Procedures above. Requestors should also specify the record contents being sought. (These procedures are in accordance with department regu1ation 45 CFR 5b.5 (a) (2)).

CONTESTING RECORDS PROCEDURES:

The subject individual should contact the system manager named above, and reasonably identify the records and specify the information to be contested. State the corrective action sought and the reasons for the correction with supporting justification. (These Procedures are in accordance with Department regulation 45 CFR 5b.7).

RECORDS SOURCE CATEGORIES:

The data collected and maintained in this system are retrieved from the following databases: Medicare Drug Data Processing System, System No. 09-70-0553 (70 *Federal Register* (Fed. Reg.) 58436 (October 6, 2005)); Medicare Beneficiary Database, System No. 09-70-0536 (71 Fed. Reg. 11425 (March 7, 2006)); Medicare Advantage Prescription Drug System, System No. 09-70-4001 (70 Fed. Reg. 60530 (October 18, 2005)); Medicaid Statistical Information System, System No. 09-70-0541 (71 Fed. Reg. ·65527 (November 8, 2006)); Retiree Drug Subsidy Program, System No. 09-70-0550 (70 Fed. Reg. 41035 (July 15, 2005)); Common Working File, System No. 09-70-0526 (71 Fed. Reg. 64955 (November 6, 2006)); National Claims History, System No. 09-70-0005 (67 Fed. Reg. 57015 (September 6, 2002)); Enrollment Database, System No. 09-70-0502 (67 Fed. Reg. 3203 (January 23, 2002)}; Multi-Carrier Claims System (formerly known as the Carrier Medicare Claims Record), System No. 09-70- 0501 (71 Fed. Reg. 64968 (November 6, 2006)); Fiscal Intermediary Shared System (formerly known as the Intermediary Medicare Claims Record), System No. 09-70-0503 (71 Fed. Reg. 64961 (November 6, 2006)); Unique Physician/Provider Identification Number, System No. 09-70-0525, (69 Fed. Reg. 75316 (December 16, 2004)); Medicare Supplier Identification File, System No. 09-70-0530 (71 Fed. Reg. 65527 (November 8, 2006). Information will also be provided from the application submitted by the individual through state Medicaid agencies, the Social Security Administration and through other entities assisting beneficiaries.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

SCHEDULE 4

MEDICARE PART D

CONFLICT OF INTEREST ATTESTATION

SCHEDULE 4: MEDICARE PART D – CONFLICT OF INTEREST ATTESTATION

[Date]

Beverly Court
Department of Social and Health Services
Research and Data Analysis Division
1114 Washington Street SE
PO Box 45204
Olympia, WA 98504-5204

Dear Beverly Court,

As a contractor of Washington's Medicaid agency, [Lead Entity Name] intends to receive Centers for Medicare & Medicaid Services (CMS) data from Washington State for coordination of care, quality improvement and/or treatment of persons enrolled in both Medicare and Medicaid. We will also be subcontracting with entities who will also access CMS data for care coordination, quality improvement and/or treatment purposes.

We understand that CMS wants assurance that potential conflict of interest related to also operating or affiliation with Part D plans is mitigated when necessary through separation and security of CMS data used for clinical treatment, case management and care coordination, and quality improvement activities.

The contact person for conflict of interest matters within our organization is [Contact's First and Last Name] who can be reached by email at [email address] or by phone at [phone number].

The following organizations are covered in this attestation that no conflict of interest exists:

[Name of Contractor/Subcontractor with no conflict of interest]
[Name of Subcontractor with no conflict of interest]

The following organizations are covered in this attestation that conflict of interest potentially does exist, and steps to mitigate said conflict of interest, including separation and security of any CMS data acquired through its work with Washington State to isolate CMS data from unrelated activities in their organization, have been taken:

[Name of Contractor/Subcontractor with potential conflict of interest]
[Name of Subcontractor with potential conflict of interest]

Sincerely,
[Signature of person who can legally bind your Organization to the statements above, such as legal staff or organization officer]
[Title]

SCHEDULE 5

PRISM ACCESS REQUEST FORM

PRISM Access Request for Multiple Organizations

An Organization may request access to PRISM for its employees or employees of Subcontractors (**Users)** under its Data Share Agreement (DSA) with HCA. The Organization **PRISM Lead** reviews and completes the "Requesting Organization" section. The PRISM Access Request form must be signed by the **PRISM Lead** authorizing the request, which attests to the **Users**' business need for electronic Protected Health Information, and in the case of a Subcontractor User, attests that the contract with the Subcontractor includes a HIPAA Business Associate Agreement and Medicare data share language, as appropriate. The **User** completes the "User Registration Information" section below and signs the "User Agreement and Non-Disclosure of Confidential Information" page. The **PRISM Lead** then forwards the request to: PRISM.Admin@dshs.wa.gov.

Upon review and acceptance, DSHS and HCA will grant the appropriate access permissions to the User and notify the **PRISM Lead**.

Changes to Access for Users

The **PRISM Lead** must notify the **PRISM Administrator** within five (5) business days whenever a **User** with access rights leaves employment or has a change of duties such that the User no longer requires access. If the removal of access is emergent, please include that information with the request.

Requesting Organizations (to be completed by PRISM Lead)	
CONTRACTOR'S NAME	STREET ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)
1.	
2.	
3.	

User Registration Information (to be completed by User)		
USER'S NAME (FIRST, MIDDLE, LAST)		USER'S JOB TITLE
USER'S BUSINESS EMAIL ADDRESS		USER'S BUSINESS PHONE NUMBER (INCLUDE AREA CODE)
USER'S EMPLOYER		DATE IT SECURITY TRAINING COMPLETED (REQUIRED YEARLY)
If user will be completing Health Action Plans (HAPs), enter the date training was completed:	DATE HAP TRAINING COMPLETED	DATE HIPAA TRAINING COMPLETED (REQUIRED)
PRISM USER'S SIGNATURE DATE		PRISM USER'S PRINTED NAME

Authorizing Signature(s)

Protected Data Access Authorization

The HIPAA Security rule states that every employee that needs access to electronic Protected Health Information (ePHI) receives authorization from an appropriate authority and that the need for this access based on job function or responsibility is documented. I, the undersigned **PRISM Lead**, verify that the individual for whom this access is being requested (User or Subcontractor User) has a business need to access this data, has completed the required HIPAA Privacy training and the annual IT Security training and has signed the required *User Agreement and Non-Disclosure of Confidential Information* included with this Access Request. This User's access to this electronic Protected Health Information (ePHI) is appropriate under the HIPAA Information Access Management Standard and the Privacy Rule. In addition, if applicable, this employee has been instructed on 42 Code of Federal Regulations (CFR) Part 2 that governs the use of alcohol and drug use information and is aware that this type of data must be used only in accordance with these regulations. I have also ensured that the necessary steps have been taken to validate the User's identity before approving access to confidential and protected information. If a Subcontractor is indicated, I attest that the contract with the Subcontractor includes a HIPAA Business Associate Agreement, and where appropriate Medicare data share language.

PRISM LEAD SIGNATURE (CONTRACTOR 1)	DATE	PRISM LEAD NAME 1 (PRINT)
PRISM LEAD SIGNATURE (CONTRACTOR 2)	DATE	PRISM LEAD NAME 2 (PRINT)
PRISM LEAD SIGNATURE (CONTRACTOR 3)	DATE	PRISM LEAD NAME 3 (PRINT)

User Agreement and Non-Disclosure of Confidential Information

Your Organization has entered into a Data Share Agreement (DSA) with the state of Washington Health Care Authority (HCA) that will allow you to access data and records that are deemed Confidential Information as defined below. Prior to accessing this Confidential Information you must sign this **User Agreement and Non-Disclosure of Confidential Information** form.

Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Protected Health Information and Personal Information.

"Protected Health Information" means information that relates to: the provision of health care to an individual; the past, present, or future physical or mental health or condition of an individual; or the past, present or future payment for provision of health care to an individual and includes demographic information that identifies the individual or can be used to identify the individual.

"Personal Information" means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, credit card numbers, any other identifying numbers, and any financial identifiers.

Regulatory Requirements and Penalties

State laws (including, but not limited to, RCW 74.04.060, RCW 74.34.095, RCW 70.02.020 and RC2.70.02.230) and federal regulations (including, but not limited to, HIPAA Privacy and Security Rules, 45 CFR Part 160 and Part 164; Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2; and Safeguarding Information on Applicants and Beneficiaries, 42 CFR Part 431, Subpart F) prohibit unauthorized access, use, or disclosure of Confidential Information. Violation of these laws may result in criminal or civil penalties or fines.

User Agreement and Assurance of Confidentiality

In consideration for DSHS and HCA granting me access to PRISM or other systems and the Confidential Information in those systems, I agree that I:

1) Will access, use, and disclose Confidential Information only in accordance with the terms of this Agreement and consistent with applicable statutes, regulations, and policies.
2) Have an authorized business requirement to access and use DSHS or HCA systems and view DSHS or HCA Confidential Information.
3) Will not use or disclose any Confidential Information gained by reason of this Agreement for any commercial, personal, or research purpose, or any other purpose that is not directly connected with client care coordination and quality improvement.
4) Will not use my access to look up or view information about family members, friends, the relatives or friends of other employees, or any persons who are not directly related to my assigned job duties.
5) Will not discuss Confidential Information in public spaces in a manner in which unauthorized individuals could overhear and will not discuss Confidential Information with unauthorized individuals, including spouses, domestic partners, family members, or friends.
6) Will protect all Confidential Information against unauthorized use, access, disclosure, or loss by employing reasonable security measures, including physically securing any computers, documents, or other media containing Confidential Information and viewing Confidential Information only on secure workstations in non-public areas.
7) Will not make copies of Confidential Information, or print system screens unless necessary to perform my assigned job duties and will not transfer any Confidential Information to a portable electronic device or medium, or remove Confidential Information on a portable device or medium from facility premises, unless the information is encrypted and I have obtained prior permission from my supervisor.
8) Will access, use or disclose only the "minimum necessary" Confidential Information required to perform my assigned job duties.
9) Will protect my DSHS and HCA systems User ID and password and not share them with anyone or allow others to use any DSHS or HCA system logged in as me.
10) Will not distribute, transfer, or otherwise share any DSHS software with anyone.
11) Will forward any requests that I may receive to disclose Confidential Information to my supervisor for resolution and will immediately inform my supervisor of any actual or potential security breaches involving Confidential Information, or of any access to or use of Confidential Information by unauthorized users.
12) Understand at any time, DSHS or HCA may audit, investigate, monitor, access, and disclose information about my use of the systems and that my intentional or unintentional violation of the terms of this Agreement may result in revocation of privileges to access the systems, disciplinary actions against me, or possible civil or criminal penalties or fines.
13) Understand that my assurance of confidentiality and these requirements will continue and do not cease at the time I terminate my relationship with my employer.

User's Signature

PRISM USER'S SIGNATURE	DATE	PRISM USER'S PRINTED NAME

Exhibit F

Federal Award Identification for Subrecipients

January through July 2021

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);	North Sound Behavioral Health Administrative Service Organization
(ii) Subrecipient's unique entity identifier; (DUNS)	958386666
(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;	1/1/2021 – 12/31//2021
(vi) Amount of Federal Funds Obligated by this action;	$3,289,438
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	$3,289,438
(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);	North Sound Behavioral Health Administrative Service Organization
(ii) Subrecipient's unique entity identifier; (DUNS)	958386666
(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;	1/1/2021 – 12/31/2021
(vi) Amount of Federal Funds Obligated by this action;	$1,426,032
(vii) Total Amount of Federal Funds Obligated to the subrecipient;	$1,426,032
(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 G
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.