



RSN AGREEMENT

DSHS Agreement Number:
0969-75011

09-11 PIHP Agreement

This Agreement is by and between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below, and is issued pursuant to the Interlocal Cooperation Act, chapter 39.34 RCW.

Program Contract Number:
Contractor Contract Number:

CONTRACTOR NAME North Sound Regional Support Network		CONTRACTOR doing business as (DBA)	
CONTRACTOR ADDRESS 117 North First Street, Suite 8 Mount Vernon WA 98273-2858		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) 601-291-840	DSHS INDEX NUMBER 1553
CONTRACTOR CONTACT Charles Benjamin	CONTRACTOR TELEPHONE (360) 664-5746 Ext:	CONTRACTOR FAX (360) 416-7017	CONTRACTOR E-MAIL ADDRESS charles_benjamin@nsmha.org
DSHS ADMINISTRATION Health and Recovery Services Administration	DSHS DIVISION Mental Health Division	DSHS CONTRACT CODE 4104LS-69	
DSHS CONTACT NAME AND TITLE Melena Thompson Program Administrator		DSHS CONTACT ADDRESS PO Box 45330 Olympia, WA 98504-5330	
DSHS CONTACT TELEPHONE (360) 725-1073 Ext:	DSHS CONTACT FAX (360) 753-7315	DSHS CONTACT E-MAIL ADDRESS melena.thompson@dshs.wa.gov	
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? Yes		CFDA NUMBER(S) 93.778	
AGREEMENT START DATE 10/1/2009	AGREEMENT END DATE 9/30/2011	MAXIMUM AGREEMENT AMOUNT Fee For Service	
EXHIBITS. The following Exhibits are attached and are incorporated into this Agreement by reference: <input checked="" type="checkbox"/> Exhibits (specify): Exhibit A - Access to Care Standards; Exhibit B - Tribal Planning Checklist; Exhibit C - Data Security Requirements; Exhibit D - Funding Exhibit; Exhibit E - Core Performance Target Measures; Exhibit D-1 WMIP Rates <input type="checkbox"/> No Exhibits.			
<p>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. The parties signing below represent that they have read and understand this Contract, and have the authority to execute this Contract. This Contract shall be binding on DSHS only upon signature by DSHS.</p>			
CONTRACTOR SIGNATURE		PRINTED NAME AND TITLE Greg C. Long, Deputy Director	DATE SIGNED
DSHS SIGNATURE		PRINTED NAME AND TITLE Michael Rice, Senior Contracts Manager HRSA, Division of Legal Services	DATE SIGNED

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PURPOSE OF AGREEMENT

Operate a Prepaid Inpatient Health Plan (PIHP) to provide medically necessary mental health services to Enrollees. Provide or purchase age, linguistic and culturally competent community mental health services for Enrollees for whom services are medically necessary and clinically appropriate pursuant to:

- (1) CFR 42 CFR 438, or any successors and Federal 1915 (b) Mental Health Waiver, Medicaid State plan or any successors.
- (2) Other provisions of Title XIX of the Social Security Act, or any successors.
- (3) RCW 70.02, 71.05, 71.24, and 71.34, or any successors.
- (4) WAC 388-865 or any successors.

This Agreement is in effect from October 1, 2009 through September 30, 2011. In the event Contractor decides not to enter into any subsequent Agreement, the Contractor shall treat the situation as a Termination of RSN Function and comply with the Termination of RSN Function Notice Requirements section of the Agreement.

1. DEFINITIONS

1.1. **Action** in the context of PIHP services means

- 1.1.1. the denial or limited authorization of a requested service, including the type or level of service.
- 1.1.2. the reduction, suspension, or termination of a previously authorized service.
- 1.1.3. the denial, in whole or in part, of payment for a service.
- 1.1.4. the failure to provide services in a timely manner, as defined by the state.
- 1.1.5. the failure of a PIHP to act within the timeframes provided in section 42 CFR 408(b).

1.2. **Administrative Cost** means costs for the administration of this Agreement for the general operation of the public mental health system. These activities cannot be identified with a specific direct services or direct services support function as defined in the BARS supplemental instructions.

1.3. **Annual Revenue** means all revenue received by the Contractor pursuant to the Agreement for July of any year through June of the next year.

1.4. **Appeal** means a request for review of an action as "action" is defined above.

1.5. **Capitation Payment** means a payment the Department of Social and Health Services (DSHS) makes monthly to a PIHP on behalf of each recipient enrolled under a Contract for the provision of mental health services under the State Medicaid Plan. The Health and Recovery Service Administration (HRSA) makes the payment regardless of whether the particular recipient receives the services during the period covered by the payment.

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

Term Inpatient Programs.

- 1.7. **Community Mental Health Agency (“CMHA”)** means a Community Mental Health Agency that is licensed by the State of Washington to provide mental health services and Subcontracted to provide services covered under this Agreement.
- 1.8. **Consumer** means a person who has applied for, is eligible for or who has received mental health services. For a child under the age of thirteen (13), or for a child age thirteen (13) or older whose parents or legal representatives are involved in the treatment plan, the definition of consumer includes parents or legal representatives.
- 1.9. **Child Study and Treatment Center (“CSTC”)** means the Department of Social and Health Services, Health and Recovery Service Administration (HRSA) child psychiatric hospital.
- 1.10. **Cultural Competence** means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.
- 1.11. **Day** for purposes of this Agreement means calendar days unless otherwise indicated in the Agreement.
- 1.12. **Deliverable** means items that are required for submission to HRSA to satisfy the work requirements of this Agreement and that are due by a particular date or on a regularly occurring schedule.
- 1.13. **Denial** - the decision by a PIHP, or their formal designee, not to authorize a covered Medicaid mental health services that have been requested by a provider on behalf of an eligible Medicaid Enrollee.
 - 1.13.1. It is also a denial if an intake is not provided upon request by a Medicaid Enrollee.
- 1.14. **Early Periodic Screening Diagnosis and Treatment (“EPSDT”)** means the Early Periodic Screening Diagnosis and Treatment program under Title XIX of the Social Security Act as amended for children who have not reached their 21st birthday.
- 1.15. **Emergent Care** means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.
- 1.16. **Emerging Best Practice or Promising Practice** means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.
- 1.17. **Enrollee** means a Medicaid recipient who is enrolled in a Pre-paid Inpatient Health Plan.
- 1.18. **Evidence Based Practice** means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.
- 1.19. **Fair Hearing** means a hearing before the Washington State Office of Administrative Hearings.

- 1.20. **Family** means:
- 1.20.1. For adult consumers, family means those the consumer defines as family or those appointed/assigned (e.g., guardians, siblings, caregivers, and significant others) to the consumer.
 - 1.20.2. For children, family means a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by the department of social and health services, or a tribe.
- 1.21. **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights (42 CFR 438.400(b)).
- 1.22. **Health and Recovery Services Administration (HRSA)** means the Health and Recovery Services Administration of the Washington State Department of Social and Health Services. DSHS has designated HRSA as the state mental health authority to administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.
- 1.23. **Large Rural Area** means areas with a population density of less than 20 people per square miles.
- 1.24. **Medicaid Funds** means funds provided by CMS Authority under Title XIX of the Social Security Act.
- 1.25. **Medical Necessity or Medically Necessary** means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

- 1.26. **Mental Health Care Provider ("MHCP")** means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field or A.A. level with two (2) years experience in the mental health or related fields.
- 1.27. **Mental Health Professional** means:
- 1.27.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW.
 - 1.27.2. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or

emotional disturbance, such experience gained under the supervision of a mental health professional.

- 1.27.3. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.
- 1.27.4. A person who had an approved waiver to perform the duties of a mental health professional that was requested by the regional support network and granted by DSHS prior to July 1, 2001; or
- 1.27.5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by HRSA consistent with WAC 388-865-0265.
- 1.28. **Publish** means an officially sanctioned document provided by HRSA on HRSA internet or intranet websites for downloading, reading, or printing. The Contractor shall be notified in writing or by e-mail when a document meets this criteria.
- 1.29. **Quality Assurance** means a focus on compliance to minimum requirements (e.g. rules, regulations, and Contract terms) as well as reasonably expected levels of performance, quality, and practice.
- 1.30. **Quality Improvement** means a focus on activities to improve performance above minimum standards/reasonably expected levels of performance, quality, and practice.
- 1.31. **Quality Strategy** means an overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations.
- 1.32. **ProviderOne** means the Department's Medicaid Management Information Payment Processing System.
- 1.33. **Recovery** means the process in which people are able to live, work, learn, and participate fully in their communities.
- 1.34. **Reduction** means the decision by a PIHP to decrease a previously authorized covered Medicaid mental health service described in the Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to decrease or change a covered service in the Individualized Service Plan is not a reduction.
- 1.35. **Regional Support Network ("RSN")** means a county authority or group of county authorities or other entity recognized by the secretary to administer mental health services in a defined region.
- 1.36. **Resilience** means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.
- 1.37. **Routine Services** means services that are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward mental health. These services do not meet the definition of urgent or emergent care.
- 1.38. **Rural Area** means areas with a population density of at least 20 and less than 500 people per square mile.
- 1.39. **Service Area** means the geographic area covered by this Agreement for which the Contractor is responsible.

- 1.40. **Suspension** means the decision by a PIHP, or their formal designee, to temporarily stop previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to temporarily stop or change a covered service in the Individualized Service Plan is not a suspension.
- 1.41. **Termination** means the decision by a PIHP, or their formal designee, to stop previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to stop or change a covered service in the Individualized Service Plan is not a termination.
- 1.42. **Urban Area** means areas that have a population density of at least 500 people per square mile.
- 1.43. **Urgent Care** means a service to be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary

2. ADMINISTRATION

2.1. Advisory Board and Governing Body Membership –

- 2.1.1. The Contractor must maintain an Advisory Board that is broadly representative of the demographic character of the region which shall include, but not be limited to, representatives of consumers and families, and law enforcement. Composition and length of terms of board members may differ between regional support networks. Membership shall be comprised of at least 51% consumers or consumer family members as defined in WAC 388-865-0222. Composition of the Advisory Board and the length of terms must be submitted to HRSA upon request.
- 2.1.2. Establish a Governing Body responsible for oversight of the Regional Support Network. The Governing Body can be an existing executive or legislative body within a county government. Each member of the Governing Body must be free from conflicts of interest and from any appearance of conflicts of interest between personal, professional and fiduciary interests. Members of the Governing Body must act within the best interests of the RSN and the Consumers. The Contractor must maintain membership roster(s) and by-laws of the Governing Body demonstrating compliance. The Governing Body by-laws must include:
 - 2.1.2.1. Actions to be taken when a conflict of interest, or the appearance of a conflict of interest, becomes evident.
 - 2.1.2.2. Requirements that members refrain from voting or joining a discussion when a conflict of interest is present.
 - 2.1.2.3. A process for the Governing Body to assign the matter to others, such as staff or advisory bodies to avoid a conflict of interest.

3. INCIDENT REPORTING:

- 3.1. The Contractor is required to report on incidents involving persons with mental illnesses and having an open case with the RSN. An open case is defined as an individual that is currently receiving crisis services or outpatient mental health services from an RSN or RSN contracted provider.
- 3.2. Initial notification and any follow up must be provided to HRSA using HRSA electronic incident

reporting system. If the electronic incident reporting system is unavailable, a standardized form shall be provided with instructions on how to submit.

- 3.3. The Contractor must notify HRSA Incident Manager within one (1) working day of becoming aware of events involving a person who has an open case (currently receiving services) and is the alleged victim or perpetrator of any of the following events:
 - 3.3.1. An allegation of rape (Chapter 9A.44 RCW) or sexual assault (as defined in RCW 70.125.030)
 - 3.3.2. Any violent act as defined in RCW 71.05.020 and RCW 9.94A.030 or any homicide or attempted homicide as defined in RCW 9A.32.010 that results in an arrest with charges or pending charges.
 - 3.3.3. Any injury to a RSN or Subcontracted staff member as the result of an assault by a client that requires any level of medical intervention.
 - 3.3.4. Any allegation of financial exploitation as defined in RCW 74.34.020
 - 3.3.5. Any suicide or a death under an unusual circumstance.
 - 3.3.6. An assault by a RSN or Subcontracted staff member involving a client with an open case.
- 3.4. The Contractor must notify HRSA Incident Manager within one (1) working day of any incident that was referred to the Medicaid Fraud Control Unit by the RSN or its Subcontractor.
- 3.5. In addition to all incidents described above, the Contractor is required to utilize professional judgment and report incidents that fall outside the scope of this section.
- 3.6. The RSN or Subcontractor shall notify the following agencies or any others when required by law:
 - 3.6.1. Adult Protective Services
 - 3.6.2. Child Protective Services
 - 3.6.3. Department of Health
 - 3.6.4. Local Law Enforcement
 - 3.6.5. Medicaid Fraud Control Unit
 - 3.6.6. Washington State Patrol
- 3.7. The Contractor must maintain policies and procedures regarding mandatory incident reporting and referrals consistent with all applicable state and federal laws. The policy must address the Contractor's oversight and review of these incidents. These policies and procedures shall be provided upon request to HRSA for review and approval.
- 3.8. HRSA may require the RSN to provide additional information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

4. ENROLLMENT

- 4.1. Service Area: The Contractor is responsible for services within the boundaries of Island, San Juan, Skagit, Snohomish and Whatcom Counties.
- 4.2. Enrollees of all ages who reside within the Contractor's service area who are enrolled in any of the programs included in the Federal 1915 (b) Mental Health Waiver are covered by this Agreement.

5. INFORMATION REQUIREMENTS

- 5.1. Enrollee Information: The Contractor must provide information to Enrollees that complies with the requirements of 42 CFR §438.100, §438.6(i)(3), and WAC 388-865-0410.
 - 5.1.1. The Contractor shall maintain written policy and procedures addressing all information requirements, and shall:
 - 5.1.1.1. Use the Mental Health Benefits Booklet published by HRSA as the mechanism by which Enrollees are notified of their benefits, rights, and responsibilities.
 - 5.1.1.2. Inform every Enrollee at the time of an intake evaluation that the Mental Health Benefits Booklet published by HRSA shall be provided upon request. The booklet can be downloaded from: <http://www1.dshs.wa.gov/Mentalhealth/benefits.shtml>.
 - 5.1.1.3. Provide to HRSA the information necessary to update the Mental Health Benefits Booklet within 14 days of any changes that are made to any Contractor or Subcontractor content contained in the booklet.
 - 5.1.1.4. Provide interpreter services for Enrollees who speak a primary language other than English for all interactions between the Enrollee and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a Grievance or Appeal.
 - 5.1.1.5. Provide written translations of generally available materials including, at minimum, applications for services, consent forms, Mental Health Benefits Booklet, Notice of Action and Notice of Determination in each of the DSHS prevalent languages that are spoken by five percent (5%) or more of the population of the State of Washington based on the most recent US census. HRSA has determined based on this criteria that Spanish is the currently required language.
 - 5.1.1.5.1. The DSHS Prevalent languages are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese. The Mental Health Benefits booklet, including client rights and Notice of Action has been provided to the Contractor by HRSA. The expectation is that these translated documents are readily available at all times from the Contractor and its contracted CMHAs.
 - 5.1.1.5.2. Materials may be provided in English if the Enrollee's primary language is other than English but the Enrollee can understand English and is willing to receive the materials in English. The Enrollee's consent to receiving information and materials in English must be documented in the client record.
 - 5.1.1.5.3. For Enrollees whose primary language is not translated, the requirement may be met by providing the information through audio or video recording in the Enrollee's primary language, having an interpreter read the materials in the

Enrollee's primary language or providing materials in an alternative format that is acceptable to the Enrollee. If one of these methods is used it must be documented in the client record.

- 5.1.1.6. Ensure that Mental Health Professionals and MHCPs have an effective mechanism to communicate with Enrollees with sensory impairments.
- 5.1.1.7. Post a multilingual notice in each of the DSHS prevalent languages, which advises consumers that information is available in other languages and how to access this information.
- 5.1.1.8. The Contractor shall post a translated copy of the consumer rights as listed in the Mental Health Benefits Booklet in each of the DSHS prevalent languages

5.2. Customer Service

- 5.2.1. The Contractor shall provide customer service that is customer-friendly, flexible, proactive, and responsive to consumers, families, and stakeholders. The Contractor shall provide a toll free number for customer service inquiries. A local telephone number may also be provided for Enrollees within the local calling area.
- 5.2.2. At a minimum, Customer Service staff shall:
 - 5.2.2.1. Promptly answer telephone calls from consumers, family members and stakeholders from 8 a.m. until 5:00 p.m. Monday through Friday, holidays excluded.
 - 5.2.2.2. Respond to consumers, family members and stakeholders in a manner that resolves their inquiry. Staff must have the capacity to respond to those with limited English proficiency or hearing loss.
- 5.2.3. Customer service staff must be trained to distinguish between a benefit inquiry, third party insurance issue, Appeal or Grievance and how to route these to the appropriate party. At a minimum, logs shall be kept to track the date of the initial call, type of call and date of attempted resolution. This log shall be provided to HRSA for review upon request.

6. PAYMENT

- 6.1. Contractor shall use all funds provided pursuant to this Agreement including interest earned to support the public mental health system.
- 6.2. Rates:

The Contractor shall be reimbursed based upon the rates contained in Exhibit D.

6.2.1. **For North Sound ONLY Washington Medicaid Integration Partnership –**

The Contractor acknowledges and agrees that the Department, in its sole discretion, and in accordance with legislative authority, shall operate the WMIP in Snohomish County. The Contractor also acknowledges and agrees that WMIP shall include both inpatient and outpatient mental health services. Except for detention services pursuant to 71.05 RCW and crisis hot line, the Contractor is not obligated to furnish services to WMIP Enrollees.

The Contractor shall not receive capitation payments for WMIP Enrollees except for the crisis hotline component. The rates to be applied as a reduction are included in Exhibit D-1.

6.2.2. For Clark RSN, King RSN, Peninsula RSN and Spokane RSN ONLY

The Local Match Rates are contained in Exhibit D. HRSA will notify the Contractor of the number of Medicaid eligibles in these categories each month. The Contract shall multiply the Qualifying Local Funds rates by the eligibles in each category and submit this amount in Qualifying Local Funds. Qualifying Local Funds received by HRSA by the 20th day of any month will be paid on the 1st business day of the following month.

HRSA will pay the Contractor the capitation rate for each category multiplied by the number of eligibles in each category for each month of the Contract period.

HRSA shall not make payment in the amounts specified if it would result in total payments exceeding the Medicaid rate approved by CMS.

Sources of revenue eligible to be used as Qualifying Local Funds are broad based taxes at the county or other local taxing authority level that are spent and have been certified by the local authority as public funds for mental health services allowable under this Agreement. Qualifying Local Funds under this Agreement may not be used as match for any other federal program. Qualifying Local Funds may be local funds that have not been previously matched with federal funds at any point. Qualifying Local Funds do not include donations.

6.3. Rate Setting Methodology

HRSA sets actuarially-sound managed care rates that:

- 6.3.1. Have been developed in accord with generally accepted actuarial principles and practices;
- 6.3.2. Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- 6.3.3. Have been certified, as meeting the requirements of 42 CFR 438.6(c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

- 6.4. Funds for July 1, 2011 through September 30, 2011 – Following the end of the annual legislative session, HRSA shall offer an Amendment with the proposed funds for the next Fiscal Year. If for any reason the Contractor does not agree to continue to provide services using the proposed funds, the Contractor must provide the appropriate notice to DSHS under the requirements of the Termination Section of the Agreement.

- 6.4.1. The Contractor shall work with HRSA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services to RSN Consumers. The transition plan shall address all issues leading to the transition of the RSN function to DSHS such as the use of Reserves, claims reconciliation, and of all items and/or requirements of the Contract that extend beyond the termination of services.

- 6.5. Capitation Payment – During the term of this Agreement, capitation payments are made at the beginning of each month of service. The Contractor shall be responsible to provide all mental health services through the end of the month for which it has received a capitation payment.

6.5.1. Capitation payments are calculated based on Medicaid Enrollee count. The information is compiled to fit HRSA's categories of eligibles, which are shown in the Rates section of the Contract. Enrollees are assigned to the Community Services Office (CSO) at the time of eligibility. In cases where the services are provided by a statewide CSO, and also in cases of TANF reinstatement Enrollees are distributed by the zip code.

6.5.2. Capitation Payments are entered into the accounting payment system on the first working day of the month. Two (2) types of capitation payments are made, the Initial Estimate and the six (6)-month Reconciliation.

6.5.3. Initial Estimate:

Estimated Gross Medicaid Payment: The initial estimate payment uses Medicaid Enrollee data from two months prior to the first day of a particular month and applies the corresponding rate to calculate a gross Medicaid payment estimate for that month.

6.6. 6-Month Reconciliation:

The six (6)-Month Reconciliation payment is an adjustment for Medicaid Enrollees for a particular month of service. After six (6) months, Medicaid Enrollee counts are final. HRSA pays for any increase in Medicaid Enrollees or collects for any decrease in Medicaid Enrollees. Reconciliation ends six (6) months after the last month of the Contract term.

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

6.6.2. HRSA shall withhold 50 percent (50%) of the final payment under this Contract until all final reports and data are received and accepted by DSHS, and until all pending corrective actions, penalties, or unpaid assessments are satisfied.

6.6.3. ProviderOne

6.6.3.1. Capitation payments made under ProviderOne system will be based on eligibles assigned to a RSN by client zip code.

6.6.3.2. The initial capitation payment will be calculated using eligibles from the current month. There will be weekly enrolment and payment updates for eligibility changes. The eligibility reconciliations will occur continuously for six (6) months.

6.7. If the Contractor terminates this Agreement or will not be entering into any subsequent Agreements, HRSA shall require that all remaining reserves and fund balances be spent within a reasonable timeframe developed with HRSA. Funds shall be deducted from the monthly payments until all reserves and fund balances are spent. The Contractor must give notice at least 90 days prior to the end of the contract if a decision is made not to enter into a subsequent agreement. Any funds not spent for the provision of services under this Contract shall be returned to HRSA with 60 days of the last day this Agreement is in effect.

6.8. The Contractor is required to limit Administration costs to no more than ten percent (10 % of the annual revenue supporting the public mental health system operated by the Contractor). Administration costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by HRSA.

- 6.9. The Contractor shall reimburse the subcontracted CMHA network and any crisis service provider accessed by Enrollees while the Enrollee is in or out of the State within 60 calendar days from the date the bill is received from the service provider.
- 6.10. If Federal Financial Participation (FFP) is recouped from the Contractor, the Contractor must reimburse the amount recouped to HRSA within 30 days of notification by HRSA.
- 6.11. If the Contractor chooses to use the MMIS system for inpatient claims processing, HRSA or its designee shall provide a bill to the Contractor on a monthly basis for claims paid on behalf of the Contractor. The Contractor has 30 days from the receipt of the inpatient claims bill to pay the costs assessed.
- 6.12. The Contractor must maintain a risk and inpatient reserve of the Contractor's annual Medicaid premium payment at 10.2% for FY 2010, and 10.2% for FY 2011. If the Contractor spends a portion of the reserve, the funds must be replenished within (1) one year, or at the end of the fiscal year in which the funds were spent, whichever is longer. These reserve funds are designated into a reserve account by official action of the RSN's Governing Body. These reserve funds may only be used for in the event costs of providing service exceed the revenue the RSN receives and for anticipated psychiatric inpatient costs.
- 6.13. The Contractor may have an additional Operating Reserves not to exceed 5.0% of the PIHP annual Medicaid premium payments. The Operating Reserves are funds that are set aside into an account by official action of the RSN/PIHP governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.
- 6.14. Financial Reporting and Certification: Financial Reports are due within 45 days of the quarter end (September, December, March, and June of each year). The first report is due 45 days after the end of December 2009. HRSA reserves the right to require more frequent submission of the Revenue and Expenditure report. The following reports and certifications, in formats provided by HRSA, must be submitted on a quarterly basis:
 - 6.14.1. The PIHP Revenue, Expenditure, Reserves and Fund Balance report in compliance with the BARS Supplemental for Mental Health Services promulgated by the Washington State Auditor's Office and the Revenue and Expenditure Report Instructions published by HRSA.
 - 6.14.2. The amounts paid to Federally Qualified Health Centers for services.
 - 6.14.3. Any revenue collected by Subcontractors for services provided under this Agreement. This includes revenue collected from Medicare, insurance companies, co-payments, and other sources. The Contractor must certify that a process is in place to demonstrate that all third party revenue resources for services provided under this Agreement are identified, pursued, and recorded by the Subcontractor, in accordance with Medicaid being the payer of last resort.
 - 6.14.4. In addition, the Contractor shall submit a single financial certification form, provided by HRSA, indicating that administrative costs, as defined in the Revenue and Expenditure Report Instructions for Mental Health Services, incurred by the Contractor are no more than 10 percent (10%) of the annual revenue supporting the public mental health system operated by the Contractor. Administrative costs shall be measured on a fiscal year basis and based on the information reported in the Revenue and Expenditure reports and reviewed by HRSA.

- 6.14.5. If the Contractor is unable to provide valid certifications or if HRSA finds discrepancies in the Revenue and Expenditure Report, HRSA may initiate remedial action. Remedial action may include recoupment from funds disbursed during the current or successive Agreement period. Recoupment shall occur within 90 days of the close of the State fiscal year or within 90 days of HRSA's receipt of the certification, whichever is later.
- 6.14.6. HRSA reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data. HRSA agrees to involve the RSN in the decision process prior to implementing changes in format, and shall request the RSN to review and comment on format changes before they go into effect whenever possible.

7. CARE MANAGEMENT

- 7.1. Care Management – Care Management is a set of clinical management oversight functions that shall be performed by the Contractor. Care Management functions shall be not delegated to a network CMHA. These activities must be performed by a Mental Health Professional.
- 7.2. Access Standards: A request may be made through a telephone call, walk-in, or written request from an Enrollee or those defined as Family in this Agreement or in the receipt of a written EPSDT referral.
- 7.3. The Contractor must verify eligibility for Title XIX prior to the provision of non-crisis services to an Enrollee.
- 7.4. The Contractor must maintain documentation of all requests for service even if no service actually occurs.
- 7.5. The Contractor shall not refer a Healthy Options Enrollee to the Enrollee's Healthy Options managed care plan for mental health services if the Enrollee is determined to be eligible based on medical necessity and the Access to Care Standards.
- 7.6. Appointment Standards: The Contractor shall comply with appointment standards that are consistent with the following:
 - 7.6.1. The Contractor shall make available crisis mental health services on a 24-hour, 7 days per week basis and may be accessed without full completion of intake evaluations and/or other screening and assessment processes.
 - 7.6.1.1. Emergent mental health care must occur with two (2) hours of a request for mental health services from any source.
 - 7.6.1.2. Urgent care must occur with 24 hours of a request for mental health services from any source.
 - 7.6.2. A routine intake evaluation appointment must be available and offered to every Enrollee within ten (10) business days of the request unless both of the following conditions are met:
 - 7.6.2.1. An intake evaluation has been provided in the previous twelve (12) months that establishes medical necessity and
 - 7.6.2.2. The PIHP agrees to use the previous intake evaluation as the basis for authorization decisions.

7.6.3. The time period from request from mental health services to first Routine services appointment offered must not exceed 28 calendar days.

7.6.3.1. The Contractor must document the reason for any delays. This includes documentation when the consumer declines an intake appointment within the first ten (10) working days following a request or declines an Routine appointment offered within the 28 day timeframe.

7.6.4. The Contractor must monitor the frequency of Routine appointments that occur after 28 days for patterns and apply corrective action where needed.

7.7. Authorization General Requirements:

7.7.1. Level of Care Guidelines: The Contractor must establish policies for authorization that include the Access to Care Standards and written Level of Care Guidelines. The Contractor's Level of Care Guidelines must be provided to HRSA upon request. HRSA reserves the right to request changes to the Contractor's Level of Care guidelines.

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

7.7.2.1. Criteria for authorization of Routine and Inpatient care at a community hospital.

7.7.2.2. The Access to Care Standards for initial authorizations.

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

7.7.2.4. Requires any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be determined by a professional who meets or exceeds the requirements of a Mental Health Professional and has appropriate clinical expertise to make that decision. A decision to deny inpatient care can only be made by a psychiatrist, doctor level-clinical psychologist.

7.7.3. The Contractor or its formal designee shall provide a written Notice of Determination or Notice of Action (in accordance with 42 CFR§438.404), to the Enrollee or their legal representative within 14 days of the authorization decision. Formulating the Notice of Determination or Notice of Action cannot be delegated to a subcontracted network CMHA, however, the CMHA may deliver the notification.

7.7.4. If the Enrollee is in the legal custody of the State of Washington such as in state foster care of group home placement, the Contractor or formal designee must provide a copy of any Notice of Action or Notice of Determination to HRSA when either an intake is denied or services beyond the intake have not been authorized. This must be mailed at the same time it is provided to the Enrollee. In these cases the legal representative which must receive the notices is the Children's Administration Regional Office. Foster children are designated by a "D" on their Medicaid ID. There may be an additional indicator of "D", "F", or "R" designating the type of placement.

7.8. Authorization for Routine Services

- 7.8.1. The Contractor shall make a determination of eligibility for an initial authorization of Routine services based on Medical Necessity and the Access to Care Standards following the initiation of the intake evaluation.
- 7.8.2. A decision by the PIHP or formal designee whether to authorize initial Routine services must occur within 14 days of the date the intake evaluation was initiated, unless the Enrollee or the CMHA requests an extension from the PIHP.
 - 7.8.2.1. Authorization and provision of Routine Services may begin before the completion of the intake evaluation once medical necessity has been established.
- 7.8.3. An extension of up to 14 additional calendar days to make the authorization decision is possible upon request by the Enrollee or the CMHA or the Contractor justifies (to HRSA upon request) a need for additional information and how the extension is in the Enrollee's interest.
 - 7.8.3.1. The Contractor must have a written policy and procedure to ensure consistent application of extensions within the service area.
 - 7.8.3.2. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary.
- 7.8.4. The Contractor must designate at least one (1) Children's Care Manager that is a Children's Mental Health Specialist or is supervised by a Children's Mental Health Specialist who oversees the authorizations of Enrollees under 21.
- 7.8.5. The Contractor or formal designee must review requests for additional services to determine a re-authorization following the exhaustion of previously authorized services by the Enrollee. This must include:
 - 7.8.5.1. An evaluation of the effectiveness of services provided during the benefit period and recommendations for changes in methods or intensity of services being provided.
 - 7.8.5.2. A method for determining if an Enrollee has met discharge criteria.

7.9. Authorization for Inpatient Services

- 7.9.1. The Contractor must have appropriate clinical staff members available 24 hours a day, 7 days a week to respond to requests for certification of psychiatric inpatient care in community hospitals. A decision regarding certification of psychiatric inpatient care must be made within twelve (12) hours of the initial request.
- 7.9.2. Only a psychiatrist, doctor level-clinical psychologist may deny a request for psychiatric inpatient care.
 - 7.9.2.1. If the authorization is denied, a Notice of Action must be provided to the Enrollee or their legal representative.
- 7.9.3. The Contractor shall adhere to the requirements set forth in the *Community Psychiatric Inpatient Instructions and Requirements* available on HRSA Intranet or upon request.

- 7.9.4. If the Contractor denies payment of any portion of a psychiatric inpatient stay for consumer and the inpatient facility has a dispute, the Contractor shall follow the dispute process provided in the Community Inpatient Instructions.
- 7.9.5. The Contractor shall ensure that authorized community psychiatric inpatient services are continued through an Enrollee's discharge should a community hospital become insolvent, including any requirement for transfer.

7.10. Utilization Management Plan

- 7.10.1. The Utilization Plan may not be structured in such a way as to provide incentives to individuals or entities to deny, limit or discontinue medically necessary services.
- 7.10.2. The Contractor shall have a medical director (consultant or staff) who is qualified to provide guidance, leadership, oversight, utilization and quality assurance for the mental health programs. These following activities may be carried out in conjunction with the administrative staff or other clinical staff, but are the responsibility of the medical director to oversee:

7.10.2.1. Utilization reviews with the following components:

- Services requested in comparison to services identified as medically necessary.
- A review of which goals identified in the Individual Service Plan have been met, have been discontinued or have continued need.
- Patterns of denials.
- Response to Appeals and access to expedited Appeals.
- Use of Evidence-Based and other identified practice guidelines.
- Use of discharge planning guidelines.
- Community standards governing activities such as coordination of care among treating professionals.
- Coordination with Tribal and Recognized American Indian Organizations (RAIO) and other consumer serving agencies.

- 7.10.3. The ability to demonstrate upon request the process used to monitor the following including any monitoring outcomes and corrective actions:

- Consistent application of Medical Necessity criteria and Level of Care Guidelines including the use of Access to Care Standards for initial authorizations.
- Consistent application of review criteria for authorization decisions for continuing stay and discharge.
- Consultation with providers, when appropriate.
- That benefits are provided in accordance with the Contractor's Level of Care Guidelines

and are not arbitrarily denied or reduced (e.g. the amount, duration, or scope of a required service) based solely upon the diagnosis, type of mental illness, or the Enrollee's mental health condition.

- Over and under-utilization of services.

7.11. Practice Guidelines

7.11.1. Practice Guidelines are systematically developed statements designed to assist in decisions about appropriate mental health treatment. The guidelines are intended to assist practitioners in the prevention, diagnosis, treatment, and management of clinical conditions.

7.11.2. The Contractor shall adopt and implement a minimum of two (2) Practice Guidelines. The Practice Guidelines must:

- 7.11.2.1. Be based on valid and reliable clinical evidence or a generally accepted practice among the mental health professionals in the community.
- 7.11.2.2. Consider the needs of the Enrollees.
- 7.11.2.3. Be adopted in consultation with mental health professionals in the contracted network of CMHAs, when applicable.
- 7.11.2.4. Be disseminated to all affected providers and, upon request, to Enrollees.
- 7.11.2.5. Be chosen with regard to utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply.

7.12. Network Capacity – The Contractor shall maintain sufficient capacity, including the number, mix, and geographic distribution of Community Mental Health Agencies (CMHA), and Mental Health Care Providers (MHCPs) to meet the needs of the anticipated number of Enrollees in the service area.

7.12.1. At a minimum the Contractor shall:

- 7.12.1.1. Provide an intake evaluation by a MHP within ten (10) working days of an Enrollee request.
- 7.12.1.2. Provide or purchase age, linguistic and culturally competent community mental health services for Enrollees for whom services are medically necessary and clinically appropriate consistent with the Medicaid state plan and the Federal 1915 (b) Mental health Waiver.
- 7.12.1.3. Maintain the ability to adjust the number, mix, and geographic distribution of MHCPs to meet Access and Distance Standards as the population or Enrollees needing mental health services shift within the service area.
- 7.12.1.4. Maintain the ability to adjust reimbursement amounts for different specialties or for different practitioners in the same specialty to meet Access and Distance Standards as the needs of the Enrollees shift within the service area.

7.12.2. The Contractor shall require that contracted network CMHAs provide upon the Enrollee's request:

- 7.12.2.1. Identification of individual MHCPs who are not accepting new Enrollees.
- 7.12.2.2. CMHA licensure, certification and accreditation status.
- 7.12.2.3. Information that includes but is not limited to, education, licensure, registration, and Board certification and/or-certification of Mental Health Professionals and MHCPs.

7.13. Distance Standards

- 7.13.1. The Contractor shall ensure that when Enrollees must travel to service sites, the sites are accessible as follows:
 - 7.13.1.1. In Rural Areas, a 30-minute drive from the primary residence of the Enrollee to the service site.
 - 7.13.1.2. In Large Rural Geographic Areas, a 90-minute drive from the primary residence of the Enrollee to the service site.
 - 7.13.1.3. In Urban Areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed 90-minutes each way.
 - 7.13.1.4. Travel standards do not apply: a) when the Enrollee chooses to use service sites that require travel beyond the travel standards; b) to mental health clubhouses when the population is insufficient to support additional clubhouses within the geographic area c) to psychiatric inpatient services including E&T; d) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

7.14. Choice of MHCP

- 7.14.1. The Contractor shall offer each Enrollee a choice of participating MHCPs in accordance with WAC 388-865-0345. If the Enrollee does not make a choice, the Contractor ors designee must assign a MHCP no later than 14 working days following the request for mental health services. The Enrollee may change MHCPs during the first 90 days of enrollment and once during a twelve-month period for any reason. Any additional change of a MHCP requested by an Enrollee during a 12 month period may be approved at the Contractor's discretion, provided that justification for the change is documented.
- 7.14.2. For continuity of care the Contractor shall encourage the Subcontractor(s) to assign Enrollees to clinicians who are anticipated to provide services to the Enrollee throughout the authorization period.

- 7.15. Co-Occurring Disorder Screening and Assessment: The Contractor must maintain the implementation of the integrated, comprehensive screening and assessment process for chemical dependency and mental disorders as required by RCW 70.96C. Failure to maintain the Screening and Assessment process shall result in remedial actions up to and including financial penalties as described in Section 15, Remedial Actions, of this Agreement.

7.15.1. The Contractor must attempt to screen all individuals aged thirteen (13) and above through the use of HRSA provided Global Appraisal of Individual Needs – Short Screener (GAIN-SS) during:

- All new intakes.
- The provision of each crisis episode of care including ITA investigations services, except when:
 - The service results in a referral for an intake assessment.
 - The service results in an involuntary detention under RCW 71.05, 71.34 or 70.96B.
 - The contact is by telephone only.
 - The professional conducting the crisis intervention or ITA investigation has information that the individual completed a GAIN-SS screening within the previous 12 months.

7.15.2. The GAIN-SS screening must be completed as self report by the individual and signed by that individual on HRSA-GAIN-SS form. If the individual refuses to complete the GAIN-SS screening or if the clinician determines the individual is unable to complete the screening for any reason this must be documented on HRSA-GAIN-SS form.

7.15.3. The results of the GAIN-SS screening, including refusals and unable-to-completes, must be reported to HRSA through the CIS system.

7.15.4. The Contractor must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by HRSA and outlined in the SAMHSA Treatment Protocol 42, to determine a quadrant placement for the individual when the individual scores a two (2) or higher on either of the first two scales (ID Screen & ED Screen) and a two (2) or higher on the third (SD Screen).

7.15.4.1. The assessment is required during the next outpatient treatment planning review following the screening and as part of the initial evaluation at free-standing, non-hospital, evaluation and treatment facilities. The assessment is not required during crisis interventions or ITA investigations.

The quadrant placements are defined as:

- Less severe mental health disorder/less severe substance disorder.
- More severe mental health disorder/less severe substance disorder.
- Less severe mental health disorder/more severe substance disorder.
- More severe mental health disorder/more severe substance disorder.

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

8. QUALITY MANAGEMENT

8.1. The Contractor shall participate with HRSA in the implementation, update and evaluation of the Quality Strategy located on HRSA internet website.

- 8.2. The Contractor shall conduct an **annual review** of the CMHA's within the contracted network. All collected data including PIHP monitoring results, external quality review findings, agency audits, sub-contract monitoring activities, consumer Grievances and services verification shall be incorporated into this review. This review must be included in the PIHP's ongoing quality management program.
- 8.2.1. This review may be combined with a formal review of services performed pursuant to the State Mental Health Agreement between the Contractor and HRSA.
- 8.2.2. The annual review must at least address the following:
- 8.2.2.1. Timely access that meets the Access Standards of this Agreement.
 - 8.2.2.2. Consistent coordination efforts with primary medical care.
 - 8.2.2.3. Efforts to pursue and report third party revenue.
 - 8.2.2.4. Quality Improvement activities including Performance Improvement Projects.
 - 8.2.2.5. The Implementation of Practice Guidelines and the provider implementation of Practice Guidelines.
 - 8.2.2.6. The implementation of the GAIN-SS and the co-occurring assessment for quadrant placement of individuals.
 - 8.2.2.7. Efforts to create the expectation and support the delivery of mental health services that are driven by and incorporate the voice of the Enrollee and those they identify as family.
 - 8.2.2.8. The degree to which mental health services delivered are age, culturally and linguistically competent.
 - 8.2.2.9. Monitoring activities performed are in place to make sure that attempts are made to provide mental health services in the least restrictive environment.
 - 8.2.2.10. A review of services that are being provided that promote recovery and resiliency.
 - 8.2.2.11. Local efforts to provide services that are integrated and coordinated with other formal/informal service delivery systems.
- 8.2.3. The Contractor shall provide quality improvement feedback to CMHAs, the Advisory Board, and other interested parties. The Contractor shall maintain documentation of the activities and provide the documentation to HRSA upon request.
- 8.2.4. The Contractor shall invite Enrollees and Enrollees' families that are representative of the community being served, including all age groups, to participate in planning activities and in the implementation and evaluation of the public mental health system. The Contractor must be able to demonstrate how this requirement is implemented.
- 8.2.5. Performance Improvement Projects - The Contractor must identify where improvement is needed and continue or implement at least two (2) Performance Improvement Projects (PIP), at all times during the Agreement period. This must include at least one clinical and one non-clinical project. The PIPs can be a mix of PIPs identified by HRSA for statewide improvement and projects identified by the RSN for local improvements. The Contractor

shall evaluate the PIPs for increased or sustained improvement over time.

8.2.6. The Contractor shall participate with HRSA in review activities. Participation shall include at a minimum:

8.2.6.1. The submission of requested materials necessary for a HRSA initiated review within 30 days of the request.

8.2.6.2. The completion of site visit protocols provided by HRSA.

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

8.2.7. The Contractor may establish measures designed to maintain quality of services, controls costs and is consistent with its responsibilities to Enrollees.

8.3. Performance Measures

8.3.1. Performance assessment, measurement, and monitoring are part of the overall QA/PI program of the Contractor. The overall goal is to incorporate quality assessment and performance improvement within the Mental Health Services Quality Strategy framework. To support this Quality Strategy and state and federal mandates, the Division plans to develop a series of performance measures over time.

Overall, there are two (2) sets of performance improvement measurements included in the Agreement: Core Performance Measures and Regional Performance Measures. The Core Performance Measures are established statewide and required of all Regional Support Network Contractors. For core performance indicators, the Division will calculate the baseline, define the measurement, establish the annual improvement target, and provide the quarterly and annual reports to the Contractor.

The Regional Performance Measures are to be developed, calculated, tracked and reported by the Contractor. The Contractor shall be responsible to collect and manage the data necessary to support the Regional Performance Measurement activities, including establishing the baseline, determining demonstrable improvement target, tracking change in performance over time, and reporting the annual findings to the Division.

The aim of the regional performance measurement is to allow the Contractor to develop a quantitative, regional understanding of the healthcare and service delivery system, to establish meaningful and relevant measures unique to its population and geographic service area, to maximize the collection of data at the local level, and to foster innovation and partnership between the Contractor and network providers.

8.3.1.1. Core Performance Measures – Specific to this Agreement period, the Division has established the Core Performance Measures and improvement targets using the following methodology.

8.3.1.1.1. Baseline and Targets: The Division shall calculate the baseline performance and establish the minimum standard and performance target for each performance measure and determine the annual improvement target for the Contractor.

- a) Contractor Baseline – A minimum of twelve (12) months of historical experience will be used to calculate the baseline performance for each RSN. The data for the baseline calculation will include at least a three (3)-month lag to ensure complete data reporting. The Division will use the baseline data to establish reasonable Minimum Standard and achievable Performance Target for each performance measure and the Annual Improvement Target for the Contractor.
- b) Minimum Standard – A minimum performance standard is the minimally expected level of performance specific to the measure. The Contractor shall be accountable for achieving the Minimum Standard by the end of the first twelve (12) months of this Agreement.
- c) Performance Target – An optimal level of performance is set for each measure. It is expected that the Contractor should continuously show improvement and strive to meet the Performance Target if the Minimum Standard has been met at the end of the first twelve (12) months. If the contractor has met or exceeded the Performance Target, the Contractor shall maintain the current level of performance, but not fall below the Performance Target.
- d) Contractor Annual Improvement Target - The Annual Improvement Target, as expressed in a percentage, is calculated to guide the Contractor to meet the Minimum Standard or to reach the Performance Target incrementally after having met the Minimum Standard. For Contractor's performance that has met the Minimum Standard, the annual improvement target will be calculated based on 20 percent (20%) incremental increase between the baseline or prior year experience and the performance target. The Contractor is expected to achieve the Contractor Annual Improvement Target by the end of each year of this Agreement.
- e) Annual Improvement Target – The Contractor Annual Improvement Target is calculated by adding the Contractor Annual Improvement Target to the Contractor's current performance. The Contractor is expected to achieve the Contractor Annual Target Goal at the end of each year of this Agreement.

8.3.1.2. Performance Measure Monitoring: The Division will calculate the Core Performance Measures and share with the Contractor on a quarterly basis. Measures will be calculated with a minimum of three (3) months lag after the end of each monitoring quarter to ensure complete data reporting.

8.3.1.3. Annual Performance Evaluation: The Division will calculate each Performance Measure annually. The annual calculation will include at least a three (3) month lag for service encounter reporting. Upon review of the annual performance results, the Division may request the Contractor to provide a explanation for Performance Measures that do not meet the annual Performance Targets. If an explanation is not received or determined to be inadequate, the Contractor shall be required to submit a corrective action plan to the Division. The corrective action plan shall be received by the Division within thirty (30) days after notification to Contractor.

8.3.1.4. Public Dissemination: The Contractor shall make the results of the core performance measure available to the public.

8.3.1.5. Core Performance Measures: (Please refer to Exhibit E for the improvement targets of the Core Performance Measures for the Contractor):

- a) A routine outpatient service must be offered to a Medicaid client within seven (7) days of discharge from a psychiatric inpatient hospital or Evaluation and Treatment (E&T) facility. This will be calculated as a percentage of discharges from community psychiatric inpatient hospitals and E&Ts with a routine outpatient service within seven (7) days, divided by the total number of discharges from community psychiatric inpatient hospitals and E&Ts.
- b) Time from a request for service to a routine service offered shall be within 28 days. This will be calculated as a percentage of Medicaid clients who received a routine service within 28 days of the service request, divided by the total number of Medicaid clients who requested, authorized and received routine services.
- c) Time from a service request to an intake service shall be within 14 days. This will be calculated as a percentage of Medicaid clients who received an intake service within 14 days of the service request, divided by the total number of Medicaid clients who requested services and received intake services.
- d) Consumer Periodics shall be submitted to the Division per requirements defined in Section 11, management Information System. A timeliness of submission measure will be calculated as a percentage of the number of Consumer Periodics that are successfully submitted within 60 days, divided by the total number of Consumer Periodics submitted in the reporting period.
- e) Outpatient encounters shall be submitted to the Division within 60 days of the close of the month in which the services were provided (i.e., service month). This will be calculated as a percentage of the number of outpatient encounters successfully submitted within 60 days after the services month, divided by the total number of outpatient encounters in the reporting period.

8.3.1.6. Regional Performance Measures: A minimum of three (3) Regional Performance Measures shall be developed, calculated, tracked, and reported by the Contractor.

The Regional Performance Measures chosen by the Contractor cannot be the same as the Core Performance Measures and/or currently calculated statewide and optional indicators from the Performance Improvement Project (PIP) by the Contractor. A Regional Performance Measure may not be deleted or modified, once the baseline and target have been established by the Contractor.

8.3.1.6.1. All Regional Performance Measures shall be chosen based on local relevance, clinical consensus, and research evidence and with input from the local Mental Health Advisory Board. The Contractor is encouraged to develop the Regional Performance Measures that reflect the following areas:

- Access and Availability
- Care Coordination and Continuity
- Effectiveness of Care
- Quality of Care
- Hope, Recovery, and Resiliency

- Empowerment and Shared Decision Making
- Self Direction
- Cultural Competency
- Health and Safety Measures
- Consumer Health Status and Functioning
- Community Integration and Peer Support
- Quality of Life and Outcomes
- Promising and Evidence-Based Practices
- Provider effectiveness and satisfaction
- Integrated Programs and Systems Integration

8.3.1.6.2. Identification and Review: The Contractor is required to provide the Regional Performance Measures to the Division for review by March 31, 2010. The description of each Regional Performance Measure chosen by the Contractor shall include the following:

- Name of the Regional Performance Measure;
- Proposed study population (or sub-populations) and time period measurement used for the measure;
- Operational definition of the measure, including descriptions of numerator and denominator;
- Proposed data source(s) and sample size if survey data or chart records will be utilized;
- Any exclusion criteria applied in the measure; and
- A brief description why the measure is chosen

8.3.1.6.3. Baseline Reporting: For Regional Performance Measures that have been reviewed by the Division, the Contractor shall calculate the baseline performance. It is expected that the Contractor shall complete and submit the performance baseline calculation to the Division by September 30, 2010.

8.3.1.6.4. Target Setting: The Contractor shall recommend to the Division an Annual Improvement Target for each Regional Performance Measure by October 31, 2010. All Annual Improvement Targets shall be mutually agreed upon by the Contractor and the Division by November 30, 2010. The agreed upon targets will be used as improvement measurements for year two (2) of the Agreement.

8.3.1.6.5. Reporting: The Contractor shall calculate and monitor the Regional Performance Measures against the established Improvement Targets throughout the year. The Contractor shall submit an annual report calculating all the Regional Performance Measures and their progress relating to the Improvement Targets. The Contractor is required to submit the annual report to the Division by January 15, 2012.

- 8.3.1.6.6. Evaluation: The Division will review the annual Regional Performance Measures report submitted by the Contractor. The Division may request the Contractor to provide an explanation for performance measures that do not meet the Annual Performance Targets. If the explanation is not received or determined to be inadequate, the Contractor shall be required to submit a corrective action plan to the Division.
- 8.3.1.6.7. Public Dissemination: The Contractor shall make the results of the Regional Performance Measures available to the public.

8.4. Quality Review Activities

- 8.4.1. The Department of Social and Health Services, Office of the State Auditor, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Comptroller General, or any of their duly-authorized representatives, may conduct announced and unannounced:
 - 8.4.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement.
 - 8.4.1.2. Reviews regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement.
 - 8.4.1.3. Audits and inspections of financial records.
- 8.4.2. The Contractor shall notify HRSA when an entity other than HRSA performs any audit or review described above related to any activity contained in this Agreement.
- 8.4.3. The Contractor shall submit to an annual EQRO monitoring review and work with the EQRO Contractor set forth by DSHS to schedule a time for the monitoring review that works for both parties.
 - 8.4.3.1. The monitoring review process shall use standard methods and data collection tools and methods found in the CMS External Quality Review Protocols to assess the Contractor's compliance with regulatory requirements, adherence to quality outcomes, and timeliness of, and access to, services provided by the Contractor.
 - 8.4.3.2. In the event the Contractor or any of the Contractor's Subcontractors do not provide ready access to any information or facilities for the EQRO monitoring review during the scheduled time, the Contractor shall incur any costs for re-scheduling the EQRO Contractor to return and finish its review.
 - 8.4.3.3. DSHS shall provide a copy of the final EQRO monitoring review report to the Contractor, through print or electronic media and upon request to interested parties such as Enrollees, mental health advocacy groups, and members of the general public.
- 8.4.4. The Contractor shall, upon request provide evidence of how external quality review findings, agency audits, Contract monitoring activities and consumer Grievances are used to identify and correct problems and to improve care and services to Enrollees.

9. SUBCONTRACTS

- 9.1. All Subcontracts must be in writing and specify all duties, responsibilities and reports delegated under this Agreement and require adherence with all federal and state laws that are applicable to the Subcontractor.
- 9.2. Provider One Readiness - In order to receive timely payment of Medicaid Reimbursement for all Subcontractors in the ProviderOne Medicaid Management Information System (P1), the Contractor shall work with DSHS to ensure all of their Subcontractors have completed the multi-step process prior to P1's expected December 2009 activation.
- 9.3. Delegation - A Subcontract does not terminate the legal responsibility of the Contractor to perform the terms of this Agreement. The Contractor shall monitor functions and responsibilities performed by or delegated to a Subcontractor on an ongoing basis.
 - 9.3.1. The PIHP responsibilities of the Care Management, Authorization Standards and Quality Management sections of this Agreement may not be delegated to a Contracted Network CMHA.
 - 9.3.2. Prior to any new delegation of any PIHP responsibility or authority described in the Management Information System, Care Management, Authorization Standards and Quality Management sections of this Agreement through a Subcontract or other legal Agreement, the Contractor shall use a delegation plan.
 - 9.3.3. The Contractor shall maintain and make available to HRSA and its EQRO Contractors all delegation plans, for currently in place Subcontractors. The delegation plan must include the following:
 - 9.3.3.1. An evaluation of the prospective Subcontractor's ability to perform delegated activities.
 - 9.3.3.2. A detailed description of the proposed subcontracting arrangements, including (1) name, address, and telephone number of the Sub-contractor(s), (2) specific contracted services, (3) compensation arrangement, and (4) monitoring plan.
 - 9.3.3.3. The required Subcontract language that specifies the activities and responsibilities delegated and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is not adequate.
- 9.4. CMHA Provider Discrimination
 - 9.4.1. The Contractor must ensure there is no discrimination in selection of providers based on:
 - a) The participation, reimbursement, or indemnification of any CMHA that is acting within the scope of its license or certification under applicable State law solely upon the basis of that license or certification.
 - b) Particular CMHAs who serve high risk mental health Enrollees or specialize in mental health conditions that require costly treatment.
 - 9.4.2. The Contractor must provide written notice to individual CMHAs or to groups of CMHAs as to the reason for the Contractor's decision if they are not selected for the Contractor's Subcontracted network of providers.

9.5. Subcontract Submission and Required Provisions

- 9.5.1. Within 30 days of execution of a Subcontract to perform any function under this Agreement, the Contractor shall submit copies of the Subcontracts to HRSA.
 - 9.5.1.1. When substantially similar Contracts are executed with multiple Subcontractors an example Contract may be provided with a list by Subcontractor of any terms that deviate from the example. A list of all Subcontractors for each contract and the period of performance must also be submitted.
 - 9.5.1.2. Amendments to Subcontracts must be submitted with a summary of the changes made to the original Subcontracts within 45 days following the end of each calendar year. In the event that the Contract performance period does not encompass a full report period the Contractor shall provide a report for the partial period.
 - 9.5.1.3. Copies are to be provided in word processing format on a portable memory device.
- 9.5.2. Subcontracts must require Subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the activity to be performed under this Agreement.
- 9.5.3. All Subcontracts with CMHAs must comply with 42 CFR §438.21(a) as enacted or amended.
- 9.5.4. Subcontracts must require adherence to the Americans with Disabilities Act.
- 9.5.5. Subcontracts for the provision of mental health services must require compliance and implementation of the Mental Health Advance Directive statutes.
- 9.5.6. Subcontracts must require Subcontractors to cooperate with Quality Review Activities and provide access to their facilities, personnel and records.
- 9.5.7. Subcontracts for the provision of mental health services must require Subcontractors to provide Enrollees access to translated information and interpreter services as described in the Information Requirements section of this Agreement.
- 9.5.8. Subcontracts must require Subcontractors to notify the Contractor in the event of a change in status of any required license or certification.
- 9.5.9. Subcontracts must require Subcontractors to participate in training when requested by HRSA. Requests for HRSA to allow an exception to participation in required training must be in writing and include a plan for how the required information shall be provided to targeted Subcontractor staff.
- 9.5.10. Subcontracts must require compliance with State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and HRSA-CIS Data Dictionary.
- 9.5.11. Subcontracts must define a clear process to be used to revoke delegation, impose corrective action, or take other remedial actions if the Subcontractor fails to comply with the terms of the Subcontract.

- 9.5.12. Subcontracts must require that the Subcontractor correct any areas of deficiencies in the Subcontractor's performance that are identified by the Contractor or HRSA as part of a Subcontractor review.
- 9.5.13. Subcontracts for the provision of mental health services must require best efforts to provide written or oral notification no later than 15 working days after termination of a MHCP to Enrollees currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the CMHA.
- 9.5.14. Subcontracts must require that the Subcontracted CMHAs comply with the Contractor's policy and procedures for utilization of Access to Care Standards, Distance Standards, and Access Standards.
- 9.5.15. Subcontracts for the provision of mental health services must require that the Subcontractor implement a Grievance process that complies with 42 CFR §438.400 or any successors as described in Section 12 of this Agreement.
- 9.5.16. In accordance with Medicaid being the payer of last resort, Subcontracts must require the pursuit and reporting of all Third Party Revenue related to services provided under this Agreement.
- 9.5.17. Subcontracts for the provision of mental health services must require the use of HRSA provided Integrated Co-Occurring Disorder Screening tool and require staff that will be using the tool to attend trainings on the use of the screening and assessment process that includes use of the tool and quadrant placement. In addition, the Subcontract must contain terms requiring corrective action if the Integrated Co-Occurring Disorder Screening and Assessment process is not implemented and maintained throughout the Contract period of performance.
- 9.5.18. Subcontracts for the provision of mental health services must require Subcontractors to resubmit data when rejected by HRSA due to errors. The Subcontract must require the data to be re-submitted within 30 days of when the error report was produced.
- 9.5.19. Changes in Capacity: A significant change in the provider network is defined as the termination or addition of a Subcontract with an entity that provides mental health services or the closing of a Subcontractor site that is providing services required under this Agreement. The Contractor must notify HRSA 30 days prior to terminating any of its Subcontracts with entities that provide direct service including mental health clubhouses or entering into new Subcontracts with entities that provide direct service including mental health clubhouses. This notification must occur prior to any public announcement of this change.
 - 9.5.19.1. If either the Contractor or the Subcontractor terminates a Subcontract in less than 30 days or a site closure occurs in less than 30 days, the Contractor must notify HRSA as soon possible and prior to a public announcement.
 - 9.5.19.2. The Contractor shall notify HRSA of any other changes in capacity that results in the Contractor being unable to meet any of the Access Standards as required in this Agreement. Events that affect capacity include: decrease in the number or frequency of a required service, employee strike or other work stoppage related to union activities, or any changes that result in the Contractor being unable to provide timely, medically necessary services.

9.5.19.3. If any event in section 9.5.19 occurs, the Contractor must submit a plan to HRSA for Enrollees and services that includes at least:

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

9.6. Excluded Providers

9.6.1. The Contractor, by signature to this Agreement certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal department or agency. The Contractor also agrees to include the above requirement into any Subcontracts entered into, resulting directly from the Contractor's duty to provide services under this Agreement.

9.6.2. The Contractor is required to ensure that the Subcontractor neither employs any person nor Contracts with any person or Community Mental Health Agency (CMHA) excluded from participation in federal health care programs under either 42 U.S.C. 1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended per this Agreement's General Terms and Conditions.

9.6.3. The Contractor and any Subcontractors must comply with 42-USC §1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of more than five percent (5%) of the Contractor's equity, or an employee, Contractor, or consultant who is significant or material to the provision of services under this Agreement, who has been, or is affiliated with someone who has been debarred, suspended, or otherwise excluded by any federal agency.

9.7. Physician Incentive Plans

9.7.1. The Contractor must ensure it does not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) does not Contract with any Subcontractor operating such a plan.

9.8. Provider Credentialing

9.8.1. The Contractor shall have written policies that require monitoring of provider credentials. The Contractor shall only use CMHAs that are licensed and/or certified by the State. Mental Health Clubhouses may be directly contracted with the PIHP without being a licensed CMHA. Clubhouses must meet all credentialing requirements put in place by the State.

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

10. ENROLLEE RIGHTS AND PROTECTIONS

10.1. The Contractor shall comply with any applicable Federal and State laws that pertain to Enrollee rights and ensure that its staff takes those rights into account when furnishing services to Enrollees.

- 10.2. The Contractor shall require that mental health professionals and MHCPs, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an Enrollee with respect to:
 - 10.2.1. The Enrollee's mental health status.
 - 10.2.2. Receiving all information regarding mental health treatment options including any alternative or self-administered treatment, in a culturally-competent manner.
 - 10.2.3. Any information the Enrollee needs in order to decide among all relevant mental health treatment options.
 - 10.2.4. The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment).
 - 10.2.5. The Enrollee's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions.
 - 10.2.6. The Enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy.
 - 10.2.7. The Enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - 10.2.8. The Enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164.
 - 10.2.9. The Enrollee's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the Contractor, CMHA or MHCP treats the Enrollee.
- 10.3. Individual Service Plans must be developed in compliance with WAC 388-865-0425.
 - 10.3.1. The Contractor shall require that consumers are actively included in the development of their individualized service plans, advance directives for psychiatric care and crisis plans.
 - 10.3.1.1. This shall include but not be limited to children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings).
 - 10.3.2. At a minimum, treatment goals must include the words of the individual receiving services and documentation must be included in the clinical record, as part of the 180 day progress review, describing how the consumer sees progress.
 - 10.3.3. The Individual Service Plan must address the overall identified needs of the Enrollee, including those that best met by another service delivery system, such as education, primary medical care, child welfare, drug and alcohol, developmental disabilities, aging and adult services, corrections and juvenile justice as appropriate. The Contractor must ensure that there is coordination with the other service delivery systems responsible for meeting the identified needs.

- 10.4. The Contractor shall ensure Enrollees are not held liable for any of the following:
- 10.4.1. Covered mental health services provided by insolvent community psychiatric hospitals with which the Contractor has directly contracted.
 - 10.4.2. Covered mental health services, including those purchased on behalf of the Enrollee.
 - 10.4.3. Covered mental health services for which the State does not pay the Contractor.
 - 10.4.4. Covered services provided to the Enrollee, for which the State or the Contractor does not pay the MHCP or CMHA that furnishes the services under a contractual, referral, or other arrangement.
 - 10.4.5. Payments for covered services furnished under a Contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Contractor provided the services directly.
 - 10.4.6. Covered mental health services provided by insolvent federally funded PIHPs.

10.5. Ombuds

- 10.5.1. The Contractor shall provide a mental health ombuds as described in WAC 388-865-0250 and RCW 71.24. An entity or Subcontractor independent of the RSN Administration must employ the ombuds and provide for the following:
 - 10.5.1.1. Separation of personnel functions (e.g. hiring, salary and benefits determination, supervision, accountability and performance evaluations).
 - 10.5.1.2. Independent decision making to include all investigation activities, findings, recommendations and reports.

10.6. Advance Directives

- 10.6.1. The Contractor shall maintain a written Advance Directive policy and procedure that respects Enrollees' Advance Directives for psychiatric care. Policies and procedures must comply with RCW 71.32 and the requirements of 42 CFR §422.128, Subpart I of Part 489, and 42 CFR §438.6 as they pertain to psychiatric care. If State law changes, HRSA shall send notice to the Contractor who must then ensure the provision of notice to Enrollees within 90 days of the change.
- 10.6.2. The Contractor shall inform Enrollees that complaints concerning noncompliance with the Advance Directive for psychiatric care requirements may be filed with HRSA by contacting the Compliance section at 1-888-713-6010.

11. MANAGEMENT INFORMATION SYSTEM

11.1. Data Submission and Error Correction

- 11.1.1. The Contractor shall provide HRSA with all data described in HRSA "Service Encounter Reporting Instructions" and the "Data Dictionary," and encounters shall be submitted as described in HRSA "Encounter Data Reporting Guide," or, any successor, incorporated herein by reference.

- 11.1.2. The Contractor shall report encounters electronically to HRSA management information system (HRSA CIS) within 60 days of the close of each calendar month in which the encounters occurred. Once the DSHS provider payment processing system (ProviderOne) is in production, the Contractor shall report encounters electronically to ProviderOne within 60 days of the close of each calendar month in which the encounters occurred.
- 11.1.3. The Contractor shall submit all other required data about Enrollees to HRSA CIS within 60 days of collection or receipt from Subcontracted providers.
- 11.1.4. Upon receipt of data submitted, both ProviderOne and HRSA CIS shall generate error reports. The Contractor shall have in place documented policies and procedures to assure that data submitted and rejected due to errors are corrected and resubmitted within 30 calendar days of when the error report was produced.
- 11.1.5. The Contractor shall require Subcontractors to resubmit data rejected due to errors. The Subcontractor must resubmit corrected data within 30 calendar days of when an error report was produced.
- 11.1.6. The Contractor shall attend meetings and respond to inquiries to assist in HRSA decisions about changes to data collection and information systems to meet the terms of this Contract. This may include requests to add, delete or change data elements that may include projected cost analysis.
- 11.1.7. The Contractor shall implement changes documented in HRSA "Service Encounter Reporting Instructions," the "Data Dictionary," and HRSA "Encounter Data Reporting Guide" within 150 days from the date published. When changes on one document require changes to the other, DSHS shall publish all affected documents concurrently. For changes to data submission methods related to the December 2009 go-live date for the new HRSA Medicaid Management Information System, ProviderOne, the Contractor may be required to implement changes in less than 150 days.
- 11.1.8. The Contractor shall implement changes to the content of national standard code sets (such as CPT, HCPC, Place of Service code sets) per the instructions and implementation schedule or deadline from the issuing organization. If the issuing organization does not provide an implementation schedule or deadline, the Contractor shall implement the changes within 150 days.
- 11.1.9. When HRSA makes changes referenced in Section 11.1.7, the Contractor shall send at least one test batch of data containing the required changes. The test batch must be received no later than 15 days prior to the implementation date.
- The test batch must include at least 100 transactions that include information effected by the change.
 - The processed test batch must result in at least 80% successfully posted transactions or an additional test batch is required.
- 11.1.10. The Contractor shall respond to requests from HRSA for information not covered by the data dictionary in a timeframe determined by HRSA that will allow for a timely response to inquiries from CMS, the legislature, DSHS, and other parties.

- 11.1.11. No RSN encounter transaction shall be accepted for initial entry or data correction after one (1) year from the date of service, except by special exception.

11.2. Business Continuity and Disaster Recovery

- 11.2.1. The Contractor shall demonstrate a primary and backup system for electronic submission of data requested by HRSA. This must include the use of the Inter-Governmental Network (IGN), Information Systems Services Division (ISSD) approved secured Virtual Private Network (VPN) or other ISSD- approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on HRSA approval.

- 11.2.2. The Contractor shall create and maintain a business continuity and disaster recovery plan that insures timely reinstatement of the consumer information system following total loss of the primary system or a substantial loss of functionality. The plan must be in written format, have an identified update process (at least annually) and a copy must be stored off site.

- 11.2.2.1. The Contractor must submit an annual certification statement indicating there is a business continuity disaster plan in place for both the Contractor and Subcontractors. The certification must be submitted by January 1 of each year of this Agreement. The certification must indicate that the plans are up to date, the system and data backup and recovery procedures have been tested, and copies of the Contractor and Subcontractor plans are available for HRSA or the contracted EQRO to review and audit. The plan must address the following:

- 11.2.2.1.1. A mission or scope statement;

- 11.2.2.1.2. An appointed Information Services Disaster Recovery Staff.

- 11.2.2.1.3. Provisions for Backup of Key personnel; Identified Emergency Procedures; Visibly listed emergency telephone numbers.

- 11.2.2.1.4. Procedures for allowing effective communication; Applications Inventory and Business Recovery priority; Hardware and software vendor list.

- 11.2.2.1.5. Confirmation of updated system and operations documentation; Process for frequent backup of systems and data.

- 11.2.2.1.6. Off site storage of system and data backups; Ability to recover data and systems from backup files.

- 11.2.2.1.7. Designated recovery options which may include use of a hot or cold site.

- 11.2.2.1.8. Evidence that disaster recovery tests or drills have been performed.

11.3. Information System Security and Protection of Confidential Information

- 11.3.1. The Contractor shall comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified in 42 USC §1320(d) et.seq. and CFR Parts 160, 162 and 164.

- 11.3.2. The Contractor shall ensure that confidential information provided through or obtained by way of this Agreement or services provided, is protected in accordance with the Data Security Requirements contained in Exhibit C.
- 11.3.3. The Contractor shall take appropriate action if a Subcontractor or Contractor employee wrongly releases confidential information.

11.4. Subcontractor Data Quality Verification

- 11.4.1. The Contractor shall maintain and either provide to Subcontractors, or require Subcontractors to also maintain, a health information system that complies with the requirements of 42 CFR §438.242 and provides the information necessary to meet the Contractor's obligations under this Agreement. The Contractor shall have in place mechanisms to verify the health information received from Subcontractors is complete and accurate. Mechanisms shall include the following:

- 11.4.1.1. Verifying the accuracy by review of error reports and/or error resolution reports and timeliness as defined in this Contract/Agreement; and screening the Subcontractors data for completeness, logic and consistency of the data received from Subcontractors.

- 11.4.1.2. The Contractor shall conduct encounter validation checks for all Subcontractors that submit encounters to the Contractor, using the following guidelines:

- 11.4.1.2.1. Minimum Sample Size: For each network CMHA Subcontractor, a review of a least one (1) percent or 411 whichever is less, of all encounters submitted for a 12-month time period within the current Agreement period.

- 11.4.1.2.2. Random Sampling: The minimum sample should be randomly drawn and representative to the proportion of client served (children vs. adults) by the Subcontractors within the RSN service delivery system of a 12-month time period:

- 11.4.1.2.3. Minimum Data Elements: Verification for each randomly selected encounter record shall include the following minimum data elements and the recipient's demographics:

- Recipient Ethnicity
 - Date of service
 - Name of service provider
 - Service location
 - Procedure code (i.e., CPT and HCPCS) & modifier (if applicable)
 - Service unit/duration
 - Provider type

- 11.4.1.2.4. Validation Analysis: The Contractor shall verify and analyze the validity (accuracy and completeness) of the minimum random sample against the clinical records documented by the Subcontractors. Analysis and reporting shall include findings of error rate for each data element and aggregate the results for the following categories:

- a) Match – Match reflects cases where there are exact matches of all the minimum data elements for each randomly selected sample between the Subcontractor’s encounters and those in the clinical records
- b) No Match – No match reflects cases where the Subcontractor’s encounters do not match the clinical records. There are three (3) error types for this category:
 - 1. Erroneous – Encounters that occurred and are presented by an electronic record, but contain incorrect data or missing any of the minimum data elements.
 - 2. Missing (i.e., Not in Encounter Record) – Clinical record contains evidence of a service but is not represented by an electronic record.
 - 3. Unsubstantiated (i.e., Not in Medical Record) – Encounters submitted by the Subcontractor but either cannot be verified in the clinical record or is duplicated.

11.4.1.2.5. Acceptable Standards: The Contractor shall aggregate the findings by the error types. If “No Match” or “Unsubstantiated” error rate is above the acceptable standard, the contractor shall include a corrective action plan in the Encounter Data Verification (EDV) report.

Type	Acceptable Standards	
	Year 1 (FFY 2009-2010)	Year 2 (FFY2010-2011)
Match	> 90%	> 95%
No Match	≤ 10%	≤ 5%
Unsubstantiated (Not in Medical Record)	≤ 4%	≤ 2%

11.4.1.2.6. Encounter Data Verification Report: The EDV Reports shall be submitted to HRSA annually within 90 days after the end of each 12 month period (October to September). The report should follow the template that HRSA provided to the Contractor or minimally address the following key areas:

- Method of validation process (i.e., study time frame, staff involved, request for record and review process).
- Sampling methodology, including data source and stratification.
- Record review tool(s) and audit guide employed.
- Scoring methods.
- Data analysis results and summary of findings.
- Conclusions, limitations, and opportunities for improvement, including corrective action plan, if applicable.

11.5. Data Certification

- 11.5.1. The Contractor shall comply with the required format provided in the Encounter Data Transaction Guide published by DSHS. Data includes encounters documenting services paid for by the Contractor and delivered to consumers through the Contractor during a specified reporting period as well as other data per HRSA Data Dictionary and Service Encounter Reporting Instructions. DSHS collects and uses this data for many reasons such as: federal reporting (42 CFR 438.242(b)(1)); rate setting and risk adjustment; service verification, managed care quality improvement program; utilization patterns and access to care; DSHS hospital rate setting; and research studies.
- 11.5.2. Data Certification Requirements: Any information and/or data required by this Contract and submitted to DSHS shall be certified by the Contractor as follows (42 CRF 438.242(b)(2) and 438.600 through 606).
 - 11.5.2.1. Source of Certification: The information and/or data shall be certified by one of the following:
 - 11.5.2.1.1. The Contractor's Chief Executive Officer.
 - 11.5.2.1.2. The Contractor's Chief Financial Officer.
 - 11.5.2.1.3. An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.
 - 11.5.2.2. Content of Certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.
 - 11.5.2.3. Timing of Certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

12. GRIEVANCE SYSTEM

- 12.1. The Contractor must have a Grievance system that complies with the following procedures. The Contractor must provide information about the Grievance System to all CMHA's and Subcontractors at the time they enter into a contract.
- 12.2. General Requirements:
 - 12.2.1. An Enrollee or representative may file a Grievance or an Appeal either orally or in writing with the Contractor and may request a Fair Hearing from the State of Washington Office of Administrative Hearings. An Enrollee may also file a Grievance with his or her provider which must have policies and procedures consistent with the requirements for Grievances described below:
 - 12.2.1.1. If an initial request for a Grievance or Appeal made orally, a written, signed request for a Grievance or an Appeal must be submitted within seven (7) days.
 - 12.2.1.2. An oral request for expedited resolution to an Appeal does not need to be followed by a written, signed request for an Appeal.

- 12.2.2. A representative, including a staff person of the Enrollee's provider, acting on behalf of the Enrollee and with Enrollee's written consent, may request a Grievance or an Appeal or a Fair Hearing.
- 12.2.3. The Enrollee must be given reasonable assistance in pursuing a Grievance, Appeal, or Fair Hearing.
 - 12.2.3.1. The Enrollee may be provided assistance from the Ombuds service, the Enrollee's provider, the Contractor, or any other person of the Enrollee's choice.
- 12.2.4. The Enrollee shall be provided access to interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- 12.2.5. The Contractor shall:
 - 12.2.5.1. Ensure that there is no retaliation against Enrollees or providers, who on behalf of the Enrollee, file a Grievance, Appeal, or Fair Hearing, or request an expedited resolution.
 - 12.2.5.2. Provide information about the Grievance system to all Community Mental Health Agencies and Subcontractors at the time they enter into an Agreement. A condition of the Agreement will be that all Community Mental Health Agencies and Subcontractors will abide by all Appeal, Grievance, and Fair Hearing decisions.

12.3. Handling of Grievances:

- 12.3.1. The Contractor or its agent shall:
 - 12.3.1.1. Acknowledge receipt of each Grievance, received either orally or in writing, within one (1) working day. If acknowledgement is made orally, it must be followed in writing within five (5) working days.
- 12.3.2. Ensure that the individuals who make decisions on Grievances are individuals who:
 - 12.3.2.1.1. Were not involved in any previous level of review or decision-making; and
 - 12.3.2.1.2. When the Grievance involves medical necessity or a request for expedited resolution to an appeal, the Contractor shall ensure that individuals involved with making decisions are Mental Health Professionals with the appropriate clinical expertise.
- 12.3.3. Grievance Resolution and Notification: The Contractor must resolve each Grievance and provide written notice as expeditiously as the Enrollee's mental health condition requires and not more than 30 days from the receipt of the statement of Grievance by the Contractor.
 - 12.3.3.1. The Contractor may extend the timeframe by up to 14 calendar days if:
 - 12.3.3.1.1. The Enrollee request the extension; or
 - 12.3.3.1.2. The Contractor shows (to the satisfaction of the state agency upon its request) that there is a need for additional information and how the delay is in the Enrollee's interest.

- 12.3.3.2. If the Contractor extends the timeframes, the Contractor must, for any extension, give the Enrollee written notice of the reason for the delay.
- 12.3.3.3. Failure to meet the timeframes above or provide a written notice of any extension constitute a denial and an adverse action for which the Enrollee shall be sent a Notice of Action.
- 12.3.3.4. The written notice of resolution must include the results of the resolution process and the date it was completed.
 - 12.3.3.4.1. For Grievances not resolved wholly in favor of the Enrollee, the notice must include the right to request a Fair Hearing and how to do so.

12.4. Notice of Action is a written notice provided to Enrollees when an Action has occurred.

- 12.4.1. Notices of Action must be provided in the prevalent non-English languages as described in Section 5.1 and meet the language and format requirements of 42 CFR §438.10 (c & d).
- 12.4.2. The Notice of Action must include:
 - 12.4.2.1. A statement of what Action the Contractor or its Subcontractor intends to take.
 - 12.4.2.2. The reasons for the intended Action.
 - 12.4.2.3. An explanation of the Enrollee's right to request an Appeal or a Fair Hearing.
 - 12.4.2.4. Definitions of Denial, Reduction, Suspension and Termination.
 - 12.4.2.5. Statement that the Enrollee has 20 days from the date on the Notice of Action to file an Appeal.
 - 12.4.2.6. The circumstances under which an expedited resolution is available and how to request it.
 - 12.4.2.7. The Enrollee's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the costs of these services.

12.4.3. The Contractor or its agent must mail the notice within the following timeframes:

- 12.4.3.1. For standard service authorization decisions that deny or limit services, no longer than 14 days from request for service.
- 12.4.3.2. Under the following circumstances, 14 additional days are possible:
 - 12.4.3.2.1. The Enrollee or the CMHA requests an extension.
 - 12.4.3.2.2. The Contractor justifies to HRSA (upon request) the need for additional information to make an authorization decision and how the extension is in the Enrollee's best interest.
- 12.4.3.3. If the Contractor extends the timeframe it must:

- 12.4.3.3.1. Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and
- 12.4.3.3.2. Issue and carry out its determination as expeditiously as the Enrollee's mental health condition requires and no later than the date the extension expires.
- 12.4.3.4. Authorization decisions must be expedited to no longer than three (3) working days after receipt of the request for services:
 - 12.4.3.4.1. When the Enrollee's presenting mental health condition affects their ability to maintain or regain maximum functioning; or
 - 12.4.3.4.2. If the Enrollee presents a potential risk to self or others.
- 12.4.3.5. For reduction, suspension, or termination of previously authorized Medicaid-covered services, at least ten (10) days before the effective date of the Action except if the criteria noted in 42 CFR §431.213 or §431.214 are met.
- 12.4.3.6. For denial or payment, at the time of any Action affecting the payment.
- 12.4.4. Standard authorization decisions not reached in accordance with the timeframes established in the Access Standards above constitute a Denial and an adverse action that are subject to Appeal.

12.5. Handling of Appeals

- 12.5.1. The Contractor or its agent shall:
 - 12.5.1.1. Acknowledge receipt of each Appeal, received either orally or in writing, with one (1) working day. If acknowledgement is made orally, it must be followed in writing with five (5) working days.
- 12.5.2. Ensure that the individuals who make decisions on Appeals are individuals who:
 - 12.5.2.1. Were not involved in any previous level of review or decision-making; and
 - 12.5.2.2. When the Appeal involves medical necessity or a request for expedited resolution to an appeal, the Contractor shall ensure that the individuals involved with making decisions are Mental Health Professionals with the appropriate clinical expertise.
- 12.5.3. Treat oral inquiries seeking to Appeal an Action as Appeals and to establish the earliest possible filing date for the Appeal.
- 12.5.4. Provide for the Enrollee:
 - 12.5.4.1. A reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
 - 12.5.4.1.1. In the case of an expedited Appeal, the Contractor must inform the Enrollee of the limited time available for this process.

- 12.5.4.2. Opportunity, before and during the Appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the Appeals process.
- 12.5.4.3. An expedited Appeal process when requested by the Enrollee or provider, on behalf of the Enrollee, or it is determined by the Contractor that the standard time for resolution would jeopardize the Enrollee's ability to maintain or regain maximum functioning.
 - 12.5.4.3.1. If the Contractor denies a request for expedited resolution of Appeal, it must:
 - 12.5.4.3.1.1. Transfer the Appeal to the 45-day timeframe for standard resolution.
 - 12.5.4.3.1.2. Make reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow up with two (2) calendar days with a written notice.
- 12.5.5. Include, as parties to the Appeal, the Enrollee and his or her representative or the legal representative of a deceased Enrollee's estate.
- 12.5.6. Appeal Resolution and Notification: Resolve each Appeal and provide written notice as expeditiously as the Enrollee's mental health condition requires and not more than 45 days from receipt of the notice of Appeal by the Contractor.
 - 12.5.6.1. The Contractor may extend the timeframe by up to 14 calendar days if:
 - 12.5.6.1.1. The Enrollee requests the extension; or
 - 12.5.6.1.2. The Contractor shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the Enrollee's interest.
 - 12.5.6.2. If the Contractor extends the timeframes, the Contractor must, for any extension, give the Enrollee written notice of the reason for the delay.
 - 12.5.6.3. The Contractor must provide written notice of disposition with prescribed timeframes for normal disposition or extension.
 - 12.5.6.3.1. For notice of expedited resolution the Contractor shall:
 - 12.5.6.3.1.1. Provide written notice of the disposition with three (3) working days; and
 - 12.5.6.3.1.2. Make reasonable effort to provide oral notice of disposition prior to written notice.
 - 12.5.6.4. Failure to meet the timeframes above or provide a written notice of any extension constitute a denial and an adverse action for which the Enrollee shall be sent a Notice of Action.
 - 12.5.6.5. The written notice of resolution must include the results of the resolution process and the date it was completed.
 - 12.5.6.6. For Appeals not resolved wholly in favor of the Enrollee, the notice must include:
 - 12.5.6.6.1. The right to request a Fair Hearing and how to do so.

- 12.5.6.6.2. The right to request to continue to receive previously authorized benefits while the hearing is pending and how to make the request.
- 12.5.6.6.3. Notice that the Enrollee may be asked to pay for the cost of those benefits if the hearing decision upholds the original action.

12.5.7. Continuation of Benefits

12.5.7.1. The Contractor must continue the Enrollee's benefits if all of the following conditions are met:

- 12.5.7.1.1. The Enrollee or the Community Mental Health Agency files the Appeal timely.
- 12.5.7.1.2. The Appeal involves the reduction, suspension, or termination of a previously authorized course of treatment.
- 12.5.7.1.3. The services were provided by a network Community Mental Health Agency.
- 12.5.7.1.4. The original period covered by the original authorization has not expired.
- 12.5.7.1.5. The Enrollee requests a continuation of benefits.

12.5.7.2. If, at the Enrollee's request, the Contractor continues or reinstates the Enrollee's benefits while the Appeal is pending, the benefits must be continued until one of following occurs:

- 12.5.7.2.1. The Enrollee withdraws the Appeal.
- 12.5.7.2.2. Ten (10) days pass after the Contractor mails the notice, providing the resolution of the Appeal against the Enrollee, unless the Enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
- 12.5.7.2.3. The Enrollee requests a Fair Hearing and the decision is adverse to the Enrollee.
- 12.5.7.2.4. The current authorization expires or the current authorization service limits are met.
- 12.5.7.2.5. Enrollees who request continuation of benefits must be notified that, if the final resolution of the Appeal is adverse to the Enrollee (upholds the Contractor's action) the Contractor may request the Enrollee to reimburse the cost of the services furnished to the Enrollee while the Appeal is pending.

12.5.7.3. Effect of Reversed Appeal Resolutions: If the Contractor or the State Fair Hearing officer reverses a decision to:

- 12.5.7.3.1. Deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the Enrollee's mental health condition requires.
- 12.5.7.3.2. If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the Appeal was pending, the Contractor must pay for those services.

12.6. Fair Hearings

12.6.1. Enrollees may request a Fair Hearing conducted by independent state agency in accordance with Chapter 388-02 WAC and provisions of mental health services per Chapter 388-865 WAC.

12.6.1.1. The parties to a Fair Hearing include the Contractor as well as the Enrollee and his or her representative or the legal representative of a deceased Enrollee's estate.

12.6.2. A Fair Hearing may be requested from the State of Washing Office of Administrative Hearings when:

12.6.2.1. An Enrollee believes there has been a violation of DSHS rule.

12.6.2.2. The Contractor or its agent does not provide a written response to a grievance or appeal within the required timeframes.

12.6.2.3. An Enrollee receives an adverse ruling by the Contractor or its agent to a grievance or appeal.

12.6.2.3.1. If the Enrollee elects to request a Fair hearing, the request must be filed within 20 days from the date of notice of adverse ruling.

12.6.3. HRSA will notify the Contractor of hearing determinations. The Contractor will be bound by the hearing determination, whether or not the hearing determination upholds the Contractor's decision.

12.7. Recordkeeping and Reporting Requirements

12.7.1. The Contractor must maintain records of Grievances, Actions, Appeals and Fair Hearings.

12.7.2. The Contractor must submit a report in a format provided by HRSA that includes:

12.7.2.1. The number and nature of Grievances, Actions, Fair Hearings, and Appeals.

12.7.2.2. The timeframes within which they were disposed of or resolved.

12.7.2.3. The nature of the decisions.

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

12.7.2.5. Reports are due to HRSA within 45 days of the end of each reporting period. Reporting periods are every six (6) months. First period ends on March 31, 2010 and will be every six (6) months forward to the end of the contracted period.

13. BENEFITS

13.1. All Medicaid Enrollees requesting covered Mental Health Services must be offered an intake evaluation as outlined in the Access Standards. Authorization for further services must be based on Medical Necessity and the Access to Care Standards.

- 13.2. The Contractor shall provide, upon request, a second opinion from a CMHA within the Service Area. If an additional CMHA is not currently available within the network, the Contractor must provide or pay for a second opinion provided by a CMHA outside the network at no cost to the Enrollee. The CMHA providing the second opinion must be currently contracted with a RSN to provide mental health services to Enrollees. The appointment for a second opinion must occur within 30 days of the request. The Enrollee may request to postpone the second opinion to a date later than 30 days.
- 13.3. The Contractor shall ensure services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- 13.4. If the Contractor is unable to provide the services covered under this Agreement, the services must be purchased within 28 days for an Enrollee with an identified need. The Contractor must continue to pay for medically necessary mental health services outside the service area until the Contractor is able to provide them within its service area.
- 13.5. The Contractor must provide the following mental health services for each Enrollee when they are Medically Necessary. If the PIHP's contracted network is unable to provide medically necessary services covered under the contract to a particular Enrollee, the entity must adequately and timely cover these services out of network for the Enrollee, for as long as the entity is unable to provide them within the network. These out of network services must be provided at no additional cost to the Enrollee. Enrollees are entitled to access Crisis Services, Freestanding Evaluation and Treatment, Stabilization and Rehabilitation Case Management prior to an intake evaluation
 - 13.5.1. Brief Intervention Treatment: Solution-focused and outcomes-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid Enrollee's Individual Service Plan must include a specific timeframe for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the Enrollee's current level of functioning and assistance with self care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.
 - 13.5.2. Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid-enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a Mental Health Professional.
 - 13.5.3. Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid Enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program

is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a Mental Health Professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

13.5.4. Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid-enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and his/her family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in his/her Individual Service Plan. This service is provided by or under the supervision of a Mental Health Professional.

13.5.5. Freestanding Evaluation and Treatment: Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by HRSA to provide medically necessary evaluation and treatment to the Medicaid-enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other Mental Health Professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow him/her to be managed at a lesser level of care. This service does not include cost for room and board.

HRSA must authorize exceptions for involuntary length of stay beyond a fourteen (14) day commitment.

13.5.6. Group Treatment Services: Services provided to Medicaid-enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills; enhancing interpersonal skills; mitigating the symptoms of mental illness, and lessening the results of traumatic experiences; learning from the perspective and experiences of others; and

counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a Mental Health Professional to two or more Medicaid-enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

- 13.5.7. High Intensity Treatment: Intensive levels of service otherwise furnished under this State plan amendment that is provided to Medicaid-enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individuals' needs. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a Mental Health Professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the Individual Service Plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning shall be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the Individual Service Plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

- 13.5.8. Individual Treatment Services: A set of treatment services designed to help a Medicaid-enrolled individual attain goals as prescribed in his/her Individual Service Plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include developing the individual's self care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid-enrolled individual. This service is provided by or under the supervision of a Mental Health Professional.

- 13.5.9. Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within 30 working days. Routine services may begin before the

completion of the intake once medical necessity is established. This service is provided by a Mental Health Professional.

- 13.5.10. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.
- 13.5.11. Medication Monitoring: Face-to-face, one-on-one cueing, observing, and encouraging a Medicaid-enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid-enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a Mental Health Professional. Time spent with the Enrollee is the only direct service billable component of this modality.
- 13.5.12. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid Enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of eight (8) hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.
- 13.5.13. Peer Support: Services provided by peer counselors to Medicaid-enrolled individuals under the consultation, facilitation or supervision of a Mental Health Professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by peer counselors to the consumer are noted in the consumer's Individualized Service Plan which delineates specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available to each Enrollee for no more than four (4) hours per day. The ratio for this service is no more than 1:20.

- 13.5.14. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.
- 13.5.15. Rehabilitation Case Management: A range of activities by the outpatient Community Mental Health Agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, maximize the benefits of the placement, minimize the risk of unplanned re-admission and to increase the community tenure for the individual. Services are provided by or under the supervision of a Mental Health Professional.
- 13.5.16. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.
- 13.5.17. Stabilization Services: Services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the Mental Health Professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

- 13.5.18. Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid-enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increase knowledge of mental illnesses and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the Medicaid-enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a Mental Health Professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

- 13.6. The following services are allowable under 1915 (b) Waiver Authority and are to be provided within the funding for B3 rates as described in Exhibit D.

- 13.6.1. Respite Care: A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer's or caregiver's home, in an organization's facilities, in the respite worker's home, etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a Mental Health Professional. Respite under the Federal 1915 (b) Mental Health Waiver is only available to those consumers who do not have this coverage under some other federal program.

- 13.6.2. Supported Employment: A service for Medicaid Enrollees who are currently not receiving federally-funded vocational services such as those provided through the Division of Vocational Rehabilitation. Services shall include:

- An assessment of work history, skills, training, education, and personal career goals.
- Information about how employment will affect income and benefits the consumer is receiving because of their disability.
- Preparation skills such as resume development and interview skills.
- Involvement with consumers served in creating and revising individualized job and career development plans that include;
 - (a) Consumer strengths
 - (b) Consumer abilities
 - (c) Consumer preferences
 - (d) Consumer's desired outcomes.
- Assistance in locating employment opportunities that is consistent with the consumer's strengths, abilities, preferences and desired outcomes.

- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.
- Services are provided by or under the supervision of a Mental Health Professional.

13.6.3. Mental Health Clubhouse - is a service specifically contracted by the PIHP to provide a consumer directed program to Medicaid Enrollees where they receive multiple services. These services may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must be certified by the Mental Health Division beginning in 2008. The Mental House Clubhouse must operate at least ten (10) hours a week outside normal business hours Monday through Friday, or anytime on Saturday or Sunday based on the needs of clubhouse members. An exception to the distance standards is granted for clubhouse services. Services include the following:

- Opportunities to work within the clubhouse. Such work contributes to the operation and enhancement of the clubhouse community.
- Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness.
- Assistance with employment opportunities, housing, transportation, education and benefits planning.
- Operate at least ten hours a week after 5:30pm Monday through Friday, or anytime on Saturday or Sunday, and
- Opportunities for socialization activities.

13.7. DSHS may petition CMS to amend the Medicaid State Plan during this Contract period. If the Medicaid State Plan is amended the Contractor shall implement any changes to the provision of Medically Necessary mental health services no later than 30 days following CMS approval of the plan.

13.8. Coordination of Care

13.8.1. Coordination with Primary Medical Care Services.

13.8.2. The Contractor must ensure that for Enrollees who have a suspected or identified physical health care problem the following shall occur:

- Appropriate referrals are made to a physical health care provider.
- The individualized service plan identifies medical concerns and plans to address them.

13.8.3. The Contractor shall coordinate with the Children's Long-term Inpatient Program (CLIP) Administration regarding all children and youth referred to CLIP. The Contractor shall identify a single RSN employee who is responsible for overall management of the RSN's voluntary and involuntary CLIP applications and the primary community contact for the CLIP Administration.

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

- 13.8.4.1. Create and maintain a local process to assess the needs of children being considered for voluntary admission and coordinate referrals to the CLIP Administration.

- 13.8.4.2. When a person under age eighteen (18) is committed for 180 days under RCW 71.34, the Contractor must assess the child's needs prior to the admission to the CLIP facility. The Contractor must provide a designee who participates in the CLIP Placement Team assignment of children subject to court-ordered involuntary treatment. A RSN representative will share the community and/or family recommendations for CLIP program assignment of committed adolescents.
- 13.8.4.3. Assess the needs of juveniles transferred for evaluation purposes by the Juvenile Rehabilitation Administration (JRA), or under RCW 10.77 to the Child Study and Treatment Center (CSTC).
- 13.8.4.4. Ensure that all required CLIP application materials, including community/family CLIP placement recommendations are submitted to the CLIP Administration prior to consideration of voluntary referrals.
- 13.8.5. After CLIP Admission, the Contractor must provide Rehabilitation Case Management, which includes a range of activities by the Contractor's or CMHA's liaison conducted in or with a facility for the direct benefit of the admitted youth. This person is the primary case contact for CLIP programs responsible for managing individual cases from pre-admission through discharge. The Contractor's liaison or designated CMHA must participate in treatment and discharge planning with the CLIP treatment team.
 - 13.8.5.1. Review for prior authorization recommendations for short-term/acute hospitalization when it is determined by the CLIP program that this is required.
- 13.8.6. Psychiatric Inpatient Services:
 - 13.8.6.1. The Contractor or its designee shall contact the inpatient unit within three (3) working days for all Enrollee admissions.
 - 13.8.6.2. The Contractor or its designee shall provide to the inpatient unit any available information regarding the Enrollee's treatment history at the time of admission. The Contractor or its designee must provide all available information related to payment resources and coverage.
 - 13.8.6.3. The Contractor's liaison or designated CMHA must participate in treatment and discharge planning with the inpatient treatment team. A contracted network CMHA must be designated prior to discharge for Enrollees and their families seeking community support services.

In the event the liaison is aware that the Enrollee is a Tribal Member or receiving mental health services from a Tribal or Urban Indian Health Program and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in discharge planning and transition for the Enrollee. If the Enrollee chooses to be served only by the Tribal Mental Health Service referral to a contracted network CMHA is not required.
 - 13.8.6.4. For Enrollees on Less Restrictive Alternatives (LRA) who meet Medical Necessity and the Access to Care Standards, the Contractor or designee shall offer covered mental health services to assist with compliance with LRA requirements.
 - 13.8.6.5. The Contractor or its designee shall respond to requests for participation, implementation, and monitoring of Enrollees on Conditional Releases (CR) consistent

with RCW 71.05.340. The Contractor or designee shall provide covered mental health services for Enrollees who meet Medical Necessity and the Access to Care Standards.

- 13.8.6.6. The Contractor shall ensure provision of covered mental health services to Enrollees on a Conditional Release under RCW 10.77.150 for Enrollees who meet Medical Necessity and the Access to Care Standards.
- 13.8.6.7. The Contractor shall use best efforts to utilize community resources and covered mental health services to minimize State Hospital admissions.
- 13.8.6.8. The Contractor or designee shall use best efforts to secure an appointment, within 30 days of release from the facility, for medication, evaluation and prescription re-fills for Enrollees discharged from inpatient care, to ensure there is no lapse in prescribed medication. This may be arranged with providers other than Subcontractors of the Contractor.
- 13.8.6.9. The Contractor shall use best efforts to offer covered mental health services for follow-up and after-care as needed when the Contractor or Subcontractor are aware that an Enrollee has been treated in an emergency room. These services shall be offered in order to maintain the stability gained by the provision of emergency room services.

13.9. Early Periodic Screening Diagnosis and Treatment (EPSDT)

- 13.9.1. EPSDT services must be structured in ways that are culturally and age appropriate, involve the family and be available to all Enrollees under the age of 21. Intake evaluations provided under EPSDT must include an assessment of the family's needs.
- 13.9.2. EPSDT requires the Contractor to respond to referrals from primary medical care providers. This must include at least:
 - 13.9.2.1. A written notice replying to the Physician, ARNP, Physician Assistant, trained public health nurse or RN who made the EPSDT referral. This notice must include at least the date of intake and diagnosis.
 - 13.9.2.2. In the event the Enrollee does not have a primary care provider, use the following number to assist them to locate a provider:

Toll free number: 1-800-562-3022

13.10. Allied System Coordination:

- 13.10.1. The Contractor shall develop new or update an existing allied system coordination plan for each of the following programs:
 - 13.10.1.1. Aging and Disability Services Administration (ADSA).
 - 13.10.1.2. Chemical Dependency and Substance Abuse services.
 - 13.10.1.3. Children's Administration.
 - 13.10.1.4. Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Healthy Options Plans.

13.10.1.5. Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections).

13.10.1.6. Division of Vocational Rehabilitation.

13.10.1.7. Juvenile Rehabilitation Administration.

13.10.1.8. Any Community Integration Assistance Program (CIAP) within the boundaries of the RSN that is not a Subcontractor of the RSN.

13.11. Allied System Coordination Plan An allied system coordination plan must contain all of the following elements. In the event any of these allied systems chooses not to jointly create a coordination plan, the Contractor must develop a plan that addresses all the requirements in this section by describing how the Contractor proposes to interact with the allied system:

13.11.1. Clarification of roles and responsibilities of the allied systems in serving multi-system consumers. For children this includes EPSDT coordination for any child serving agency, including a process for participation by the agency in the development of a cross-system Individual Service Plan when indicated under EPSDT.

13.11.2. Processes for the sharing of information related to eligibility, access and authorization.

13.11.3. Identification of needed local resources, including initiatives to address those needs.

13.11.4. A process for facilitation of community reintegration from out-of-home placements (e.g. State hospitals, Children's Long- term Inpatient facilities, Juvenile Rehabilitation Administration facilities, foster care, nursing homes, acute inpatient settings) for consumers of all ages.

13.11.5. A process or format to address disputes related to service or payment responsibility.

13.11.6. A process to evaluate progress in cross-system coordination and integration of services.

14. TRIBAL RELATIONSHIPS

14.1. The Contractor must develop or attempt to develop a Tribal and Recognized American Indian Organization (RAIO) Coordination Implementation Plan with each Tribe and RAIO as listed in section 14.1.1. The Contractor must provide documentation of attempts to develop a plan if any Tribe or RAIO declines to participate. The Contractor must submit the matrix below for each Tribe or RAIO listed in Section 14.1.1 to HRSA on or before March 1, 2010.

14.1.1. The Tribes or RAIOs listed below have service areas within the contracted Service Area of the RSN which are defined in the following documents:

- The Indian Health Services map that represents Contract Health Service Delivery areas as published in the Federal Register;
- The Bureau of Indian Affairs Service Area map; and
- The DSHS 7.01 Policy, which identifies the Recognized American Indian Organizations (RAIOs).

Lummi, Nooksack, Samish, Auk-Suiattle, Snoqualmie, Stillaguamish, Swinomish, Tulalip, Upper Skagit

- 14.1.2. A Planning Checklist is attached as Exhibit B to assist with developing the Tribal and RAIO Coordination Implementation Plan. The Contractor shall consider the planning checklist in developing the Tribal and RAIO Coordination Implementation Plan.
- 14.1.3. As part of the Tribal and RAIO Coordination Implementation planning, the RSN must extend an invitation to those listed in section 14.1.1 to participate as members of the RSN Advisory Board. Any issues that arise from this invitation must be detailed in the plan, including a timeline to address these issues and expected outcomes. This includes any Governing Board by-laws or other local rules or regulations that would need to be changed to accommodate the Tribal representation occurring.

Tribal and RAIO Coordination Implementation Plan and Progress Report For Regional Support Networks				
Due to HRSA on or before March 1, 2010.				
Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Fiscal Year Starting Last July 1

- 14.2. Subcontracts with Tribes and Recognized American Indian Organizations (RAIO).
 - 14.2.1. If the Contractor chooses to enter into a Subcontract with a Tribe the Subcontract must include one (1) of the following:
 - 14.2.1.1. General Terms and Conditions that are modeled on the DSHS and Indian Nation Agreement General Terms and Conditions.
 - 14.2.1.2. General Terms and Conditions modeled on the Intergovernmental Agreement for Social and Health Services between Tribes and The Washington State Department of Social and Health Services.
 - 14.2.1.3. General Terms and Conditions that were developed through a process facilitated by a HRSA Tribal Liaison.
 - 14.2.1.4. General Terms and Conditions that were developed between the Tribe and the Contractor. In this case, a written statement must be provided to HRSA Tribal Liaison from each party that verifies both are in Agreement with the content in the General Terms and Conditions.
 - 14.2.2. If the Contractor chooses to enter into a Subcontract with a RAIO, the Contract must include one (1) of the following:
 - 14.2.2.1. General Terms and Conditions that were developed through a process facilitated by a HRSA Tribal Liaison.
 - 14.2.2.2. General Terms and Conditions that were developed between the RAIO and the Contractor. In this case a written statement must be provided to a HRSA Tribal Liaison

from each party that verifies both are in Agreement with the content in the General Terms and Conditions.

- 14.2.3. Any Subcontracts with Tribes and RAIOS must be consistent with the laws and regulations that are applicable to the Tribe or RAIOS. The Contractor must work with each Tribe to identify those areas that place legal requirements on the Tribe that do not apply and refrain from passing these requirements on to Tribes.
- 14.2.4. HRSA Tribal Liaison may be available for technical assistance in identifying what legal requirements the Contractor can be relieved of in Tribal or RAIOS Subcontracts.
- 14.2.5. The Contractor shall have a policy and procedure that requires efforts to recruit and maintain Ethnic Minority Mental Health Specialists – Native American from each Tribe or RAIOS listed in section 14.1.1 for use in specialists consults whenever possible.
- 14.2.6. The Contractor may not implement fees or policies that would create a charge, deduction, copayment or other similar charges on American Indians and Alaska Natives for services provided under this Agreement.

15. REMEDIAL ACTIONS

15.1. HRSA may initiate remedial action if it is determined that any of the following situations exist:

- 15.1.1. A problem exists that negatively impacts individuals receiving services.
- 15.1.2. The Contractor has failed to perform any of the mental health services required in this Agreement.
- 15.1.3. The Contractor has failed to develop, produce, and/or deliver to HRSA any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Agreement.
- 15.1.4. The Contractor has failed to perform any administrative function required under this Agreement. For the purposes of this section, “administrative function” is defined as any obligation other than the actual provision of mental health services.
- 15.1.5. The Contractor has failed to implement corrective action required by the State and within HRSA prescribed timeframes.

15.2. HRSA may impose any one or more of the following remedial actions in any order:

- 15.2.1. Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to HRSA within 30 calendar days of notification. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Agreement. HRSA may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

15.2.1.1. Corrective action plans must include:

- 15.2.1.1.1. A brief description of the situation requiring corrective action.
- 15.2.1.1.2. The specific actions to be taken to remedy the situation.

- 15.2.1.1.3. A timetable for completion of the actions.
- 15.2.1.1.4. Identification of individuals responsible for implementation of the plan.
- 15.2.1.2. Corrective action plans are subject to approval by HRSA, which may:
 - 15.2.1.2.1. Accept the plan as submitted.
 - 15.2.1.2.2. Accept the plan with specified modifications.
 - 15.2.1.2.3. Request a modified plan.
 - 15.2.1.2.4. Reject the plan.
- 15.2.1.3. Any corrective action plan that was in place as part of a previous PIHP Agreement shall be applied to this Agreement in those areas where the Contract requirements are substantially similar.
- 15.2.2. Withhold up to five percent (5%) of the next monthly capitation payment and each monthly capitation payment thereafter until the situation has been resolved. HRSA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.
 - 15.2.2.1. Increase Withholdings identified above by up to an additional three percent (3%) for each successive month during which the remedial situation has not been resolved.
- 15.2.3. Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which HRSA provides incentives.
- 15.2.4. Terminate for Default as described in the General Terms and Conditions.

16. GENERAL TERMS AND CONDITIONS

- 16.1. **Definitions.** The words and phrases listed below, as used in the Agreement, shall each have the following definitions:
 - 16.1.1. **“Agreement”** means this document, the General Terms and Conditions, and the Special Terms and Conditions, including any Exhibits and other documents attached or incorporated by reference.
 - 16.1.2. **“Central Contract Services”** means the DSHS statewide agency headquarters contracting office, or successor section or office.
 - 16.1.3. **“CFR”** means Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation. The CFR may be accessed at <http://www.gpoaccess.gov/cfr/index.html>
 - 16.1.4. **“Contracts Administrator”** means the manager, or successor, of Central Contract Services or successor section or office.
 - 16.1.5. **“Contractor”** means the regional support network (RSN) designated by the county authority, group of county authorities or other entity recognized by the Secretary, and has authority to establish and operate a community mental health program.

- 16.1.6. **“Debarment”** means an action taken by a federal official to exclude a person or business entity from participating in transactions involving certain federal funds.
- 16.1.7. **“DSHS” or “the department” or “the Department”** means the Department of Social and Health Services of the State of Washington and its Secretary, officers, employees, and authorized agents.
- 16.1.8. **“DSHS Representative”** means any DSHS employee who has been delegated contract-signing authority by the DSHS Secretary or his/her designee.
- 16.1.9. **“General Terms and Conditions”** means the contractual provisions contained within this Agreement, which govern the contractual relationship between DSHS and the Contractor, under this Agreement.
- 16.1.10. **“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.
- 16.1.11. **“RCW”** means the Revised Code of Washington. All references in this Agreement to RCW chapters or sections shall include any successor, amended, or replacement statute. The RCW can be accessed at <http://apps.leg.wa.gov/rcw>
- 16.1.12. **“Secretary”** means the individual appointed by the Governor, State of Washington, as the head of DSHS, or his/her designee.
- 16.1.13. **“Subcontract”** means a separate Contract between the Contractor and an individual or entity (“Subcontractor”) to perform all or a portion of the duties and obligations that the Contractor shall perform pursuant to this Agreement.
- 16.1.14. **“USCA”** means United States Code Annotated. All references to USCA chapters or sections in this Agreement shall include any successor, amended, or replacement statute. The USCA may be accessed at <http://www.gpoaccess.gov/uscode/>
- 16.1.15. **“WAC”** means the Washington Administrative Code. All references in this Agreement to WAC chapters or sections shall include any successor, amended, or replacement regulation. The WAC can be accessed at <http://apps.leg.wa.gov/wac>
- 16.2. **Amendment.** This Agreement, or any term or condition, may be modified only by a written amendment signed by both parties. Only personnel authorized to bind each of the parties shall sign an amendment.
- 16.3. **Assignment.** Except as otherwise provided herein, the Contractor shall not assign rights or obligations derived from this Agreement to a third party without the prior, written consent of the DSHS Contracts Administrator and the written assumption of the Contractor’s obligations by the third party.
- 16.4. **Billing Limitations.** Unless otherwise specified in this Agreement, DSHS shall not pay any claims for services submitted more than twelve (12) months after the calendar month in which the services were performed.

- 16.5. Compliance with Applicable Law. At all times during the term of this Agreement the Contractor and DSHS shall comply with all applicable federal, state, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations.
- 16.6. Confidentiality. The parties shall use Personal Information and other confidential information gained by reason of this Agreement only for the purpose of this Agreement. DSHS and the Contractor shall not disclose, transfer, or sell any such information to any other party, except as provided by law or, in the case of Personal Information except as provided by law or with the prior written consent of the person to whom the Personal Information pertains. The parties shall maintain the confidentiality of all Personal Information and other confidential information gained by reason of this Agreement and shall return or certify the destruction of such information if requested in writing by the party to this Agreement that provided the information.
- 16.7. Contractor Certification Regarding Ethics. By signing this Agreement, the Contractor certifies that the Contractor is in compliance with Chapter 42.23 RCW and shall comply with Chapter 42.23 RCW throughout the term of this Agreement.
- 16.8. Debarment Certification. The Contractor, by signature to this Agreement, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal department or agency. The Contractor also agrees to include the above requirement in all Subcontracts into which it enters.
- 16.9. Entire Agreement. This Agreement, including all documents attached to or incorporated by reference, contains all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or bind the parties.
- 16.10. Governing Law and Venue. The laws of the State of Washington govern this Agreement. In the event of a lawsuit by the Contractor against DSHS involving this Agreement, venue shall be proper only in Thurston County, Washington. In the event of a lawsuit by DSHS against the Contractor involving this Agreement, venue shall be proper only as provided in RCW 36.01.050.
- 16.11. Independent Status. For purposes of this Agreement, the Contractor acknowledges that the Contractor is not an officer, employee, or agent of DSHS or the State of Washington. The Contractor shall not hold out itself or any of its employees as, nor claim status as, an officer, employee, or agent of DSHS or the State of Washington. The Contractor shall not claim for itself or its employees any rights, privileges, or benefits, which would accrue to an employee of the State of Washington. The Contractor shall indemnify and hold harmless DSHS from all obligations to pay or withhold federal or state taxes or contributions on behalf of the Contractor or the Contractor's employees.
- 16.12. Inspection. Either party may request reasonable access to the other party's records and place of business for the limited purpose of monitoring, auditing, and evaluating the other party's compliance with this Agreement, and applicable laws and regulations. During the term of this Agreement and for one (1) year following termination or expiration of this Agreement, the parties shall, upon receiving reasonable written notice, provide the other party with access to its place of business and to its records which are relevant to its compliance with this Agreement, and applicable laws and regulations. This provision shall not be construed to give either party access to the other party's records and place of business for any other purpose. Nothing herein shall be construed to authorize either party to possess or copy records of the other party.

- 16.13. Insurance. DSHS certifies that it is self-insured under the State's self-insurance liability program, as provided by RCW 4.92.130, and shall pay for losses for which it is found liable. The Contractor certifies that it is self-insured, is a member of a risk pool, or maintains insurance coverage as required in this Agreement. The Contractor shall pay for losses for which it is found liable.
- 16.14. Lawsuits. Nothing in this Agreement shall be construed to mean that the Contractor, a County, RSN, or their Subcontractors, agents or employees, can bring a legal claim for declaratory relief, injunctive relief, judicial review under RCW 34.05, or civil liability against the state or state agencies for actions or inactions performed pursuant to the administration of RCW 71.05 or RCW 71.24 with regard to the following: (a) allocation or payment of federal or state funds; (b) the use or allocation of state hospital beds; or (c) financial responsibility for the provision of long term or short term inpatient mental health care.
- 16.15. Maintenance of Records. During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, both parties shall maintain records sufficient to:
- 16.15.1. Document performance of all acts required by law, regulation, or this Agreement.
 - 16.15.2. Demonstrate accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Agreement.
 - 16.15.3. For the same period, the Contractor shall maintain records sufficient to substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance.
- 16.16. Order of Precedence. In the event of an inconsistency in this Agreement, unless otherwise provided herein, the inconsistency shall be resolved by giving precedence, in the following order, to:
- 16.16.1. Applicable federal and State of Washington statutes and regulations.
 - 16.16.2. The General Terms & Conditions of this Agreement.
 - 16.16.3. The Special Terms & Conditions of this Agreement.
 - 16.16.4. Any Exhibits attached or incorporated into this Agreement by reference.
- 16.17. Ownership of Material. Material created by the Contractor and paid for by DSHS as a part of this Agreement shall be owned by DSHS and shall be "work made for hire" as defined by Title 17 USCA, Section 101. This material includes, but is not limited to: books; computer programs; documents; films; pamphlets; reports; sound reproductions; studies; surveys; tapes; and/or training materials. Material which the Contractor uses to perform this Agreement but is not created for or paid for by DSHS is owned by the Contractor and is not "work made for hire"; however, DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.
- 16.18. Responsibility. Each party to this Agreement shall be responsible for the negligence of its officers, employees, and agents in the performance of this Agreement. No party to this Agreement shall be responsible for the acts and/or omissions of entities or individuals not party to this Agreement. DSHS and the Contractor shall cooperate in the defense of tort lawsuits, when possible. Both parties agree and understand that this provision may not be feasible in all circumstances. DSHS and the Contractor agree to notify the attorneys of record in any tort lawsuit where both are parties

if either DSHS or the Contractor enters into settlement negotiations. It is understood that the notice shall occur prior to any negotiations, or as soon as possible, and the notice may be either written or oral.

16.19. Severability. The provisions of this Agreement are severable. If any court holds any provision of this Agreement, including any provision of any document incorporated by reference, invalid, that invalidity shall not affect the other provisions this Agreement.

16.20. Subcontracting. The Contractor may Subcontract services to be provided under this Agreement. If DSHS, the Contractor, and a Subcontractor of the Contractor are found by a jury or trier of fact to be jointly and severally liable for personal injury damages rising from any act or omission from the Contract, then DSHS shall be responsible for its proportionate share, and the Contractor shall be responsible for its proportionate share. Should the Subcontractor be unable to satisfy its joint and several liability, DSHS and the Contractor shall share in the Subcontractor's unsatisfied proportionate share in direct proportion to the respective percentage of their fault as found by the jury or trier of fact. Nothing in this term shall be construed as creating a right or remedy of any kind or nature in any person or party other than DSHS and the Contractor. This term shall not apply in the event of a settlement by either DSHS or the Contractor.

16.21. Subrecipients.

16.21.1. General. If the Contractor is a subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Agreement, the Contractor shall:

16.21.1.1. Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity.

16.21.1.2. Maintain internal controls that provide reasonable assurance that the Contractor is managing federal awards in compliance with laws, regulations, and provisions of Contracts or grant Agreements that could have a material effect on each of its federal programs.

16.21.1.3. Prepare appropriate financial statements, including a schedule of expenditures of federal awards.

16.21.1.4. Incorporate OMB Circular A-133 audit requirements into all Agreements between the Contractor and its Subcontractors who are subrecipients.

16.21.1.5. Comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation.

16.21.1.6. Comply with the applicable requirements of OMB Circular A-87 and any future amendments to OMB Circular A-87, and any successor or replacement Circular or regulation.

- 16.21.1.7. Comply with the Omnibus Crime Control and Safe Streets Act of 1968; Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; Title II of the Americans with Disabilities Act of 1990; Title IX of the Education Amendments of 1972; The Age Discrimination Act of 1975; and The Department of Justice Non-Discrimination Regulations, 28 C.F.R. Part 42, Subparts C D E, and G, and 28 C.F.R. Part 35 and Part 39. (See www.ojp.usdoj/gov/ocr for additional information and access to the aforementioned Federal laws and regulations.)
- 16.21.2. Single Audit Act Compliance. If the Contractor is a subrecipient and expends \$500,000 or more in federal awards from all sources in any fiscal year, the Contractor shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the Contractor shall:
 - 16.21.2.1. Submit to the DSHS contact person, listed on the first page of this Agreement, the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor.
 - 16.21.2.2. Follow-up and develop corrective action for all audit findings; in accordance with OMB Circular A-133, and prepare a "Summary Schedule of Prior Audit Findings."
- 16.22. Overpayments. If it is determined by DSHS, or during the course of the required audit, that the Contractor has been paid unallowable costs under this Agreement or any, DSHS may require the Contractor to reimburse DSHS in accordance with OMB Circular A-87.
- 16.23. Survivability. The terms and conditions contained in this Agreement, which by their sense and context, are intended to survive the expiration of the particular Agreement shall survive. Surviving terms include, but are not limited to: Confidentiality, Disputes, Inspection, Lawsuits, Maintenance of Records, Ownership of Material, Responsibility, Termination for Default, Termination Procedure, and Title to Property.
- 16.24. Termination Due to Change in Funding. If the funds upon which DSHS relied to establish this Agreement are withdrawn, reduced, or limited, or if additional or modified conditions are placed on such funding, DSHS may terminate this Agreement by providing at least five (5) business days' written notice to the Contractor. The termination shall be effective on the date specified in the notice of termination.
- 16.25. Termination for Convenience. DSHS may terminate this Agreement in whole or in part for convenience by giving the Contractor at least thirty (30) calendar days' written notice. The Contractor may terminate this Agreement for convenience by giving DSHS at least thirty (30) calendar days' written notice addressed to the DSHS contact person (or to his or her successor) listed on the first page of this Agreement.
- 16.26. Termination for Default.
 - 16.26.1. The Contracts Administrator may terminate this Agreement for default, in whole or in part, by written notice to the Contractor, if DSHS has a reasonable basis to believe that the Contractor has:
 - 16.26.1.1. Failed to meet or maintain any requirement for contracting with DSHS.
 - 16.26.1.2. Failed to perform under any provision of this Agreement.

16.26.1.3. Violated any law, regulation, rule, or ordinance applicable to this Agreement.

16.26.1.4. Otherwise breached any provision or condition of this Agreement.

16.26.2. Before the Contracts Administrator may terminate this Agreement for default, DSHS shall provide the Contractor with written notice of the Contractor's noncompliance with the Agreement and provide the Contractor a reasonable opportunity to correct the Contractor's noncompliance. If the Contractor does not correct the Contractor's noncompliance within the period of time specified in the written notice of noncompliance, the Contracts Administrator may then terminate the Agreement. The Contracts Administrator may terminate the Agreement for default without such written notice and without opportunity for correction if DSHS has a reasonable basis to believe that a client's health or safety is in jeopardy.

16.26.3. The Contractor may terminate this Agreement for default, in whole or in part, by written notice to DSHS, if the Contractor has a reasonable basis to believe that DSHS has:

16.26.3.1. Failed to meet or maintain any requirement for contracting with the Contractor;

16.26.3.2. Failed to perform under any provision of this Agreement;

16.26.3.3. Violated any law, regulation, rule, or ordinance applicable to this Agreement; and/or

16.26.3.4. Otherwise breached any provision or condition of this Agreement.

16.26.4. Before the Contractor may terminate this Agreement for default, the Contractor shall provide DSHS with written notice of DSHS' noncompliance with the Agreement and provide DSHS a reasonable opportunity to correct DSHS' noncompliance. If DSHS does not correct DSHS' noncompliance within the period of time specified in the written notice of noncompliance, the Contractor may then terminate the Agreement.

16.27. Termination Procedure. The following provisions apply in the event this Agreement is terminated:

16.27.1. The Contractor shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of clients, distribution of property, and termination of services.

16.27.2. The Contractor shall promptly deliver to the DSHS contact person (or to his or her successor) listed on the first page of this Agreement, all DSHS assets (property) in the Contractor's possession, including any material created under this Agreement. Upon failure to return DSHS property within ten (10) working days of this Agreement termination, the Contractor shall be charged with all reasonable costs of recovery, including transportation. The Contractor shall take reasonable steps to protect and preserve any property of DSHS that is in the possession of the Contractor pending return to DSHS.

16.27.3. DSHS shall be liable for and shall pay for only those services authorized and provided through the effective date of termination. DSHS may pay an amount mutually agreed upon by the parties for partially completed work and services, if work products are useful to or usable by DSHS.

16.27.4. If the Contracts Administrator terminates this Agreement for default, DSHS may withhold a sum from the final payment to the Contractor that DSHS determines is necessary to protect DSHS against loss or additional liability. DSHS shall be entitled to all remedies available at

law, in equity, or under this Agreement due to Contractor's default. If it is later determined that the Contractor was not in default, or if the Contractor terminated this Agreement for default, the Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement except as to the limitations set forth in Section 16.14 entitled "Lawsuits".

- 16.28. **Treatment of Client Property.** Unless otherwise provided in this Agreement, the Contractor shall ensure that any adult client receiving services from the Contractor under this Agreement has unrestricted access to the client's personal property. The Contractor shall not interfere with any adult client's ownership, possession, or use of the client's property. The Contractor shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon termination or completion of this Agreement, the Contractor shall promptly release to the client and/or the client's guardian or custodian all of the client's personal property. This section does not prohibit the Contractor from implementing such lawful and reasonable policies, procedures and practices as the Contractor deems necessary for safe, appropriate, and effective service delivery (for example, appropriately restricting client access to, or possession or use of lawful or unlawful weapons and drugs).
- 16.29. **Title to Property.** Title to all property purchased or furnished by DSHS for use by the Contractor during the term of this Agreement shall remain with DSHS. Title to all property purchased or furnished by the Contractor for which the Contractor is entitled to reimbursement by DSHS under this Agreement shall pass to and vest in DSHS. The Contractor shall take reasonable steps to protect and maintain all DSHS property in its possession against loss or damage and shall return DSHS property to DSHS upon Agreement termination or expiration, reasonable wear and tear excepted.
- 16.30. **Waiver.** Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Agreement unless amended as set forth in Section 16.2, "Amendment". Only the Contracts Administrator or designee has the authority to waive any term or condition of this Agreement on behalf of DSHS.

17. SPECIAL TERMS AND CONDITIONS

- 17.1. **Compliance with Applicable Law.** At all times during the term of this Agreement, the Contractor shall comply with all applicable federal, State, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations, and the following, whether or not a specific citation is identified in various sections of this Agreement:
- 17.1.1. Title XIX and Title XXI of the Social Security Act and Title 42 of the Code of Federal Regulations.
- 17.1.2. All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement.
- 17.2. **Confidentiality of Personal Information**
- 17.2.1. The Contractor shall protect all Personal Information, records, and data from unauthorized disclosure in accordance with 42 CFR §431.300 through §431.307, RCWs 70.02, 71.05, 71.34, and for individuals receiving substance abuse services, in accordance with 42 CFR Part 2 and RCW 70.96A. The Contractor shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services. Pursuant to 42 CFR §431.301 and §431.302, personal information concerning applicants and recipients may be disclosed for

purposes directly connected with the administration of this Agreement and the State Medicaid Plan. Such purposes include, but are not limited to:

- 17.2.1.1. Establishing eligibility.
- 17.2.1.2. Determining the amount of medical assistance.
- 17.2.1.3. Providing services for recipients.
- 17.2.1.4. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan.
- 17.2.1.5. Assuring compliance with federal and State laws and regulations, and with terms and requirements of the Agreement.
- 17.2.2. The Contractor shall comply with all confidentiality requirements of the Health Insurance Portability and Accountability Act (45 CFR160 and 164).
- 17.2.3. In the event a Consumer's picture or personal story will be used, the Contractor shall first obtain written consent from that Consumer.
- 17.3. Declaration That Individuals Served Under the Medicaid and Other Mental Health Programs Are Not Third-Party Beneficiaries Under this Agreement.
 - 17.3.1. Although DSHS and the Contractor mutually recognize that services under this Agreement shall be provided by the Contractor to individuals receiving services under the Medicaid program, and RCW 71.05, RCW 71.24, and RCW 71.34, it is not the intention of either DSHS or the Contractor that such individuals, or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement.
- 17.4. Disputes. When a dispute arises over an issue concerning the terms of this Agreement, the parties agree to the following process to address the dispute.
 - 17.4.1. The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and DSHS Contact listed on page one (1) of this Agreement.
 - 17.4.2. If the Contractor is not satisfied with the outcome, the Contractor may submit the disputed issue, in writing to DSHS/ HRSA/Division of Healthcare Services 625 8th Ave SE, PO Box 45530, Olympia, WA 98504-5330.
 - 17.4.3. The written submission must contain the following information:
 - 17.4.3.1. The Contractor's Contact for the issue.
 - 17.4.3.2. The Issue in dispute.
 - 17.4.3.3. The Contractor's position on the issue.
 - 17.4.4. Each party to this Agreement shall then appoint one (1) member to a dispute board. The members so appointed shall jointly appoint an additional member to the dispute board. The dispute board shall review the facts, Agreement terms, and applicable statutes and rules and make a determination of the dispute.

- 17.4.5. Both parties agree to make their best efforts to resolve disputes arising from this Agreement and agree that this dispute resolution process is the sole administrative remedy available under this Agreement. Participation in this dispute process shall precede any judicial or quasi-judicial action not otherwise prohibited by contract or law, and shall be the final administrative remedy available to the parties.
- 17.5. Duplicative Reports and Deliverables. If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties the Contractor may provide one (1) report or deliverable that contains the information required by both Agreements.
- 17.6. Fraud and Abuse. Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person and includes any act that constitutes fraud under applicable federal or State law. Abuse means provider actions that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. The Contractor shall do the following to guard against Fraud and Abuse:
- 17.6.1. Create and maintain a mandatory compliance plan that includes provisions to educate RSN staff and provider staff of the false claim act and whistle blower protections.
- 17.6.2. Develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards.
- 17.6.3. Designate a compliance officer and a compliance committee that is accountable to senior management;
- 17.6.4. Provide effective ongoing training and education for the compliance officer, staff of the Contractor, and selected staff of the CMHAs.
- 17.6.5. Facilitate effective communication between the compliance officer, the Contractor's employees, and the Contractor's network of CMHAs.
- 17.6.6. Enforce standards through well-publicized disciplinary guidelines.
- 17.6.7. Conduct internal monitoring and auditing of the PIHP and providers.
- 17.6.8. Respond promptly to detected offenses and develop corrective action initiatives.
- 17.6.9. Report fraud and/or abuse information to HRSA as soon as it is discovered to include the source of the complaint, the involved CMHA, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.
- 17.7. Information Requests: The Contractor shall maintain information necessary to promptly respond to written requests by HRSA Director, an Office Chief or their designee. The Contractor shall submit information detailing the amount spent throughout its service area on specific items upon request by HRSA Director, an Office Chief or their designee.
- 17.8. Commercial General Liability Insurance (CGL). If the Contractor is not a member of a risk pool, the Contractor shall carry CGL to include coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The policy shall include liability arising out of premises, operations, independent

Contractors, products, completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. The State of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds.

- 17.9. Lobby Activities Prohibited. Federal Funds must not be used for Lobbying activities.
- 17.10. Records Retention. During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records is started before expiration of the six year period, the records shall be retained until completion and resolution of all issues arising there from or until the end of the six (6) year period, whichever is later.
 - 17.10.1. The Contractor shall maintain records sufficient to:
 - 17.10.1.1. Maintain the content of all medical records in a manner consistent with utilization control requirements of 42 CFR §456, 42 CFR §456.111, and 42 CFR §456.211.
 - 17.10.1.2. Document performance of all acts required by law, regulation, or this Agreement.
 - 17.10.1.3. Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance.
 - 17.10.1.4. Demonstrate the accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Agreement.
 - 17.10.2. The Contractor and its Subcontractors shall cooperate in all reviews, including but not limited to, surveys, and research conducted by DSHS or other Washington State Departments.
 - 17.10.3. Evaluations under this Agreement shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services, and to determine whether the Contractor and its Subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable State and federal regulations as existing or hereafter amended.
 - 17.10.4. DSHS shall maintain books, records, documents, and other materials relevant to this Agreement which sufficiently and properly reflect all payments made, including the Department's rate setting activities related to the Contractor, or other actions taken in regard to the Contractor's performance of the services described herein.
- 17.11. Subcontracting. The Contractor shall not subcontract with an individual provider or an entity with an individual who is an officer, director, agent, or manager, or who owns or has a controlling interest in the entity, and who has been convicted of crimes as specified in 42 USC §1320a section 1128 of the Social Security Act.
- 17.12. Termination of RSN Function Notice Requirements
 - 17.12.1. Either party to this Agreement must provide 180 days notice of any issue that may cause the party to voluntarily terminate, refuse to renew, or refuse to sign a mandatory amendment to this Agreement.

- 17.12.2. If the Contractor at any time decides it shall no longer be a RSN within the Washington state mental health system for any reason, the Contractor must provide the DSHS contact person, or successor, listed on the first page of this Agreement with written notice at least 90 days prior to the effective date of termination and work with HRSA to develop a mutually agreed upon transition plan with the collaborative goal of minimizing the disruption of services to RSN consumers. The transition plan shall address all issues leading to the transition of the RSN function to DSHS such as the use of Reserves, claims reconciliation, and of all items and/or requirements of the Contractor that extend beyond the termination of services.
- 17.12.3. DSHS must provide the contractor contact person, or successor, listed on the first page of this Agreement with written notice at least 90 days written notice if DSHS decides to voluntarily terminate, refuses to renew, or refuses to sign a mandatory amendment to this Agreement.