



RSN AGREEMENT

DSHS Agreement Number:
0969-74901

09-11 SMHC 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		CONTRACTOR doing business as (DBA)	
North Sound Regional Support Network		North Sound RSN	
CONTRACTOR ADDRESS		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)	DSHS INDEX NUMBER
117 North First Street, Suite 8 Mount Vernon WA 98273-2858		601-291-840	1553
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR FAX	CONTRACTOR E-MAIL ADDRESS
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DSHS ADMINISTRATION	DSHS DIVISION	DSHS CONTRACT CODE	
Health and Recovery Services Administration	Mental Health Division	4105LS-69	
DSHS CONTACT NAME AND TITLE		DSHS CONTACT ADDRESS	
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(360) 725-1073 Ext:	(360) 753-7315	melena.thompson@dshs.wa.gov	
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT?		CFDA NUMBER(S)	
No			
AGREEMENT START DATE	AGREEMENT END DATE	MAXIMUM AGREEMENT AMOUNT	
10/1/2009	9/30/2011	\$39,603,842.00	
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 - State Hospital Bed Allocation; Exhibit F - PALS Bed Allocation <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	DATE SIGNED
		Greg C. Long, Deputy Director	
DSHS SIGNATURE		PRINTED NAME AND TITLE	DATE SIGNED
		Michael Rice, Senior Contracts Manager HRSA, Division of Legal Services	

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PURPOSE OF AGREEMENT - RSN

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

Period of Performance – This Agreement is in effect from 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. **Administrative Cost** means costs for the general operation of the public mental health system. These activities cannot be identified with a specific direct services or direct service support function as defined in the BARS supplemental instructions.
- 1.2. **Allen and Marr Class Members.** Allen Class Member refers specifically to any DDD enrolled client who was admitted to, or already in, Western State Hospital, on or after June 1, 1997. Marr Class Member refers specifically to any DDD enrolled client who was admitted to, or already in, Eastern State Hospital on or after December 2, 1999. The class members are established based on ***Allen, et al. v. WSH, et al. and Marr, et al. v. ESH, et al. cases.***
- 1.3. **Available Resources** means funds appropriated for the purpose of providing community MH programs: federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under RCW 71.24 or RCW 71.05 by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other MH services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.
- 1.4. **Budget Narrative.** The Budget Narrative serves two purposes - it identifies how the costs were estimated and it justifies the need for the cost.
- 1.5. **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.
- 1.6. **Child Study and Treatment Center ("CSTC")** means the Department of Social and Health Services child psychiatric hospital.
- 1.7. **Community Mental Health Agency ("CHMA")** 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, or for a child age thirteen or older, whose parents or legal guardians are involved in the treatment plan, the definition of Consumer includes parents or legal guardians.
- 1.9. **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.

- 1.10. **Day** for purposes of this Agreement means calendar days unless otherwise indicated in the Agreement.
- 1.11. **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.
- 1.12. **Direct Care Staff** means persons employed by community mental health agencies whose primary responsibility is providing direct treatment and support to people with mental illness, or whose primary responsibility is providing direct support to such staff in areas such as client scheduling, client intake, client reception, client records-keeping, and facilities maintenance.
- 1.13. **Eastern Washington RSNs** includes RSNs contracted by DSHS to provide services in the following Washington counties: Ferry, Stevens, Pend Oreille, Lincoln, Okanogan, Grant, Adams, Chelan, Douglas, Spokane, Skamania, Klickitat, Yakima, Kittitas, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin, and Whitman.
- 1.14. **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.
- 1.15. **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.
- 1.16. **Enrollee** means a Medicaid recipient who is currently enrolled in a Pre-paid Inpatient Health Plan.
- 1.17. **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.
- 1.18. **Fair Hearing** means a hearing before the Washington State Office of Administrative Hearings.
- 1.19. **Family** means:
 - 1.19.1. 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.
 - 1.19.2. 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.
- 1.20. **Grievance** means an expression of dissatisfaction about any matter. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the mental health Consumer's rights.
- 1.21. **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.

- 1.22. **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.

- 1.23. **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.

- 1.24. **Mental Health Professional** means:

- 1.24.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in Chapters 71.05 and 71.34 RCW.
- 1.24.2. A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two (2) years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional.
- 1.24.3. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.
- 1.24.4. 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.
- 1.24.5. A person who has been granted a time-limited exception of the minimum requirements of a Mental Health Professional by DSHS consistent with WAC 388-865-0265.

- 1.25. **Notice of Determination** means a written notice that must be provided to Consumers to inform them that medically necessary services have been authorized or that, following an intake no additional services have been requested and/or authorized, and the reason for this determination. A Notice of Determination must contain all of the following:

- A description of authorized services and time frames.
- The right to a second opinion and to access the second opinion if services beyond the intake or previously authorized services have not been determined by the network CMHA to be Medically Necessary.
- The right to a Fair Hearing.

- 1.26. **Patient Days of Care** includes all voluntary patients and involuntarily committed patients under Chapter 71.05 RCW, regardless of where in the State Hospital they reside. Patients who are committed to the State Hospital under 10.77 RCW are not included in the Patient Days of Care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the Patient Days of Care until a petition for 90 days of civil commitment under Chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the Patient Days of Care until the patient is civilly committed under Chapter 71.05 RCW.
- 1.27. **ProviderOne** means the Department's Medicaid Management Information Payment Processing System.
- 1.28. **Publish** means an officially sanctioned document provided by HRSA on the HRSA internet or intranet websites for downloading, reading, or printing. The Contractor will be notified in writing or by e-mail when a document meets this criterion.
- 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. **Recovery** means the process by which people are able to live, work, learn, and participate fully in their communities.
- 1.33. **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.
- 1.34. **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.
- 1.35. **Routine Services** means non-emergent and non-urgent services are offered within fourteen (14) calendar days to individuals authorized to receive services as defined in the Access to Care Standards. Routine services 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.
- 1.36. **Service Area** means the geographic area covered by this Agreement for which the Contractor is responsible.
- 1.37. **Urgent** means a service to be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that Emergent Care is necessary.
- 1.38. **Washington Program of Assertive Community Treatment (WA-PACT)** is a team-based, evidence-based mental health service delivery model that incorporates the values of Recovery and

Resiliency. PACT is also a client-centered, Recovery-oriented mental health service delivery model that utilizes a multi-disciplinary team approach providing services to individuals with severe and persistent mental illnesses and co-occurring disorders. The funds for WA-PACT teams are expressly intended to achieve reductions during fiscal year (FY) 2008 and thereafter in the number of beds at the State Hospitals used by the RSNs.

- 1.39. **Western Washington RSNs** includes RSNs contracted by DSHS to provide services in the following Washington counties: San Juan, Whatcom, Island, Skagit, Snohomish, Clallam, Jefferson, Kitsap, King, Pierce, Thurston, Mason, Grays Harbor, Lewis, Pacific, Wahkiakum, Cowlitz, and Clark.

2. ADMINISTRATION

The Contractor Service Area is the geographic boundaries of Island, San Juan, Skagit, Snohomish and Whatcom Counties. The Contractor must:

- 2.1. 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.
- 2.2. 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:
 - 2.2.1. Actions to be taken when a conflict of interest, or the appearance of a conflict of interest, becomes evident.
 - 2.2.2. Requirements that members refrain from voting or joining a discussion when a conflict of interest is present.
 - 2.2.3. 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

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 who is currently receiving crisis services or outpatient mental health services from a RSN or RSN contracted provider.

- 3.1. Initial notification and any follow up must be provided to HRSA using the HRSA electronic incident reporting system. If the electronic incident reporting system is unavailable, a standardized form will be provided with instructions on how to submit.

- 3.2. The Contractor must notify the HRSA Incident Manager within one (1) business day of becoming aware of events involving a person who has an open case and is the alleged victim or perpetrator of any of the following events:
 - 3.2.1. An allegation of Rape (Chapter 9A.44 RCW) or sexual assault (as defined in RCW 70.125.030).
 - 3.2.2. 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.
 - 3.2.3. 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.
 - 3.2.4. Any allegation of financial exploitation as defined in RCW 74.34.020.
 - 3.2.5. Any suicide or a death under an unusual circumstance.
 - 3.2.6. An assault by a RSN or Subcontracted staff member involving a client with an open case.
 - 3.2.7. The Contractor must notify the 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.
 - 3.2.8. 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.
- 3.3. The RSN or Subcontractor will notify the following agencies or any others when required by law.
 - 3.3.1. Adult Protective Services.
 - 3.3.2. Child Protective Services.
 - 3.3.3. Department of Health.
 - 3.3.4. Local Law Enforcement.
 - 3.3.5. Medicaid Fraud Control Unit.
 - 3.3.6. Washington State Patrol.
- 3.4. The Contractor must maintain appropriate 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 will be provided upon request to HRSA for review and approval.
- 3.5. HRSA may require the RSN to provide additional information regarding efforts designed to prevent or lessen the possibility of future similar incidents.
- 3.6. Law enforcement inquiries regarding firearm possession. In accordance with RCW 9.41.097, the Contractor shall respond in a full and timely manner to law enforcement inquiries regarding an individual's eligibility to possess a firearm.

4. INFORMATION REQUIREMENTS

- 4.1. The Contractor must provide information to Consumers consistent with WAC 388-865-0410. The Contractor shall maintain written policy and procedures addressing all information requirements, and shall:
 - 4.1.1. Provide interpreter services for Consumers who speak a primary language other than English for all interactions between the consumer and the Contractor including, but not limited to, customer service, all appointments for any covered service, crisis services, and all steps necessary to file a Grievance or Fair Hearing.
 - 4.1.2. Provide written translations of generally available materials including, at minimum, applications for services, consent forms, and Notice of Determination in each of the DSHS prevalent languages that are spoken by five percent (5%) or more of the population of the State of Washington based on the most recent US census. HRSA has determined based on this criteria that Spanish is the currently required language.
 - 4.1.2.1. The DSHS Prevalent languages are Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish and Vietnamese. The Client rights have been provided to the Contractor by HRSA. The expectation is that this translated document is readily available at all times from the Contractor and its contracted CMHAs.
 - 4.1.2.2. Materials may be provided in English if the Consumers primary language is other than English but the Consumer can understand English and is willing to receive the materials in English. The Consumers consent to receiving information and materials in English must be documented in the client record.
 - 4.1.2.3. For Consumers whose primary language is not translated, the requirement may be met by providing the information through audio or video recording in the Consumers primary language, having an interpreter read the materials in the Consumers primary language or providing materials in an alternative format that is acceptable to the Consumer. If one of these methods is used it must be documented in the client record.
 - 4.1.3. Ensure that Mental Health Professionals and MHCPs have an effective mechanism to communicate with Consumers with sensory impairments.
 - 4.1.4. 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.
 - 4.1.5. The Contractor shall post a translated copy of the consumer rights as provided by HRSA in each of the DSHS prevalent languages.
 - 4.1.6. Upon an individual's request, the Contractor shall provide:
 - 4.1.6.1. CMHA licensure, certification and accreditation status.
 - 4.1.6.2. Information that includes but is not limited to, education, licensure, and Board certification or re-certification or registration of Mental Health Professionals and MHCPs.
- 4.2. Customer Services

- 4.2.1. The Contractor shall provide Customer Services that are customer-friendly, flexible, proactive, and responsive to Consumers, families, and stakeholders. The Contractor shall provide a toll free number for Customer Service. A local telephone number may also be provided for those Consumers within the local calling area.
- 4.2.2. At a minimum, Contractor Customer Services staff shall:
 - 4.2.2.1. Promptly answer telephone calls from Consumers, family members and stakeholders from 8 a.m. until 5:00 p.m. Monday through Friday, holidays excluded.
 - 4.2.2.2. Respond to Consumers, family members and stakeholders in a manner that resolves their inquiry. Staff must have the ability to respond to those with limited English proficiency or hearing loss.
- 4.2.3. Customer Services staff must be trained on how to refer these calls to the appropriate party. Logs shall be kept that, at a minimum, track the date of the initial call, type of call and date of attempted resolution. This log will be provided to HRSA for review upon request.

5. PAYMENT AND FISCAL MANAGEMENT

- 5.1. The Contractor shall ensure that all funds, including interest earned, provided pursuant to this Agreement are used to support the public mental health system.
- 5.2. In accordance with ESHB 1244 Sec(204)(1)(m), the Contractor shall make all possible efforts to maintain current compensation levels of "Direct Care Staff". The Contractor shall require its Subcontractors to make similar efforts. Such efforts shall include, but not be limited to, indentifying local administrative reductions at the regional support network level, and engaging stakeholders on cost-savings ideas that maintain client services and staff compensation. Upon request, the Contractor shall provide information to the department on efforts to comply with these statutory requirements.
- 5.3. State funds will be paid based upon the categories of services contained in Exhibit D. Payments are entered into the accounting payment system the first working day of the month.
 - 5.3.1. (SPOKANE AND PIERCE ONLY) Funding is provided as described in Exhibit D for the costs of Involuntary Court costs for 180 day commitment hearings that occur at the state psychiatric hospital.
 - 5.3.2. (North Sound Only) The Contractor acknowledges and agrees that the Department, at its sole discretion, and in accordance with legislative authority will operate the Washington Medicaid Integration Partnership (WMIP) in Snohomish County. The Contractor also acknowledges and agrees that WMIP will 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.

Non Medicaid funding will be reduced as indicated in Exhibit D for non Medicaid allowable costs associated with providing services for WMIP Enrollees.
 - 5.3.3. (Spokane Only) The Contractor is provided funding as contained in Exhibit D to implement the following services to reduce the utilization and the census at Eastern State Hospital.
 - 5.3.3.1. High intensity treatment team for persons who are high utilizers of psychiatric inpatient services, including those with co-occurring disorders and other special needs.

- 5.3.3.2. Crisis outreach and diversion services to stabilize in the community those individuals who are at risk of requiring inpatient care or jail services.
- 5.3.3.3. Mental health services provided in nursing facilities to individuals with dementia, and consultation to facility staff treating those individuals.
- 5.3.3.4. Services at a sixteen (16) bed evaluation and treatment facility.
 - 5.3.3.4.1. The Contractor shall assess the effectiveness of the above services in reducing the utilization at Eastern State Hospital, identify services that are not optimally effective, and modify those services to improve their effectiveness. The Contractor shall submit a report to HRSA by December 31, 2010, and annually thereafter, in a format that will be provided by HRSA to the Contractor by September 1, 2010.
- 5.3.3.5. DSHS shall return to the Contractor fifty percent (50%) of the amounts assessed against the Contractor during the last six (6) months of calendar year 2009 for state hospital utilization in excess of its contractual limit. The payment of funds will be made approximately five (5) months after the end of the applicable month. (For example, the October month of service will be billed in January and reimbursed in March.) The Contractor shall use these funds for operating during its initial months, new sixteen-bed evaluation and treatment facility to reduce its use of the state hospital, and for diversion and community support services for persons with dementia who likely otherwise require care at the state hospital.
- 5.4. 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.
 - 5.4.1. 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.
- 5.5. If the Contractor elects to use the Medicaid Management Information System (MMIS) system for inpatient claim processing, HRSA, or its designee, will bill the Contractor on a monthly basis for claims paid on behalf of the RSN. The Contractor has 30 days from receipt of the inpatient claim bill to pay the costs assessed.
- 5.6. The Contractor shall provide the DSHS Aging and Disabilities Services Administration program funds equal to the general-fund state cost of Medicaid Personal Care Services used by the Contractor for individuals who are determined to have personal care needs, as per the CARE assessment, and the need is due solely to a psychiatric disability when such payments have been authorized by the Contractor.
- 5.7. HRSA will withhold fifty percent (50%) of the final payment under this Agreement until all final reports and data are received and accepted by DSHS, and until all pending corrective actions, penalties, or unpaid assessments are satisfied.

5.8. Each payment will be reduced by the amount paid by HRSA on behalf of the Contractor for unpaid assessments, penalties, and other payments pending a dispute resolution process. If the dispute is still pending October 1, 2011, HRSA will withhold the amount in question from the final payment until the dispute is resolved.

5.9. State Hospital reimbursement and State Hospital related payments.

5.9.1. The Contractor shall pay a reimbursement for each State Hospital patient day of care that exceeds the Contractor's daily allocation of State Hospital beds identified in Exhibit E.

5.9.2. The rate of payment for reimbursement for Eastern State Hospital is \$584.18.

The rate of payment for reimbursement for Western State Hospital is \$511.75.

DSHS will bill the Contractor on a monthly basis for State Hospital Patient Days of Care which exceed the Contractor's daily allocation of State Hospital beds. Bills will be processed and sent two months after the last day of each month the Contractor exceeds their daily allocation. (For example, the September month of service will be billed in December.) The Contractor has 30 days from receipt of the reimbursement bill to pay the costs assessed.

5.9.3. On any day that the Contractor utilizes less than the Contractor's daily allocation of State Hospital beds and reimbursements have been collected from other RSNs, the Contractor shall receive a payment in accordance with the following methodology:

5.9.3.1. Fifty percent (50%) of the reimbursements collected by DSHS from Eastern Washington RSNs for their use of more State Hospital Patient Days Of Care than their daily allocation of State Hospital beds will be distributed to all Eastern Washington RSNs that used fewer Patient Days Of Care than their daily allocation of State Hospital beds.

Each of the Eastern Washington RSNs using fewer Patient Days Of Care than their daily allocation of State Hospital beds will receive a portion of the funding collected proportional to their share of the total number of Patient Days Of Care that were not used.

Payment of funds will be made approximately five (5) months after the end of the applicable month. (For example the October month of service will be billed in January and reimbursed the following March.)

5.9.3.2. Fifty percent (50%) of the reimbursements collected by DSHS from Western Washington RSNs for their use of more State Hospital Patient Days Of Care than their daily allocation of State Hospital beds will be distributed to all Western Washington RSNs that used fewer Patient Days Of Care than their daily allocation of State Hospital beds.

Each of the Western Washington RSNs using fewer Patient Days Of Care than their daily allocation of State Hospital beds will receive a portion of the funding collected proportional to their share of the total number of Patient Days Of Care that were not used.

Payment of funds will be made approximately five (5) months after the end of the applicable month. (For example the October month of service will be billed in January and reimbursed the following March.)

- 5.10. If the Contractor terminates this Agreement or will not be entering into any subsequent Agreements, HRSA will require that all remaining reserves and fund balances be spent within a reasonable timeframe developed with HRSA. Funds will be deducted from the monthly payments until all reserves and fund balances are spent. The Contractor must give notice at least 90 days prior to the end of the 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 within 60 days of the last day this Agreement is in effect.
- 5.11. 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.
- 5.12. The Contractor must ensure the existence of inpatient reserve at 5.4% of the Contractor's annual payment. The Inpatient Reserves are funds set aside into an account by official action of the RSN governing body. Inpatient reserve funds may only be set aside for anticipated psychiatric inpatient costs.
- 5.13. The Contractor may have an Operating Reserve not to exceed 5.0% of the maximum consideration for this Agreement. The Operating Reserves are funds set aside into an account by official action of the RSN governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.
- 5.14. Financial Reporting and Certification: 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 December 31, 2009. The following reports and certifications, in formats provided by HRSA, must be submitted on a quarterly basis:
 - 5.14.1. 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.
 - 5.14.2. A report of 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.
 - 5.14.3. Certification that Administrative Costs, as defined in the Revenue and Expenditure Report Instructions for Mental Health Services, incurred by the Contractor are 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.
 - 5.14.4. If the Contractor is unable to provide a valid certification or if DSHS finds discrepancies in the Revenue and Expenditure Report, DSHS 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 the HRSA's receipt of the certification, whichever is later.

- 5.14.5. For those RSNs receiving PACT funding, the Contractor shall provide certification that the funds provided in this Agreement for WA-PACT are used specifically to fund existing programs and not to supplant or support other PACT, PACT-like programs or High Intensity Treatment programs.
- 5.14.6. 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.

6. QUALITY OF CARE

- 6.1. The Contractor shall conduct an annual review of the CMHA's within the contracted network. All collected data including monitoring results, agency audits, sub-contract monitoring activities, Consumer Grievances and services verification shall be incorporated into this review. This review must be included in the Contractors ongoing quality management program.
 - 6.1.1. This review may be combined with a formal review of services performed pursuant to the Pre-Paid Inpatient Health Plan Agreement between the Contractor and HRSA.
 - 6.1.1.1. The annual review must at least address the following:
 - 6.1.1.1.1. Timely access that meets the Access Standards of this Agreement.
 - 6.1.1.1.2. Efforts to pursue and report third party revenue.
 - 6.1.1.1.3. The implementation of the GAIN-SS and the co-occurring assessment for quadrant placement of individuals.
 - 6.1.1.1.4. Efforts to create the expectation and to support the delivery of mental health services that are driven by and incorporate the voice of the Consumer and those they identify as Family.
 - 6.1.1.1.5. The degree to which mental health services delivered are age, culturally and linguistically competent.
 - 6.1.1.1.6. Monitoring activities are in place to make sure that attempts are made to provide mental health services in the least restrictive environment.
 - 6.1.1.1.7. A review of services that are being provided that promote Recovery and Resiliency.
 - 6.1.1.1.8. Local efforts are undertaken to provide services that are integrated and coordinated with other formal/informal service delivery systems.
- 6.2. The Contractor shall provide Quality Improvement feedback to CMHAs, the Advisory Board, and other interested parties. The Contractor will maintain documentation of the activities and provide the documentation to HRSA upon request.
- 6.3. The Contractor shall invite Consumers and Consumers' 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.

- 6.4. The Contractor shall participate with HRSA in review activities. Participation will include at a minimum:
 - 6.4.1. The submission of requested materials necessary for a HRSA initiated review within 30 days of the request.
 - 6.4.2. The completion of site visit protocols provided by HRSA.
 - 6.4.3. Assistance in scheduling interviews and agency visits required for the completion of the review.
- 6.5. Quality Review Activities
 - 6.5.1. The Department of Social and Health Services, Office of the State Auditor, or any of their duly-authorized representatives, may conduct announced and unannounced:
 - 6.5.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement.
 - 6.5.1.2. Audits regarding the quality, appropriateness, and timeliness of mental health services provided under this Agreement.
 - 6.5.1.3. Audits and inspections of financial records.
 - 6.5.2. The Contractor shall notify HRSA when an entity other than DSHS performs any audit described above related to any activity contained in this Agreement.

7. SUBCONTRACTS

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.

- 7.1. ProviderOne 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.
- 7.2. Delegation - A Subcontract does not terminate the legal responsibility of the Contractor to perform the terms of this Agreement. The Contractor will monitor functions and responsibilities performed by, or delegated to, a Subcontractor on an ongoing basis.
 - 7.2.1. The responsibilities of the Quality Management section of this Agreement may not be delegated to a Contracted Network CMHA.
 - 7.2.2. Prior to any new delegation of any responsibility or authority described in the 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.
 - 7.2.3. The Contractor shall maintain and make available to HRSA all delegation plans, for currently in place Subcontractors. The delegation plan must include the following:
 - 7.2.3.1. An evaluation of the prospective Subcontractor's ability to perform delegated activities.

- 7.2.3.2. 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.
- 7.2.3.3. 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.

7.3. Subcontract Submission and Required Provisions

- 7.3.1. 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.
 - 7.3.1.1. 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.
 - 7.3.1.2. Amendments to Subcontracts must be submitted with a summary of the changes made to the original Subcontracts annually 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.
 - 7.3.1.3. Copies are to be provided in word processing format on a portable memory device.
- 7.3.2. 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.
- 7.3.3. Subcontracts must require adherence to any applicable terms in the Americans with Disabilities Act.
- 7.3.4. Subcontracts for the provision of mental health services must require compliance and implementation of the Mental Health Advance Directive statutes.
- 7.3.5. Subcontracts must require Subcontractors to cooperate with Quality Review Activities and provide access to their facilities, personnel and records.
- 7.3.6. Subcontracts for the provision of mental health services must require Subcontractors to provide Consumers access to translated information and interpreter services as described in the Information Requirements section of this Agreement.
- 7.3.7. Subcontracts must require Subcontractors to notify the Contractor in the event of a change in status of any required license or certification.
- 7.3.8. 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 Subcontracted staff.
 - 7.3.8.1. Annually, all community mental health employees who work directly with clients shall be provided with training on safety and violence prevention topics described in RCW 49.19.030.

- 7.3.8.1.1. The curriculum for the training shall be developed collaboratively among the DSHS, contracted mental health providers, and employee organizations that represent community mental health workers.
- 7.3.9. Subcontracts must require compliance with State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and the HRSA-CIS Data Dictionary.
- 7.3.10. 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.
- 7.3.11. 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.
- 7.3.12. 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 Consumers currently open for services who have received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the CMHA.
- 7.3.13. Subcontracts must require that the subcontracted CMHAs comply with the Contractor's policy and procedures for utilization of Access to Care Standards and timeframes as described in the Services section of this Agreement.
- 7.3.14. Subcontracts for the provision of mental health services must require that the Subcontractor implement a Grievance process that complies with WAC 388-865 or any successors as described in the Grievance Section of this Agreement.
- 7.3.15. Subcontracts must require the pursuit and reporting of all Third Party Revenue related to services provided under this Agreement.
- 7.3.16. Subcontracts for the provision of mental health services must require the use of the HRSA provided Integrated Co-Occurring Disorder Screening and Assessment Tool and require staff that will be using the tool 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 Tool process is not implemented and maintained throughout the contract period of performance.
- 7.3.17. 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.
- 7.3.18. Subcontracts must contain the same requirements for crisis services as in this Agreement.
- 7.3.19. Subcontracts for the provision of mental health services must require, in accordance with 71.05.390(17), the sub-Contractor shall respond in a full and timely manner to law enforcement inquiries regarding an individual's eligibility to possess a firearm under RCW 9.41.040(2)(a)(ii).

- 7.4. 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 under this Agreement. The Contractor must notify HRSA 30 days prior to terminating any of its Subcontracts with entities that provide direct services, including mental health clubhouses, or entering into new Subcontracts with entities that provide direct services, including mental health clubhouses. This notification must occur prior to any public announcement of this change.
- 7.4.1. 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.
- 7.4.2. 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.
- 7.4.3. If any of the events described in this section occur, the Contractor must submit a plan to HRSA 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.

7.5. Credentialing

- 7.5.1. The Contractor shall have written policies that require monitoring of provider credentials. The Contractor shall only use CMHAs or others who are licensed or certified for the services for which they perform.
- 7.5.2. 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.

8. CONSUMER RIGHTS AND PROTECTIONS

- 8.1. The Contractor shall comply with any applicable Federal and State laws that pertain to individual rights and require that its staff takes those rights into account when furnishing services to Consumers.
- 8.2. 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 individual with respect to:
- 8.2.1. The individual's mental health status.
- 8.2.2. Receiving all information regarding mental health treatment options including any alternative or self administered treatment, in a culturally-competent manner.

- 8.2.3. Any information the Consumer needs in order to decide among all relevant mental health treatment options.
- 8.2.4. The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment).
- 8.2.5. The Consumer's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions.
- 8.2.6. The Consumer's right to be treated with respect and with due consideration for his or her dignity and privacy.
- 8.2.7. The Consumer's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- 8.2.8. The Consumer's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.
- 8.2.9. The Consumer's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the RSN, CMHA or MHCP treats the individual.
- 8.3. The Contractor shall provide or purchase age, linguistic and culturally competent community mental health services for Consumers for whom services are Medically Necessary and clinically appropriate.
- 8.4. Individual service plans must be developed in compliance with WAC 388-865-0425.
 - 8.4.1. The Contractor shall require that Consumers are included in the development of their individualized service plans, advance directives for psychiatric care and crisis plans.
 - 8.4.1.1. 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).
 - 8.4.1.2. 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.
- 8.5. Ombuds
 - 8.5.1. 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:
 - 8.5.1.1. Separation of personnel functions (e.g. hiring, salary and benefits determination, supervision, accountability and performance evaluations).
 - 8.5.1.2. Independent decision making to include all investigation activities, findings, recommendations and reports.

8.6. Advance Directives

- 8.6.1. The Contractor shall maintain a written Advance Directive policy and procedure that respects individuals' Advance Directives for psychiatric care. Policy and procedures must comply with RCW 71.32. If State law changes, HRSA will send notice to the Contractor who must then ensure the provision of notice to individuals within 90 days of the change.
- 8.6.2. The Contractor shall inform individuals that complaints concerning noncompliance with the Advance Directive for psychiatric care requirements may be filed with HRSA by contacting the Quality Improvement and Assurance section at 1-888-713-6010.

9. CARE MANAGEMENT PROGRAM

Care management is a set of clinical management oversight functions that shall be performed by the Contractor. Care management focuses on access, referrals, oversight of care coordination, utilization review, resource management, risk management and Quality Improvement. These activities must be performed by a Mental Health Professional.

9.1. Utilization Management Program

- 9.1.1. 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:
 - 9.1.1.1. A process for access to an intake evaluation and a process for referral to crisis intervention services.
 - 9.1.1.2. A utilization review of requested services against Medical Necessity criteria, authorization of necessary care, review of Grievances and consistent application of criteria for provision of services within Available Resources.
 - 9.1.1.3. Review of assessment and treatment services against clinical practice standards. Clinical practice standards include but are not limited to Evidenced-Based Practice guidelines, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals. This review must include a review of the coordination with Tribal and Recognized American Indian Organizations (RAIO) and other Consumer serving agencies.
 - 9.1.1.4. Monitoring for over-utilization and under-utilization of services and ensuring that resource management and utilization management activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue Medically Necessary mental health services inconsistent with the Contractors policy and procedures for determining eligibility for services within Available Resources.
 - 9.1.1.5. Maintenance of written policies and procedures implementing Level of Care Guidelines for determining continued stay and discharge within the Contractor's Service Area.
 - 9.1.1.6. The ability to demonstrate upon request:
 - Consistent application of Policies and Procedures for the provision of services within Available Resources, 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.
- 9.1.2. The Contractor must have policies and procedures that establish a standardized methodology for determining when resources are available for the provision of Routine mental health services and established Level of Care Guidelines that include the Access to Care Standards in the eligibility criteria for initial authorizations of Routine Services.
- 9.1.2.1. The Contractor's Level of Care Guidelines must also include: criteria for use in determining authorization for the continuation of services following the exhaustion of previously authorized services and criteria for use in determining when an individual shall be discharged from outpatient community mental health services.
- 9.1.2.2. The Contractor's Level of Care Guidelines must also include criteria for authorization of inpatient care at a community hospital and extensions to community hospital episodes of care.
- 9.1.2.3. The Access to Care Standards may not be used as continuing stay and discharge criteria.
- 9.1.2.4. 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.
- 9.1.3. The Contractor's Care Management system must include a periodic review of the Individual Service Plan to ensure the requirements of WAC 388-865-0425 are being met. This review additionally can be used by the contracted network CMHA to meet the requirements of the 180 day review required in WAC 388-865-0425. The review shall document:
- 9.1.3.1. A review of which goals identified in the individual service plan have been met, have been discontinued or have continued need.
- 9.1.3.2. The Consumer (and those the Consumer identifies as Family when appropriate) is a participant in the development of the treatment plan.
- 9.1.3.3. Input from other health, education, social service, and justice agencies as appropriate and consistent with privacy requirements.
- 9.2. The Contractor shall ensure services are provided in accordance with the Contractors Level of Care Guidelines and policies and procedures for determining Available Resources and are not arbitrarily denied or reduced (e.g. the amount, duration, or scope of a service) based solely upon the diagnosis, type of mental illness, or the individual's mental health condition.
- 9.2.1. The Contractor must provide a written Notice of Determination if a denial, reduction, termination or suspension occurs based on the Level of Care Guidelines or the policies and procedures used to determine when services are to be provided within Available Resources.
- 9.2.2. The Contractor must have Care Managers 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.

- 9.2.2.1. 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.
- 9.2.2.2. If the authorization is denied, a Notice of Determination must be provided to the Consumer or their legal representative.
- 9.2.3. The Contractor shall adhere to the requirements set forth in the Community Psychiatric Inpatient Instructions and Requirements available on the HRSA Intranet or upon request.
- 9.2.4. If the Contractor denies payment of any portion of a psychiatric inpatient stay for a Consumer and the inpatient facility has a dispute, the Contractor shall follow the dispute process provided in the Community Psychiatric Inpatient Instructions and Requirements.
- 9.3. Medicaid Personal Care: DSHS Aging and Disabilities Administration (ADSA) or its designee uses the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine personal care needs. The Contractor or its designee must respond to requests for Medicaid Personal Care (MPC) from ADSA within five (5) working days of the request. The Contractor and the local ADSA office may mutually agree in writing to extend the five (5) working day requirement. Authorization decisions must be based on the following:
 - 9.3.1. A review of the request to determine if the individual is currently authorized to receive services from the Prepaid Inpatient Health Plan in the Contractor's Service Area.
 - 9.3.2. A verification that need for MPC services is based solely due to a psychiatric disability.
 - 9.3.3. A review of the requested MPC services to determine if the individual's personal care needs could be met through provision of other available RSN services.
 - 9.3.3.1. The Contractor may not limit or restrict authorization for personal care services due to insufficient resources.
 - 9.3.4. If the Contractor denies authorization of the state match portion for MPC, the written response to ADSA must include the reason for the determination and other available RSN provided services that will be used to meet the personal care needs identified in the CARE.
 - 9.3.4.1. When the Contractor denies authorization of the state match portion based on provision of other RSN services, a plan (e.g., Individual Service Plan) must be developed and implemented to meet the personal care needs identified in the CARE assessment.
 - 9.3.5. The Contractor must provide the following documentation to HRSA or ADSA on request:
 - 9.3.5.1. The original ADSA referral and request for authorization.
 - 9.3.5.2. Any information provided by ADSA including the CARE assessment.
 - 9.3.5.3. A copy of the Contractor's determination and written response provided to ADSA.
 - 9.3.5.4. A copy of the plan developed and implemented to meet the individual's needs through provision of other available RSN services when the MPC request has been denied based on this determination.

10. MANAGEMENT INFORMATION SYSTEM

10.1. Data Submission and Error Correction

- 10.1.1. The Contractor shall provide HRSA with all data described in the HRSA “Service Encounter Reporting Instructions” and the “Data Dictionary,” and encounters shall be submitted as described in the HRSA “Encounter Data Reporting Guide,” or, any successor, incorporated herein by reference.
- 10.1.2. 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.
- 10.1.3. The Contractor shall submit all other required data about Enrollees to HRSA CIS within 60 days of collection or receipt from Subcontracted providers.
- 10.1.4. Upon receipt of data submitted, both ProviderOne and the 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.
- 10.1.5. 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.
- 10.1.6. 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.
- 10.1.7. The Contractor shall implement changes documented in the HRSA “Service Encounter Reporting Instructions,” the “Data Dictionary,” and the 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.
- 10.1.8. 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.
- 10.1.9. When HRSA makes changes referenced in Section 10.1.7, 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.

10.1.10. 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.

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

10.2. Business Continuity and Disaster Recovery

10.2.1. 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.

10.2.2. 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.

10.2.2.1. 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 to review and audit. The plan must address the following:

10.2.2.1.1. A mission or scope statement;

10.2.2.1.2. An appointed Information Services Disaster Recovery Staff.

10.2.2.1.3. Provisions for Backup of Key personnel, Identified Emergency Procedures and visibly listed emergency telephone numbers.

10.2.2.1.4. Procedures for allowing effective communication, Applications Inventory and Business Recovery priority and hardware and software vendor list.

10.2.2.1.5. Confirmation of updated system and operations documentation and process for frequent backup of systems and data.

10.2.2.1.6. Off site storage of system and data backups and ability to recover data and systems from backup files.

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

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

10.3. Information System Security and Protection of Confidential Information

- 10.3.1. 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 45 CFR Parts 160, 162 and 164.
- 10.3.2. 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.
- 10.3.3. The Contractor shall maintain a statement on file for each individual service provider and Contractor staff who has access to the Contractor's mental health information system that is signed by the provider and attested to by a witness's signature, acknowledging that the provider understands and agrees to follow all regulations on confidentiality.
- 10.3.4. The Contractor shall take appropriate action if a Subcontractor or Contractor employee wrongly releases confidential information.

10.4. Subcontractor Data Quality Verification

- 10.4.1. 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:
 - 10.4.1.1. 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.
 - 10.4.1.2. The Contractor shall conduct encounter validation checks for all Subcontractors that submit encounters to the Contractor, using the following guidelines:
 - 10.4.1.2.1. Minimum Sample Size: For each network CMHA Subcontractor, a review of at least one (1) percent or 411, whichever is less, of all encounters submitted for a 12-month time period within the current Agreement period.
 - 10.4.1.2.2. 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.
 - 10.4.1.2.3. 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

10.4.1.2.4. 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:

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

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.

10.4.1.2.5. 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%

10.4.1.2.6. 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.

- a) Method of the validation process (i.e., study time frame, staff involved, request for record and review process)
- b) Sampling methodology, including data source and stratification
- c) Record review tool(s) and audit guide employed

- d) Scoring methods
- e) Data analysis results and summary of findings
- f) Conclusions, limitations, and opportunities for improvement, including corrective action plan, if applicable.

11. GRIEVANCE SYSTEM

11.1. **Procedures.** The Contractor shall have a Grievance system that has the following procedures:

- 11.1.1. The individual or representative may file a Grievance either orally or in writing.
- 11.1.2. If an initial request for a Grievance is made orally, a written, signed request for a Grievance must be submitted within seven (7) days.

11.2. Handling of Grievances

11.2.1. In handling Grievances, each RSN must meet the following requirements:

- 11.2.1.1. Give individuals any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, provision of Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability.
- 11.2.1.2. Acknowledge receipt of each Grievance received either orally or in writing within one working day. If acknowledgement is made orally, it must be followed-up in writing within five (5) working days.
- 11.2.1.3. Ensure that the individuals who make decisions on Grievances are individuals who were not involved in any previous level of review or decision-making.
- 11.2.1.4. Ensure that no retaliation is taken against individuals who file a Grievance.

11.3. Resolution and Notification: Individuals who file a Grievance shall be notified:

- 11.3.1. Of their right to request a Fair Hearing, and how to do so.
- 11.3.2. Of their right to request to receive Medically Necessary services while the hearing is pending.
- 11.3.3. How to make the request.
- 11.3.4. That an individual may be asked to pay for the cost of those services if the hearing decision upholds the original decision.

11.4. Continuation of Services

11.4.1. During the grievance process, the RSN must continue the individual's Medically Necessary services that are provided within Available Resources if all of the following conditions are met:

- 11.4.1.1. The Grievance involves the termination, suspension, or reduction of a previously authorized course of treatment.
- 11.4.1.2. The services were provided by an authorized Community Mental Health Agency.

11.4.1.3. The original period covered by the original authorization has not expired.

11.4.1.4. The individual requests a continuation of services.

11.5. Information Subcontractors

11.5.1. The RSN must provide information about the Grievance system to all Community Mental Health Agencies and Subcontractors at the time they enter into a contract. A condition of the sub-contract will be that all CMHAs and other Subcontractors will abide by all Grievance and administrative hearing decisions.

11.6. Record-keeping and Reporting Requirements

11.6.1. The Contractor must maintain records of Grievances and Fair Hearings and must review the information per the timelines listed below.

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

11.6.2.1. The number and nature of, Fair Hearings and Grievances.

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

11.6.2.3. The nature of the decisions.

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

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

12. SERVICES

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

12.1.1. Contractor must attempt to screen all individuals aged 13 and above through the use of the 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 RCW 70.96B.
 - The contact is by telephone only.
 - The professional conducting the crisis intervention or ITA investigation has information that the individual completed a GAIN-SS screening within the previous 12 months.

- 12.1.1.1. The GAIN-SS screening must be completed as self report by the individual and signed by that individual on the 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 the HRSA-GAIN-SS form.
- 12.1.1.2. The results of the GAIN-SS screening, including refusals and any where the Consumer was unable to complete, must be reported to HRSA through the CIS system.
- 12.1.1.3. The Contractor must complete a co-occurring mental health and chemical dependency disorder assessment, consistent with training provided by HRSA and outlined in SAMHSA Treatment Protocol 42, to determine a quadrant placement for the individual when the individual scores a 2 or higher on either of the first two scales (ID Screen & ED Screen) and a 2 or higher on the third (SD Screen).
 - 12.1.1.3.1. 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.

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

12.2. First Priority Services. The Contractor shall provide the following services as described in Crisis Mental Health, Inpatient, Ancillary Costs and Residential Programs Sections and prioritize such services above any other services unless otherwise specified in this Agreement.

12.2.1. Crisis Mental Health Services: The Contractor must provide 24-hour, 7 day a week crisis mental health services to individuals who are within the Contractor's Service Area and report they are experiencing a mental health crisis. There must be sufficient staff available, including Designated Mental Health Professionals, to respond to requests for crisis services. Crisis services must be provided regardless of the individual's ability to pay. Crisis mental health services must include each of the following:

12.2.1.1. Crisis Services: Evaluation and treatment of mental health crisis to all individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, the outcome of which decides whether possible bad consequences will follow. Crisis services must 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 must be provided by or under the supervision of a Mental Health Professional.

- 12.2.1.2. Stabilization Services: Services provided to individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the Mental Health Professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training and with the understanding of medication effects and side effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a Mental Health Professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services. This service may include cost for room and board.
 - 12.2.1.3. Involuntary Treatment Act Services: Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05 RCW 71.24. 300 and RCW 71.34. This includes all clinical services, costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional (DMHP) determines an individual must be evaluated for involuntary treatment. The decision making authority of the DMHP must be independent of the RSN administration. ITA services continue until the end of the involuntary commitment.
 - 12.2.1.4. Freestanding Evaluation and Treatment Services provided in freestanding inpatient residential (non-hospital) facilities licensed by the Department of Health and certified by HRSA to provide Medically Necessary evaluation and treatment to the individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other Mental Health Professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.
- 12.2.2. Crisis mental health services may be provided without an intake evaluation or screening process. The Contractor must provide:
 - 12.2.2.1. Emergent Care within two (2)-hours of the request received from any source for crisis mental health services.
 - 12.2.2.2. Urgent care within 24-hours of the request received from any source for crisis mental health services.
 - 12.2.3. The Contractor must provide access to all components of the Involuntary Treatment Act to persons who have mental disorders in accordance with state law (RCW 71.05 and RCW 71.34) and without regard to ability to pay.
 - 12.2.4. The Contractor must incorporate the statewide protocols for Designated Mental Health Professionals (DMHP) or its successor into the practice of Designated Mental Health Professionals. The protocols can be accessed on the HRSA intranet and copies will be provided upon request.
 - 12.2.5. The Contractor must have policies and procedures for crisis and ITA services that implement the following requirements:

- 12.2.5.1. No DMHP or crisis intervention worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act, unless a second trained individual accompanies them.
 - 12.2.5.2. The clinical team supervisor, on-call supervisor, or the individual professional acting alone based on a risk assessment for potential violence, shall determine the need for a second individual to accompany them.
 - 12.2.5.3. The second individual may be a law enforcement officer, a Mental Health Professional, a mental health paraprofessional who has received training required in RCW 49.19.030, or other first responder, such as fire or ambulance personnel.
 - 12.2.5.4. No retaliation may be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.
 - 12.2.5.5. The Contractor must have a plan to provide training, mental health staff back-up, information sharing, and communication for crisis outreach staff who respond to private homes or other private locations.
 - 12.2.5.6. Every Mental Health Professional dispatched on a crisis visit, shall have prompt access to information about any history of dangerousness or potential dangerousness on the client they are being sent to evaluate that is documented in crisis plans or commitment records and is available without unduly delaying a crisis response.
 - 12.2.5.7. Every Mental Health Professional who engages in home visits to Consumers or potential Consumers for the provision of crisis services shall be provided by the Contractor or Subcontractor with a wireless telephone or comparable device for the purpose of emergency communication.
- 12.2.6. Psychiatric Inpatient Services: Community Hospitals and Evaluation and Treatment Facilities:
The Contractor shall:
- 12.2.6.1. Develop, maintain or purchase Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.300(6) (c).
 - 12.2.6.2. Provide or purchase psychiatric inpatient services for the following:
 - 12.2.6.2.1. Individuals who agree to be admitted voluntarily and who are beneficiaries of the Psychiatric Indigent Inpatient (PII) and General Assistance Unemployable (GA-U) when it is determined to be Medically Necessary.
 - 12.2.6.2.2. Individuals who are involuntarily detained in accordance with RCW 71.05 or RCW 71.34, and who are either eligible under General Assistance-Unemployable (GA-U), or who are not eligible for any other medical assistance program that would cover this hospitalization.
 - 12.2.6.2.3. Individuals at least 22 years of age and under 65 years of age who are Medicaid-Enrollees and are admitted to a residential facility that is classified as an Institution for Mental Diseases (IMD) defined in 42 CFR 435.1010.

- 12.2.7. Community Hospital Certification Process: Adhere to the requirements set forth in the Community Psychiatric Inpatient Process as provided by HRSA.
- 12.2.7.1. The Contractor shall have a Care Manager available 24 hours a day to respond to requests for inpatient certification. Certification decisions for psychiatric inpatient care must be made within twelve hours of the initial call.
 - 12.2.7.2. A Notice of Determination must be provided if certification is denied for the admission.
- 12.2.8. Psychiatric Inpatient Services: State Hospitals
- 12.2.8.1. The Contractor shall reimburse DSHS for State Hospital days of care that exceed the daily allocation of State Hospital beds. The Contractor's daily allocation of State Hospital beds is provided in Exhibit D.
 - 12.2.8.1.1. If the Contractor disagrees with the RSN/patient assignment, it must request a reassignment within 30 days of admission. If a request to change the assignment is made within 30 days of admission and the request is granted, the reassignment will be retroactive to the date of admission.
 - 12.2.8.1.2. If a request comes in after the 30th day of admission and is granted, the effective date of the reassignment will be based on the date DSHS receives the reassignment request form. All reassignment requests are to be made using the Hospital Correction Request Form. The form is attached to the State Hospital/RSN Working Agreement. This process shall be described in the working Agreement between the Contractor and the State Hospital.
 - 12.2.8.2. Ensure Consumers are medically cleared, if possible, prior to admission to a State Psychiatric Hospital.
 - 12.2.8.3. Respond to State Hospital census alerts by using best efforts to divert admissions and expedite discharges by utilizing alternative community resources and mental health services.
 - 12.2.8.4. The Contractor or its designee shall monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320.
 - 12.2.8.5. The Contractor or its designee shall offer covered mental health services to assist with compliance with LRA requirements for individuals who meet Medical Necessity and the Access to Care Standards.
 - 12.2.8.6. The Contractor or its designee shall respond to requests for participation, implementation, and monitoring of individuals receiving services on Conditional Releases (CR) consistent with RCW 71.05.340. The Contractor or designee shall provide covered mental health services for individuals that meet Medical Necessity and the Access to Care Standards.
 - 12.2.8.7. The Contractor or designee shall ensure provision of covered mental health services to individuals on a Conditional Release under RCW 10.77.150 for individuals that meet Medical Necessity and the Access to Care Standards within Available Resources.
 - 12.2.8.8. For conditional releases under RCW 10.77, if the individual is placed on a transitional status in the RSN which holds the State psychiatric hospital, it is expected that the

individual will transfer back to the RSN for the individual's county of residence once transitional care is complete. The Inter-RSN Transfer process described in the State Hospital Working Agreement will be used when an individual is on Conditional Release or discharged to an area other than the RSN responsible for the individual's county of residence.

12.2.8.9. Maintain or develop a written working agreement with the State Hospital in its Service Area within 90 days of the effective date of this Agreement. The Agreements must include:

- 12.2.8.9.1. Specific roles and responsibilities of the parties related to transitions between the community and the hospital.
- 12.2.8.9.2. A process for the completion and processing of the Inter-RSN Transfer Request Form for individuals requesting placement outside of the RSN of residence.
- 12.2.8.9.3. A process for resolution of disputes between RSNs and the assignment of individual costs when individuals are transferred between RSNs. Disputes that are not resolved between the RSNs will be decided by HRSA.
- 12.2.8.9.4. Collaborative discharge planning and coordination with cross-system partners.
- 12.2.8.9.5. Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's Service Area.

12.2.9. Children's Long-Term Inpatient Programs (CLIP)

12.2.9.1. The Contractor shall coordinate with the Children's Long-term Inpatient Programs ("CLIP") Administration to develop CLIP resource management guidelines and admissions procedures. The Contractor shall enter into, and comply with, a written agreement with the CLIP Administration regarding resource management guidelines and admissions procedures.

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

- 12.2.9.1.1. Create and maintain a local process to assess the needs of children being considered for voluntary admission and coordinate referrals to the CLIP Administration.
- 12.2.9.1.2. 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.
- 12.2.9.1.3. 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).
- 12.2.9.1.4. 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.

- 12.2.9.2. 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.
- 12.2.9.3. Review for prior authorization recommendations for short-term/acute hospitalization when it is determined by the CLIP program that this is required.

12.2.10. Inpatient Coordination of Care

- 12.2.10.1. The Contractor must provide Rehabilitation Case Management which includes a range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of an individual in the mental health system.
 - 12.2.10.2. Rehabilitation Case Management 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. Services are provided by or under the supervision of a Mental Health Professional
 - 12.2.10.3. The Contractor shall ensure that contact with the inpatient staff occurs within three (3) working days of an authorized voluntary or involuntary admission. The Contractor's liaison or CMHA must participate throughout the admission in treatment and discharge planning with the hospital staff.
 - 12.2.10.4. The Contractor or its designee shall provide to the inpatient unit any available information regarding the individual's treatment history at the time of admission. The Contractor or its designee must provide all available information related to payment resources and coverage.
 - 12.2.10.5. The Contractor's liaison or designated CMHA must participate in treatment and discharge planning with the inpatient treatment team.
 - 12.2.10.6. The Contractor's liaison or designated CMHA must participate throughout the inpatient admission to assist with appropriate and timely discharge for all individuals regardless of diagnosis. This includes providing assistance with developing treatment plans and appropriate community alternatives.
 - 12.2.10.7. The Contractor must designate a CMHA who has the primary responsibility to coordinate outpatient and residential services that are to be provided based on Medical Necessity and Available Resources. The assigned CMHA must offer, at minimum, one follow-up service within seven (7) days from discharge to an individual who has been authorized for an inpatient admission or involuntarily committed.
- 12.2.11. Ancillary Costs: With the funds provided under this Agreement the Contractor is also expected to prioritize payments for expenditures associated with providing Medically Necessary crisis services for Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b)

Waiver. Costs include, but are not limited to, room and board in hospital diversion settings or in freestanding Evaluation and Treatment facilities and Administrative Costs related to the Involuntary Treatment Act.

12.2.12. Residential Programs: A full range of residential settings and programs shall be available and provided based on the individual's needs, Medical Necessity and within Available Resources per the Contractor's policies and procedures. The Contractor must maintain a detailed plan to meet individual needs for residential programs. This plan may include memorandums of understanding or contracts to purchase or provide a residential program outside of the Contractor's Service Area when an individual requires a level of residential support which is not available within the Contractor's Service Area. The full range of residential programs and settings include the following:

12.2.12.1. Long-term intensive adaptive and rehabilitative psychiatric care such as is provided in Adult Residential Rehabilitation Centers.

12.2.12.2. Supervised living such as residential programs developed to serve individuals diagnosed with a major mental illness in nursing homes, boarding homes or adult family homes.

12.2.12.3. Supported housing services such as intensive services provided to maintain individuals in unlicensed individual or group home settings including transitional or permanent housing.

12.3. Second Priority Services, Outpatient Mental Health Services: When the Contractor has Available Resources, the Contractor shall provide intake evaluations and other services including but not limited to those described in this section that are Medically Necessary to members of priority populations (RCW 71.24). The Contractor must have policies and procedures that determine how the availability of resources for these services is determined, including how decisions are made to authorize intake evaluations or deny provision of services due to insufficient resources.

12.3.1. Access to Outpatient Mental Health Services: Once it is determined resources are available for Outpatient services, access must be based on the following:

12.3.1.1. A routine intake evaluation appointment must be available and offered within 10 business days of the request unless both of the following conditions are met:

12.3.1.1.1. An intake evaluation has been provided in the previous 12 months that establishes medical necessity and

12.3.1.1.2. The RSN agrees to use the previous intake evaluation as the basis for authorization decisions.

12.3.1.2. A request may be made through a telephone call, walk-in, or written request including requests on behalf of an individual by those defined as family.

12.3.1.2.1. The Contractor must maintain documentation of all requests for service even if no service actually occurs. If no service occurs the Contractor must document the reason. This documentation must be provided to HRSA upon request.

12.3.1.2.2. The intake evaluation must include the Co-Occurring Disorder Screening that is required by RCW 70.96C.

- 12.3.2. Authorization of initial services following an intake shall be based on Medical Necessity, the Contractor's Level of Care Guidelines and the Contractor's policies and procedures for the provision of services with Available Resources.
- 12.3.3. A decision to authorize routine mental health services must occur within 14 calendar days from the date the intake evaluation is initiated, unless the Consumer or the CMHA request an extension from the RSN.
 - 12.3.3.1. An extension of up to 14 additional calendar days to make the authorization decision is possible upon request by the individual or the CMHA. The Contractor must have a written policy and procedure to ensure consistent application of extension requests within the Service Area. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary.
 - 12.3.3.2. The Contractor or its formal designee shall provide a written Notice of Determination to the Consumer or their legal guardian within 14 days of the authorization decision. Formulating the Notice of Determination cannot be delegated to a subcontracted network CMHA; however, the CMHA may deliver the notification.
- 12.3.4. The time period from request for services to first Routine Services appointment offered must not exceed 28 calendar days unless the Contractor documents a reason for the delay.
 - 12.3.4.1. The Contractor shall make a determination of eligibility for continuation of Routine Services based on the Contractor's Level of Care Guidelines and policies and procedures for determining Available Resources.
 - 12.3.4.1.1. The decision by the Contractor or formal designee to authorize additional Routine mental health services following an initial authorization must occur within 14 days of the date the request is received from the contracted network CMHA.
 - 12.3.4.1.2. If the Contractor or its formal designee: a) denies a service authorization request; or b) authorizes a service in an amount, duration, or scope that is less than requested, the Contractor shall notify the requesting CMHA and provide the Consumer with a Notice of Determination within 14 working days of the decision.
- 12.3.5. Outpatient Mental Health Services: The following Outpatient Service Modalities may be provided based on the individual's needs and Medical Necessity, within Available Resources per the Contractor's policies and procedures.
 - 12.3.5.1. Brief Intervention Treatment: Solution-focused and outcome-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 models of treatment. Functional problems and/or needs identified in the Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of an individual's current level of functioning or assistance with self/care or life skills training. An individual 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.

- 12.3.5.2. 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) to promote improved functioning or 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 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, schools, clubhouses, community centers). This service is available up to five (5) hours per day, five (5) days per week.
- 12.3.5.3. Family Treatment: Counseling provided for the direct benefit of an 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 is intended to benefit the client to obtain reintegration and Recovery into the community. 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 their Individual Service Plan. This service is provided by, or under the supervision of, a Mental Health Professional.
- 12.3.5.4. Group Treatment Services: Services provided to 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, 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 environments. 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 individuals at the same time. Staff to Consumer ratio is no more than 1:12. Maximum group size is 24.
- 12.3.5.5. High Intensity Treatment: Intensive service that is provided to individuals who require a multi-disciplinary treatment team in the community that is available during extended hours. Twenty-four (24) hours per day, seven (7) days per week, access is required if necessary for the individual. 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 team also has the ability to promptly assess, re-assess, and modify the individual service plan if the need arises. The team closely monitors symptoms and provides immediate feedback to the individual and to other team members. The team

service intensity is individualized based upon continual assessment of need and adjustment to the individual service plan. 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. Services provided by the Mental Health Professionals, mental health care providers and peer counselors are reportable components of this modality. The staff to Consumer ratio for this service is no more than 1:15. *Although they participate, these team members are paid staff of other Departments.

- 12.3.5.6. Individual Treatment Services: A set of treatment services designed to help an individual attain goals as prescribed in their 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 individual. This service is provided by, or under the supervision of, a Mental Health Professional.
- 12.3.5.7. 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.
- 12.3.5.8. Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging an individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the 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. Individuals with low medication compliance history or newly on medication are most likely to receive this service. This service is provided by, or under the supervision of, a Mental Health Professional.
- 12.3.5.9. Mental Health Clubhouse: A service specifically contracted by the RSN to provide a Consumer-directed program to individuals 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 (10) hours a week after 5:30pm Monday through Friday, or anytime on Saturday or Sunday, and
- Opportunities for socialization activities.

12.3.5.10. **Mental Health Services provided in Residential Settings:** A specialized form of rehabilitation service (non-hospital) that offers a sub-acute psychiatric management environment for individuals who do not meet hospital admission criteria. 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, and treatment cannot be safely provided in a less restrictive environment. 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 individual. 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 differs from other services in the terms of location and duration.

12.3.5.11. **Peer Support:** Services provided by certified peer counselors to 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. These services may include self-help support groups, telephone support lines, drop-in centers, and engaging activities in locations where Consumers are known to gather. Drop-in centers are required to maintain a log documenting identification of the Consumers. This includes locations such as churches, parks, community centers, etc. Services are geared toward Consumers with severe and persistent mental illness. Consumers actively participate in decision-making and the operation of the programmatic supports. 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, but 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 an individual for no more than four hours per day. The ratio for this service is no more than 1:20.

12.3.5.12. **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.

12.3.5.13. **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 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.

12.3.5.14. Special Population Evaluation: Evaluation by a child, geriatric, disability, or ethnic minority specialist who 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 component of this service.

12.3.5.15. Supported Employment - Services will 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 his/her 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:
 - Consumer strengths.
 - Consumer abilities.
 - Consumer preferences.
 - 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.

12.3.5.16. Therapeutic Psychoeducation: Informational and experiential services designed to aid 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 and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the 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.

12.3.6. In addition to these services the Contractor may use the funds provided under this Agreement to do any of the following:

12.3.6.1. Provide or purchase any other clinically appropriate outpatient or residential services to a non-Medicaid individual.

12.3.6.2. Provide or purchase clinically appropriate outpatient or residential services to Medicaid Enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver.

12.3.6.3. Provide assistance with transportation.

12.3.6.4. Provide assistance with application for entitlement programs.

12.3.6.5. Provide assistance with meeting the requirements of the Medically Needy spend down program.

12.3.6.6. Provide Training for Peer Counselors when the training meets the following requirements:

- Training is structured in compliance with the Peer Counseling Program Guidelines posted on the HRSA intranet. The guidelines specify the amount of classroom time required for each topic and define participant responsibilities.
- Training is provided consistent with the Peer Counseling Training Manual posted on the HRSA intranet.
- Each Participant is provided with a training manual and a copy of Wellness Recovery Action Plan by Mary Ellen Copeland. The Contractor may obtain copies of Wellness Recovery Action Plan from HRSA.
- The Contractor has submitted a copy of all training materials that were provided to participants for HRSA approval 30 days prior to dissemination. This excludes materials contained in the Peer Counseling Training Manual issued by HRSA.
- The names and qualifications of each presenter have been submitted to HRSA for approval no later than 30 days prior to initiation of the training.
- A completed Peer Counselor Application, provided on the HRSA intranet, for each participant has been submitted and approved by HRSA no later than 15 days prior to attendance at the training.
- Each participant is over age 18 and meets the WAC 388-865-0150 definition of Consumer, unless HRSA approval for exception has been obtained in writing prior to attendance at the training.
- Within 14 days of the completed training a list is submitted to HRSA of all participant names and verification of their completion of the approved 40-hour training.

13. COMMUNITY COORDINATION

- 13.1.1. The Contractor must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by HRSA. The Contractor shall:
 - 13.1.1.1. Attend HRSA-sponsored training regarding the role of the public mental health system in disaster preparedness and response.
 - 13.1.1.2. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.
 - 13.1.1.3. Provide disaster outreach in Contractor's Service Area in the event of a disaster/emergency; "Disaster Outreach" means contacting persons in their place of residence or in non-traditional settings for the purpose of assessing their mental health and social functioning following a disaster or increasing the utilization of human services and resources.
 - 13.1.1.4. There are two (2) basic approaches to outreach: mobile (going to person to person) and community settings (e.g. temporary shelters, disaster assistance sites, disaster information forums). The Outreach Process must include the following:
 - 13.1.1.4.1. Locating persons in need of disaster relief services.
 - 13.1.1.4.2. Assessing their needs.
 - 13.1.1.4.3. Engaging or linking persons to an appropriate level of support or disaster relief services.
 - 13.1.1.4.4. Providing follow-up mental health services when clinically indicated.
 - 13.1.1.4.5. Disaster outreach can be performed by trained volunteers, peers and/or persons hired under a federal Crisis Counseling Grant. These persons should be trained in disaster crisis outreach which is different than traditional mental health crisis intervention.
 - 13.1.1.5. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs.
 - 13.1.1.6. Provide the name and contact information to HRSA for person(s) coordinating the RSN disaster/emergency preparedness and response upon request.
 - 13.1.1.7. Provide information and preliminary disaster response plans to HRSA within seven (7) days following a disaster/emergency or upon request.
 - 13.1.1.8. Partner in disaster preparedness and response activities with HRSA and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations. This must include:
 - 13.1.1.8.1. Participation when requested in local and regional disaster planning and preparedness activities.
 - 13.1.1.8.2. Coordination of disaster outreach activities following an event.

- 13.2. Allen and Marr Class Members. For Allen and Marr Class members who are in the contracted Service Area the Contractor shall:
- 13.2.1. Participate in quarterly community comprehensive reviews. Each review must be conducted using the *Allen/Marr Internal Oversight Review Tool*. This tool is incorporated by reference and is available on the HRSA Intranet.
 - 13.2.2. Work directly with Regional Division of Developmental Disabilities (DDD) representatives in coordinating and conducting these reviews. The Contractor representative and the Regional DDD Quality Assurance Manager will be “lead staff” for Regional Review Teams (RRTs). In addition to coordinating for, and participating in these reviews the “lead staff” will be responsible for preparing and submitting final reports from the reviews to the HRSA Program Administrator.
 - 13.2.2.1. Develop a corrective action plan to address deficiencies based on the results of a review. Require Subcontractors to respond to any identified deficiency and to develop and implement the corrective action plan. The corrective action timelines are specific to this section of this Agreement are:
 - 13.2.2.1.1. No more than 20 days following the date of the review, the RSN will provide the contracted provider a copy of the review and the corrective action required.
 - 13.2.2.1.2. No more than 20 days following the receipt of the review the contracted provider must provide the corrective action plan to the RSN.
 - 13.2.2.1.3. No later than the final calendar day for each quarter the RSN will provide the HRSA Program Administrator a copy of the final comprehensive review and the completed corrective action or, plan for date of completion of all corrective action.

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 and/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.
 - The DSHS 7.01 Policy, which identifies the following Tribes and/or Recognized American Indian Organizations (RAIOS).

Lummi, Nooksack, Samish, Sauk-Suiattle, Snoqualmie, Stillaguamish, Swinomish, Tulalip, Upper Skagit
- 14.1.2. A Planning Checklist is available on the HRSA Intranet 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

- 14.2.1. If the Contractor chooses to enter into a Subcontract with a Tribe the Contract must include one 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 the 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 the 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 of the following:

- 14.2.2.1. General Terms and Conditions that were developed through a process facilitated by the 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 the 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 RAIO. The Contractor must work with each Tribe to identify those areas that place legal requirements on the Tribe that are not applicable and refrain from passing these requirements on to Tribes.
- 14.2.4. The HRSA Tribal Liaison may be available for technical assistance in identifying what legal requirements the Contractor can be relieved of in Tribal or RAIO 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 RAIO listed in section 14.1.1 for use in specialists consults whenever possible.

15. SPECIAL PROJECTS

15.1. **Jail Coordination Services** – Are to be provided within the identified resources in Exhibit D.

- 15.1.1. The Contractor shall coordinate with local law enforcement and jail personnel. This shall include the development or maintenance of Memoranda of Understanding with local county and city jails in the Contractors' Service Area.

The MOU must identify the process and procedures to be implemented when the local jails contract the placement of offenders in other jurisdictions, such as tribal jails or those in other counties. The MOU must detail a referral process for persons who are incarcerated and have been diagnosed with a mental illness or identified as in need of mental health services. It must also include a process to include services to offenders placed in an out of jurisdiction contract facility.

- 15.1.1.1. The Contractor shall identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.
- 15.1.1.2. The Contractor shall accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24. The Contractor shall conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.
- 15.1.1.3. The Contractor shall develop and execute a Memorandum of Understanding with local community service offices (CSO) for expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs. The Contractor shall assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.
- 15.1.1.4. Pre-release services shall include:
 - Mental health screening for individuals who display behavior consistent with a need for such screening or who have been referred by jail staff, or officers of the court.
 - Mental health intake assessments for persons identified during the mental health screening as a member of the priority populations as defined in Chapter 71.24 RCW.
 - Facilitation of expedited medical and financial eligibility determination with the goal of immediate access to benefits upon release from incarceration.

- Other prudent pre-release (including pre-trial) case management and transition planning.
- 15.1.1.5. Provision of direct mental health services to individuals who are in jails that have no mental health staff.
- 15.1.1.6. Implement intensive post-release outreach to ensure best possible follow-up with the CSO and appointments for mental health and other services (e.g. substance abuse) engagement with mental health services to stabilize client in the community.
- 15.1.2. If the Contractor has provided the jail services above the Contractor may use the Jail Coordination Services funds provided to facilitate any of the following activities if there are sufficient resources:
 - 15.1.2.1. Daily cross-reference between new bookings and the RSN database to identify newly booked, persons known to the RSN.
 - 15.1.2.2. Development of individual alternative service plans (alternative to the jail) for submission to the courts.
 - 15.1.2.3. Inter-local Agreements with juvenile detentions facilities.
 - 15.1.2.4. Provision of up to a seven (7) day supply of medications prescribed for the treatment of mental health symptoms following the release from jail.
 - 15.1.2.5. Training to local law enforcement and jail services personnel.
- 15.2. Expanded Community Services (ECS) (These terms are only in the following RSN's – Clark, King, North Sound, Peninsula, Pierce, Thurston, Timberlands) The ECS funding provided in Exhibit D is provided for the provision of enhanced community support services for long term State Hospital patients whose treatment needs constitute substantial barriers to community placement.
 - 15.2.1. The Contractor shall provide or maintain community residential and support services for Consumers with treatment needs that constitute substantial barriers to community placement. The Consumer must no longer need an inpatient Level of Care and be determined clinically ready for discharge.
 - 15.2.2. The Contractor shall screen all new referrals for ECS using the state developed ECS screening form. Consumers are determined to be eligible for services under ECS by the Contractor. Additional Consumers may be identified during this contract period to participate in ECS if there is capacity.
 - 15.2.3. Prior to placement of a new ECS Consumer the Contractor must convene and participate in a team of community professionals who will become familiar with the Consumer and treatment plan. This includes:
 - 15.2.3.1. Assessment of the Consumer's strengths, preferences and needs.
 - 15.2.3.2. Arrangement of a safe, clinically-appropriate, and stable residence.
 - 15.2.3.3. Assessment and planning for other needed medical, behavioral, and social services.

- Thurston-Mason RSN 1/2 Team

- 15.3.2. Require that the primary individuals served by the WA-PACT team(s) are individuals who demonstrate or have demonstrated a Medical Necessity for inpatient psychiatric hospitalization. In addition, priority shall be given to referrals from current State Hospital patients who are ready for discharge and meet criteria for admission into PACT teams as delineated in the revised *Washington State PACT Standards*.
- 15.3.3. Strive to maintain state hospital census bed reductions achieved during this contract period. HRSA may invoke provisions of the remedial actions section of this Agreement if the actual reduction in utilization of State Hospitals is not determined to be satisfactory by HRSA.
- 15.3.4. Admit Consumers in accordance with the revised *Washington State PACT Program Standards* to maintain the Consumer participation at a minimum monthly average of 42 Consumers for half teams and 90 Consumers for full teams.
- 15.3.5. Maintain capacity for priority re-admission for discharged Consumers who need re-admission to the PACT team to maintain stability within the community. These Consumers must meet Medical Necessity requirements for this Level of Care.
 - 15.3.5.1. In the case of emergent re-admission, the overall maximum team capacity may be waived.
- 15.3.6. Incorporate stakeholder involvement in the implementation of the WA-PACT by development of Stakeholder Advisory Groups.
 - 15.3.6.1. The RSN may determine whether the Stakeholder Advisory Group is included within the RSN Advisory Board or is managed by the RSN's WA-PACT provider. If the Stakeholder Advisory Group is managed by the provider, the RSN shall have a RSN representative attend all Stakeholder Advisory Group meetings.
 - 15.3.6.2. The RSN shall maintain and make available to HRSA upon request membership rosters of participants on the WA-PACT Stakeholder Advisory Group. The roster must identify each individual serving as a member, the stakeholder group represented, and the duration of their terms. The revised *Washington State PACT Program Standards* requires a representation of at least 51% Consumer and Consumer family members.
 - 15.3.6.3. Stakeholder Advisory Groups shall meet at least quarterly throughout this Agreement.
- 15.3.7. Require in subcontracts for WA-PACT providers to attend and participate in HRSA required training and technical assistance activities. The RSNs shall monitor WA-PACT provider's attendance and maintain documentation of monitoring efforts.
- 15.3.8. Maintain and make available to HRSA upon request formally adopted, signed, and dated WA-PACT policies and procedures. The policies and procedures shall address all content areas identified in the revised *Washington State PACT Program Standards*.
- 15.3.9. Any exception to the staffing pattern required by the revised *Washington State PACT Program Standards* and the Contractor's approved staffing pattern must be submitted to HRSA for prior approval. Approvals for modifications to the staffing pattern will include an end date or a review for ongoing approval by HRSA.

- 15.3.10. RSNs must have teams which comport with the *Washington State PACT Program Standards* identified staffing patterns.

If the Contractor is not able to maintain full staffing, the Contractor must immediately notify HRSA, in writing, if staffing falls below the revised Washington State PACT Program Standard's staffing pattern.

- 15.3.11. Funds for WA-PACT will be provided in accordance with Exhibit D. for the provision of WA-PACT services as described in the revised *Washington State PACT Program Standards* and in accordance with the Contractors HRSA approved budget. Prior to significant changes to the staffing plan that are below the specifications in the revised WA-PACT standards, requests for approval must be submitted to HRSA.
- 15.3.12. Only these funds provided for the provision of WA-PACT may be used to provide the WA-PACT services. No other funds provided in this Agreement or as part of a PIHP Agreement may be used to provide these services, with the exception of Crisis Services, ITA Evaluations, E&T Services, Inpatient Mental Health Hospitalization Services, and Direct Care Wages. Any exceptions to this requirement must be submitted in writing to HRSA for consideration and must be approved prior to the expenditure.
- 15.3.12.1. [Spokane RSN Only] Spokane RSN shall use Federal grant-funded resources to increase the capacity of their WA-PACT team from 80-100 Consumers to 100-120 Consumers.
- 15.3.12.1.1. [Spokane RSN Only] If at any point Spokane RSN loses the Federal grant-funded resources the RSN will find another funding resource to maintain the enhanced capacity of the WA-PACT team.
- 15.3.12.1.2. Spokane Only If the RSN is unable to secure the additional funding, the RSN will develop a Transition Plan for decreasing the WA-PACT to 80-100 Consumers. The Transition Plan will indicate how Consumers will be transitioned from PACT to a clinically appropriate and efficacious Level of Care. The Plan must be submitted to HRSA for approval six (6) months prior to implementation.
- 15.3.12.2. The Contractor shall submit to HRSA, by December 31, 2009, an updated WA-PACT budget. The budget shall be detailed and comply with the provided format and include a Budget Narrative which will describe and clarify budget details.
- 15.3.12.3. The Contractor shall submit outcome data quarterly on individuals served by the WA-PACT teams in a format provided by HRSA. Reports will be submitted to HRSA within 60 days of the end of the quarter. The Contractor shall also submit to HRSA any other data or reports as required under this Agreement.
- 15.3.12.4. The Contractor shall maintain a roster of all PACT participants. The roster will include Consumer name, Consumer ID, referral source, PACT admit date, PACT discharge date and discharge disposition. The roster will comport with a template provided by HRSA and made available to HRSA upon request.
- 15.3.12.4.1. The Contractor shall maintain a waiting list of individuals referred for PACT who meet the admission criteria but cannot be enrolled because of capacity issues. The list shall include the referral date and shall be provided to HRSA upon request.

15.3.12.5. The Contractor shall maintain a roster of all PACT staff and their respective positions in accordance with the revised *Washington State PACT Program Standards*. The roster shall be submitted to HRSA upon request in a format provided by HRSA.

15.3.13. Performance/Fidelity

15.3.13.1. The Contractor shall cooperate with fidelity monitoring by providing to HRSA representatives, upon request, access to all RSN WA-PACT program documentation, Subcontractor facilities, RSN and Subcontractor staff, and records related to this program for review. In addition Contractor and Subcontractor staff shall facilitate and support Consumer interviews. The Contractor shall be subject to corrective actions as described in the remedial action section of this Agreement for failure to adequately meet fidelity requirements as determined by HRSA reviews.

15.3.13.2. WA-PACT Teams are expected to admit Consumers in accordance with the revised Published WA-PACT Program Standards. The Contractor shall maintain minimum targets of actively enrolled Consumers for WA-PACT teams as identified in the WA-PACT Fidelity Protocols. The active enrollment target must be maintained by the final day of the period in accordance with the schedule in the WA-PACT Fidelity Protocols. Failure to meet targets shall subject the Contractor to corrective actions as described in the remedial action section of this Agreement.

15.4. Program for Adaptive Living Skills (Western RSNs Only)

15.4.1. Funds will be provided according to Exhibit D for programs that significantly reduce the use of beds at the Program for Adaptive Living Skills (PALS) and State Hospitals. The Contractor may use funds in this section to pay for costs associated with individuals remaining in PALS.

15.4.2. The Contractor shall pay HRSA \$378 per month for each PALS bed. The Contractor shall be required to pay the full amount regardless of whether these beds are fully utilized. The PALS beds allocated to each RSN are contained in Exhibit F.

15.4.3. Individuals to be served at PALS no longer require long-term inpatient care as defined in RCW 71.24.025. The services and staffing provided at PALS are for transitional rehabilitative services and are not an inpatient Level of Care.

15.4.3.1. The PALS staff shall participate with the community in communicating to PALS residents that PALS is a transitional residential treatment program.

15.4.3.2. The services and staffing shall actively participate in the transition of PALS residents to community-based care.

15.4.3.3. HRSA shall not transfer individuals into PALS that have not been authorized by the Contractor.

15.4.3.4. In the event that the Contractor's census at PALS exceeds the number of contracted beds:

15.4.3.4.1. The Contractor shall be required to pay the hospital's bed-day rate for those days the Contractor is over census.

15.4.3.4.2. The Contractor shall submit a corrective action plan detailing the Contractor's plan to achieve a return to census. HRSA shall not transfer individuals into PALS

that have not been authorized by the RSNs. If a patient is determined by the WSH treatment team to be clinically ready for placement, and the RSN does not authorize a requested placement at PALS, the RSN shall arrange an alternative placement. Any disputes concerning placement will be resolved under the WSH Discharge Policy Dispute Resolution process

15.4.4. HRSA is not required to accept transfers of individuals into PALS when:

15.4.4.1. The Contractor's census at PALS exceeds their contracted beds.

15.4.4.2. WSH determines that the patient should not be transferred to PALS for clinical reasons

15.4.4.3. The PALS program is unable to meet the needs of the individual as determined by WSH and PALS staff.

16. REMEDIAL ACTIONS

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

16.1.1. A problem exists that negatively impacts Consumers receiving services.

16.1.2. The Contractor has failed to perform any of the mental health services required in this Agreement.

16.1.3. 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.

16.1.4. 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.

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

16.2. HRSA may impose any of the following remedial actions:

16.2.1. 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.

16.2.1.1. Corrective action plans must include:

16.2.1.1.1. A brief description of the situation requiring corrective action.

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

16.2.1.1.3. A timetable for completion of the actions.

16.2.1.1.4. Identification of individuals responsible for implementation of the plan.

- 16.2.1.2. Corrective action plans are subject to approval by HRSA, which may:
 - 16.2.1.2.1. Accept the plan as submitted.
 - 16.2.1.2.2. Accept the plan with specified modifications.
 - 16.2.1.2.3. Request a modified plan.
 - 16.2.1.2.4. Reject the plan.
- 16.2.2. Withhold up to five percent (5%) of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. HRSA, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.
- 16.2.3. 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.
- 16.2.4. 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.
- 16.2.5. Terminate for Default as described in the General Terms and Conditions; this may include releasing a Request for Proposals to re-procure the services provided under this Agreement.

17. GENERAL TERMS AND CONDITIONS

- 17.1. **Definitions.** The words and phrases listed below, as used in the Agreement, shall each have the following definitions:
 - 17.1.1. "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.
 - 17.1.2. "Central Contract Services" (CCS) means the DSHS statewide agency headquarters contracting office, or successor section or office.
 - 17.1.3. "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>
 - 17.1.4. "Contracts Administrator" means the manager, or successor, of Central Contract Services or successor section or office.
 - 17.1.5. "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.
 - 17.1.6. "Debarment" means an action taken by a federal official to exclude a person or business entity from participating in transactions involving certain federal funds.
 - 17.1.7. "DSHS" or "the department" or "the Department" means the Department of Social and Health Services of the State of Washington and its Secretary.

- 17.1.8. "DSHS Representative" means any DSHS employee who has been delegated contract-signing authority by the DSHS Secretary or his/her designee.
- 17.1.9. "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.
- 17.1.10. "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.
- 17.1.11. "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>
- 17.1.12. "Secretary" means the individual appointed by the Governor, State of Washington, as the head of DSHS, or his/her designee.
- 17.1.13. "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.
- 17.1.14. "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://apps.leg.wa.gov/wac>
- 17.1.15. "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://www.gpoaccess.gov/uscode/>
- 17.2. **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.
- 17.3. **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.
- 17.4. **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.
- 17.5. **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.
- 17.6. **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.

- 17.7. **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.
- 17.8. **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.
- 17.9. **Entire Agreement.** This Agreement, including all documents attached to or incorporated by reference, contain all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or bind the parties.
- 17.10. **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.
- 17.11. **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.
- 17.12. **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.
- 17.13. **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.
- 17.14. **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.

- 17.15. **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:
- 17.15.1. Document performance of all acts required by law, regulation, or this Agreement.
 - 17.15.2. 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.
 - 17.15.3. 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.
- 17.16. **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:
- 17.16.1. Applicable Federal and State of Washington statutes and regulations.
 - 17.16.2. The General Terms & Conditions of this Agreement.
 - 17.16.3. The Special Terms & Conditions of this Agreement.
 - 17.16.4. Any Exhibits attached or incorporated into this Agreement by reference.
- 17.17. **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.
- 17.18. **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.
- 17.19. **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.
- 17.20. **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 arising 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.

17.21. Sub-recipients.

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

17.21.1.1. 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.

17.21.1.2. 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.

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

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

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

17.21.1.6. 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.

17.21.1.7. 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.)

17.21.2. Single Audit Act Compliance. If the Contractor is a sub-recipient 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:

17.21.2.1. 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.

17.21.2.2. 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."

17.22. **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.

17.23. **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.

17.24. **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.

17.25. **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.

17.26. **Termination for Default.**

17.26.1. 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:

17.26.1.1. Failed to meet or maintain any requirement for contracting with DSHS.

17.26.1.2. Failed to perform under any provision of this Agreement.

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

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

17.26.2. 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.

17.26.3. 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:

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

17.26.3.2. Failed to perform under any provision of this Agreement.

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

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

17.26.4. 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.

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

17.27.1. 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.

17.27.2. 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 protect and preserve any property of DSHS that is in the possession of the Contractor pending return to DSHS.

17.27.3. 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 by the parties for partially completed work and services, if work products are useful to or usable by DSHS.

17.27.4. 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 17.14 entitled "Lawsuits".

17.27.5. 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).

17.28. **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.

17.29. **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 17.2. Only the Contracts Administrator or designee has the authority to waive any term or condition of this Agreement on behalf of DSHS

18. SPECIAL TERMS AND CONDITIONS

18.1. **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:

18.1.1. All applicable Office of Insurance Commissioner's (OIC) statutes and regulations.

18.1.2. All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement.

18.1.3. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC §1857(h)), Section 508 of the Clean Water Act (33 USC §1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, Department of Health and Human Service (DHHS), and the EPA.

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

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

18.1.6. Those specified in Title 18 RCW for professional licensing.

18.1.7. Reporting of abuse as required by RCW 26.44.030.

18.1.8. Industrial insurance coverage as required by Title 51 RCW.

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

18.1.10. Any provision of this Agreement which conflicts with State and federal statutes, or regulations, or Centers for Medicare and Medicaid Services (CMS) policy guidance is hereby amended to conform to the provisions of State and federal law and regulations.

18.2. Confidentiality of Personal Information

18.2.1. 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. Such purposes include, but are not limited to:

18.2.1.1. Establishing eligibility.

18.2.1.2. Determining the amount of medical assistance.

18.2.1.3. Providing services for recipients.

18.2.1.4. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan.

18.2.1.5. Assuring compliance with Federal and State laws and regulations, and with terms and requirements of the Agreement.

18.2.1.6. Improving quality.

18.2.2. The Contractor shall comply with all confidentiality requirements of the Health Insurance Portability and Accountability Act (45 CFR §§ 160 and 164).

18.2.3. In the event a Consumer's picture or personal story will be used, the Contractor shall first obtain written consent from the Consumer.

18.3. Declaration That Individuals Served Under Mental Health Programs Are Not Third-Party Beneficiaries Under this Agreement. Although DSHS and the Contractor mutually recognize that services under this Agreement will be provided by the Contractor to individuals receiving services under RCW chapters 71.05, 71.24, and 71.34 RCW, it is not the intention of either 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.

18.4. 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.

18.4.1. 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.

18.4.2. 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.

18.4.2.1. The written submission must contain the following information:

18.4.2.2. The Contractor's Contact for the issue.

- 18.4.2.3. The Issue in dispute.
- 18.4.2.4. The Contractor's position on the issue.
- 18.4.3. 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.
- 18.4.4. 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.
- 18.5. 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.
- 18.6. Failure to Expend Funds. In the event that the Contractor fails to expend funds under this Agreement in accordance with state laws and/or the provisions of this Agreement, the Department reserves the right to recapture state funds in an amount equivalent to the extent of the noncompliance. This is in addition to any other remedies available at law or in equity.
 - 18.6.1. Such right of recapture shall exist for a period not to exceed 24 months following contract termination. Repayment by the Contractor of funds under this recapture provision shall occur within 60 days of demand. In the event that the Department is required to institute legal proceedings to enforce the recapture provision, the Department shall be entitled to its costs thereof, including attorneys' fees.
- 18.7. 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:
 - 18.7.1. Create and maintain a mandatory compliance plan that includes provisions to educate staff and providers of the false claim act and whistle blower protections.
 - 18.7.2. Develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State standards.
 - 18.7.3. Designate a compliance officer and a compliance committee that is accountable to senior management.
 - 18.7.4. Provide effective ongoing training and education for the compliance officer, staff of the PIHP, and selected staff of the CMHAs.
 - 18.7.5. Facilitate effective communication between the compliance officer, the PIHP employees, and the Contractor's network of CMHAs.

- 18.7.6. Enforce standards through well-publicized disciplinary guidelines.
- 18.7.7. Conduct internal monitoring and auditing.
- 18.7.8. Respond promptly to detected offenses and develop corrective action initiatives.
- 18.7.9. Report fraud and/or abuse information to HRSA as soon as it is discovered including the source of the complaint, the involved CMHA, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.
- 18.8. Information Requests: The Contractor shall maintain information necessary to promptly respond to written requests by a HRSA Director, or Office Chief or their designee. The Contractor shall submit information detailing the amount spent throughout its Service Area on specific items upon request by a HRSA Director, or an Office Chief.
- 18.9. 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.
- 18.10. 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 year period, whichever is later.
 - 18.10.1. The Contractor shall maintain records sufficient to:
 - 18.10.1.1. Maintain the content of all medical records in a manner consistent with utilization control requirements of 42 CFR §456.
 - 18.10.1.2. Document performance of all acts required by law, regulation, or this Agreement.
 - 18.10.1.3. Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance.
 - 18.10.1.4. 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.
 - 18.10.2. 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.
 - 18.10.3. 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.

18.10.4. 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.

18.11. Termination of RSN Function Notice Requirements

18.11.1. 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.

18.11.2. 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.

18.11.3. DSHS must provide the Contractor contact person, or successor, listed on the first page of this Agreement with 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.