CONTRACT AMENDMENT
PIHP Amendment

DSHS CONTRACT NUMBER: 1669-58002

Amendment No. 03

This Contract Amendment is between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below.

Program Contract Number
Click here to enter text.
Contractor Contract Number

CONTRACTOR NAME		CONTRACTOR doing business as (DBA)	
North Sound Behavioral Health Organization, LLC		North Sound Behavioral Health Organization	
CONTRACTOR ADDRESS 301 Valley Mall Way Ste 110 Mount Vernon, WA 98273-5462		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) 603-583-336	DSHS INDEX NUMBER 1553
CONTRACTOR CONTACT Joe Valentine	CONTRACTOR TELEPHONE (360) 416-7013	CONTRACTOR FAX (360) 416-7017	CONTRACTOR E-MAIL ADDRESS joe_valentine@northsoundbho.org

DSHS ADMINISTRATION	DSHS DIVISION	DSHS CONTRACT CODE
Behavioral Health Administration	Division of Behavioral Health and Recovery	1684LS-69
DSHS CONTACT NAME AND TITLE Melinda Trujillo Program Manager	DSHS CONTACT ADDRESS Sky Valley CSO 19705 SR 2 Monroe, WA 98272	
DSHS CONTACT TELEPHONE (360)805-8362	DSHS CONTACT FAX (360) 794-1334	DSHS CONTACT E-MAIL ADDRESS melinda.trujillo@dshs.wa.gov
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? No	CFDA NUMBERS 93.778	
AMENDMENT START DATE 07/01/2017	**CONTRACT END DATE** 09/30/2017	
PRIOR MAXIMUM CONTRACT AMOUNT $0.00	AMOUNT OF INCREASE OR DECREASE $0.00	TOTAL MAXIMUM CONTRACT AMOUNT $0.00

REASON FOR AMENDMENT;
CHANGE OR CORRECT CONTRACT TERMS OR SOW, SEE PAGE TWO

ATTACHMENTS. When the box below is marked with an X, the following Exhibits are attached and are incorporated into this Contract Amendment by reference:
☒ Additional Exhibits (specify): Exhibit C & Exhibit D

This Contract Amendment, including all Exhibits and other documents incorporated by reference, contains all of the terms and conditions agreed upon by the parties as changes to the original Contract. No other understandings or representations, oral or otherwise, regarding the subject matter of this Contract Amendment shall be deemed to exist or bind the parties. All other terms and conditions of the original Contract remain in full force and effect. The parties signing below warrant that they have read and understand this Contract Amendment, and have authority to enter into this Contract Amendment.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
	Joe Valentine, Executive Director	
DSHS SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

This Contract between the State of Washington Department of Social and Health Services (DSHS) and the Contractor is extended to September 30, 2017. The Contract is additional amended as follows:

Section 2. Definitions:

Definitions 2.1, 2.4, 2.5, 2.10, 2.46, 2.47, 2.49, 2.66, and 2.67 are deleted and replaced with the following:

2.1 "Administrative Hearing" means a proceeding before an administrative law judge to review an Adverse Benefit Determination as defined below.

2.4 "Appeal" means a review by a Behavioral Health Organization (BHO) of an adverse benefit determination, as defined above. See also "Expedited Appeal".

2.5 "Appeal Process" means one of the processes included in the grievance and appeal system that allows an Enrollee to appeal an Adverse Benefit Determination made by the Contractor and communicated on a Notice of Adverse Benefit Determination.

2.10 "Authorized Representative" means an individual appointed in writing by an Enrollee, or authorized under State or other applicable law, to act on behalf of an Enrollee or other party involved in an Appeal or Grievance. If the Enrollee gives written permission, the Authorized Representative may include a behavioral health practitioner working on behalf of the Enrollee.

2.46 "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, an Enrollee's right to dispute an extension of time proposed by the BHO to make an authorization decision, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a behavioral health provider or employee, and failure to respect the Enrollee's rights regardless of whether a specific action is requested by the Enrollee.

2.47 "Grievance and Appeal System" means the processes a Behavioral Health Organization (BHO) implements to handle appeals of adverse benefit determinations and grievances as well as the processes to collect and track information about them. The BHO must establish the grievance and appeal system and meet the requirements of 42 C.F.R. Sec. 438, Subpart F and include:

2.47.1 A grievance process;

2.47.2 An appeal process; and

2.47.3 Access to the department's administrative hearing process.

2.49 "Individual" means a person who applies for, is eligible for, or receives BHO-authorized behavioral health services from an agency licensed or certified by the Department as a behavioral health agency. In the case of a minor, the Individual's parent or, if applicable, the Individual's custodian.

2.49.1 For the purposes of accessing the Grievance and Appeal System, the definition of Individual also includes the following if another person is acting on the Individual's behalf:

2.49.2 The Individual's legal guardian; or

2.49.3 The Individual's representative if the Individual gives written permission.

2.49.4 The individual's behavioral health provider if the individual gives written consent.

2.66 "Notice of Adverse Benefit Determination" is a written notice a Behavioral Health Organization provides to an Individuals, or the Individual's Authorized Representative, to communicate an Adverse Benefit Determination.

2.67 "Opiate Treatment Program" ("OTP") means the provision of treatment services and medication

management to Individuals addicted to opiates.

The following new definitions are added at the end of the current definitions:

"Adverse Benefit Determination" means:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state;
- The failure of a Behavioral Health Organization (BHO) to act within the grievance and appeal system timeframes as provided in WAC 388-877-0660 through 388-877-0670 regarding the standard resolution of grievances and appeals.

"Emergency Medical Condition" means: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 C.F.R. § 438.114(a)). For behavioral health care; this would include instances where imminent likelihood of serious harm to self or others, or imminent danger due to grave disability has been determined by a designated mental health professional or treating physician.

"Emergency Services" means covered inpatient and outpatient services needed to evaluate or stabilize an emergency medical condition and that are furnished by a provider who is qualified to furnish these services.

"Post-stabilization services" means medically necessary services related to an emergency medical condition that are received at the site at which the patient is treated for an emergency medical condition, after the individual's condition is sufficiently stabilized that he or she could alternatively be safely discharged or transferred to another facility.

"Primary Care Provider (PCP)" means a health care provider who has the responsibility for supervising, coordinating, and providing primary health care to an Enrollee. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Naturopathic physicians, medical residents (under the supervision of a teaching physician), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNPs), as designated by the Contractor. The definition of PCP is inclusive of primary care physician as it is used in 42 C.F.R. § 438. All federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Contract.

"Psychiatric Inpatient Services" means services provided to an individual admitted under appropriate written orders of a physician or other practitioner in a facility qualified to furnish services under 42 CFR.

"Stabilized" means that the treating physician has determined that the individual is safe to be discharged or transferred. Psychiatric patients are considered stable when they are protected and prevented from harming themselves or others.

Section 3. Special Terms and Conditions.

Subsection 3.1.4 is amended to read:

3.1.4 Audit and inspect any books, records, computers, or electronic systems of the Contractor and of any subcontractor, that pertain to the ability of the entity to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract per Section 1903(m)(A)(iv) of the Social Security Act; and

New subsection 3.1.7 is added:

3.1.7 The right to audit under this section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

New section 3.9. is added:

3.9 The Contractor shall submit audited financial reports specific to this Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

Section 4. Payment and Fiscal Management.

Subsection 4.4.5. is amended to read:

4.4.5 The Contractor must reimburse the subcontracted BHA and any crisis service provider accessed by Enrollees while the Enrollee is in or out of the State within sixty (60) calendar days from the date the bill is received from the service provider.

New subsection 4.4.8. is added:

4.4.8 IMD reporting and recoupment.

4.4.8.1 The Contractor shall provide a monthly report no later than the 10th day of each month in a format provided by DSHS which identifies enrollees who spent sixteen (16) or more days in an IMD during any previous month without duplication. The initial start date of this report shall be July 1, 2017.

4.4.8.2 The Contractor shall not cover any services for the enrollee during the month in which the enrollee spent sixteen (16) or more days in an IMD with funds provided under this contract. The Contractor is responsible for payment of authorized IMD services.

4.4.8.3 IMD services provided in lieu of State Plan Services are limited to fifteen (15) days in a calendar month. Date of discharge is not to be counted towards the fifteen (15) day limit.

4.4.8.4 The monthly capitation payment for any enrollee who spends sixteen (16) or more days in a single month in an IMD will be recouped by DSHS.

New subsection 4.4.9. is added:

4.4.9 The Contractor must report to DSHS within sixty (60) calendar days when it becomes aware of an overpayment of the monthly capitation payment or other payment under this contract.

New section 4.7. Medical Loss Ratio (MLR) is added:

4.7 Medical Loss Ratio (MLR)

4.7.1 General Reporting Requirements. The contractor must calculate and report an MLR once per state fiscal year, consistent with the MLR standards as described in this section and in 42 CFR 438.8. The first MLR report shall cover state fiscal

year 2017-2018 and will be submitted on November 30th, 2018.

4.7.2 The contractor provided annual MLR report will be in a format provided by DSHS that includes the following:

- Total incurred claims.
- Expenditures on quality improving activities.
- Expenditures related to activities compliant with program integrity requirements.
- Non-claims costs.
- Premium revenue.
- Taxes.
- Licensing fees.
- Regulatory fees.
- Methodology(ies) for allocation of expenditures.
- Any credibility adjustment applied.
- The calculated MLR.
- A comparison of the information reported with the audited financial report.
- A description of the aggregation method used to calculate total incurred claims.
- The number of member months.

4.7.3 The contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

4.7.4. Third Party Claims Adjudication

The contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

4.7.5. Retroactive Changes to Capitation Payments.

4.7.5.1 In any instance where a state makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the contractor must:

- Re-calculate the MLR for all MLR reporting years affected by the change.
- Submit a new MLR report meeting the applicable requirements.

4.7.6. Credibility Adjustments.

The contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the state.

The contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

If a contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

4.7.7. Insolvency

The contractor must submit data on the basis of which the state determines that the contractor has made adequate provision against the risk of insolvency. This requirement is met through reporting of the contractor's inpatient and risk reserve amounts through annual revenue and expenditures reporting.

Section 5. Access to Care.

Section 5.2 hyperlink is updated to:

https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information

Subsection 5.8.5.1. is amended to read:

5.8.5.1. Offer a mental health intake evaluation by a MHP within ten (10) business days of an Enrollee request. If a FFS individual was previously authorized for outpatient services under the managed care system, the BHO may re-enroll the person in care without a new intake if they return to the managed care system before the end of previously authorized period."

Subsection 5.8.5.9. is amended to read:

5.8.5.9 The provider network must include access to medication assisted treatment when it's clinically appropriate and medically necessary. This can be provided either through DSHS licensed and certified Opiate Treatment Program providers or through a medical Medicaid benefit.

New section 5.15. is added:

5.15 Individuals identified as AI/AN in Medicaid enrollment are only to be included if the individual chooses to opt in to the BHO. In the event they choose not to be part of the BHO behavioral health services for that individual shall be provided on a fee-for-service basis and billed to The State.

5.15.1 AI/AN individuals who are current Medicaid clients and opt in to the BHO shall have their effective date be set to the first day of the month following their request for enrollment.

5.15.**2** Newly eligibly AI/AN individuals who opt in to the BHO shall have their effective date set to the first day of the month following enrollment.

Section 6. Utilization Management.

New section 6.6.12. is added:

6.6.12 Out of Area Placement. The Contractor is responsible for payment of services that occur outside of the boundaries listed in the *Exhibit B – BHOs and Service Areas of the DSHS and BHO agreement on General Terms and Conditions* when the Contractor or their agent authorize these services. Responsibility for costs of care continues regardless of whether or not Capitation Payments are issued to the placing Contractor until either:

6.6.12.1 Medicaid eligibility in any of the programs included in the Federal 1915 (b) Behavioral Health Waiver ends or

6.6.12.2 The individual is discharged from the authorized services. The Contractor is not responsible for enrollees placed out of area by entities not directly contracting with them.

Section 6.7 is deleted and replaced with the following:

6.7 Authorization for Payment of Psychiatric Inpatient Services. The Contractor must have appropriate clinical staff members available twenty-four (24) hours per day, seven (7) days per week to respond to requests for authorization of psychiatric inpatient care in community hospitals.

6.7.1 Non-emergent admissions: The Contractor must make an expedited authorization decision and provide notice as expeditiously as the Individual's health condition requires and no later than three (3) business days following the receipt of an authorization request for inpatient care. Extensions of up to (fourteen) 14 calendar days are permitted if the Enrollee or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the Individual's best interest.

6.7.2 Emergency services: The contractor must cover and pay for emergency inpatient services necessary to evaluate and stabilize an enrollee's EMC; and may not deny payment for treatment obtained under either of the following circumstances:

6.7.2.1 An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition in this agreement.

6.7.2.2 A representative of the contractor instructs the enrollee to seek emergency services.

6.7.3 Prior authorization decisions for inpatient post-stabilization care services must be made within one (1) hour of the provider's initial call following determination of stabilization.

The contractor is financially responsible for post-stabilization care services that are not pre-approved, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the contractor for pre-approval of further post-stabilization care services;

The contractor is financially responsible for post-stabilization care services that are not pre-approved, but administered to maintain, improve, or resolve the enrollee's stabilized condition if;

6.7.3.1 The contractor does not respond to a request for pre-approval within 1 hour;

6.7.3.2 The contractor cannot be contacted; or

6.7.3.3 The contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and the Contractor's physician is not available for consultation. In this situation, the treating physician may continue to care for the patient until the Contractor's physician is reached or one of the criteria in 42 CFR§422.113(c)(3) is met.

6.7.4 End of the contractor's financial responsibility. Excluding pre-approved post-stabilization services the contractor's financial responsibility for post-stabilization care services, ends when;

6.7.4.1 The contractor's representative and the treating physician reach an agreement concerning the enrollee's care; or

6.7.4.2 The enrollee is discharged.

6.7.5 Only a psychiatrist or doctoral level-clinical psychologist may deny a request for psychiatric inpatient care.

6.7.6 Adverse Benefit Determinations must be issued to the enrollee or the enrollee's representative (including the inpatient facility if acting as such) **whenever the contractor** does not approve an inpatient service from an enrollee or accepting hospital, or authorizes the inpatient service in an amount that is less than requested.

Section 6.10 "**Transition for Payment of Substance Use Disorder Treatment Services"** is renamed **"Transition for Payment of Behavioral Health Services"**

New subsection 6.10.2 is added.

6.10.2 As of July 1, 2017, the Contractor will be responsible for payment of all services provided for individuals receiving behavioral health treatment that was initiated under a fee for service arrangement and opts into the PIHP.

The Contractor must:

6.10.2.1. Develop a safe, medically appropriate transition plan, considering the health and safety of the transitioning individual.

6.10.2.2. Complete an assessment of the individual or accept the most recent assessment by the individual's current provider to determine medical necessity.

6.10.2.3. If the individual is being treated by an out of network provider, the Contractor shall authorize and accept responsibility for continuing Medicaid services for up to sixty (60) calendar days after the date of PIHP enrollment, or until one of the following occurs based on a medical necessity determination:

- The course of treatment is complete, or
- The Contractor evaluates the client and determines that services are no longer necessary, or
- The Contractor determines that a different course of treatment is indicated or
- The individual agrees to transition to a BHO contracted provider.

Section 6.11 is deleted and replaced with the following:

6.11. Additional Allowable Services.

6.11.1. The Contractor may provide services in lieu of those described in the Medicaid State Plan and allowed under Medicaid. The services must meet all DSHS licensing and certification standards and be medically necessary. The Contractor is not required to provide these services in lieu of Medicaid state plan services. All costs and encounter reporting requirements are the same for any provided in lieu of services.

6.11.2 The Contractor may provide services necessary for the BHO or its subcontractors to ensure compliance with CFR 438.910 – Parity Requirements.

6.11.3 The Contractor may voluntarily provide any other service not covered in the State Plan, although the cost of these services cannot be included when determining the payment rates.

New subsection 6.13 is added.

6.13 Medicaid Funded Personal Care and Related Services: DSHS Aging and Long Term

Support Administration (ALTSA), Home and Community Services (HCS) Division uses the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine personal care needs.

6.13.1. Personal care and related services authorized by HCS must not duplicate services the Contractor is required to provide.

6.13.2 Requests for information.

6.13.2.1. The Contractor or its designee must respond to requests from HCS within five (5) business days of the request.

6.13.2.2. The Contractor and the local HCS office may mutually agree in writing to extend the five (5) business day requirement.

6.13.2.3. The Contractor must or its designee must enter into an agreement with ALTSA/HCS or its designee that identify processes and procedures related to shared clients.

6.13.3 Authorization decisions for personal care and related services must be based on the following:

6.13.3.1 A review of the request to determine if the Individual is currently authorized to receive Behavioral Health services in the Contractor's Service Area;

6.13.3.2 A verification of the need for personal care and related services is based solely on a psychiatric disability;

6.13.3.3 A review of the requested services to determine if the Individual's personal care and related services or other needs could be met through the provision of other available behavioral health services;

6.13.4 Services may include personal care, relief care, cluster care, nurse delegation, training required by an individual provider to continue providing personal care, or client responsibility reimbursement.

6.13.5 Authorization denials:

6.13.5.1 If the Contractor denies authorization for personal care or related services, and the Individual's diagnosis is psychiatric, a written response must be provided to HCS or its designee and must include the reason for the determination and alternative services authorized that will be used to meet the personal care needs identified in the CARE assessment;

6.13.5.2 When the Contractor denies authorization based on provision of other services, a plan (e.g. Individual Service Plan) must be developed by the Contractor and implemented to meet the service needs identified in the CARE assessment.

6.13.6 Reporting. The Contractor must provide the following documentation to DBHR, HCS, or its designee on request:

6.3.6.1 The original referral from HCS or its designee and request for authorization;

6.3.6.2 Any information provided by HCS or its designee including the CARE assessment;

6.3.6.3 A copy of the Contractor's determination and written response provided to HCS or its designee;

6.3.6.4 A copy of the plan developed and implemented to meet the Individual's needs through provision of other services when the personal care or other related services request has been denied based on the Contractor's determination.

Section 7. is deleted in its entirety and replaced with the following:

7. GRIEVANCE AND APPEAL SYSTEM

7.1 General Requirements. The Contractor must have a Grievance and Appeal System that complies with the requirements of 42 CFR § 438 Subpart F and WAC 388-877-0654 through WAC 388-877-0675, insofar as those WACs are not in conflict with 42 CFR § 438 Subpart F. The Grievance and Appeal System must include a Grievance Process, an Appeal Process, and access to the Administrative Hearing process.

7.1.1 The Contractor must have policies and procedures addressing the grievance and appeal system, which comply with the requirements of this Agreement. These must be provided to DSHS upon the department's request. If requested, DSHS will approve, in writing, all Grievance and Appeal System policies and procedures and related Notices to Enrollees regarding the Grievance and Appeal System.

7.1.2 The Contractor must provide Enrollees with any reasonable assistance necessary to complete forms and other procedural steps for Grievances and Appeals as required in 42 CFR § 438.406(a). This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Enrollees may also use the free and confidential Ombuds services provided within the BHO network.

7.2 Grievance Process. The following requirements are specific to the Grievance Process:

7.2.1 Only an Enrollee or the Enrollee's Authorized Representative may file a Grievance with the Contractor to express dissatisfaction in person, orally, or in writing about any matter other than an Adverse Benefit Determination to:

7.2.1.1 The BHA providing the behavioral health services; or

7.2.1.2 The Contractor

7.2.2 Designation of an Authorized Representative requires the Enrollee's written consent. The Enrollee's Behavioral Health Provider or BHA may act as an Authorized Representative, with the Enrollee's written consent.

7.2.3 The Ombuds serving the Contractor or BHA may assist the Enrollee in resolving the Grievance at the lowest possible level.

7.2.4 An Enrollee may choose to file a Grievance with the Contractor or with the BHA, subject to the following:

7.2.4.1 Filing a Grievance with a BHA. If the Enrollee first files a Grievance with the BHA and the Enrollee is not satisfied with the BHA's written decision on the Grievance, or if the Enrollee does not receive a copy of that decision from the BHA within the timelines established this Agreement, the Enrollee may then choose to file the Grievance with the Contractor. The Contractor's written decision on the grievance is the final decision. The grievance cannot progress

to an administrative hearing except under circumstances identified in 42 CFR § 438.400 (b)(5).

7.2.4.2 Filing a Grievance with the Contractor. If the Enrollee first files a Grievance with the Contractor (and not the BHA), and the Enrollee is not satisfied with the Contractor's written decision on the Grievance, the Enrollee cannot file the same Grievance with the BHA. The Contractor's written decision on the grievance is the final decision. The grievance cannot progress to an administrative hearing except under circumstances identified in 42 CFR § 438.400(b)(5).

7.2.4.3 There is no time limit to filing a grievance.

7.2.5 When an Enrollee files a Grievance, the Contractor or BHA receiving the Grievance must:

7.2.5.1 Acknowledge the receipt of the Grievance in writing within five (5) business days;

7.2.5.2 Investigate the Grievance;

7.2.5.3 At the Enrollee's request, give the individual reasonable assistance in taking any procedural steps;

7.2.5.4 Inform the Enrollee about Ombuds services and how to access these services; and

7.2.5.5 Send the Enrollee who filed the Grievance a written Notice describing the decision as expeditiously as the Enrollee's health condition requires, or no later than ninety (90) calendar days from the date the Grievance was filed.

7.2.6 The Contractor or BHA receiving the Grievance must ensure the following:

7.2.6.1 Other people, if the Enrollee chooses, are allowed to participate in the Grievance process.

7.2.6.2 That a Grievance is resolved even if the Enrollee is no longer receiving behavioral health services.

7.2.6.3 That the persons who make decisions on a Grievance:

7.2.6.3.1 Were not involved in any previous level of review or decision-making nor a subordinate of any person who reviewed or decided on a previous level of the grievance; and

7.2.6.3.2 Are MHPs or CDPs who have appropriate clinical expertise if the Grievance involves clinical issues or when the grievance involves the denial of an expedited resolution on an appeal.

7.2.6.3.3 Consider all comments, documents, records, and other information submitted by the Enrollee or the Enrollee's representative regardless of whether the information was considered in the initial review.

7.2.6.4 That the Enrollee and, if applicable, the Enrollee's Authorized Representative, receive a written Notice containing the decision as expeditiously as the Enrollee's health condition requires, or within ninety (90) calendar days from the date a Grievance is received by the Contractor or BHA.

7.2.6.5 This timeframe can be extended up to an additional fourteen (14) calendar days, if:

7.2.6.5.1 Requested by the Enrollee or the Enrollee's Authorized Representative; or

7.2.6.5.2 By the Contractor or BHA when additional information is needed and the BHA or Contractor can demonstrate to DSHS upon the department's request that it needs additional information and that the added time is in the Enrollee's interest. If timeframe is extended not at the request of the Enrollee, the Contractor must make reasonable efforts to provide the Enrollee prompt verbal notice of the delay and give the Enrollee written notice within 2 calendar days. Written notice must include the reason for the decision to extend and inform the Enrollee of the right to file a grievance if the Enrollee disagrees with this decision.

7.2.6.6 That the written Notice includes:

7.2.6.6.1 The resolution of the Grievance;

7.2.6.6.2 The reason for the decision and the date the decision was made; and

7.2.6.6.3 Is provided in the prevalent non-English languages as described in the Information Requirements section and meets the language and format requirements identified in 42 CFR § 438.10 (d).

7.2.6.7. Then the Contractor does not act within the grievance process timeframes described in this section, the Enrollee is considered to have exhausted the appeal process and has a right to request an Administrative Hearing.

7.3 Notice of Adverse Benefit Determination. The Contractor must provide a written Notice of Adverse Benefit Determination, to the Enrollee or his or her Authorized Representative, in accordance with 42 CFR § 438.404. The Contractor must provide a written Notice of Adverse Benefit Determination, to the Enrollee or his or her Authorized Representative, when conducting a Children and Adolescent Needs and Strengths (CANS) screen that results in denying the request for Wraparound Intensive Services (WISe)The Contractor must also provide a written Notice of Adverse Benefit Determination to the requesting provider for any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

7.3.1 The Notice of Adverse Benefit Determination must include an understandable explanation of:

7.3.1.1 The Adverse Benefits Determination the Contractor has made or intends to make;

7.3.1.2 The reasons for the Adverse Benefit Determination, including citation of the rule(s) and criteria used for the basis of the decision;

7.3.1.3 The right of the Enrollee to be provided reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's adverse benefit determination upon request and free of charge. Such information includes medical necessity criteria, and any processes, strategies, or standards used in setting coverage limits;

7.3.1.4 The Enrollee's right to file an Appeal with the Contractor, the process to file an appeal, including information on exhausting the Contractor's one level appeal process and the Enrollee's right to request an administrative hearing;

7.3.1.5 The circumstances under which an expedited appeal process is available and how to request it; and

7.3.1.6 The Enrollee's right to receive behavioral health services while an Appeal is pending, how to make the request that benefits be continued, and that the Enrollee may be held liable for the cost of services received while the Appeal is pending if the Appeal decision upholds the decision in the Notice of Adverse Benefit Determination.

7.3.1.7 Notices of Adverse Benefit Determinations must be provided in the prevalent non-English languages as described in the Information Requirements section and meet the language and format requirements identified in 42 CFR § 438.10(d).

7.3.2 When the Contractor or its contracted BHA does not reach service authorization decisions within the required timeframes, or fails to provide services in a timely manner, or when the Contractor does not act within the grievance and appeal system timeframes, it is considered an adverse benefit determination. In these cases, the Enrollee is considered to have exhausted the appeal process and the Contractor sends a formal notice of adverse benefit determination, which includes the Enrollee's right to request an administrative hearing.

7.3.3 Mailing Timeframes. The Contractor or its agent must mail the Notices of Adverse Benefit Determinations within the following timeframes:

7.3.3.1 For Routine Service authorization decisions that deny or limit services, no longer than fourteen (14) calendar days from the request for service.

7.3.3.2 For terminations, suspensions, or reductions of previously authorized services, no longer than ten (10) calendar days before the date of the Adverse Benefit Determination.

7.3.3.3 For Actions that are issued because the Contractor has verifiable information indicating probable beneficiary fraud the notice can be provided in as few as five (5) calendar days before the date of the Adverse Benefit Determination.

7.3.3.4 When any of the following occur the Contractor must issue the notice by the date of the Adverse Benefit Determination:

7.3.3.4.1 The Enrollee has died.

7.3.3.4.2 The Enrollee submits a signed written statement requesting service termination.

7.3.3.4.3 The Enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he or she understands that service termination or reduction will result.

7.3.3.4.4 The Enrollee has been admitted to an institution in which he or she is ineligible for Medicaid services.

7.3.3.4.5 The Enrollee's address is determined unknown based on returned mail with no forwarding address.

7.3.3.4.6 The Enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

7.3.3.4.7 A change in the level of medical care is prescribed by the Enrollee's physician.

7.3.3.4.8 The Notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.

7.3.3.4.9 The transfer or discharge from a facility will occur in an expedited fashion as described in 42 CFR § 483.12(c)(3).

7.3.3.4.10 Denial of payment or at the time of any Adverse Benefit Determination directly affecting the claim.

7.3.3.5 Under the following circumstances, authorization decisions may be extended an additional fourteen (14) calendar days:

7.3.3.5.1 The Enrollee or the BHA requests an extension.

7.3.3.5.2 The Contractor demonstrates the need for additional information to make an authorization decision and that the extension is in the Enrollee's best interest.

7.3.3.6 If the Contractor extends the timeframe it must:

7.3.3.6.1 Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and

7.3.3.6.2 Issue and carry out its determination as expeditiously as the Enrollee's behavioral health condition requires and no later than the date the extension expires.

7.3.4 The Contractor must provide a Notice on the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.

7.4 Appeals Process. The Contractor must have a single level appeal process that conforms to the following:

7.4.1 The Contractor must ensure that the Appeals Process allows an Enrollee, the Enrollee's Authorized Representative, a provider, or a BHA acting on behalf of the Enrollee and with the Enrollee's written consent, to appeal a Contractor's Adverse Benefit Determination (42 CFR § 438.402(c)(2)(ii)). If a written Notice of Adverse Benefit Determination was not received, an appeal may still be filed. The appeal may be filed orally or in writing and unless the Enrollee requests expedited resolution, the Enrollee must follow an oral filing with a written, signed appeal.

7.4.2 The Enrollee requesting review of an Adverse Benefit Determination:

7.4.2.1 Must file an Appeal and receive a Notice of Resolution from the Contractor before requesting an Administrative Hearing; and

7.4.2.2 May not file a Grievance with the BHA or the Contractor for the same issue as the Appeal once an Appeal has been filed.

7.4.3 The Appeals process must:

7.4.3.1 Provide an Enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The Contractor must inform the Enrollee of the limited time available during an Expedited Appeal Process.

7.4.3.2 Provide the Enrollee the opportunity, free of charge and sufficiently in advance, to examine the Enrollee's clinical record, including examining new or additional

evidence, medical records, and any other documents and records considered during the Appeal Process.

7.4.3.3 At the Enrollee's request, give the individual reasonable assistance in taking any procedural steps.

7.4.3.4 Inform the Enrollee about Ombuds services and how to access these services;

7.4.3.5 Include as parties to the Appeal as applicable:

7.3.3.6.3 The Enrollee.

7.3.3.6.4 The Enrollee's Authorized Representative.

7.3.3.6.5 The legal representative of a deceased Enrollee's estate.

7.4.3.6 The Contractor must ensure that the persons who make decisions on an Appeal:

7.3.3.6.6 Were not involved in any previous level of review or decision-making nor a subordinate of any person who reviewed or decided on a previous level of review or decision making;

7.3.3.6.7 Are mental health professionals or chemical dependency professionals who have appropriate clinical expertise if deciding an appeal of an adverse benefit determination concerning medical necessity or an appeal that involves any clinical issues;

7.3.3.6.8 Consider all comments, documents, records, and other information submitted by the individual regardless of whether the information was considered in the initial decision.

7.4.4 **Standard Appeals Process for an Adverse Benefit Determination – continued services not requested**

7.4.4.1 An Enrollee who disagrees with a decision communicated on an Adverse Benefit Determination may file an Appeal orally or in writing. An oral appeal must be followed with a written, signed appeal.

7.4.4.2 The Enrollee or the Enrollee's Authorized Representative must file the Appeal within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination.

7.4.4.3 The Contractor must confirm receipt of Appeals in writing within five (5) business days.

7.4.4.4 The Contractor must send the Enrollee a written notice of the resolution within thirty (30) calendar days of receiving the Appeal.

7.4.5 **Notice of Resolution of an Appeal – continued services not requested.** The Contractor must provide a written Notice of Resolution that includes:

7.4.5.1 The Contractor's decision and date of decision;

7.4.5.2 The reason for the decision;

7.4.5.3 The right to request an Administrative Hearing if the Enrollee disagrees with the decision, how to request a hearing, and the timeframes to do so;

7.4.5.4 The right to request and receive services pending a hearing and how to request continuation of services;

7.4.5.5 That the Enrollee may be held liable for the cost of continued services if the administrative hearing upholds the Contractor's decision; and

7.4.5.6 Be provided in the prevalent non-English languages as described in the Information Requirements section and meet the language and format requirements identified in 42 CFR § 438.10 (d).

7.4.5.7 The Contractor may extend the timeframe up to fourteen (14) additional calendar days if the Enrollee requests an extension or the Contractor is able to demonstrate to DSHS upon the department's request that it needs additional information and that the added time is in the Enrollee's interest. If the extension is not requested by the Enrollee or the Enrollee's representative, the Contractor must provide a written notice to the Enrollee stating the reason for the extension.

7.4.6 Standard Appeals for termination, suspension, or reduction of previously authorized services – continued services requested.

7.4.6.1 The Contractor must ensure that an Enrollee receiving a Notice of Adverse Benefit Determination from the Contractor that terminates, suspends, or reduces previously authorized services contains information that the Enrollee may file an Appeal and request continuation of those services pending the Contractor's decision on the Appeal, and how to do so.

7.4.6.2 The Enrollee must file the Appeal and request continuation of services with the Contractor on or before the later of the following:

7.4.6.2.1 Ten (10) calendar days after the date on the Notice of Adverse Benefit Determination; or

7.4.6.2.2 The intended effective date of the Contractor's proposed Adverse Benefit Determination.

7.4.6.3 The Contractor must confirm receipt of the Appeal and the request for continued services with the Enrollee orally or in writing within five business days. The oral appeal must be confirmed in writing by the BHO.

7.4.6.4 Include in the Notice that if the Appeal decision is adverse to the Enrollee, the Contractor may recover the cost of the behavioral health services provided pending the Contractor's decision.

7.4.6.5 Notice of Resolution of an Appeal with continued services requested: The Contractor must send the Enrollee a written Notice of the Resolution within thirty (30) calendar days of receiving the Appeal that includes:

7.4.6.5.1 The Contractor's decision on the Appeal and the date of decision;

7.4.6.5.2 The reason for the decision;

7.4.6.5.3 The right to request an Administrative Hearing if the Enrollee disagrees with the decision, how to request a hearing, and the timeframes to do so;

7.4.6.5.4 The right to request and receive services pending a hearing and how to request continuation of services;

7.4.6.5.5 That the Enrollee may be held liable for the cost of continued services if the administrative hearing upholds the Contractor's decision;

7.4.6.5.6 Be provided in the prevalent non-English languages as described in the Information Requirements section and meet the language and format requirements identified in 42 CFR § 438.10 (d).

7.4.6.6 The Contractor may extend the timeframe up to fourteen (14) additional calendar days if the Enrollee requests an extension or the Contractor is able to demonstrate to DSHS upon the department's request that it needs additional information and that the added time is in the Enrollee's interest. If the extension is not requested by the Enrollee or the Enrollee's representative, the Contractor must provide a written notice to the Enrollee stating the reason for the extension.

7.5 **Expedited Appeal Process.** The Contractor must establish and maintain an Expedited Appeal Process for Appeals when an enrollee or the enrollee's provider states that taking the time for standard resolution for an appeal could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function (42 CFR § 438.410(a)).

7.5.1 If the Contractor denies the request for the expedited Appeal and resolution of an Appeal, it must transfer the Appeal to the timeframe for standard resolutions (found in the Standard Appeals Process subsection of this Agreement), and make reasonable efforts to give the Enrollee prompt oral notice of the denial and respond in writing within two (2) calendar days.

7.5.2 The following apply to Expedited Appeal requests:

7.5.2.1 The Adverse Benefit Determination is for denial of requested services, termination, suspension, or reduction of previously authorized behavioral health services;

7.5.2.2 The Enrollee or the Enrollee's Authorized Representative may file an Appeal with the Contractor, either orally or in writing, within ten (10) calendar days from the date on the Contractor's written Notice of Adverse Benefit Determination, if the individual is requesting continued benefits.

7.5.3 The Enrollee, the Enrollee's Authorized Representative, or BHA acting on behalf of the Enrollee and with the Enrollee's written consent, may file an Appeal with the Contractor either orally or in writing, within sixty (60) calendar days from the date on the Contractor's written Notice of Adverse Benefit Determination, if the individual is not requesting continued services.

7.5.4 Only the Enrollee or the Enrollee's Authorized Representative may ask for continued services pending the outcome of the Expedited Appeal. A BHA acting on behalf of the Enrollee may not request continued services pending the outcome of the Expedited Appeal.

7.5.5 The Contractor must make a decision on the Enrollee's request for Expedited Appeal and provide written notice, as expeditiously as the Enrollee's condition requires, within seventy two (72) hours after the Contractor receives the Appeal (42 CFR § 438.408(b)(3)). The Contractor must also make reasonable efforts to provide oral notice.

7.5.6 If the Contractor determines that an Expedited Appeal is appropriate the Contractor must make a final decision on the appeal within seventy two (72) hours of approving the request for an Expedited Appeal.

7.5.7 Notice of Resolution – Expedited Appeals. The Contractor's written Notice of the Resolution must contain:

7.5.7.1 The Contractor's decision on the Appeal and the date the decision was made;

7.5.7.2 The reason for the decision;

7.5.7.3 The right to request an Administrative Hearing if the Enrollee disagrees with the decision, how to request a hearing, and the timeframes to do so;

7.5.7.4 The right to request and receive services pending a hearing and how to request continuation of services;

7.5.7.5 That the Enrollee may be held liable for the cost of continued services if the Administrative Hearing upholds the Contractor's decisions; and

7.5.7.6 Be provided in the prevalent non-English languages as described in the Information Requirements section and meet the language and format requirements identified in 42 CFR § 438.10 (d).

7.5.7.7 The Contractor must also make a reasonable effort to provide oral notice regarding the expedited resolution.

7.5.8 The Contractor must ensure that punitive action is not taken against a BHA who requests an expedited resolution or supports an Enrollee's Appeal (42 CFR § 438.410(b)).

7.5.9 The Contractor may extend the timeframe up to fourteen (14) additional calendar days if the Enrollee requests an extension or the Contractor is able to demonstrate to DSHS upon the department's request that it needs additional information and that the added time is in the Enrollee's interest.

7.5.10 For any extension not requested by an Enrollee, the Contractor must give the Enrollee written notice of the reason for the delay within two calendar days and make reasonable efforts to give the Enrollee prompt oral notice.

7.5.11 The Enrollee has a right to file a Grievance regarding the Contractor's Denial of a request for expedited resolution. The Contractor must inform the Enrollee of their right to file a Grievance in the Notice of Denial.

7.6 **Continued services during the Appeal Process.** The Contractor must continue services if all the following occurs:

7.6.1 The appeal involves the termination, suspension, or reduction of a previously authorized service;

7.6.2 The Enrollee's services were requested by an authorized provider;

7.6.3 The period covered by the original authorization has not expired;

7.6.4 The request for continuation of services is filed on or before the later of the following:

7.6.4.1 Within 10 calendar days of the Contractor sending the Notice of Adverse Benefit Determination, or

7.6.4.2 The intended effective date of the proposed Adverse Benefit Determination.

7.7 **Duration of Continued Services during the Appeal Process.** When an Enrollee has requested continued behavioral health services pending the outcome of the Appeal Process, the Contractor must ensure that services are continued until the following occurs:

7.7.1 The Enrollee withdraws the Appeal; or

7.7.2 The Contractor provides a written Notice of the resolution that contains a decision that is not in favor of the Enrollee and the Enrollee does not request an administrative hearing within ten calendar days from the date the Contractor mails the Notice.

7.8 **Recovery of the Cost of Behavioral Health Services in Adverse Decisions of Appeals**. If the final written Notice of the Resolution of the Appeal is not in favor of the Enrollee, the Contractor may recover the cost of the behavioral health services furnished to the Enrollee while the Appeal was pending to the extent that they were provided solely because of the requirements of appeal process.

7.9 **Administrative Hearings.**

7.9.1 Only the Enrollee or the Enrollee's Authorized Representative may file a request for an Administrative Hearing.

7.9.2 If an Enrollee does not agree with the Contractor's resolution of the Appeal, the Enrollee may file a request for a hearing within the following timeframes:

7.9.2.1 Within one hundred twenty (120) calendar days of the date on the Contractor's mailing of the Notice of the resolution of the Appeal (42 C.F.R. § 438.408 (f)(2), if continued services are not requested.

7.9.2.2 Within ten (10) calendar days of the date on the Contractor's mailing of the Notice of the resolution of the Appeal, if for hearings regarding termination, suspension, or reduction of a previously authorized service and continued services are requested. If the Enrollee is notified in a timely manner and the Enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for a hearing regarding a standard service apply (42 C.F.R. § 438.420).

7.9.2.3 Within ten (10) calendar days of the date on the Contractor's mailing of the Notice of resolution of the Appeal, if the Enrollee requests an expedited administrative hearing.

7.9.3 The Enrollee must exhaust the Appeal Process prior to filing a request for an Administrative Hearing. The parties to the Administrative Hearing include the Contractor as well as the Enrollee and his/her Authorized Representative or the legal representative of a deceased Enrollee's estate.

7.9.4 If the Enrollee requests continuation of services within ten (10) calendar days of the date on the Contractor's mailing of the resolution of the Appeal, then the Contractor must continue the Enrollee's behavioral health treatment services during the administrative hearing process until one of the following occurs:

(a) The Enrollee withdraws the hearing request; or

(b) The Administrative Law Judge issues a hearing decision adverse to the individual.

7.9.5 DSHS must be responsible for the implementation of the hearing decision, even if the hearing decision is not within the purview of this Agreement.

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

7.9.7 If the Contractor or the state Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor must authorize or provide the disputed services as expeditiously as the Enrollee's behavioral health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

7.10 **Recordkeeping Requirements**. The Contractor must maintain full records of all Grievances and Appeals and ensure an Enrollee's records are:

7.10.1 Kept for a period no less than ten (10) years after the completion of the Grievance or Appeal Process;

7.10.2 Made available to DSHS upon request as part of the state quality strategy and made available upon request to The Center for Medicare and Medicaid Services (CMS);

7.10.3 Kept in confidential files separate from the Enrollee's clinical record;

7.10.4 Not disclosed without the individual's written permission, except to DSHS or as necessary to resolve the Appeal; and

7.10.5 Are accurately maintained and contain, at a minimum, all the following information:

7.10.5.1 A general description of the reason for the grievance or appeal;

7.10.5.2 The date received;

7.10.5.3 The date of each review or, if applicable, review meeting;

7.10.5.4 Resolution at each level of the grievance or appeal, if applicable;

7.10.5.5 Date of resolution at each level, if applicable; and

7.10.5.6 Name of the Enrollee for whom the grievance or appeal was filed.

7.11 **Reporting Requirements.**

7.11.1 The Contractor must incorporate the results of the Grievance and Appeal System and address any trends in its quality improvement plan.

7.11.2 The Contractor must submit Individual-level grievance reports for children/youth ENROLLED OR referred to WISe in a format provided by DSHS and that contains the following:

7.11.2.1 Individual's full name;

7.11.2.2 Date of birth;

7.11.2.3 P1 or CIS identifier; and

7.11.2.4 Date and type.

7.11.3 The Contractor must submit quarterly aggregate reports for all grievances and appeals in a format provided by DSHS and accompanied by a brief report identifying trends and plans for improvement.

7.11.4 Quarterly reports are due as follows:

Quarterly Grievance Report Schedule	
Period Covered	**Due Date**
July 1 – September 30, 2017	October 31, 2017
October 1 – December 31, 2017	January 31, 2018
January 1 – March 31, 2018	April 30, 2018
April 1 – June 30, 2018	July 30, 2018

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

Section 8: Program Integrity.

Section 8.3 is deleted and replaced with the following:

8.3. The Contractor must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include a compliance program that includes all of the following elements:

8.3.1 Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.

8.3.2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.

8.3.3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract.

8.3.4. A system for training and education for the Compliance Officer, the organization's senior management, and the organizations' employees for the Federal and State standards and requirements under the Contract.

8.3.5. Effective lines of communication between the compliance officer and the organization's employees.

8.3.6. Enforcement of standards through well-publicized disciplinary guidelines.

8.3.7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.

Subsection 8.4.1. is amended to read:

8.4.1 The Contractor must disclose to the DSHS upon contract execution, renewal, or extension and within thirty five (35) days after a change in ownership the following:

New Subsection 8.5.5. is added:

8.5.5 The Contractor must notify DSHS immediately when it receives information regarding a change to a network provider's situation that may affect that entity's eligibility to continue as a PIHP subcontractor.

Subsection 8.6.3.1 is amended to read:

8.6.3.1. Provision of detailed information to employees and subcontractors regarding Fraud and Abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(68) of the Social Security Act including information regarding the rights of employees to be protected as whistleblowers.

Section 8.8 Excluded Providers is amended to read as follows:

8.8 Excluded Providers. The Contractor and its subcontractors are prohibited from paying with funds received under this Agreement for goods and services furnished, ordered, or prescribed by excluded individuals and entities: (Social Security Act (SSA) Section 1903(i)(2); 42 CFR § 455.104; 42 CFR 455.106; and 42 CFR § 1001.1901(b). In addition, the Contractor must ensure that it does not employ or contract with anyone that is excluded from participation in Federal health care programs under Section 1128 or Section 1128A of the SSA, Executive Order 12549 or 45 CFR § 92.35.

Section 9. Quality Assurance and Performance Improvement (QAPI).

Section 9.2. is deleted and replaced with the following:

9.2. The Contractor must provide quality improvement feedback to DSHS, Advisory Board, and other interested parties. The Contractor must maintain documentation of the following activities and provide the documentation to DSHS by January 15 of each calendar year:

9.2.1. Performance on required quality measures;

9.2.2. Medical management committee reports and minutes (when applicable);

9.2.3. An annual risk assessment that is shared with the Contractor's executive team, governing board, and appropriate committees. The leadership and discussions need to include developing actions plans to regularly monitor risks and vulnerable areas, and seek interventions where appropriate to mitigate risks.

9.2.4. The Contractor's annual quality improvement plan that is based on the risks identified in its annual risk assessment and findings from the External Quality Review process.

9.2.5. The Contractor's process for evaluating the impact and effectiveness of its own quality assessment and performance improvement program; and

9.2.6. Customer service performance data to include any enrollee or provider satisfaction surveys conducted by the Contractor.

Section 9.5. is deleted and replaced with the following:

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

9.5.1. The Contractor must adopt Practice Guidelines that:

9.5.1.1 Are based on valid and reliable clinical evidence or a generally accepted practice among the Behavioral Health Professionals in the community;

9.5.1.2 Consider the needs of the Enrollees;

9.5.1.3 Are adopted in consultation with Behavioral Health professionals in the contracted network of BHAs, when applicable;

9.5.1.4 Are disseminated to all affected providers and, upon request, to Enrollees;

9.5.1.5 Are chosen with regard to utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply; and

9.5.1.6 Are reviewed and updated periodically as appropriate.

9.5.2 Practice Guidelines must be provided to DBHR in the format requested.

9.5.3 Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply must be consistent with the guidelines.

Subsection 9.8.1. is amended to read:

9.8.1. Performance Improvement Projects. The Contractor must determine where improvement is needed, in alignment with the DSHS Strategic Plan, and continue to conduct or implement at least three (3) Performance Improvement Projects (PIPs), at all times during the Agreement period. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.

Subsection 9.8.2.4 is deleted and replaced with the following:

9.8.2.4. Core PM #3: Substance Use Disorder Treatment Initiation and Engagement (Washington Circle Adaptation): The percentage of adults and youth who initiate outpatient and intensive outpatient SUD treatment by receiving a face-to-face treatment session within 14 days of the start of a SUD outpatient or intensive outpatient services episode. The percentage of adults and youth who engage in SUD outpatient or intensive outpatient services by receiving at least two face-to-face treatment sessions within 30 days following “initiation” of SUD treatment during an outpatient or intensive outpatient service episode.

Section 10. Subcontractors.

Subsection 10.2.4. WAC citation 388-865-0284 is replaced with WAC 388-865-0268.

Subsection 10.4.15. is amended to read:

10.4.15 Third Party Liability, subcontracts must require the following:

10.4.15.1. The pursuit and reporting of all Third Party Revenue related to services provided under this Agreement in accordance with Medicaid being the payer of last resort and,

10.4.15.2 Pursuit and reporting of Fee-For-Service Medicaid funds provided for AI/AN enrollees who did not opt in to the BHO.

New subsection 10.4.21. is added:

10.4.21. Subcontracts must require that network providers share with other BHOs, network providers, or government agencies that are serving the enrollee the results of any identification and assessment of that enrollee’s needs as to avoid duplication of effort.

New subsection 10.4.22. is added:

10.4.22. Subcontracts must require that when subcontractors shares enrollee health records they do so in accordance with the appropriate current professional standards.

Subsection 10.9.4.13 WAC citation 388-865-0270 is replaced with WAC 388-86-0268.

Subsection 10.11.1. is amended to read as follows:

10.11.1 Any information and/or data required by this Contract and submitted to DSHS must be certified by the Contractor per (42 CFR 438.604-606) and be certified by one of the following:

10.11.1.1 The Contractor's Chief Executive Officer.

10.11.1.2 The Contractor's Chief Financial Officer.

10.11.1.3 An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.

New Subsection 10.13 Marketing is added:

10.13 Marketing. Marketing activities by the subcontractor shall abide by the following guidelines:

10.13.1. All marketing materials must be preapproved by DSHS prior to distribution.

10.13.2. Distribution shall be to the entire service area as indicated in the contract between the BHO and the subcontractor.

10.13.3. Marketing activities shall not attempt to influence enrollment in conjunction with the sale or offering of any private insurance.

10.13.4. Marketing activities shall not include door-to-door, telephone, email, text, or other cold-call marketing activities.

New Subsection 10.14 Transferring Enrollees:

10.14 Transferring Enrollees. The Contractor shall ensure that subcontractors are providing intake assessments to enrollees relocating from a different BHO to the Contractor's region by a MHP or CDP as appropriate within ten (10) business days of the Enrollee requesting services in the Contractor's region. Prior authorization shall not be required by the BHO or the subcontractor prior to the assessment.

Section 11. Enrollee Rights and Protections.

Subsection 11.3.6. is amended to read:

11.3.6. The Contractor must maintain a list of network providers on its website that is updated monthly. This must include at least, names, locations, contact information, indication of non-English languages spoken by the provider and providers who are not accepting new enrollees. If there are providers who are not under contract with the BHO that can be accessed on a case by case basis, information on how to access these providers must be included. This provider list must be made available in paper form upon request.

Section 11.5 WAC citation is updated 388-865-0250 is replaced with WAC 388-865-0262.

Subsection 11.6.1. is amended to read:

11.6.1. The Contractor must inform all Enrollees of their right to a Mental Health Advance Directive, and must provide technical assistance to those who express an interest in developing and maintaining one.

Subsection 11.9.2.1. is deleted and replaced with the following:

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

Section 12. Care Management.

Section 12.4. is amended to read:

12.4. Coordination with other BHOs. The Contractor shall follow the directives as set forth in *Exhibit B, BHO Transfer Protocol* which is incorporated by reference herein.

Section 14. Reporting Requirements.

Subsection 14.5.4.1.2. is amended to read:

Unauthorized leave of a mentally ill offender from a mental health facility, including evaluation and treatment centers, crisis stabilization units, and triage facilities that accept involuntary individuals.

Subsection 14.5.6.3. is amended to read:

14.5.6.3. Documentation of whether the Individual is receiving behavioral health services from the Contractor at the time the incident is being closed

New subsection 14.5.7. is added:

14.5.7. Handling of Patient Identifying Information. Patient identifying information may be copied, disclosed to, or removed from the Contractor's premises for audit and evaluation of critical incidents by any person who:

14.5.7.1. Agrees in writing to:

14.5.7.1.1. Maintain the patient identifying information in accordance with the security requirements provided in 42 CFR § 2.16;

14.5.7.1.2. Destroy all the patient identifying information upon completion of the audit or evaluation; and

14.5.7.1.3. Comply with the limitations on disclosure and use in 42 CFR § 2.16(d); and

14.5.7.2. Performs the audit or evaluation activity on behalf of DSHS or any:

14.5.7.2.1. Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

14.5.7.2.2. Any private person which provides financial assistance to the program, which is a third part payer covering patients in the program, or which is a quality improvement organization performing a utilization or quality control review.

Subsection 14.6.1.2. is amended to read:

14.6.1.2. The Contractor must meet identified capacity targets outlined in Exhibit C, Projected WISe Capacity Expansion.

Subsection 14.6.2. is amended to read:

14.6.2 The Contractor must submit a bi-monthly progress report to begin on the month following Agreement execution to DBHR at WISeSupport@dshs.wa.gov by 5:00 p.m. on the final day of that month, containing the following:

14.6.2.1 The current WISe service capacity for the region and the number of youth enrolled in WISe each month during the reporting period.

14.6.2.2 The increase or decrease in WISe capacity compared to the previous progress report.

If the Contractor experiences a decrease, the Contractor must include an explanation for the decrease along with an action plan for bringing the Contractor back into compliance.

14.6.2.3 If the Contractor has an identified action plan from the previous progress report, the Contractor must identify what action items were accomplished.

14.6.2.4 The Contractor must identify challenges in meeting their service capacity targets and identify strategies to address those challenges.

Section 15. Benefits.

New Section 15.10. is added:

15.10. **Behavioral Health Parity.**

15.10.1. Limitations on Behavioral Health Benefits. The Contractor and its subcontractors shall not:

15.10.1.1. Include an aggregate lifetime or annual dollar limit on any benefits.

15.10.1.2. Apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees. 42 CFR 438.910(b)(1).

15.10.1.3. Apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification. 42 CFR 438.910(c)(3)

15.10.1.4. Impose Non Qualitative treatment limits (NQTL) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. 42 CFR 438.910(d)

15.10.2. If an enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the enrollee in every classification in which medical/surgical benefits are provided. 42 CFR 438.910(b)(2)

15.10.2.1 Reporting Requirements

15.10.2.1.2. The contractor shall comply with all requests for documentation from the state regarding the state's ongoing

assessments of behavioral health parity as required by 42 CFR part 438, subpart K.

15.10.2.1.3. The contractor's prior authorization requirements must comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d).

15.10.2.2. Covered Services

15.10.2.2.1. The contractor must comply with the state's final parity plan. In addition to services covered under the state plan, the contractor may voluntarily cover any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K.

15.10.2.2.2. The contractor must coordinate with, and refer to Managed Care Organizations (MCOs) regarding the mental health benefits managed by MCOs deliver an integrated set of benefits to enrollees.

Section 16. Tribal Relationships.

Subsection 16.2.1. is amended to read:

16.2.1. The Contractor must develop or attempt to develop a Tribal and Recognized American Indian Organization (RAIO) Coordination Implementation Plan in partnership with each Federally Recognized Tribe and RAIO within its service area as defined in this Agreement.

16.2.1.1. This plan must include provisions for coordination of ongoing care and appropriate services during and following a disaster, regardless of the disaster's cause.

16.2.1.2. The Contractor must provide documentation of attempts to develop a plan if any Federally Recognized Tribe or RAIO declines to participate. The Contractor must work with each Federally Recognized Tribe or RAIO to submit the matrix below for each Federally Recognized Tribe or RAIO listed on or before July 1, 2016, and by March 1 on every subsequent year.

Section 16.3.

The Centers for Medicare & Medicaid Services Model BHO Addendum for Indian Behavioral Health Care Providers is replaced with the DSHS Model BHO Indian Addendum for Indian Behavioral Health Care Providers.

Section 16.4 is amended to read:

16.4 Non-crisis services.

16.4.1. If a Member of a Federally Recognized Tribe who has opted into the BHO and is referred to or presents for non-crisis services and they, or their legal representative, completes a release of information and requests coordination; the Contractor must make documented efforts to notify the Tribal Authority or RAIO requesting assistance in treatment planning and service provision for the Individual.

16.4.2. If the Individual chooses to be served only by the Tribal Behavioral Health Program, and is not under a Less Restrictive Alternative Order requiring them to receive treatment from a BHO provider, a referral to a contracted network BHA is not required.

New Section 16.7 is added:

16.7. Indian Health Care Providers

16.7.1. AI/AN enrollees must be allowed to obtain services covered under this Contract from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive services from.

16.7.2. Payments to Indian Health Care Providers (IHCP), whether members of the established provider network or not, must be paid for covered services at a rate negotiated between the Contractor and the IHCP. In the absence of an established rate the IHCP may not be paid at a rate less than the Contractor would provide to a non-IHCP network provider.

16.7.3. An IHCP is entitled to receive its applicable encounter rate published in the Federal Register by the Indian Health Services, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's fee-for-service payment methodology. This is regardless of the IHCP's status as a FQHC or network provider.

Exhibit B

BHO Transfer Protocol

Section 3.1 is amended to read:

3.1. If a Medicaid Enrollee re-locates to a region outside of their current BHO they are entitled to an intake assessment in the new region by a MHP or CDP within ten (10) business days of and Enrollee request. The Contractor and its network providers will not require a prior authorization or notification from the Enrollee's previous BHO prior to providing services.

The transferring enrollee shall then be provided all medically necessary mental health services required in the PIHP contract, based on the BHO's level of care guidelines and clinical assessment.

Exhibit C
Projected WISe Capacity Expansion

BHO:	FY 2018			
	START OF Q1 [Jul. 2017]	**START OF Q2** [Oct. 2017]	**START OF Q3** [Jan. 2018]	**START OF Q4** [Apr. 2018]
North Central WA BHO	70	70	90	90
Great Rivers BHO	130	130	200	200
Greater Columbia BHO	310	310	420	420
King Co. BHO	450	450	530	530
North Sound BHO	350	350	460	460
Optum Pierce BHO	300	300	350	350
Salish BHO	120	120	190	190
Spokane County Regional BHO	260	260	410	410
Thurston-Mason BHO	200	200	200	200

Exhibit D
7/1/2017 – 9/30/2017

Funding

North Sound

Eligible Rates	
Non-Disabled Adults	$32.48
Disabled Adults	$148.48
Non-Disabled Children	$12.65
Disabled Children	$67.78
Newly Eligible	$50.26

WISe Service-Based Enhancement (SBE) Case Rate	$2,721

Reserves

Inpatient & Risk Reserves	
MINIMUM	MAXIMUM

Operating Reserves
MAXIMUM