Thurston-Mason Behavioral Health Administrative Services Organization

BEHAVIORAL HEALTH NON-MEDICAID PROVIDER GUIDE

Version 5.0

Effective: January 1, 2025

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INTRODUCTION

We are pleased that you have chosen to participate in our network of dedicated providers and share in our organization's goal of delivering accessible behavioral health care services and improve the health of our communities.

This Thurston-Mason BH-ASO Provider Guide serves as a provider resource and is an extension of the contract. It is reviewed and updated annually or as needed per contract changes. This includes information and guidance related to Compliance Program requirements, the Credentialing and Re-Credentialing process, Utilization Management, supplemental and Encounter data submissions, Reimbursement Policies, and Statements of Work.

Any changes made to this Thurston-Mason BH-ASO Provider Guide, are presented in the Co-Occurring System of Care quarterly meeting or Quality Management/Utilization Management biannual meeting depending on the timing of updates. This will be sent via email to the network provider contact person identified within each contract.

All services delivered under this Guide shall be delivered in accordance with all applicable laws, regulations, the general terms and conditions, and service delivery requirements.

MISSION

Provide access to an effective, reliable safety net of behavioral health crisis and recovery support services throughout our region.

Address and Phone Numbers

Communication and Availability to Individuals and Providers

24/7 toll free crisis line	Available to individuals and providers twenty-four (24) hours a day, seven (7) days a week	**360-754-1338 or 1-800-270-0041**
TTY/TDD services	Available for individuals who are deaf, hard of hearing, or speech impaired. Language assistance is also always available.	**711 or 1-800-833-6388**
Thurston-Mason Behavioral Health – Administrative Services Organization (Thurston-Mason BH-ASO) Staff	Available during normal business hours from 8:00 a.m. to 5:00 p.m. Monday – Friday, excluding holidays for information and authorization/ coordination of care. When initiating, receiving or returning calls the Utilization Management (UM) staff will identify the organization, their name, and title	**360-763-5828 or 800-658-4105**
General contact information		**Thurston-Mason BH-ASO** **670 Woodland Square Loop SE Suite 301** **Lacey, WA 98503** **P: 360-763-5828 |800-658-4105** **F: 360-489-1435**
Service/program-related contact information – submit documents to the email addresses listed	Involuntary and Voluntary Inpatient Mental Health Services	**iprequest@tmbho.org**
	SUD Residential and Outpatient Behavioral Health Services (medically necessary and non-medically necessary services)	**oprequest@tmbho.org**
	Quality Management – Critical Incident reports, Grievance-related documents, and any other quality related documents	**qualitymanagement@tmbho.org**
	Invoices – submit them monthly on the 10th, for all Thurston-Mason BH-ASO Individuals served within the invoice month and if applicable, provide backup documentation	**invoices@tmbho.org**
	Contracts – any questions related to the contract	**contracts@tmbho.org**
	Credentialing – submit all documents	**credentialing@tmbho.org**

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	related to credentialing to this inbox as soon as they are received by the provider such as, DOH license renewals, on-site review results, accreditation renewals, insurance coverage renewals	

Chapter One

Section 1.1: ADVISORY BOARD

See also Thurston-Mason BH-ASO Policy 307 Behavioral Health Advisory Board.

The purpose of the Thurston-Mason BH-ASO Advisory Board is set forth in its bylaws, the Thurston-Mason BH-ASO contract with the Health Care Authority (HCA), the Interlocal Agreement, and as mandated by law (RCW 71.24.300(8) and WAC 182-538D-0252). An extrapolation of these documents indicates that the Advisory Board's primary responsibility is to provide independent and objective advice and feedback to the Thurston-Mason BH-ASO Governing Board, local jurisdictions (County Advisory Boards) and service providers.

Thurston-Mason BH-ASO appoints Advisory Board members and maintain an Advisory Board in order to:

- Promote active engagement with individuals with behavioral health disorders, their families, and behavioral health agencies; and,
- Solicit and use Advisory Board members input to improve service delivery and outcome.

The Thurston-Mason BH-ASO Advisory Board previously known as the Thurston-Mason Behavioral Health Organization (TMHBO) Advisory Board is the result of integration between the previous Thurston-Mason Regional Support Network and Thurston-Mason Chemical Dependency Advisory Boards and in compliance with RCW 39.34.030, RCW 71.24, and Chapter 205, Section 5, Laws of 1989.

The membership of the Advisory Board is representative of the following:

- Representative of the geographic and demographic mix of service population;
- Have at least fifty one percent (51%) of the membership be persons with lived experience, parents or legal guardians of person with lived experience and/or self-identified as a person in recovery from a behavioral health disorder;
- Law enforcement representation;
- Tribal representation;
- No more than four elected officials;
- No employees, managers or other decision makers of subcontracted agencies who have the authority to make policy or fiscal decisions on behalf of the subcontractor; and
- Three-year term limit, multiple terms may be served, based on rules set by the Advisory Board.
- The 15-member Thurston-Mason BH-ASO Advisory Board consists of delegates from each county as follows:

Mason County	4 delegates
Thurston County	7 delegates
Law enforcement	2 delegates (1 from each county)
Tribes	One from each tribe (3)

The principal responsibility of the Thurston-Mason BH-ASO Advisory Board, as prescribed by law, is to review and provide comment on plans and policies drafted by the governing body of the Thurston-Mason BH-ASO. The Advisory Board is empowered by the Thurston-Mason BH-ASO and the Behavioral Health Division of HCA to:

- Solicit and use the input of individuals with mental health and/or substance disorder to improve the behavioral health services delivery in the region;
- Provide quality improvement feedback to key stakeholders and other interested parties defined by HCA. Thurston-Mason BH-ASO shall document the activities and provide to HCA upon request; and
- Review applications and provide recommendations to the Thurston-Mason BH-ASO Governing Board for approval

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of the annual Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) plans for the area.

Chapter Two Administrative Functions

Thurston-Mason BH-ASO delegates Administrative Functions, identified in this Chapter except where noted, to Network Providers under the terms of the HCA BH-ASO contract, in addition to those requirements found in subsection 9.3.1 of the HCA BH-ASO contract that are incorporated throughout this document. The following provisions apply:

- Clear description of any Administrative Functions delegated by Thurston-Mason BH-ASO.
- Requirements for information and data sharing to support Care Coordination consistent with the HCA BH-ASO contract.
- A requirement to provide Individuals access to translated information and interpreter services, as described in the Materials and Information Section of the HCA BH-ASO contract and Chapter 7 Cultural Considerations and Section 7.1 Interpretation and Translation Requirements.
- A requirement for subcontracted staff to participate in training when requested by HCA. Exceptions must be in writing and include a plan for how the required information shall be provided to them.
- A requirement to conduct criminal background checks and maintain related policies and procedures and personnel files consistent with requirements in chapter 43.43 RCW and chapter 246-341 WAC.
- Requirements for nondiscrimination in employment and the provision of delegated administrative functions to Individuals.
- A means to keep records necessary to adequately document services provided to Individuals for all delegated activities in a manner consistent with state and federal laws and regulations.
- A provision for ongoing monitoring and compliance review when the Contractor identifies deficiencies or areas requiring improvements and provide for corrective action.
    - See Remedial Actions section of this Guide for provisions to revoke delegation or impose sanctions if the Network Provider's performance is inadequate.

A Network Provider providing Administrative Functions must have a conflict-of-interest policy that:

- Requires screening of employees upon hire and board members at the time of initial appointments, and annually thereafter, for conflicts of interests related to performance of services under the HCA BH-ASO contract.
- Prohibits employees and/or board members from participating in actions which could impact or give the appearance of impacting a personal interest or the interest of any corporate, partnership or association in which the employee or board member is directly or indirectly involved.
- Prohibits access to information regarding proprietary information for other providers including but not limited to, reimbursement rates, for any subcontractor that provides behavioral health services and administrative services under the Contract.

SECTION 2.1: SERVICE ELIGIBILITY

See Thurston-Mason BH-ASO Policy 3045 Eligibility Verification and 1590 Non-Medicaid Services, General Fund State and Federal Block Grant.

- All individuals in the Thurston-Mason BH-ASO's Regional Service Area (RSA) regardless of insurance status, ability to pay, county of residence, or level of income are eligible to receive medically necessary behavioral health crisis services, and services related to the administration of the Involuntary Treatment Act and Involuntary Commitment Act (Chapters 71.05 and 71.34 RCW).
- Thurston-Mason BH-ASO has discretion on the use of funds for the provision of non-crisis behavioral health services including crisis stabilization and voluntary behavioral health admissions for individuals in the RSA who are not eligible for Medicaid and/or do not have third party insurance and/or on a spend-down. Additionally, certain populations have

priority to receive services.

- Providers are **delegated** the responsibility for determining whether the individual is eligible for non-crisis behavioral health services. The individual must meet the financial eligibility criteria and the clinical or program eligibility criteria for the General Fund State (GFS)/Federal Block Grant (FBG) service, see below for priority populations and requirements for these funding sources.
- Individuals who do not qualify for Medicaid, including individuals in spend-down status, and have income up to two hundred twenty percent (220%) of the federal poverty level (GFS only) meet the financial eligibility for GFS/FBG services.
- For services in which medical necessity criteria applies, all services must be medically necessary.
- Meeting the eligibility requirements does not guarantee the individual will receive a non-crisis behavioral health service. Services other than behavioral health crisis services and ITA-related services are contingent upon available resources as managed by the Thurston-Mason BH-ASO.

Non-crisis behavioral health services, pre-authorized services (See section 2.13 Utilization Management): The Network Provider continues to verify the Individual's eligibility for services at each session or as new information is presented throughout the authorization period.

Non-crisis behavioral health services, Thurston-Mason BH-ASO prior authorization required (See section 2.13 Utilization Management): If services are approved, the Network Provider will continue to verify the Individual's eligibility for services at each session and as new information is presented and send information to Thurston-Mason BH-ASO utilizing the Request Form when requesting extensions of the authorization period and/or specific criteria.

Residential treatment providers need to ensure that priority admission is given to priority populations identified by the HCA BH-ASO Contract.

Substance Abuse Block Grant (SABG) - Priority Population Considerations

Certain populations have priority to receive services. For Substance Abuse Block Grant (SABG) services:

- SABG services shall be provided in the following priority order to:
    - Pregnant injecting drug users.
    - Pregnant substance abusers.
    - Women with dependent children.
    - Injecting drug users.
- The following are additional priority populations for SABG services, in no particular order:
    - Postpartum women up to one (1) year, regardless of pregnancy outcome.
    - Individuals transitioning from residential care to outpatient care.
    - Youth.
    - Offenders.

Access to SABG Services

1. The provider shall, utilizing the appropriate authorization protocols and within Available Resources, ensure that SABG services are not denied to any eligible Individuals regardless of:
    a. The Individual's drug(s) of choice.
    b. The fact that an Individual is taking medically prescribed medications.
    c. The fact that an Individual is using over the counter nicotine cessation medications or actively participating in a nicotine replacement therapy regimen.

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2. The provider shall, as required by the SABG Block Grant, ensure Interim Services are provided for Pregnant and Post-partum Women and Individuals Using Intravenous Drugs utilizing the appropriate authorization protocols.
3. Interim Services shall be made available within forty-eight (48) hours ofseeking treatment.
4. The provider shall document the provision of Interim Services. Interim Services shall include, at a minimum:
    a. Counseling on the effects of alcohol and drug use on the fetus for pregnant women.
    b. Referral for prenatal care.
    c. Human immunodeficiency virus (HIV) and tuberculosis (TB) education.
    d. TB treatment services if necessary IUID.
5. Admission to treatment services for the intravenous drug user shall be provided within fourteen (14) days after the individual makes the request, regardless of funding source.
6. If there is no treatment capacity within fourteen (14) days of the initial individual's request, the provider shall have up to one hundred twenty (120) days after the date of such request to admit the individual into treatment. The Provider shall offer or refer the individual to Interim Services within forty-eight (48) hours of the initial request for treatment services.
7. A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of detoxification, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within twenty-four hours.
8. The expected utilization of services, the characteristics and health care needs of the population, the number and types of providers (training, experience and specialization) able to furnish services, and the geographic location of providers and individuals (including distance, travel time, means of transportation ordinarily used by Individuals, and whether the location is ADA accessible) for all Thurston-Mason BH-ASO funded behavioral health programs and services based on available resources.
9. The provider shall:
    a. Ensure that all services and activities provided under the Contract are designed and delivered in a manner sensitive to the needs of the diverse population; and,
    b. Initiate actions to develop or improve access, retention, and cultural relevance of treatment, relapse prevention or other appropriate services, for ethnic minorities and other diverse populations in need of services under the Contract asidentified in their needs assessment.

Mental Health Block Grant (MHBG)

The network provider shall provide MHBG services to promote recovery for an adult with SMI and resilience for SED children in accordance with federal and state requirements.

General Fund State (GFS)

For non-crisis behavioral health services funded by GFS:

- The provider shall provide non-crisis behavioral health services funded by GFS, within Available Resources, to individuals who meet financial eligibility standards and (if they do not qualify for Medicaid and have income up to 220% of the federal poverty level, and meet the medical necessity or non-medically necessary criteria for all services provided to them and meet one of the following criteria:
    - Are uninsured;
    - Have insurance, but are unable to pay the co-pay or deductible for services;
    - Are using excessive Crisis Services due to inability to access non-crisis behavioral health services; and,
    - Have more than five (5) visits over six (6) months to the emergency department, detox facility, or a sobering center due to a substance use disorder (SUD).

Section 2.1.1 Medicaid Spenddown

See also Thurston-Mason BH-ASO Policy 1592 Medicaid Spenddown Payments.

Spenddown for qualifying medical expenses (voluntary and involuntary inpatient, crisis stabilization and crisis residential stays) with State Funds for incurred costs.

HCA designates and approves the Thurston-Mason BH-ASO as a public program as described in WAC 182-519-0110(9). Qualified expenses paid by Thurston-Mason BH-ASO shall be used to reduce an individual's spenddown liability.

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

Responsible Parties: Facility and Thurston-Mason BH-ASO UM specialist
Activity:

Identification and authorization

- Provider/Facility representative seeks authorization for services within required timeframes and identifies spenddown amount.
- Thurston-Mason BH-ASO UM clinician confirms eligibility criteria for fund and service.
- Thurston-Mason BH-ASO UM specialist updates Thurston-Mason BH-ASO management on the request and a determination is made.
- Thurston-Mason BH-ASO UM clinician provides authorization for service and confirms payment of spenddown amount to provider/facility representative (units or dollar amount).

Responsible Party: Provider/Facility
Activity:

Report of spenddown, confirmation and payment

- Provider/Facility reports the Individual's incurred costs that count toward the spenddown amount and confirm submission with UM specialist and management.
- Facility confirms Medicaid assignment after spenddown processing.
- Facility submits monthly invoices for payment of the agreed spenddown amount to Thurston-Mason BH-ASO.

*Fax documentation of incurred medical expenses to the statewide fax number 1-888-338-7410. Providers with authorization from the individuals may call 1-877-501-2233 to inquire about status and/or request urgent processing. If urgent medical need is required, processing occurs within two business days or less. Regular processing is completed with 2 business days.

Responsible Party: Thurston-Mason BH-ASO UM specialist
Activity:

- Review invoice and submit for payment.

Responsible Party: Thurston-Mason BH-ASO Fiscal Team
Activity:

- Tracking and Reporting
    - Track spenddown amounts by individual and facility. Report expenses on the R&E with a note indicating the total amount spent.

Additionally, see the following related HCA resources:

https://www.hca.wa.gov/assets/billers-and-providers/fs_spenddownstepbystep.pdf

https://www.hca.wa.gov/health-care-services-supports/program-administration/apple-health-medically-needy-and-spenddown

SECTION 2.2: MEDICAID ELIGIBILITY VERIFICATION AND/OR ENROLLMENT

See also Thurston-Mason BH-ASO Policy 3045 Eligibility Verification.

Eligibility for Medicaid – Network Provider Delegated: Network Providers are **delegated** the responsibility for determining whether the Individual has a Medicaid eligibility status. HCA determines Medicaid eligibility and updates information in the ProviderOne system. Thurston-Mason BH-ASO Network Providers will check this system at each visit to determine Medicaid eligibility and mid-month changes in MCO enrollment. Network Providers will also check for Medicare and other forms of insurance. This process is to determine if any third-party liabilities apply to the services provided. If the Individual does not have insurance or the financial resources to pay for services, the Network Provider will obtain necessary information to assess eligibility for sliding fee scale (see Thurston-Mason BH-ASO Policy 828 Sliding Fee Scale).

ASO can verify an individual's eligibility by checking the following:

- Identification Cards: An individual determined to be eligible for medical assistance is issued a ProviderOne Services Card by Health Care Authority (HCA). It is issued once upon enrollment. Providers must use the ProviderOne Client ID on the card to verify eligibility either through the ProviderOne website at https://www.waproviderone.org/ or via a Services Card swipe card reader.

Providers must check individual eligibility at each visit and should make note of the following information:

- Eligibility dates (be sure to check for the current month and year)
- MCO enrollment status (has the Individual changed MCOs)
- The ProviderOne Client ID number other specific information (e.g. Medicare, Apple Health, FIMC, BHSO, AI/AN, etc.).

If the individual does not have Medicaid, but is eligible, the provider must assist the individual with the process, including:

- Call 1-800-562-3022, or
- Go to https://www.wahealthplanfinder.org – this allows an individual to renew their coverage, report a change, and apply for coverage

Medical assistance program coverage is not transferable. If you suspect a Member has presented a ProviderOne (Services Card) belonging to someone else, you should request to see a photo ID or another form of identification. To report suspected fraud, call the Medicaid Fraud Hotline at (800) 562-6906. Do not accept a Services Card that appears to have been altered.

Providers may use a Medical Eligibility Verification (MEV) service. Some MEV services provide access to online Medicaid Member eligibility data and can be purchased through approved HCA vendors. MEV services provide eligibility information for billing purposes, such as:

- Eligibility status
- Plan enrollment and plan name

HCA updates the MEV vendor list as new vendors develop MEV services. For more information and a current list of HCA vendors, please call (800) 562-3022.

Providers can also access eligibility information for individuals free of charge using the ProviderOne online service. In order to access eligibility on the website you must register online and complete an application. Online enrollment information can be found at: https://www.hca.wa.gov/billers-providers-partners/providerone/providerone-security

Thurston-Mason BH-ASO shall monitor Network Providers on the delegated functions of determining eligibility (including Medicaid) and follow Remedial Action process when performance is inadequate.

- Thurston-Mason BH-ASO shall develop eligibility data collection protocols for Network Providers to follow to ensure that the Network Provider checks the Individual's Medicaid eligibility prior to providing a service and captures sufficient demographic, financial, and other information to support eligibility and authorization decisions and reporting requirements. See Section 9.2 Management Information Systems as the Network Providers must comply with the data dictionary requirements.
    - Tools to monitor eligibility and reporting include but are not limited to:
        - Eligibility and Income Check Report (frequent eligibility changes);
        - A-19 and Block Grant Plan reviews (services provided and FBG priority populations);
        - Fiscal Review Tool (looks for initial and ongoing income verification checks for non-Medicaid services and third-party payments); and,
        - Invoice and data verifications through Avatar and backup documentation (services provided and priority populations based on funding source).
            - Thurston-Mason BH-ASO reserves the right to conduct onsite reviews and periodic desk audits.

See Remedial Action section for provisions related to revoking delegation or imposing sanctions if the provider's performance is inadequate.

SECTION 2.3: INDIVIDUAL RIGHTS

See also Thurston-Mason BH-ASO Policy 206 Employee Code of Conduct – Business and Professional Practice Standards and Policy 401 Informational Requirements.

The provider shall guarantee each individual has the following rights under the HCA BH-ASO Contract, Section 10 Individual Rights and Protections:

- To information regarding the Individual's behavioral health status.
- To receive all information regarding your behavioral health treatment options including any alternative or self-administered treatment, in a culturally-competent manner.
- To receive information about the risks, benefits and consequences of behavioral health treatment (including the option of no treatment).
- To participate in decisions regarding their behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To be treated with respect and with due considerations for their dignity and privacy;
- To be free from any sort of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. part 164.
- To be free to exercise their rights and to ensure that to do so does not adversely affect the way the Thurston-Mason BH-ASO, the Network Provider, or practitioner treats the Individual.

The provider shall guarantee each individual has the following rights under WAC:

- Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;
- Practice the religion of choice, as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;
- Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;
- Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent

possession or use of contraband on the premises or to address risk of harm to the individual or others. "Reasonable" is defined as minimally invasive searches to detect contraband or invasive searches only upon the initial intake process or if there is reasonable suspicion of possession of contraband or the presence of other risk that could be used to cause harm to self or others;

- Be free of any sexual harassment;
- Be free of exploitation, including physical and financial exploitation;
- Have all clinical and personal information treated in accord with state and federal confidentiality regulations;
- Participate in the development of your individual service plan and receive a copy of the plan if desired;
- Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;
- Receive a copy of agency grievance system procedures at the time of admission and upon request, and information on how to file a grievance with the agency, or BH-ASO, or, Medicaid managed care organization (MCO) if applicable, if you believe your rights have been violated; and,
- Lodge a complaint with the department (Department of Health) when you feel the agency has violated a WAC requirement regulating behavior health agencies.

SECTION 2.4: MEDICAL NECESSITY

See also Thurston-Mason BH-ASO Policy 1594 Utilization Management Requirements and 1006 Level of Care Guidelines and 1006.01 LOC for Authorizations.

The provider shall collect all information necessary to make medical necessity determinations. The provider shall determine which services are medically necessary according to the definition of Medical Necessity Services, see below.

Medical Necessity means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the Individual that; endanger life, cause pain and suffering, result in illness or infirmity, 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 Individual requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

- Provider shall make the determination of medical necessity.
- Medical Necessity for Mental Health Services is based on the presence of a covered DSM 5 mental health diagnosis following the initiation of the intake evaluation.
- Medical Necessity for Substance Use Disorder (SUD) Treatment Services is based on the presence of a DSM 5 substance related diagnosis and application of the ASAM criteria following an Assessment.

While medical necessity determination is performed by the Network Providers, Thurston-Mason BH-ASO determines validity of medical necessity through annual assessment of interrater reliability related to authorization decisions and Thurston-Mason BH-ASO Level of Care Guidelines 1006 and 1006.01. See Section 2.6 Provider Oversight and Monitoring.

SECTION 2.5: TUBERCULOSIS SCREENING, TESTING AND REFERRAL

For services funded by Substance Abuse Block Grant (SABG) the following is available:

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

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

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

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

SECTION 2.6: PROVIDER OVERSIGHT AND MONITORING

See also Thurston-Mason BH-ASO Policy 207 Subcontractual Relationships and Delegation.

This is not a delegated Administrative Function but Thurston-Mason BH-ASO's responsibilities to subcontract along with oversight and monitoring activities of the Network Providers to ensure adherence to delegated functions which requires their role in the process.

Thurston-Mason BH-ASO shall evaluate any prospective Subcontractor's ability to perform the activities for which that Subcontractor is contracting, including the Subcontractor's ability to perform delegated activities described in the Subcontracting document.

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

Thurston-Mason BH-ASO shall not provide GFS or FBG funds to a county unless a county is a licensed service provider and is providing direct services.

Required provisions include and are not limited to:
Subcontracts shall be in writing and available to TMBH-ASO and HCA upon request. The Provider will comply with the applicable state and federal statutes, rules and regulations as set forth in this Contract and comply with any term or condition of this subcontract and the HCA BH-ASO Contract that is applicable to the services to be performed under this subcontract.

- Identification of the parties of the subcontract and their legal basis for operation in the state of Washington per Exhibit A Scope of Services that outlines the necessary licenses as required by law to perform the services under the contract.
- The process for revoking delegation or imposing other sanctions if the Network Provider's performance is inadequate. See Remedial Actions section of this Guide under Program Integrity, under Compliance and Oversight Monitoring.
- Procedures and specific criteria for terminating the subcontract.
- Identification of the services to be performed by the Network Provider are listed in Exhibit A Scope of Services. If Thurston-Mason BH-ASO allows the Network Provider to subcontract and all subcontracting requirements contained in the HCA BH-ASO contract must be propagated downward into any other lower tiered Subcontracts (45 CFR § 92.35).
    - The services performed as listed in Exhibit A, and any other provisions of the contract, may not be subcontracted unless a formal agreement is issued in writing by Thurston-Mason BH-ASO per General Terms and Conditions, Assignment.
- Thurston-Mason BH-ASO shall release to the Network Provider any information necessary to perform any of its obligations under the HCA BH-ASO Contract.

Delegated Activities:

Delegated activities of the Contract are documented and agreed upon between Thurston-Mason BH-ASO and the Network Provider. Thurston-Mason BH-ASO may not delegate its responsibility to contract with a provider network. This does not prohibit a contracted, licensed provider from subcontracting with other appropriately licensed providers so long as the subcontracting provisions of the HCA BH-ASO Contract are met. The responsibilities found in the Quality Management section of the HCA BH-ASO Contract may not be delegated to a contracted network Behavioral Health Agency. HCA may place limits on delegating financial risk to any subcontractor in any amount, and is subject to review and approval by HCA. The document outlining delegation must include:

- Assigned responsibilities.
- Delegated activities.
- A mechanism for evaluation.
- Corrective action policy and procedure.

Network Providers must keep records necessary to adequately document services provided to Individuals for all delegated activities, when applicable, including QI, Utilization Management, and Individual Rights and Protections. See also Thurston-Mason BH-ASO Policy 5002 Records Retention.

Thurston-Mason BH-ASO reserves the right to monitor network providers at any time. Reviews will be based on the specific contract with each Provider, and shall address compliance with Contract requirements for each function including, but not limited to:

- Documentation and appropriateness of medical necessity determinations.
- Individual record reviews to ensure services are appropriate based on diagnosis, and the treatment plan is based on the Individual's needs and progress notes support the use of each service.
- Ensure criminal background checks are conducted, personnel files, and provider policies are consistent with the requirements in Chapter 43.43 RCW and Washington Administrative Code (WAC) 246-341.
- Timeliness of service.
- Cultural, ethnic, linguistic, disability or age-related needs are addressed.
- Coordination with other service providers.
- Provider adherence to relevant practice guidelines.
- Provider processes for reporting, tracking, and resolving Grievances.
- Provider compliance with reporting and managing critical incidents.
- Information security.
- Disaster recovery plans.
- Oversight of any issues noted during licensing and/or certification reviews conducted by DOH and communicated to Thurston-Mason BH-ASO.
- Providers shall comply with all applicable required audits including authority to conduct a facility inspection, and the federal Office of Management and Budget (0MB) Super Circular 2 C.F.R. 200.501 and 45 C.F.R. 75.501 audits.
    - If a Provider is subject to OMB Super Circular audit, the Thurston-Mason BH-ASO shall require a copy of the completed Single Audit within ninety (90) calendar days and ensure corrective action is taken for any audit finding, per OMB Super Circular requirements.
    - If a Provider is not subject to OMB Super Circular, the Thurston-Mason BH-ASO shall perform sub-recipient monitoring in compliance with federal requirements.
- Providers will comply with data submission requirements established by Thurston-Mason BH-ASO/HCA for all services funded under the Contract.
- Network Providers shall respond with all available records in a timely manner to law enforcement inquiries regarding an Individual’s eligibility to possess a firearm under RCW 9.41.040(2)(C)(iv).
    - Network Providers shall report new commitment data within 24 hours. Commitment information does not need to be re-sent if it is already in the possession of HCA. Thurston-Mason BH-ASO and HCA shall be immune from liability related to the sharing of commitment information under this Section (RCW 71.05.740).
- All network providers receiving GFS or FBG funds shall cooperate with all Quality Improvement (QI) activities, audits, and investigations performed by duly authorized representatives of the state of Washington, HCA, and Washington State Medicaid Fraud Control Division (MFCD), as well as the federal DHHS, auditors from the federal Government Accountability Office, federal Office of the Inspector General and federal Office of Management and Budget.
- The Provider shall provide access to their facilities and the records documenting the performance of this Contract, for purpose of audits, investigations, and for the identification and recovery of overpayments within thirty (30) calendar days, and access to its facilities and the records pertinent to this Contract to monitor and evaluate performance under

this Contract, including, but not limited to, encounter payment and the quality, cost, use, health and safety and timeliness of services. The Provider and its Subcontractors shall provide reasonable access to facilities, financial and medical records for duly authorized representatives of HCA or DOH for audit purposes and immediate access for Medicaid Fraud Investigators.

- Thurston-Mason BH-ASO shall monitor the Provider's performance on an ongoing basis and subject to formal review consistent with industry standards or State Law and Regulation.
- Fiscal management, including documenting the provider's cost allocations, revenues, and expenditures in order to ensure that funds under the Contract are being spent. A fiscal review shall be conducted at least annually of Providers receiving Federal Block Grant funds, regardless of reimbursement methodology, to ensure expenditures are accounted for by revenue source, no expenditures were made for items identified as prohibited in the HCA BH-ASO Contract, expenditures are made only for the purposes stated in this Contract and that services were actually provided.
- Oversight of any issues noted during licensing and/or certification reviews conducted by Department of Health (DOH) and communicated to the Thurston-Mason BH-ASO.
- Thurston-Mason BH-ASO has a process to ensure that the offices of all Providers meet its office-site and clinical record keeping practices standards. Thurston-Mason BH-ASO continually monitors individual complaints for all office sites to determine the need of an office site visit and will conduct office site visits within sixty (60) calendar days.
- Thurston-Mason BH-ASO assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. This includes an assessment of:
    - Physical accessibility
    - Physical appearance
    - Adequacy of waiting and clinical/evaluation room space
    - Adequacy of clinical/treatment record keeping
- Physical accessibility
    - Thurston-Mason BH-ASO evaluates office sites to ensure that Individuals have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for physically disabled patients.
- Physical appearance
    - The site visits include, but is not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety.
- Adequacy of Waiting and Clinical Room Space
    - During the site visit, Thurston-Mason BH-ASO assesses waiting and clinical room spaces to ensure that the office offers appropriate accommodations to individuals. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and precautions to protect privacy.
- Adequacy of Medical/Clinical Record-Keeping Practices
    - During the site-visit, Thurston-Mason BH-ASO discusses office documentation practices with the Provider or Provider’s staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records.
- Hours of Operation
    - Provider will offer hours of operation for Individuals that are no less than the hours of operation offered to any other individual.
- Administration and Confidentiality of Facilities
    - Facilities contracted with Thurston-Mason BH-ASO must demonstrate an overall compliance with the

guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building entrances are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Basic emergency equipment is located in an easily accessible area.
- At least one CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with 10 or more employees.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from individuals. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Clinical records are stored away from common areas. Record rooms and/or file cabinets are locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in clinical/evaluation rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.
- If the Provider does not achieve the required compliance with the site review standards and/or the clinical record keeping practices review standards, the Site Reviewer will do all of the following:
    - Send a letter to the Provider that identifies the compliance issues.
    - Send sample forms and other information to assist the Provider to achieve a passing score on the next review.
    - Request the Provider to submit a written corrective action plan to Thurston-Mason BH-ASO within thirty (30) calendar days. The request for a CAP will be sent certified mail/electronic mail, return receipt requested. This improvement plan should be submitted by the Provider and must include the expected time frame for completion of activities, identified in contract.
    - Send notification that another review will be conducted of the office in six (6) months. Additional reviews are conducted at the office at six-month intervals until compliance is achieved. At each follow-up visit a full assessment is done to ensure the office meets performance standards. The information and any response made by the Provider is included in the Provider's permanent credentials file and reported to the Credentialing Committee on the watch status report. If compliance is not attained at follow-up visits, an updated CAP will be required.
    - Providers who do not submit a CAP may be terminated from network participation. Any further action is conducted in accordance with the Thurston-Mason BH-ASO policy.

Interrater Reliability

Thurston-Mason BH-ASO outpatient Network Providers determine medical necessity and can enroll Individuals into services

when there are dedicated funds in the Network Provider's contract per Thurston-Mason BH-ASO Policy 3045 Eligibility Verification and Authorization. Preauthorization requires adherence to Thurston-Mason BH-ASO's Policy 1006 Level of Care Guidelines, which includes use of a Thurston-Mason BH-ASO approved comprehensive intake, use of a validated level of care instrument (i.e., Level of Care Utilization System, Child and Adolescent Level of Care Utilization System, Child and Adolescent Needs and Strengths, or American Society of Addiction Medicine), and evidence that medical necessity criteria is met. Preauthorized services and ongoing re-authorizations are subject to Thurston-Mason BH-ASO quality review and to interrater reliability checks.

- Thurston-Mason BH-ASO conducts/monitors interrater reliability using the following processes for all Network Providers receiving dedicated funds that are preauthorized to provide specified services:

Network Providers must agree via signed contract to adhere to Thurston-Mason BH-ASO Policy 1006 Level of Care Guidelines.

- Network Providers must submit the following annually for Thurston-Mason BH-ASO approval:
    - Internal intake assessment tools;
    - LOC tools; and,
    - Written protocols/processes for determining medical necessity, eligibility, level of care (LOC), and utilization management.
- Network Providers must conduct an internal reliability evaluation on a minimum of 20 (or 20%, whichever is less) of their Individuals' records. This process includes a minimum of two qualified (MHP and/or SUDP) clinical staff independently reviewing the completed intake, and re-authorization (if applicable), and LOC instruments of randomly selected Individual records to make an eligibility determination and assign an LOC. The data must be entered into a scoring template and evaluated for reliability. Results of the study must be submitted to Thurston-Mason BH-ASO annually. If there is greater than a 10% discrepancy in scoring, the Network Provider must submit an improvement and training plan to increase reliability. Or,

- Network Providers may request that Thurston-Mason BH-ASO participate in the interrater reliability assessment. In this case, Thurston-Mason BH-ASO will randomly select the Individual records for review and require the Network Provider to submit these records via our SFTP site. A qualified Thurston-Mason BH-ASO MHP and/or SUDP will blindly review the intake, and re-authorization (if applicable) and LOC tool and make an eligibility and LOC determination. Thurston-Mason BH-ASO will create a scoring grid and enter both the Network Provider and BH-ASO data. This data will be evaluated for reliability. If there is greater than a 10% discrepancy in scoring, the Network Provider must submit an improvement and training plan to increase accuracy of determining eligibility and LOC.

- Thurston-Mason BH-ASO conducts interrater reliability on services authorized by Thurston-Mason BH-ASO when services are requested, and funds are not dedicated in the Network Provider's contract. The Network Provider must submit records when requested by Thurston-Mason BH-ASO to utilize the interrater reliability process outlined in Thurston-Mason BH-ASO Policy 1594 Utilization Management Requirements.

SECTION 2.7: ADMINISTRATIVE REVIEWS

See also Thurston-Mason BH-ASO Policy 5001 Administrative Contract Compliance. See also, Section 15, Monitoring of Subcontracts (formerly Federal Block Grant).

This is not a delegated Administrative Function but Thurston-Mason's description of monitoring activities conducted during Administrative Reviews and the Network Provider's responsibility to participate and their identified roles to ensure adherence to delegated functions.

Thurston-Mason BH-ASO shall conduct monitoring and compliance reviews when Thurston-Mason BH-ASO identifies deficiencies or areas requiring improvement and provide for corrective action. The Administrative review is limited in scope and the primary purpose is to ensure compliance with the terms of the contract the network provider has with Thurston-Mason BH-ASO. Corrective actions are issued based on the Remedial Action section of this guide.

The Thurston-Mason BH-ASO will ensure Providers:

- Comply with established data submission requirements for all services funded under the HCA BH-ASO Contract.
- Update individual funding information when the funding source changes.
- Thurston-Mason BH-ASO will maintain written or electronic records of all Network Provider monitoring activities and make them available to HCA upon request.

Thurston-Mason BH-ASO shall conduct and/or make arrangements for an annual fiscal review of each Provider receiving FBG funds regardless of reimbursement methodology (e.g. through fee-for-service, set rate, performance- based or cost reimbursement Contracts). The annual fiscal review shall ensure that:

- Expenditures are accounted for by revenue source.
- No expenditures were made for items identified in the Federal Block Grant Section.
- Expenditures are made only for the purposes stated in the Contract, and for services that were actually provided.

SECTION 2.8: PROVIDER NONDISCRIMINATION

See also Thurston-Mason BH-ASO Policy 1008 Network Provider Selection.

- Thurston-Mason BH-ASO will not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold; however, Thurston-Mason BH-ASO is free to establish criteria and/or standards for providers' inclusion in a network of providers based on their specialties.
- If Thurston-Mason BH-ASO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.
- Thurston-Mason BH-ASO policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- Consistent with Thurston-Mason BH-ASO responsibilities to HCA and individuals in/seeking services, Thurston-Mason BH-ASO is not:
    - Required to contract with providers beyond the number necessary to meet the behavioral health requirements under the Contract.
    - Precluded from using different reimbursement amounts for different specialties or for different providers in the same specialty.
    - Precluded from establishing measures that are designed to maintain quality of services and control costs.

SECTION 2.9: PROVIDER EDUCATION AND TRAINING

- The Provider shall verify all staff credentials, licenses, education, and competency prior to initiating work with any individuals receiving services under this contract. This shall include maintaining appropriate documentation in employee files. Credentials and licensing must be verified for employees providing direct services, including, but not limited to:
    - Medical practitioners;
    - Mental health professionals (includes mental health specialists);
    - Substance use disorder professionals;
    - Certified peer counselors; and,
    - Agency affiliated counselors.
- The Provider shall:
    - Document that direct service staff, clinical supervisors, and management are qualified for the positions they

hold and have the education, experience, and skills to perform job functions related to this contract.

- Assign, orient, supervise, monitor and perform regularly scheduled performance review sessions for all employee positions.
- Conduct and/or make available formal training for all staff pertinent to their position and required by WAC, CFR, or licensing requirements. An annual training plan must be implemented for each direct service employee and supervisor. The plan must be available for review during audits and must include, at a minimum:
  - The skills each employee needs to effectively perform the functions included in their job description and the population in which they directly serve;
  - Annual violence prevention training on the safety and violence prevention topics described in RCW 49.19.030. In addition, any staff that provides crisis services or community outreach must receive the Marty Smith Training or equivalent. The staff member's personnel record must document the training(s).
  - Use of the current version of the Integrated Co-Occurring Disorder Screening Tool (GAIN-SS). Network providers are required to provide training for staff that will be using the tool(s) to address the screening and assessment process, the tool and quadrant placement. Corrective action will be implemented if the process is not utilized and maintained throughout the Contract's period of performance.
  - HIPAA compliance and confidentiality consistent with 71.05, 71.24 and 70.02 RCW.
- Thurston-Mason BH-ASO shall maintain regular provider meetings, Co-Occurring System of Care (COD SOC) for the purpose of verbally informing providers on the following written requirements:
  - Contracted services for Individuals served under the BH-ASO Contract
  - Coordination of care requirements;
  - HCA and the Thurston-Mason BH-ASO's policies and procedures as related to the Contract;
  - Data interpretation;
  - Practice guidelines as described in the provisions of this Provider Service Guide and Thurston-Mason BH-ASO Policy 1004 Clinical Practice Guidelines;
  - Requirements for Utilization Management (UM) decision making;
  - Procedure coding, and encounter submission for contracted services;
  - Care management staff who can assist in care transitions and care management activities; and,
  - Program Integrity and Quality Management requirements;
  - Ensure Thurston-Mason BH-ASO sponsored Certified Peer Counselor trainings are offered in accordance with DBHR policies. Policy requirements include the use of DBHR approved curriculum, trainers, testers, and applicants.
  - The Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to Thurston-Mason BH-ASO's Regional Service Area.

- Providers are expected to participate in training when requested by HCA. exceptions must be in writing and include a plan for how the required information shall be provided to staff.
- Thurston-Mason BH-ASO will provide continuing education and training opportunities through various online and live trainings, as resources allow.
- Providers are encouraged to use the Relias Learning System for all staff training needs and participate in live in person trainings for specialized training.

SECTION 2.10: GRIEVANCE AND APPEAL SYSTEM

See also Thurston-Mason BH-ASO Policy 1001 Grievance and Appeal System.

- Thurston-Mason BH-ASO does not delegate the Grievance and Appeal System. This section describes the Network Provider's responsibility to participate and their identified roles to ensure adherence to the Thurston-Mason BH-ASO Grievance and Appeal System as described in the HCA BH-ASO contract and in compliance with WAC 182-538C-110.
- Providers are required to participate in Thurston-Mason BH-ASO's Grievance Program, adhering to Thurston-Mason BH-ASO Policy 1001 Grievance and Appeal System and cooperate with Thurston-Mason BH-ASO in identifying, processing, and promptly resolving all individual complaints, grievances, or inquiries.
- If an individual has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If an individual appeals a decision, the Provider will participate by providing medical records or a statement if needed. This includes the maintenance and retention of Individual records for a period of not less than ten (10) years and retained further if the records are under review or audit until such time that the review or audit is complete.

Definitions:

Grievance means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Individual's rights.

Grievance Process means the procedure for addressing Individuals' grievances.

Grievance and Appeal System means the overall system that includes Grievances and Appeals handled by Thurston-Mason BH-ASO and access to the Administrative Hearing system.

- Providers are required to implement a Grievance process that complies with WAC 182-538C-110 and as described in the Grievance Section in the HCA BH-ASO contract and in Thurston-Mason BH-ASO Policy 1001 Grievance and Appeal System.
- Termination of a Subcontract shall not be grounds for an appeal, Administrative Hearing, or a Grievance for the Individual if similar services are immediately available in the service area.
- Providers shall notify individuals on how they will be informed of their right to a Grievance or Appeal in the case of:
    - Denial or termination of service related to medical necessity determinations.
    - Failure to act upon a request for services with reasonable promptness.
- The Provider shall provide the following information regarding the Grievance and Appeal System for all GFS/FBG funded contracted services. Providers can access Thurston-Mason BH-ASO Policy 1001 Grievance and Appeal System that outlines the specific information for Individuals accessing services on the website, wwwm.tmbho.org:
    - The toll-free number, (800) 658-4105 to file verbal Grievances and Appeals.
    - The availability of assistance in filing a Grievance or Appeal, including interpretation and translation services at no cost to the individual.
    - The Individual's right to file Grievances and Appeals and their requirements and timeframes for filing.
    - The Individual's right to an Administrative Hearing, how to obtain an Administrative Hearing and representation rules at an Administrative Hearing.
    - For filing or help in filing a Grievance or Appeal, call (360) 763-5793 or (800) 658-4105.

9. For individuals assigned to an Apple Health Managed Care Plan and need to file or need help filing a Grievance or Appeal, they should contact their Managed Care Plan or the Office of Behavioral Health Advocacy (OBHA).

SECTION 2.11: CRITICAL INCIDENTS

See also Thurston-Mason BH-ASO Policy 1009 Critical Incidents for the categories and details of each critical incident.

Thurston-Mason BH-ASO does not delegate Critical Incidents. This section describes the Network Provider's responsibility to participate and their identified roles to ensure adherence to the Critical Incident section as described in the HCA BH-ASO contract.

The Provider shall develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of critical incident reporting (Thurston-Mason BH-ASO Policy 1009 Critical Incident Reporting).

The Provider shall report Critical Incidents within one (1) business day in which the Provider becomes aware of the incident and shall report incidents that have occurred within the last thirty (30) calendar days, with the exception of incidents that have resulted in or are likely to attract media coverage using the Thurston-Mason BH-ASO Critical Incident Reporting form found on the website. Media related incidents should be reported to HCA as soon as possible, not to exceed one (1) business day.

The Provider shall report Critical Incidents to Thurston-Mason BH-ASO by sending an encrypted email to qualitymanagement@tmbho.org.

The Provider shall submit follow-up reports and close the case within forty-five (45) calendar days after the Critical Incident was initially reported. A case cannot be closed until the following information is provided:

- A summary of any debriefings;
- Whether the Individual is in custody Jail, in the hospital or in the community;
- Whether the Individual is receiving services and include the types of services provided;
- If the Individual cannot be located, the steps the Provider has taken to locate the Individual using available, local resources; and
- In the case of the death of an Individual, verification from official sources that includes the date, name and title of the sources. When official verification cannot be made, the Provider shall document all attempts to retrieve it.

SECTIONS 2.12: SINGLE CASE AGREEMENTS

Thurston-Mason BH-ASO will document and confirm in writing all single-case agreements with non-Network Providers. The Agreement shall include:

- Identification of the individual;
- The description of the services;
- The authorization period for the services, including the begin date and the end date for approved services;
- Service logs or other related data documents specific to the services provided which supplement the invoice;
- The rate of reimbursement for the service or reference to the Thurston-Mason BH- ASO's fee schedule or other documents that define payment; and
- Any other specifics of the negotiated rate.
- Thurston-Mason BH-ASO must supply documentation to the Provider no later than five (5) business days following the signing of the agreement. Updates to the unique contract, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).
- Thurston-Mason BH-ASO shall maintain a record of the single-case agreements for a period of six (6) years.

SECTIONS 2.13: UTILIZATION MANAGEMENT

See also Thurston-Mason BH-ASO Policy 1594 Utilization Management Requirements, 1594.01 Thurston-Mason BH-ASO Provider Services Reference Guide, 1571 Psychiatric Inpatient Authorization, 1572 Alien Emergency Medical Inpatient Psychiatric Admission Authorization, 1005 Notice Requirements, 1006 Level of Care Guidelines and 1006.01 Level of Care for Authorizations.

To define utilization management (UM) processes and requirements for Thurston-Mason BH-ASO and its providers. To describe the variety of mechanisms used to monitor and identify over- and under-utilization of resources and implement remedial action when indicated.

UM of behavioral health services will be conducted in a systematic manner by qualified staff to ensure the appropriateness and quality of access to and delivery of behavioral health services to eligible residents of the Thurston-Mason region. Thurston-Mason BH-ASO shall ensure all UM activities are structured to not provide incentives for any individual or entity to deny, limit, or discontinue medically necessary behavioral health services to any individual.

Thurston-Mason BH-ASO may specify what constitutes medical necessity in a manner that is no more restrictive than the State Medicaid program. For the purpose of UM, Thurston-Mason BH-ASO may place appropriate limits on a behavioral health service based on criteria applied under the State plan, such as medical necessity, provided the behavioral health services furnished could reasonably be expected to achieve their purpose.

Thurston-Mason BH-ASO reviews all treatment records in accordance with state and federal law. Substance use disorder (SUD) records are reviewed in accordance with 42 CFR §2.53. Reviewers do not copy or remove any treatment records during a review.

Authorization Process (as described in Thurston-Mason BH-ASO Policy 1594 Utilization Management Requirements)

Network Providers are delegated the function of conducting eligibility verification processes for Individuals being served to determine their financial eligibility status for services, eligibility criteria to enroll the Individual into services if contracted funds allow, and to determine any third-party payments per Thurston-Mason BH-ASO Policy 3045 Eligibility Verification. The Network Provider collects specific details about the Individual seeking services and makes a determination based on all information gathered and follows the instructions in 1594.01 Thurston-Mason BH-ASO Provider Services Reference Guide for authorizations to determine if services are pre-authorized or need Thurston-Mason BH-ASO prior authorization.

Pre-authorized services: Once the Individual has been identified as Medicaid ineligible by the Network Provider and the Network Provider has dedicated funds in their non-crisis behavioral health contract to provide specific services, they must verify the additional eligibility criteria listed in the following documents in order to enroll the Individual into services:

a) Thurston-Mason BH-ASO Policy 1006 Level of Care Guidelines and 1006.01 Level of Care Authorizations (verify the Individual meets criteria for the medically necessary and/or non-medically necessary services and the authorization criteria for those services);

b) Verify the Individual meets all criteria for the services requested as outlined in the Thurston-Mason BH-ASO Behavioral Health Provider Guide Statement of Work(s) (SOW) and/or Attachments which provide specific SOW(s) as listed in the non-crisis behavioral health contract.

    i) If the Individual meets criteria for non-Medicaid funds, meets (1) (2a) and (2b), Network Providers may enroll the Individual directly into services within the program scope and available resources (up to the contracted funding amount).

    ii) The Network Provider continues to verify the Individual's eligibility for services at each session and as new information is presented throughout the authorization period and adheres to Utilization Management requirements as outlined in this policy.

        (1) If the Individual does not meet medically necessary criteria or an Action needs to be taken at any time on a request for service, the Network Provider will contact Thurston-Mason BH-ASO to follow requirements to submit a Notice of Action or Notice of Adverse Authorization Determination per Thurston-Mason BH-ASO Policy 1005 Notice Requirements.

Thurston-Mason BH-ASO prior authorization required, voluntary inpatient mental health: Prior to the initiation of voluntary inpatient mental health, once the Individual has been identified as Medicaid ineligible as delegated to the Network Provider, Thurston-Mason BH-ASO must pre-authorize services. To make an authorization request (and for continued stay requests), the Network Provider must complete the TMBH-ASO Authorization/Notification Form, found at:

https://www.tmbhaso.org/information-for-providers or click HERE for the form. Once the form is submitted, Thurston-Mason BH-ASO will determine funding within Available Resources and verify criteria eligibility using Thurston-Mason BH-ASO Policy 1006 Level of Care Guidelines and 1006.01 Level of Care Authorizations to ensure the Individual meets criteria for the medically necessary services. **If inpatient mental health services are approved**, Thurston-Mason BH-ASO sends a confirmation email to the referring provider with an authorization decision and any other information needed for the authorization request. **If inpatient mental health services are denied**, Thurston-Mason BH-ASO follows procedures in Policy 1005 Notice Requirements to issue notices.

Thurston-Mason BH-ASO prior authorization required, outpatient behavioral health services and SUD residential: Prior to the initiation of any type of non-crisis behavioral health service, once the Individual has been identified as Medicaid ineligible as delegated to the Network Provider, and the Network Provider is requesting the use of non-Medicaid funds that are **not** dedicated in the non-crisis behavioral health contract, Thurston-Mason BH-ASO must pre-authorize the services. The Network Provider calls Thurston-Mason BH-ASO customer service line (360-763-5828) to complete a verification screen per the TM BH-ASO Non-Medicaid Request Form for medically necessary services and the TM BH-ASO Non-Medically Necessary Request Form for non-medically necessary services. A Thurston-Mason BH-ASO representative will determine funding within Available Resources and verify criteria eligibility using Thurston-Mason BH-ASO Policy 1006 Level of Care Guidelines and 1006.01 Level of Care Authorizations to ensure the Individual meets criteria for the medically necessary and/or non-medically necessary services and the authorization criteria for those services. If applicable, Thurston-Mason BH-ASO will direct the Network Provider to submit via secure email the appropriate Request Form to oprequest@tmbho.org

These forms include but are not limited to: financial information, clinical information; priority population status; specific to the appropriate Request Form: medical necessity criteria (Covered DSM-5-TR diagnosis) and criteria for non-medically necessary services; and, if applicable, the need for SUD interim services and waiting list criteria.

a) If there are no funds available or the Individual is determined to not be eligible for non-crisis services through Thurston-Mason BH-ASO, the Request Form is not completed by the Network Provider and Thurston-Mason BH-ASO provides case management services to the Network Provider for other appropriate services.

b) **If outpatient behavioral health services or SUD residential services are approved**, Thurston-Mason BH-ASO returns the approved Request Form to the Network Provider and sends a notice to the Individual, following notification guidelines in Thurston-Mason BH-ASO Policy 1005 Notice Requirements. If the services are approved for SUD residential, the Network Provider must refer to the "Placement" section of the approved Request Form and select the in-network, admitting residential facility **or** outline the reasons why an in-network provider was not used, and a Single Case Agreement (SCA) must be issued by Thurston-Mason BH-ASO. This approved Request Form must be returned via encrypted email to Thurston-Mason BH-ASO for review and final placement authorization.

c) The Network Provider will continue to verify the Individual's eligibility for services at each session or as new information is presented throughout the authorization period and send information to Thurston-Mason BH-ASO utilizing the Request Form when requesting extensions of the authorization period and/or specific criteria, see also Thurston-Mason BH-ASO Policies 1005 Notice Requirements (for authorization periods) 1006 Level of Care Guidelines (for medical necessity and non-medically necessary criteria), and 1590 Non-Medicaid Services, General Fund State and Federal Block Grant (for additional criteria specific to funding source).

    i) If the Individual does not meet medically necessary criteria or an Action needs to be taken at any time on a request for service, Thurston-Mason BH-ASO will follow requirements to submit a Notice of Action or Notice of Adverse Authorization Determination per Thurston-Mason BH-ASO Policy 1005 Notice Requirements.

d) Thurston-Mason BH-ASO will utilize the Request Forms for maintaining Waiting Lists and providing Interim Services for Individuals of SABG priority populations, who are eligible but for whom SUD

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treatment services are not available due to limitations in Network Provider capacity or available resources. Based on data gathered, Thurston-Mason BH-ASO will submit the SABG Capacity Management Form quarterly, or otherwise required, to HCA and notify, in writing, within two (2) business days when the network is at 90% capacity.

e) **If inpatient mental health services are approved**, Thurston-Mason BH-ASO sends a confirmation email to the referring provider with an authorization decision and any other information needed for the authorization request.

For SUD residential approved authorizations, paperwork must be completed by the Network Provider and submitted to Thurston-Mason BH-ASO with the invoice for payment and service activity log. This includes, depending on the ASAM level of care for either SUD residential or Withdrawal Management (WM):

a) TMBH-ASO Residential Client Admission Form

b) TMBH-ASO Residential Authorization Utilization Review Form

c) TMBH-ASO Residential Client Discharge Form

d) TMBH-ASO WM Client Admission Form

e) TMBH-ASO WM Client Discharge Form

Non-Medicaid ITA related services. Requests for initial authorization will be directed to TMBH-ASO. Notification to Thurston-Mason BH-ASO is required for all Involuntary Non-Medicaid admissions (within 24 hours of admission) and continued stay requests on the TM BH-ASO Non-Medicaid ITA Notification Form.

- Continued stay request determinations will be made within 24 hours or one (1) business day from the request and can be authorized up to seven (7) days by Thurston-Mason BH-ASO.
- Requests for post service authorizations (retrospective) will be considered only if all other funding/insurance options have been exhausted and the Individual is eligible for non-Medicaid assistance as verified by TMBH-ASO.
- Continued stay request determinations will be made within 24 hours or one (1) business day from the request and can be authorized for three (3) days depending on clinical presentation, this can be extended by Thurston-Mason BH-ASO.

For all inpatient authorizations.

- Hospital providers requesting prior authorization for continued stay requests are encouraged to submit requests during regular business hours. For requests that fall outside of regular business hours, Thurston-Mason BH-ASO will offer alternatives to allow the prior authorization review to occur.
- Once given, inpatient authorizations are not terminated, suspended, or reduced unless Medicaid eligibility is established for dates of service. Thurston-Mason BH-ASO shall administer Network Provider inpatient claims payment in accordance with WAC 182-502-150, which includes timeliness standards and adhered to Thurston-Mason BH-ASO Policy 216 Claims Payment.
- The authorization decision must be documented on authorization forms and must be provided to the hospital within three (3) business days of the authorization, unless the hospital requires receipt of the form prior to continuation of the stay.
- **Discharge notification:** Network providers are required to provide discharge notification and clinical disposition in order for Thurston-Mason BH-ASO to close out the authorization record. The Network Provider must complete the TMBH-ASO Inpatient Discharge Notification Form, found at: https://www.tmbhaso.org/information-for-providers or click HERE for the form.

SECTIONS 2.14: TELEMEDICINE

See also Thurston-Mason BH-ASO Policy 1010 Telemedicine

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Thurston-Mason BH-ASO allows contracted providers to utilize telemedicine to deliver covered services that are within the practitioner's scope of practice to an individual at a site where the provider is located. The platform must be Health Insurance Portability and Accountability Act (HIPAA)-compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store and forward technology.

As telemedicine is an evolving platform, Thurston-Mason BH-ASO relies on direction from the HCA for the most recent policies and procedures for adherence to regulations.

Providers must verify readiness from Thurston-Mason BH-ASO IS Department prior to utilizing telemedicine.

Providers must have a plan in place for ensuring the telemedicine platform adheres to HCA's WAC 182-531-1730.

Providers are responsible for ensuring an individual's privacy to the best of their ability and to retain responsibility with respect to an individual's privacy, only sharing or communicating personal health information with individuals authorized to receive the information. Providers should enable all available encryption and privacy modes when using such platforms.

Providers must ensure that the standard of care for telemedicine is the same as that for in-person visit providing the same service. Best practices may include but are not limited to:

- Consider the individual's resources when deciding the best platform to provide telehealth services.
- Test the process and have a back-up plan; connections can be disrupted with heavy volume. Communicate a back-up plan in the event the technology fails.
- Introduce yourself, including what your credential is and what specialty you practice. Show a badge when applicable.
- Providers must inform individuals of the use of telemedicine. Consent must be provided by the individual and documented and dated in the chart note.
- Ask the individual their name and verify their identity. Consider requesting a photo ID when applicable/available.
- Inform the individual of how the individual can see a clinician in-person in the event of an emergency or as otherwise needed.
- Inform individuals they may want to be in a room or space where privacy can be preserved during the conversation.

Documentation requirements for telemedicine services are the same as those for documenting in-person care and, at a minimum, should also include:

- Date of the service, including start and stop time or duration of service.
- The names of all participants in the encounter, including other patients and providers involved.
- The location of the individual and a note of any medical personnel with the individual, as well as the location of the provider.
- That the encounter was conducted via telemedicine, which telemedicine platform was used, and whether it is HIPAA compliant.
- Providers must use the modifier identified by Thurston-Mason BH-ASO's IS Department to code the service accurately for billing purposes.
- Thurston-Mason BH-ASO will keep providers informed of the most current and up-to-date HCA telemedicine policies and procedures at the Co-Occurring System of Care meetings.

Chapter Three

SECTION 3.0: CREDENTIALING AND RECREDENTIALING

See also Thurston-Mason BH-ASO Policy 1026 Provider Credentialing for the full scope of credentialing and re-credentialing activities required for individuals and organizations. Thurston-Mason BH-ASO retains this function and does not delegate it to subcontractors. This function is to ensure that all subcontractors meet the licensure and certification requirements as established by state and federal statute, administrative code, or as directed in the HCA BH-ASO Contract.

Thurston-Mason BH-ASO's Medical Director has direct responsibility for and participation in the credentialing program.

Thurston-Mason BH-ASO shall maintain a Credentialing Committee to oversee the credentialing process and follow the State's requirements for credentialing which are in accordance with the standards defined by the National Committee for Quality Assurance (NCQA) for health care professionals who have signed contracts or participation agreements per Chapter 246-12 WAC. Organizational provider refers to facilities providing services to individuals where individuals are directed for services rather than being directed to a specific practitioner.

Thurston-Mason BH-ASO's credentialing and recredentialing program shall include:

- Identification of the type of providers credentialed and recredentialed, including mental health and SUD providers.
- Specification of the verification sources used to make credentialing and recredentialing decisions, including any evidence of provider sanctions.
- Use and dissemination of the Washington Provider Application (WPA).
- Prohibition against employment or contracting with providers excluded from participation in federal health care programs under federal law as verified through List of Excluded Individuals and Entities (LEIE).
- A process for provisional credentialing that affirms that:
    - The practitioner may not be held in a provisional status for more than sixty (60) calendar days; and
    - The provisional status will only be granted one time and only for providers applying for credentialing the first time.
    - The provisional credentialing shall include an assessment of:
        - Primary source verification of a current, valid license to practice;
        - Primary source verification of the past five (5) years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner; and,
        - A current signed application with attestation.
- Prohibition against employment or contracting with providers excluded from participation in federal health care programs under federal law as verified through List of Excluded Individuals and Entities (LEIE).
- Verification of provider compliance with all Program Integrity requirements in the HCA BH-ASO Contract.

Network providers are credentialed prior to inclusion as network providers and are recredentialed a minimum of every 36 months to ensure they remain in good standing with regulatory and accrediting bodies, continue to maintain the appropriate level of malpractice insurance and are free from sanctions or ethical violations which indicate a problem with the quality-of-service delivery.

Thurston-Mason BH-ASO's credentialing and recredentialing process allows for a decision within sixty (60) calendar days of the submission of the credentialing application with the provider application is complete upon submission.

Application Process:

Network providers must complete an initial application documenting their business and clinical structure to be credentialed as an organization. For individual practitioners, see the requirements in Thurston-Mason BH-ASO Policy 1026 Provider Credentialing. The application includes an attestation signed by a duly authorized representative of the facility. The following information must be included with the application:

- Copies of documents that indicate that the provider is in good standing with state and federal regulatory bodies;
- Copies of documents that indicate the provider has been accredited by one or more of the following:
    - Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
    - Commission on Accreditation of Rehabilitation Facilities (CARF);
    - Council on Accreditation (COA);

  - Community Health Accreditation Program (CHAP);
  - American Association for Ambulatory Health Care (AAAHC);
  - Critical Access Hospitals (CAH);
  - Healthcare Facilities Accreditation Program (HFAP, through AOA);
  - National Integrated Accreditation for Healthcare Organizations (NIAHO, through DNV Healthcare);
  - ACHC (Accreditation Commissions for Healthcare) and/or American Osteopathic Association (AOA); or
    - Other appropriate accrediting bodies as identified by the Managed Care Organizations (MCOs).
- If the provider is not approved by a recognized accrediting body, a facility site audit is conducted to determine the quality of programming, types of staff providing service, staff competencies, quality of treatment record documentation, and physical environment to ensure access, safety and satisfaction for our members.
  - This audit is conducted as part of the credentialing activity.
  - Unaccredited providers are surveyed by Thurston-Mason BH-ASO using the appropriate Thurston-Mason BH-ASO audit tools. Providers that fail to meet these standards are not approved for participation in the network.
    - In lieu of a site visit by Thurston-Mason BH-ASO, the provider must have been reviewed or received certification by Center for Medicare and Medicaid Services (CMS) or Department of Health (DOH) within the past three years. Thurston-Mason BH-ASO has certified that CMS requirements for facilities fully meet Thurston-Mason BH-ASO facility site requirements. DOH requirements are reviewed to determine if they meet Thurston-Mason BH-ASO facility site requirements. Thurston-Mason BH-ASO obtains a copy of the CMS or DOH's report from the facility when they are accepted in lieu of a Thurston-Mason BH-ASO site visit.
- Copies of professional and general liability insurance of $1 million/occurrence and $3 million/aggregate for non-acute care settings. Coverage limitations may vary depending on HCA/MCO specific requirements.
  - If the provider does not meet liability coverage requirements, it must be reviewed by the Credentialing Committee to be considered for network participation.

Thurston-Mason BH-ASO Credentialing Committee Activities:

- Credential personnel obtains or queries prior to the credentialing/recredentialing decision date.
- A copy of the licenses from the provider or verification of the licensure directly from the state agency (https://fortress.wa.gov/doh/facilitysearch/).
- A copy of the accreditation certificate or report from the entity or verification directly from the accreditation organization. If non-accredited, confirmation that the site audit visit was completed or copy of the state/CMS audit results are in the file if they are being accepted in lieu of a Thurston-Mason BH-ASO site visit.
- Exclusion on the Office of Inspector General (OIG) and List of Excluded Individuals and Entities (LEIE) query (https://oig.hhs.gov/exclusions/exclusions_list.asp).
- Sanctions by the Excluded Parties List System (EPLS) on the Systems for Awards Management (SAM) site (https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf)
- Verification of state Medicaid exclusions sites where required (https://www.hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/provider-termination-and-exclusion-list).
- Credentialing Committee Decision. When Thurston-Mason BH-ASO has reached a credentialing decision, the provider will be notified, in writing, within 15 calendar days of the decision date.
- The Provider must have written policies that require monitoring of employee credentials, including maintenance of their state-issued license or certification and any findings or concerns about the agency or any of its employees that is identified by Thurston-Mason BH-ASO or the Department of Health.

- Provider recredentialing is performed a minimum of every 36 months. It is the responsibility of the network provider to send Thurston-Mason BH-ASO any documents related to the credentialing process including actions, investigations, revisions, or renewals throughout the period to stay current with the credentialing status.

Chapter Four

SECTION 4.0: COORDINATION OF BENEFITS AND THIRD-PARTY

See also Thurston-Mason BH-ASO Policy 3044 Third Party.

The services and benefits available under the contract will be secondary to any other coverage. Nothing in this Section negates any of Thurston-Mason BH-ASO's responsibilities under the HCA BH-ASO contract. Thurston-Mason BH-ASO shall:

- Not refuse or reduce services provided under the HCA BH-ASO contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable COB rules in WAC 284-51.
- Attempt to recover any third-party resources available to Individuals and make all records pertaining to COB collections for Individuals available for audit and review.
- Pay claims for Contracted Services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed.
- Coordinate with out-of-network providers with respect to payment to ensure the cost to Individuals is no greater than it would be if the services were furnished within the network.
- Communicate the requirements of this Section to Network Providers that provide services under the terms of the HCA BH-ASO contract and assure compliance with them.

Network Providers must pursue and report all third party revenue related to services provided, including pursuit of FFS Medicaid funds provided for AI/AN Individuals who did not opt into managed care.

Chapter Five

SECTION 5.0: CHARITABLE CHOICE

See also Thurston-Mason BH-ASO Policy 1008 Provider Network Selection.

Thurston-Mason BH-ASO shall ensure that the Charitable Choice Requirements of 42 CFR Part 54 are followed and that Faith-Based Organizations (FBO) are provided opportunities to compete with traditional Substance Use Disorder (SUD) treatment providers for funding.

If Thurston-Mason BH-ASO contracts with FBOs, Thurston-Mason BH-ASO shall require the FBO to meet the requirements of 42 C.F.R. Part 54 as follows:

- Individuals requesting or receiving SUD services shall be provided with a choice of SUD treatment providers.
- The FBO shall facilitate a referral to an alternative provider within a reasonable time frame when requested by the recipient of services.
- The FBO shall report to Thurston-Mason BH-ASO all referrals made to alternative providers.
- The FBO shall provide Individuals with a notice of their rights.
- The FBO provides Individuals with a summary of services that includes any religious activities.
- Funds received from the FBO must be segregated in a manner consistent with federal Regulations.
- No funds may be expended for religious activities.

Chapter Six

SECTION 6.0: ENCOUNTER SUBMISSION AND COMPENSATION

See also Thurston-Mason BH-ASO Fiscal Management Policies 215 Revenue and Expenditures and 216 Claims Payments.

As a network provider, it is important to understand how the encounter submission process works to avoid delays in processing your payments.

Please refer to the Thurston-Mason BH-ASO Data Dictionary for encounter and supplemental demographic data submission requirements.

In order for a provider to submit data and have encounters considered for payment it must past the following edit processes and procedures:

- Provider must be contracted with Thurston-Mason BH-ASO and have the capability to comply with all aspects of data collection and submission requirements as described in the Thurston-Mason BH-ASO Data Dictionary.
- All practitioner and agency data requirements for system setup must be fulfilled prior to any data submission or payment expectations.
- Provider must attend all Thurston-Mason BH-ASO Information Services training sessions prior to any data submission.
- Provider must designate a named superuser and a named backup superuser whose responsibility it will be to attend all Thurston-Mason BH-ASO monthly superuser meetings, to have a thorough understanding of data systems and how to interpret data dictionary requirements and edit report in order to disseminate all data system information, changes and updates to necessary staff within their organization and be the primary contact person for Thurston-Mason BH-ASO Information Services staff.
- Encounters must meet all data requirements in order to pass through EDI transmission process and file successfully in the Thurston-Mason BH-ASO MSO data base.
- Encounter must successfully transmit to Thurston-Mason BH-ASO as described above by 11:59 PM on the 10th of the month following date of service.

Data certification

- The Provider shall provide certification of data and encounters required by this contract and submitted to Thurston-Mason BH-ASO. The data and encounters shall be certified by one of the following:
    - The Provider's Chief Executive Officer (CEO);
    - The Provider's Chief Financial Officer (CFO);
    - An individual who has delegated authority to sign for and who reports directly to the CEO or CFO.
- The Contractor shall use only the TMBH-ASO-supplied certification form as provided in the contract and on the website.
- The Provider shall submit a signed certification form in either electronic format (via email or SFTP) no later than the 11th day of the month following month of service. The Provider shall ensure that each certification contains an original signature of the signing authority.

Financial Certification

If a Contractor receives any funding from Thurston-Mason BH-ASO they must submit the Quarterly Financial Report Certification form, see Section 21, Deliverables. The form can be found on the website www.tmbhaso.org.

Provider Payment Standards

- Thurston-Mason BH-ASO shall meet the timeliness of payment standards as specified in the Provider Payment Standards Section of the HCA BH-ASO Contract. To be compliant with payment standards Thurston-Mason BH-ASO shall pay or deny, and shall require Network Providers to pay or deny, 95 percent of clean claims and encounters within thirty (30) calendar days of receipt, 95 percent of all claims within sixty (60) calendar days of receipt and 99 percent of claims within ninety (90) calendar days of receipt. Thurston-Mason BH-ASO and its Network Providers may agree to a different payment requirement in writing on an individual claim.

- A claim is a bill for services, a line item of service, or all services for one (1) Individual within a bill.
- A clean claim is a claim that can be processed without obtaining additional information from the Network Provider of the service or from a third party.
- The date of receipt is the date Thurston-Mason BH-ASO receives the claim or encounter from the Network Provider.
- The date of payment is the date of the check or other form of payment.
- Thurston-Mason BH-ASO shall update its claims and encounter system to support hardcopy and electronic submission of claims, adjustment claims, encounters, payments and bills for all Contracted Services types for which claims submission is required.

Section 6.1: FEE SCHEDULE

Thurston-Mason ASO has established the rate schedule for 2024 with a 15% increase as HCA received a budget increase for General Fund State and this amount is reflected in the rates. The fees listed apply to all funding types, GFS, SABG, MHBG, and Legislative Provisos as consistent with the Payments and Sanctions section of the HCA BH-ASO contract. The services funded are found in Exhibit B-Compensation of the contract (services allowable under the Network Provider contract) along with reporting requirements and rules for payer responsibility as found in the Apple Health Mental Health Services Billing Guide.

*Daily Rate Includes Room and Board

Behavioral Health Disorder Outpatient Treatment	Rate	Unit
Individual Treatment		
Psychiatrist/MD	$608.85	Per Hour
Nurse Practitioner/Physician Assistant	$384.81	Per Hour
Registered Nurse/LPN	$242.48	Per Hour
PhD and Master's Level	$185.82	Per Hour
Bachelor's and AA Level	$147.60	Per Hour
Peer Counselor	$117.29	Per Hour
Substance Use Disorder Professional	$185.82	Per Hour
Substance Use Disorder Professional Trainee	$147.60	Per Hour
Group Treatment		
Psychiatrist/MD	$152.23	Per Hour
Nurse Practitioner/Physician Assistant	$96.20	Per Hour
Registered Nurse/LPN	$60.63	Per Hour
PhD and Master's Level	$46.45	Per Hour
Bachelor's and AA Level	$36.90	Per Hour
Peer Counselor	$29.32	Per Hour
Substance Use Disorder Professional	$46.45	Per Hour
Substance Use Disorder Professional Trainee	$36.90	Per Hour
Other Behavioral Health Disorder Services	**Rate**	**Unit**
MH Request for Service	$81.58	Per Hour
Screening Tests/UAs	$12.61	Per Screen

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SUD Assessment	$166.36	Per Assessment
SUD Case Management	$58.44	Per Hour
PPW Housing Support Services (Minimum 3 Contacts Per Month)	$407.91	Per Client/Per Month
Child Care for PPW	Actual Costs	N/A
PPW Outreach	$69.03	Per Hour
Opiate Substitution Treatment	$19.85	Per Dose Day
***Withdrawal Management Treatment**	**Rate**	**Unit**
Youth Sub-Acute Withdrawal Management	$215.88	Per Day
Adult Sub-Acute Withdrawal Management	$195.80	Per Day
Acute Withdrawal Management	$389.08	Per Day
Secure Withdrawal Management	$815.82	Per Day
***Substance Use Disorder Residential Treatment**	**Rate**	**Unit**
Youth Recovery House	$209.60	Per Day
Adult Recovery House	$67.78	Per Day
Adult Long-Term	$181.99	Per Day
Adult Intensive Inpatient	$244.75	Per Day
Youth Intensive Inpatient	$345.16	Per Day
Pregnant and Parenting Women (PPW) w/ child	$283.65	Per Day
Pregnant and Parenting Women (PPW) w/o child	$194.54	Per Day
Therapeutic Interventions for Children (Max 4hrs day/5 days wk)	$69.03	Per Hour

Section 6.2: SLIDING FEE SCHEDULE

See also Thurston-Mason BH-ASO Policy 828 Sliding Fee Scale.

Network providers may develop and implement a sliding fee schedule that takes into consideration an individual's circumstances and ability to pay (individuals who are not eligible for Medicaid coverage or are unable to pay co-pays or deductibles). If the network provider selects to develop a fee schedule, the fee schedule must be reviewed and approved by Thurston-Mason BH-ASO. In developing sliding fee schedules, Network providers must comply with the following:

- Put the sliding fee schedule in writing that includes non-discriminatory language that states that no individual shall be denied services (crisis, ITA, E&T, or SUD involuntary services) due to inability to pay.
- Network providers ensure education and signage to the Individual to let them know about the sliding fee schedule.
- Network providers protect the individual's privacy when assessing fees.
- Network providers maintain a record to account for each individual visit or service and the charges incurred.
- Network provider sliding fee scale will reflect either no charge or a nominal charge for those individuals that are at or below 100% of the Federal Poverty Level (FPL).
- Network provider sliding fee scale will have at least three incremental amounts for individuals between 101-220% FPL.

Chapter Seven

SECTION 7.0: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

See also Thurston-Mason BH-ASO Policy 1596 Cultural Considerations and 401 Informational Requirements.

Thurston-Mason BH-ASO works to ensure all individuals receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services.

Thurston-Mason BH-ASO complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Individuals, including those with Limited English Proficiency and Individuals who are deaf, hard of hearing or have speech or cognitive/intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

The Provider shall not discriminate in employment and Individual services. The Provider shall make reasonable accommodation for Individuals with disabilities, in accord with the Americans with Disabilities Act, for all contracted services and shall assure physical and communication barriers shall not inhibit Individuals with disabilities from obtaining contracted services.

Nondiscrimination of Healthcare Service Delivery

Thurston-Mason BH-ASO requires Providers to deliver services to Thurston-Mason BH-ASO Individuals without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must adhere to Thurston-Mason BH-ASO Policy 401 Informational Requirements as it uses HCA BH-ASO contract language to outline the standards regarding information requirements for Individuals and equal access for Individuals with communication barriers. Additionally, Providers may not limit their practices because of an Individual's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care.

Should you or a Thurston-Mason BH-ASO Individual need more information you can refer to the Health and Human Services website for more information: https://www.federalregister.gov/d/2016-11458.

Thurston-Mason BH-ASO Commitment to Cultural Competency

Thurston-Mason BH-ASO is committed to reducing healthcare disparities. Training employees, Provider's staff, and quality monitoring are the cornerstones of successful culturally competent service delivery. Thurston-Mason BH-ASO Providers shall participate in efforts to promote National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Behavioral Health Care. Additional information on CLAS Standards and a Self-Assessment Checklist can be found on the Thurston-Mason BH-ASO website. An integrated quality approach intends to enhance the way people think about service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Thurston-Mason BH-ASO offers a training opportunity in cultural competency concepts for Providers, their staff, and Community Based Organizations. The required annual CLAS Training with reference to Thurston-Mason BH-ASO Policy 1596 Cultural Consideration (see also Deliverables) is due on January 31st of each year, or as the training is updated. Other trainings or educational opportunities are provided within Available Resources.

Training modules, delivered through a variety of methods, include:

- On-site cultural competency training delivered by experts in the field;
- Access to reference materials available through the Thurston-Mason BH-ASO; and,
- Integration of cultural competency concepts and nondiscrimination ofservice delivery into Provider communications.

Integrated Quality Improvement – Ensuring Access

Thurston-Mason BH-ASO ensures Individuals access to language services such as oral interpreting, American Sign Language (ASL), written translation and access to programs, and aids and services that are congruent with cultural norms. Thurston-Mason BH-ASO supports Individuals with disabilities and assists Individuals with Limited English Proficiency.

Thurston-Mason BH-ASO develops materials according to Plain Language Guidelines. Individuals may also request written materials in alternate languages and formats, leading to better communication, understanding and satisfaction. Information delivered in digital form meet accessibility requirements to support persons with visual impairments.

Program and Policy Review Guidelines

Thurston-Mason BH-ASO conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its individuals, families, and providers:

Collection and analysis of race, ethnicity and language data from:

- Eligible individuals to identify significant culturally and linguistically diverse populations within the Thurston-Mason RSA
- Contracted Providers to assess gaps in network demographics
- Local geographic population demographics and trends derived from publicly available sources
- Applicable national demographics and trends derived from publicly available sources
- Network Assessment of adequate providers for services
- Identification of specific cultural and linguistic disparities found within the region's diverse populations.

SECTION 7.1: INTERPRETER AND TRANSLATION REQUIREMENTS

See also Thurston-Mason BH-ASO Policy 401 Informational Requirements.

- For individuals receiving services funded by GFS, SABG, MHBG or Legislative Proviso and need interpreter and/or translation services the Provider will submit encounters to the Thurston-Mason BH-ASO for payment. For individuals receiving Apple Health Medicaid covered services the Provider must use Universal Language Services through HCA.

The network provider shall assure equal access for all Individuals when verbal or written language creates a barrier to such access.

For Medicaid Services: Network providers will utilize and follow the registration process on HCA's website for interpreter services and will submit reimbursement for those services as applicable for the contractually required services and for other support services.

For non-Medicaid Services: Network providers will maintain a log of all requests for interpreter services, or translated written materials. This log shall be provided to Thurston-Mason BH-ASO upon request.

- The provider shall utilize a DSHS authorized vendor for translation or interpretation services, which may include CTS LanguageLink; http://www.ctslanguagelink.com/.
    - Step 1: Call 1-888-338-7394
    - Step 2: Enter Account Number 24578, followed by # sign
    - Step 3: Select the number for the type of interpreter needed, or 9 for all other languages
    - NOTE: If you require a 3rd party call, press 9 to reach a Customer Service Representative
        - A 3rd party call is when you need LanguageLink to call the LEP client and then bridge the call together with you and the interpreter.
    - Step 4: Enter Client Code (this is accessed by contacting Thurston-Mason BH-ASO as each client code is unique to each provider so please do not share), followed by # sign.

Thurston-Mason BH-ASO provides verbal interpretation of written information to individuals who speak any non-English language regardless of whether that language meets the threshold of a prevalent non-English language.

Thurston-Mason BH-ASO notifies individuals and families of the availability of verbal interpreting services and informs them how to access verbal interpreting services at no cost to them on all significant Thurston-Mason BH-ASO materials. Thurston-Mason BH-ASO serves a diverse population with specific cultural needs and preferences.

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Providers are responsible for supporting access to interpreter services at no cost for Individuals with sensory impairment and/or who have Limited English Proficiency.

24 Hour Access to Interpreter Services

Thurston-Mason BH-ASO Providers must support access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset.

Providers may offer individuals interpreter services if the individuals do not request them on their own. It is never permissible to ask a family member, friend or minor to interpret.

Documentation

As a contracted Thurston-Mason BH-ASO Provider, your responsibilities for documenting language services/needs in the individual's medical record are as follows:

- Record the individual's language preference in a prominent location in the medical record.
- Document all requests for interpreter services.
- Document who provided the interpreter service. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if an individual insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his orher right to have a qualified interpreter at no cost.

Individuals with Hearing Impairment

- Thurston-Mason BH-ASO provides a TTY/TDD connection accessible by dialing 711.
- Thurston-Mason BH-ASO strongly recommends that Provider offices make available assistive listening devices for individuals who are deaf and hard of hearing. Assistive listening devices enhance the sound of the provider's voice to facilitate a better interaction.
- Provider shall assure equal access for all Individuals when verbal or written language creates a barrier to access for Individuals with communication barriers.
- Provider shall offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Verbal Information

The Provider shall assure that interpreter services are provided for Individuals with a preferred language other than English, free of charge. Interpreter services include the provision of interpreters for Individuals who are deaf or hearing impaired at no cost to the Individual, including American Sign Language (ASL). Interpreter services shall be provided for all interactions between such Individuals and the Provider including, but not limited to:

- Customer service;
- All appointments with any provider for any covered service; and
- All steps necessary to file Grievances and Appeals.

Written Information

The Provider shall provide all generally available and person-specific written materials in a language and format which may be understood by each Individual in each of the prevalent languages that are spoken by five percent (5%) or more of the population of the Regional Service Area (RSA) based on information obtained from Thurston-Mason BH- ASO/HCA.

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

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

- Providing the material in an audio format in the Individual's preferred language;
- Having an interpreter read the material to the Individual in their preferred language;
- Providing the material in another alternative medium or format acceptable to the Individual. The Provider shall document the Individual's acceptance of the material in an alternative medium or format in the Individual's record; or
- Providing the material in English, if the Provider documents the Individual's preference for receiving material in English

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

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

Educational materials that are not developed by the Provider are not required to meet the sixth (6th) grade reading level requirement and do not require approval.

For Individual-specific written materials, the Provider may use templates that have been pre-approved in writing by Thurston-Mason BH-ASO/HCA.

Chapter Eight

SECTION 8.0: QUALITY IMPROVEMENT

See also Thurston-Mason BH-ASO Policy 1105 Quality Management Plan.

Thurston-Mason BH-ASO has established a Quality Assessment and Performance Improvement (QAPI) Program that complies with regulatory and accreditation guidelines. The QAPI Program provides structure and outlines specific activities designed to improve the care, service and health of individuals receiving services.

Thurston-Mason BH-ASO hosts biannual Quality Management/Utilization Management meetings with Providers to ensure inclusion of provider voice and experience as it relates to quality and utilization. This meeting also reviews critical incidents, OBHA report-statewide Ombuds (when applicable), grievances, monitoring/audits, policies & procedures, compliance/program integrity, care coordination, contracts, utilization management, and crisis services. As time allows, the TMBH-ASO Medical Director will conduct a training related to topics suggested by the network.

Thurston-Mason BH-ASO requires Providers to comply with the following core elements and standards of care and to:

- Have a Quality Improvement Program in place (and make it available upon request to Thurston-Mason BH-ASO, see Deliverables section);
- Comply with and participate in Thurston-Mason BH-ASO QAPI Program including reporting of Access and Availability and provision of clinical records review process; and
- Allow access to Thurston-Mason BH-ASO personnel for site and clinical record review processes.

Clinical Records

Thurston-Mason BH-ASO requires that clinical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Individuals is consistently documented and that necessary information is readily available in the record. All entries will be indelibly added to the Individual's record.

Clinical Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Individual's records:

- Each individual has a separate record;
- Clinical records are stored away from public areas and locked;

- Clinical records are available at each visit and archived records are available within twenty-four (24) hours;
- If hardcopy, pages are securely attached in the clinical record and records are organized by dividers or color-coded when thickness of the record dictates;
- If electronic, all those with access have individual passwords;
- Record keeping is monitored for Quality Improvement and HIPAA compliance;
- Storage maintenance for the determined timeline and disposal per record management processes;
- Process for archiving medical/clinical records and implementing improvement activities; and,
- Clinical records are kept confidential and there is a process for release of behavioral health care records.

Confidentiality

Providers shall develop and implement confidentiality procedures to guard Individual protected health information, including medical records, in accordance with HIPAA privacy standards and all other applicable Federal and State regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or State law in pursuant to court orders or subpoenas;
- Maintain records and information in an accurate and timely manner;
- Ensure timely access by individuals to the records and information that pertain to them;
- Abide by all Federal and State Laws regarding confidentiality and disclosure of behavioral health records or other health information;
- Clinical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted; and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

Improvement Plans/Corrective Action Plans

If the Provider does not achieve the required compliance with the site review standards and/or the Clinical record keeping practices review standards, the Site Reviewer will follow the corrective action steps outlined in Remedial Actions section of this Guide under Program Integrity, under Compliance and Oversight Monitoring.

Agency Licensing and Credentialing

The Provider shall meet all DOH licensing requirements as a Behavioral Health Agency (BHA) as defined in WAC 246-341, as they now exist or are hereinafter amended. The Provider shall ensure that appropriately licensed and certified staff is employed when required by State and Federal regulations and statutes.

The Provider shall submit copies to Thurston-Mason BH-ASO of agency licenses, certifications, and proof of insurance annually upon renewal or when any changes occur.

The Provider shall notify Thurston-Mason BH-ASO immediately if there is any change in licensing status or in the event a license or certification is revoked or not renewed.

Chapter Nine Data Security

SECTION 9.1: DATA SECURITY REQUIREMENTS

See Thurston-Mason BH-ASO Information Services Policies 701-719.

Data Transport. When transporting HCA Confidential Information electronically, including via email, the data will be protected by:

- Transporting the data within the (State Governmental Network) SGN or BH-ASO internal network, or;

- Encrypting any data that will be in transit outside the SGN or BH-ASO internal network. This includes transit over the public Internet.

Protection of Data. The BH-ASO agrees to store data on one or more of the following mediums and protect the data as described:

- **Hard disk drives**. Data stored on local workstation hard disks. Access to the data will be restricted to authorized users by requiring logon to the local workstation using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Workstation hard disks are protected by Whole Disk Encryption (WDE) and boot time drive locks, each requiring a passcode on startup before arriving at the login screen. Portable computers are configured to require the drive lock and encryption keys when waking up from hibernation.
- **Network server disks**. Data stored on hard disks mounted on network servers and made available through shared folders. Access to the data will be restricted to authorized users using access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password, or other authentication mechanisms which provide equal or greater security such as biometrics or smart cards. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
- **Optical discs (CDs or DVDs) in local workstation optical disc drives**. Data provided by HCA on optical discs which will be used in local workstation optical disc drives and which will not be transported out of a secure area. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only authorized users have the key, combination or mechanism required to access the contents of the container. Workstations which access HCA data on optical discs must be in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
- **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers**. Data provided by HCA on optical discs which will be attached to network servers and which will not be transported out of a secure area. Access to data on these discs will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
- **Paper documents**. Any paper records must be protected by storing the records in a secure area which is only accessible to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.
- **Access via remote terminal/workstation over the State Governmental Network (SGN)**. Data accessed and used interactively over the SGN. Access to the data will be controlled by HCA staff who will issue authentication credentials (e.g. a unique user ID and complex password) to authorized Provider staff. The Thurston-Mason BH-ASO will notify HCA staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the Thurston-Mason BH-ASO, and whenever a user's duties change such that the user no longer requires access to perform work for this contract.
- **Access via remote terminal/workstation over the Internet through Secure Access Washington**. Data accessed and used interactively over the SGN. Access to the data will be controlled by HCA staff who will issue authentication credentials (e.g. a unique user ID and complex password) to authorized Thurston-Mason BH-ASO staff. The Thurston-Mason BH-ASO will notify HCA staff immediately whenever an authorized person in possession of such credentials is terminated or otherwise leaves the employ of the Thurston-Mason BH-ASO and whenever a user's duties change such that the user no longer requires access to perform work for this contract.
- **Data storage on portable devices or media.**
    - HCA data shall not be stored by the Thurston-Mason BH-ASO on portable devices or media unless specifically authorized within the Special Terms and Conditions of the contract. If so authorized, the data shall be given the

following protections:

- Encrypt the data with a key length of at least 128 bits
- Control access to devices with a unique user ID and password or stronger authentication method such as physical token or biometrics.
- Manually lock devices whenever they are left unattended and set devices to lock automatically after a period of inactivity, if this feature is available. Maximum period of inactivity is 20 minutes.
- Physically protect the portable device(s) and/or media by
- Keeping them in locked storage when not in use
- Using check-in/check-out procedures when they are shared, and
- Taking frequent inventories

o When being transported outside of a secure area, portable devices and media with confidential HCA data must be under the physical control of Thurston-Mason BH-ASO staff authorized to access that data.

- Portable devices include, but are not limited to; handhelds/PDAs, Ultramobile PCs, flash memory devices (e.g. USB flash drives, personal media players), portable hard disks, and laptop/notebook computers if those computers may be transported outside of a secure area.
- Portable media includes but is not limited to; optical media (e.g. CDs, DVDs), magnetic media (e.g. floppy disks, tape, Zip or Jaz disks), or flash media (e.g. CompactFlash, SD, MMC).

Data Segregation

- HCA data must be segregated or otherwise distinguishable from non-HCA data. This is to ensure that when no longer needed by the Thurston-Mason BH-ASO, all HCA data can be identified for return or destruction. It also aids in determining whether HCA data has or may have been compromised in the event of a security breach.
- HCA data will be kept on media (e.g. hard disk, optical disc, tape, etc.) which will contain no non-HCA data. Or,
- HCA data will be stored in a logical container on electronic media, such as a partition or folder dedicated to HCA data. Or,
- HCA data will be stored in a database which will contain no non-HCA data. Or,
- HCA data will be stored within a database and will be distinguishable from non-HCA data by the value of a specific field or fields within database records. Or,
- When stored as physical paper documents, HCA data will be physically segregated from non-HCA data in a drawer, folder, or other container.
- When it is not feasible or practical to segregate HCA data from non-HCA data, then both the HCA data and the non-HCA data with which it is commingled must be protected as described in this exhibit.

Data Disposition. When the contracted work has been completed or when no longer needed, data shall be returned to HCA or destroyed. Media on which data may be stored and associated acceptable methods of destruction are as follows:

Data stored on:	Will be destroyed by:
Server or workstation hard disks, or Removable media (e.g. floppies, USB flash drives, portable hard disks, Zip or similar disks)	Using a "wipe" utility which will overwrite the data at least three (3) times using either random or single character data, or
	Degaussing sufficiently to ensure that the data cannot be reconstructed, or Physically destroying the disk

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Paper documents with sensitive or confidential data	Recycling through a contracted firm provided the contract with the recycler assures that the confidentiality of data will be protected.
Paper documents containing confidential information requiring special handling (e.g. protected health information)	On-site shredding, pulping, or incineration
Optical discs (e.g. CDs or DVDs)	Incineration, shredding, or completely defacing the readable surface with a course abrasive
Magnetic tape	Degaussing, incinerating or crosscut shredding

Notification of Compromise or Potential Compromise. The compromise or potential compromise of HCA shared data must be reported to the HCA Contact designated on the contract within one (1) business day of discovery.

Data shared with Sub-contractors. If HCA data provided under this contract is to be shared with a sub-contractor, the contract with the sub-contractor must include all the data security provisions within this contract and within any amendments, attachments, or exhibits within this contract. If the Provider cannot protect the data as articulated within this contract, then the contract with the sub-contractor must be submitted to the HCA Contact specified for this contract for review and approval.

SECTION 9.2: MANAGEMENT INFORMATION SYSTEMS

See also Thurston-Mason BH-ASO Policy 1002 Data Accuracy Verification, 1003 Provider Data Certification, and 1007 Data Submission Verification and Error Correction.

Network Providers must submit complete and accurate reports and data required under the Contract, including encounter data that complies with HCA SERI Guide, HCA Encounter Data Reporting Guide (EDRG), and Behavioral Health Supplemental Transactions that complies with the BHDS Guide, to Thurston-Mason BH-ASO. Thurston-Mason BH-ASO shall ensure that all Network Providers required to report encounter and Behavioral Health Supplemental Transactions data have the capacity to submit all HCA required data to enable Thurston-Mason BH-ASO to meet the requirements under the HCA BH-ASO Contract. Behavioral Health Supplemental Transactions related to services provided to Individuals must be submitted within thirty (30) calendar days from the date of service or event.

- Provider shall ensure the existence and operation of an information system within their organization that complies with the requirements of the Office of the Chief Information Officer (OCIO) Security Standard 141.10 and the Data Sharing Terms, Exhibit 1. It shall have the ability to be used internally, and to collect and report data as required by Thurston-Mason BH-ASO for services which the Provider is contracted to deliver. This data shall be useable as management data for audit purposes and contain enough information to track termination from Thurston-Mason BH-ASO services. (42 CFR 434.53).
- Provider shall notify Thurston-Mason BH-ASO of any change to their information system, at the time planning begins for implementation that will have any effect on the data submitted to or otherwise required to be collected by Thurston-Mason BH-ASO. Prior to implementing changes to production systems, Provider shall conduct testing as noted below.
- Provider shall participate in the Thurston-Mason BH-ASO Super User Workgroup and information systems policy groups when requested by Thurston-Mason BH-ASO.
- Provider shall comply with Thurston-Mason BH-ASO policies and procedures regarding quality, accuracy, and data reporting.
- Periodically, Thurston-Mason BH-ASO may receive requests for information from Centers for Medicare and Medicaid Services (CMS), the legislature, Health Care Authority (HCA), etc., that may not be readily available in the Thurston-Mason BH-ASO data system and require collection of this information from Provider. Provider shall ensure that requested information is received in a manner that will allow Thurston-Mason BH-ASO to make a timely response to these inquiries.
- Thurston-Mason BH-ASO shall work with IHCPs to develop a mechanism to collect reports and data that will minimize duplication of reporting for IHCPs that submit reports and data to HCA without using Thurston-Mason BH-ASO's

processes or systems.

Thurston-Mason BH-ASO Data Dictionary

Thurston-Mason BH-ASO adds SERI and BHDG requirements to the TMBH-ASO Data Dictionary and then reviews any changes at the quarterly SuperUser meeting. The Thurston-Mason BH-ASO myAvatar Practice Management (PM) Data Dictionary can be found online at: https://www.tmbhaso.org. This set of documents describes the data, format, and content that is to be electronically submitted to Thurston-Mason BH-ASO.

- Provider shall provide all applicable data as described in the Thurston-Mason BH-ASO CIS Data Dictionary.
- Provider shall participate in Thurston-Mason BH-ASO meetings and trainings related to Thurston-Mason BH-ASO myAvatar PM Data Dictionary changes.
- Provider shall implement changes made to the Thurston-Mason BH-ASO myAvatar PM Data Dictionary within the timeframe established by the Thurston-Mason BH-ASO. In the event of timelines for implementation of changes required or necessitated by either a court order or agreement resulting from a lawsuit or legislative action Thurston-Mason BH-ASO will provide as much notice as possible of the impending changes and provide specifications for the changes as soon as they are available. Provider will implement the changes required by the timeline established in the court order, legal agreement, or legislative action.
- Provider shall implement changes to the content of national standard code sets (such as Current Procedural Terminology [CPT] Codes, Healthcare Common Procedural Coding System [HCPCS], Place of Service code sets) per the instructions and implementation schedule or deadline from the issuing organization.

Timeliness

At a minimum, Provider shall transmit data to Thurston-Mason BH-ASO once per week except as noted below.

Routine Data Submission

Required data must be reported by the 10th calendar day of the close of each calendar month in which the event occurred. For example:

- An encounter that occurred in January shall be submitted by the 10th of February.
- A change in a client's address that occurred in March must be reported by the 5th of April.

Error Resolution

After Thurston-Mason BH-ASO receives your submitted data, a service detail report will be generated that will show each record submitted per the Thurston-Mason BH-ASO myAvatar PM Data Dictionary and any errors that may be applicable to the record. Validation rules applied to submitted records can be found in the Thurston-Mason BH-ASO myAvatar PM Data Dictionary. This report will be made available in the Provider 'Service Detail Report' folder on the Thurston-Mason BH-ASO SFTP site.

Provider shall make corrections in their data system for any record that errors and submit the corrected data to Thurston-Mason BH-ASO within 10 calendar days of notification.

Outstanding Errors

Provider shall ensure sufficient resources are made available to Information System and/or Data Integrity staff to correct any errors that are present on the Service Detail report. The Service Detail report will be generated monthly or upon request and will be located in the Provider 'Service Detail Report' folder on the Thurston-Mason BH- ASO SFTP site. Errors that have been outstanding for more than 10 calendar days will be an indication, in part, of non-compliance with error resolution timelines.

Additional Data Cleanup Reports

Thurston-Mason BH-ASO will routinely generate additional data cleanup reports that will be made available to Provider. Provider shall review these reports within 10 calendar days and do one of the following:

- Make corrections in Behavioral Health Agency (BHA) information system then submit corrected data to Thurston-Mason BH-ASO; or

- Notify Thurston-Mason BH-ASO IS/IT Administrator that the record(s) on the cleanup report is/are correct.

Business Continuity and Disaster Recovery

Provider shall create and maintain a business continuity and disaster recovery plan (BCDRP) that ensures timely reinstitution 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.

Provider BCDRP must address, at a minimum, the following:

- A mission or scope statement;
- An appointed Information Services Disaster Recovery Staff;
- Provisions for backup of key personnel, identified emergency procedures, and visibly listed emergency telephone numbers;
- Procedures for allowing effective communication, applications inventory and business recovery priority, and hardware and software vendor list;
- Confirmation of updated system and operations documentation;
- Process for frequent backup of systems and data;
- Off-site storage of system and data backups;
- Ability to recovery data and systems from backup files;
- Designated recovery options which may include use of a hot or cold site;
- Evidence that disaster recovery tests or drills have been performed.
- Provider will submit an updated BCDRP and Business Associate Satisfactory Assurances Attestation (Certification) to Thurston-Mason BH-ASO by December 15 of each calendar year.

Chapter Ten

SECTION 10: PROTECTED HEALTH INFORMATION (PHI) AND HEALTH INSURANCE PORTIABILITY AND ACCOUNTABILITY ACT (HIPAA)

See also Thurston-Mason BH-ASO HIPAA Privacy Policies 2000 through 2090 and Security Policies S-01 through S-09.

Thurston-Mason BH-ASO's Commitment to Privacy

Protecting the privacy of Individuals' personal health information is a core responsibility that Thurston-Mason BH-ASO takes very seriously. Thurston-Mason BH-ASO is committed to complying with all Federal and State Laws regarding the privacy and security of Individuals' protected health information (PHI).

Provider Responsibilities

Thurston-Mason BH-ASO requires that its contracted Providers respect the privacy of Thurston-Mason BH-ASO Individuals (including Thurston-Mason BH-ASO individuals who are not in service with the Provider) and comply with all applicable laws and regulations regarding the privacy of an individuals' PHI.

Applicable Laws

Providers must understand and comply with all State and Federal health care privacy Laws applicable to their practice and organization. In general, most health care Providers are subject to various Laws and regulations pertaining to privacy of health information, including, without limitation, the following:

Compliance with Laws:

- 45 CFR Part 160 General Administrative Requirements;

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- 45 CFT Part 164, Security and Privacy;
- The Health Information Technology for Economic and Clinical Health Act (HITECH);
- 42 CFR Part 2 (Part 2) Confidentiality of Substance Use Disorder Patient Records;
- 42 CFR 432 State Organization and General Administration; Subpart F Safeguarding Information on Applicants and Recipients;
- RCW 70.12 Uniform Health Care Information Confidentiality Act; and
- RCW 70.02.230 Mental health services, confidentiality of records-Permitted disclosures.
- State Medical Privacy Laws and Regulations.
- Providers must be aware that they are required to comply with the law or regulation that is the most stringent in each circumstance and should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Workforce members will use and disclose PHI only as permitted under HIPAA, Part 2 and Washington law. Workforce members will provide additional protections for Part 2 Information, mental health information, and sexually transmitted disease information as Required by Law.

- **Minimum Necessary.** When using, disclosing, or requesting PHI, Workforce members will make reasonable efforts to limit the use, disclosure, or request to the minimum necessary to accomplish the intended and permissible purpose of the use, disclosure, or request, to the extent required by HIPAA, Part 2, Washington law and in accordance with Thurston-Mason BH-ASO Policy 2030 Minimum Necessary in PHI Use Disclosure and Requests. For example, it would be improper to disclose everything in an Individual's file if the recipient of the information needs only one (1) specific piece of information. A general guideline for disclosure of confidential information is to disclose only the minimum necessary, for only as long as is necessary and to only necessary recipients considering the purpose of the communication.
- **Authorization.** For any uses and disclosures of PHI not specifically permitted by law or Required by Law, Providers must obtain an authorization by the Individual or the Individual's Authorized Representative. See Policy 2025 Use and Disclosures of PHI Requiring Patient Authorization.
- **No Marketing or Sale of PHI.** Providers will not engage in Marketing or Sale of PHI unless it meets an exception recognized by HIPAA and Washington law or obtains a valid authorization by or on behalf of the Individual.

Inadvertent Disclosures of PHI

Thurston-Mason BH-ASO may, on occasion, inadvertently misdirect or disclose PHI pertaining to Thurston-Mason BH-ASO Individual(s) who are not the clients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Thurston-Mason BH-ASO Individual in order to protect their privacy. The Provider agrees to not further use or disclose such PHI, unless otherwise permitted by Law.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Privacy Rights

Individuals are afforded various rights under HIPAA. Thurston-Mason BH-ASO Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

Notice of Privacy Practices

Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide individuals with a notice of privacy practices that explains privacy rights and the process the individual should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

Requests for Restrictions on Uses and Disclosures of PHI

Individuals may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

Requests for Confidential Communications

Individuals may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the individual.

Requests for Access to PHI

Individuals have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Individual's care or payment for care.

Request to Amend PHI

Individuals have a right to request that the Provider amend information in their designated record set.

Request Accounting of PHI Disclosures

Individuals may request an accounting of disclosures of PHI made by the Provider during the preceding ten (10) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

PHI Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Thurston-Mason BH-ASO Individual and PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care. Providers are to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Thurston-Mason BH-ASO.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Thurston-Mason BH-ASO and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days of the change. Providers must use their NPI on all Encounters submitted to Thurston-Mason BH-ASO.

42 CFR Part 2

Part 2 Information means any records containing information, whether recorded or not, received or acquired by a Part 2 Program that identifies an Individual as a recipient of services from a Part 2 Program. (e.g., diagnosis, Treatment and referral for Treatment information, billing information, emails, voice mails, and texts). Essentially, Part 2 Information will state or suggest the Individual has a SUD or has been treated by a Part 2 Program.

Part 2 Program means a federally assisted program engaged in the provision of SUD diagnosis, treatment, or referral for treatment. Part 2 means those regulations at 42 CFR Part 2 related to the confidentiality of substance abuse disorder treatment information.

Business Associate and Qualified Service Agreements

Thurston-Mason BH-ASO will determine whether any vendor, independent contractor, or Subcontractor is a Business Associate

and/or a Qualified Service Organization (QSO). The Thurston-Mason BH-ASO will not permit a Business Associate/QSO to create, receive, maintain, or transmit any PHI, including Part 2 information, unless the Business Associate QSO first provides written assurances, usually in the form of a BAA/QSO.

Business Associate Agreement (BAA)

A BAA is written assurance from a Business Associate to permit the Business Associate to create, receive, maintain, or transmit PHI on behalf of a Covered Entity or upstream Business Associate. A BAA, in part, establishes the Business Associate's: permitted or required uses and disclosures of PHI; obligations to safeguard PHI; and facilitation of the rights of Individuals with respect to PHI. At a minimum, the BAA must contain the language required by HIPAA for a BAA. A BAA may take many forms including a stand-alone contract, addendum to a service contract, or amendment to a contract. Thurston-Mason BH-ASO, at times, will be contracting both with Business Associates and as a Business Associate. The provider must submit the HIPAA Business Associate Satisfactory Assurances Attestation form annually on December 15th.

Qualified Service Organization or "QSO"

A person or entity who provides services to a Part 2 Program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and has entered into a written Qualified Service Agreement (QSA) or QSOA with a Part 2 Program.

Additional Requirements for Delegated Providers

Providers that are delegated for Utilization Management activities are the "business associates" of Thurston-Mason BH-ASO. Under HIPAA and 42 CFR Part 2 Thurston-Mason BH- ASO must obtain contractual assurances from all business associates that they will safeguard PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Chapter Eleven

SECTION 11.0: PROGRAM INTEGRITY

See Thurston-Mason BH-ASO Program Integrity Policies:

- 201 Program Integrity Guidelines
- 202.01 Excluded Provider Monitoring Process
- 203 Remedial Actions
- 205 Compliance Plan
- 206 Employee Code of Conduct – Business and Professional Practice Standards
- 206.01 Thurston-Mason BH-ASO Code of Ethics and Standards of Conduct
- 207 Subcontractual Relationships and Delegation
- 209 Whistleblower
- 210 Civil Money Payments and Assessments
- 211 Contracting Funds
- 212 Fraud, Waste, and Abuse

Thurston-Mason BH-ASO is committed to ensuring it and its' Network Providers comply with all elements of Program Integrity through its Compliance Program. Thurston-Mason BH-ASO expects it provider network to deliver services in compliance with federal and state laws and regulations, as well as policies and procedures. In addition, it expects the individuals served to be responsible in helping providers prevent fraud, waste and abuse by being aware of fraud prevention and the appropriate way to utilize their benefits.
Program Integrity will be performed through the following:

Compliance Program
Thurston-Mason BH-ASO's Compliance Program includes the seven elements of an effective compliance program as defined by the US Federal Sentencing Guidelines:

- **Standards and Procedures**: Written standards of conduct and policies and procedures that promote the organization's commitment to compliance.
- **Oversight**: A Compliance Officer and Compliance Committee to provide oversight of the program with the Compliance Officer having direct access to the Governing Board.
- **Education and Training**: Mandatory for all new hires within the organization and at the Provider level, with annual training for all personnel.
- **Monitoring and Auditing**: Avenues for identify potential areas of risk and detecting criminal conduct.
- **Reporting Guidelines**: Processes to receive anonymous complaints and to allow complaints from personnel without any fear of retaliation – hotline and email.
- **Enforcement and Discipline**: Responding to allegations of improper activities and taking reasonable steps to prevent or deter non-compliant behavior.
- **Response and Prevention**: Triaging and handling investigations and ensuring non-employment or retention of sanctioned individuals.

This program has the commitment of everyone at Thurston-Mason BH-ASO, including the Governing Board, Advisory Board, executives, management, employees, vendors and others associated with Thurston-Mason BH-ASO.

The program provides education, conducts investigations where there are allegations of misconduct, takes part in monitoring activities, such as audits, to assess areas of risk within the organization.

This program provides a pro-active approach to compliance thereby helping the organization maintain its commitment to the highest level of compliance and ethical standards.

Code of Ethics and Standards of Conduct

The Thurston-Mason BH-ASO Code of Ethics is designed to ensure that all individuals associated with Thurston-Mason BH-ASO conduct themselves with the highest degree of integrity and uphold the values of Thurston-Mason BH-ASO. As further described below, each employee (paid, volunteer, or intern), officer, Governing Board member, and Network Providers are expected to:

- Conduct themselves in accordance with ethical principles that reflect the highest standard of corporate and individual behavior.
- Foster an environment in which all employees of Thurston-Mason BH-ASO and contractors are treated fairly and with respect.
- Conduct themselves in accordance with Thurston-Mason BH-ASO's values.
- Avoid all conflicts of interest between work responsibilities and personal affairs.
- Abide by all applicable laws, regulations, policies and procedures in all work performed on behalf of or under contract with Thurston-Mason BH-ASO.
- Ensure the spirit of the law is obeyed, not just the letter of the law.
- Report any violations of law, regulation, policy or procedure by any Thurston-Mason BH-ASO employee, officer, Governing Board Member of Network Providers.

In furtherance of maintaining and promoting Thurston-Mason BH-ASO's reputation for excellence and integrity, the Governing Board has promulgated these Standards of Conduct, which sets forth the general principles to which Thurston-Mason BH-ASO subscribes, and to which Thurston-Mason BH-ASO expects each Thurston-Mason BH-ASO employee, officer, Governing Board member, and Network Provider to adhere.

These standards have been derived from federal, state, and local laws and regulations, Thurston-Mason BH-ASO policies and procedures, contractual and grant obligations, and generally accepted principles of ethical conduct. In adopting these Standards of Conduct, the Thurston-Mason BH-ASO Governing Board expresses its clear commitment to compliance and high standards of professional conduct. Standards of Conduct include elements of the following:

- Respect for and compliance with the law
- Compliance with all contract terms and conditions
- Fraud, Waste, and Abuse (as described in detail below)
- Respect for the rights and dignity of others
- Highest standards of individual care
- Conducting business practices with honesty and integrity
- Conflicts of interest
- Taking opportunities for personal gain
- Confidentiality
- Organization assets and resources
- Fair employment practices
- Use of company technological and information resources
- Prohibiting acceptance of gifts and entertainment

Thurston-Mason BH-ASO employees and its Network Providers and vendors (to include volunteers and board members) shall receive orientation and training in compliance policies and procedures, to include a copy of the Compliance Plan and annual training on the Compliance Program. This includes written acknowledgement from the person that they have read, reviewed, and understood the contents of the Compliance Program.

Thurston-Mason BH-ASO employees and its Network Providers and vendors (to include volunteers and board members) shall also receive an annual training on Fraud and Abuse – to include information on how to identify potential sources of fraud and abuse, how to report suspected fraud and abuse, and assurances that reporting suspected fraud and abuse will **not** result in retaliation or retribution by the employee's supervisor.

- Training is provided upon hire by Thurston-Mason BH-ASO through the Thurston-Mason BH-ASO Compliance Training Program and 206.01 Thurston-Mason BH-ASO Code of Ethics and Standards of Conduct and monitoring is completed by annual attestations.

Exclusions and debarment monitoring and reporting

Thurston-Mason BH-ASO monitors for exclusions and sanctions of individuals and Providers upon credentialing and recredentialing and monthly to ensure it does not employ or contract with anyone that is excluded from participation in any State or Federal health care program. Thurston-Mason BH-ASO will not contract with any Provider that is presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded in any Washington State of federal department or agency from participating in transactions. Thurston-Mason BH-ASO requires subcontractors to screen as follows:

- An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR § 455.104(a), and 42 § CFR 1001.1001(a)(1)).
- The Contractor's directors, officers, employees, interns, volunteers, board members, and partners prior to entering a contractual, employment, or other relationship.
- Individuals and entities with an ownership or control interest of at least five percent (5%) of the Contractor's equity prior to entering a contractual or other relationship.
- Individuals with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract.

For a Provider under a Behavioral Health Contract with Thurston-Mason BH-ASO, the Provider is required to perform monthly exclusion checks through each of the following systems:

- Exclusion on the Office of Inspector General (OIG) and List of Excluded Individuals and Entities (LEIE) query. (https://oig.hhs.gov/exclusions/exclusions_list.asp)

- Sanctions by the Excluded Parties List System (EPLS) on the Systems for Awards Management (SAM) site. (https://sam.gov/portal/SAM/#1)
- Verification of state Medicaid Exclusions sites where required. (https://www.hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/provider-termination-and-exclusion-list)

The Provider shall maintain records of all monthly exclusion checks which may be audited by Thurston-Mason BH-ASO, during administrative reviews, or at any time Thurston-Mason BH-ASO or HCA chooses to monitor for Program Integrity.

- The Provider must make available exclusion records showing names of every individual searched through each of the systems listed. If the Provider uses a process where the exclusion databases are downloaded and cross referenced with a 'duplicates' query, the Provider must be able to demonstrate their process and provide copies of the database search results.

The Provider shall submit the annual Exclusion Attestation Form, provided by Thurston-Mason BH-ASO, by January 31st of that year. Reports shall be submitted to program.integrity@tmbho.org.

  - If the monthly exclusion checks reveal that an individual and/or Provider or any other person with 5% or more ownership has been excluded, suspended, or debarred through any one of the systems listed above, the Provider must: Report any exclusions discovered within five business days to the Thurston-Mason BH-ASO Compliance Officer and include the following information:
    - Individual provider/entities' name;
    - Individual provider/entities' NPI number;
    - Source of termination;
    - Nature of the termination; and
    - Legal action against the individual/entities.

- If it is an individual or an individual employed by the Provider, Thurston-Mason BH-ASO shall require the employee to **immediately** stop providing any services regarding Thurston-Mason BH-ASO funded services.
- If it is a director, officer, partner or other individual with 5% or more ownership, the Thurston-Mason BH-ASO shall **immediately** follow contract termination procedures per the General Terms and Conditions.

Thurston-Mason BH-ASO shall report any exclusions to HCA within 10 business days, per reporting requirements, or any successor. Thurston-Mason BH-ASO will not provide payment for any services provided by an excluded individual. Thurston-Mason BH-ASO may recoup payments for any services that were provided by an excluded individual.

SECTION 11.1: COMPLIANCE AND OVERSIGHT MONITORING

The Network Provider must adhere to all Thurston-Mason BH-ASO Policies, that guide and require Network Providers officers, employees, agents, and Subcontractors to comply with Program Integrity requirements.

Information on Persons Convicted of Crimes and Reporting

Along with notifying Thurston-Mason BH-ASO, the Network Provider will investigate and disclose to HCA immediately upon becoming aware of any person in their employment who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act since the inception of those programs.

Fraud, Waste, and Abuse, See also Thurston-Mason BH-ASO Policy 212 Fraud, Waste and Abuse

Thurston-Mason BH-ASO is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Thurston-Mason BH-ASO's Compliance program maintains a comprehensive plan, which addresses how Thurston-Mason BH-ASO will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste and abuse prevention and detection along with and the education of appropriate

employees, vendors, Providers and associates doing business with Thurston-Mason BH-ASO.

- Thurston-Mason BH-ASO regards behavioral health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in anefficient and affordable manner. Thurston-Mason BH-ASO has therefore implemented a plan to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality behavioral health care.
- Thurston-Mason BH-ASO requires all Providers to have the following safeguards in place to prevent Fraud, Waste, and Abuse as also outlined in General Terms and Conditions, Fraud and Abuse:
    - A process to inform officers, employees, agents, and Network Providers of the False Claims Act;
    - An administrative procedure to detect and prevent fraud, waste, and abuse outlined in the Provider Compliance Plan;
    - Standards of conduct that articulate the Network Providers commitment to comply withall Thurston-Mason BH-ASO and applicable federal and state standards;
    - The designation of a Compliance Officer and a Compliance Committee thatis accountable to senior management;
    - Training for all affected parties;
    - Effective lines of communication between the Compliance Officer and employees;
    - Enforcement of standards through well-publicized disciplinary policies;
    - Provision for internal monitoring and auditing of services provided;
    - Provision for prompt response to detected violations, and for development of corrective action initiatives;
    - Provision of detailed information to employees regarding fraud and abuse policies and procedures and the False Claims Act and the Washington false claims statutes, Chapter 74.66 RCW and RCW 74.09.210.

Referring of Allegations of Potential Fraud, Invoking Provider Payment Suspensions, and Reporting

Thurston-Mason BH-ASO shall establish policies and procedures for referring all identified allegations of potential Fraud to HCA, as well as for the provider payment suspensions. When HCA notifies Thurston-Mason BH-ASO that a credible Allegation of Fraud exists, Thurston-Mason BH-ASO shall follow up the provisions for payment suspension as outlined in this Policy.

- When Thurston-Mason BH-ASO has concluded that an allegation of potential Fraud exists, Thurston-Mason BH-ASO shall make a Fraud referral to HCA within five (5) business Days of the determination. The referral must be emailed to HCA at HotTips@hca.wa.gov. Thurston-Mason BH-ASO shall report using the WA Fraud Referral Form.
- When HCA determines Thurston-Mason BH-ASO's referral of potential Fraud is a credible Allegation of Fraud, HCA shall notify Thurston-Mason BH-ASO's Compliance Officer.
    - To suspend provider payments, in full, in part, or if a good cause exception exists to not suspend.
        - Unless otherwise notified by HCA to suspend payment, Thurston-Mason BH-ASO shall not suspend payment of any provider(s) identified in the referral.
    - Whether HCA or appropriate law enforcement agency, accepts or declines the referral.
        - If HCA or appropriate law enforcement agency accepts the referral, Thurston-Mason BH-ASO must "stand-down" and follow the requirements in the Investigation section of this Policy.
    - If HCA or appropriate law enforcement agency decline to investigate the potential Fraud referral, Thurston-Mason BH-ASO may proceed with its own investigation and comply with the Reporting Requirements in this Policy.
- Upon receipt of payment suspension notification from HCA, Thurston-Mason BH-ASO shall send notice of the decision to suspend program payments to the provider within five (5) calendar days of HCA's notification to suspend payment, unless an appropriate law enforcement agency requests a temporary withhold of notice.

- The notice of payment suspension notification must include or address all of the following:
    - State that payments are being suspended in accordance with this provision;
    - Set forth the general allegations identified by HCA. The notice should not disclose any specific information concerning an ongoing investigation;
    - State that the suspension is for a temporary period and cite suspension will be lifted when notified by HCA that it is no longer in place;
    - Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and,
    - Where applicable and appropriate, inform the provider of any Appeal rights available to this provider, along with the provider's right to submit written evidence for consideration by the Healthcare Authority.
- All suspension of payment actions under this Policy will be temporary and will not continue after either of the following:
    - Thurston-Mason BH-ASO is notified by HCA or appropriate law enforcement agency that there is insufficient evidence of Fraud by the provider; or
    - Thurston-Mason BH-ASO is notified by HCA or appropriate law enforcement agency that the legal proceedings related to the provider's alleged Fraud are completed.
- Thurston-Mason BH-ASO must document in writing the termination of a payment suspension and issue a notice of the termination to the provider. A copy must be sent to HCA at programintegrity@hca.wa.gov.
- HCA may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible Allegation of Fraud if any of the following are applicable:
    - A law enforcement agency has specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
        - Other available remedies are available to Thurston-Mason BH-ASO, after HCA approves the remedies as more effective or timely to protect Medicaid funds.
        - HCA determines, based upon the submission of written evidence by Thurston-Mason BH-ASO, individual or entity that is the subject of the payment suspension, there is no longer a credible Allegation of Fraud and that the suspension should be removed. HCA shall review evidence submitted by Thurston-Mason BH-ASO or provider. Thurston-Mason BH-ASO may include a recommendation to HCA. HCA shall direct Thurston-Mason BH-ASO to continue, reduce, or remove the payment suspension within thirty (30) calendar days of having received the evidence.
        - Individual's access to items or services would be jeopardized by a payment suspension because of either of the following:
            - An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
            - The individual or entity serves a large number of Individuals within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.
        - A law enforcement agency declines to certify that a matter continues to be under investigation.
        - HCA determines that payment suspension is not in the best interests of the Medicaid program.
- Thurston-Mason BH-ASO shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:
    - Details of payment suspensions that were imposed in whole or in part; and
    - Each instance when a payment suspension was not imposed or was discontinued for good cause.

- If Thurston-Mason BH-ASO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible Allegation of Fraud without good cause, and HCA directed Thurston-Mason BH-ASO to suspend payments, HCA may impose sanctions in accordance with the Sanctions Subsection of the HCA BH-ASO contract.
- If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery belongs exclusively to the state of Washington and Thurston-Mason BH-ASO and any involved subcontractor have no claim to any portion of this recovery.
- Furthermore, Thurston-Mason BH-ASO is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the state of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims Thurston-Mason BH-ASO or subcontractor has or may have against any entity or individual that directly or indirectly receives funds under the HCA BH-ASO contract including, but not limited to, any Health Care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, Medical Equipment, or other health care related products or services.
- Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

Reporting Fraud, Waste and Abuse

Thurston-Mason BH-ASO Providers have a responsibility to raise questions about business ethics and regulatory compliance, to report incidents of potential non-compliance and to report suspected fraud and abuse identified during performing work responsibilities to Thurston-Mason BH-ASO Compliance Officer.

- Thurston-Mason BH-ASO shall submit to HCA a report of any recoveries made, or overpayments identified by the Thurston-Mason BH-ASO during the course of claims review/analysis. The report must be submitted to HCA at programintegrity@hca.wa.gov.
- Thurston-Mason BH-ASO is responsible for investigating Individual Fraud, waste and abuse, see section below, Investigation**. If Thurston-Mason BH-ASO suspects Client Fraud at any time during the investigation process, Thurston-Mason BH-ASO shall**:
    - Notify and submit all associated information of any alleged or investigated cases in which Thurston-Mason BH-ASO believes there is a serious likelihood of Fraud by an individual to the HCA Office of Medicaid Eligibility and Policy (OMEP) by any of the following:
        - Sending an email to WAHeligibilityfraud@hca.wa.gov;
        - Calling OMEP at 360-725-0934 and leaving a detailed message;
        - Mailing a written referral to:

          Health Care Authority
          Attn: OMEP
          P.O. Box 45534
          Olympia, WA 98504-5534
        - Faxing the written complaint to Washington Apple Health Eligibility Fraud at 360-725-1158.
- Thurston-Mason BH-ASO, its employees, board members, and subcontractors shall be able to report anonymously without fear of retaliation, any suspected non-compliance or concerns of Fraud, Waste, and Abuse 24 hours a day to the Thurston-Mason BH-ASO Compliance Officer by:
    - Calling the Compliance Hotline at (800) 867-7130;
    - Emailing to program.integrity@tmbho.org; or
    - Making a report directly to the Compliance Officer.
- Thurston-Mason BH-ASO shall notify and submit all associated information of any alleged or investigated cases in which Thurston-Mason BH-ASO believes there is a serious likelihood of provider Fraud by an

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individual or group using the WA Fraud Referral Form within five (5) business days from the date of determining an allegation of potential Fraud exists.

Review of Provider Claims and Claims System

Thurston-Mason BH-ASO fiscal staff are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the fiscal staff suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Officer.

The encounter payment system utilizes system edits to validate elements of encounters are billed in accordance with standardized billing practices; ensure that encounters are processed accurately and ensure that payments reflect the service performed as authorized.

Thurston-Mason BH-ASO performs auditing to ensure the accuracy of data input into the data system. The Information Services department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

On-Site Inspections and Post-payment Recovery Activities

Upon request, the Provider shall allow HCA, Thurston-Mason BH-ASO or any authorized state or federal agency or authorized representative, access to all records pertaining to this Contract and the HCA BH-ASO Contract, including computerized data stored by the Provider. The Provider shall provide and furnish the records at no cost to the requesting agency. Documents and records must be readily accessible at the location where the Provider provides services. The Provider shall assist the auditing agency during the review, including the provision of complete copies of records. Auditable documents and records include, but are not limited to, medical charts; billing records; financial records; any record related to services rendered, quality, appropriateness, and timeliness of service; any record relevant to an administrative, civil or criminal investigation or prosecution; and coordination of benefits information. Production of auditable documents and complete copies of records must be provided in a timely manner, as requested by the authorized representative. In the event Thurston-Mason BH-ASO or HCA or another state or federal agency or authorized representative identifies fraud, waste or abuse, the Provider agrees to repay funds or Thurston-Mason BH-ASO may seek recoupment.

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

If a Thurston-Mason BH-ASO auditor is denied access to Provider's records, all of the encounters for which the Provider received payment from Thurston-Mason BH-ASO is immediately due and owing. If the Provider fails to provide all requested documentation for any encounter, the entire amount of the paid encounter is immediately due and owing. Thurston-Mason BH-ASO may offset such amounts against any amounts owed by Thurston-Mason BH-ASO to the Provider. Encounters for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to recoupment.

Provider Education

When Thurston-Mason BH-ASO identifies through an audit or other means a situation with a Provider (e.g. coding, billing) that is either inappropriate or deficient, Thurston-Mason BH- ASO may determine that a Network Provider education visit is appropriate.

Remedial Action

See also Thurston-Mason BH-ASO Policy 203 Remedial Actions

Thurston-Mason BH-ASO may initiate remedial action if it is determined that any of the following situations exist:

- The network provider has failed to perform any of the behavioral health services required.

- The network provider has failed to develop, produce, and/or deliver to Thurston-Mason BH-ASO any of the statements, reports, data, data corrections, accountings, encounters, and/or documentation described, in compliance with all of the provisions of the Subcontract.
- The network provider has failed to perform any administrative function required under the Subcontract. Administrative function is defined as any obligation other than the actual provision of behavioral health services.
- The network provider has failed to implement corrective action required by Thurston-Mason BH-ASO and within prescribed timeframes.

Thurston-Mason BH-ASO may impose any one or more of the following remedial actions in any order:

- Require the network provider to develop and execute a corrective action plan. Corrective action plans developed by the Subcontractor must be submitted for approval to Thurston-Mason BH-ASO within thirty (30) calendar days of notification. Corrective action plans may require modification of any policies or procedures by the network provider relating to the fulfillment of its obligations pursuant to the Subcontract. Thurston-Mason BH-ASO may extend or reduce the time allowed for corrective action depending upon the nature of the situation.
    - Corrective action plans must include:
        - A brief description of the situation requiring corrective action.
        - The specific actions to be taken to remedy the situation.
        - A timetable for completion of the actions.
        - Identification of individuals responsible for implementation of the plan.
    - Corrective action plans are subject to approval by Thurston-Mason BH-ASO, which may:
        - Accept the plan as submitted.
        - Accept the plan with specified modifications.
        - Request a modified plan.
        - Reject the plan.
    - Any corrective action plan that was in place as part of a previous Subcontract shall be applied to the current Subcontract in those areas where the Subcontract requirements are substantially similar.
- Withhold up to five percent of the next payment and each payment thereafter if the Contractor fails to submit, gain Thurston-Mason BH-ASO approval of or implement the requested corrective action plan within agreed upon timeframes. The amount of withhold will be based on the severity of the situation. Thurston-Mason BH-ASO, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.
    - Increase withholdings by up to an additional three (3) percent for each successive month during which the corrective action plan has not been submitted or implemented.
- Deny any incentive payment to which the network provider might otherwise have been entitled under the Subcontract or any other arrangement by which Thurston-Mason BH-ASO provides incentives.
- Terminate for Default as described in the General Terms and Conditions; this may include following the procedures in Thurston-Mason BH-ASO Policy 1008, Provider Network Selection to ensure a Network Provider delivers the service(s) that are terminated, as it relates to the Network Provider's contract.

Thurston-Mason BH-ASO will:

- Evaluate the Subcontractor's performance prior to imposing a remedial action.
- Monitor activity on a consistent basis.
- Evaluate data quarterly and/or when necessary.
- Determine if a trend is emerging and whether the Subcontractor is failing to meet contract requirements.
    - Based on this determination, remedial action may be initiated, unless otherwise agreed to.

- Allow Subcontractor 30 days from receipt of remedial action letter to submit a corrective action plan. The Subcontractor shall have 60 days for implementation of the accepted plan, with the exception of a situation that poses a threat to the health or safety of any person or that poses a threat of property damage and/or an incident has occurred that resulted in injury or death to any person and/or that resulted in damage to property, for which immediate action shall be required.
- Maintain an internal process for reporting and tracking remedial actions issued by Thurston-Mason BH-ASO and corrective actions provided by the Subcontractor using the Behavioral Health Agency Monitoring Report.

Chapter Twelve

SECTION 12.0: ADVANCE DIRECTIVE

See Thurston-Mason BH-ASO Policy 305 Advanced Directives.

Mental Health Advance Directives (MHAD) are a written choice for mental health care. Under Washington State Law, RCW 71.32, Provider policy and procedure must be in compliance with the law.

The Provider shall inform all individuals seeking mental health services and individuals with a history of frequent crisis system utilization of their right to a Mental Health Advance Directive and shall provide technical assistance to those who express an interest in developing and maintaining a MHAD.

Providers must document the presence of a Mental Health Advance Directive in a prominent location of the clinical record. Under no circumstances may any Provider refuse to treat an individual or otherwise discriminate against them because the individual has completed a Mental Health Advance Directive.

Providers shall inform individuals that complaints concerning noncompliance with a MHAD should be referred to the Department of Health.

Chapter Thirteen - Empty

Chapter Fourteen

SECTION 14.0: FAMILY YOUTH SYSTEM PARTNER ROUNDTABLE (FYSPRT)

1. FYSPRTs are intended to influence child serving systems and to promote proactive changes that will improve access to, and the quality of, services for families and youth with complex behavioral health challenges and the outcomes they experience. FYSPRT provides a forum for regional information exchange and problem solving, as well as an opportunity for identifying and addressing barriers to providing comprehensive behavioral health services and supports to children and youth. Thurston-Mason BH-ASO will identify a provider to deliver FYSPRT to our community and add a statement of work to their contract.

Chapter Fifteen

SECTION 15.0: MONITORING OF SUBCONTRACTS

See also Thurston-Mason BH-ASO Policy 1590 Non-Medicaid Services, General Fund State and Federal Block Grant and 800 Subrecipient Determination and Monitoring.

All activities and services shall be performed in accordance with the Contract, which are not performed directly by Thurston-Mason BH-ASO, must be subcontracted according to the terms set forth by the Thurston-Mason BH-ASO Behavioral Health Advisory Board and Governing Board approved Mental Health Block Grant (MHBG) project plan and/or Substance Abuse Block Grant (SABG) project plan.

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

The Network Provider shall retain, on site, all Subcontracts. Upon request by Thurston-Mason BH-ASO, the Network Provider will immediately make available any and all copies, versions, and amendments of Subcontracts.

FBG fee-for-service, set rate, performance-based, Cost Reimbursement, and lump sum contracts shall be based on reasonable costs.

Thurston-Mason BH-ASO will submit an annual Certification in writing to HCA that the Subcontractor meets all requirements under the HCA BH-ASO contract and that the subcontract contains all required language under the contract, including any data security, confidentiality, and/or Business Associate language as appropriate.

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

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under the Federal Drug Administration (FDA)-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned substance under federal law.

Thurston-Mason BH-ASO shall conduct and/or make arrangements for an annual fiscal review of each Provider receiving FBG funds regardless of reimbursement methodology (e.g. through fee-for-service, set rate, performance- based or cost reimbursement contracts). The annual fiscal review shall ensure that:

- Expenditures are accounted for by revenue source.
- For FBG services, the Contractor shall comply with the utilization funding agreement guidelines within the State's most recent FBG plan. The Contractor agrees to comply with Title V, Section 1911-1935 and 1941-1957 of the Public Health Services Act (42 U.S.C. §§ 300x-1 – 300x-9; 300x-21 – 300x-35; and 300x-51 – 300x-67, as amended). The Contractor shall not use FBG funds for the following:
    - Construction and/or renovation.
    - Capital assets or the accumulation of operating reserve accounts.
    - Equipment costs over $5,000.
    - Cash payments to Individuals.
- Expenditures are made only for the purposes stated in the provider's contract, and for services that were actually provided.
- As negotiated through consultation between HCA and Tribes, Thurston-Mason BH-ASO shall not request on-site inspections of Tribes, including facilitates and programs operated by Tribes or Tribal Organizations.

The Provider shall provide MHBG services to promote recovery for an adult with a SMI and resiliency for Serious Emotional Disturbance (SED) children in accordance with federal and state requirements. SABG funds shall be used to provide services to priority populations.

The Provider shall ensure that FBG funds are used only for services to individuals who are not enrolled in Medicaid or for services that are not covered by Medicaid as described below:

Benefits	Services	Use MHBG	Use Medicaid
Individual is not a Medicaid recipient	Any type	Yes	No
Individual is a Medicaid recipient	Allowed under Medicaid	No	Yes
Individual is a Medicaid recipient	Not allowed under Medicaid	Yes	No

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

Thurston-Mason BH-ASO may use block grant funds to help Individuals satisfy cost-sharing requirements for SABG-authorized SUD services or MHBG-authorized mental health services. Funds may be used to cover health insurance deductibles, coinsurance, and copayments to assist Individuals in meeting their cost sharing responsibilities. Thurston-Mason BH-ASO must ensure that:

- The Network Provider is a recipient of block grant funds;
- Cost sharing is for a block grant authorized service;
- Payments are in accordance with SABG or MHBG laws and regulations;
- Cost sharing payments are made directly to the Network Provider of the service; and,
- A report is provided to HCA upon request that identifies:
    - The number of Individuals provided cost sharing assistance;
    - The total dollars paid out for cost sharing; and,
    - Network Providers who received cost sharing funds.

Thurston-Mason BH-ASO shall reduce the amount paid to providers by any sliding fee schedule amounts collected from Individuals in accordance with Policy.

The Provider shall notify Thurston-Mason BH-ASO when Federal Block Grant funded PPW and IUID services are at 90% capacity.

Upon request by Thurston-Mason BH-ASO/HCA, the Provider shall attend or send a representative to the Washington State Behavioral Health Advisory Committee meetings to discuss priorities for future FBG supported services.

FBG requires annual peer reviews by individuals with expertise in the field of mental health treatment (for MHBG) and by individuals with expertise in the field of drug abuse treatment (for SABG) consisting of at least five percent (5%) of treatment providers. Thurston-Mason BH-ASO and Providers shall participate in a peer review process when requested HCA (42 U.S.C. § 300x- 53 (a) and 45 C.F.R. § 96.136, MHBG Service Provisions).

The Provider shall submit regional MHBG and SABG Final Reports annually for services provided in the prior state fiscal year. Reports must be provided on the current templates provided with your contract.

Chapter Sixteen

SECTION 16.0: CLINICAL PRACTICE GUIDELINES

See also Thurston-Mason BH-ASO Policy 1004 Clinical Practice Guidelines.

Thurston-Mason BH-ASO, under the oversight of the Behavioral Health Medical Director, has adopted behavioral health practice guidelines known to be effective in improving outcomes. Practice guidelines are based on the following:

- Valid and reliable clinical scientific evidence;
- In the absence of scientific evidence, professional standards; or
- In the absence of scientific evidence and professional standards, a consensus of Health Care Professionals in the

particular field.

Thurston-Mason BH-ASO has adopted guidelines from recognized sources that develop or promote evidence-based clinical practice guidelines such as voluntary health organizations, National Institute of Health Centers, or SAMHSA. If the Thurston-Mason BH- ASO did not adopt guidelines from recognized sources, board-certified Behavioral Health Professionals participated in the development of the guidelines.

The guidelines:

- Consider the needs of Individuals and support them and their family involvement in care plans.
- Are adopted in consultation with contracting Behavioral Health Professionals within the state of Washington.
- Are reviewed and updated at least every two (2) years and more often if national guidelines change during that time.
- Are disseminated to all affected providers and, upon request, to HCA and Individuals/families.

Thurston-Mason BH-ASO has included its Behavioral Health Medical Director in the evaluation of emerging technologies for the treatment of behavioral health conditions and related decisions. Thurston-Mason BH-ASO has also had a Child or Adolescent Psychiatrist available for consultation related to other emerging technologies for the treatment of behavioral health conditions in children and youth.

The Thurston-Mason BH-ASO Provider Network shall adopt and adhere to the Thurston-Mason BH-ASO Clinical Practice Guidelines. Providers will utilize the practice guidelines as a training and supervision tool for direct service clinical staff.

Chapter Seventeen

SECTION 17.0: CARE COORDINATION

See also Thurston-Mason BH-ASO Policy 1595 Care Management and Coordination and 1728 Single Bed Certification.

The Provider shall develop and implement protocols that ensure coordination, continuity, and quality of care that adhere to Thurston-Mason BH-ASO Policy 1595 Care Management and Coordination, Thurston-Mason BH-ASO Policy 1728 Single Bed Certification, and also address the following:

- Access to crisis safety plan and coordination information for individuals in crisis which includes information and data sharing.
- Providers must support care coordination through data and information sharing consistent with the HCA BH-ASO Contract.
- Care for Individuals in alternative settings such as homeless shelters, permanent supported housing, nursing homes or group homes.
- Strategies to reduce unnecessary crisis system utilization.
- Care transitions and sharing of information among jails, prisons, hospitals, residential treatment centers, detoxification and sobering centers, homeless shelters and service providers for Individuals with complex behavioral health and medical needs.
- Continuity of Care for individuals in an active course of treatment for an acute or chronic behavioral health condition, including preserving Individual- provider relationships through transitions.
- Best, good-faith efforts to schedule prescriber and other provider appointments within seven (7) calendar days of an Individual's discharge and communicate it back to the facility, including for Individuals discharging from the state hospital forensic units.
- The Provider shall coordinate with External Entities including, but not limited to:
    - Family Youth System Partner Roundtable (FYSPRT);
    - Apple Health Managed Care Organizations to facilitate enrollment of Individuals who are eligible for Medicaid;

- Tribal entities regarding tribal members who access the crisis system;
- Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHC);
- The Criminal Justice system (courts, jails, law enforcement, publicdefenders, Department of Corrections, juvenile justice system);
- State and federal agencies and local partners that manage access to housing;
- Education systems, to assist in planning for local school district threat assessment process;
- First Responders.

SECTION 17.1: TRIBAL COORDINATION

See also Thurston-Mason BH-ASO Policy 1595 Care Management and Coordination and 1733 Scope of Crisis Services.

The Thurston-Mason BH-ASO has a long-standing relationship with the Thurston-Mason Region Tribes. It is a relationship based on trust and respect. Our work with the local Tribes is a partnership working to create a culture that provides equity in services and opportunities to partner on reducing barriers to treatment.

At a minimum the Thurston-Mason BH-ASO and its Provider Network will work with local Tribes on the following services for American Indian/Alaska Native individuals in the FFS Medicaid Program who have opted out of Medicaid managed care, in coordination with the individual's IHCP, if applicable:

- Coordination for Crisis and Involuntary Commitment Evaluation Services, see information regarding Protocols for Coordination with Tribes and non-Tribal IHCPs in Policy 1733 Scope of Crisis Services.
- Joint meetings shall be conducted in accordance with the HCA government-to- government relationship with Washington Tribes.
- Invite Tribal representation on Family Youth Partner System Roundtable as community system partners.
- Ensure Tribal representation is invited to Thurston-Mason BH-ASO hosted meetings and events.

SECTION 17.2: DISCHARGE PLANNING

Providers will provide discharge planning services to all individuals exiting services to ensure individuals and families have the resources necessary to transition back into services and the community.

Providers will conduct the following activities as part of the discharge planning process:

- Coordinate a community-based discharge plan for each Individual served under the Contract beginning at intake. Discharge planning shall apply to all Individuals regardless of length of stay or whether they complete treatment.
- Coordinate exchange of assessment, admission, treatment progress, and continuing care information with the referring entity. Contact with the referral agency shall be made within the first week of residential treatment
- Establish referral relationships with assessment entities, outpatient providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of entities making referrals in treatment activities;
- Coordinate, as needed, with DBHR prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including the DCYF, and the DSHS Economic Services Administration including Community Service Offices (CSOs), Tribal governments and non-Tribal IHCPs
- Coordinate services to financially-eligible Individuals who are in need ofmedical services.

Evaluation & Treatment Facility Discharge Planners

E&T Discharge Planners shall be provided within the identified resources in the Provider Contract. Thurston-Mason BH-ASO shall pay the Provider upon receipt and acceptance by Thurston-Mason BH-ASO of verification that an E&T Discharge Planner position has been fully staffed by an individual whose sole function is the E&T Discharge Planner role, as described in Policy.

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

The Provider shall submit to Thurston-Mason BH-ASO the E&T Discharge Planner's reports that track the total number of all discharges from their E&T location and differentiate between those that were deemed complex and those that were deemed standard. The report is due the tenth (10th) of the month following the month being reported.

Chapter Eighteen

SECTION 18.0: DISASTER RESPONSE

The Provider must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by HCA and/or Thurston-Mason BH-ASO. The Provider shall:

- Attend Thurston-Mason BH-ASO and HCA-sponsored training regarding the role of the public behavioral health system in disaster preparedness and response.
- Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.
- Provide Disaster Outreach in Provider's Service Area in the event of a disaster/emergency; "Disaster Outreach" means contacting person's in their place of residence or in non-traditional settings for the purpose of assessing their behavioral health and social functioning following a disaster. This also includes a determination if additional behavioral health services and resources are needed as a result of a disaster.
- There are two 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:
    - Locating persons in need of disaster relief services.
    - Assessing their needs.
    - Engaging or linking persons to an appropriate level of support or disaster relief services.
    - Providing follow-up behavioral health services when clinically indicated.

Chapter Nineteen

SECTION 19.0: STATE FUNDED SPECIALIZED PROGRAMS

SECTION 19.1: ASSISTED OUTPATIENT TREATMENT

Funds received to support Assisted Outpatient Treatment (AOT) is a State Legislative Proviso. AOT is an order for Less Restrictive Alternative Treatment for up to ninety days from the date of judgment and does not include inpatient treatment. See also Thurston-Mason BH-ASO Policy 1734 Assisted Outpatient Treatment.

SECTION 19.2: DEDICATED CANNABIS ACCOUNT

Dedicated Cannabis Account (DCA) funds are to be provided within the identified resources in the contract with Thurston-Mason BH-ASO.

DCA Funding can provide:

- Outpatient and residential SUD treatment for youth and children;
- Youth drug courts; and,

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- Programs that support intervention, treatment, and recovery support services for middle school and high school aged students.

DCA funds shall be used to fund Substance Use Disorder treatment services for youth living at or below two hundred and twenty percent (220%) of the federal poverty level, without insurance coverage or who are seeking services independent of their parent/guardian.

DCA funds may be used for development, implementation, maintenance, and evaluation of programs that support intervention, treatment, and Recovery Support Services for middle school and high school aged students.

All new programs and services must direct at least eighty-five percent (85%) of funding to evidence-based or research-based programs and practices that produce objectively measurable results and are expected to be cost beneficial.

Up to fifteen percent (15%) of the funds appropriated for new programs and new services may be used to provide support to proven and tested practices, emerging best practices or promising practices.

Chapter Twenty

SECTION 20.0: STATEMENTS OF WORK

SECTION 20.1: BEHAVIORAL HEALTH OUTPATIENT SERVICES STATEMENT OF WORK

1. Within available non-Medicaid funds, behavioral health services may be authorized on a limited basis by Thurston-Mason BH-ASO.
2. If it is determined that an individual meets Service Eligibility criteria in Section 2.1 (above) and the individual meets medical necessity criteria, the Provider may provide non-crisis behavioral health services to individuals.
3. Behavioral health services must adhere to WAC 246-341 and may include any or all of the services in Exhibit A Scope of Services.
4. Within available non-Medicaid funds, the following services may be authorized on a limited basis by Thurston-Mason BH-ASO. Medical necessity does not apply to the following:
    a. Other services
        1) Alcohol/Drug Information School
        2) Childcare
        3) Community Outreach-Substance Abuse Block Grant (SABG) priority populations PPW and IUID
        4) Continuing Education and Training
        5) PPW Housing Support Services
        6) Recovery Support Services
        7) Sobering Services
        8) Therapeutic Interventions for Children
        9) Transportation

5. The Provider shall adopt a standardized risk assessment instrument that will assist in determining future crisis prevention services. The Provider shall perform a risk assessment when it is clinically indicated and in the best interest of the individual. If it determined a crisis plan is required, the plan (see also Thurston-Mason BH-ASO Policy 1587 Crisis Planning):
    a. Shall be written with the individual and other natural supports, as available.
    b. Can be written in the form of an advance directive.
    c. Shall include the following elements:

i. Date completed;
ii. Dependent record, to include information on persons and pets;
iii. Prescriber name;
iv. Prescriber phone number;
v. Any current substance use disorder issues;
vi. High risk and de-compensation patterns; and,
vii. Plan for care providers, emergency personnel and other who might be responding to the actual crisis.

d. The Provider shall ensure the individual is provided with a copy of their crisis plan upon completion.
e. The crisis plan shall be reviewed and/or updated every six (6) months until no longer clinically necessary.

SECTION 20.2: COMMUNITY HOSPITAL PSYCHIATRIC SERVICES STATEMENT OF WORK

PURPOSE

To provide a standardized protocol for inpatient psychiatric services funded solely or in part through non-Medicaid funds.

INPATIENT PSYCHIATRIC HOSPITAL LEVEL OF CARE CRITERIA

Case specific UM review decisions maintain the following Level of Care Guidelines for making authorizations, continued stay, and discharge determinations:

1. Medically necessary as defined in WAC 182-500-0070 and the following:
    a. Ambulatory care resources available in the community do not meet the treatment needs of the individual; AND
    b. Proper treatment based on the acuity of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170); AND
    c. The individual's Level of Care Utilization System (LOCUS/CALOCUS/CANS) assessment warrants medically monitored inpatient psychiatric services; AND
    d. Services can reasonably be expected to improve the individual's level of functioning or prevent further regression of functioning; AND
    e. The individual has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder and warrants extended care in the most intensive and restrictive setting; OR
    f. The individual was evaluated and met the criteria for emergency involuntary detention (RCW 71.05 or 71.34) but agreed to inpatient care.
2. Approved (ordered) by the professional in charge of the hospital or hospital unit; and
3. Certified or authorized by the Thurston-Mason BH-ASO.
4. Involuntary inpatient psychiatric care must be in accordance with the admission criteria specified in RCW 71.05 and 71.34.
5. All services will be provided that are:
    a. Culturally and linguistically competent;
    b. Working towards recovery and resiliency; AND
    c. Appropriate to the age and developmental stage of the individual.

PROVIDER REQUIREMENTS

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Inpatient psychiatric care, as defined in WAC 246-320 and 246-322, shall be provided by one of the following Department of Health (DOH) licensed hospitals or units:

1. Free-standing psychiatric hospitals determined by the Health Care Authority (HCA) to meet the federal definition of an Institution for Mental Diseases (IMD), which is: "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care and related services".
2. Medicare-certified, distinct psychiatric units, or State-designated pediatric psychiatric units.
3. In addition to DOH licensure, hospitals providing involuntary hospital inpatient psychiatric care must be certified in accordance with WAC 246-341-1131 and 246-341-0365.

CONSENT FOR TREATMENT

Individuals 18 years of age and older may be admitted to voluntary treatment only with the individual's voluntary and informed written consent, a properly executed advance directive that allows for admission when the Individual is unable to consent, or the consent of the individual's legal representative when appropriate. Individuals 13-17 years of age may be admitted to treatment only with the permission of:

1. The minor and the minor's parent/legal guardian; or
2. The minor without parental consent; or
3. The minor's parent/legal guardian without the minor's consent (Parent-Initiated Treatment [PIT]). (It is treated as a voluntary stay for utilization management purposes).
4. Individuals 12 years of age and under may be admitted to treatment only with the permission of the minor's parent/legal guardian.

AUTHORIZATION REQUIREMENTS FOR INPATIENT HOSPITAL PSYCHIATRIC CARE

The hospital must obtain authorization for payment from Thurston-Mason BH-ASO for all voluntary inpatient hospital psychiatric stays when the Thurston-Mason BH-ASO is the payor. See Section 2.13 Utilization Management for the process to request an authorization.

Hospitals shall provide all required clinical data for authorization of services.

TIMEFRAMES FOR AUTHORIZATION DECISIONS

Length-of-Stay – Concurrent Review

1. Hospital providers requesting prior authorization for length of stay extensions shall submit requests during regular business hours. For requests that fall outside of regular business hours, Thurston-Mason BH-ASO will offer alternatives to allow the prior authorization review to occur.
2. Unless Thurston-Mason BH-ASO specifies otherwise, hospitals must submit requests for extension reviews at least 24 hours prior to the expiration of the authorized period.
3. Length-of-stay extension determinations will be made within 24 hours or one (1) business day from the request and authorized three (3) depending on clinical presentation. Once given, inpatient authorizations are not terminated, suspended, or reduced.

If the required clinical information is not received by Thurston-Mason BH-ASO to construct an authorization record within 24 hours of the request, the request will be categorized as either cancelled or withdrawn, not denied.

POST SERVICE AUTHORIZATION REQUESTS

Requests for post service authorizations (retrospective) will be considered only if the individual became eligible for GFS assistance after admission or the hospital was not notified of or able to determine eligibility for GFS funding.

PEER-TO-PEER CLINICAL REVIEWS

Thurston-Mason BH-ASO will ensure any decision to authorize or deny actions must be peer-to-peer, that is, the credential of the licensed clinician making the decision to authorize service in an amount, duration, or scope that is less than requested must be at least equal to that of the recommending clinician. A physician board-certified or board-eligible in General Psychiatry must review all inpatient level of care actions for psychiatric treatment.

INVOLUNTARY PSYCHIATRIC ADMISSIONS

1. Involuntary admissions occur in accordance with the Involuntary Treatment Act (ITA) RCW 71.05 and 71.34; therefore, no consent is required. Only individuals thirteen (13) years of age and older may be subject to the provisions of these laws. Thurston-Mason BH-ASO also authorizes services that are provided to individuals detained under ITA law when the individual either refuses to apply for, or does not qualify for, any Apple Health program. Hospitals shall document efforts to enroll eligible individuals.
2. Requests for initial authorization shall be directed to Thurston-Mason BH-ASO.
3. Notification to Thurston-Mason BH-ASO is required for all involuntary non-Medicaid admission requests within 24 hours of admission. To make a notification, the Network Provider must complete the TMBH-ASO Authorization/Notification Form, found at: https://www.tmbhaso.org/information-for-providers or click HERE for the form.
4. Requesting ITA authorization will be conducted by the hospital.
5. Required clinical information will be provided by the hospital within seventy-two (72) judicial hours of admission.
6. The number of initial days authorized for an involuntary psychiatric admission is limited to twenty (20) days from date of detention.
7. Hospitals providing involuntary treatment must submit an extension authorization request for continued stay at least twenty-four (24) hours before the expiration of the previously authorized days (WAC 182-550-2600).
8. Thurston-Mason BH-ASO cannot deny extension requests for individuals who are detained in accordance of the ITA unless another Less Restrictive Alternative (LRA) is available and approved by the court.
9. Individuals on a continuance will be granted a length-of-stay extension until their next court date. Individuals awaiting placement at Western State Hospital (WSH) or Long-Term Civil Commitment (LTCC) facilities will be granted a length-of-stay extension until admission.
10. Requests for individuals whose legal status changes from involuntary to voluntary, will be reviewed by UM and authorized or denied depending upon clinical presentation.

CHANGES IN STATUS

Changes in the individual's status include, legal, principle diagnosis, or hospital of service, should be directed to Thurston-Mason BH-ASO within 24 hours of the change of status. Thurston-Mason BH-ASO will respond with any authorization determinations within 12 hours.

ALIEN EMERGENCY MEDICAL

Thurston-Mason BH-ASO shall establish if the individual is an undocumented alien, possibly qualifying for the AEM program and will instruct the requesting hospital to assist the individual in submitting an AEM eligibility request. Thurston-Mason BH-ASO will receive the admission notification for ITA admissions and make medical necessary determinations for voluntary psychiatric admissions. The required data and clinical information includes, but is not limited to:

1. The Individual's name and date of birth;
2. The hospital to which the admission occurred;
3. If the admission is an ITA or voluntary;
4. The diagnosis code;
5. The date of admission;
6. The date of discharge;
7. The number of covered days, with dates as indicated;

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8. The number of denied dates, with dates as indicated; and
9. For voluntary admissions, a brief statement as to how the stay met medical necessity criteria.

DISCHARGE NOTIFICATION

Hospitals shall work toward discharge beginning at admission.

Hospitals are required to provide discharge notification and clinical disposition in order for Thurston-Mason BH-ASO to close out the authorization record. The Network Provider must complete the TMBH-ASO Inpatient Discharge Notification Form, found at: https://www.tmbhaso.org/information-for-providers or click HERE for the form.

SECTION 20.3: EVALUATION AND TREATMENT SERVICES STATEMENT OF WORK

Purpose Statement

Provider must provide adequate staffing and appropriate treatment services as outlined below and in compliance with laws and regulations governing the operation of an Evaluation and Treatment (E&T) Center.

Evaluation and Treatment Services

Provider shall furnish the necessary personnel and services and do all things necessary for the performance of the work set forth herein in accordance with Thurston-Mason BH-ASO Policy and Procedure.

Compliance with Specific Laws and Regulations

All services provided under this Agreement shall be in accordance with the following, where applicable. Where there is conflict between current or any successors or additional State or Federal regulations, the more restrictive standard shall apply.

1. RCW 71.05, RCW 71.24
2. WAC 246-341-1005 Behavioral Health residential and inpatient intervention, assessment, and treatment services – certification standards.
3. WAC 246-341-1133
4. WAC 246-337

Involuntary Treatment Act (ITA) Coordination

Provider shall provide support and timely information to the mental health professionals and the Prosecutor's Office in the form of consultation, testimony, records and reports at ITA proceedings for specific individuals. Provider shall provide the Mental Health Professionals, the Prosecutors office and the Court with prior notice of release of detained persons. Provider specifically understands that all information and records in connection with performance of services pursuant to RCW 71.05 and the Community Mental Health Act, RCW 71.24, are strictly confidential and may only be released in accordance with the exceptions provided by state and federal law.

Residential Treatment Facility (RTF)

1. The Evaluation and Treatment Centers shall be operated as a certified RTF for the governmental purposes of the Washington State ITA, RCW 71.05. The Evaluation and Treatment Centers shall be utilized by residents of the Thurston-Mason Region, and other State residents in accordance with State law and the terms in Thurston-Mason BH-ASO Agreements.
2. Services, at a minimum, shall include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other Mental Health Professionals. Discharge planning involving the individual, family, significant others shall begin at admission, so as to ensure continuity of behavioral 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.

Admission Criteria

Individuals must meet admission criteria per Thurston-Mason BH-ASO policy including medical clearance and required diagnostic tests to be eligible for admission.

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Services

Providers operating an E&T program shall serve individuals with mental illness held under a 120-hour involuntary detention and/or 14-day, 90-day, or 180-day civil commitment orders in accordance with the Washington State ITA, RCW 71.05, 71.34, and Thurston-Mason BH- ASO policies. Providers may provide services for individuals who are not detained or committed. These services will be provided in an environment using a trauma informed care approach designed to support safety and confidentiality for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness. Provider will be able to demonstrate a universal principle and commitment to nonviolence and the creation of a trauma informed culture.

Serving Youth

1. Per WAC 246-341-1133, an agency providing E&T services for youth must be a contracted child long-term inpatient treatment facility (CLIP), except as specified in Section 4 (see below).
    a. Section 4: states an agency providing short-term involuntary services to youth, which are not contracted as a CLIP facility, may provide treatment for a child on a 180-day inpatient involuntary commitment order only until the child is discharged from the order to the community, or until a bed is available for that child in a CLIP facility.
2. The CLIP facility must develop a written plan for assuring that services provided are appropriate to the developmental needs of children, including all of the following:
    a. If there is not a child psychiatrist on the staff, there must be a child psychiatrist available for consultation.
    b. There must be a psychologist with documented evidence of skill and experience in working with children available either on the clinical staff or by consultation, responsible for planning and reviewing psychological services and for developing a written set of guidelines for psychological services.
    c. There must be a registered nurse, with training and experience in working with psychiatrically impaired children, on staff as a full-time or part-time employee who must be responsible for all nursing functions.
    d. There must be a social worker with experience in working with children on staff as a full-time or part-time employee who must be responsible for social work functions and the integration of these functions into the individual treatment plan.
    e. There must be an educational/vocational assessment of each resident with appropriate educational/vocational programs developed and implemented or assured on the basis of that assessment.
    f. There must be an occupational therapist licensed under chapter **18.59** RCW available, who has experience in working with psychiatrically impaired children, responsible for occupational therapy functions and the integration of these functions into treatment.
    g. There must be a registered recreational therapist under chapter **18.230** RCW available, who has had experience in working with psychiatrically impaired children, responsible for the recreational therapy functions and the integration of these functions into treatment
    h. Disciplinary policies and practices must be stated in writing and all of the following must be true:
        i. Discipline must be fair, reasonable, consistent, and related to the behavior of the resident. Discipline, when needed, must be consistent with the individual treatment plan.
        ii. Abusive, cruel, hazardous, frightening, or humiliating disciplinary practices must not be used. Seclusion and restraints must not be used as punitive measures. Corporal punishment must not be used
        iii. Disciplinary measures must be documented in the individual service record
        iv. Residents must be protected from assault, abuse, and neglect. Suspected or alleged incidents of nonaccidental injury, sexual abuse, assault, cruelty, or neglect to a child must be reported to a law enforcement agency or to the department of children, youth, and families and comply with chapter **26.44** RCW.

i. Orientation material must be made available to any facility personnel, clinical staff, or consultants informing practitioners of their reporting responsibilities and requirements. Appropriate local police department phone numbers must be available to personnel and staff
j. When suspected or alleged abuse is reported, the individual service record must reflect the fact that an oral or written report has been made to the child protective services of the department of children, youth, and families, or to a law enforcement agency within the timelines identified in chapter **26.44** RCW. This note must include the date and time that the report was made, the agency to which it was made, and the signature of the person making the report. Contents of the report need not be included in the individual service record.

3. Agencies that provide child long-term inpatient treatment services are exempt from the requirement in WAC **246-341-1131** to admit individuals needing treatment seven days a week, 24 hours a day.
4. An agency providing E&T services must follow the service standards for inpatient and residential mental health services in WAC 246-341-1105.

Eligibility

The E&T program shall serve individuals with mental illness who are residents primarily from the Thurston-Mason region. The following are ineligible for admission:

1. Sexually violent offenders being detained pursuant to RCW 71.09 or high-risk sex offenders classified by the local law enforcement agencies will not be served by the E&T. Level III individuals are the highest risk and shall be excluded from the E&T. Level I and II individuals shall be considered on a case-by- case basis prior to admission. The DCR, in consultation with E&T staff, shall make the determination regarding Level I and II individuals as to the level of danger and appropriateness for admission.
2. Any individual with any pending (not dismissed or otherwise disposed) felony charge shall be excluded from admission. Individuals released on a Temporary Release (TR) may be considered for admission on a case-by-case basis after consultation with the DCR.
3. Any DCR within Thurston-Mason BH-ASO Service Area, in consultation with E&T staff and in adherence with established admission criteria will review pending detentions for medical care needs, safety and security to ensure appropriate admissions. This shall be done in collaboration with E&T staff which may require basic medical clearance and/or consultation with a physician prior to accepting an admission. If medical care, safety, or security needs cannot be met by the E&T per the E&T licensed independent practitioner, the individual will be detained at an appropriate facility elsewhere.
4. Aside from the limitations above, the E&T will have a no decline policy for any referrals from any DCR within the Thurston-Mason BH-ASO Service Area provided the individual being referred meets the criteria for admission.

Facilities Certification and Maintenance Services

The RTF shall be certified as an RTF (Inpatient Component) by the Department of Health (DOH), HCA and any other state required facility certification or licensure.

Provider shall provide services in the RTF, which will be certified as an RTF and operated in accordance with the standards of WAC 246-337. It will be Provider's responsibility to establish certification or licensure. Provider shall comply with and meet all state and local health, fire and safety codes and regulations. Provider shall be responsible for all routine maintenance and minor repairs (less than $200.00 per repair) and temporary repairs.

Program Components

Services provided in Evaluation and Treatment facilities must be licensed and certified by the Department of Health. These facilities must have adequate staff to provide a safe and secure environment for the staff, patients and the community. The facilities will provide evaluation and treatment services to limit the duration of involuntary treatment until the person can be discharged back to their home community to continue their treatment without the loss of their civil liberties. The treatment shall be evidence-based practices to include supportive housing, supported employment, Pharmacological services, psycho-social classes, withdrawal management as needed, discharge planning, and warm handoff to follow-up treatment including any less restrictive alternative care ordered by the court.

Services shall be in accordance with WAC 246-337, WAC 246-341-1105, -1118, -1124, -1131, -1133 and RCW 71.05 and 71.24.

1. WAC 246-341-1105 BH residential and inpatient intervention, assessment, and treatment services – certification standards

    a. Agencies certified for behavioral health residential and inpatient services provide behavioral health intervention, assessment, and treatment services in a residential treatment facility or hospital. Residential and inpatient services under this certification include:

        1) In accordance with the service standards in WAC 246-341-1108:

            (i) Adult residential and inpatient substance use disorder treatment; and

            (ii) Youth residential and inpatient substance use disorder treatment;

        2) In accordance with the service standards in WAC 246-341-1118:

            (i) Adult residential and inpatient mental health treatment; and

            (ii) Youth residential and inpatient mental health treatment.

    b. Agencies certified for behavioral health residential and inpatient services must:

        1) Be a facility licensed by the department as:

            (i) A hospital licensed under chapter 70.41 RCW;

            (ii) A private psychiatric hospital licensed under chapter 71.12 RCW;

            (iii) A private alcohol and substance use disorder hospital licensed under chapter 71.12 RCW; or

            (iv) A residential treatment facility licensed under chapter 71.12 RCW;

        2) Ensure access to necessary medical treatment, including emergency life-sustaining treatment and medication;

        3) Review the individual's crisis or recovery plan, if applicable and available;

        4) Determine the individual's risk of harm to self, others, or property;

        5) Coordinate with the individual's current treatment provider, if applicable, to assure continuity of care during admission and upon discharge;

        6) Develop and provide to the individual a discharge summary that must include:

            (i) A continuing care recommendation; and

            (ii) Scheduled follow-up appointments, including the time and date of the appointment(s) when possible.

    c. If providing services to adults and minors, an agency must ensure that a minor who is at least age 13 but not yet age 18 is served with adults only if the minor's individual service record contains:

        1) Documentation that justifies such placement;

        2) A professional judgment that placement in an inpatient facility that serves adults will not harm the minor; and

        3) Ensure the following for individuals who share a room:

            (i) An individual 15 years of age or younger must not room with an individual 18 years of age or older;

            (ii) Anyone under 13 years of age must be evaluated for clinical appropriateness before being placed in a room with an individual 13 to 16 years of age; and

            (iii) An individual 16 or 17 years of age must be evaluated for clinical appropriateness before being

placed in a room with an individual 18 years of age or older.

d. An agency providing residential or inpatient mental health or substance use disorder services to youth must follow these additional requirements:

1) Allow communication between the youth and the youth's parent, or if applicable, a legal guardian, and facilitate the communication when clinically appropriate.

2) Notify the parent or legal guardian within two hours of any significant decrease in the behavioral or physical health status of the youth and document all notification and attempts of notification in the individual service record.

3) Discharge the youth to the care of the youth's parent, or if applicable, legal guardian. For an unplanned discharge and when the parent or legal guardian is not available, the agency must contact the relevant state's child protective services.

4) Ensure a staff member who demonstrates knowledge of adolescent development and substance use disorders is available at the agency or available by phone.

5) Ensure staff members are trained in safe and therapeutic techniques for dealing with a youth's behavior and emotional crisis, including:

(i) Verbal de-escalation;

(ii) Crisis intervention;

(iii) Emotional regulation;

(iv) Suicide assessment and intervention;

(v) Conflict management and problem solving skills;

(vi) Management of assaultive behavior;

(vii) Proper use of therapeutic physical intervention techniques; and

(viii) Emergency procedures.

6) Unless otherwise advised by the treatment provider:

(i) Provide group meetings to promote social and emotional growth.

(ii) Provide leisure and other therapy or related activities.

(iii) Provide seven or more hours of structured recreation each week, that is led or supervised by staff members.

(iv) For each youth who is unable to attend school for an estimated period of four weeks or more during the academic school year, the agency must work with the school district in which the youth is enrolled or the youth's educational provider to assure the academic needs of the youth are met.

7) Conduct random and regular room checks when an individual is in their room, and more often when clinically indicated.

8) Ensure each individual's individual service record:

(i) Contains any consent or release forms signed by the youth and their parent or legal guardian;

(ii) Contains the parent's or other referring person's agreement to participate in the treatment process, as appropriate, and if possible; and

(iii) Documents any problems identified in specific youth assessment, including any referrals to school and community support services, on the individual service plan.

e. An agency that provides services to youth may continue to provide services to a youth who turns 18 years old

while admitted, so long as it is documented that it is in the best interest of the individual and the agency meets the requirements in subsection (d)(8) of this section.

f. An agency certified for behavioral health residential and inpatient intervention, assessment and treatment services may choose to provide services to individuals on a less restrictive alternative order in accordance with the requirements in WAC 246-341-0805.

2. WAC 246-341-1118 Residential and inpatient mental health services – service standards

a. An agency providing residential and inpatient mental health services must develop and implement an individualized annual training plan for agency staff members, to include at least:

1) Least restrictive alternative options available in the community and how to access them;

2) Methods of providing individualized treatment; and

3) De-escalation training and management of assaultive and self-destructive behaviors, including proper and safe use of seclusion and restraint procedures.

b. If contract staff are providing direct services, the facility must ensure compliance with the training requirements in subsection (1) of this section,

c. A behavioral health agency providing mental health inpatient services must:

1) Document that each individual has received evaluations to determine the nature of the disorder and the treatment necessary, including:

(i) A health assessment of the individual's physical condition to determine if the individual needs to be transferred to an appropriate hospital for treatment;

(ii) Examination and medical evaluation within 24 hours of admission by a licensed physician, advanced registered nurse practitioner, or physician assistant;

(iii) Consideration of less restrictive alternative treatment at the time of admission; and

(iv) The admission diagnosis and what information the determination was based on.

2) Ensure examination and evaluation of a minor by a children's mental health specialist occurs within 24 hours of admission.

3. WAC 246-341-1124 Residential and inpatient mental health services – Rights related to antipsychotic medications – All individuals have a right to make informed decisions regarding the use of antipsychotic medication consistent with the provisions of RCW 71.05.215 and 71.05.217. The provider must develop and maintain a written protocol for the involuntary administration of antipsychotic medications, including all of the following requirements.

a. The clinical record must document all of the following:

1) An attempt to obtain informed consent.

2) The individual was asked if they wish to decline treatment during the 24-hour period prior to any court proceeding wherein the individual has the right to attend and is related to their continued treatment. The answer must be in writing and signed when possible. In the case of a child under the age of 18, the psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority must be able to explain to the court the probable effects of the medication.

3) The reasons why any antipsychotic medication is administered over the individual's objection or lack of consent.

b. The psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority may administer antipsychotic medications over an individual's objections or lack of

consent only when:

1) An emergency exists, provided there is a review of this decision by a second psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority within 24 hours. An emergency exists if all of the following are true:

    (i) The individual presents an imminent likelihood of serious harm to self or others;

    (ii) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and

    (iii) In the opinion of the psychiatrist, physician assistant working with the supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority, the individual's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority.

2) There is an additional concurring opinion by a second psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority for treatment up to 30 days.

3) For continued treatment beyond 30 days through the hearing on any 180-day petition filed under RCW 71.05.217, provided the facility medical director or director's medical designee reviews the decision to medicate an individual. Thereafter, antipsychotic medication may be administered involuntarily only upon order of the court. The review must occur at least every 60 days.

c. The examining psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority must sign all 180-day petitions for antipsychotic medications filed under the authority of RCW 71.05.217.

d. Individuals committed for 180 days who refuse or lack the capacity to consent to antipsychotic medications have the right to a court hearing under RCW 71.05.217 prior to the administration of antipsychotic medications.

e. In an emergency, antipsychotic medications may be administered prior to the court hearing provided that an examining psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority files for an antipsychotic medication order the next judicial day.

f. All involuntary medication orders must be consistent with the provisions of RCW 71.05.217, whether ordered by a psychiatrist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority or the court.

4. WAC 246-341-1131 Involuntary behavioral health residential and inpatient services – Certification standards

a. Agencies certified for involuntary behavioral health residential and inpatient services provide behavioral health intervention, assessment and treatment services in a residential treatment facility or hospitals to individuals subject to a civil commitment or court-order under chapter 71.05 or 71.34 RCW; or to individuals who have been court ordered to receive treatment at a certified agency pursuant to chapter 10.77 RCW. Involuntary residential and inpatient services under this certification include the following services:

1) In accordance with the service standards in WAC 246-341-1133:

(i) Adult involuntary evaluation and treatment; and

(ii) Youth involuntary evaluation and treatment;

2) In accordance with the service standards in WAC 246-341-1135:

(i) Adult secure withdrawal management; and

(ii) Youth secure withdrawal management;

3) Court ordered treatment at a certified agency pursuant to chapter 10.77 RCW.

b. An agency providing involuntary behavioral health services must:

1) Follow the applicable statutory requirements in chapter 10.77, 71.05, or 71.34 RCW;

2) Ensure that services are provided in a secure environment. "Secure" means having:

(i) All doors and windows leading to the outside locked at all times;

(ii) Visual monitoring, in a method appropriate to the individual;

(iii) A space to separate persons who are violent or may become violent from others when necessary to maintain safety of the individual and others;

(iv) The means to contact law enforcement immediately in the event of an elopement from the facility; and

(v) Adequate numbers of staff present at all times that are trained in facility security measures;

c. An agency providing services under chapter 71.05 or 71.34 RCW must:

1) Ensure at least daily contact between each involuntarily admitted individual and a mental health professional, substance use disorder professional, or person with a co-occurring disorder specialist enhancement as appropriate, for the purpose of evaluation as to:

(i) The need for further treatment;

(ii) Whether there is a change in involuntary status, or

(iii) Possible discharge;

2) For an individual who has been delivered to the facility by a peace officer for evaluation, the individual service record must contain:

(i) A statement of the circumstances under which the individual was brought to the unit;

(ii) The admission date and time;

(iii) Determination of whether to refer to a designated crisis responder (DCR) to initiate civil commitment proceedings;

(iv) If evaluated by a DCR, documentation that the evaluation was performed within the required time period, the results of the evaluation, and the disposition of the person;

3) Upon discharge of the individual the agency shall provide notification to the DCR office responsible for the initial commitment, which may be a federally recognized Indian tribe or other Indian health care provider if the DCR is appointed by the health care authority, and the DCR office that serves the county in which the individual is expected to reside.

d. Agencies certified for involuntary behavioral health residential and inpatient services must also follow the certification standards for residential and inpatient behavioral health services in WAC 246-341-1105.

e. An agency certified for involuntary behavioral health residential and inpatient services may choose to provide services on a less restrictive alternative order in accordance with the requirements in WAC 246-341-0805.

5. WAC 246-341-1133 Evaluation and treatment services – Service standards.

   a. Evaluation and treatment services are provided for individuals who are held for 120-hour detention or on 14-day, 90-day, or 180-day civil commitment orders according to chapters 71.05 and 71.34 RCW. An agency providing evaluation and treatment services may choose to serve individuals who are held for 120-hour detention, or on short-term commitment orders (14-day), long-term commitment orders (90-day and 180-day), or all three. Agencies providing evaluation and treatment services may also provide services for individuals who are not detained or committed.

   b. An agency providing evaluation and treatment services for youth must be a contracted child long-term inpatient treatment facility (CLIP) except as specified in subsection (d) of this section. The CLIP facility must develop a written plan for assuring that services provided are appropriate to the developmental needs of children, including all of the following:

      1) If there is not a child psychiatrist on the staff, there must be a child psychiatrist available for consultation.

      2) There must be a psychologist with documented evidence of skill and experience working with children available either on the clinical staff or by consultation, responsible for planning and reviewing psychological services and for developing a written set of guidelines for psychological services.

      3) There must be a registered nurse, with training and experience in working with psychiatrically impaired children, on staff as a full-time or part-time employee who must be responsible for all nursing functions.

      4) There must be a social worker with experience working with children on staff as a full-time or part-time employee who must be responsible for social work functions and the integration of these functions into the individual treatment plan.

      5) There must be an educational/vocational assessment of each resident with appropriate educational/vocational programs developed and implemented or assured on the basis of that assessment.

      6) There must be an occupational therapist licensed under chapter 18.59 RCW available, who has experience in working with psychiatrically impaired children, responsible for occupational therapy functions, and the integration of these functions into treatment.

      7) There must be a registered recreational therapist under chapter 18.230 RCW available, who has had experience in working with psychiatrically impaired children, responsible for the recreational therapy functions and the integration of these functions into treatment.

      8) Disciplinary policies and practices must be stated in writing and all of the following must be true:

         (i) Discipline must be fair, reasonable, consistent, and related to the behavior of the resident. Discipline, when needed, must be consistent with the individual treatment plan.

         (ii) Abusive, cruel, hazardous, frightening, or humiliating disciplinary practices must not be used. Seclusion and restraints must not be used as punitive measures. Corporal punishment must not be used.

         (iii) Disciplinary measures must be documented in the individual service record.

      9) Residents must be protected from assault, abuse, and neglect. Suspected or alleged incidents of nonaccidental injury, sexual abuse, assault, cruelty, or neglect to a child must be reported to a law enforcement agency or to the department of children, youth, and families and comply with chapter 26.44 RCW.

      10) Orientation material must be made available to any facility personnel, clinical staff, or consultants informing practitioners of their reporting responsibilities and requirements. Appropriate local police department phone numbers must be available to personnel and staff.

      11) When suspected or alleged abuse is reported, the individual service record must reflect the fact than an oral or written report has been made to the child protective services or the department of children, youth, and families, or to a law enforcement agency within the timelines identified in chapter 26.44 RCW. This note

must include the date and time that the report was made, the agency to which it was made, and the signature of the person making the report. Contents of the report need not be included in the individual service record.

c. Agencies that provide child long-term inpatient treatment services are exempt from the requirement in WAC 246-341-1131 to admit individuals needing treatment seven days a week, 24 hours a day.

d. An agency providing short-term involuntary services to youth, which are not contracted as a CLIP facility, may provide treatment for a child on a 180-day inpatient involuntary commitment order only until the child is discharged from the order to the community, or until a bed is available for that child in a CLIP facility.

e. An agency providing evaluation and treatment services must follow the service standards for inpatient and residential mental health services in WAC 246-341-1105.

6. Operate 24 hour per day, seven (7) days per week, 365 days per year including all legal holidays.
7. Evaluation, treatment and recovery support provided by or under the direction of licensed psychiatrists, nurses and other Mental Health Professionals as well as Peer Support staff and discharge planners.
8. Involuntary Treatment Act services.
9. Discharge planning involving the individual, family, and significant others to ensure continuity of care and services and provide adequate support in making the transition from crisis to wellness.
10. Meet Washington State Licensing and certification standards for operating an E & T.
11. Ensure services will meet the requirements delineated in WAC 246-341, and WAC 246-337, or its successors, and be based on the best and promising practices of recovery published by SAMHSA.
12. Utilize a recovery-oriented model of care and team approach that focuses on individual's personal needs as well as strengths, talents and capabilities that can be utilized to achieve wellness post discharge.
13. Support, training and supervision of Peer Support and paraprofessional staff.
14. Directly provide all medically necessary rehabilitation services.
15. Individuals will be detained initially for a 120-hour period by a DCR and, if indicated, will be subsequently detained by a Superior Court Judge or Commissioner for a 14-day period, including any subsequent period pending 90-day judicial proceedings. Individuals shall also be detained pursuant to RCW 71.05 on a non-emergency basis when ordered by superior court. Other admissions will occur when patients are revoked from a Less Restrictive Court Order or Conditional Release under RCW 71.05.340 and WAC 246-341.
16. Pre-Admission Screening: All individuals referred for admission will be screened according to Thurston-Mason BH- ASO policy. All referrals will be documented including name, date, referral source, and disposition.
17. Evaluation: Each admitted individual shall be provided with an intake assessment in accordance with WAC requirements. Evaluation and treatment components shall include physical examination, psychosocial assessment, and mental status examination. Treatment services shall include:

    a. An individual treatment and discharge plan as required by WAC 246-341 and 246-337. If individuals are enrolled in outpatient services, the therapist, case manager or other appropriate professional will be contacted upon admission and involved in the development of the discharge plan. If outpatient services are not being provided by a Thurston-Mason BH-ASO contracted provider, the E&T will ensure that discharge planning occurs in accordance with Thurston-Mason BH-ASO policy. If individuals are eligible for Thurston-Mason BH-ASO outpatient services, an intake assessment will occur prior to discharge so that outpatient services may begin within five business days of discharge.

    b. A structured, daily program of activities and services.

    c. Mental health treatment, including individual, group, and family therapy to be available at a minimum of five hours per day.

d. Related ancillary services and activities, to include socialization and recreational activities and exercise.

e. Medications, medication evaluation and monitoring, and health education.

f. Mental health related laboratory services, as required.

g. Routine medical service within the limits of medical resources available on the involuntary unit to include nursing assessments as needed. Individuals requiring medical treatment in excess of what is available at the E&T will be transferred to an appropriate hospital for treatment.

h. Services to address the needs of those individuals with mental illness who have special needs, such as the hearing impaired, cultural and linguistic, developmentally disabled, head injured, elderly, and those with alcohol and substance abuse problems.

i. The capability of detaining persons dangerous to themselves and others with use of calming spaces and following WAC procedures.

j. The right to the least restrictive alternative to maintain health and safety when detaining persons dangerous to themselves or others as established in Thurston-Mason BH-ASO policies and in accordance with WAC requirements.

k. Individuals shall be discharged from the E&T with appropriate transportation arrangements provided.

l. Any individual who is allowed to convert to a voluntary status during the involuntary admission shall legally consent to and follow all conditions applied to involuntary individuals.

m. Individuals converting to voluntary status shall have the right to request discharge at any time and if discharged will have transportation arrangements provided.

n. Provider must at a minimum offer a substance use disorder assessment by a SUDP/SUDPT within ten (10) business days of a request.

Court Evaluation and Testimony

Court may be held within the E&T. When Superior Court judicial proceedings occur, these proceeding shall have priority over all other uses of the conference/hearing room. Provider shall provide the following for Court Evaluation and Testimony:

1. Provide and coordination of the legal documents in a timely manner pertaining to the involuntary detention of individuals as required by Thurston-Mason BH-ASO counties' Superior Court systems.
2. As requested, provide records and court testimony at probable cause hearings or trials by other professional staff employed at the E&T. These records and testimony shall be provided, as needed, pertaining to the individual's mental health status during detention at the E&T.
3. Provide support to the DCRs, County Prosecutor's office, and State Attorney General's office in the form of consultation, live and telephonic testimony, records, and reports, where required, at ITA proceedings for specific individuals. When necessary for judicial proceedings, Provider shall promptly supply a certified copy of all medical and psychological records and make available, if necessary, a records custodian capable of testifying in order to introduce medical and psychological records per RCW 5.45.020 and the civil rules of Washington State Superior Court.
4. Accompany and provide support for individuals during court proceedings away from facility.
5. Arrange for transportation.
6. Provider shall collaborate and facilitate the evaluation and expert witness testimony for court purposes by a licensed physician, psychiatrist, or licensed psychologist. Treating physician records and testimony shall be provided when necessary per RCW 71.05.
7. Initial screening and evaluation (and court testimony as needed) for court hearings will be done by the Designated Crisis Responder staff. A court hearing room is located in the E&T where court hearings and non-jury trials shall occur.

Personnel

Provider shall provide staffing in the number, quality and appropriate backgrounds, and licensure needed to assure compliance with state law. Provider shall designate a person to be the individual in charge of the E&T for the following purposes and responsibilities:

1. All decisions concerning medical or psychiatric treatment.
2. Physician with responsibility for treatment.
3. Explanation of rights to refuse medical treatment 24 hours prior to hearings and documentation of such.
4. Compliance with rights notifications to persons admitted and ensuring rights afforded under statute and law to persons admitted.
5. All transfers and/or referrals to appropriate facilities for alcohol or medical treatment after admission.
6. Temporary releases under RCW 71.05. When transported off site, individuals are to be in the custody and care of an E&T staff and/or other mental health agency staff at all times. This includes residential facility screening visits by individuals who are ready for discharge and are considering placement at such facilities, or for medical appointments. At no time shall individuals be given temporary passes from the facility.
7. To complete requirements that less restrictive alternatives be considered and to provide research of less restrictive alternatives to involuntary hospitalization and discharge planning.
8. Determining and coordinating with the Designated Mental Health Professional conditional releases and/or releases to less restrictive alternative to inpatient treatment.
9. Unconditional releases, including transportation and other assistance to released individuals.
10. Notification under RCW 71.05.

Training and Education of Staff

An employee trained in cardiopulmonary resuscitation and emergency first-aid will be present at all times.

1. Provider shall establish a training plan for each staff, including temporary or on-call staff. Training shall include a planned documented orientation for each new employee and an ongoing program of in-service training for all staff designed to maintain and update competencies needed to perform assigned duties.
2. Orientation and in-service education plans shall be maintained, and attendance documented in each employee's personnel record.
3. Training for all staff shall meet WAC and 246-337 requirements. At a minimum, all staff will receive mandatory training in the following:
    a. Managing assaultive behavior and limited use of seclusion and restraints per WAC and medical/ethical standards.
    b. Nursing assessment review requirements for all licensed nurses.
    c. Individual civil rights and ITA due process procedures.
    d. Confidentiality of records/information.
    e. Notification requirements.

Designated Crisis Responders (DCRs)

DCRs will be responsible for the following in comport with Thurston-Mason BH-ASO Policy and Procedure:

1. Screening decisions concerning whether a person should be excluded from the facility as a Level III sex offender, an offender with mental illness, or in need of medical treatment at another facility prior to admission.
2. Decisions on initial detention, provisional acceptance, and admission at the E&T.

Peer Counselors

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1. Provider shall hire the staffing sufficient to provide adequate coverage of peer support services at the E&T. Peer Counselors shall be integrated into the treatment team. Utilizing peer supports, individuals receiving services from the E&T will have an opportunity to learn alongside employees that have similar life experiences and are recovering from mental illness or have a history of trauma. The E&T is an environment for individuals to discover their strengths and be supported in their transition into wellness. Within the context of mutually responsible relationships, and with the help, support, and experiential knowledge of peer support staff, individuals can achieve wellness.
2. Provider shall provide support, training and supervision of peer counselors.
3. Peer Counselors shall provide services that comport with WAC 246-341-0901 and include the following, as indicated:
    a. Participate in the admission/welcoming process
    b. Promote recovery, wellness, and healthy lifestyle
    c. Reduce identifiable behavioral health and physical health risks
    d. Support the individual in building skills that enable whole health improvement
    e. Providing health support and coaching interventions about daily health choices
    f. Participate in discharge planning
    g. Provide follow up within three (3) days of discharge
    h. Conduct groups, and
    i. Provide individual support on the development of a Wellness Recovery Action Plan (WRAP)

Discharge Planning

Provider shall begin discharge planning within 24 hours of admission. Engagement shall begin immediately with the identification of natural supports, community behavioral health provider, primary care provider, Managed Care Organization (MCO) and other resources beneficial to the individual's recovery. The discharge plan shall be strength based, person-centered and goal driven. Provider shall ensure the following elements are addressed in the discharge plan:

1. Safe housing
2. Coordination with supports, natural, familial and community providers
3. Coordination with the individual's Managed Care Organization (MCO) to ensure continuity of outpatient services following discharge
4. Risk assessment
5. Wellness Recovery Action Plan (WRAP)
6. Scheduled appointments

Complex Discharge Planner

The Provider shall have a designated E&T Discharge Planner staff member. The primary role of this person will include developing and coordinating discharge plans that are: complex, multi system, mixed funding, and specific to Enrollees that would otherwise be transferred to the state hospitals and tracking the individuals progress upon discharge for no less than 30 days after discharge from the E&T facility. The E&T Discharge Planner will use a report to track the total number of all discharges from their E&T location and differentiate between those that were deemed complex and those that were deemed standard. This is due the 10th of the month following the month being reported.

Primary Discharge Planner Job Responsibilities

1. In collaboration with the treatment team, identify appropriate complex patients to receive these services;
2. Work primarily with the complex patients that are on the Western State Hospital (WSH) list;
3. Through a thorough assessment identify barriers to discharging to the community;

4. Work closely with established outpatient providers to provide continuity of care.
5. Prepare a treatment plan for discharge to the community which incorporates solutions to the identified barriers;
6. Engage patients through groups and individual work about relapse prevention and engagement in services;
7. Use motivational interviewing and other appropriate Evidenced- based Practices
8. (EBP) to make progress on treatment plan goals;
9. Once the patient has discharged, in collaboration with other assigned service providers, implement a plan for appropriate follow up in the community to keep patient from being readmitted;
10. Develop a meaningful relapse prevention plan with patient; and
11. Offer assistance and supervision to the other clinicians.

Restraint Monitoring/Usage

Provider shall assess the usage of restraints and work with Thurston-Mason BH-ASO to explore the development of a culture in the E&T that is "no force" and trauma informed.

SECTION 20.4: MENTAL HEALTH SERVICES IN A RESIDENTIAL SETTING

1. A specialized form of rehabilitation service (non-hospital/non-Institution for Mental Diseases [IMD]) that offers a sub-acute psychiatric management environment.
2. Individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Services. The Mental Health Care Provider is sited at the residential location (i.e., boarding homes, supported housing, cluster housing, single room occupancy [SRO] apartments) for extended hours to provide direct mental health care to an individual.
3. 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 them to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of eight (8) hours of service must be provided. This service does not include the costs for room and board, custodial care and medical services and differs for other services in the terms of location and duration.

SECTION 20.5: OPIATE DEPENDENCY OUTREACH STATEMENT OF WORK

Purpose

To provide outreach services to individuals who use opioid drugs intravenously, in order to facilitate access to and admission into substance use disorder (SUD) treatment services.

Target Population

Individuals who experienced an opiate overdose reversal. Individuals admitted to the hospital due to opioid overdose. Individuals referred by law enforcement and other first responders.

Services

Opiate Outreach services shall include the following:

1. Provide outreach, coordination and liaison services to individuals who use opioids intravenously;
2. Screen and determine the individual's needs;

3. Assist with access to services to meet individual needs as identified such as housing, medical, food, mental health care, and clothing;
4. Assist in access to or coordination of buprenorphine and other medication assisted treatment as indicated;
5. Facilitate access to and coordinate SUD assessment and treatment services; and
6. Resume supportive contact when individual relapses or falls out of treatment services, as needed.

The outreach services will:

1. Increase individual engagement in SUD treatment services;
2. Decrease time to enter SUD treatment services; and
3. Lower the barrier to accessing medication assisted treatment and SUD treatment services.

Monthly Reporting

Complete the Opiate Outreach Report, as attached in the contract, and submit with each monthly invoice

SECTION 20.6: PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT (PACT) STATEMENT OF WORK

Required Services

1. Provider must provide the following required services to individuals in the Service Area: recovery-based service delivery, comprehensive mental health assessments, individualized treatment planning, service coordination, crisis assessment and intervention services, symptom assessment and management, medication prescription, administration, monitoring and documentation, dual diagnosis and substance use services, work related services, activities to daily living services, social and/or interpersonal and leisure-time skill training, supported employment services, peer support and wellness recovery services, support services, education support and consultation with individual's families and other major supports, individual medical record maintenance, individual's rights and grievance procedures, culturally linguistically and appropriate services (CLAS), performance and improvement, program evaluation and stakeholder advisory committee.
2. In providing PACT services in the Thurston-Mason Regional Service Area, Provider shall mutually develop and routinely review policies and procedures that address how the availability of resources for these services is determined, including how decisions are made to deny services due to insufficient resources. Other Services are to be provided in accordance with the specific requirements outlined for the service and in accordance with the Washington State PACT Program Standards, website listed at the end of this section.

Comprehensive Mental Health Assessments

1. Provider must initiate and complete a comprehensive assessment within 30 days of an individual's acceptance into the PACT.
2. Each part of the assessment must be completed by a PACT team member with the skill and knowledge in the area being assessed.
3. The assessment must include, but is not limited to, the following: a client interview/self-report, family members and other significant parties, written summaries where applicable, such as; law enforcement, courts, outpatient/inpatient services and other community services/supports the individual may be engaged.
4. In collaboration with the individual, the comprehensive assessment shall include an evaluation in the following areas and in accordance with Washington State PACT Program Standards, website listed at the end of this section:
    a. Psychiatric History, Mental Status and Diagnosis;
    b. Physical Health;
    c. Use of Drugs and/or Alcohol;
    d. Education and Employment;

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e. Social Development and Functioning;

f. Activities of Daily Living (ADL); and

g. Family Structure and Relationships.

The service coordinator and team members will be assigned in collaboration with the psychiatric subscriber by the first treatment planning meeting or 30 days after admission, whichever is first.

Individualized Treatment Recovery Planning

1. The treatment plan shall be developed in collaboration with the individual and the family/significant parties or guardian, when feasible and appropriate. The treatment plan shall be developed in accordance with Washington State PACT Program Standards, website listed at the end of this section.
2. The treatment plan shall:
    a. Identify individual challenges/problems;
    b. Identify individual strengths;
    c. Include measurable goals;
    d. Be specific in approaches and interventions necessary for the individual to meet his/her goals; and,
    e. Focus on achieving the maximum level of recovery.
3. The following key areas shall be addressed in every individual's treatment plan.
    1. Psychiatric illness/symptom reduction;
    2. Housing;
    3. Transportation;
    4. Health and Dental care;
    5. Income;
    6. Drug and/or alcohol treatment;
    7. Activities of Daily Living;
    8. Daily structure and employment; and,
    9. Family and social relationships.
4. Individual Treatment Team (ITT) is responsible to ensure the individual is actively engaged in the development of his/her recovery-oriented treatment and goals. The treatment plan will be reviewed at the request of the individual, when significant change occurs in individual's condition/goals or 180 days, whichever occurs first.
    a. Be developed collaboratively with the individual and other people identified by the individual. The treatment plan should be in language and terminology that is understandable to individuals, their family and include goals that are measurable;
    b. Address age, cultural, or disability issues of the individual;
    c. Include measurable goals for progress toward rehabilitation, recovery and reintegration into the mainstream of social, daily living, employment and educational choices, involving other systems when appropriate;
    d. Document shall be reviewed and signed by the individual. The plan must also be reviewed, signed/acknowledged by the service coordinator, ITT members, team leader, psychiatric prescriber and all PACT team members.
    e. Document review and update at least every 180 days or more often at the request of the individual and/or as the need arises.

Service Coordination

PACT Team shall operate as a continuous and integrated treatment service. The team shall have the capacity to provide comprehensive treatment, rehabilitation and support services as a self-contained service unit. Each individual shall be assigned a service coordinator who will coordinate and monitor the activities of the ITT and full PACT team. The responsibility of the Service Coordinator is to ensure the individual's wishes, rights and preferences are honored. Service Coordinator will provide individual supportive counseling, working with the client to write their treatment plan, offer choice in the treatment plan and advocate for the individual to ensure changes are immediate to address the needs in a timely manner.

Crisis Assessment

Crisis assessment and intervention shall be provided 24 hours per day, 7 days per week by PACT team prior to engaging any crisis response in the Thurston-Mason region; PACT team shall be the first responder. These services will include telephone and face-to-face contact. Mental Health Professionals (MHP) who are experienced in crisis intervention procedures shall be available on-call for crisis intervention responding by telephone or face-to-face contact. The goal of these crisis services is to maintain PACT participants living independently in the community, teach crisis self- management skills, and reduce psychiatric hospitalization.

Symptom Assessment and Management

This shall include, but is not limited to, the following:

1. Ongoing comprehensive assessment of individual's mental illness symptoms, accurate diagnosis, and client's response to treatment;
2. Psycho-education regarding mental illness and the effects and side effects of prescribed medications, when appropriate;
3. Symptom management efforts to help each individual identify/target the symptoms and occurrence patterns of his/her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects;
4. Individual supportive therapy;
5. Psychotherapy; and
6. Substantial psychological support to clients, both on a planned and as needed basis, to help accomplish their personal goals, to cope with the stressors for day-to-day living and recovery.

Medical Prescription, Administration, Monitoring and Documentation

1. PACT team psychiatric prescriber shall:
    a. Establish an individual clinical relationship with each individual;
    b. Assess each individual's mental illness symptoms and provide verbal and written information about their particular mental illness. Verbal and written information to be provided in a cultural and educational format acceptable and understood by the individual;
    c. Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatric prescriber will follow;
    d. Provide education about medication, benefits and risks and obtain informed consent. Education to be provided in a cultural and educational format acceptable and understood by the individual;
    e. Assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor and document medication side effects; and
    f. Provide psychotherapy.
2. All PACT team members shall assess and document individual's mental illness symptoms and behavior in response to medication and shall monitor medication side effects.
3. PACT team shall establish medication policies and procedures.

Dual Diagnosis Substance Use Services

1. Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance use, and has client- determined goals. This shall include, but is not limited to, individual and group interventions in:
    a. Engagement;
    b. Assessment;
    c. Motivational enhancement;
    d. Active treatment; and
    e. Continuous relapse prevention.

Work Related Services

Work-related services to help individual's value, find and maintain meaningful employment in community-based job sites and involve job development and coordination with employers.

Activities of Daily Living Services

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g., prompts, assignments, monitoring and encouragement) and environmental adaptations to assist individuals to gain and use the skills needed to accomplish daily living tasks.

Social/Interpersonal Relationship and Leisure-Time Skill Training

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy, social-skill teaching and assertiveness training, planning, structuring and prompting of social and leisure-time activities to structure individuals' time, increase their social experiences, and provide individuals with opportunities to practice social skills and receive feedback and support.

Peer Support and Wellness Recovery Services

Services shall validate an individual's experience to guide and encourage and to take responsibility for and actively participate in their own recovery as outlined in SAMHSA's 10 Fundamental Components of Recovery. In addition, services to help individuals identify, understand and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self-imposed stigma. Services and strategies include, but are not limited to, Peer Counseling, Wellness Recovery and Action Plan (WRAP) and Illness Management and Recovery Services (IMR).

Support Services

Support services and/or direct assistance to ensure that clients obtain the basic necessities of daily life. Support services are not limited and should be tailored to individual need and/or request.

Education, Support and Consultation to Individual's Families and Other Major Supports

Services provided under this category to individual's families and other major supports are with individual agreement and consent.

Individual Medical Record

PACT team shall maintain a treatment record for each PACT participant. The treatment record is a confidential document that is complete, accurate and contains up-to-date information relevant to the individual's care and treatment.

Culturally and Linguistically Appropriate Services (CLAS)

PACT team will ensure that individuals receive from all staff members, effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language. Provider and subcontractors shall adhere to the CLASguidelines.

Performance Improvement and Program Evaluation (PACT)

1. PACT team shall have a performance improvement and program evaluation plan. The Performance Improvement and Program Evaluation Plan will include all elements listed in Washington State PACT Program Standards to be submitted to Thurston-Mason BH-ASO for approval within 30 days of the execution of this agreement. The Performance Improvement and Program Evaluation Plan shall include recommendations from PACT Stakeholder Advisory Committee.
2. Provider shall meet Washington State PACT Standards as the fidelity standard for this evidence-based practice. Provider shall complete a fidelity compliance checklist supplied by Thurston-Mason BH-ASO or HCA every 90 days. When Provider or subcontractors become aware that PACT is not meeting Washington State PACT fidelity Standard, it shall notify PACT Stakeholder Advisory Committee and Thurston-Mason BH-ASO in writing of the deficiency within 14 days. Within 30 days after the notice of deficiency, Provider shall submit a plan to correct the deficiency and bring PACT into compliance with State Standards, to PACT Advisory Committee and Thurston-Mason BH-ASO.
3. Provider shall participate in audits by Thurston-Mason BH-ASO, HCA and/or any Providers hired to evaluate compliance with fidelity standards.

Policies and Procedures

PACT will in collaboration with Thurston-Mason BH-ASO develop and maintain Policies and Procedures specific to PACT team and services. The following 10 content areas requiring Policies and Procedures are identified in Washington State PACT Program Standards and listed below:

1. Admission and Discharge;
2. Personnel/Staff Competencies, Orientation/Training;
3. Program Operations, Coverage, Staff Communication/Supervision;
4. Assessment and Treatment Planning;
5. Core Services;
6. Medical Records Management;
7. Advance Directive;
8. Individual Rights/Grievance Procedures;
9. Culturally and Linguistically Appropriate Services;
10. Performance Improvement and Program Evaluation; and
11. Stakeholder Advisory Committee.

WA-PACT Standards: https://www.hca.wa.gov/assets/billers-and-providers/PACTProgramStandards.pdfrecovery/program-assertive-community-treatment-pact

SECTION 20.7: SUBSTANCE USE DISORDER (SUD) RESIDENTIAL

SUD residential contractors shall ensure the minimal data elements for admission, utilization review/continued stay, and discharge are reported to Thurston-Mason BH-ASO for all individuals served within the month being invoiced. These data elements must be submitted **via an encrypted email to oprequest@tmbho.org** using the following forms, found on our website:

1. **TMBH-ASO Residential Client Admission:** reported for any client admitted into services within 5 business days of admit.
2. **TMBH-ASO Residential Services Utilization Review:** reported at least two business days prior to expiration of initial authorization period.
3. **TMBH-ASO Residential Client Discharge:** reported for any client discharged from services within 5 business days of

discharge. The Provider shall not include the discharge date as a payment day. The Provider is not eligible for payment for the day of discharge.

4. **TMBH-ASO Residential Service Activity Log:** submit an updated log for each invoice period, including, all new admissions and discharges and submit with the invoice. If the invoice includes this information, the service activity log is not required.

SECTION 20.7.1: SUD RESIDENTIAL ADULT INTENSIVE INPATIENT STATEMENT OF WORK

Purpose

The Provider shall provide adult SUD residential treatment within available resources in the form of Intensive Inpatient services designed from a recovery and resiliency perspective that will enable residents to live in the community with minimal dependence on public safety and acute care resources.

Program Description

General Program Requirements. The Provider shall provide access to services as follows:

1. The Provider shall ensure that treatment services are not denied to any individual solely on the basis of that individual's drug(s) of choice.
2. The Provider shall accept and make the necessary adjustments to continue treatment for any clinically-appropriate client actively taking an opiate substitution medication.
3. The Provider shall not have policies or procedures in place that deny treatment services to any individual solely on the basis that the client is taking prescribed medication(s). However, the Provider reserves the right to deny admission to any individual when the Provider determines that the individual is beyond the scope of the Provider's ability to safely or adequately treat.
4. The Provider shall ensure that access to treatment services is not denied solely on the basis that a client is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.
5. Services shall be provided according to all of the following values:
    a. Cultural, linguistic and disability competent
    b. Oriented toward promoting recovery and resiliency
    c. Appropriate to the age and developmental stage of the resident
    d. Preference for the most independent living setting
6. The Provider shall provide adult SUD residential services within the identified levels of care as defined in the WAC 246-341 and as described by ASAM. Services shall be provided in accordance with the Department of Health regulations as stated in WAC 246-337 or its successor for a Residential Treatment Facilities (RTF).
    1) Intensive Inpatient services provide a concentrated program of SUD treatment, individual and group counseling, education, relapse prevention and related recovery activities, including room and board, in a twenty- four-hour-a-day supervised facility in accordance with WAC 246-341. This level of SUD treatment satisfies the level of intensity in ASAM Level 3.5.

Priority Populations:

Per the Substance Abuse Block Grant (SABG) requirements, Thurston-Mason BH-ASO and the Provider shall prioritize treatment admissions according to the following priority categories:

1. Women who are pregnant and injecting drugs
2. Women who are pregnant with a SUD(s)
3. Women with dependent children
4. Individuals who are injecting drugs

Access to Services

1. Eligibility – Provider must follow steps in Section 2.1, Service Eligibility
    a. Adult 18 years or older
    b. Resides in Thurston or Mason Counties.
    c. Diagnosed per DSM-5-TR criteria for Substance Use Disorder (SUD)
    d. Meets specific ASAM placement criteria for residential level of care.
    e. The individual's needs cannot be more appropriately met by any other formal or informal system of support.
    f. Has been authorized by Thurston-Mason BH-ASO for this level of care.
    g. The initial authorization for Thurston-Mason regional residents for residential services shall be procured by the community-based assessor or outpatient provider after verifying bed availability with Provider.
    h. The Provider shall ensure there is an authorization in place prior to admitting the individual into the program.
    i. Thurston-Mason BH-ASO shall not reimburse SUD residential services without documented authorization.
2. Treatment
    a. The Provider shall provide services according to WAC 246-341, individual need, and to each resident and his or her family or support system, in order to help the individual, achieve recovery and resiliency through mutually negotiated goals of treatment.
    b. The Provider shall ensure residents have a voice in developing their Individual Service Plan (ISP).
    c. The Provider shall ensure significant others, as identified by the resident, are involved in the service plan development and implementation.
    d. The Provider shall ensure treatment goals are written in words understood by the resident.
    e. The Provider shall ensure documentation related to progress toward treatment goals includes the resident's views on his or her progress.
    f. The Provider shall provide each resident the necessary personal items; i.e., soap, toothbrush, toothpaste, and sanitary items from the funds included in the daily bed rate.
3. Clinical Records and Documentation
    a. The Provider shall ensure that residential facility staff maintains individual clinical records and individualized clinical documentation.
    b. Contain release of information forms (ROI) for care coordinating.
    c. Include referrals to community support services.
    d. An ISP is developed within five days of placement.
        1) Personalized to the individual's unique treatment needs as identified on the SUD assessment.
        2) The ISP is written in clear, straightforward language that is understandable to the individual and family (e.g., does not contain references, abbreviations and/or technical language that the individual may not understand or be familiar with)
        3) Initiated with at least one goal identified by the individual during the initial assessment or at the first service session following the assessment.
        4) Document at least weekly ISP reviews and progress towards goals and/or objectives.
        5) Includes individual needs identified in the diagnostic and periodic reviews, addressing:
            (a) All substance use needing treatment, including tobacco, if necessary;

(b) Resident's bio-psychosocial identified needs and concerns;

(c) Age, cultural and/or disability issues relevant to treatment;

(d) Estimated dates or conditions for completion of each treatment goal;

(e) Contains measurable goals or objectives or both, and interventions/approaches; and

(f) The interventions listed are aligned with the identified objective.

6) Documents are approved by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.

7) Documents that the plan was updated to reflect any changes in the individual's treatment needs, status, ASAM dimensions, and progress towards goals, or as requested by the individual.

8) Demonstrates the resident's participation in the development of the plan and that plan was mutually agreed upon with copy provided to resident.

9) The ISP is strength-based.

10) If the ISP includes assignments of work to an individual, the assignment of work must be therapeutic in value.

11) Daily documentation of progress notes

(a) Progress notes must include the date, time, duration, participant names, and a brief summary of the session with the treatment goal, objection or intervention the session addressed, and the name of the staff person who provided it.

(b) Progress notes document:

1. Significant changes in the resident's clinical and health status;
2. Implementation of interventions listed on ISP and progress towards meeting goals and objectives.
3. Coordination and communication with outside providers;
4. Medical appointments; and
5. Contacts with family identified by the resident.

(c) Progress notes are documented in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur.

e. Provider must document at minimum one daily service encounter.

1) A service encounter consists of: individual sessions, group sessions, or other therapeutic interaction addressing ISP goals, objectives, or interventions.

2) Provider must document at least a minimum weekly individual session.

f. Continuing Stay Criteria

1) Continued stay assessments are person-centered based upon the resident's individual treatment needs and progress in residential treatment.

2) Continued stay eligibility criteria are:

(a) The resident meets the ASAM placement criteria for the requested residential level of care.

(b) The resident has demonstrated progress toward achieving treatment goals during the initial authorization period.

(c) The resident's needs cannot be more appropriately met by any other formal or informal

system or support.

3) The Provider shall request a continuation of an individual's stay by submitting a Utilization Review form, encrypted, to oprequest@tmbho.org to Thurston-Mason BH-ASO no later than five working days before expiration of initial authorization. Failure to provide complete information within this timeline may result in a rejection of the continuing stay request.

4) The required written documentation must include:

   (a) Updated ASAM evaluation by each dimension;

   (b) Requested number of days for continuing stay with goals to be accomplished; and

   (c) Brief description of resident's progress on ISP goals, additional goals and interventions added, projected treatment goals, and, the individualized reason and need for continued stay at the residential level of care.

5) Thurston-Mason BH-ASO shall make a decision on the continuing stay request and notify the Provider of disposition within two working days of receiving the continuing stay request submittal.

6) If it is determined that the resident does not meet continuing stay eligibility criteria, the resident and/or resident's family (if legal guardian) may appeal the disposition. Discharge planning includes documentation to supports the reason for discharge (planned or unplanned) in the clinical record.

   (a) The Provider collaboratively developed discharging planning with individual.

   (b) Discharge planning initiated during the first week of treatment.

   (c) Planned discharges identifies the Continuing Care Plan and recommendations by the Provider to assist in the successful transition to the next level of care:

7) SUD Outpatient is established with a set appointment date & time for the individual to return.

8) Other follow up services both recommended and secured including, but not limited to: housing, transportation, mental health services, education,

9) Employment assistance, medical, dental, legal, other resources or services in the discharge plan to meet the needs of the individual.

10) Continuing Care Plan provided to individual/family and/or legal guardian.

4. Planned Leave

   a. The Provider shall allow a resident to leave the facility for the purposes of obtaining medical treatment not available at the center, conducting personal business, visiting with family members or significant others and for other reasons that may be beneficial to the resident's treatment program. The outpatient program shall be informed of the need for a planned leave.

   b. If a resident shall be absent from the Provider's facility on approved planned leave for more than 72 hours, the following applies:

      1) Residential staff must notify Thurston-Mason BH-ASO and indicate the total number of days the resident will be absent and the reason for the absence.

      2) Notification for planned absence shall occur prior to leave.

      3) Staff shall complete and submit Residential Absence Authorization form.

      4) The Thurston-Mason BH-ASO will review the planned leave request, determine if the SUD residential bed should remain open for the resident, and if so, approve payment for the bed days. Thurston-Mason BH-ASO will forward a copy of the approved absence authorization to the Provider within three business days.

      5) All planned leaves must be consistent with the resident's Individual Service Plan (ISP).

c. Residential staff shall be responsible for providing ongoing case management at all times during a resident's planned leave, including crisis intervention and stabilization, until the individual has returned to the residential bed.

d. Residential staff shall be responsible for linking the resident to appropriate services if the resident will not be returning to facility developed in collaboration with the outpatient treatment facility that made the bed placement.

5. Unplanned Leave

   a. The Provider may maintain a benefit for 24 hours without requesting Thurston-Mason BH-ASO's absence authorization for a resident's unplanned voluntary exit should the individual's return remain a possibility.

      1) The termination date is the date of exit if the person does not return to the program.

   b. If the Provider wants to maintain the benefit beyond 24 hours following a resident's unplanned, voluntary exit from the program, the following applies:

      1) Residential staff shall notify Thurston-Mason BH-ASO documenting the total number of days requested and reason(s) for the request.

      2) The Thurston-Mason BH-ASO will review the absence authorization request and notify the residential facility of the disposition.

      3) The Thurston-Mason BH-ASO will authorize a benefit for maximum of 72 hours from the date of the resident's unplanned, voluntary exit from the program.

6. Termination and Discharge - the Provider shall not include the discharge date as a payment day. The Provider is not eligible for payment for the day of discharge.

   a. SUD residential benefit will terminate under the following circumstances:

      1) The Thurston-Mason BH-ASO authorization period expires;

      2) The resident permanently exits the program prior to the expiration date of the authorization period;

      3) The resident dies;

      4) The resident gains enough resources during the benefit to be treated as a private-pay client; or

      5) Provider discharges resident to ensure the safety of other residents and staff.

   b. A terminated benefit is payable to the date of termination.

      1) For the required terminations above, the date of the termination is the date of the event, unless otherwise specified.

      2) When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped by Thurston-Mason BH-ASO.

SECTION 20.7.2: SUD RESIDENTIAL YOUTH INTENSIVE INPATIENT STATEMENT OF WORK

Purpose

The Provider shall provide youth SUD residential treatment within available resources in the form of Intensive Inpatient services designed from a recovery and resiliency perspective that will enable residents to live in the community with minimal dependence on public safety and acute care resources.

Program Description

1. General Program Requirement

   a. The Provider shall provide access to services as follows:

1) The Provider shall ensure that treatment services are not denied to any individual solely on the basis of that individual's drug(s) of choice.
2) The Provider shall accept and make the necessary adjustments to continue treatment for any clinically-appropriate client actively taking an opiate substitution medication.
3) The Provider shall not have policies or procedures in place that deny treatment services to any individual solely on the basis that the client is taking prescribed medication(s). However, the Provider reserves the right to deny admission to any individual when the Provider determines that the individual is beyond the scope of the Provider's ability to safely or adequately treat.
4) The Provider shall ensure that access to treatment services is not denied solely on the basis that a client is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.
5) Services shall be provided according to all of the following values:
    1) Cultural, linguistic and disability competent
    2) Oriented toward promoting recovery and resiliency
    3) Appropriate to the age and developmental stage of the resident
    4) Preference for the most independent living setting
6) The Provider shall provide youth SUD residential services within the identified levels of care as defined in the WAC 246-341 and as described by ASAM. Services shall be provided in accordance with the Department of Health regulations as stated in WAC 246-337 or its successor for a Residential Treatment Facilities (RTF).
7) Intensive Inpatient services provide a concentrated program of SUD treatment, individual and group counseling, education, relapse prevention and related recovery activities, including room and board, in a twenty- four-hour-a-day supervised facility in accordance with WAC 246-341. This level of SUD treatment satisfies the level of intensity in ASAM Level 3.5.

b. Priority Populations
    1) Per the Substance Abuse Block Grant (SABG) requirements, Thurston-Mason BH-ASO and the Provider shall prioritize treatment admissions according to the following priority categories:
        1) Women who are pregnant and injecting drugs
        2) Women who are pregnant with SUDs
        3) Women with dependent children
        4) Individuals who are injecting drugs

2. Access to Services
    a. Eligibility– Provider must follow steps in Section 2.1, Service Eligibility
        1) Youth 17 years or younger
        2) Resides in Thurston or Mason County
        3) Diagnosed per DSM-5-TR criteria for Substance Use Disorder (SUD)
        4) Meets specific ASAM placement criteria for residential level of care.
        5) The individual's needs cannot be more appropriately met by any other formal or informal system of support.
        6) Has been authorized by Thurston-Mason BH-ASO for this level of care.
    b. The initial authorization for Thurston-Mason regional residents for residential services shall be procured by the

community-based assessor or outpatient provider after verifying bed availability with Provider.

c. The Provider shall ensure there is an authorization in place prior to admitting the individual into the program.

d. Thurston-Mason BH-ASO shall not reimburse SUD residential services without documented authorization.

3. Treatment

a. The Provider shall provide services according to WAC 246-341, individual need, and to each resident and his or her family or support system, in order to help the individual achieve recovery and resiliency through mutually negotiated goals of treatment.

b. The Provider shall ensure residents have a voice in developing their Individual Service Plan (ISP).

c. The Provider shall ensure family, as identified by the resident, are involved in the service plan development and implementation.

d. The Provider shall ensure treatment goals are written in words understood by the resident.

e. The Provider shall ensure documentation related to progress toward treatment goals includes the resident's views on his or her progress.

f. The Provider shall provide each resident the necessary personal items; i.e., soap, toothbrush, toothpaste, and sanitary items from the funds included in the daily bed rate.

g. Treatment provided is consistent with ASAM 3.5 level of care appropriate for youth.

4. Clinical Records and Documentation

a. The Provider shall ensure that residential facility staff maintains individual clinical records and individualized clinical documentation.

b. Contain release of information forms (ROI) for care coordinating.

c. Include referrals to community support services.

d. An ISP is developed within five days of admission.

1) Personalized to the individual's unique treatment needs as identified on the SUD assessment.

2) The ISP is written in clear, straightforward language that is understandable to the individual and family (e.g., does not contain references, abbreviations and/or technical language that the individual may not understand or be familiar with)

3) Initiated with at least one goal identified by the individual during the initial assessment or at the first service session following the assessment.

4) The Provider must conduct a minimum of weekly face to face individual sessions.

5) Includes individual needs identified in the diagnostic and periodic reviews, addressing:

1) All substance use needing treatment, including tobacco, if necessary;

2) Resident's bio-psychosocial identified needs and concerns;

3) Age, cultural and/or disability issues relevant to treatment;

4) Estimated dates or conditions for completion of each treatment goal;

5) Contains measurable goals or objectives or both, and interventions/approaches; and

6) The interventions listed are aligned with the identified objective.

6) Documents are approved by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.

7) Documents that the plan was updated to reflect any changes in the individual's treatment needs,

status, ASAM dimensions, and progress towards goals, or as requested by the individual.

8) Demonstrates the resident's participation in the development of the plan and that plan was mutually agreed upon with copy provided to resident.

9) The ISP is strength-based

10) If the ISP includes assignments of work to an individual, the assignment of work must be therapeutic in value.

5. Daily documentation of progress notes

a. Progress notes must include the date, time, duration, participant names, and a brief summary of the session with the treatment goal, objection or intervention the session addressed, and the name of the staff person who provided it.

b. Progress notes document:

1) Significant changes in the resident's clinical and health status;

2) Implementation of interventions listed on ISP and progress towards meeting goals and objectives.

3) Coordination and communication with outside providers;

4) Medical appointments; and

5) Contacts with family identified by the resident.

c. Progress notes are documented in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur.

d. Provider must document at minimum one daily service encounter.

1) A service encounter consists of: individual sessions, group sessions, or other therapeutic interaction addressing ISP goals, objectives, or interventions.

2) Provider must document at least a minimum weekly individual session.

e. Continuing Stay Criteria

1) Continued stay assessments are person-centered based upon the resident's individual treatment needs and progress in residential treatment.

2) Continued stay eligibility criteria are:

(a) The resident meets the ASAM placement criteria for the requested residential level of care.

(b) The resident has demonstrated progress toward achieving treatment goals during the initial authorization period.

(c) The resident's needs cannot be more appropriately met by any other formal or informal system or support.

3) The Provider shall request a continuation of an individual's stay by submitting a Utilization Review form, encrypted, to oprequest@tmbho.org to Thurston-Mason BH-ASO no later than five working days before expiration of initial authorization. Failure to provide complete information within this timeline may result in a rejection of the continuing stay request.

4) The required written documentation must include:

(a) Updated ASAM evaluation by each dimension;

(b) Requested number of days for continuing stay with goals to be accomplished; and

(c) Brief description of resident's progress on ISP goals, additional goals and interventions added, projected treatment goals, and, the individualized reason and need for continued stay at the residential level of care.

5) Thurston-Mason BH-ASO shall make a decision on the continuing stay request and notify the Provider of disposition within two working days of receiving the continuing stay request submittal.

6) If it is determined that the resident does not meet continuing stay eligibility criteria, the resident and/or resident's family (if legal guardian) may appeal the disposition.

f. Discharge planning includes documentation to supports the reason for discharge (planned or unplanned) in the clinical record.

1) The Provider collaboratively developed discharging planning with individual.

2) Discharge planning initiated during the first week of treatment.

3) Planned discharges identifies the Continuing Care Plan and recommendations by the Provider to assist in the successful transition to the next level of care:

(a) SUD Outpatient is established with a set appointment date & time for the individual to return.

(b) Other follow up services both recommended and secured including, but not limited to: housing, transportation, mental health services, education, employment assistance, medical, dental, legal, other resources or services in the discharge plan to meet the needs of the individual.

(c) Continuing Care Plan provided to individual/family and/or legal guardian.

6. Planned Leave

a. The Provider shall allow a resident to leave the facility for the purposes of obtaining medical treatment not available at the center, conducting personal business, visiting with family members or significant others and for other reasons that may be beneficial to the resident's treatment program. The outpatient program shall be informed of the need for a planned leave.

b. If a resident shall be absent from the Provider's facility on approved planned leave for more than 72 hours, the following applies:

1) Residential staff must notify Thurston-Mason BH-ASO and indicate the total number of days the resident will be absent and the reason for the absence.

2) Notification for planned absence shall occur prior to leave.

3) Staff shall notify Thurston-Mason BH-ASO documenting the total number of days requested and reason(s) for the request.

4) The Thurston-Mason BH-ASO will review the planned leave request, determine if the SUD residential bed should remain open for the resident, and if so, approve payment for the bed days. Thurston-Mason BH-ASO will notify the provider of the approval within three business days.

5) All planned leaves must be consistent with the resident's Individual Service Plan (ISP).

c. Residential staff shall be responsible for providing ongoing case management at all times during a resident's planned leave, including crisis intervention and stabilization, until the individual has returned to the residential bed.

d. Residential staff shall be responsible for linking the resident to appropriate services if the resident will not be returning to facility developed in collaboration with the outpatient treatment facility that made the bed placement.

7. Unplanned Leave

a. The Provider may maintain a benefit for 24 hours without requesting Thurston-Mason BH-ASO's absence authorization for a resident's unplanned voluntary exit should the individual's return remain a possibility.

1) The termination date is the date of exit if the person does not return to the program.

b. If the Provider wants to maintain the benefit beyond 24 hours following a resident's unplanned, voluntary exit from the program, the following applies:

1) Residential staff shall complete and submit to Thurston-Mason BH-ASO the Residential Absence Authorization form documenting the total number of days requested and reason(s) for the request.

2) The Thurston-Mason BH-ASO will review the absence authorization request and notify the residential facility of the disposition.

3) The Thurston-Mason BH-ASO will authorize a benefit for maximum of 72 hours from the date of the resident's unplanned, voluntary exit from the program.

8. Termination and Discharge - the Provider shall not include the discharge date as a payment day. The Provider is not eligible for payment for the day of discharge.

a. SUD residential benefit will terminate under the following circumstances:

1) The Thurston-Mason BH-ASO authorization period expires;

2) The resident permanently exits the program prior to the expiration date of the authorization period;

3) The resident dies;

4) The resident gains enough resources during the benefit to be treated as a private-pay client; or

5) Provider discharges resident to ensure the safety of other residents and staff.

b. A terminated benefit is payable to the date of termination.

1) For the required terminations above, the date of the termination is the date of the event, unless otherwise specified.

2) When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped by Thurston-Mason BH-ASO.

SECTION 20.7.3: SUD RESIDENTIAL ADULT LONG-TERM RESIDENTIAL STATEMENT OF WORK

Purpose

The Provider shall provide adult SUD residential treatment within available resources in the form of Long-term residential services designed from a recovery and resiliency perspective that will enable residents to live in the community with minimal dependence on public safety and acute care resources.

Program Description

1. General Program Requirement.

a. The Provider shall provide access to services as follows:

1) The Provider shall ensure that treatment services are not denied to any individual solely on the basis of that individual's drug(s) of choice.

2) The Provider shall accept and make the necessary adjustments to continue treatment for any clinically-appropriate client actively taking an opiate substitution medication.

3) The Provider shall not have policies or procedures in place that deny treatment services to any individual solely on the basis that the client is taking prescribed medication(s). However, the Provider reserves the right to deny admission to any individual when the Provider determines that the individual is beyond the scope of the Provider's ability to safely or adequately treat.

4) The Provider shall ensure that access to treatment services is not denied solely on the basis that a client is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.

5) Services shall be provided according to all of the following values:
    a. Cultural, linguistic and disability competent
    b. Oriented toward promoting recovery and resiliency
    c. Appropriate to the age and developmental stage of the resident
    d. Preference for the most independent living setting
6) The Provider shall provide adult SUD residential services within the identified levels of care as defined in the WAC 246-341 and as described by ASAM. Services shall be provided in accordance with the Department of Health regulations as stated in WAC 246-337 or its successor for a Residential Treatment Facilities (RTF).
7) Long-term treatment services are substance use disorder residential treatment services that provide a program for an individual needing consistent structure over a longer period of time to develop and maintain abstinence, develop recovery skills, and to improve overall health while in a supervised facility in accordance with WAC 246-341. This level of SUD treatment satisfies the level of intensity in ASAM Level 3.3.

b. Priority Populations
    1) Per the Substance Abuse Block Grant (SABG) requirements, Thurston-Mason BH-ASO and the Provider shall prioritize treatment admissions according to the following priority categories:
        (a) Women who are pregnant and injecting drugs
        (b) Women who are pregnant with SUDs
        (c) Women with dependent children
        (d) Individuals who are injecting drugs

2. Access to Services
    a. Eligibility– Provider must follow steps in Section 2.1, Service Eligibility
        1) Adult, 18 years or older
        2) Resides in Thurston or Mason County
        3) Diagnosed per DSM-5-TR criteria for Substance Use Disorder (SUD)
        4) Meets specific ASAM placement criteria for residential level of care
        5) The individual's needs cannot be more appropriately met by any other formal or informal system of support.
        6) Has been authorized by Thurston-Mason BH-ASO for this level of care.
    b. The initial authorization for Thurston-Mason regional residents for residential services shall be procured by the community-based assessor or outpatient provider after verifying bed availability with Provider.
    c. The Provider shall ensure there is an authorization in place prior to admitting the individual into the program.
    d. Thurston-Mason BH-ASO shall not reimburse SUD residential services without documented authorization.
3. Treatment
    a. The Provider shall provide services according to WAC 246-341, individual need, and to each resident and his or her family or support system, in order to help the individual, achieve recovery and resiliency through mutually negotiated goals of treatment.
    b. The Provider shall ensure residents have a voice in developing their Individual Service Plan (ISP).
    c. The Provider shall ensure significant others, as identified by the resident, are involved in the service plan

development and implementation.

d. The Provider shall ensure treatment goals are written in words understood by the resident.

e. The Provider shall ensure documentation related to progress toward treatment goals includes the resident's views on his or her progress.

f. The Provider shall provide each resident the necessary personal items; i.e., soap, toothbrush, toothpaste, and sanitary items from the funds included in the daily bed rate.

g. Treatment provided is consistent with ASAM 3.3 level of care appropriate for adult.

4. Clinical Records and Documentation

   a. The Provider shall ensure that residential facility staff maintains individual clinical records and individualized clinical documentation.

   b. Contain release of information forms (ROI) for care coordinating.

   c. Include referrals to community support services.

   d. An ISP is developed within five days of admission.

      1) Personalized to the individual's unique treatment needs as identified on the SUD assessment.

      2) The ISP is written in clear, straightforward language that is understandable to the individual and family (e.g., does not contain references, abbreviations and/or technical language that the individual may not understand or be familiar with)

      3) Initiated with at least one goal identified by the individual during the initial assessment or at the first service session following the assessment.

      4) Document at least every two weeks ISP reviews and progress towards goals and/or objectives.

      5) Includes individual needs identified in the diagnostic and periodic reviews, addressing:

         (a) All substance use needing treatment, including tobacco, if necessary;

         (b) Resident's bio-psychosocial identified needs and concerns;

         (c) Age, cultural and/or disability issues relevant to treatment;

         (d) Estimated dates or conditions for completion of each treatment goal;

         (e) Contains measurable goals or objectives or both, and interventions/approaches; and

         (f) The interventions listed are aligned with the identified objective.

      6) Documents are approved by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.

      7) Documents that the plan was updated to reflect any changes in the individual's treatment needs, status, ASAM dimensions, and progress towards goals, or as requested by the individual.

      8) Demonstrates the resident's participation in the development of the plan and that plan was mutually agreed upon with copy provided to resident.

      9) The ISP is strength-based

      10) If the ISP includes assignments of work to an individual, the assignment of work must be therapeutic in value.

5. Daily documentation of progress notes

   a) Progress notes must include the date, time, duration, participant names, and a brief summary of the session with the treatment goal, objection or intervention the session addressed, and the name of the staff person who provided it.

b) Progress notes document:

1) Significant changes in the resident's clinical and health status;

2) Implementation of interventions listed on ISP and progress towards meeting goals and objectives.

3) Coordination and communication with outside providers;

4) Medical appointments; and

5) Contacts with family identified by the resident.

c) Progress notes are documented in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur.

1) Provider must document at minimum one daily service encounter.

2) A service encounter consists of: individual sessions, group sessions, or other therapeutic interaction addressing ISP goals, objectives, or interventions.

6. Continuing Stay Criteria

b. Continued stay assessments are person-centered based upon the resident's individual treatment needs and progress in residential treatment.

c. Continued stay eligibility criteria are:

1) The resident meets the ASAM placement criteria for the requested residential level of care.

2) The resident has demonstrated progress toward achieving treatment goals during the initial authorization period.

3) The resident's needs cannot be more appropriately met by any other formal or informal system or support.

d. The Provider shall request a continuation of an individual's stay by submitting a Utilization Review form, encrypted, to oprequest@tmbho.org to Thurston-Mason BH-ASO no later than five working days before expiration of initial authorization. Failure to provide complete information within this timeline may result in a rejection of the continuing stay request.

e. The required written documentation must include:

1) Updated ASAM evaluation by each dimension;

2) Requested number of days for continuing stay with goals to be accomplished; and Brief description of resident's progress on ISP goals, additional goals and interventions added, projected treatment goals, and, the individualized reason and need for continued stay at the residential level of care.

f. Thurston-Mason BH-ASO shall make a decision on the continuing stay request and notify the Provider of disposition within two working days of receiving the continuing stay request submittal. If it is determined that the resident does not meet continuing stay eligibility criteria, the resident and/or resident's family (if legal guardian) may appeal the disposition.

7. Discharge planning includes documentation to supports the reason for discharge (planned or unplanned) in the clinical record.

a. The Provider collaboratively developed discharging planning with individual.

b. Discharge planning initiated during the first week of treatment.

c. Planned discharges identifies the Continuing Care Plan and recommendations by the Provider to assist in the successful transition to the next level of care:

1) SUD Outpatient is established with a set appointment date & time for the individual to return.

2) Other follow up services both recommended and secured including, but not limited to: housing,

transportation, mental health services, education, employment assistance, medical, dental, legal, other resources or services in the discharge plan to meet the needs of the individual.

3) Continuing Care Plan provided to individual/family and/or legal guardian.

8. Planned Leave

   a. The Provider shall allow a resident to leave the facility for the purposes of obtaining medical treatment not available at the center, conducting personal business, visiting with family members or significant others and for other reasons that may be beneficial to the resident's treatment program. The outpatient program shall be informed of the need for a planned leave.

   b. If a resident shall be absent from the Provider's facility on approved planned leave for more than 72 hours, the following applies:

      1) Residential staff must notify Thurston-Mason BH-ASO and indicate the total number of days the resident will be absent and the reason for the absence.

      2) Notification for planned absence shall occur prior to leave.

      3) Staff shall notify Thurston-Mason BH-ASO documenting the total number of days requested and reason(s) for the request.

      4) The Thurston-Mason BH-ASO will review the planned leave request, determine if the SUD residential bed should remain open for the resident, and if so, approve payment for the bed days. Thurston-Mason BH-ASO will notify the provider of the approval within three business days.

      5) All planned leaves must be consistent with the resident's Individual Service Plan (ISP).

   c. Residential staff shall be responsible for providing ongoing case management at all times during a resident's planned leave, including crisis intervention and stabilization, until the individual has returned to the residential bed.

   d. Residential staff shall be responsible for linking the resident to appropriate services if the resident will not be returning to facility developed in collaboration with the outpatient treatment facility that made the bed placement.

9. Unplanned Leave

   a. The Provider may maintain a benefit for 24 hours without requesting Thurston-Mason BH-ASO's absence authorization for a resident's unplanned voluntary exit should the individual's return remain a possibility.

      1) The termination date is the date of exit if the person does not return to the program.

   b. If the Provider wants to maintain the benefit beyond 24 hours following a resident's unplanned, voluntary exit from the program, the following applies:

      1) Residential staff shall notify Thurston-Mason BH-ASO documenting the total number of days requested and reason(s) for the request.

   c. The Thurston-Mason BH-ASO will review the absence authorization request and notify the residential facility of the disposition.

   d. The Thurston-Mason BH-ASO will authorize a benefit for maximum of 72 hours from the date of the resident's unplanned, voluntary exit from the program.

10. Termination and Discharge - the Provider shall not include the discharge date as a payment day. The Provider is not eligible for payment for the day of discharge.

    a. SUD residential benefit will terminate under the following circumstances:

       1) The Thurston-Mason BH-ASO authorization period expires;

       2) The resident permanently exits the program prior to the expiration date of the authorization period;

3) The resident dies;

4) The resident gains enough resources during the benefit to be treated as a private-pay client; or

5) Provider discharges resident to ensure the safety of other residents and staff.

b. A terminated benefit is payable to the date of termination.

1) For the required terminations above, the date of the termination is the date of the event, unless otherwise specified.

2) When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped by Thurston-Mason BH-ASO.

SECTION 20.7.4: SUD RESIDENTIAL PREGNANT AND PARENTING WOMEN (PPW) RESIDENTIAL SERVICES

STATEMENT OF WORK

Purpose

The Provider shall provide adult SUD residential treatment within available resources in the form of residential services designed from a recovery and resiliency perspective that will enable residents to live in the community with minimal dependence on public safety and acute care resources.

Program Description

1. General Program Requirement

a. The Provider shall provide access to services as follows:

1) The Provider shall ensure that treatment services are not denied to any individual solely on the basis of that individual's drug(s) of choice.

2) The Provider shall accept and make the necessary adjustments to continue treatment for any clinically-appropriate client actively taking an opiate substitution medication.

3) The Provider shall not have policies or procedures in place that deny treatment services to any individual solely on the basis that the client is taking prescribed medication(s). However, the Provider reserves the right to deny admission to any individual when the Provider determines that the individual is beyond the scope of the Provider's ability to safely or adequately treat.

4) The Provider shall ensure that access to treatment services is not denied solely on the basis that a client is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.

5) Services shall be provided according to all of the following values:

a) Cultural, linguistic and disability competent

b) Oriented toward promoting recovery and resiliency

c) Appropriate to the age and developmental stage of the resident

d) Preference for the most independent living setting

6) The Provider shall provide adult SUD residential services within the identified levels of care as defined in the WAC 246-341 and as described by ASAM. Services shall be provided in accordance with the Department of Health regulations as stated in WAC 246-337 or its successor for a Residential Treatment Facilities (RTF).

7) Pregnant and Parenting Women (PPW) residential services are licensed, facility-based services that provide an enhanced curriculum for high risk pregnant and parenting women that include linkages to prenatal and postpartum care and assurance of ongoing pediatric care for newborns, infants and

children. Services may include a focus on domestic violence, childhood sexual abuse, child abuse prevention, mental health issues, employment skills and education, linkages to pre- and post-natal medical care, legal advocacy and safe affordable housing. The service as described satisfies the level of intensity in ASAM Level 3.5 and 3.3.

b. Priority Populations

1) Per the Substance Abuse Block Grant (SABG) requirements, Thurston-Mason BH-ASO and the Provider shall prioritize treatment admissions according to the following priority categories:

a) Women who are pregnant and injecting drugs

b) Women who are pregnant with SUDs

c) Women with dependent children

d) Individuals who are injecting drugs

2. Access to Services

a. Eligibility– Provider must follow steps in Section 2.1, Service Eligibility

1) Adult PPW, 18 years or older

2) Resides in Thurston or Mason County

3) Diagnosed per DSM-5-TR criteria for Substance Use Disorder (SUD)

4) Meets specific ASAM placement criteria for residential level of care

5) The individual's needs cannot be more appropriately met by any other formal or informal system of support.

6) Has been authorized by Thurston-Mason BH-ASO for this level of care.

7) The initial authorization for Thurston-Mason regional residents for residential services shall be procured by the community-based assessor or outpatient provider after verifying bed availability with Provider.

8) The Provider shall ensure there is an authorization in place prior to admitting the individual into the program.

9) Thurston-Mason BH-ASO shall not reimburse SUD residential services without documented authorization.

b. Pregnant and Parenting Women (PPW) Services

1) The Provider shall:

a) Provide an opportunity for a resident's clinical individual and group services to be provided by someone of the same gender.

b) Provide residential family support to residents participating in the treatment program to ensure a successful completion and shall include:

a) Crisis and anger management;

b) Treatment and program rules compliance;

c) Medication and medical emergency management;

d) Situational parenting support and education and care of children;

e) Family management skills; and

f) Behavioral management.

2) Provide the following case management and social services to pregnant, postpartum, parenting women:
    a) Orientation to facility and treatment;
    b) Assistance to access public medical, financial, social services benefits;
    c) Applications, appointments, transportation for housing, medical, mental health, support services;
    d) Interface with criminal and juvenile justice system;
    e) Interface with child welfare services;
    f) Eating disorders, sexual assault, domestic violence, childhood abuse, family dysfunction (these may be referred out);
    g) Discharge planning that ensures continuity of care and includes local Community Service Office (CSO) and continuing care as applicable; and
    h) Parenting education and support services.
3) Provide the following medical and health services to pregnant, postpartum, parenting women:
    a) Nursing assessments including, but not limited to, TB and immunizations;
    b) Labor and delivery plans for pregnant residents;
    c) Medical Stabilization/Triage;
    d) Daily health assessments;
    e) Health crisis management;
    f) Medication procurement, disbursement, monitoring;
        a) Primary physician arrangement and recommended follow-up lab work;
        b) At least ten hours of education regarding child and adult nutrition, pregnancy, labor & delivery, lactation, HIV/AIDS, birth control, exercise, smoking, sexually transmitted disease, FASD; and
        c) Dental services by referral.
4) Provide the following mental health services to pregnant, postpartum, parenting women:
    a) Assessment/referral;
    b) Follow-up; and
    c) Interface with mental health professionals.
5) Coordinate a re-entry preparation for residents who have under gone treatment and may include:
    a) Basic adult education/GED preparation;
    b) College readiness;
    c) Job skill assessment;
    d) Employment plans;
    e) Job readiness - resume writing, clothing, appropriate behavior;
    f) Community resource utilization;
    g) Coordination with CSO Case Manager for Work First Requirements.

c. Therapeutic Interventions for Children (TIC)

1) Therapeutic Interventions for Children (TIC) are services to promote the health and welfare of children accompanying parents participating in a substance abuse program. Services include developmental assessment using recognized, standardized instruments; play therapy; behavioral modification; individual counseling; self-esteem building; and family intervention to modify parenting behavior and/or the child's environment to assure age-appropriate develop mental expectations and interactions. The Provider shall:

    a) Ensure that the required staff functions and qualifications are met.

    b) Offer TIC services a minimum of four hours per day, including staffing time, five days per week. The services shall maintain a ratio of one staff person for every three children under 24 months, and one staff person for every five children over 24 months.

    c) Ensure the SUD residential facility is licensed as a childcare center by the Department of Children, Youth and Families (DCYF) and shall post a current copy of the license. In the event licensure is not possible, the Provider shall comply with each of the components of childcare relatedto the selected standards for an acceptable child care program incorporated in WAC 170-295 or its successor.

    d) Develop and document an initial individualized parenting education plan within fourteen days of admission. The plan shall be based on length of stay, parent's ability to engage in education, the child's needs, and the parent's goals. The plan shall be developed in conjunction with the parent and include the parent's goals.

    e) Provide or arrange for an initial health assessment by a licensed health care provider for each child within two weeks of admission or as recommended by the well-baby schedule.

    f) Provide or arrange for a standardized developmental assessment for each child within two weeks of admission that includes gross motor, fine motor, social, self-help, and communication/language skills. The assessmentshall be administered by an individual trained in the method and use of the standardized assessment instrument.

2) Based on information obtained through initial assessments and observations, establish goals and objectives for the child's development and progress while in the childcare program.

3) Coordinate with Child Protective Services (CPS), when involved, regarding their goals and objectives for the child and parent while in treatment.

3. Treatment

    a. The Provider shall provide services according to WAC 246-341, individual need, and to each resident and his or her family or support system, in order to help the individual achieve recovery and resiliency through mutually negotiated goals of treatment.

    b. The Provider shall ensure residents have a voice in developing their Individual Service Plan (ISP).

    c. The Provider shall ensure significant others, as identified by the resident, are involved in the service plan development and implementation.

    d. The Provider shall ensure treatment goals are written in words understood by the resident.

    e. The Provider shall ensure documentation related to progresstoward treatment goals includes the resident’s views on his or herprogress.

    f. The Provider shall provide each resident the necessary personal items; i.e., soap, toothbrush, toothpaste, and sanitary items from the funds included in the daily bed rate.

4. Clinical Records and Documentation

    a. The Provider shall ensure that residential facility staff maintains individual clinical records and individualized clinical documentation.

b. Contain release of information forms (ROI) for care coordinating.

c. Include referrals to community support services.

d. An ISP is developed within five days of admission.

1) Personalized to the individual's unique treatment needs as identified on the SUD assessment.

2) The ISP is written in clear, straightforward language that is understandable to the individual and family (e.g., does not contain references, abbreviations and/or technical language that the individual may not understand or be familiar with)

3) Initiated with at least one goal identified by the individual during the initial assessment or at the first service session following the assessment.

4) Document ISP reviews and progress towards goals and/or objectives every two weeks for ASAM level 3.3 or weekly for ASAM level 3.5.

5) Includes individual needs identified in the diagnostic and periodic reviews, addressing:

a) All substance use needing treatment, including tobacco, if necessary;

b) Resident's bio-psychosocial identified needs and concerns;

c) Age, cultural and/or disability issues relevant to treatment;

d) Estimated dates or conditions for completion of each treatment goal;

e) Contains measurable goals or objectives or both, and interventions/approaches; and

f) The interventions listed are aligned with the identified objective.

6) Documents are approved by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.

7) Documents that the plan was updated to reflect any changes in the individual's treatment needs, status, ASAM dimensions, and progress towards goals, or as requested by the individual.

8) Demonstrates the resident's participation in the development of the plan and that plan was mutually agreed upon with copy provided to resident.

9) The ISP is strength-based

10) If the ISP includes assignments of work to an individual, the assignment of work must be therapeutic in value.

c. Daily documentation of progress notes

1) Progress notes must include the date, time, duration, participant names, and a brief summary of the session with the treatment goal, objection or intervention the session addressed, and the name of the staff person who provided it.

(a) Progress notes document:

(1) Significant changes in the resident's clinical and health status;

(2) Implementation of interventions listed on ISP and progress towards meeting goals and objectives.

(3) Coordination and communication with outside providers;

(4) Medical appointments; and

(5) Contacts with family identified by the resident.

2) Progress notes are documented in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this

did not occur.

(a) Provider must document at minimum one daily service encounter.

(b) A service encounter consists of individual sessions, group sessions, or other therapeutic interaction addressing ISP goals, objectives, or interventions.

d. Continuing Stay Criteria

1) Continued stay assessments are person-centered based upon the resident's individual treatment needs and progress in residential treatment.

2) Continued stay eligibility criteria are:

(a) The resident meets the ASAM placement criteria for the requested residential level of care.

(b) The resident has demonstrated progress toward achieving treatment goals during the initial authorization period.

(c) The resident's needs cannot be more appropriately met by any other formal or informal system or support.

(d) The Provider shall request a continuation of an individual's stay by submitting a Utilization Review form, encrypted, to oprequest@tmbho.org to Thurston-Mason BH-ASO no later than five working days before expiration of initial authorization. Failure to provide complete information within this timeline may result in a rejection of the continuing stay request.

(e) The required written documentation must include:

(1) Updated ASAM evaluation by each dimension;

(2) Requested number of days for continuing stay with goals to be accomplished; and

(3) Brief description of resident's progress on ISP goals, additional goals and interventions added, projected treatment goals, and, the individualized reason and need for continued stay at the residential level of care.

3) Thurston-Mason BH-ASO shall make a decision on the continuing stay request and notify the Provider of disposition within two working days of receiving the continuing stay request submittal.

(a) If it is determined that the resident does not meet continuing stay eligibility criteria, the resident and/or resident's family (if legal guardian) may appeal the disposition.

e. Discharge planning includes documentation to supports the reason for discharge (planned or unplanned) in the clinical record.

1) The Provider collaboratively developed discharging planning with individual.

2) Discharge planning initiated during the first week of treatment.

3) Planned discharges identifies the Continuing Care Plan and recommendations by the Provider to assist in the successful transition to the next level of care:

a) SUD Outpatient is established with a set appointment date & time for the individual to return.

b) Other follow up services both recommended and secured including, but not limited to: housing, transportation, mental health services, education, employment assistance, medical, dental, legal, other resources or services in the discharge plan to meet the needs of the individual.

c) Continuing Care Plan provided to individual/family and/or legal guardian.

11. Planned Leave

a. The Provider shall allow a resident to leave the facility for the purposes of obtaining medical treatment not

available at the center, conducting personal business, visiting with family members or significant others and for other reasons that may be beneficial to the resident's treatment program. The outpatient program shall be informed of the need for a planned leave.

b. If a resident shall be absent from the Provider's facility on approved planned leave for more than 72 hours, the following applies:

    1) Residential staff must notify Thurston-Mason BH-ASO and indicate the total number of days the resident will be absent and the reason for the absence.

    2) Notification for planned absence shall occur prior to leave.

    3) Staff shall notify Thurston-Mason BH-ASO documenting the total number of days requested and reason(s) for the request.

    4) The Thurston-Mason BH-ASO will review the planned leave request, determine if the SUD residential bed should remain open for the resident, and if so, approve payment for the bed days. Thurston-Mason BH-ASO will notify the provider of the authorization within three business days.

    5) All planned leaves must be consistent with the resident's Individual Service Plan (ISP).

c. Residential staff shall be responsible for providing ongoing case management at all times during a resident's planned leave, including crisis intervention and stabilization, until the individual has returned to the residential bed.

d. Residential staff shall be responsible for linking the resident to appropriate services if the resident will not be returning to facility developed in collaboration with the outpatient treatment facility that made the bed placement.

12. Unplanned Leave

    a. The Provider may maintain a benefit for 24 hours without requesting Thurston-Mason BH-ASO's absence authorization for a resident's unplanned voluntary exit should the individual's return remain a possibility.

        1) The termination date is the date of exit if the person does not return to the program.

    b. If the Provider wants to maintain the benefit beyond 24 hours following a resident's unplanned, voluntary exit from the program, the following applies:

        1) Residential staff shall notify Thurston-Mason BH-ASO documenting the total number of days requested and reason(s) for the request.

        2) The Thurston-Mason BH-ASO will review the request and notify the residential facility of the disposition.

        3) The Thurston-Mason BH-ASO will authorize a benefit for maximum of 72 hours from the date of the resident's unplanned, voluntary exit from the program.

13. Termination and Discharge - the Provider shall not include the discharge date as a payment day. The Provider is not eligible for payment for the day of discharge.

    a. SUD residential benefit will terminate under the following circumstances:

        1) The Thurston-Mason BH-ASO authorization period expires;

        2) The resident permanently exits the program prior to the expiration date of the authorization period;

        3) The resident dies;

        4) The resident gains enough resources during the benefit to be treated as a private-pay client; or

        5) Provider discharges resident to ensure the safety of other residents and staff.

    b. A terminated benefit is payable to the date of termination.

1) For the required terminations above, the date of the termination is the date of the event, unless otherwise specified.

2) When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped by Thurston-Mason BH-ASO.

SECTION 20.7.5: SUD RESIDENTIAL ADULT RECOVERY HOUSE STATEMENT OF WORK

Purpose

The Provider shall provide adult SUD residential treatment within available resources in the form of Recovery House services designed from a recovery and resiliency perspective that will enable residents to live in the community with minimal dependence on public safety and acute care resources.

Program Description

1. General Program Requirement

   a. The Provider shall provide access to services as follows:

      1) The Provider shall ensure that treatment services are not denied to any individual solely on the basis of that individual's drug(s) of choice.

      2) The Provider shall accept and make the necessary adjustments to continue treatment for any clinically-appropriate client actively taking an opiate substitution medication.

      3) The Provider shall not have policies or procedures in place that deny treatment services to any individual solely on the basis that the client is taking prescribed medication(s). However, the Provider reserves the right to deny admission to any individual when the Provider determines that the individual is beyond the scope of the Provider's ability to safely or adequately treat.

      4) The Provider shall ensure that access to treatment services is not denied solely on the basis that a client is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.

      5) Services shall be provided according to all of the following values:

         (a) Cultural, linguistic and disability competent

         (b) Oriented toward promoting recovery and resiliency

         (c) Appropriate to the age and developmental stage of the resident

         (d) Preference for the most independent living setting

      6) The Provider shall provide adult SUD residential services within the identified levels of care as defined in the WAC 246-341 and as described by ASAM. Services shall be provided in accordance with the Department of Health regulations as stated in WAC 246-337 or its successor for a Residential Treatment Facilities (RTF).

      7) Recovery house services are substance use disorder residential treatment services that provide a program of care and treatment with social, vocational, and recreational activities to aid in individual adjustment to abstinence, relapse prevention, recovery skills development, and to aid in job training, employment, or participating in other types of community services while in a supervised facility in accordance with WAC 246-341. This level of SUD treatment satisfies the level of intensity in ASAM Level 3.1.

   b. Priority Populations

      1) Per the Substance Abuse Block Grant (SABG) requirements, Thurston-Mason BH-ASO and the Provider shall prioritize treatment admissions according to the following priority categories:

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a) Women who are pregnant and injecting drugs
b) Women who are pregnant with SUDs
c) Women with dependent children
d) Individuals who are injecting drugs

2. Access to Services
    a. Eligibility– Provider must follow steps in Section 2.1, Service Eligibility
        1) Adult, 18 years or older
        2) Resides in Thurston or Mason Counties.
        3) Diagnosed per DSM-5-TR criteria for Substance Use Disorder (SUD)
        4) Meets specific ASAM placement criteria for residential level of care
        5) The individual's needs cannot be more appropriately met by any other formal or informal system of support.
        6) Has been authorized by Thurston-Mason BH-ASO for this level of care.
            a) The initial authorization for Thurston-Mason regional residents for residential services shall be procured by the community-based assessor or outpatient provider after verifying bed availability with Provider.
            b) The Provider shall ensure there is an authorization in place prior to admitting the individual into the program.
            c) Thurston-Mason BH-ASO shall not reimburse SUD residential services without documented authorization.
3. Treatment
    a. The Provider shall provide services according to WAC 246-341, individual need, and to each resident and his or her family or support system, in order to help the individual, achieve recovery and resiliency through mutually negotiated goals of treatment.
    b. The Provider shall ensure residents have a voice in developing their Individual Service Plan (ISP).
    c. The Provider shall ensure significant others, as identified by the resident, are involved in the service plan development and implementation.
    d. The Provider shall ensure treatment goals are written in words understood by the resident
    e. The Provider shall ensure documentation related to progress toward treatment goals includes the resident's views on his or her progress.
    f. The Provider shall provide each resident the necessary personal items; i.e., soap, toothbrush, toothpaste, and sanitary items from the funds included in the daily bed rate.
    g. Treatment provided is consistent with ASAM 3.1 level of care appropriate for adult.
4. Clinical Records and Documentation
    a. The Provider shall ensure that residential facility staff maintains individual clinical records and individualized clinical documentation.
    b. Contain release of information forms (ROI) for care coordinating.
    c. Include referrals to community support services.
    d. An ISP is developed within five days of admission.

1) Personalized to the individual's unique treatment needs as identified on the SUD assessment.
2) The ISP is written in clear, straightforward language that is understandable to the individual and family (e.g., does not contain references, abbreviations and/or technical language that the individual may not understand or be familiar with)
3) Initiated with at least one goal identified by the individual during the initial assessment or at the first service session following the assessment.
4) Document at least monthly ISP reviews and progress towards goals and/or objectives.
5) Includes individual needs identified in the diagnostic and periodic reviews, addressing:
    a) All substance use needing treatment, including tobacco, if necessary;
    b) Resident's bio-psychosocial identified needs and concerns;
    c) Age, cultural and/or disability issues relevant to treatment;
    d) Estimated dates or conditions for completion of each treatment goal;
    e) Contains measurable goals or objectives or both, and interventions/approaches; and
    f) The interventions listed are aligned with the identified objective.
6) Documents are approved by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.
7) Documents that the plan was updated to reflect any changes in the individual's treatment needs, status, ASAM dimensions, and progress towards goals, or as requested by the individual.
8) Demonstrates the resident's participation in the development of the plan and that plan was mutually agreed upon with copy provided to resident.
9) The ISP is strength-based
10) If the ISP includes assignments of work to an individual, the assignment of work must be therapeutic in value.

e. Daily documentation of progress notes

1) Progress notes must include the date, time, duration, participant names, and a brief summary of the session with the treatment goal, objection or intervention the session addressed, and the name of the staff person who provided it.
2) Progress notes document:
    a) Significant changes in the resident's clinical and health status;
    b) Implementation of interventions listed on ISP and progress towards meeting goals and objectives.
    c) Coordination and communication with outside providers;
    d) Medical appointments; and
    e) Contacts with family identified by the resident.

a) Progress notes are documented in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur.

b) Provider must document at minimum one daily service encounter.

    a) A service encounter consists of: individual sessions, group sessions, or other therapeutic interaction addressing ISP goals, objectives, or interventions.

5. Continuing Stay Criteria

1) Continued stay assessments are person-centered based upon the resident's individual treatment needs and progress in residential treatment.
2) Continued stay eligibility criteria are:
    a) The resident meets the ASAM placement criteria for the requested residential level of care.
    b) The resident has demonstrated progress toward achieving treatment goals during the initial authorization period.
    c) The resident's needs cannot be more appropriately met by any other formal or informal system or support.
3) The Provider shall request a continuation of an individual's stay by submitting a Utilization Review form, encrypted, to oprequest@tmbho.org to Thurston-Mason BH-ASO no later than five working days before expiration of initial authorization. Failure to provide complete information within this timeline may result in a rejection of the continuing stay request.
4) The required written documentation must include:
    a) Updated ASAM evaluation by each dimension;
    b) Requested number of days for continuing stay with goals to be accomplished; and
    c) Brief description of resident's progress on ISP goals, additional goals and interventions added, projected treatment goals, and, the individualized reason and need for continued stay at the residential level of care.
5) Thurston-Mason BH-ASO shall make a decision on the continuing stay request and notify the Provider of disposition within two working days of receiving the continuing stay request submittal.
6) If it is determined that the resident does not meet continuing stay eligibility criteria, the resident and/or resident's family (if legal guardian) may appeal the disposition.
7) Discharge planning includes documentation to supports the reason for discharge (planned or unplanned) in the clinical record.
    a) The Provider collaboratively developed discharging planning with individual.
    b) Discharge planning initiated during the first week of treatment.
    c) Planned discharges identifies the Continuing Care Plan and recommendations by the Provider to assist in the successful transition to the next level of care:
        1) SUD Outpatient is established with a set appointment date & time for the individual to return.
        2) Other follow up services both recommended and secured including, but not limited to: housing, transportation, mental health services, education, employment assistance, medical, dental, legal, other resources or services in the discharge plan to meet the needs of the individual.
        3) Continuing Care Plan provided to individual/family and/or legal guardian.

2. Planned Leave

a. The Provider shall allow a resident to leave the facility for the purposes of obtaining medical treatment not available at the center, conducting personal business, visiting with family members or significant others and for other reasons that may be beneficial to the resident's treatment program. The outpatient program shall be informed of the need for a planned leave.

b. If a resident shall be absent from the Provider's facility on approved planned leave for more than 72 hours, the following applies:
    1) Residential staff must notify Thurston-Mason BH-ASO and indicate the total number of days the

resident will be absent and the reason for the absence.

2) Notification for planned absence shall occur prior to leave.

3) The Thurston-Mason BH-ASO will review the planned leave request, determine if the SUD residential bed should remain open for the resident, and if so, approve payment for the bed days. Thurston-Mason BH-ASO will notify the provider of the authorization within three business days.

4) All planned leaves must be consistent with the resident's Individual Service Plan (ISP).

c. Residential staff shall be responsible for providing ongoing case management at all times during a resident's planned leave, including crisis intervention and stabilization, until the individual has returned to the residential bed.

d. Residential staff shall be responsible for linking the resident to appropriate services if the resident will not be returning to facility developed in collaboration with the outpatient treatment facility that made the bed placement.

3. Unplanned Leave

a. The Provider may maintain a benefit for 24 hours without requesting Thurston-Mason BH-ASO's absence authorization for a resident's unplanned voluntary exit should the individual's return remain a possibility.

1) The termination date is the date of exit if the person does not return to the program.

b. If the Provider wants to maintain the benefit beyond 24 hours following a resident's unplanned, voluntary exit from the program, the following applies:

1) Residential staff shall notify Thurston-Mason BH-ASO documenting the total number of days requested and reason(s) for the request.

2) The Thurston-Mason BH-ASO will review the absence authorization request and notify the residential facility of the disposition.

3) The Thurston-Mason BH-ASO will authorize a benefit for maximum of 72 hours from the date of the resident's unplanned, voluntary exit from the program.

4. Termination and Discharge - the Provider shall not include the discharge date as a payment day. The Provider is not eligible for payment for the day of discharge.

a. SUD residential benefit will terminate under the following circumstances:

1) The Thurston-Mason BH-ASO authorization period expires;

2) The resident permanently exits the program prior to the expiration date of the authorization period;

3) The resident dies;

4) The resident gains enough resources during the benefit to be treated as a private-pay client; or

5) Provider discharges resident to ensure the safety of other residents and staff.

b. A terminated benefit is payable to the date of termination.

1) For the required terminations above, the date of the termination is the date of the event, unless otherwise specified.

2) When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped by Thurston-Mason BH-ASO.

SECTION 20.7.6: SUD RESIDENTIAL YOUTH RECOVERY HOUSE STATEMENT OF WORK

Purpose

The Provider shall provide youth SUD residential treatment within available resources in the form of Recovery House services designed from a recovery and resiliency perspective that will enable residents to live in the community with minimal dependence on public safety and acute care resources.

Program Description

1. General Program Requirement
    a. The Provider shall provide access to services as follows:
        1) The Provider shall ensure that treatment services are not denied to any individual solely on the basis of that individual's drug(s) of choice.
        2) The Provider shall accept and make the necessary adjustments to continue treatment for any clinically-appropriate client actively taking an opiate substitution medication.
        3) The Provider shall not have policies or procedures in place that deny treatment services to any individual solely on the basis that the client is taking prescribed medication(s). However, the Provider reserves the right to deny admission to any individual when the Provider determines that the individual is beyond the scope of the Provider's ability to safely or adequately treat.
        4) The Provider shall ensure that access to treatment services is not denied solely on the basis that a client is using over the counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.
        5) Services shall be provided according to all of the following values:
            (a) Cultural, linguistic and disability competent
            (b) Oriented toward promoting recovery and resiliency
            (c) Appropriate to the age and developmental stage of the resident
            (d) Preference for the most independent living setting
        6) The Provider shall provide youth SUD residential services within the identified levels of care as defined in the WAC 246-341 and as described by ASAM. Services shall be provided in accordance with the Department of Health regulations as stated in WAC 246-337 or its successor for a Residential Treatment Facilities (RTF).
        7) Recovery house services are substance use disorder residential treatment services that provide a program of care and treatment with social, vocational, and recreational activities to aid in individual adjustment to abstinence, relapse prevention, recovery skills development, and to aid in job training, employment, or participating in other types of community services while in a supervised facility in accordance with WAC 246-341.
        8) This level of SUD treatment satisfies the level of intensity in ASAM Level 3.1.
    b. Priority Populations
        1) Per the Substance Abuse Block Grant (SABG) requirements, Thurston-Mason BH-ASO and the Provider shall prioritize treatment admissions according to the following priority categories:
            (a) Women who are pregnant and injecting drugs
            (b) Women who are pregnant with SUDs
            (c) Women with dependent children
            (d) Individuals who are injecting drugs
2. Access to Services
    a. Eligibility– Provider must follow steps in Section 2.1, Service Eligibility

1) Youth 17 years or younger
2) Resides in Thurston or Mason Counties.
3) Diagnosed per DSM-5-TR criteria for Substance Use Disorder (SUD)
4) Meets specific ASAM placement criteria for residential level of care.
5) The individual's needs cannot be more appropriately met by any other formal or informal system of support.
6) Has been authorized by Thurston-Mason BH-ASO for this level of care.
7) The initial authorization for Thurston-Mason regional residents for residential services shall be procured by the community-based assessor or outpatient provider after verifying bed availability with Provider.
8) The Provider shall ensure there is an authorization in place prior to admitting the individual into the program.
9) Thurston-Mason BH-ASO shall not reimburse SUD residential services without documented authorization.

3. Treatment
    a. The Provider shall provide services according to WAC 246-341, individual need, and to each resident and his or her family or support system, in order to help the individual, achieve recovery and resiliency through mutually negotiated goals of treatment.
    b. The Provider shall ensure residents have a voice in developing their Individual Service Plan (ISP).
    c. The Provider shall ensure family, as identified by the resident, are involved in the service plan development and implementation.
    d. The Provider shall ensure treatment goals are written in words understood by the resident.
    e. The Provider shall ensure documentation related to progress toward treatment goals includes the resident's views on his or her progress.
    f. The Provider shall provide each resident the necessary personal items; i.e., soap, toothbrush, toothpaste, and sanitary items from the funds included in the daily bed rate.
    g. Treatment provided is consistent with ASAM 3.1 level of care appropriate for youth.
4. Clinical Records and Documentation
    a. The Provider shall ensure that residential facility staff maintains individual clinical records and individualized clinical documentation.
    b. Contain release of information forms (ROI) for care coordinating.
    c. Include referrals to community support services.
    d. An ISP is developed within five days of admission.
        1) Personalized to the individual's unique treatment needs as identified on the SUD assessment.
        2) The ISP is written in clear, straightforward language that is understandable to the individual and family (e.g., does not contain references, abbreviations and/or technical language that the individual may not understand or be familiar with)
        3) Initiated with at least one goal identified by the individual during the initial assessment or at the first service session following the assessment.
        4) Document monthly ISP reviews and progress towards goals and/or objectives.
        5) Includes individual needs identified in the diagnostic and periodic reviews, addressing:
            (a) All substance use needing treatment, including tobacco, if necessary;

(b) Resident's bio-psychosocial identified needs and concerns;

(c) Age, cultural and/or disability issues relevant to treatment;

(d) Estimated dates or conditions for completion of each treatment goal;

(e) Contains measurable goals or objectives or both, and interventions/approaches; and

(f) The interventions listed are aligned with the identified objective.

6) Documents are approved by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.

7) Documents that the plan was updated to reflect any changes in the individual's treatment needs, status, ASAM dimensions, and progress towards goals, or as requested by the individual.

8) Demonstrates the resident's participation in the development of the plan and that plan was mutually agreed upon with copy provided to resident.

9) The ISP is strength-based

10) If the ISP includes assignments of work to an individual, the assignment of work must be therapeutic in value.

b. Daily documentation of progress notes

1) Progress notes must include the date, time, duration, participant names, and a brief summary of the session with the treatment goal, objection or intervention the session addressed, and the name of the staff person who provided it.

2) Progress notes document:

a) Significant changes in the resident's clinical and health status;

b) Implementation of interventions listed on ISP and progress towards meeting goals and objectives.

c) Coordination and communication with outside providers;

d) Medical appointments; and

e) Contacts with family identified by the resident.

3) Progress notes are documented in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur.

(a) Provider must document at minimum one daily service encounter.

(i) A service encounter consists of: individual sessions, group sessions, or other therapeutic interaction addressing ISP goals, objectives, or interventions.

c. Continuing Stay Criteria

1) Continued stay assessments are person-centered based upon the resident's individual treatment needs and progress in residential treatment.

2) Continued stay eligibility criteria are:

(a) The resident meets the ASAM placement criteria for the requested residential level of care.

(b) The resident has demonstrated progress toward achieving treatment goals during the initial authorization period.

(c) The resident's needs cannot be more appropriately met by any other formal or informal system or support.

3) The Provider shall request a continuation of an individual's stay by submitting a Utilization Review form, encrypted, to oprequest@tmbho.org to Thurston-Mason BH-ASO no later than five working days before expiration of initial authorization. Failure to provide complete information within this timeline may result in a rejection of the continuing stay request.

4) Failure to provide complete information within this timeline may result in a rejection of the continuing stay request. The required written documentation must include:

   (a) Updated ASAM evaluation by each dimension;

   (b) Requested number of days for continuing stay with goals to be accomplished; and

   (c) Brief description of resident's progress on ISP goals, additional goals and interventions added, projected treatment goals, and, the individualized reason and need for continued stay at the residential level of care.

5) Thurston-Mason BH-ASO shall make a decision on the continuing stay request and notify the Provider of disposition within two working days of receiving the continuing stay request submittal.

   (a) If it is determined that the resident does not meet continuing stay eligibility criteria, the resident and/or resident's family (if legal guardian) may appeal the disposition.

6) Discharge planning includes documentation to supports the reason for discharge (planned or unplanned) in the clinical record.

   (a) The Provider collaboratively developed discharging planning with individual.

   (b) Discharge planning initiated during the first week of treatment.

   (c) Planned discharges identifies the Continuing Care Plan and recommendations by the Provider to assist in the successful transition to the next level of care:

      (i) SUD Outpatient is established with a set appointment date & time for the individual to return.

      (ii) Other follow up services both recommended and secured including, but not limited to: housing, transportation, mental health services, education, employment assistance, medical, dental, legal, other resources or services in the discharge plan to meet the needs of the individual.

      (iii) Continuing Care Plan provided to individual/family and/or legal guardian.

2. Planned Leave

   a. The Provider shall allow a resident to leave the facility for the purposes of obtaining medical treatment not available at the center, conducting personal business, visiting with family members or significant others and for other reasons that may be beneficial to the resident's treatment program. The outpatient program shall be informed of the need for a planned leave.

   b. If a resident shall be absent from the Provider's facility on approved planned leave for more than 72 hours, the following applies:

      1) Residential staff must notify Thurston-Mason BH-ASO and indicate the total number of days the resident will be absent and the reason for the absence.

      2) Notification for planned absence shall occur prior to leave.

      3) Staff shall notify Thurston-Mason BH-ASO documenting the total number of days requested and reason(s) for the request.

      4) The Thurston-Mason BH-ASO will review the planned leave request, determine if the SUD residential bed should remain open for the resident, and if so, approve payment for the bed days. Thurston-Mason BH-ASO will notify the provider of the authorization within three business days.

5) All planned leaves must be consistent with the resident's Individual Service Plan (ISP).

c. Residential staff shall be responsible for providing ongoing case management at all times during a resident's planned leave, including crisis intervention and stabilization, until the individual has returned to the residential bed.

d. Residential staff shall be responsible for linking the resident to appropriate services if the resident will not be returning to facility developed in collaboration with the outpatient treatment facility that made the bed placement.

3. Unplanned Leave

a. The Provider may maintain a benefit for 24 hours without requesting Thurston-Mason BH-ASO's absence authorization for a resident's unplanned voluntary exit should the individual's return remain a possibility.

1) The termination date is the date of exit if the person does not return to the program.

b. If the Provider wants to maintain the benefit beyond 24 hours following a resident's unplanned, voluntary exit from the program, the following applies:

1) Residential staff shall notify Thurston-Mason BH-ASO documenting the total number of days requested and reason(s) for the request.

c. The Thurston-Mason BH-ASO will review the absence authorization request and notify the residential facility of the disposition.

1) The Thurston-Mason BH-ASO will authorize a benefit for maximum of 72 hours from the date of the resident's unplanned, voluntary exit from the program.

4. Termination and Discharge - the Provider shall not include the discharge date as a payment day. The Provider is not eligible for payment for the day of discharge.

a. SUD residential benefit will terminate under the following circumstances:

1) The Thurston-Mason BH-ASO authorization period expires;

2) The resident permanently exits the program prior to the expiration date of the authorization period;

3) The resident dies;

4) The resident gains enough resources during the benefit to be treated as a private-pay client; or

5) Provider discharges resident to ensure the safety of other residents and staff.

b. A terminated benefit is payable to the date of termination.

1) For the required terminations above, the date of the termination is the date of the event, unless otherwise specified.

2) When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped by Thurston-Mason BH-ASO.

SECTION 20.7.7: SUD SUB-ACUTE (LEVEL 3.2) AND ACUTE (LEVEL 3.7) WITHDRAWAL MANAGEMENT SERVICES (INCLUDING SECURE WITHDRAWAL MANAGEMENT)

SUD withdrawal management contractors shall ensure the minimal data elements for admission, utilization review/continued stay, and discharge are reported to Thurston-Mason BH-ASO for all individuals served within the month being invoiced. These data elements must be submitted **via an encrypted email to oprequest@tmbho.org** using the following forms, found on our website:

1. **TMBH-ASO WM Client Admission:** reported for any client admitted into services within 5 business days of admit.

2. **TMBH-ASO WM Services Utilization Review:** reported at least two business days prior to expiration of initial authorization period.
3. **TMBH-ASO WM Client Discharge:** reported for any client discharged from services within 5 business days of discharge. The Provider shall not include the discharge date as a payment day. The Provider is not eligible for payment for the day of discharge.
4. **TMBH-ASO WM Service Activity Log:** submit an updated log for each invoice period, including, all new admissions and discharges and submit with the invoice. If the invoice includes this information, the service activity log is not required.

STATEMENT OF WORK

1. Purpose
    a. The Provider shall provide withdrawal management services within the identified level of care as defined in the American Society of Addiction Medicine (ASAM) Criteria. Services shall be provided in accordance with the Department of Health regulations as stated in WAC 246-337 or its successor for a Residential Treatment Facility (RTF) and WAC 246-341-1100 or any successors.
    b. For withdrawal management Services, the Provider shall:
        (1) Ensure facility, staffing, and procedures are provided sufficient to deliver services necessary for individuals presenting for care as described in RCW 70.96A.120(4), and as otherwise detailed in this Contract.
            a) Provide screening and assessment of all individuals using standard tools. For youth only: provide screening, referral, and support services to the family/guardian of the individual.
            b) For youth only: In the event that ASO-funded residential treatment beds are not readily available upon discharge from withdrawal management/stabilization service, and the likelihood exists that a youth individual will return to drinking/using without any immediate placement, the Provider may, within available funds, provide stabilization and pre-treatment services until a residential bed has been ensured.
2. **Secure Withdrawal Management**
    a. Secure Withdrawal Management Services may be provided in a facility licensed and certified by DOH in accordance with 246-341-1135 to provide evaluation and treatment services to individuals detained by a DCR for ITA related to SUD.
    b. Services provided in Involuntary Treatment facilities such as Secure Withdrawal Management and Stabilization facilities must be licensed and certified by the Department of Health. These facilities must have adequate staff to provide a safe and secure environment for the staff, patients and the community. The facilities will provide evaluation and treatment services to limit the duration of involuntary treatment until the person can be discharged back to their home community to continue their treatment without the loss of their civil liberties. The treatment shall be evidence-based practices to include supportive housing, supported employment, Pharmacological services, psycho-social classes, withdrawal management as needed, discharge planning, and warm handoff to follow-up treatment including any less restrictive alternative care ordered by the court.
    c. Appropriate care for Individuals with a history of SUD who have been found to meet criteria for involuntary treatment includes:
        1) Evaluation and assessment, provided by a CDP;
        2) Acute or subacute detoxification services;
        3) SUD treatment; and,
        4) Discharge assistance provided by CDPs, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to LRA as appropriate for the individual.
3. Eligibility – Provider must follow steps in Section 2.1, Service Eligibility. Individuals must meet the following criteria to be eligible for this level of care:

a. Need for SUD service is established;
b. The specific ASAM Criteria for placement is determined;
c. The individual's needs cannot be more appropriately met by any other informal or formal system or support.
d. When admitting individuals the Provider shall:
    1) Contact Thurston-Mason BH-ASO for authorization using the "TM BH-ASO Non-Medicaid SUD ITA Notification Form."
    2) Not establish any other policy limiting admission of an eligible individual unless it is approved in writing by Thurston-Mason BH-ASO.
    3) Ensure that priority to admission is given to the following populations:
        a) Women who are pregnant and injecting drugs;
        b) Women who are pregnant with SUDs;
        c) Women with dependent children and;
        d) Individuals who are injecting drugs;
    4) The Provider shall not have policies or procedures in place that deny treatment services to any individual solely on the basis that the client is taking prescribed medication(s). Should the Provider have concerns regarding prescribed psychotropic or opiate medications, the Provider shall call the Contract Care Manager to discuss treatment options.

2. Continuing Stay Criteria. Continued stay assessments are person-centered based upon the individual's treatment needs and progress in withdrawal management services. Continued stay eligibility criteria are as follows:
    a. The individual meets the ASAM placement criteria for the requested withdrawal management service level.
    b. The individual has demonstrated progress toward achieving treatment goals during the initial authorization period.
    c. The individual's needs cannot be more appropriately met by any other formal or informal system or support.
    d. Thurston-Mason BH-ASO shall not reimburse for withdrawal management services beyond the initial authorization period without Thurston-Mason BH-ASO documented approval.
3. Individual Abuse.
    a. The Provider shall notify Thurston-Mason BH-ASO and report all instances of suspected individual abuse to the proper authorities in accordance with state laws. In addition, the Provider shall notify the Thurston-Mason BH-ASO Quality Manager in accordance with the critical incident reporting policy.
4. Termination of Benefit.
    a. SUD withdrawal management benefit will terminate under the following circumstances
        1) Thurston-Mason BH-ASO authorization period expires;
        2) The individual permanently exits the program prior to the expiration date of the authorization period;
        3) The individual gains enough resources during the benefit to be treated as a private-pay individual; or
        4) Provider discharges individual for disciplinary reasons and/or to ensure the safety of other individuals and staff.
    b. A terminated benefit is payable to the date of termination.
        1) For the required terminations above, the date of the termination is the date of the event, unless otherwise specified.
        2) When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped by Thurston-Mason BH-ASO.
    c. The Provider may maintain a benefit for 72 hours following an individual's unplanned, voluntary exit should re-entry remain a possibility after approval from Thurston-Mason BH-ASO. Should the individual not re-enter the program, the termination date is the date of exit.

5. Discharge and Continuing Care Planning. The Provider shall not include the discharge date as a payment day. The Provider is not eligible for payment for the day of discharge.
    a. All Providers shall provide discharge planning services which shall, include at a minimum:
        1) Coordinate a community-based discharge plan for each individual served under this Contract beginning at intake in order to procure the best available recovery plan and environment for the individual. Discharge planning shall apply to all individuals regardless of length of stay or whether they complete treatment.
        2) The individual shall have an appointment date for the ASAM level of care service, and any mental health services, identified in the discharge summary. These discharge plans and care coordination efforts shall include the individual and his/her family, if applicable. In cases where an assessment was not completed prior to admission into withdrawal management service or while in care, individuals ready for discharge shall have an appointment date for a SUD assessment.
        3) If an individual began receiving mental health care or new/modified mental health medication, this shall be communicated to the receiving provider.
        4) Establish referral relationships with assessment entities, outpatient providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of referents in treatment activities.
    b. Coordinate, as needed, vocational services, and other community resources and services that may be appropriate, including the Division of Children and Family Services, the Community Services Division including Community Service Offices (CSOs), and other behavioral health services.
    c. Coordinate services to financially-eligible individuals who are in need of medical services.

SECTION 20.8: PREGNANT AND PARENTING WOMEN (PPW) HOUSING SUPPORTS:

a. The purpose is to provide housing support services for women who are pregnant, post-partum, or parenting, and their children, in drug and alcohol-free residences for up to 18 months. Housing Support Services are classified as support services rather than treatment services.

b. Provider must provide adequate staffing and appropriate treatment services for Pregnant, Post-Partum, or Parenting Women (PPW) as outlined below and in compliance with laws and regulations governing the operation of a PPW Center.

2. Target Population: The Provider shall ensure individuals are eligible for housing support services, five (5) days per week, based on the following criteria. If they are:
    a. PPW with (children age 17 and under) at the time they enter housing support services;
    b. Pregnant includes any stage of gestation; and
    c. Post-Partum includes up to one (1) year, regardless of the outcome of pregnancy or placement of children.
    d. Currently participating in outpatient treatment for chemical dependency (CD) or have completed residential or outpatient substance use disorder (SUD) treatment within the last 12 months;
    e. At or below 220% of the Federal Poverty Level (FPL) or on Medicaid at the time they enter transition housing; and
    f. Not actively involved in using alcohol and other drugs.
3. Housing Support Eligibility: The Provider shall ensure individuals are eligible for housing support services, five (5) days per week, based on the following criteria. If they are:

a. PPW with (children age 17 and under) at the time they enter housing support services;
    b. Pregnant includes any stage of gestation;
    c. Post-Partum includes up to one (1) year, regardless of the outcome of pregnancy or placement of children;

d. Currently participating in outpatient treatment for CD or have completed residential or outpatient SUD treatment within the last 12 months;

e. At or below 220% of the FPL or on Medicaid at the time they enter transition housing; and

f. Not actively involved in using alcohol and other drugs.

SECTION 20.9 OUTPATIENT LESS RESTRICTIVE ALTERNATIVE OR CONDITIONAL RELEASE SUPPORT BEHAVIORAL HEALTH SERVICES

See also Thurston-Mason BH-ASO Policy 1734 Assisted Outpatient Treatment

LEAST RESTRICTIVE ALTERNATIVE (LRA) MONITORING

1.1. When serving individuals on a less restrictive alternative (LRA) or conditional release court order, shall provide or monitor the provision of court-ordered services, including psychiatric, substance use disorder treatment, and medical components of community support services. The provider, when providing court-ordered LRA support and conditional release services, shall, in accordance with RCW 246-341-085:

1.1.1. Have a written policy and procedure that allows for the referral of an individual to an involuntary treatment facility.

1.1.2. Have a written policy and procedure for an individual who requires involuntary detention that includes procedures for:

1.1.2.1. Contacting the Designated Crisis Responder (DCR) regarding revocations or extension of an LRA or conditional release; and

1.1.2.2. The transportation of an individual, in a safe and timely manner, for the purpose of:

1.1.2.2.1. Evaluation; or

1.1.2.2.2. Evaluation and detention

1.1.2.3. Ensure the individual is provided everything their rights afford them to and protect them from under RCW 71.05 or RCW 71.34, as applicable.

1.1.2.4. Include in the clinical record a copy of the LRA or Conditional Release and a copy of any subsequent modification.

1.1.2.5. Ensure the Individual Service Plan addresses the conditions of the LRA or Conditional Release and a plan for transition to voluntary treatment.

1.1.2.6. Ensure that the individual receives medication services including an assessment of the need for and prescription of medications to treat mental health or substance use disorders, appropriate to the needs of the individual as follows:

1.1.2.6.1. At least one time in the initial fourteen days following release from inpatient treatment for an individual on a ninety-day or one hundred eighty-day less restrictive alternative court order or conditional release, unless the individual's attending physician, physician assistant, or psychiatric advanced registered nurse practitioner (ARNP) determines another schedule is more appropriate and documents the new schedule and the reason(s) in the individual's clinical record; and

1.1.2.6.2. At least one time every thirty days for the duration of the less restrictive alternative court order or conditional release, unless the individual's attending physician, physician assistant, or psychiatric ARNP determines another schedule is more appropriate and documents the new schedule and the reason(s) in the individual's clinical record.

1.1.2.7. Keep a record of the periodic evaluation of each individual for release from, or continuation of, an involuntary treatment order. Evaluations must occur at least every thirty days for the

duration of the commitments and include documentation of the evaluation and rationale:

1.1.2.7.1. For requesting a petition for an additional period of less restrictive or conditional release treatment under an involuntary treatment order; or

1.1.2.7.2. Allowing the less restrictive court order or conditional release to expire without an extension request.

Chapter Twenty-one

SECTION 21.0: Deliverables

The Provider is responsible for submitting all deliverables described in this section and throughout the Contract in a timely manner. Deliverables shall be submitted in the format that is identified or provided by Thurston-Mason BH-ASO and shall be submitted via email (encrypted, when necessary) to the person identified on the front of the contract or otherwise agreed upon by both parties.

1. If this Contract requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Contract between the parties the Provider may provide one (1) report or deliverable that contains the information required by both Contracts.
2. The Provider shall submit the following deliverables as identified in the table below and throughout the contract. Please note, submitting deliverables is the responsibility of the Provider and there may additional deliverables listed in the contract. In addition, there are also deliverables in attachments and exhibits included as part of this contract.

Deliverable	Section	Submitted/Due
Training Plans	Provider Guide, 2.9 – Provider Education and Training	Available for review
Data Certification	Provider Guide, 6 – Encounter Submission and Compensation	11th day of the month following month of service
Quarterly Financial Report Certification	Provider Guide, 6 – Encounter Submission and Compensation Provider Guide, 4 – Coordination of Benefits and Third-Party	Quarterly, due the 15th of the following month
Agency Licensing, Credentialing, and Insurance	Provider Guide, 8 – Quality Improvement	Upon Renewal
Business Continuity and Disaster Recovery Plan	Provider Guide, 9.2 – Management Information Systems	Annually by Dec 15th; TMBH-ASO sends certification to HCA by January 31st
HIPAA Business Associate Satisfactory Assurances Attestation	Provider Guide, 10 – Protected Health Information	Annually by Dec 15th
Exclusion Attestation	Provider Guide, 11 – Program Integrity	Annually by January 31st
Compliance Attestation (Compliance Training and Code of Ethics/Standards of Conduct)	Policy 205 Compliance Plan, Policy 206 Employee Code of Conduct – Business and Professional Practice Standards, and Policy 212 Fraud Waste and Abuse	Annually by January 31st, or upon updates made to the trainings
CLAS Training Attestation	Provider Guide, Section 7 –	Annually by January 31st, or upon updates made to the

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	Culturally and Linguistically Appropriate Services and Policy 1596 Cultural Considerations	training
Data Shared with Subcontractors Attestation (Note: only if network provider is subcontracting and this must have prior TMBH-ASO approval)	Provider Guide, 23.1 – Exhibit 1 Data Sharing Terms	Annually by January 15th ; TMBH-ASO sends to HCA by January 31st
Certification Attestation (Note: only if network provider is subcontracting and this must have prior TMBH-ASO approval) indicating the subcontract contains all required language under the HCA BH-ASO contract.	Provider Guide, 15 – Federal Block Grant	Annually by January 15th; TMBH-ASO sends to HCA by January 31st
Quality Management Plans	Provider Guide, 8 – Quality Improvement	Upon request by Thurston-Mason BH-ASO
Attachments and Exhibits	Please see each individual document for specific deliverables. These are found in the contract package, for example, Exhibit B: Compensation can contain deliverables related to specific funding types if the provider receives dedicated funds, such as Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG), Treatment Sales Tax (TST), etc.	

SECTION 22.0: Guide Changes

N/A; 2025 New Provider Guide

SECTION 23.0: Attachments

Chapter 23.1: Exhibit 1 Data Sharing Terms

1 Definitions

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The definitions below apply to this Exhibit:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.17 **"Security Incident"** means the attempted or successful unauthorized access, Use, Disclosure, modification or destruction of information or interference with system operations in an information system.

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

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

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

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

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

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

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

2 Data Classification

2.1 The State classifies data into categories based on the sensitivity of the data pursuant to the Security policy and standards promulgated by the Office of the state of Washington Chief Information Officer. See WaTech Data Classification Standards at: https://watech.wa.gov/sites/default/files/2023-12/Data%20Classification%20Standard_Approved_2023.pdf and which is incorporated hereby incorporated by reference.

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

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

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

3 Purpose

3.1 This Exhibit covers all data sharing, collection, maintenance, and Use of Data by the Contractor for work performed under the HCA BH-ASO contract.

4 PRISM Access

4.1 Purpose. To provide the Contractor, and Subcontractors, with access to pertinent Individual-level Medicaid and when appropriate Medicare Data via look-up access to the online PRISM application and to provide the Contractor staff and the Subcontractor staff who have a need to know Individual-level Data in order to coordinate care, improve quality, and manage services for Individuals.

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

4.3 PRISM Data Constraints

4.3.1 The Data contained in PRISM is owned and belongs to DSHS and HCA. Access to PRISM Data is administered by DSHS.

4.3.2 The Data shared may only be used for care coordination and quality improvement purposes, and no other purposes. The Data in PRISM cannot be used for research.

4.4 System Access. The Contractor may request access for specific Authorized Users with a need-to-know to view Data in the PRISM System under this Contract.

4.4.1 The Contractor Contract Manager, or their designee, and the proposed Authorized User must complete and sign the PRISM Access Request Form, Schedule 2, for each proposed Authorized User. The completed form must be sent to prism.admin@dshs.wa.gov. mailto:HCA and DSHS will only accept requests from the Contractor Contract Manager or their designee.

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4.4.2 Authorized Users may view Medicare Data in PRISM once forms Schedule 1 and Schedule 2 are completed, submitted, and accepted as complete. No Medicare Data is released to the Contractor's Authorized User(s) until the two forms are completed and accepted by DSHS.

4.4.3 The Contractor must access the system through SecureAccessWashington (SAW) or through another method of secure access approved by HCA and DSHS.

4.4.4 DSHS will grant the appropriate access permissions to the Contractor's employees or Subcontractor employees.

4.4.5 HCA and DSHS **do not** allow shared User IDs and passwords for use with Confidential Information or to access systems that contain Confidential Information. The Contractor must ensure that only Authorized Users access and use the systems and do not allow employees, agents, or Subcontractors who are not authorized to borrow a User ID or password to access any systems.

4.4.6 The Contractor will notify the prism.admin@dshs.wa.gov within five (5) Business Days whenever an Authorized User who has access to the Data is no longer employed or contracted by the Contractor, or whenever an Authorized User's duties change such that the user no longer requires access to the Data.

4.4.7 The Contractor's access to the system may be continuously tracked and monitored. HCA and DSHS reserve the right at any time to terminate the Data access for an individual, conduct audits of systems access and use, and to investigate possible violations of this Exhibit, federal, or state laws and regulations governing access to Protected Health Information.

5 Constraints on Use of Data

5.1 This Contract does not constitute a release of the Data for the Contractor's discretionary use. The Contractor must use the Data received or accessed under this Contract only to carry out the purpose of this Contract. Any ad hoc analyses or other use or reporting of the Data is not permitted without HCA's prior written consent. Any ad hoc analyses or other use or reporting of PRISM Data is not permitted without DSHS's and HCA's prior written consent.

5.2 Data shared under this Contract includes data protected by 42 C.F.R. Part 2. In accordance with 42 C.F.R. § 2.32, this Data has been disclosed from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit Receiving Party from making any further Disclosure of the Data that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further Disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42
C.F.R. Party 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (42 C.F.R. § 2.31). The federal rules restrict any use of the SUD Data to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 C.F.R. § 2.12(c)(5) and § 2.65.

5.2.1 The information received under Required Reporting for Behavioral Health Supplemental Data Subsection of this Contract is also protected by federal law, including 42 C.F.R. Part 2, Subpart D, § 2.53, which requires HCA and their Subcontractors to:

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5.2.1.1 Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under 42 C.F.R. § 2.16;

5.2.1.2 Retain records in compliance with applicable federal, state, and local record retention laws; and

5.2.1.3 Comply with the limitations on Disclosure and Use in 42 C.F.R. Part 2, Subpart D, § 2.53(d).

5.3 Any Disclosure of Data contrary to this Contract is unauthorized and is subject to penalties identified in law.

5.4 The Contractor must comply with the *Minimum Necessary Standard*, which means the Contractor will use the least amount of PHI necessary to accomplish the Purpose of this Contract.

5.4.1 The Contractor must identify:

5.4.1.1 Those persons or classes of persons in its workforce who need access to PHI to carry out their duties; and

5.4.1.2 For each such person or class of persons, the category or categories of PHI to which access is needed and any conditions appropriate to such access.

5.4.2 The Contractor must implement policies and procedures that limit the PHI disclosed to such persons or classes of persons to the amount reasonably necessary to achieve the purpose of the Disclosure, in accordance with this Contract.

5.5 For all Data, including claims data, that is individually identifiable, shared outside of the Contractor's system for research or data analytics not conducted on behalf of the Contractor, the Contractor must provide HCA with 30 calendar days' advance notice and opportunity for review and advisement to ensure alignment and coordination between Contractor and HCA data governance initiatives. The Contractor will provide notice to HCAData@hca.wa.gov and hcamcprograms@hca.wa.gov. Notice will include:

5.5.1 The party/ies the Data will be shared with;

5.5.2 The purpose of the sharing; and

5.5.3 A description of the types of Data involved, including specific data elements to be shared.

5.6 The Contractor must provide a report by the 15th of each month of all Data, individually identifiable and de-identified, regarding Individuals, including claims data, shared with external entities, including but not limited to Subcontractors and researchers, to HCA via hcabhaso@hca.wa.gov on the supplied template, Data Shared with External Entities Report.

6 Security of Data

6.1 Data Protection

6.1.1 The Contractor must protect and maintain all Confidential Information gained by reason of this

Contract, information that is defined as confidential under state or federal law or regulation, or Data that HCA has identified as confidential, against unauthorized use, access, Disclosure, modification or loss. This duty requires the Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:

6.1.1.1 Allowing access only to staff that have an authorized business requirement to view the Confidential Information.

6.1.1.2 Physically securing any computers, documents, or other media containing the Confidential Information.

6.2 Data Security Standards

6.2.1 The Contractor must comply with the Data Security Requirements set out in this section and the Washington OCIO Security Policies and Standards, hyperlink at: https://watech.wa.gov/sites/default/files/2023-12/141.10_SecuringITAssets_2023_12_Parts_Rescinded.pdf.All Washington OCIO Security Policies and Standards are hereby incorporated by reference into this Contract.

6.2.2 Data Transmitting

6.2.2.1 When Transmitting Data electronically, including via email, the Data must be encrypted using NIST 800-series approved algorithms (http://csrc.nist.gov/publications/PubsSPs.html). This includes transmission over the public internet.

6.2.2.2 When Transmitting Data via paper documents, the Contractor must use a Trusted System.

6.2.3 Protection of Data. The Contractor agrees to store and protect Data as described.

6.2.3.1 Data at Rest:

Data will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data. Access to the Data will be restricted to Authorized Users through the use of access control lists, a Unique User ID, and a Hardened Password, or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Systems that contain or provide access to Confidential Information must be located in an area that is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

6.2.3.2 Data stored on Portable/Removable Media or Devices

Confidential Information provided by HCA on Removable Media will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the Data.

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HCA's Data must not be stored by the Contractor on Portable Devices or Media unless specifically authorized within the Contract. If so authorized, the Contractor must protect the Data by:

a. Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;

b. Controlling access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics;

c. Keeping devices in locked storage when not in use;

d. Using check-in/check-out procedures when devices are shared;

e. Maintaining an inventory of devices; and

f. Ensuring that when being transported outside of a Secured Area, all devices containing Data are under the physical control of an Authorized User.

6.2.3.3 Paper Documents. Any paper records containing Confidential Information must be protected by storing the records in a Secured Area that is accessible only to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

6.2.4 Data Segregation

6.2.4.1 HCA Data received under this Contract must be segregated or otherwise distinguishable from non-HCA Data. This is to ensure that when no longer needed by the Contractor, all of HCA's Data can be identified for return or destruction. It also aids in determining whether HCA's Data has or may have been compromised in the event of a security Breach.

6.2.4.2 HCA's Data must be kept in one of the following ways:

On media (e.g. hard disk, optical disc, tape, etc.) which contains only HCA Data;

In a logical container on electronic media, such as a partition or folder dedicated to HCA's Data;

In a database that contains only HCA Data;

Within a database – HCA data must be distinguishable from non- HCA Data by the value of a specific field or fields within database records; or

Physically segregated from non-HCA Data in a drawer, folder, or other container when stored as physical paper documents.

6.2.4.3 When it is not feasible or practical to segregate HCA's Data from non-HCA data, both HCA's Data and the non-HCA data with which it is commingled must be protected as described in this Exhibit.

6.3 Data Disposition

6.3.1 Upon request by HCA, at the end of the Contract term, or when no longer needed, Confidential Information/Data must be returned to HCA or disposed of as set out below, except as required to be maintained for compliance or accounting purposes.

6.3.2 Media are to be destroyed using a method documented within NIST 800-88 (http://csrc.nist.gov/publications/PubsSPs.html).

6.3.3 For Data stored on network disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in the Section, above. Destruction of the Data as outlined in this section of this Exhibit may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

7 Data Confidentiality and Non-Disclosure

7.1 Data Confidentiality.

7.1.1 The Contractor will not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Contract for any purpose that is not directly connected with the purpose of this Contract, except:

7.1.1.1 as provided by law; or

7.1.1.2 with the prior written consent of the person or personal representative of the person who is the subject of the Confidential Information.

7.2 Non-Disclosure of Data

7.2.1 The Contractor will ensure that all employees or Subcontractors who will have access to the Data described in this Contract (including both employees who will use the Data and IT support staff) are instructed and aware of the use restrictions and protection requirements of this Exhibit before gaining access to the Data identified herein. The Contractor will ensure that any new employee is made aware of the use restrictions and protection requirements of this Exhibit before they gain access to the Data.

7.2.2 The Contractor will ensure that each employee or Subcontractor who will access the Data signs a non-disclosure of confidential information agreement regarding confidentiality and non-disclosure requirements of Data under this Contract. The Contractor must retain the signed copy of the employee non-disclosure agreement in each employee's personnel file for a minimum of six years from the date the employee's access to the Data ends. The Contractor will make this documentation available to HCA upon request.

7.3 Penalties for Unauthorized Disclosure of Data

7.3.1 The Contractor must comply with all applicable federal and state laws and regulations concerning collection, Use, and Disclosure of Personal Information and PHI. Violation of these laws may result in criminal or civil penalties or fines.

7.3.2 The Contractor accepts full responsibility and liability for any noncompliance with applicable laws or this Contract by itself, its employees, and its Subcontractors.

8 Data Shared with Subcontractors

If Data access is to be provided to a Subcontractor under this Contract, the Contractor must include all of the Data security terms, conditions and requirements set forth in this Exhibit in any such Subcontract.
However, no subcontract will terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any subcontractor. The Contractor must provide an attestation by January 31, each year that all Subcontractor meet, or continue to meet, the terms, conditions, and requirements in this Exhibit.

9 Data Breach Notification

9.1 The Breach or potential compromise of Data must be reported to the HCA Privacy Officer at **PrivacyOfficer@hca.wa.gov** and to the BH-ASO Contract Manager at **hcabhaso@hca.wa.gov** within five (5) Business Days of discovery. If the Contractor does not have full details, it will report what information it has, and provide full details within fifteen (15) Business Days of discovery. To the extent possible, these reports must include the following:

9.1.1 The identification of each non-Medicaid Individual whose PHI has been or may have been improperly accessed, acquired, used, or disclosed;

9.1.2 The nature of the unauthorized Use or Disclosure, including a brief description of what happened, the date of the event(s), and the date of discovery;

9.1.3 A description of the types of PHI involved;

9.1.4 The investigative and remedial actions the Contractor or its Subcontractor took or will take to prevent and mitigate harmful effects, and protect against recurrence;

9.1.5 Any details necessary for a determination of the potential harm to Individuals whose PHI is believed to have been used or disclosed and the steps those Individuals should take to protect themselves; and

9.1.6 Any other information HCA reasonably requests.

9.2 The Contractor must take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or HCA including but not limited to 45 C.F.R. Part 164, Subpart D; RCW 42.56.590; RCW 19.255.010; or WAC 284-04-625.

9.3 The Contractor must notify HCA in writing, as described in 8.a above, within two (2) business days of determining notification must be sent to non-Medicaid Individuals.

9.4 At HCA's request, the Contractor will provide draft Individual notification to HCA at least five (5) Business Days prior to notification, and allow HCA an opportunity to review and comment on the notifications.

9.5 At HCA's request, the Contractor will coordinate its investigation and notifications with HCA and the Office of the state of Washington Chief Information Officer (OCIO), as applicable.

10 HIPAA Compliance

This Section of the Exhibit is the Business Associate Agreement (BAA) required by HIPAA. The Contractor is a "Business Associate" of HCA as defined in the HIPAA Rules.

10.1 HIPAA Point of Contact. The point of contact for the Contractor for all required HIPAA-related reporting and notification communications from this Section and all required Data Breach Notification from Section above, is:

HCA Privacy Officer
Washington State Health
Care Authority 626 8th
Avenue SE
PO Box 42704
Olympia, WA 98504-2704
Telephone: (360) 725-2108
Email: PrivacyOfficer@hca.wa.gov

10.2 Compliance. The Contractor must perform all Contract duties, activities, and tasks in compliance with HIPAA, the HIPAA Rules, and all attendant regulations as promulgated by the U.S. Department of Health and Human Services, Office for Civil Rights, as applicable.

10.3 Use and Disclosure of PHI. The Contractor is limited to the following permitted and required uses or disclosures of PHI:

10.3.1 Duty to Protect PHI. The Contractor must protect PHI from, and will use appropriate safeguards, and comply with Subpart C of 45 C.F.R. Part 164, Security Standards for the Protection of Electronic Protected Health Information, with respect to ePHI, to prevent unauthorized Use or Disclosure of PHI for as long as the PHI is within the Contractor's possession and control, even after the termination or expiration of this Contract.

10.3.2 Minimum Necessary Standard. The Contractor will apply the HIPAA Minimum Necessary standard to any Use or Disclosure of PHI necessary to achieve the purposes of this Contract. See 45 C.F.R. § 164.514(d)(2) through (d)(5).

10.3.3 Disclosure as Part of the Provision of Services. The Contractor will only Use or disclose PHI as necessary to perform the services specified in this Contract or as required by law, and will not Use or disclose such PHI in any manner that would violate Subpart E of 45 C.F.R. Part 164, Privacy of Individually Identifiable Health Information, if done by Covered Entity, except for the specific Uses and disclosures set forth below.

10.3.4 Use for Proper Management and Administration. The Contractor may Use PHI for the proper management and administration of the Contractor or to carry out the

legal responsibilities of the Contractor.

10.3.5 Disclosure for Proper Management and Administration. The Contractor may Disclosure PHI for the proper management and administration of the Contractor, subject to HCA approval, or to carry out the legal responsibilities of the Contractor, provided the disclosures are required by law, or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware in which the confidentiality of the information has been Breached.

10.3.6 Impermissible Use or Disclosure of PHI. The Contractor must report to the HIPAA Point of Contact, in writing, all Uses or disclosures of PHI not provided for by this Contract within five (5) business days of becoming aware of the unauthorized Use or Disclosure of PHI, including Breaches of unsecured PHI as required at 45 C.F.R. § 164.410, Notification by a Business Associate, as well as any Security Incident of which Contractor becomes aware. Upon request by HCA, the Contractor will mitigate, to the extent practicable, any harmful effect resulting from the impermissible Use or Disclosure.

10.3.7 Failure to Cure. If HCA learns of a pattern or practice of the Contractor that constitutes a violation of the Contractor's obligations under the term of this Exhibit and reasonable steps by the Contractor do not end the violation, HCA may terminate this Contract, if feasible. In addition, if the Contractor learns of a pattern or practice of its Subcontractor(s) that constitutes a violation of the Contractor's obligations under the terms of their contract and reasonable steps by the Contractor do not end the violation, the Contractor must terminate the Subcontract, if feasible.

10.3.8 Termination for Cause. The Contractor authorizes immediate termination of this Contract by HCA, if HCA determines the Contractor has violated a material term of this Business Associate Agreement. HCA may, at its sole option, offer the Contractor an opportunity to cure a violation of this Business Associate Agreement before exercising a termination for cause.

10.3.9 Consent to Audit. The Contractor must give reasonable access to PHI, its internal practices, records, books, documents, electronic data, and/or all other business information received from, or created, received by the Contractor on behalf of HCA, to the Secretary of the United States Department of Health and Human Services (HHS) and/or to HCA for use in determining compliance with HIPAA privacy requirements.

10.3.10 Obligations of Business Associate upon Expiration or Termination. Upon expiration or termination of this Contract for any reason, with respect to PHI received from HCA, or created, maintained, or received by the Contractor, or any Subcontractors, on behalf of HCA, the Contractor must:

10.3.10.1 Retain only that PHI which is necessary for the Contractor to continue its proper management and administration or to carry out its legal responsibilities;

10.3.10.2 Return to HCA or destroy the remaining PHI that the Contractor or any Subcontractors still maintain in any form;

10.3.10.3 Continue to use appropriate safeguards and comply with Subpart C of 45
C.F.R. Part 164, Security Standards for Protection of Electronic Protected Health Information, with respect to ePHI to prevent Use or Disclosure of the PHI, other than as provided for in this Section, for as long as Contractor or any Subcontractor retains PHI;

10.3.10.4 Not Use or disclose the PHI retained by the Contractor or any Subcontractors other than for the purposes for which such PHI was retained and subject to the same conditions section out in the Section above, Use and Disclosure of PHI, that applied prior to termination; and

10.3.10.5 Return to HCA or destroy the PHI retained by the Contractor, or any Subcontractors, when it is no longer needed by the Contractor for its proper management and administration or to carry out its legal responsibilities.

10.3.11 Survival. The obligations of the Contractor under this Section will survive the termination or expiration of the Contract.

10.4 Individual Rights.

10.4.1 Accounting of Disclosures.

10.4.1.1 The Contractor will document all disclosures, except those disclosures that are exempt under 45 C.F.R. § 164.528, of PHI and information related to such disclosures.

10.4.1.2 Within ten (10) Business Days of a request from HCA, the Contractor will make available to HCA the information in the Contractor's possession that is necessary for HCA to respond in a timely manner to a request for an accounting of disclosures of PHI by the Contractor. See 45 C.F.R. §§ 164.504(e)(2)(ii)(G) and 164.528(b)(1).

10.4.1.3 At the request of HCA or in response to a request made directly to the Contractor by an Individual, the Contractor will respond, in a timely manner and in accordance with HIPAA and the HIPAA Rules, to requests by Individuals for an accounting of disclosures of PHI.

10.4.1.4 The Contractor record keeping procedures will be sufficient to respond to a request for an accounting under this Section for the six

(6) years prior to the date on which the accounting was requested.

10.4.2 Access.

10.4.2.1 The Contractor will make available PHI that it holds that is part of a Designated Record Set when requested by HCA or the Individual as necessary to satisfy HCA's obligations under 45 C.F.R. § 164.524, Access of Individuals to Protected Health Information.

10.4.2.2 When the request is made by the Individual to the Contractor or if HCA ask the Contractor to respond to a request, the Contractor must comply with requirements in 45 C.F.R. § 164.524, Access of Individuals to Protected Health Information, on form, time and manner of access. When the request is made by HCA, the Contractor will provide the records to HCA within ten (10) Business Days.

10.4.3 Amendment.

10.4.3.1 If HCA amends, in whole or in part, a record or PHI contained in an Individual's Designated Record Set and HCA has previously provided the PHI or record that is the subject of the amendment to Contractor, then HCA will inform the Contractor of the amendment pursuant to 45 C.F.R. § 164.526(c)(3), Amendment of Protected Health Information.

10.4.3.2 The Contractor will make any amendments to PHI in a Designated Record Set as directed by HCA or as necessary to satisfy HCA's obligations under 45 C.F.R.
§ 164.526, Amendment of Protected Health Information.

10.5 Subcontracts and other Third Party Agreements. In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii), 164.504(e)(1)(i), and 164.308(b)(2), the Contractor must ensure that any agents, Subcontractors, independent contractors, or other third parties that create, receive, maintain, or transmit PHI on the Contractor's behalf, enter into a written contract that contains the same terms, restrictions, requirements, and conditions as the HIPAA compliance provisions in this Contract with respect to such PHI. The same provisions must also be included in any contracts by a Contractor's Subcontractor with its own business associates as required by 45 C.F.R. §§ 164.314(a)(2)(b) and 164.504(e)(5).

10.6 Obligations. To the extent the Contractor is to carry out one or more of HCA's obligation(s) under Subpart E of 45 C.F.R. Part 164, Privacy of Individually Identifiable Health Information, the Contractor must comply with all requirements that would apply to HCA in the performance of such obligation(s).

10.7 Liability. Within ten (10) Business Days, the Contractor must notify the HIPAA Point of Contact of any complaint, enforcement or compliance action initiated by the Office for Civil Rights based on an allegation of violation of the HIPAA Rules and must inform HCA of the outcome of that action. The Contractor bears all responsibility for any penalties, fines or sanctions imposed against the Contractor for violations of the HIPAA Rules and for any imposed against its Subcontractors or agents for which it is found liable.

10.8 Miscellaneous Provisions.

10.8.1 Regulatory References. A reference in this Contract to a section in the HIPAA Rules means the section as in effect or amended.

10.8.2 Interpretation. Any ambiguity in this Exhibit will be interpreted to permit compliance with the HIPAA Rules.

11 Inspection

HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Individuals collected, used, or acquired by the Contractor during the terms of this Contract. All HCA representatives conducting onsite audits of the Contractor agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

12 Indemnification

The Contractor must indemnify and hold HCA and its employees harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Individuals.

Medicare Data Use Requirement Documents

Schedule 1: Medicare Part D – Conflict of Interest Attestation

Schedule 2: PRISM Access Request Form