

CONTRACT AMENDMENT A

This CONTRACT AMENDMENT is made and entered into between SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION, through Kitsap County, as its administrative entity, a political subdivision of the State of Washington, with its principal offices at 614 Division Street, Port Orchard, Washington 98366, hereinafter "SBHASO", and Peninsula Behavioral Health, hereinafter "CONTRACTOR."

In consideration of the mutual benefits and covenants contained herein, the parties agree that their Contract, numbered as Kitsap County Contract No. KC-058-26, and executed on March 23, 2026, shall be amended as follows:

1. **Exhibit A** Schedule of Services is deleted and replaced as attached.
2. **Exhibit B** Compensation is deleted and replaced as attached.
3. **Exhibit C** Delegation Agreement is deleted and replaced as attached.
4. **Exhibit C-1** Crisis Services – Additional Delegation Requirements is deleted and replaced as attached.
5. **Exhibit C-2** Credentialing Delegation Grid is deleted and replaced as attached.
6. **Exhibit C-3** Utilization Management Delegation Grid is deleted and replaced as attached.
7. **Exhibit C-4** Claims and Encounters Delegation Grid is deleted and replaced as attached.
8. **Exhibit C-5** Quality Improvement Delegation Grid is deleted and replaced as attached.
9. If this Contract Amendment extends the expiration date of the Contract, then the Contractor shall provide an updated certificate of insurance evidencing that any required insurance coverages are in effect through the new contract expiration date. The Contractor shall submit the certificate of insurance to:

Program Lead, Salish Behavioral Health Administrative Services
Organization
Kitsap County Department of Human Services
614 Division Street, MS-23
Port Orchard, WA 98366

Upon receipt, the Human Services Department will ensure the submission of all insurance documentation to the Risk Management Division, Kitsap County Department of Administrative Services.

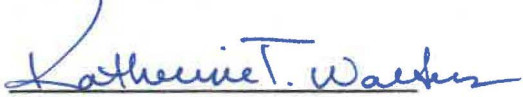
10. Except as expressly provided in this Contract Amendment, all other terms and conditions of the original Contract, and any subsequent amendments, addenda or modifications thereto, remain in full force and effect.

This amendment shall be effective July 1, 2026.

Dated this ____ day of _____, 2026.

**SALISH BEHAVIORAL HEALTH
ADMINISTRATIVE SERVICES
ORGANIZATION, By
KITSAP COUNTY BOARD OF
COMMISSIONERS, Its Administrative
Entity**


ORAN ROOT, Chair


KATHERINE T. WALTERS,
Commissioner


CHRISTINE ROLFES, Commissioner

DATE

July 8, 2026

ATTEST:


Kirsten Jewell,
Interim Deputy Clerk of the Board

**CONTRACTOR: Peninsula
Behavioral Health**


Name: Wendy Sisk
Title: Chief Executive Officer

I attest that I have the authority to sign
this contract on behalf of Peninsula
Behavioral Health.

DATE

June 22, 2026



Kitsap County Face Sheet

For Sub-recipient Contracts Using Federal Awards

CFR 200.332 Ensure that every subaward is clearly identified to the subrecipient as a subaward and includes the information provided below. A pass-through entity must provide the best available information when some of the information below is unavailable. A pass-through entity must provide unavailable information when it is obtained. Required information includes:

(Fill in)

Subrecipient's unique entity identifier: N/A

Federal Award Identification Number (FAIN): N/A

Federal Revenue Award Date: N/A

Subaward Period of Performance Start and End Date: N/A

☐ Check to verify the information is in contract:

☐ Subrecipient's name (must match the name associated with its unique entity identifier):

☐ Federal award identification:

☐ Subaward Budget Period Start and End Date:

☐ Amount of Federal Funds Obligated in the subaward:

☐ Amount of Federal Funds Obligated to the sub by the pass-through entity, including the current financial obligation:

☐ Total Amount of the Federal Award committed to the subrecipient by the pass-through entity:

☐ Federal award project description, as required by the Federal Funding Accountability and Transparency Act (FFATA):

☐ Name of the Federal agency, pass-through entity, and contact information for awarding official of the pass-through entity:

☐ Dollar amount made available under each Federal award and the Assistance Listings Number at the time of disbursement:

☐ Indirect cost rate for the Federal award (including if the de minimis rate is used in accordance with § 200.414):

Salish Behavioral Health Administrative Services Organization (SBHASO)
Exhibit A
Schedule of Services
July 1, 2026 through December 31, 2026

Identification of Contracted Services

The Crisis Services Provider, Peninsula Behavioral Health, shall provide covered services, as indicated in the Contracted Services Grid below, within the scope of Provider's business, licensure(s) and practice, in accordance with the Base Provider Agreement, SBHASO Policies and Procedures, Peninsula Behavioral Health Policies and Procedures, MCO and HCA standards, MCO Provider Manuals, the terms, conditions and eligibility outlined in Contract Exhibits, and the requirements of any applicable government sponsored program.

Contracted Services Grid

Crisis Services		
Contracted Service	Service Type	SBHASO Policies and Procedures
☒	Crisis Services (includes Mobile Crisis Outreach, Community-Based Crisis Stabilization, Behavioral Health Disaster Response, and Involuntary Treatment Act Evaluations)	Integrated Crisis System, Ensuring Care Coordination for Individuals, Crisis Stabilization Services
☐	Regional Behavioral Health Crisis Hotline	Integrated Crisis System, Toll-free Crisis Line Management
☒	Facility-Based Crisis Stabilization	Integrated Crisis System, Ensuring Care Coordination for Individuals, Crisis Stabilization Services

Salish Behavioral Health Administrative Services Organization (SBHASO)

EXHIBIT B - COMPENSATION SCHEDULE

Contractor: Peninsula Behavioral Health
Time Period: January 1, 2026 – December 31, 2026

Payment Type	Service Detail	Monthly Base Medicaid	Monthly Endorsed Team Medicaid
Capacity	Schedule of Services – Crisis Services	89,293	N/A
Cost Reimbursement by case rate (effective July 1, 2026)	Schedule of Services – Facility-based Crisis Stabilization	Up to 35,165	N/A

- For toll-free crisis line provider, compensation is based on H0030 services.
- For all other crisis providers, compensation is based on (H2011*) H2011: HA/HB , H2019: HA/HB, H0038: HA/HB services.
- For facility-based crisis stabilization services compensation is based on S9485, S9484 services.

* H2011 services with HW modifier are excluded from Medicaid compensation.

**Salish Behavioral Health Administrative Services Organization
(SBHASO)**

EXHIBIT C

DELEGATION AGREEMENT

This Exhibit C: Sub-Delegation Agreement ("Exhibit C") is attached to and a part of the Administrative Services Agreement (the "Agreement") by and between Salish Behavioral Health Administrative Services Organization ("SBHASO"), and Peninsula Behavioral Health (Provider), and is effective as of the Effective Date.

This Exhibit C sets forth additional requirements applicable to Provider's performance and SBHASO's oversight of Provider's performance of all Subdelegated Functions under the Agreement.

1. **DEFINITIONS.** Capitalized terms not otherwise defined in this Exhibit C shall have the meanings given under the Agreement.

1.1 **BH-ASO.** "Behavioral Health Administrative Services Organization" or "BH-ASO" means the entity selected by HCA to administer crisis behavioral health services and programs for residents in a defined regional services area, regardless of ability to pay, including Medicaid eligible individuals.

1.2 **BH-ASO Contract.** "Behavioral Health Administrative Services Organization Contract" or "BH-ASO Contract" means (SBHASO's) contract with the HCA for the provision of BH-ASO services, including Members, in the Salish regional service area ("Region").

1.3 **General Fund State.** "General Fund State" or "GFS" means the source of funding for services provided pursuant to Apple Health - Fully Integrated Managed Care - Behavioral Health Services wrap-around contract.

1.4 **Grievance.** "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination, as defined under the applicable HCA Contract(s). Possible subjects for Grievances may include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or an employee, or failure to respect a Member's rights.

1.5 **HEDIS**. "HEDIS" means the Healthcare Effectiveness Data and Information Set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

1.6 **NCQA Standards**. "NCQA Standards" means certain National Committee for Quality Assurance ("NCQA") standards and guidelines applicable to MCO, BH-ASO, Provider and/or the Services, published by NCQA and modified from time to time.

1.7 **Program Documents**. "Program Documents" means, for each Subdelegated Function, SBHASO's and/or Provider's comprehensive set of documents and materials that describe and govern one or more of the services or activities provided or performed by SBHASO in carrying out each Subdelegated Function. Program Documents shall, at a minimum: (i) define the purpose and objectives of each Delegated Function; (ii) describe the manner in which the activities and services related to the Delegated Function are performed; (iii) roles and responsibilities related to performance and oversight of the Delegated Function; (iv) whether any of the activities or services will be subdelegated; and (v) SBHASO's processes, policies, desk procedures, job aides, and other information and materials, related to the performance of the Delegated Function.

1.8 **Provider Policies and Procedures**. Provider's Policies and Procedures shall contain information useful and applicable to credentialing, utilization management, prior authorization requirements, claims submissions, and Provider's online demographic information.

2 SUBDELEGATED FUNCTIONS.

2.1 For each Subdelegated Function, Provider shall ensure that all services and activities related to that Subdelegated Function are performed (i) in a professional manner and in accordance with industry standards; (ii) as outlined in the applicable exhibits and any attachments or other addenda thereto; (iii) in accordance with SBHASO's Program Documents; and (iv) in accordance with the Agreement.

2.2 **Joint Oversight**. Throughout the Term of the Agreement, the Managed Care Organizations (MCOs) and SBHASO shall conduct joint oversight to monitor and improve the Provider's performance of the Subdelegated Functions.

Oversight activities will include, at a minimum: established roles and responsibilities related to oversight and reporting; Provider's timely preparation and the MCO's and SBHASO's review of regularly delivered reports; annual and ad hoc audits of Provider's performance, including file and other documentation review; regular and ad hoc operational review and performance improvement meetings; and development and implementation of appropriate correctives actions, as needed and as set forth herein and in any attachments and addenda hereto.

3 SPECIFIC DELEGATIONS/SUBDELEGATIONS.

3.1 **Crisis Administration Services.** Crisis Administration Services are delegated to SBHASO by the Managed Care Organizations (MCOs), and shall be performed by SBHASO in accordance with MCO Exhibits and Attachments. Any Crisis Administration Services Subdelegated by the SBHASO to the Provider shall be performed by the Provider in accordance with the SBHASO policies and procedures and Exhibit C and Attachment C-1. Attachment C-1 is attached to this Exhibit C and by this reference incorporated herein.

3.2 **Delegated/Subdelegated Provider Credentialing.** Credentialing activities related to SBHASO's subcontracted Crisis Services Providers are delegated to SBHASO by the MCO's, and shall be performed by SBHASO in accordance with Attachment C-2, which is attached to this Exhibit C and by this reference incorporated herein. Any Credentialing activities Subdelegated by the SBHASO to Provider shall be performed by the Provider in accordance with Exhibit C and Attachment C-2, which is attached to this Exhibit C and by this reference incorporated herein.

3.3 **Delegated/Subdelegated Utilization Management.** Certain Utilization Management activities related to SBHASO's administration of Crisis Services are delegated to SBHASO in accordance with Attachment C-3, which is attached to this Exhibit C and by this reference incorporated herein. If applicable, Utilization Management activities Subdelegated by the SBHASO to the Provider shall be performed by the Provider in accordance with Exhibit C and Attachments C-3, which is attached to this Exhibit C and by this reference incorporated herein.

3.4 **Delegated/Subdelegated Encounter Data Services.** Encounter Data Services related to SBHASO's administration of Crisis Services are delegated

to SBHASO in accordance with Attachment C-4, which is attached to this Exhibit C and by this reference incorporated herein. Any Encounter Data Services Subdelegated by the SBHASO to the Provider shall be performed by the Provider in accordance with Exhibit C and Attachment C-4, which are attached to this Exhibit C and by this reference incorporated herein.

3.5 Delegated/Subdelegated Quality Improvement Services. Certain Quality Improvement activities related to SBHASO's administration of Crisis Services are delegated to SBHASO in accordance with Attachment C-5, which is attached to this Exhibit C and by this reference incorporated herein. If applicable, Quality Improvement activities Subdelegated by the SBHASO to the Provider shall be performed by the Provider in accordance with Exhibit C and Attachment C-5, which are attached to this Exhibit C and by this reference incorporated herein.

4 PRE-CONDITIONS OF SUB-DELEGATION. The delegation of any part of a Delegated Function is contingent upon SBHASO's determination that the Provider is capable of and willing to perform such Subdelegated Function(s), and all related services and activities, in a manner that complies with the Agreement, including this Exhibit C and all attachments and addenda hereto.

4.1 Pre-Subdelegation Assessment and Corrective Actions. SBHASO shall conduct a pre-subdelegation assessment to determine whether the Provider is capable of performing each Delegated Function in accordance with applicable Compliance Requirements and SBHASO's established standards for quality and efficiency. If SBHASO's pre-subdelegation assessment indicates that Provider is unable to perform a Subdelegated Function in full compliance with the terms and conditions hereof, or otherwise fails to meet established standards, Provider shall submit, implement and comply with a Corrective Action Plan ("CAP"), acceptable to SBHASO within a mutually agreed upon time frame and prior to performing any part of the Subdelegated Function(s).

4.2 Failure to Meet Pre-Conditions. If Provider is not able to complete the CAP, or is otherwise unable to perform the Subdelegated Function(s) as required hereunder, to SBHASO's satisfaction, SBHASO may, in addition to any other available remedies, suspend or terminate Provider's performance under this Exhibit C or any attachment or addenda hereto.

5 CONTACT WITH MEMBERS.

- 5.1 **Definitions.** Consistent with the requirements of 42 C.F.R. §438.10(c)(4)(i), any managed care terms used by Provider in communications with Members shall have meanings consistent with the definitions of the managed care terms provided in Health Care Authority's model managed care contracts found here: <https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts>.
- 5.2 **Member Rights.** In furnishing service to Apple Health Members under the Agreement, Provider shall take into account federal and state law pertaining to Member rights.
- 5.3 **Access to Member Records.** The MCOs and SBHASO shall have access to Provider's medical records, to the extent permitted by state and federal law.
- 5.4 **Confidentiality of Member Records.** Provider shall maintain the confidentiality of Member information and records in accordance with state and federal law.
- 5.5 **Equal Access.** Provider will provide all information, including both oral and written information, in a manner and format that is easily understood and readily accessible to the Member(s) receiving the information.
- 5.6 **Treatment Options.** Provider will freely communicate with Members about treatment options, including medication treatment options, regardless of benefit coverage limitations.
- 5.7 **Interpreter Services.** Provider shall access and utilize appropriate interpreter services for all interactions between Provider and a Member who is deaf or hearing impaired, or whose primary language is other than English.
- 5.8 **Written Information.** Provider shall ensure that all written information it provides to Members is accurate, not misleading, comprehensible to its intended audience, designed to provide the greatest degree of understanding, and is written at a sixth (6th) grade reading level. Wherever appropriate or required, Provider shall use form letters and notices provided by the MCOs or SBHASO. Generally applicable written communications, including educational materials, must be reviewed and approved by the MCOs and SBHASO prior to use.

5.8.1 Generally available written communications must be translated into each language spoken by five percent (5%) of Members, or 1,000 Members, whichever is less. SBHASO will provide to Provider, a list of languages meeting this requirement upon request.

5.8.2 For Members whose primary language is not translated or whose need cannot be addressed by translation, Provider will use one of the following alternatives to address the Member's communication needs: (i) translating the material into the Member's primary reading language; (ii) providing the material in an audio format in the Member's primary language; (iii) having an interpreter read the material to the Member in the Member's primary language; (iv) providing the material in another alternative medium or format acceptable to the Member, in which case Provider shall document the Member's acceptance of the material in the alternative medium or format in the Member's record; or (v) providing the material in English, if Provider documents the Member's preference for receiving written materials in English.

5.9 **Telephonic Communication.** Provider may not use an automated call system to make outbound calls to Members for care coordination, or for calls related to behavioral health or prescription verification.

5.10 **Marketing.** Unless otherwise agreed to by the parties in writing, Provider shall not perform marketing activities on the MCO's or SBHASO's behalf or in manner that suggests Provider is acting under the authority or as a representative of the MCOs or SBHASO. The Parties acknowledge that door-to-door, telephonic and other cold-c, all marketing, are not permitted. Provider shall at all times comply 42 C.F.R. §§ 438.10 and 438.104 and HCA's Managed Care Marketing Guidelines.

6 **GRIEVANCES.** The MCOs and SBHASO maintain a Grievance Process consistent with applicable state and federal requirements, including those that apply to General Fund State-funded services. SBHASO retains, and does not delegate to Provider, responsibility for responding to and resolving Grievances. Not later than the end of the next business day following the day of Provider's receipt, Provider shall transfer or refer to SBHASO any Grievance Provider receives, irrespective of whether such Grievance is related to Provider, SBHASO, a SBHASO subcontractor, including any Subdelegates, a provider, or the MCO. SBHASO shall provide the appropriate MCO information on the Grievance of a Medicaid Enrollee. The MCO of a Medicaid

Enrollee shall undertake an initial review of all Grievances. After the MCO's initial review and upon the MCO's request, SBHASO and Provider shall provide all reasonable assistance to the MCO in its investigation and resolution of a Grievance that relates to a Service provided by Provider or a SBHASO subcontractor, or relates to or involves information held by Provider. The MCO shall be responsible for providing notice of the resolution of a Grievance to the affected Member or provider.

6.1 Provider and SBHASO shall promptly refer to the MCO any non-Grievance inquiries or requests it receives from Members or MCO providers that are unrelated to the Services provided by Provider under this Agreement.

7 SBHASO OBLIGATIONS.

7.1 **Ultimate Legal Responsibility and Oversight.** The MCOs shall at all times retain ultimate responsibility for and oversight of all Delegated Functions to SBHASO. SBHASO is responsible for oversight of all Subdelegated Functions to Provider.

7.1.1 The MCOs and SBHASO will review Provider's regular (e.g., daily, weekly, monthly, and semi-annual) reports related to each Delegated and Subdelegated Functions, identified in the attachments and addenda hereto.

7.1.2 At least annually, and more often as SBHASO deems reasonably necessary, SBHASO will conduct an audit of Provider's performance of each Subdelegated Function. Such audits will evaluate, at a minimum, the extent to which Provider's performance of each Subdelegated Function meets applicable Compliance Requirements. Where possible, SBHASO will provide Provider at least than thirty (30) days' written notice of an audit, including the scope and format of the audit.

7.2 **Termination of Provider's Responsibilities.** SBHASO retains the right to suspend or terminate a Subdelegate of SBHASO, if SBHASO reasonably determines that such Subdelegate's performance under the Agreement is deficient, non-compliant, or otherwise unsatisfactory, and SBHASO provides written notice to Provider regarding such deficiency, non-compliance, or dissatisfaction.

- 7.3 **HCA Reporting.** SBHASO shall be responsible for submitting reports or other information related to the Services to the MCOs which are responsible to submit reports and other information related to Services to HCA.

8 PROVIDER OBLIGATIONS.

- 8.1 Provider shall employ, subcontract or otherwise arrange for sufficient staff to provide each Subdelegated Function in a manner which permits the parties to satisfy applicable Compliance Requirements.
- 8.2 Provider shall ensure that its other business relationships do not interrupt the continuity of services provided to MCO and SBHASO Members under this Exhibit C.
- 8.3 **NCQA Compliance.** The MCOs are accredited by NCQA and operate in accordance with the NCQA Standards. SBHASO and Provider shall comply with the most current version of the NCQA Standards and shall cooperate with and assist the MCOs in demonstrating SBHASO's and Provider's compliance with NCQA Standards.
- 8.4 **Record Keeping; Reporting.** Provider shall maintain a record keeping system or systems adequate to fully document its performance of each Subdelegated Function. Provider will prepare and timely submit to SBHASO regular (e.g., daily, weekly, monthly, and semi-annual) reports or other documentation as identified in the attachments or addenda hereto, related to each Subdelegated Function. Provider will investigate and, if necessary, correct any issues or concerns, including errors or inconsistencies, SBHASO or Provider identifies related to Provider's reports, and will resubmit corrected reports, as needed.
- 8.5 **Audits.** Provider shall promptly respond to and cooperate with all requests for information, including permitting reasonable access to facilities, and clinical, financial and/or administrative records related to the provision of Services under the Agreement from SBHASO related to audits and other oversight activities.
- 8.6 **Eligibility.** SBHASO and, where applicable, Provider, shall adhere to SBHASO's established protocols for determining an individual's eligibility for the Services. Provider shall ensure that patient funding information is updated upon a change to the funding source.

8.7 HCA Compliance. SBHASO and Provider shall comply with the applicable terms and conditions of the HCA Contracts. In the event HCA makes changes to the applicable terms and conditions of the HCA Contracts, SBHASO and Provider shall accept such changes without modification.

8.7.1 Provider shall cooperate with SBHASO's Quality Improvement program and provide open communication on quality improvement strategies.

8.7.2 Provider shall maintain a quality improvement system tailored to the nature and type of health care services rendered under the contract, and which affords quality control for the health care provided.

8.7.3 Provider shall cooperate with MCO-, SBHASO- and HCA-sponsored Quality Improvement activities.

8.7.4 Provider shall provide to SBHASO all information needed to support care coordination activities.

8.7.5 Provider shall participate in training as requested or required by an MCO, SBHASO or the HCA.

8.7.6 Provider shall respond to law enforcement inquiries regarding an individual's eligibility to possess a firearm under RCW 9.41.040(2)(a), and shall concurrently provide to SBHASO a copy of the inquiry and response. SBHASO shall provide a copy of the inquiry and response to the appropriate MCO for Medicaid Enrollees.

8.8 SBHASO/Provider Program Documents. SBHASO and Provider will develop and maintain Program Documents related to each Subdelegated Function. At least sixty (60) days prior to commencement of Provider's performance of any Subdelegated Function hereunder, or a shorter period of time to which the parties agree, SBHASO shall provide Provider copies of its Program Documents. SBHASO shall provide Provider at least fifteen (15) business days advance written notice of any material change to SBHASO's Program Documents.

8.9 Oversight of SBHASO's Subdelegates. SBHASO shall obtain the MCO's written approval prior to subdelegating any portion of its performance hereunder. Subdelegation agreements must be in writing and comply with the requirements set forth in Section 3.6 of the MCO's Agreement. SBHASO shall provide, and document its provision of, active and ongoing oversight of any approved Subdelegate(s). SBHASO shall have a written oversight plan, including a process to evaluate, on at least an annual basis, each Subdelegate's performance relative to the applicable Compliance Requirements and the terms and conditions of the written sub-delegation agreement between SBHASO and the Subdelegate. SBHASO's written process must include a process for issuing a corrective action and revoking subdelegation. SBHASO shall maintain and provide to the MCOs, upon request, a record of its oversight of each Subdelegate's performance, including SBHASO's monitoring process and activities, and any finds or other results.

8.10 Provider shall provide written notification to the SBH-ASO at least thirty (30) days prior to implementing any change expected to materially alter Provider's performance of a Subdelegated Function.

8.11 **HCA Data Reporting.** Provider shall provide to SBHASO timely, complete, and accurate reports and data, including encounter data in accordance with the HCA's Encounter Data Transaction Guide. SBHASO shall ensure that its subcontractors, who are required to report data, have the capacity to submit all HCA required data to enable SBHASO to meet the reporting requirements under the MCO and HCA Contracts. SBHASO shall ensure that its subcontractor(s) comply with data submission requirements established by the HCA for all Services.

8.12 **Program Integrity.** Where possible, SBHASO shall perform ongoing analysis of utilization and claims, billing, or encounter data to detect overpayments or other errors or inconsistencies. Such oversight will include audits and investigations of SBHASO's subcontractors, including provider entities, and a process to verify that services billed by providers were actually provided to Members.

8.13 **Authorizations and Coverage Decision.** If the Subdelegated Functions include authorizations, SBHASO shall comply with 42 C.F.R. § 438.210, Chapters 182-538 and 182-550 WAC, WACs 182-501-0160, 182-501-0169, and WAC 284-43-410, and applicable terms of SBHASO's HCA Contracts.

Where applicable, SBHASO shall follow the coverage decision of the Washington Health Technology Assessment program.

9 PERFORMANCE IMPROVEMENT AND CORRECTIVE ACTIONS.

9.1 Deficiencies and Non-Compliances. If SBHASO reasonably determines that Provider's performance of a Subdelegated Function, including any service or activity related thereto, does not meet applicable Compliance Requirements or is otherwise deficient, SBHASO shall provide Provider written notice describing the non-compliances and/or deficiencies. In addition to its other remedies available under this Agreement, SBHASO may take one or more of the following steps to address a non-compliance or deficiency:

9.1.1 **Audit.** Upon reasonable notice to Provider, conduct an audit of Provider's performance of the non-compliant or deficient Subdelegated Function, service or activity to further investigate the nature, source and extent of the non-compliance or deficiency.

9.1.2 **Corrective Action Plan(s).** Following notice of a non-compliance or deficiency, require Provider to prepare and submit to SBHASO, within a reasonable time-frame, a corrective action plan ("CAP") designed to correct the identified non-compliance or deficiency. Such CAP shall be in the form of a written response to SBHASO's notice of non-compliance or deficiency and shall detail Provider's process for correcting the identified issue(s) within a proposed time period, not to exceed thirty (30) days, including implementation and completion, or such other period as is reasonable given the nature or severity of the non-compliance or deficiency. SBHASO shall review and approve each CAP prior to Provider's implementation.

9.1.3 **Suspension of Performance, Compensation.** If, in SBHASO's sole judgment, Provider's non-compliance or deficiency poses unreasonable risk to the well-being of Members, the timely provision of medically necessary health care and other services, or otherwise materially jeopardizes the quality or continuity of SBHASO operations, then SBHASO may suspend part or all of Provider's performance of the non-compliant or deficient Subdelegated Function until such time as Provider has corrected the non-compliance or deficiency to SBHASO's satisfaction. In such event, SBHASO reserves the right to suspend Provider's

compensation related to the suspended Subdelegated Function(s) until such time as the non-compliance or deficiency has been resolved to SBHASO's satisfaction.

9.2 CAP Implementation and Completion. SBHASO shall oversee Provider's implementation of a CAP to ensure that the instance(s) of non-compliance or deficiency is fully resolved. At the earlier of Provider's completion of the CAP or the time-frame for correction stated in the CAP, SBHASO shall review evidence of Provider's implementation and/or completion of the CAP.

9.2.1 Upon SBHASO's finding that all issues related to the CAP are resolved, SBHASO shall provide written notice to Provider of closure of the CAP.

9.2.2 SBHASO may, in its sole discretion, permit Provider additional time to provide satisfactory evidence of CAP completion.

9.3 Suspension or Termination of Delegation. If, in SBHASO's reasonable judgment, Provider's performance remains non-compliant or deficient after the agreed-to time-frame for correction, SBHASO may suspend or terminate part or all Provider's performance of the non-compliant or deficient Subdelegated Function, or take any other remedial action permitted under this Exhibit C or the Agreement. In the event SBHASO suspends Provider's performance of all or part of a Subdelegated Function, SBHASO reserves the right to suspend Provider's compensation related to the suspended Subdelegated Function(s) until such time as the non-compliance or deficiency has been resolved to SBHASO's satisfaction. In the event SBHASO revokes delegation and terminates Provider's performance of all or part of a Subdelegated Function, Provider acknowledges and agrees that it has no right to and shall not seek any compensation related to the revoked Subdelegated Function(s) as of the effective date of revocation

Salish Behavioral Health Administrative Services Organization (SBHASO)
Exhibit C-1: Crisis Services - Additional Delegation Requirements Grid

The purpose of this Crisis Services Delegation Grid is to specify the responsibilities of Peninsula Behavioral Health (“Sub-Delegate”) under the Agreement with respect to the specific activities that are delegated for Crisis Services, including reporting requirements.

“Crisis Services,” is defined by HCA and means, generally, the screening, evaluation, assessment and clinical interventions provided to an Apple Health Member experiencing a behavioral health crisis. A “behavioral health crisis” means a significant internal or external change in behavior in which instability and/or risk of harm to self or others increases, which would lead to significant negative outcomes or harm to the individual or others if not timely addressed. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration, provide immediate treatment and intervention, de-escalation, and coordination/referral efforts with health, social, and other services and supports as needed to affect symptom reduction, harm reduction, and/or to safely transition the individual in acute crisis to the appropriate environment for continued stabilization. Crisis Services should take place in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation. As used herein, “Crisis Services” shall explicitly include in-home and facility-based crisis stabilization, and the services of crisis relief centers.

The delegation grid below may be amended from time to time during the term of this Agreement by SBHASO to reflect changes in delegation standards, delegation status, performance measures, reporting requirements, or other provisions.

The sections that follow describe the process by which SBHASO evaluates Sub-Delegate’s performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of Exhibit C, the Delegation Agreement, and all obligations and remedies set forth in the parties’ Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, the terms and conditions of the Agreement shall prevail.

Process of Evaluating Sub-Delegate’s Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit to ensure all delegated activities comply with applicable compliance requirements,
- Provide written feedback on the results of the annual audit, and

- Require Sub-Delegate to implement corrective action plans if the delegate does not fully meet compliance requirements.

If SBHASO determines that Sub-Delegate has failed to adequately perform the delegated activities, SBHASO may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Sub-Delegate.

Ongoing performance of accredited sub-delegates is evaluated through the semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, SBHASO will work with Sub-Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Sub-Delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement all together.

Subdelegation

It may be allowable for SBHASO to subdelegate specific activities that relate to Crisis Services. As provided for under the Agreement and as set forth herein, subdelegation requires the prior written approval of MCO. In addition to the requirements for subdelegation set forth in the Agreement, SBHASO will submit to MCO a Delegation Chart (template to be provided by MCO). If a subdelegation is approved, SBHASO will be responsible for ongoing oversight of the subdelegate's performance and will be required to report performance results to MCO.

Function	Sub-Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
HCA CONTRACT REQUIREMENTS				
Administration of Crisis Services	☐ Sub-Delegated ☒ Not Sub-Delegated	Administer Crisis Services, including in-home and facility-based crisis stabilization, which includes the services of		

Function	Sub-Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
		crisis relief centers.		
24-7 Availability	☒ Sub-Delegated ☐ Not Sub-Delegated	Crisis Services shall be available 24-7-365, including regional crisis hotline that provides screening and referral services		
Immediate Access	☒ Sub-Delegated ☐ Not Sub-Delegated	Crisis Services shall be available to Members without the need for the member to complete an intake evaluation or other screening or assessment processes.		
Encounter Data	☒ Sub-Delegated ☐ Not Sub-Delegated	Require submission of complete and accurate encounter data related to the provision of Crisis Services in HCA-prescribed formats	Weekly basis provide to SBHASO batches of such data	Weekly basis provide batches of such data to appropriate MCO
Daily Crisis Service Log	☒ Sub-Delegated ☐ Not Sub-Delegated	Daily crisis services will be kept on a standardized log and submitted each business	Daily (business day)	SBHASO will assist as needed to coordinate any services.

Function	Sub-Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
		day to the SBHASO		
WASHINGTON ADMINISTRATIVE CODE REQUIREMENTS				
Crisis Services standards	☒ Sub-Delegated ☐ Not Sub-Delegated	Crisis services shall be performed in accordance with all state agency requirements, including Washington Department of Health and HCA regulatory requirements, applicable to Crisis Services and Crisis Services providers		Annual monitoring of Sub-Delegate's Policies and Procedures and Clinical Records

Salish Behavioral Health Administrative Services Organization (SBHASO)

Exhibit C-2: Credentialing (CR) Delegation Grid

The purpose of the following grid is to specify the responsibilities of Peninsula Behavioral Health (“Sub-Delegate”) under the Agreement with respect to the specific activities that are delegated for Credentialing. The grid also describes the semi-annual reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the delegation of Credentialing for Crisis Services by SBHASO to Sub-Delegate.

The delegation grid may be amended from time to time during the term of the Agreement by SBHASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which SBHASO evaluates Sub-Delegate’s performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of Exhibit C, the Delegation Agreement, and all obligations and remedies set forth in the parties’ Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, the terms and conditions of the Agreement shall prevail.

Process of Evaluating Sub-Delegate’s Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit to ensure all sub-delegated activities comply with applicable compliance requirements,
- Provide written feedback on the results of the annual audit, and
- Require Sub-Delegate to implement corrective action plans if the sub-delegate does not fully meet compliance requirements.

If SBHASO determines that Sub-Delegate has failed to adequately perform the delegated activities, SBHASO may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Sub-Delegate.

Ongoing performance of accredited sub-delegates is evaluated through the semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, SBHASO will work with Sub-Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Sub-Delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement altogether.

Subdelegation

It may be allowable for SBHASO to subdelegate specific activities that relate to Credentialing. As provided for under the Agreement and as set forth herein, subdelegation requires the prior written approval of MCO. In addition to the requirements for subdelegation set forth in the Agreement, SBHASO will submit to MCO a Delegation Chart (template to be provided by MCO). If a subdelegation is approved, the SBHASO will be responsible for ongoing oversight of the subdelegate's performance and will be required to report performance results to MCO.

DELEGATION GRID				
Function	Sub-Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
CR 7: Assessment of Organizational Providers	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A		

Decision Making	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A	At least monthly standard reporting in electronic format to designated MCO Staff/email	Agency: Approved, Denied, Terminated, Pending. All verifications have 180 days freshness from date of decision. SBHASO retains the right to approve, suspend and terminate individual practitioners, providers and sites
Ongoing Monitoring	☒ Sub-Delegated ☐ Not Sub-Delegated	State Exclusion Website OIG SAM	Completed by 15 th of Month-Sub-Delegate to submit monthly exclusion check attestation and is to maintain documentation	SBHASO completes monthly organizational level exclusion checks.
Disclosure and/or Ownership Form	☒ Sub-Delegated ☐ Not Sub-Delegated	Collected at initial contracting and 36 months after or if any changes	N/A	

Salish Behavioral Health Administrative Services Organization (SBHASO)

Exhibit C-3: Utilization Management (UM) Crisis Services Delegation Grid

The purpose of the following grid is to specify the responsibilities of Peninsula Behavioral Health (“Sub-Delegate”) under the Agreement with respect to the specific activities that are delegated for Utilization Management. The grid also describes the semi-annual reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the sub-delegation of Behavioral Health Utilization Management Crisis Services by SBHASO to Sub-Delegate.

The delegation grid may be amended from time to time during the term of this Agreement by SBHASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which SBHASO evaluates Sub-Delegate’s performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of the Delegation Agreement and all obligations and remedies set forth in the parties’ Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, the terms and conditions of the Agreement shall prevail.

Process of Evaluating Sub-Delegate’s Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit to ensure all delegated activities comply with applicable compliance requirements,
- Provide written feedback on the results of the annual audit, and
- Require Sub-Delegate to implement corrective action plans if the delegate does not fully meet compliance requirements.

If SBHASO determines that Sub-Delegate has failed to adequately perform the delegated activities, SBHASO may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Sub-Delegate.

Ongoing performance of accredited delegates is evaluated through the at minimum semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plan (CAP)

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, SBHASO will work with Sub-Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. CAPs will be implemented for any untimely, inaccurate, or missing information. If Sub-Delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the delegation agreement and scope or revoke the delegation agreement all together.

Subdelegation

It may be allowable for SBHASO to subdelegate specific activities that relate to access to staff to discuss UM issues. As provided for under the Agreement and as set forth herein, subdelegation requires the prior written approval of Health Plan. In addition to the requirements for subdelegation set forth in the Agreement, SBHASO will submit to MCO a Delegation Chart (template to be provided by Health Plan). If a subdelegation is approved, the SBHASO will be responsible for ongoing oversight of the subdelegate's performance and will be required to report performance results to Health Plan.

Delegation

SBHASO hereby delegates to Sub-Delegate, and Sub-Delegate hereby agrees to perform all UM services as described below in Delegation Grids for all Covered Services provided to Members by MCO or Sub-Delegate's Participating Providers. MCO UM requirements are established by NCQA, CMS, and state Medicaid requirements and guidelines and MCO business needs.

NCQA DELEGATION GRID				
Function	Sub-Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
UM 1: Program Structure The organization's UM program has clearly defined	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Program Description. The organization's written UM program description specifies: Factors: 1. The UM Program structure. • UM staff assigned activities. • UM staff with the authority to deny coverage. • Involvement of a designated physician and a	N/A	

structures and processes, and assigns responsibility to appropriate individuals. The organization has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner. The UM Program description is organized and written so that staff members and others can understand the program's structure, scope, processes and information sources used to make UM		designated behavioral healthcare practitioner. • The process for evaluating, approving and revising the UM program, and the staff responsible for each step. • The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities. • The organization's process for handling appeals and making appeal determinations. • Staff size. 2. The behavioral healthcare aspects of the UM program, if applicable. • The program description specifies how the organization addresses sites of behavioral healthcare services (e.g., psychology groups) and levels of behavioral healthcare services (e.g., inpatient psychiatric care, outpatient psychiatrist visits.) If the organization has a process for triage and referral to behavioral health services, the program description specifies the process. 3. The involvement of a designated senior-level physician in program implementation. * UM Committee meeting minutes or other reports documenting active involvement. • The program description specifies how a senior-level physician (a medical director, associate medical director or equivalent) is actively involved on the organization's UM Committee and in UM activities, including implementation, supervision, oversight and evaluation of the UM program. 4. The involvement of a designated behavioral healthcare practitioner in program implementation, if applicable. * UM Committee meeting minutes or other reports documenting active involvement.		
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determinations.		- The program description specifies how a designated behavioral healthcare physician or a doctoral-level behavioral healthcare practitioner is actively involved on the organization's UM Committee and in implementing and evaluating the behavioral health aspects of the UM Program. The behavioral healthcare practitioner must be a physician or have a clinical PhD or PsyD, and may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable.) 5. The oversight of the UM program by a UM Committee. - The committee may be a standing committee, the organization's UM or QI Committee, Pharmaceutical and Therapeutics Committee or another committee. The committee includes participation of a senior-level physician and a designated behavioral healthcare practitioner as applicable. - The organization describes the committee's oversight of the UM program. The committee oversees the UM functions, and annually: - Evaluates the UM program structure, scope, processes and information sources used to determine benefit coverage and medical necessity. - Reviews UM rates - Identifies needed actions based on the evaluation. 6. The process for determining which items and services require prior authorization. - The program description describes the organization's decision-making process and criteria		
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		for determining items and services that require prior authorization and when prior authorization is no longer required. 7. The process for determining benefit coverage and medical necessity. (applicable to factor 7 and 8) • The program description specifies: ○ The organization's UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity, including: ▪ How the organization develops and selects criteria. ▪ How the organization review, updates and modifies criteria. ○ How medical necessity and benefits coverage for inpatient and outpatient services are determined. ○ The description of the data and information the organization uses to make determinations and guide the UM decision-making process. The description should not be burdensome for the member, the practitioner or the health delivery organization staff. ○ The triage and referral process for behavioral healthcare services. ○ How sites of service and levels of care are evaluated for behavioral healthcare services. • The program description lists the information (e.g. patient records, conversations with appropriate physicians) the organization uses to make UM determinations. 8. The information sources used to determine benefit		
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		coverage and medical necessity. See factor 7 above		
UM 1: Program Structure	☐ Sub-Delegated ☒ Not Sub-Delegated	Element B: non-behavioral health care UM rates	N/A	N/A
UM 1: Program Structure	☐ Sub-Delegated ☒ Not Sub-Delegated	Element C: behavioral healthcare UM rates. For requests requiring authorization, the organization annually reports: 1. Overall approval rates* 2. Overall denial rates* 3. Overall timeliness of notification rate for denials. 4. Timelines of notification rate for urgent concurrent denials. 5. Timeliness of notification rate for urgent preservice denials. 6. Timeliness of notification rate for non-urgent preservice denials. 7. Timeliness of notification rate for post-service denials. *Critical factors: Score cannot exceed partially met if one critical factor is scored “no.” Score cannot exceed not met if two or more critical factors are scored “no.”	N/A	
UM 1: Program Structure	☐ Sub-Delegated ☒ Not Sub-Delegated	Element D: Pharmacy UM Rates Element E: UM Appeal rates	N/A	N/A
UM 1: Program Structure	☐ Sub-Delegated	Element F: Evaluation of UM rates. The organization annually evaluates the following UM rates, and reports its	N/A	

	☒ Not Sub-Delegated	findings to the UM Committee: 2. Behavioral healthcare UM rates		
UM 1: Program Structure	☐ Sub-Delegated ☒ Not Sub-Delegated	Element F: Evaluation of UM rates. The organization annually evaluates the following UM rates, and reports its findings to the UM Committee: 1. Non-behavioral healthcare UM rates 3. Pharmacy UM rates 4. Appeal rates	N/A	N/A
UM 1: Program Structure	☐ Sub-Delegated ☒ Not Sub-Delegated	Element G: UM Committee. The organization's UM Committee annually: 1. Reviews the UM rate evaluation. 2. Evaluates the UM Program. • Structure, scope, processes and information sources used to determine medical necessity. • Rates. • Criteria. • Prior authorization requirements. • Level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM Program. 3. Identifies actions to address opportunities from factors 1 and 2. • Update program, UM rates, based on evaluation in factors 1, and 2. • Committee prioritizes actions based on their significance.	N/A	
UM 1: Program Structure	☐ Sub-Delegated	Element H: Implementation of Improvement Actions. The organization annually implements recommended actions from the UM Committee related to: 1. The UM program	N/A	

	☒ Not Sub-Delegated	2. UM rates.		
UM 2: Clinical Criteria for UM Decisions The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria.	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: UM Criteria. The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence. 2. Has written policies for applying the criteria based on individual needs. 3. Has written policies for applying the criteria based on an assessment of the local delivery system. 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews the UM criteria and the procedures for applying them and update the criteria when appropriate.	N/A	
UM 2: Clinical Criteria for UM Decisions	☐ Sub-Delegated ☒ Not Sub-Delegated	Element B: Availability of UM Criteria. The organization makes UM criteria electronically available to practitioners, so they are available at the point of care.	N/A	
UM 2: Clinical Criteria for UM Decisions	☐ Sub-Delegated ☒ Not Sub-Delegated	Element C: Consistency in Applying Criteria. At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. 2. Acts on opportunities to improve consistency, if applicable.	N/A	

UM 3: Communication Services The organization provides access to staff for members and practitioners seeking information about the UM Process and the authorization of care. Members and practitioners can access staff to discuss UM issues.	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Access to Staff. The organization provides the following communication services for members and practitioners: 1. Staff are available at least 8 hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. 2. Staff can receive inbound communication regarding UM issues after normal business hours. 3. Staff are identified by name, title and organization name when initialing or returning calls regarding UM issues. 4. TDD/TTY services for members who need them. 5. Language assistance for members to discuss UM issues.	N/A	
UM 4: Appropriate Professionals Qualified licensed health professionals assess the clinical information used to support UM decisions. UM decisions are	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Licensed Health Professionals. The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions. 2. Specifying the type of personnel responsible for each level of UM decision making.	N/A	

made by qualified health professionals.				
UM 4: Appropriate Professionals	☐ Sub-Delegated ☒ Not Sub-Delegated	Element B: Use of Practitioner for UM Decisions. The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training or professional experience in medical or clinical practice. 2. A current clinical license to practice or an administrative license to review UM cases.	N/A	
UM 4: Appropriate Professionals	☐ Sub-Delegated ☒ Not Sub-Delegated	Element C: Practitioner Review of Nonbehavioral Healthcare Denials. The organization uses a physician, or other appropriate practitioner, to review nonbehavioral health care denials based on medical necessity.	N/A	
UM 4: Appropriate Professionals MUST PASS ELEMENT	☐ Sub-Delegated ☒ Not Sub-Delegated	Element D: Practitioner Review of Behavioral Healthcare Denials. The organization uses a physician or behavioral healthcare practitioner to review behavioral healthcare denials of care based on medical necessity.	N/A	
UM 4: Appropriate Professionals	☐ Sub-Delegated ☒ Not Sub-Delegated	Element E: Practitioner Review of Pharmacy Denials.	N/A	N/A
UM 4: Appropriate	☐ Sub-Delegated	Element F: Use of Board-Certified Consultants. The organization:	N/A	

Professionals	☒ Not Sub-Delegated	1. Has written procedures for using board-certified consultants to assist in making medical necessity determinations. 2. Provides evidence that it uses board-certified consultants for medical necessity determinations. * Critical factors: Score cannot exceed Not Med if one critical factor is scored "No."		
UM 5: Timeliness of UM Decisions The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care.	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Notification of nonbehavioral healthcare decisions.	N/A	N/A
UM 5: Timeliness of UM Decisions MUST PASS ELEMENT	☐ Sub-Delegated ☒ Not Sub-Delegated	Element B: Notification of Behavioral Healthcare Decisions. The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. For urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 2. For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicare and Medicaid nonurgent preservice	N/A	

		decisions, the organization gives electronic or written notification of the decision to members and practitioners with 7 calendar days of the request. 5. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days to the request.		
UM 5: Timeliness of UM Decisions	☐ Sub-Delegated ☒ Not Sub-Delegated	Element C: Notification of Pharmacy Decisions.	N/A	N/A
UM 5: Timeliness of UM Decisions MUST PASS ELEMENT	☐ Sub-Delegated ☒ Not Sub-Delegated	Element D: Interim: Policies and Procedures. The organization has written policies and procedures in place for the following time frames for timeliness of nonbehavioral healthcare, behavioral healthcare UM decision making: 1 3. For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request. 6. For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 7 calendar days of the request. 9. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of receipt of the request.	N/A	
UM 5: Timeliness of UM Decisions	☐ Sub-Delegated	Element D: Interim: Policies and Procedures. The organization has written policies and procedures in place for the following time frames for timeliness of nonbehavioral healthcare, behavioral healthcare and pharmacy UM	N/A	N/A

	☒ Not Sub-Delegated	decision making: 1. For urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request. N/A for Medicaid 2. For Medicare Part B and Medicaid pharmaceutical urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request. 4. For Medicare Part B and Medicaid pharmaceutical urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request. 5. For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of receipt of the request. N/A for Medicaid 7. For Medicare Part B pharmaceutical nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 8. For Medicaid pharmaceutical nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request. 10. For Medicare Part D nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request. N/A for Medicaid 11. For Medicare Part D urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of		
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		receipt of the request. N/A for Medicaid 12. For Medicare Part D postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of receipt of the request. N/A for Medicaid		
UM 6: Clinical Information When determining coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner. The organization uses all information relevant to a member's care when it makes	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Relevant Information for Nonbehavioral Healthcare Decisions.	N/A	N/A

coverage decisions.				
UM 6: Clinical Information	☐ Sub-Delegated ☒ Not Sub-Delegated	Element B: Relevant Information for Behavioral Healthcare Decisions. There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare decision making.		
UM 6: Clinical Information	☐ Sub-Delegated ☒ Not Sub-Delegated	Element C: Relevant Information for Pharmacy Decisions.	N/A	N/A
UM 7: Denial Notices The organization documents and communicates the reasons for a denial. Members and practitioners receive enough information to help them understand a decision to	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Discussing a Denial With a Nonbehavioral Healthcare Reviewer Element B: Written Notification of Nonbehavioral Healthcare Denials. Element C: Written Notification of Nonbehavioral Healthcare Appeal Rights/Process		

deny care or coverage and to decide whether to appeal the decision.				
UM 7: Denial Notices	☐ Sub-Delegated ☒ Not Sub-Delegated	Element D: Discussing a Behavioral Healthcare Denial With Reviewer. The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer.		
UM 7: Denial Notices MUST PASS ELEMENT	☐ Sub-Delegated ☒ Not Sub-Delegated	Element E: Written Notification of Behavioral Healthcare Denials. The organization's written notification of behavioral healthcare denials, that it provided to members and their treating practitioners, contains: 1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based. 3. A statement that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.		
UM 7: Denial Notices MUST PASS Element	☐ Sub-Delegated	Element F: Written Notification of Behavioral Healthcare Appeal Rights/Process. The organization's written notification of behavioral healthcare denials, which it provides to members and their		

	☒ Not Sub-Delegated	treating practitioners, contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal. 2. An explanation of the appeal process, including members' right to representation and appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.		
UM 7: Denial Notices	☐ Sub-Delegated ☒ Not Sub-Delegated	Element G: Discussing a Pharmacy Denial With a Reviewer. Element H: Written Notification of Pharmacy Denials. Element I: Written Notification of Pharmacy Appeal Rights/Process.		
UM 8: Policies for Appeals The organization has written policies and procedures for thorough, appropriate and timely resolution of member appeals.	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Internal Appeals		
UM 9: Appropriate Handling of	☐ Sub-Delegated	Element A: Preservice and Postservice Appeals. Element B: Timeliness of the Appeal Process.		

Appeals The organization adjudicates member appeals in a thorough, appropriate and timely manner.	☒ Not Sub-Delegated	Element C: Appeal Reviewers.		
UM 9: Appropriate Handling of Appeals MUST PASS Element	☐ Sub-Delegated ☒ Not Sub-Delegated	Element D: Notification of Appeal Decision/Rights. An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based. 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request. 4. Notification that the member is entitled to receive reasonable access to and copies of all documents, free of charge, upon request. 5. A list of titles and qualifications, including specialties, of individuals participating in the appeal review. 6. A description of the next level of appeal, either within the organization or to an independent external		

		organization, as applicable, along with any relevant written procedures. 7. Notification that members are not required to bear costs of the IRO, including filing fees.		
UM 10: Procedures for Pharmaceutical Management	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Pharmaceutical Management Procedures Element B: Pharmaceutical Restrictions/Preferences. Element C: Pharmaceutical Patient Safety Issues Element D: Reviewing and Updating Procedures Element E: Considering Exceptions	N/A	N/A
UM 11: UM Information Integrity MUST PASS Element The organization has UM information integrity policies and procedures, audits UM information for inappropriate documentatio n and updates	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Protecting the Integrity of UM Denial Information. The organization has UM denial information integrity policies and procedures that specify: 1. The scope of UM information. 2. The staff responsible for performing UM activities. 3. The process for documenting updates to UM information. 4. Inappropriate documentation and updates. 5. The organization audits UM staff and the process for documenting and reporting identified information integrity issues.		

and implements corrective actions that address identified information integrity issues. The organization demonstrates its commitment to protecting the integrity of UM information used in the processing of UM denials and UM appeals.				
UM 11: UM Information Integrity	☐ Sub-Delegated ☒ Not Sub-Delegated	Element B: Protecting the Integrity of UM Appeal Information	N/A	N/A

UM 11: UM Information Integrity	☐ Sub-Delegated ☒ Not Sub-Delegated	Element C: Information Integrity Training. The organization annually trains UM staff on: 1. In appropriate documentation and updates 2. Organization audits of staff, documenting and reporting information integrity issues.		
UM 11: UM Information Integrity	☐ Sub-Delegated ☒ Not Sub-Delegated	Element D: Audit and Analysis-Denial Information. The organization annually: 1. Audits for inappropriate documentation and updates to UM denial receipt and notification dates. 2. Conducts qualitative analysis of inappropriate documentation and updates to UM denial receipt and notification dates.		
UM 11: UM Information Integrity	☐ Sub-Delegated ☒ Not Sub-Delegated	Element E: Improvement Actions-Denial Information. The organization: 1. Implements corrective actions to address all inappropriate documentation and updates found in Element D. 2. Conducts an audit of the effectiveness of corrective actions (factor 1) on the findings 3–6 months after completion of the annual audit in Element D.		
UM 11: UM Information Integrity	☐ Sub-Delegated ☒ Not Sub-Delegated	Element F: Audit and Analysis-Appeal Information Element G: Improvement Actions-Appeal Information		
UM 12: Delegation of UM If the organization delegates UM activities, there is evidence of	☐ Sub-Delegated ☒ Not Sub-Delegated	Element A: Delegation Agreement 1. Mutually agreed upon. 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization		

oversight of the delegated activities. The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated UM activities.		evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation for the delegation agreement. Element B: Predelegation Evaluation Element C: Review of the UM Program Element D: Opportunities for Improvement Element E: Review of Non -NCQA Accredited Delegates		
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HCA IMC MEDICAID DELEGATION GRID MCOUM requirements are established by NCQA, CMS, and state Medicaid requirements and guidelines and MCO business needs. In addition, the following minimum provisions are required for delegation in the state of Washington:				
Function IMC Contract Section	Sub- Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
3.6 Information Requirements for Enrollees and Potential Enrollees	☐ Sub-Delegated ☒ Not Sub-Delegated	Policy regarding Members right to translation services		
11.6 Service Authorization Decisions and	☐ Sub-Delegated	WA Medicaid STANDARD Electronic Request: Decision and notification within 3 calendar days, excluding holidays, if request contains sufficient information.		

Timeframes	☒ Not Sub-Delegated			
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Electronic Request: If insufficient information is submitted, additional info must be requested within 1 calendar day of the original receipt		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Electronic Request: Provider given 4 calendar days to submit the information		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Electronic Request Requiring Additional Information: determination must be made within 7 calendar days from initial request; if a formal extension was requested, timeline may be extended for an additional 14 days for a total of 21 days. NOTE: The additional 14 calendar days start on the date that the additional information is requested.		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Electronic Request: Decision and notification within one calendar day, if request contains sufficient information.		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Electronic Request: If insufficient information is submitted, additional info must be requested within 24 hours of the original date of receipt		

11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Electronic Request: Provider given 24 hours to submit the information		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Electronic Request Requiring Additional Information: Decision must be made within 72 hours from the initial request; if a formal extension was requested, timeline be extended for an additional 10 calendar days not to exceed 13 calendar days total		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Non-Electronic REQUEST: Decision and notification within 5 calendar days		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Non-Electronic REQUEST: If insufficient information is submitted, additional info must be requested within 1 calendar day of the original receipt		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Non-Electronic Request: Provider given 4 calendar days to submit the information		

11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Non-Electronic Request Requiring Additional Information: determination must be made within 7 calendar days from initial request; if a formal extension was requested, timeline may be extended for an additional 14 days for a total of 21 days. NOTE: The additional 14 calendar days start on the date that the additional information is requested.		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Non-Electronic Request: Decision and notification within 2 calendar days		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Non-Electronic Request: If insufficient information is submitted, additional info must be requested within 24 hours of the original date of receipt		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Electronic Request Requiring Additional Information: Decision must be made within 72 hours from the initial request; if a formal extension was requested, timeline be extended for an additional 10 calendar days not to exceed 13 calendar days total		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Non-Electronic REQUEST: Decision and notification within 5 calendar days		

11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Non-Electronic REQUEST: If insufficient information is submitted, additional info must be requested within 1 calendar day of the original receipt		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Non-Electronic Request: Provider given 4 calendar days to submit the information		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid STANDARD Non-Electronic Request Requiring Additional Information: determination must be made within 7 calendar days from initial request; if a formal extension was requested, timeline may be extended for an additional 14 days for a total of 21 days. NOTE: The additional 14 calendar days start on the date that the additional information is requested.		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Non-Electronic Request: Decision and notification within 2 calendar days		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Non-Electronic Request: If insufficient information is submitted, additional info must be requested within 24 hours of the original date of receipt		

11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid EXPEDITED Non-Electronic Request: Provider given 24 hours to submit the information		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	Make concurrent reviews within one (1) business day, may be extended to within three (3) business days if Provider has made at least one attempt to obtain needed clinical, and notification of review shall be made withing one (1) business day.		
11.6 Service Authorization Decisions and Timeframes	☐ Sub-Delegated ☒ Not Sub-Delegated	Post-service authorizations, decision within 30 calendar days of receipt of authorization request. Notify the Enrollee, requesting Provider, and Facility in writing within 3 business days of the decision. Effective date is the date the service was first administered.		
11.7 Notification of Coverage and Authorization Determinations	☐ Sub-Delegated ☒ Not Sub-Delegated	Denial letters include language informing Members of potential financial responsibility for services received with no prior authorization, when a benefit is not covered, member is not eligible, or adverse decision from an Appeal/Fair Hearing when a benefit extension is requested		
11.7 Notification of Coverage and Authorization Determinations	☐ Sub-Delegated ☒ Not Sub-Delegated	Non-Covered benefit denial letters include exception to rule language		
11.7 Notification of Coverage and	☐ Sub-Delegated	Benefit exhausted denial letters include limitation extension language		

Authorization Determinations	☒ Not Sub-Delegated			
16.9 Qualifying Clinical Trials	☐ Sub-Delegated ☒ Not Sub-Delegated	WA Medicaid - Attestation form in member file if member is participating in clinical trial		

MCO REQUIREMENTS DELEGATION GRID				
MCO UM requirements are established by NCQA, CMS, and state Medicaid requirements and guidelines and MCO business needs.				
	☐ Sub-Delegated ☒ Not Sub-Delegated	Care for Members needing Case Management services Care for Members needing Disease Management services Practitioner and/or Member Satisfaction with the UM Program All components of Pharmacy Benefits Management Evaluation of new technologies UM activities for services other than those that Delegate is at risk Review, discussion, and approval of annual information integrity audits and subsequent report from the Delegate Review, discussion and approval of any of the Delegate's measurement of effectiveness of actions audit, to ensure the	Not Applicable	

		actions have sufficiently addressed the initially identified integrity issues, if applicable Oversight of Delegate's responsibilities, monitoring the quality and timeliness of decisions Implementing CAP when deficiencies are identified		
	☐ Sub-Delegated ☒ Not Sub-Delegated	Adoption and application of UM decision criteria		
	☐ Sub-Delegated ☒ Not Sub-Delegated	Identification and reporting to MCO those Members needing Case and/or Disease Management, Care Coordination services.		
	☐ Sub-Delegated ☒ Not Sub-Delegated	Communicating Member specific utilization management decisions to requesting provider, Member, Member's PCP, and MCO as appropriate, using MCO approved letter templates		
	☐ Sub-Delegated ☒ Not Sub-Delegated	Identification of potential Member fraud, waste, or abuse.		

	☐ Sub-Delegated ☒ Not Sub-Delegated	Support MCO Appeals and Grievance process including investigations scientific and technical review aspects and communicating with Delegate's subcontracted network.		
	☐ Sub-Delegated ☒ Not Sub-Delegated	Sub-Delegate agrees to not further sub delegate UM responsibilities without MCO approval. All pre assessment documents completed by Sub-Delegate must be submitted to MCO for review and approval, prior to sub-delegation effective date. MCO maintains the right to require Sub-Delegate to modify pre assessment documents, and/or pre assessment processes, to ensure that MCO requirements and state and federal standards applicable to sub delegation are met.		
	☐ Sub-Delegated ☒ Not Sub-Delegated	Policy for process and timeframes for extensions when additional information is needed		
	☐ Sub-Delegated ☒ Not Sub-Delegated	Policy for downgrading requests from Expedited/Urgent to Standard, including timeframes for downgrading and notification to Member and Provider		
	☐ Sub-Delegated ☒ Not Sub-Delegated	Policy addressing document withdrawals or dismissals		

Salish Behavioral Health Administrative Services Organization (SBHASO)

Exhibit C-4: Claims and Encounters Delegation Grid

The purpose of the following grid is to specify the responsibilities of Peninsula Behavioral Health (“Sub-Delegate”) under the Agreement with respect to the specific activities that are delegated regarding Claims and Encounter Data. The grid also describes the reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the delegation of Claims Processing and Payment and Encounter Data Submission by SBHASO to Sub-Delegate.

The delegation grid may be amended from time to time during the term of the Agreement by SBHASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which SBHASO evaluates Sub-Delegate’s performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of the Delegation Agreement, and all obligations and remedies set forth in the parties’ Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, the terms and conditions of the Agreement shall prevail.

Definitions

Claim – A formal request for payment submitted by a provider to the Sub-Delegate for covered services.

Encounter – A single healthcare service or a period of examination or treatment. HCA requires all contracted entities to report encounter data for services delivered to clients who may or may not be enrolled in managed care.

Process of Evaluating Sub-Delegate’s Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit to ensure all delegated activities comply with applicable compliance requirements,
- Provide written feedback on the results of the annual audit, and
- Require Sub-Delegate to implement corrective action plans if the delegate does not fully meet compliance requirements.

If SBHASO determines that Sub-Delegate has failed to adequately perform the delegated activities, SBHASO may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Sub-Delegate.

Ongoing performance of accredited sub-delegates is evaluated through the semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, SBHASO will work with Sub-Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements

and categories. If Sub-Delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement altogether.

Subdelegation

It may be allowable for Sub-Delegate to subdelegate specific activities that relate to Claims and Encounter Data. As provided for under the Agreement and as set forth herein, subdelegation requires the prior written approval of SBHASO. In addition to the requirements for subdelegation set forth in the Agreement, SBHASO will submit to MCO a Delegation Chart. If a subdelegation is approved, the SBHASO will be responsible for ongoing oversight of the subdelegate's performance and will be required to report performance results to Managed Care Organizations.

CLAIMS/ENCOUNTER BUSINESS REQUIREMENTS				
Function	Sub-Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
1. Encounter Data Definition of Encounter Data	☒ Sub-Delegated ☐ Not Sub-Delegated	Encounter Data means records of physical or behavioral health care services submitted as electronic data files created by the Sub-Delegate's system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format.	N/A	N/A
2. Encounter Data Dedicated Resource	☒ Sub-Delegated ☐ Not Sub-Delegated	Designate a person dedicated to work collaboratively with SBHASO on quality control and review of encounter data submitted to HCA.	N/A	SBHASO resource will partner with Sub-Delegate resource for quality control and review of encounter data.
3. Encounter Data Reporting requirements	☒ Sub-Delegated ☐ Not Sub-Delegated	Submit complete, accurate, and timely data for all services for which the Sub-Delegate has incurred any financial liability, whether directly or	Weekly	SBHASO will provide oversight of Sub-Delegate encounter data.

		through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA.		
4. Encounter Data Expected turnaround time reporting encounter data	☒ Sub-Delegated ☐ Not Sub-Delegated	Encounter data must be submitted to SBHASO at a minimum weekly, and no later than thirty (30) calendar days from the end of the month in which the Delegate paid the financial liability.	Weekly	SBHASO will monitor turnaround.
5. Encounter Data Submission and edits	☒ Sub-Delegated ☐ Not Sub-Delegated	Submitted encounters and encounter records must pass all system edits with a disposition of accept and listed in the Encounter Data Reporting Guide (ERDG) or sent out in communications from HCA/SBHASO to the Sub-Delegate.	N/A	N/A
6. Encounter Data Duplicates	☒ Sub-Delegated ☐ Not Sub-Delegated	Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.	N/A	N/A
7. Encounter Data RCW 42.56.270(11)	☐ Sub-Delegated	N/A	N/A	SBHASO must report the paid date, paid unit, and paid

	☒ Not Sub-Delegated			amount for each encounter. The “paid amount” data is considered the SBHASO’s proprietary information and is protected from public disclosure. “Paid amount” is defined as the amount paid for the service, or zero pay for cost based/invoice payments.
8. Encounter Data 42 C.F.R. § 438.606 Attestations	☒ Sub-Delegated ☐ Not Sub-Delegated	The Sub-Delegate shall send attestation to SBHASO to certify the accuracy and completeness of all encounter data concurrently with each file upload.	Weekly	SBHASO will receive weekly attestations from the Sub-Delegate. SBHASO will review and complete the monthly certification letter and send to the MCOs.
9. Encounter Data 837 Requirements	☒ Sub-Delegated ☐ Not Sub-Delegated	The Sub-Delegate must be able to meet the requirements outlined in the attached requirements document.	N/A	N/A
10. Encounter Data Quality Assurance	☒ Sub-Delegated ☐ Not Sub-Delegated	The Sub-Delegate must validate the accuracy and completeness of all encounter data for behavioral health care services compared to the year-to-date general ledger of paid claims for the health care services.	Quarterly	SBHASO will oversee the quality assurance of the Sub-Delegate encounters. The MCOs will oversee the quality assurance of the SBHASO encounters.

11. Encounter Data Form D	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A	Quarterly	Within sixty (60) calendar days of the end of each calendar quarter, the SBHASO shall provide aggregate totals of all encounter data submitted and accepted during that quarter on the Apple Health - Integrated Managed Care Quarterly Encounter/General Ledger Reconciliation (Form D). SBHASO shall reconcile the cumulative encounter data submitted and accepted for the quarter and contract year with the general ledger paid claims for the quarter. The SBHASO shall provide justification for any discrepancies. SBHASO will complete Form D and send to MCO. HCA will approve or reject the discrepancy justifications and notify the MCO of the decision 120 calendar days of the end of each calendar quarter.
12. Claims Payment Standards	☐ Sub-Delegated		Monthly	SBHASO shall meet the timeliness of payment

Section 1902(a)(37) of the Social Security Act 42 C.F.R. § 447.45 WAC 284-170-431	☒ Not Sub-Delegated			standards. These standards shall also be applicable to State-only and federal block grant fund payments. To be compliant with payment standards the SBHASO shall pay or deny 95 percent of clean claims within thirty (30) calendar days of receipt, 95 percent of all claims within sixty (60) calendar days of receipt and 95 percent of clean claims within ninety (90) calendar days of receipt. SBHASO shall provide a monthly report to the MCO of claims timeliness results. If standard is not met, provide root cause and corrective action until performance expectation is met.
13. Claims processing Top Claims Denials Reporting	☐ Sub-Delegated ☒ Not Sub-Delegated		Quarterly	SBHASO shall produce and submit a quarterly claims denial analysis report. The report shall include the following data: Total number of approved claims for which there was at least one denied line. Completely denied claims. Total number of

				claims adjudicated in the reporting claim. Total number of behavioral health claims denied by claim line. Summary by reason and type of claims denied. The total number of denied claims divided by the total number of claims. For each of the five (5) network billing providers with the highest number of total denied claims, the number of total denied claims expressed as a ratio to all claims adjudicated. Total number of Behavioral Health claims received, that were not approved upon initial submission. The total number of rejected/non-clean behavioral health claims, divided by the total number of claims submitted. The top five reasons for behavioral health claims being rejected upon initial submission. The report shall include a narrative, including the action steps planned to address. The top five (5) reasons for denial,
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				including provider education to the five network billing providers with the highest number of total denied claims. Provider education must address root causes of denied claims and actions to address them.
14. TPL Reporting	☒ Sub-Delegated ☐ Not Sub-Delegated	The Sub-Delegate shall report all third party revenue for each submitted claim to the SBHASO.	Monthly	The Delegate shall submit a quarterly <i>Recovery and Cost Avoidance Report</i> that includes any recoveries for third party resources as well as claims that the Delegate denies due to TPL coverage. The report shall include recoveries or denied claim payments for any covered service. The Delegate shall calculate cost savings in categories. The Delegate shall treat funds recovered from third parties as offsets to claims payments and reflect those offsets in encounter data. The report is due by the sixtieth (60th) calendar day following the end of the quarter. The Delegate shall submit to the MCO on the 15th of the

				month following the end of the monthly reporting period a report (Enrollees with Other Health Care Insurance) of Enrollees with any other health care insurance coverage with any carrier, including the Delegate. The Delegate shall submit to the MCO on the 20th of the following month a report (Subrogation Rights of Third Party Liability (TPL) – Investigations) of any Enrollees who the Delegate newly becomes aware of a cause of action to recover health care costs for which the Delegate has paid under the Agreement.
15. Participating and Non-Participating Reporting	☐ Sub-Delegated ☒ Not Sub-Delegated			SBHASO shall track and record all payments to Participating Providers and Non-Participating Providers in a manner that allows for reporting to the MCO the number, amount, and percentage of claims paid to Participating Providers and Non-Participating

				Providers separately. The Delegate shall identify the type of providers and Subspecialty. The Delegate shall also track, document and report to the MCO any known attempt by Non-Participating Providers to balance bill Enrollees. The SBHASO shall provide annual reports to the MCO for the preceding state fiscal year (July 1 through June 30). The reports shall indicate the proportion of services provided by the Delegate's Participating Providers and Non-Participating Providers, by county, and including hospital-based physician services. Delegate shall submit the reports to the MCO no later than August 15 of each year.
16. Sub-delegation Agreements Delegate sub-delegation agreements with a vendor	☐ Sub-Delegated ☒ Not Sub-Delegated			SBHASO will notify the MCO of sub-delegation vendor agreements the Delegate has; what duties do they perform, and how often.

17.Claims/Encounter Delegation Oversight Audit Quality Assurance Audits	☐ Sub- Delegated ☒ Not Sub- Delegated		Annual	MCO is required to perform an annual oversight delegation audit of encounter data reporting/ claims processing. The objective of this audit is to assess the effectiveness of key internal controls by ensuring the accuracy, completeness, and timeliness of the claims/encounter processing functions. SBHASO will provide MCO claims data set for specified time period. MCO will review the claims data set for the following: • Review encounter/claims universe sample of all services paid or denied for 1 year; • Verify the member was eligible for benefits on the dates of service; • Review encounter submission and reconciliation to ensure requirements are met;

				• Review claim payment calculations and verify that claims were paid accurately; • Verify claims were submitted by the provider within 365 days of dates of service; • Review responses to audit questionnaire to ensure compliance.
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Salish Behavioral Health Administrative Services Organization (SBHASO)

Exhibit C-5: Quality Improvement (QI) Delegation Grid

The purpose of the following grid is to specify the responsibilities of Peninsula Behavioral Health (“Sub-Delegate”) under the Agreement with respect to the specific activities that are delegated for Quality Improvement. The grid also describes at minimum semi-annual reporting requirements. The specific scope of activities that relates to this delegation arrangement includes Behavioral Health Telephone Access for Crisis Services. These activities may not be sub-delegated without notification to, and with prior approval by MCO. (See section below on sub delegation.)

SBHASO does not formally sub-delegate the responsibility for performing quality management and improvement activities on behalf of SBHASO. However, SBHASO does require Sub-Delegates to maintain a quality improvement and management program pertaining to delegated activities and participate and cooperate in SBHASO quality improvement program, collect data for SBHASO quality improvement activities, and carry out corrective actions as required by SBHASO.

The delegation grid may be amended from time to time during the term of the Agreement by SBHASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; or other provisions.

The process by which SBHASO evaluates Sub-Delegate performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its' obligations are as follows.

Process of Evaluating Sub-Delegate’s Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit, to be performed offsite or onsite, to ensure compliance with all sub-delegated activities,
- Provide written feedback on the results of the annual audit, and
- Implement corrective action plans if the sub-delegate does not fully meet delegation requirements.

The consequences for failure to perform can include:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with sub-delegate

On-going performance of accredited sub-delegates is evaluated through the semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual or ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulators.

Corrective Action Plans

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification requirements, SBHASO will work with sub-delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If sub-delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the delegation agreement and scope or revoke the delegation agreement all together.

Subdelegation

It may be allowable for SBHASO to subdelegate specific activities that relate to Crisis Services telephone operations. Subdelegation will require approval by Managed Care Organizations evidenced by the signature at the end of this Delegation Grid and upon submission of a Delegation Chart (template to be provided by MCO). If sub-delegate chooses to subdelegate any activities, SBHASO is giving the third-party authority to perform the delegated activities. As such, SBHASO is responsible for ongoing oversight of the subdelegate's performance and is required to report performance results to MCO.

DELEGATION GRID				
Function	Sub-Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
Behavioral Health Telephone Access [QI 4.B.1 and QI 4.B.2]	☐ Sub-Delegated ☒ Not Sub-Delegated	Telephones are answered by a live voice within 30 seconds with an abandonment rate within 5 percent.	Submission to SBHASO staff of a quarterly summary report that includes total calls, call answer time and abandonment rate. Reports provided in electronic or hard copy.	SBHASO staff will receive and review quarterly reports for performance review. Quality and Compliance Committee will review monthly reports on a quarterly basis

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