| Washington State Health Care Authority | **CONTRACT AMENDMENT BEHAVIORAL HEALTH – ADMINSTRATIVE SERVICES ORGANIZATION** | HCA Contract No.: K6896<br>Amendment No.: 02<br>KC-328-23-B |
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**THIS AMENDMENT TO THE BEHAVIORAL HEALTH – ADMINISTRATIVE SERVICES ORGANIZATION CONTRACT** is between the Washington State Health Care Authority and the party whose name appears below, and is effective as of the date set forth below.

| **CONTRACTOR NAME** | **CONTRACTOR DOING BUSINESS AS (DBA)** |
|---|---|
| Kitsap County | Salish Behavioral Health Administrative Services Organization |
| **CONTRACTOR ADDRESS**<br>614 Division Street, MS23<br>Port Orchard, WA 98366-4676 | **WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)**<br>182-002-345 |

| **AMENDMENT START DATE** | **AMENDMENT END DATE** | **CONTRACT END DATE** |
|---|---|---|
| January 1, 2024 | June 30, 2025 | June 30, 2025 |
| **PRIOR MAXIMUM CONTRACT AMOUNT**<br>$9,136,064.00 | **AMOUNT OF INCREASE**<br>$1,795,025.00 | **TOTAL MAXIMUM CONTRACT AMOUNT**<br>$10,931,089.00 |

WHEREAS, HCA and Contractor previously entered into a Contract for behavioral health services, and;

WHEREAS, HCA and Contractor wish to amend the Contract to 1) update requirements and provide editorial changes to the BH-ASO Contract to ensure clarity of contract expectations; 2) revise WAC references; 3) update Exhibit A, Non-Medicaid Funding Allocation; 4) revise Exhibit D, Service Area Matrix; 5) revise Exhibit G, Peer Bridger Program; and 6) add Schedule C, Trueblood Quarterly Enhanced Crisis Stabilization/Crisis Triage.

NOW THEREFORE, the parties agree the Contract is amended as follows:

1. The Total Maximum Contract Amount for this Contract is increased by $1,795,025.00, from $9,136,064.00 to $10,931,089.00.

2. Section 1, Definitions, 1.15 Assessment and Substance Use Disorder, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

3. Section 1, Definitions, a new subsection 1.19 Behavioral Health Care Coordination and Community Integration, is added as follows:

   1.19 Behavioral Health Care Coordination and Community Integration

   "Behavioral Health Care Coordination and Community Integration" means a range of activities furnished to engage Individuals in treatment and assist them in transitioning from a variety of inpatient, residential, or non-permanent settings back into the broader community. To be eligible, the Individual must need transition support services in order to ensure timely and appropriate Behavioral Health treatment and Care Coordination. This service is further described in the Medicaid State Plan at Attachment 3, Section 13.d.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

4. Section 1, Definitions, 1.52 Crisis Services (Behavioral Health), is amended to read as follows:

   1.52 Crisis Services (Behavioral Health)

   "Crisis Services", also referred to as "Crisis Intervention Services" means screening, evaluation, assessment, and clinical intervention are provided to all Individuals experiencing a Behavioral Health crisis. A Behavioral Health crisis is defined as a significant change in behavior in which instability increases, and/or risk of harm to self or others increases. The reasons for this change could be external or internal to the Individual. If the crisis is not addressed in a timely manner, it could lead to significant negative outcomes or harm to the Individual or others. Crisis services are available on a 24-hour basis, 365 days a year. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration, and 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 Individuals in acute crisis to the appropriate environment for continued stabilization. Crisis intervention 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.

5. Section 1, Definitions, 1.55 Day Support, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

6. Section 1, Definitions, 1.70 Evaluation and Treatment (E&T), is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

7. Section 1, Definitions, 1.74 Family Treatment, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

8. Section 1, Definitions, 1.100 Intake Evaluation, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

9. Section 1, Definitions, a new subsection 1.100 Intake Evaluation, Assessment, and Screenings (Mental Health), is added as follows:

   1.100 Intake Evaluation, Assessment, and Screenings (Mental Health)

   "Intake Evaluation, Assessment, and Screenings (Mental Health)" also referred to as "Intake" means an evaluation to establish the medical necessity for treatment, determine service needs, and formulate recommendations for treatment. Intake evaluations must be initiated prior to the provision of any other behavioral health services, except those specifically stated as being available prior to an intake. Services may begin before the completion of the intake once medical necessity is established. This service is further described in the Medicaid State Plan at Attachment 3, Section 13.d.

   All remaining subsections are subsequently renumbered and internal references updated accordingly.

10. Section 1, Definitions, a new subsection 1.101 Intake Evaluation, Assessment, and Screenings (Substance Use or Problem Gambling Disorder), is added as follows:

    1.101 Intake Evaluation, Assessment, and Screenings (Substance Use or Problem Gambling Disorder)

    "Intake Evaluation, Assessment, and Screenings (Substance Use or Problem Gambling Disorder)" also referred to as "SUD assessment" means a comprehensive evaluation of an Individual's behavioral health, along with their

ability to function within a community, to determine current priority needs and formulate recommendations for treatment. The intake evaluation for substance use disorder includes a review of current intoxication and withdrawal potential, biomedical complications, emotional, behavioral, cognitive complications, readiness to change, relapse potential, and recovery environment. Intake evaluations for problem gambling disorders includes a biopsychosocial clinical assessment. Information from the intake is used to work with the Individual to develop an individualized service plan to address the identified issues. Intake evaluations must be initiated prior to the provision of any other substance use or problem gambling disorder services. Services may begin before the completion of the intake once medical necessity is established.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

11. Section 1, Definitions, 1.117 Medication Management, is amended to read as follows:

    1.117 Medication Management

    "Medication Management" means the prescribing and/or administering of psychiatric medications and reviewing of medications and their side effects. This service may be provided in consultation with primary therapists, case managers, and/or natural supports, without the Individual present, but the service must be for the benefit of the Individual.

12. Section 1, Definitions, 1.119 Medication Monitoring, is amended to read as follows:

    1.119 Medication Monitoring

    "Medication Monitoring" means one-on-one cueing, observing, and encouraging an Individual to take their psychiatric medications as prescribed. Also includes reporting back to persons licensed to perform Medication Management services for the direct benefit of the Individual. This service is designed to facilitate medication compliance and positive outcomes.

13. Section 1, Definitions, a new subsection 1.125 Mental Health Treatment Interventions, is added as follows:

    1.125 Mental Health Treatment Interventions

    "Mental Health Treatment Intervention" means services delivered in a wide variety of settings that promote recovery, using therapeutic techniques. These services are provided, as Medically Necessary, along a continuum from outpatient up through residential and inpatient levels of care and include evaluation, stabilization, and treatment. Services provided in facility settings must have the appropriate state facility licensure. This service is further described in the Medicaid State Plan at Attachment 3, Section 13.d.

    All remaining subsections are subsequently renumbered and internal references updated accordingly.

14. Section 1, Definitions, a new subsection 1.126 Mobile Rapid Response Crisis Team (MRRCT), is added as follows:

    1.126 Mobile Rapid Response Crisis Team (MRRCT)

    "Mobile Rapid Response Crisis Team (MRRCT)" means a team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for Individuals who experiencing a Behavioral Health crisis, that shall include certified peer counselors as a best practice to the extent practicable based on workforce availability, and that meets standards for response items established by the HCA. MRRCT teams that primarily serve children, youth, and families follow the Mobile

Response and Stabilization Services (MRSS) model and may refer to themselves as an MRSS team or as a child, youth and family MRRCT.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

15. Section 1, Definitions, 1.143 Peer Support Services, is amended to read as follows:

    1.143 Peer Support Services

    "Peer Support Services" means scheduled activities that promote wellness, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services provided by Certified Peer Counselors, as noted in the Individuals' Individualized Service Plan (ISP), or without an ISP when provided during/post crisis episode. In this service, Certified Peer Counselors model skills in recovery and self-management to help Individuals meet their self-identified goals.

16. Section 1, Definitions, 1.153 Psychological Assessment, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

17. Section 1, Definitions, 1.158 Rehabilitation Case Management, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

18. Section 1, Definitions, 1.169 Special Population Evaluation, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

19. Section 1, Definitions, 1.169 Stabilization Services, is amended as follows:

    1.169 Stabilization Services

    "Stabilization Services" (also referred to as Crisis Stabilization), means services provided to Individuals who are experiencing a Behavioral Health crisis. This service includes follow-up after a crisis intervention. These services are to be provided in the Individual's own home, or another home-like setting, or a setting which provides safety for the Individual and the Mental Health Professional. Stabilization services may include short-term assistance with life skills training and understanding medication effects. It may also include providing services to the Individual's natural and community supports, as determined by a Mental Health Professional, for the benefit of supporting the Individual who experienced the crisis. Stabilization services may be provided prior to an intake evaluation for Behavioral Health services. Stabilization services may be provided by a team of professionals, as deemed appropriate and under the supervision of a Mental Health Professional.

20. Section 1, Definitions, 1.174 Substance Use Disorder Outpatient Treatment, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

21. Section 1, Definitions, 1.177 Therapeutic Psychoeducation, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

22. Section 2, General Terms and Conditions, 2.3 Report Deliverable Templates, is amended to read as follows:

    2.3. Report Deliverable Templates

    2.3.1 Templates for all reports that the Contractor is required to submit to HCA are hereby incorporated by reference into this Contract. HCA may update the templates from time to time, and any such updated templates will also be incorporated by reference into this Contract. The report templates

are located at:https://www.hca.wa.gov/billers-providers-partners/program-information-providers/model-managed-care-contracts. All deliverables must be named and submitted using the naming convention identified on the HCA reports template page. Documents and email subject headings to utilize the same naming convention. The Contractor may email HCA at any time to confirm the most recent version of any template to HCABHASO@hca.wa.gov.

2.3.1.1 Report templates include:

2.3.1.1.1 Community Behavioral Health Enhancement (CBHE) Funds Quarterly Report

2.3.1.1.2 Co-Responder report

2.3.1.1.3 Criminal Justice Treatment Account (CJTA) Quarterly Progress Report

2.3.1.1.4 Crisis Housing Voucher Log (King and Thurston/Mason only)

2.3.1.1.5 Crisis System Metrics Report

2.3.1.1.6 Crisis Triage/Stabilization and Increasing Psychiatric Bed Capacity report

2.3.1.1.7 Data Shared with External Entities Report

2.3.1.1.8 E&T Discharge Planner Report

2.3.1.1.9 Federal Block Grant Annual Progress Report

2.3.1.1.10 Gift card purchase and distribution tracker

2.3.1.1.11 Grievance, Adverse Authorization Determination, and Appeals

2.3.1.1.12 Juvenile Court Treatment Program Reporting

2.3.1.1.13 Mental Health Block Grant (MHBG) Project Plan

2.3.1.1.14 Mobile Rapid Response Crisis (MRRC) report

2.3.1.1.15 Non-Medicaid Expenditure Report

2.3.1.1.16 Non-Medicaid Spending Plan template

2.3.1.1.17 Peer Bridger Participant Treatment Engagement Resources report

2.3.1.1.18 Peer Bridger Program

2.3.1.1.19 Peer Pathfinder Jail Transition Report

2.3.1.1.20 Recovery Navigator Program Quarterly Report

2.3.1.1.21 Semi-Annual Trueblood Misdemeanor Diversion Fund Report

2.3.1.1.22 Substance Abuse Block Grant (SABG) Capacity Management Form

2.3.1.1.23 Substance Abuse Block Grant (SABG) Project Plan

2.3.1.1.24 Supplemental Data Daily Submission Notification

2.3.1.1.25 Supplemental Data Monthly Certification Letter

2.3.1.1.26 Systems of Care Mobile Response and Stabilization Services (MRSS) (Carelon and Spokane only)

2.3.1.1.27 Trauma Informed Counselling Services to Children and Youth in Whatcom County Schools (Whatcom only)

2.3.1.1.28 Trueblood Enhanced Crisis Stabilization quarterly report (King only)

2.3.1.1.29 Trueblood Enhanced Crisis Stabilization Services Staff details (King only)

2.3.1.1.30 Trueblood Enhanced Crisis Stabilization/Crisis Triage quarterly report (Carelon and Spokane only)

2.3.1.1.31 Trueblood Enhanced Crisis Stabilization/Triage Services Staff details (Carelon and Spokane only)

2.3.1.1.32 Whatcom County Crisis Stabilization Center – Diversion Pilot (Whatcom only)

23. Section 2, General Terms and Conditions, 2.11 Disputes, subsection 2.11.2 is amended to read as follows:

2.11 Disputes

When a dispute arises over an issue that pertains in any way to this Contract (other than overpayments, as described below), the parties agree to the following process to address the dispute:

2.11.1 The Contractor shall request a dispute resolution conference with the Agency Director. The request for a dispute resolution conference must be in writing and shall clearly state all of the following:

2.11.1.1 The disputed issue(s).

2.11.1.2 An explanation of the positions of the parties.

2.11.1.3 Any additional facts necessary to explain completely and accurately the nature of the dispute.

2.11.2 Requests for a dispute resolution conference must be mailed in a manner providing proof of receipt (delivery) to the Director, Washington State HCA, P.O. Box 45502, Olympia, WA 98504-5502. Any such requests must be received by the Director within thirty (30) calendar days after the Contractor receives notice of the disputed issue(s).

2.11.2.1 The Contractor shall also email a courtesy copy of the request for a dispute resolution conference to the email address(es) provided in the notice of the HCA decision the Contractor is disputing.

2.11.3 The Director, in his or her sole discretion, shall determine a time for the parties to present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's discretion. The Director shall provide written notice of the time, format, and location of the conference. The conference is informal in nature and is not governed in any way by the Administrative Procedure Act, chapter 34.05 RCW.

2.11.4 The Director shall consider all of the information provided at the conference and shall issue a written decision on the disputed issue(s) within thirty (30) calendar days after the conclusion of the conference. However, the Director retains the option of taking up to an additional sixty (60) calendar days to consider the disputed issue(s) or taking additional steps to attempt to resolve them. If the Director determines, in his or her sole discretion, that an additional period of up to sixty (60) calendar days is needed for review, he or she shall notify the Contractor, in writing, of the delay and the anticipated completion date before the initial thirty-day period expires.

2.11.4.1 The Director, at his or her sole discretion, may appoint a designee to represent him or her at the dispute conference. If the Director does appoint a designee to represent him or her at the dispute conference, the Director shall retain all final decision-making authority regarding the disputed issue(s). Under no circumstances shall the Director's designee have any authority to issue a final decision on the disputed issue(s).

2.11.5 The parties hereby agree that this dispute process shall precede any judicial or quasi judicial proceeding and is the sole administrative remedy under this Contract.

2.11.6 Disputes regarding overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Section.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

24. Section 2, General Terms and Conditions, 2.17 Insurance, subsection 2.17.8 is amended to read as follows:

2.17.8 Evidence of Coverage: Upon request, the Contractor shall submit certificates of insurance in accordance with the Notices Section of the General Terms and Conditions, for each coverage required under this Contract. If requested, each certificate of insurance shall be executed by a duly authorized representative of each insurer.

25. Section 2, General Terms and Conditions, 2.30 Notices, subsection 2.30.3 is amended to read as follows:

2.30.3 Notices delivered through the United States Postal Service will be effective on the date delivered as evidenced by the return receipt. Notices delivered by email, will be deemed to have been received when the recipient acknowledges, by email reply, having received that email.

26. Section 2, General Terms and Conditions, 2.31 Notice of Overpayment, subsection 2.31.2 is amended to read as follows:

2.31.2 The Contractor may contest a Notice of Overpayment by requesting an adjudicative proceeding. The request for an adjudicative proceeding must:

2.31.2.1 Comply with all of the instructions contained in the Notice of Overpayment;

2.31.2.2 Be received by HCA within twenty-eight (28) calendar days of service receipt of the Notice of Overpayment by the Contractor;

2.31.2.3 Be sent to HCA by certified mail (return receipt), or other manner providing proof of receipt (delivery) to the location specified in the Notice of Overpayment;

2.31.2.4 Include a statement and supporting documentation as to why the Contractor thinks the Notice of Overpayment is incorrect; and

2.31.2.5 Include a copy of the Notice of Overpayment.

27. Section 2, General Terms and Conditions, 2.36 Reserves, subsection 2.36.1 is amended to read as follows:

2.36.1 In RSAs where HCA has authorized reserves, the Contractor shall maintain a reserve, within the levels specified in the table found in this Section, for Flexible General Funds State (GF-S) funding of required non-Medicaid services within the region. The Flexible GF-S funds must be deposited into a designated reserve account and may only drop below the allocated amount in the event the cost of providing psychiatric inpatient services or crisis services exceeds the revenue the Contractor receives. The Contractor may also use the allocated reserve funds that are in excess of the minimum required reserve level to ensure a smooth transition to integrated managed care up to the maximum reserve level. This includes maintaining existing levels of regional BH crisis and diversion programs, and other required BH-ASO services, and to stabilize the crisis services system.

| BH-ASO | Minimum Reserve Fund Balance Amount Distributed | Maximum Reserve Fund Balance Amount 200% of Distribution |
|---|---|---|
| Greater Columbia | $1,796,025.00 | $3,592,050.00 |
| Great Rivers | $719,341.69 | $1,438,683.38 |
| King | $5,370,943.03 | $10,741,886.06 |
| Thurston-Mason | $874,872.33 | $1,749,744.66 |
| North Central | $638,393.00 | $1,276,786.00 |
| North Sound | $3,065,156.00 | $6,130,312.00 |
| Pierce | $2,143,190.00 | $4,286,380.00 |
| Salish | $942,786.05 | $1,885,572.09 |
| Spokane | $1,486,293.00 | $2,972,586.00 |
| Southwest | $1,500,000.00 | $3,000,000.00 |

2.36.2 If the Contractor spends a portion of these funds, and the reserve balance drops below the allocated reserve amount, the Contractor must replenish the reserve account within one year, or at the end of the state fiscal year in which the funds were spent, whichever is longer. If the reserve fund balance goes above the maximum allowable amount at the end of calendar year or fiscal year, a spending plan must be provided to HCA within sixty (60) calendar days to show the Contractor's strategies to meet contract limits. If HCA determines the reserves are outside the allocation found in the table in this Section, HCA may require a corrective action plan.

2.36.3 All expenditures of reserve funds and proviso funding balances shall be documented and included on the Non-Medicaid Quarterly Expenditure Report.

2.36.4 If the Contractor terminates this Contract for any reason or will not enter into any subsequent contracts, HCA shall require that all remaining reserves and fund balances be spent within a reasonable timeframe determined by HCA. Funds will be deducted from the monthly payments made by HCA to the Contractor until all reserves and fund balances are spent. Any funds not spent for the provision of services under this Contract shall be returned to HCA within sixty (60) calendar days of the last day of this Contract is in effect.

28. Section 5, Payment and Sanctions, 5.1 Funding, 5.1.2 is amendment to read as follows:

5.1.2 HCA will provide the Contractor with its budget of state-only, proviso, and FBG funds prior to the beginning of the state fiscal year as identified in Exhibit A. HCA will provide the Contractor with its Federal Award Identification for Subrecipients prior to the beginning of the state fiscal year as identified in Exhibit F. The Contractor's budget will be based upon available funding for the RSA. At HCA's discretion, the Contractor's budget of GFS and proviso funds may be amended as described in subsection 5.1.8.

5.1.2.1 When there is a funding increase provided to the Contractor, the Contractor is required to pass that on to the Providers as written in the proviso language. Should the proviso language contain a rate increase, the specified increase shall be provided to subcontractors as an increase to contracted amounts with the effective date as stated.

29. Section 5, Payment and Sanctions, 5.1 Funding, subsection 5.1.5 is amended to read as follows:

5.1.5 HCA will pay the Contractor FBG funds on a monthly cost reimbursement basis upon receipt and approval of an A-19 invoice.

5.1.5.1 The Contractor must make a good faith effort to submit invoices for costs due and payable under this Contract within forty-five (45) days of the month services were provided.

5.1.5.2 The Contractor must submit final invoices within forty-five (45) calendar days after the Contract expiration date or after the funding source end date, except as otherwise authorized through written notification from HCA to the Contractor.

5.1.5.2.1 HCA is under no obligation to pay any delayed or supplementary invoices received past the 45-day requirement above. Late billing resulting from unexpected or third-party billing issues, including inpatient billing, will be reviewed, and paid on a case-by-case basis.

30. Section 5, Payment and Sanctions, 5.1 Funding, 5.1.8 is amended to read as follows:

5.1.8 HCA will perform a reconciliation of the Contractor's expenditure reports to its budget. Based upon the results of the reconciliation, at HCA's discretion, the allocation and distribution of GFS and proviso funds may be re-evaluated, and unspent funds may be reallocated retrospectively. If the expenditures reported by the Contractor on the expenditure report exceed the Contractor's budget identified in Exhibit A, HCA will not reimburse the Contractor for the amount that exceeds the budget.

5.1.8.1 Funding provided for specific purposes in the Exhibits shall be utilized for expenditures related to the outlined purpose. HCA will recoup the funds, in whole or in part, if the Contractor (i) does not utilize the funding within the term of this Contract, or (ii) does not provide a spending plan within sixty (60) calendar days of the funding expiration date. The spending plan must contain a clear

contracted purpose and be approved in writing by the HCA. HCA has the discretion to reallocate all or any portion of any recouped funds to other regions.

31. Section 6, Access to Care and Provider Network, 6.1 Network Capacity, subsection 6.1.3 is amended to read as follows:

    6.1.3 The Contractor must submit a network of contracted service Providers adequate to serve the population in the Contractor's RSA annually by November 1. If the Contractor fails to provide evidence of or HCA is unable to validate contracts with a sufficient number of Providers, HCA may terminate this Contract. The network must have sufficient capacity to serve the RSA and include, at a minimum:

    6.1.3.1 24/7/365 Telephone Crisis Intervention;

    6.1.3.2 Designated Crisis Responder (DCR);

    6.1.3.3 Evaluation and treatment (E&T) and Secure Withdrawal Management and Stabilization capacity to serve the RSA's non Medicaid population;

    6.1.3.4 Psychiatric inpatient beds to serve the RSA's non-Medicaid population, including direct contracts with community hospitals at a rate no greater than that outlined in the HCA FFS schedule; and

    6.1.3.5 Staff to provide MRRCT outreach in the RSA.

32. Section 6, Access to Care and Provider Network, 6.1 Network Capacity, subsection 6.1.6 is amended to read as follows:

    6.1.6 The Contractor shall meet the following requirements when developing its network:

    6.1.6.1 Only licensed or certified Behavioral Health Providers shall provide behavioral health services. Licensed or certified Behavioral Health Providers include, but are not limited to: Health Care Professionals, IHCPs, licensed agencies or clinics, or professionals operating under an agency affiliated license.

    6.1.6.2 Within Available Resources, establish and maintain contracts with office-based opioid treatment Providers that have obtained a waiver under the Drug Addiction Treatment Act of 2000 to practice medication-assisted opioid addiction therapy.

    6.1.6.3 Assist the state in expanding community-based alternatives for crisis stabilization, such as MRRCT outreach or crisis residential and respite beds.

    6.1.6.4 Assist the state in expanding community-based, Recovery oriented services, use of Certified Peer Counselors and Research- and Evidence-Based Practices.

33. Section 9, Subcontracts, 9.3 Required Provisions, a new subsection 9.3.2 is added as follows:

    9.3.2 The Contractor shall administer Subcontractor inpatient claims payment in accordance with WAC 182-502-150, which includes timeliness standards.

    All remaining subsections are subsequently renumbered and internal references updated accordingly.

34. Section 9, Subcontracts, 9.5 Provider Subcontracts, is amended to read as follows:

    9.5 Provider Subcontracts

The Contractor's Subcontracts shall contain the following provisions:

9.5.1 A statement that Subcontractors receiving GFS or FBG funds shall cooperate with the Contractor or HCA-sponsored Quality Improvement (QI) activities.

9.5.2 A means to keep records necessary to adequately document services provided to Individuals for all delegated activities including QI, Utilization Management, and Individual Rights and Protections.

9.5.3 For FBG funding, the Subcontractor shall make a good faith effort to invoice the Contractor for all services rendered:

9.5.3.1 within thirty (30) calendar days after the end of the month services were provided; or

9.5.3.2 within thirty (30) days after the funding source end date or the end of the grant funding year.

9.5.4 For Providers, a requirement to provide discharge planning services which shall, at a minimum:

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

9.5.5 A requirement that residential treatment Providers ensure that priority admission is given to the populations identified in this Contract.

9.5.6 Requirements for information and data sharing to support Care Coordination consistent with this Contract.

9.5.7 A requirement to implement a Grievance Process that complies with WAC 182-538C-110 and as described in the Grievance and Appeal System Section of this Contract.

9.5.8 A requirement that termination of a Subcontract shall not be grounds for an Appeal, Administrative Hearing, or a Grievance for the Individual if similar services are immediately available in the service area.

9.5.9 Requirements for how Individuals will be informed of their right to a Grievance or Appeal in the case of:

9.5.9.1 Denial or termination of service related to medical necessity determinations.
9.5.9.2 Failure to act upon a request for services with reasonable promptness.

9.5.10 A requirement that the Subcontractor shall comply with chapter 71.32 RCW (Mental Health Advance Directives).

9.5.11 A requirement to provide Individuals access to translated information and interpreter services as described in the Materials and Information Section of this Contract.

9.5.12 A requirement for adherence to established protocols for determining eligibility for services consistent with this Contract.

9.5.13 A requirement to use the Integrated Co-Occurring Disorder Screening Tool (GAIN-SS found at 14-479-gain-short-screening-setup_0.doc (live.com). The Contractor shall include requirements for training staff that will be using the tool(s) to address the screening and assessment process, the tool and quadrant placement as well as requirements for corrective action if the process is not implemented and maintained throughout the Contract's period of performance.

9.5.14 A requirement for subcontracted staff to participate in training when requested by HCA. Exceptions must be in writing and include a plan for how the required information shall be provided to them.

9.5.15 A requirement to conduct criminal background checks and maintain related policies and procedures and personnel files consistent with requirements in chapter 43.43 RCW and chapter 246-341 WAC.

9.5.16 Requirements for nondiscrimination in employment and Individual services.

9.5.17 Protocols for screening for Debarment and suspension of certification.

9.5.18 Requirements to identify funding sources consistent with the Payments and Sanctions Section of this Contract, FBG reporting requirements and the rules for payer responsibility found in the table "How do Providers identify the correct payer" within the Apple Health Mental Health Services Billing Guide.

9.5.19 A requirement to participate in the peer review process when requested by HCA. (42 U.S.C. § 300x-53(a) and 45 C.F.R. § 96.136). The MHBG and SABG requires an annual peer review by individuals with expertise in the field of drug abuse treatment (for SABG) and individuals with expertise in the field of mental health treatment (for MHBG). At least 5 percent of treatment Providers will be reviewed.

9.5.20 The Contractor shall ensure that the Charitable Choice Requirements of 42 C.F.R. Part 54 are followed, and that Faith-Based Organizations (FBO) are provided opportunities to compete with SUD Providers for funding.

9.5.21 If the Contractor Subcontracts with FBOs, the Contractor shall require the FBO to meet the requirements of 42 C.F.R. Part 54 as follows:

- 9.5.21.1 Individuals requesting or receiving SUD services shall be provided with a choice of SUD treatment Providers.
- 9.5.21.2 The FBO shall facilitate a referral to an alternative Provider within a reasonable time frame when requested by the recipient of services.
- 9.5.21.3 The FBO shall report to the Contractor all referrals made to alternative Providers.
- 9.5.21.4 The FBO shall provide Individuals with a notice of their rights.
- 9.5.21.5 The FBO provides Individuals with a summary of services that includes any religious activities.
- 9.5.21.6 Funds received from the FBO must be segregated in a manner consistent with federal Regulations.

9.5.21.7 No funds may be expended for religious activities.

9.5.22 A requirement that the Subcontractor shall respond with all available records in a timely manner to law enforcement inquiries regarding an Individual's eligibility to possess a firearm under RCW 9.41.040(2)(C)(iv).

9.5.22.1 The Contractor shall report new commitment data within 24 hours. Commitment information under this Section does not need to be re-sent if it is already in the possession of HCA. The Contractor and HCA shall be immune from liability related to the sharing of commitment information under this Section (RCW 71.05.740).

9.5.23 Delegated activities are documented and agreed upon between Contractor and Subcontractor. The document must include:

9.5.23.1 Assigned responsibilities.
9.5.23.2 Delegated activities.
9.5.23.3 A mechanism for evaluation.
9.5.23.4 Corrective action policy and procedure.

9.5.24 A requirement that information about Individuals, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and Regulations.

9.5.25 The Subcontractor agrees to hold harmless HCA and its employees, and all Individuals served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors.

9.5.26 A ninety (90) calendar day termination notice provision.

9.5.27 A specific provision for termination with short notice when a Subcontractor is excluded from participation in the Medicaid program.

9.5.28 A provision for ongoing monitoring and compliance review when the Contractor identifies deficiencies or areas requiring improvement and provide for corrective action.

9.5.28.1 The Contractor shall ensure that Subcontractors have complied with data submission requirements established by HCA for all services funded under the Contract.
9.5.28.2 The Contractor shall ensure that the Subcontractor updates individual funding information when the funding source changes.
9.5.28.3 The Contractor shall maintain written or electronic records of all Subcontractor monitoring activities and make them available to HCA upon request.

9.5.29 A statement that Subcontractors shall comply with all applicable required audits including authority to conduct a Facility inspection, and the federal OMB Super Circular, 2 C.F.R. § 200.501 and 45 C.F.R. § 75.501 audits.

9.5.29.1 The Contractor shall submit a copy of the OMB audit performed by the state Auditor to the HCA Contact identified on page one of the Contract within ninety (90) calendar days of receipt by the Contractor of the completed audit.

9.5.29.1.1 If a Subcontractor is subject to OMB Super Circular audit, the Contractor shall require a copy of the completed Single Audit and ensure corrective action is taken for any audit finding, per OMB Super Circular requirements.

9.5.29.1.2 If a Subcontractor is not subject to OMB Super Circular, the Contractor shall perform sub-recipient monitoring in compliance with federal requirements.

9.5.30 The Contractor shall document and confirm in writing all single case agreements with Providers. The agreement shall include:

9.5.30.1 The description of the services;

9.5.30.2 The authorization period for the services, including the begin date and the end date for approved services;

9.5.30.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other documents that define payment; and

9.5.30.4 Any other specifics of the negotiated rate.

9.5.31 The Contractor must supply documentation to the Subcontractor no later than five (5) Business Days following the signing of the agreement. Updates to the unique contract, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).

9.5.32 The Contractor shall maintain a record of the single case agreements for a period of six (6) years.

35. Section 15, Care Management and Coordination, 15.4 Care Coordination and Continuity of Care: State Hospitals and Long Term Civil Commitment (LTCC) Facilities, subsection 15.4.4.5 is amended to read as follows:

15.4.4.5 Data reporting. The Contractor shall:

15.4.4.5.1 Submit to HCA the Peer Bridger Monthly Report by the fifteenth of the month following the month being reported, for each region, on the template provided by HCA;

15.4.4.5.2 When reporting service encounters, use the Behavioral Health Care Coordination and Community Integration code for services within inpatient settings or other appropriate outpatient modalities ensuring no duplication of services occur; and

15.4.4.5.3 When reporting Behavioral Health Supplemental Transactions into BHDS, ensure the "Program ID – 42" start/stop date is recorded.

36. Section 15, Care Management and Coordination, 15.6 Care Coordination and Continuity of Care: Evaluation and Treatment (E&T) Facilities, subsection 15.6.3 is amended to read as follows:

15.6.3 The Contractor shall submit to HCA the E&T Discharge Planner's reports that track the total number of all discharges from their E&T location and differentiate between those that were deemed complex and those that were deemed standard. The report is due the last Business Day of the month following the quarter being reported using the template provided by HCA.

37. Section 16, General Requirement for Service Delivery, 16.1 Special Provisions Regarding Behavioral Health Crisis Services, is amended to read as follows:

16.1 Special Provisions Regarding Behavioral Health Crisis Services

For each RSA, the Contractor's administration of behavioral health services shall comply with the following:

16.1.1 The location of the telephone crisis intervention and triage services (call center staff) is within Washington or within 200 miles of the Contractor's Service Area unless approved by HCA.

16.1.2 The same staffing requirements as defined in this Contract and the same performance standards apply regardless of the location of call center operations.

16.1.3 Data management and reporting, claims administration and financial management may be located out of Washington State. If claims are administered in another location, the Contractor shall have access to the claims payment and reporting platform during Pacific Time Business Hours.

16.1.4 The Contractor shall have sufficient staff to ensure effective Provider relations, network development, utilization management, quality management and performance of Grievances and Appeals.

16.1.5 The Contractor shall have sufficient staff with clinical expertise, to include:

16.1.5.1 A Behavioral Health Medical Director. Upon approval from HCA, the Behavioral Health Medical Director may be a subcontracted position.

16.1.5.2 A Children's Specialist.

16.1.5.3 An Addictions Specialist.

16.1.6 In addition, the Contractor shall have a sufficient number of staff to support data analytics and data systems, claims administration, encounter and Behavioral Health Supplemental Transactions data processing and all reporting requirements under the Contract.

16.1.7 The Contractor shall maintain current organizational charts and upon request will provide organizational charts to HCA that identifies what positions are responsible for the requirements under the contract.

16.1.8 The Contractor shall develop and implement staff training plans that address how the Contractor's applicable staff will be trained on the requirements of this Contract.

16.1.9 The Contractor shall ensure development and implementation of training programs for network Providers that deliver, coordinate, or oversee behavioral health services to Individuals, to include contract requirements, Contractor policies and SABG outreach requirements related to pregnant Individuals with intravenous drug use, pregnant Individuals with a SUD, and other Individuals with intravenous drug use.

16.1.9.1 Crisis triage staff shall have training in crisis triage and management for Individuals of all ages and behavioral health conditions, including SMI, SUDs, and co-occurring disorders.

38. Section 17, Scope of Services-Crisis System, 17.1 Crisis System General Requirements, subsection 17.1.3 is amended to read as follows:

    17.1.3 Crisis Services shall be provided in accordance with WAC 246-341-0670, WAC 246-341-0715, and WAC 246-341-0901.

39. Section 17, Scope of Services-Crisis System, Section 17.3 Crisis System Staffing Requirements, subsection 17.3.3 is amended to read as follows:

    17.3.3 The Contractor shall ensure Provider compliance with DCR qualification requirements in accordance with chapters 71.05 and 71.34 RCW and WAC 246-341-0912. The Contractor shall ensure Providers incorporate the statewide DCR Protocols, listed on the HCA website, into the practice of DCRs.

40. Section 17, Scope of Services-Crisis System, Section 17.3 Crisis System Staffing Requirements, subsection 17.3.3 is amended to read as follows:

    17.3.6 The Contractor shall ensure Providers of ITA services establish policies and procedures that implement WAC 246-341-0901 and the following requirements:

        17.3.6.1 No DCR or crisis worker shall be required to respond to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's ITA, unless a second trained individual accompanies them.

        17.3.6.2 The team supervisor, on-call supervisor, or the individual, shall determine the need for a second individual to accompany them based on a risk assessment for potential violence.

        17.3.6.3 The second individual who responds may be a First Responder, a Mental Health Professional, a SUDP, or a mental health Provider who has received training required in RCW 49.19.030.

        17.3.6.4 No retaliation shall be taken against an individual who, following consultation with the clinical team or supervisor, refuses to go to a private home or other private location alone.

        17.3.6.5 Have a plan to provide training, mental health staff back up, information sharing, and communication for crisis staff who respond to private homes or other private locations.

        17.3.6.6 Every DCR dispatched on a crisis visit shall have prompt access to information about an Individual's history of dangerousness or potential dangerousness documented in crisis plans or commitment records and is available without unduly delaying a crisis response.

        17.3.6.7 The Contractor or Subcontractor shall provide a wireless telephone or comparable device to every DCR or crisis worker, who participates in home visits to provide Crisis Services.

41. Section 17, Scope of Services-Crisis System, Section 17.4 Crisis System Operational Requirements, subsection 17.4.4 is amended to read as follows:

    17.4.4 Through the use of FBG stimulus funds the Contractor will enhance MRRCT services by adding CPC.

        17.4.4.1 Contractor will issue funds to existing MRRCT to add a minimum of one CPC.

            17.4.4.1.1 CPCs will be required to complete the HCA CPC continuing education curriculum for peer services in crisis environments.

17.4.4.1.2 MRRCT supervisors of CPCs must complete the HCA sponsored Operationalizing Peer Support training for supervisors within six months of hire.

17.4.4.2 Each BH-ASO will receive additional funding for up to two CPCs per RSA, training costs and associated administration (10 percent).

42. Section 17, Scope of Services-Crisis System, 17.4 Crisis System Operational Requirements, subsection 17.4.5 is amended to read as follows:

17.4.5 The Contractor will have established new MRRCT, or enhanced existing MRRCT staffing, for adult and children, youth and family teams that meet the intention of Engrossed Substitute Senate Bill 5092; Section 215(65); Chapter 334; Laws of 2021. Each BH ASO will have a minimum of one adult MRRCT and one children, Youth and family MRRCT in the region and continue to work on increasing capacity.

17.4.5.1 The Contractor will submit a quarterly MRRCT report using the most recent template provided by the HCA. This report will include quarterly data on CPC services and adult and youth crisis services. Reports are due January 31 (October-December), April 30 (January-March), July 31 (April-June), and October 31 (July-September). Submit reports to HCABHASO@hca.wa.gov.

17.4.5.2 The goal for each MRRCT is to have the capacity to provide services in the community 24 hours per day, seven days per week, 365 days per year with a two-person dyad (peer and clinician). Each MRRCT Provider must have a minimum of one Mental Health Professional supervisor to provide clinical oversight and supervision of all staff, at all times.

17.4.5.3 Implementation must include the following elements:

17.4.5.3.1 Each team will adhere to the HCA crisis team model.

17.4.5.3.2 Each team will require at a minimum, a Mental Health Professional to provide clinical assessment and a peer trained in Crisis Services, responding jointly. Mental Health Care Provider (MHCPs), with WAC 246-341-0302 exemption, can respond jointly with a peer in place of an MHP, as long as at least one Mental Health Professional is available 24/7 for any MHCP or peer to contact for consultation, this Mental Health Professional does not have to be the supervisor.

17.4.5.3.3 All peers must complete the HCA sponsored peer crisis training.

17.4.5.3.4 All individuals providing MRRCT services, whether they are new or previously existing staff, must complete the following trainings:

17.4.5.3.5 HCA trainings in Trauma Informed Care, De-escalation Techniques, and Harm Reduction.

17.4.5.3.6 HCA sponsored Certified Crisis Intervention Specialist – II (CCIS-II) EDGE Approach training by July 1, 2024. Each Participant will receive certification in CCIS-II through the National Anger Management Association (NAMA) upon completion. If individuals already hold a CCIS-II credential or greater, that was issued by NAMA, you can submit their name to HCABHASO@hca.wa.gov.

17.4.5.3.7 The Contractor will work collaboratively with HCA staff in standing up the teams, coordinating service delivery, adhering to the MRRCT service model and participating in required training. MRRCT shall follow the established Tribal Crisis Coordination Protocols established between the HCA and the Tribe.

17.4.5.4 The Contractor will work with the HCA staff in developing statewide standards for the delivery of MRRCT services. These standards must include the following elements:

17.4.5.4.1 Align with MRRCT practices and values as identified in the SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, SAMHSA National Guidelines for Child and Youth Behavioral Health Crisis Care and NASMHPD A Safe Place to Be, Crisis Stabilization Services and Other Supports for Children and Youth.

17.4.5.4.2 For child, Youth and family MRRCT, the standards will minimally include the following elements of the Mobile Response and Stabilization Services (MRSS) model:

17.4.5.4.2.1 MRRCT services are delivered in-person, whenever possible.

17.4.5.4.2.2 Services are provided in home or in community settings.

17.4.5.4.2.3 MRRCT services provided are available within two hours of contact for emergent, within 24 hours for an urgent crisis, and best practice is a response within 60 minutes for all call types.

17.4.5.4.2.4 The crisis is defined by the Individual, including adults, Youth, young adults and/or the parent/caregiver.

17.4.5.5 The standards for the Youth teams will incorporate the values and practices of the MRSS model and the National Association of State Mental Health Program Directors (NASMHPD) guidance on Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm and will include the following components:

17.4.5.5.1 Responders will provide developmentally appropriate services.

17.4.5.5.2 Responders are intentionally inclusive of family/caregivers and natural supports throughout a stabilization period.

17.4.5.5.3 Responders are able to serve children, Youth, young adults and families or caregivers in their natural environments including (but not limited to) at home or in school.

17.4.5.6 Crisis interventions will include partnerships with children, Youth, young adults and family/caregivers to identify, restore and increase family and community connections and create linkages to necessary resources.

17.4.5.7 The minimum standards for adult and Youth teams as defined in this Contract section, will be incorporated into the Contractor's subcontracts by September 1, 2022.

17.4.5.8 The Contractor will submit all mobile rapid crisis response services under the MCR transaction as delineated in the most current Behavioral Health Supplemental Data Guide.

43. Section 17, Scope of Services-Crisis System, 17.4 Crisis System Operational Requirements, subsection 17.4.6 is amended to read as follows:

    17.4.6 MRRCT goals should:

    17.4.6.1 Support and maintain Individuals in their current living situation and community environment, reducing the need for out-of-home placements, which reduces the need for inpatient care and residential interventions.

    17.3.6.2 Support Individuals, Youth, and families by providing trauma informed care.

    17.3.6.3 Promote and support safe behavior in home, school, and community settings.

    17.3.6.4 Reduce the use of emergency departments (ED), hospital boarding, and detention centers due to a behavioral health crisis.

    17.3.6.5 Assist Individuals, Youth, and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services, as needed.

44. Section 17, Scope of Services-Crisis System, Section 17.4 Crisis System Operational Requirements, subsection 17.4.9 is amended to read as follows:

    17.4.9 Individuals shall be able to access Crisis Services without full completion of Intake Evaluation, Assessment, and Screenings (Mental Health).

45. Section 17, Scope of Services-Crisis System, 17.4 Crisis System Operational Requirements, subsection 17.4.12 is amended to read as follows:

    17.4.12 The Contractor shall ensure that Crisis Service Providers document calls, services, appropriate coordination with Tribes and IHPCs, and outcomes.

46. Section 17, Scope of Services-Crisis System, 17.5 Crisis System Services, subsection 17.5.1 is amended to read as follows:

    17.5.1 The Contractor shall make the following services available to all Individuals in the Contractor's RSAs, in accordance with the specified requirements:

    17.5.1.1 Crisis Triage and Intervention to determine the urgency of the needs and identify the supports and services necessary to meet those needs. Dispatch MRRCT or connect the Individual to services. For Individuals enrolled with a MCO, assist in connecting the Individual with current or prior service Providers. For Individuals who are AI/AN, assist in connecting the Individual to services available from a Tribal government or IHCP.

    17.5.1.2 Behavioral Health ITA Services shall be provided in accordance with WAC 246-341-0912. Services shall include investigation and evaluation activities, management of the court case findings and legal proceedings in order to ensure the due process rights of the Individuals who are detained for involuntary treatment. The Contractor shall reimburse the county for direct costs associated with providing judicial services for civil commitment and shall provide for evaluation and treatment services as ordered by the court for Individuals who are not eligible for Medicaid, including Individuals detained by a DCR. Reimbursement for judicial services shall be provided per civil commitment case at a rate to be determined based on an independent assessment of the county's actual direct costs. This assessment must be based on an average of the expenditures for judicial services within the county over the past three years. In the event that a baseline cannot be established because there is no significant history

of similar cases within the county, the reimbursement rate shall be equal to 80 percent of the median reimbursement rate of counties included in the independent assessment.

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

17.5.1.4 Assisted Outpatient Treatment (AOT) shall be provided to those who are identified as meeting the need. Each BH-ASO shall employ an AOT program coordinator. The Contractor will use funding provided in FY2023 to hire and train the BH-ASO AOT coordinator to oversee system coordination and legal compliance for AOT under RCW 71.05.148 and RCW 71.34.755.

17.5.1.4.1 The coordinator shall work with HCA AOT program staff to develop program requirements and best practices, policy and procedures, and implement them within the BH-ASO region.

17.5.1.4.2 The program will require coordination and collaboration with superior courts, MCOs, contractors providing services to Individuals released on AOT orders, and other stakeholders within their region.

17.5.1.4.3 Requirements of this funding include developing and implementing a plan with HCA, Regional ITA courts, AOT Providers, and community stakeholders, to have a AOT program in operation by July 1, 2023.

17.5.1.4.4 The Contractor, must provide notice to the tribe and IHCP regarding the filing of an AOT petition concerning a person who is an AI/AN who receives medical or behavioral health services from a tribe within the state of Washington.

17.5.1.4.5 The Contractor will coordinate with superior courts in their region to assure a process for the court to provide notification to the Contractor of petitions filed where the court has knowledge that the respondent is an AI/AN who receives medical or behavioral health services from a tribe within the state of Washington so that the Contractor can complete a notification of that fact to the tribe or IHCP.

17.5.1.4.6 Beginning February 15, 2023, the Contractor will submit quarterly narrative reports to HCABHASO@hca.wa.gov. Reports are due: February 15 (October through December); May 15 (January through March); August 15 (April through June); and November 15 (July through September). The narrative will describe updates related to the AOT implementation progress.

17.5.1.4.7 AOT and AOT LRA fund balances not utilized or planned for may be redistributed or reclaimed by HCA.

17.5.1.5 Contractor will be responsible for tracking orders for LRA treatment that are issued by a superior court within their geographic regions, including LRAs orders, CRs and AOT orders.

17.5.1.5.1 Tracking responsibility includes notification to the Individual's MCO of the order for LRA treatment so that the MCO can coordinate LRA treatment services.

17.5.1.5.1.1 The MCO is responsible to coordinate care with the Individual and the treatment Provider for the provision of LRA treatment services.

17.5.1.5.1.2 The MCO is responsible to monitor or purchase monitoring services for Individuals receiving LRA treatment services.

17.5.1.5.1.3 Monitoring will include coordination with the appropriate DCR Provider, including non-compliance.

17.5.1.5.2 For Individuals not enrolled in a managed care plan, the Contractor is responsible for coordinating LRA treatment services with the Individual and the LRA treatment Provider for the following:

17.5.1.5.2.1 Unfunded Individuals.

17.5.1.5.2.2 Individuals who are not covered by the Medicaid FFS program.

17.5.1.5.2.3 Individuals who are covered by commercial insurance.

17.5.1.5.3 The Contractor will monitor or purchase monitoring services for Individuals receiving LRA treatment services.

17.5.1.5.3.1 Monitoring will include reporting non-compliance with the appropriate DCR Provider.

17.5.1.5.3.2 For out of region Individuals who will be returning to their home region, upon notification from the regional superior court, the Contractor will notify the home region BH-ASO of the order for LRA treatment. The home region BH-ASO will then be responsible for notifying the appropriate MCO (if applicable), tracking the order for LRA treatment, coordinating with the Individual and the LRA treatment Provider, and purchasing or providing LRA monitoring service.

17.5.1.5.3.3 The Contractor may utilize unspent funds from AOT funds provided in subsection 17.5.1.4.

17.5.1.6 Authority for treatment of services for Individuals released from a state hospital in accordance with RCW 10.77.086(4), competency restoration. Contractor may submit an A-19, not to exceed $9,000 without prior written approval from HCA, for transition teams services and treatment services provided to non-Medicaid individuals released from a state hospital in accordance with RCW 71.05.320 or who are found not guilty by reason of insanity (NGRI).

47. Section 17, Scope of Services-Crisis System, 17.6 Coordination with External Entities, subsection 17.6.8 is amended to read as follows:

17.6.8 The Contractor shall require that MRRCT services coordinate with co-responders within their region.

48. Section 17, Scope of Services-Crisis System, Section 17.9 Crisis System Reporting, is amended to read as follows:

17.9.1 For each RSA, the Contractor shall provide crisis system reports to include quarterly and annual reports. Reports must be submitted to HCA at HCABHASO@hca.wa.gov.

17.9.1.1 The quarterly report is due forty-five (45) calendar days following each quarter. The Contractor must use the HCA provided Crisis System Metrics Report template.

17.9.1.2 The annual report is due by the last day of February for the previous calendar year. The report must include:

17.9.1.2.1 A summary and analysis about each region's crisis system, to include information from the quarterly Crisis System Metrics Report, callers funding sources (Medicaid, non-Medicaid, other) and caller demographics including age, gender, and ethnicity.

17.9.1.2.2 A summary of crisis system coordination activities with external entities, including successes and challenges. External entities addressed in the summary must include but are not limited to regional MCOs, community behavioral health Providers, First Responders, partners within the criminal justice system, and Tribal entities.

17.9.1.2.3 A summary of how Individuals' crisis prevention plans are used to inform DCRs dispatched on crisis visits, reduce unnecessary crisis system utilization and maintain the Individual's stability. Include in the summary an analysis of the consistency of use and effectiveness of the crisis prevention plans.

17.9.1.2.4 Provide a summary of the development, implementation, and outcomes of activities and strategies used to improve the crisis system. To include:

17.9.1.2.4.1 An overview and analysis of available information and data about the disposition of crisis calls.

17.9.1.2.4.2 Coordination of referrals to Provider agencies or MCOs for case management, awareness of frequent crisis line callers and reduction of law enforcement involvement with the crisis system.

17.9.1.2.4.3 A description of how crisis system data is used throughout the year, including the use of information from community partners about the crisis system effectiveness.

17.9.1.2.4.4 Any systemic changes to the crisis system planned in the upcoming year as a result of the information and data.

49. Section 21, Jail Transition Services, is amended to read as follows:

21.1.1 Jail Transition Services are to be provided within the identified resources in Exhibit A.

21.1.2 The Contractor shall coordinate with local and Tribal law enforcement, courts and jail personnel to meet the needs of Individuals detained in city, county, tribal, and regional jails.

21.1.3 The Contractor must identify and provide transition services to Individuals with mental illness and/or co-occurring disorders to expedite and facilitate their return to the community.

21.1.4 The Contractor shall accept referrals for intake of Individuals who are not enrolled in community mental health services but who meet priority populations as defined in chapter 71.24 RCW. The Contractor must conduct Intake Evaluation, Assessment, and Screenings for these Individuals and when appropriate provide transition services prior to their release from jail.

21.1.5 The Contractor shall assist Individuals with mental illness in completing and submitting an application for medical assistance prior to release from jail.

21.1.6 The Contractor shall assist Individuals with mental illness and/or co-occurring disorders with the coordination of the re-activation of Medicaid benefits if those benefits were suspended while the Individual was incarcerated, which may involve coordinating the submission of Prior Authorization with the MCOs, or the FFS Medicaid Program.

21.1.7 Pre-release services shall include:

21.1.7.1 Mental health and SUD screening for Individuals who display behavior consistent with a need for such screening who submit a Health Kite requesting services, or have been referred by jail staff, or officers of the court.

21.1.7.2 Intake Evaluation, Assessment, and Screenings (Mental Health) for Individuals identified during the mental health screening as a member of a priority population.

21.1.7.3 Facilitation of expedited medical and financial eligibility determination with the goal of immediate access to benefits upon release from incarceration.

21.1.7.4 Other prudent pre-release and pre-trial case management and transition planning.

21.1.7.5 Direct mental health or SUD services to Individuals who are in jails that have no mental health staff working in the jail providing services.

21.1.7.6 Post-release outreach to ensure follow-up for mental health and other services (e.g., SUD) to stabilize Individuals in the community.

21.1.8 If the Contractor has provided the jail services in this Section the Contractor may also use the Jail Coordination Services funds, if sufficient, to facilitate any of the following:

21.1.8.1 Identify recently booked Individuals that are eligible for Medicaid or had their Medicaid benefits suspended for purposes of establishing Continuity of Care upon release.

21.1.8.2 Develop individual alternative service plans (alternative to the jail) for submission to the courts. Plans will incorporate evidence-based risk assessment screening tools.

21.1.8.3 Interlocal agreements with juvenile detention facilities.

21.1.8.4 Provide up to a seven (7) day supply of medications for the treatment of mental health symptoms following the release from jail.

21.1.8.5 Training to local law enforcement and jail services personnel regarding de-escalation, crisis intervention, and similar training topics.

21.1.9 The Contractor will submit the Annual Jail Transition Services Report by August 31 of each year, for services provided in the prior state fiscal year. The report must be submitted to HCA at HCABHASO@hca.wa.gov. The report will include the following:

21.1.9.1 Number of Jail Transition Services provided;

21.1.9.2 Number of Individuals served with Jail Transition funding;

21.1.9.3 Narrative describing Jail Transition Services provided;

21.1.9.4 Narrative describing barriers to providing Jail Transition Services; and

21.1.9.5 Narrative describing strategies to overcome identified Jail Transition Services barriers.

50. Section 22, Peer Pathfinders Transition From Incarceration Pilot Program, , 22.3 Peer Pathfinder Program Duties is amended to read as follows:

22.3.6 Peer Pathfinders should demonstrate that recovery is possible and model SAMHSA's Working Definition of Recovery along with The 10 Guiding Principles of Recovery identified by SAMHSA in the following link: https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf.

51. Section 24, Family Youth System Partner Roundtable (FYSPRT), 24.1 General Requirements, a new subsection 24.1.9 is added as follows:

24.1.9 Between January and March 2024, survey the Regional FYSPRT membership using an outreach method of the region's choice, to gather feedback on the format of future meetings. The outreach method must include all members on the FYSPRT roster and provide an opportunity for all members to provide feedback on meeting preferences for in person, hybrid, or virtual meetings. A narrative document, including survey findings and an implementation plan, shall be submitted by April 30, 2024 to HCABHASO@hca.wa.gov.

All remaining subsections are subsequently renumbered and internal references updated accordingly.

52. Section 26, Behavioral Health Advisory Board (BHAB), 26.1 BHAB Requirements, subsection 26.1.1 is amended to read as follows:

26.1.1 The Contractor shall maintain a Community BHAB in each RSA that is broadly representative of the demographic character of the region.

53. Section 26, Behavioral Health Advisory Board (BHAB), 26.1 BHAB Requirements, subsection 26.1.4 is added as follows:

26.1.4 The Contractor shall submit a Behavioral Health Advisory Board Annual report that includes the following information:

26.1.3.426.1.4.1 A list of the BHAB membership that includes the composition and length of terms of the BHAB members to demonstrate membership requirements are being met; and

26.1.3.526.1.4.2 An accounting of the funding amount spent by the BHAB to fulfill their yearly contractual obligations as outlined in this Contract.

26.1.3.626.1.4.3 The report shall be submitted annually by February 15 for the previous calendar year (January – December) and shall be submitted to HCABHASO@hca.wa.gov.

54. Section 28, Recovery Navigator Program, 28.2 Recovery Navigators Plan, subsection 28.2.8 is amended as follows:

28.2.8 The Contractor must participate in scheduled reviews of the Recovery Navigator Program including the following activities:

28.2.8.1 Monthly technical assistance with HCA;

28.2.8.2 Meetings every other month hosted by HCA; and

28.2.8.3 HCA hosted trainings.

55. Exhibit A-2, Non-Medicaid Funding Allocation, supersedes and replaces Exhibit A-1 and is attached hereto and incorporated herein.

56. Exhibit D-1, Service Area Matrix, supersedes and replaces Exhibit D and is attached hereto and incorporated

57. Exhibit G-1, Peer Bridger Program, supersedes and replaces Exhibit G and is attached hereto and incorporated herein.

58. Schedule C, Trueblood Quarterly Enhanced Crisis Stabilization/Crisis Triage, is attached hereto and incorporated herein.

59. This Amendment will be effective as of January 1, 2024 ("Effective Date").

60. All capitalized terms not otherwise defined herein have the meaning ascribed to them in the Contract.

61. All other terms and conditions of the Contract remain unchanged and in full force and effect.

The parties signing below warrant that they have read and understand this Amendment and have authority to execute the Amendment. This Amendment will be binding on HCA only upon signature by both parties.

| CONTRACTOR SIGNATURE | PRINTED NAME AND TITLE | DATE SIGNED |
|---|---|---|
| Katherine T. Walters | KATHERINE T. WALTERS, CHAIR | 5/29/24 |
| **HCA SIGNATURE**<br>DocuSigned by:<br>Annette Schuffenhauer<br>4F259FCAF7C2450... | **PRINTED NAME AND TITLE**<br>Annette Schuffenhauer<br>Chief Legal Officer | **DATE SIGNED**<br>3/26/2024 |

**Exhibit A-2: Non-Medicaid Funding Allocation**
**Salish BH-ASO**

This Exhibit addresses non-Medicaid funds in the Salish RSA for the provision of crisis services and non-crisis behavioral health services for January 1, 2024, through June 30, 2024, of state fiscal year (SFY) 2024. Amounts can be utilized during SFY ending June 30, 2024, unless otherwise noted.

MHBG and SABG funds will be administered by the BH-ASO in accordance with the plans developed locally for each grant. Block grant funding in Table 2 is shown for the full SFY 2024.

Table 1: Salish RSA January - June SFY 2024 GF-S Funding

| Fund Source | Monthly | Total 6 Months | Amended 6 Month Amount |
|---|---|---|---|
| Flexible GF-S | $549,267.00 | $3,295,602.00 | $714,492.00 |
| PACT | $15,788.00 | $94,728.00 | |
| Assisted Outpatient Tx | $5,147.00 | $30,882.00 | |
| Flexible GF-S (ASO)- Begin FY2021- Proviso (7B) | $16,342.00 | $98,052.00 | |
| Jail Services | $9,318.00 | $55,908.00 | |
| ITA - Non-Medicaid funding | $13,605.00 | $81,630.00 | |
| Detention Decision Review | $2,291.00 | $13,746.00 | |
| Crisis Triage/Stabilization | $37,167.00 | $223,002.00 | |
| Long-Term Civil Commitment Court Costs | $1,562.00 | $9,372.00 | |
| Trueblood Misdemeanor Diversion | $10,940.00 | $65,640.00 | |
| DCA - Dedicated Cannabis Account | $18,880.00 | $113,280.00 | |
| CJTA | $21,817.00 | $130,902.00 | |
| CJTA Therapeutic Drug Court | $21,892.00 | $131,352.00 | |
| CJTA State Drug Court | $17,573.00 | $105,438.00 | |
| Secure Detox | $8,466.00 | $50,796.00 | |
| Behavioral Health Advisory Board | $3,333.00 | $19,998.00 | |
| New Journey First Episode Psychosis | $4,264.00 | $25,584.00 | |
| Room & Board | $1,163.00 | $6,978.00 | |
| 988 Enhanced Crisis funding (Proviso 112) | One-Time payment (Annual) | $671,350.00 | $671,350.00 |
| Kitsap crisis triage services BHASO | One-Time payment (Six months) | $125,000.00 | |
| Discharge Planners | One-Time payment (Six months) | $53,647.00 | |
| BH Service Enhancements | One-Time payment (Six months) | $114,952.00 | |
| 5092(65) Added Crisis Teams/child crisis teams | One-Time payment (Six months) | $584,097.00 | $284,183.00 |
| Recovery Navigator Program | One-Time payment (Six months) | $619,917.00 | |
| Recovery Navigator Lead Admin | One-Time payment (Six months) | $70,000.00 | |
| HB 1773 AOT LRA/LRO FTE Coordinator to ASO | One-Time payment (Six months) | $70,000.00 | |
| HB 1773 AOT LRA/LRO Service and Hearing cost | One-Time payment (Six months) | $95,974.00 | |
| Youth Inpatient Navigators | One-Time payment (Six months) | $202,250.00 | |
| **Total** | **$758,815.00** | **$7,160,077.00** | **$1,670,025.00** |

## Table 2: Salish RSA SFY 2024 Block Grant Funding (12 months)

| Fund Source | Total FY2024 | Amended 6 Month Amount |
|---|---|---|
| MHBG (Full Year SFY2024) | $329,354.00 | |
| MHBG Co-Responder (Full year SFY2024) | $75,000.00 | |
| Peer Bridger (Full Year SFY2024) | $160,000.00 | |
| SABG (Full Year SFY2024) | $1,132,110 | |
| SABG Co-Responder (Full Year SFY2024) | $25,000.00 | |
| **Total** | **$1,721,464.00** | |

## Table 3: Salish RSA ARPA Grant Funding (Utilization until September 30, 2025)

| Fund Source | Total FY2024 | Amended 6 Month Amount |
|---|---|---|
| MHBG ARPA General Allocation | $501,140.00 | |
| MHBG ARPA (BH-ASO) Treatment -Crisis Services | $165,296.00 | |
| MHBG ARPA Mobile Crisis CPCs | $190,900.00 | |
| MHBG ARPA Peer Pathfinders Transition from Incarceration | $79,000.00 | |
| MHBG ARPA Peer Bridger Participant Support Funds | $8,201.00 | |
| SABG ARPA General Allocation | $383,011.00 | |
| SABG ARPA Peer Pathfinders Transition from Incarceration | $79,000.00 | |
| MHBG ARPA Youth Inpatient Navigator | $330,000.00 | |
| **Total** | **$1,736,548.00** | |

## Table 4: Salish RSA -SFY 2024 Budgeted Program funds to be Reimbursement via A-19

| Fund Source | Total FY2024 | Amended 6 Month Amount |
|---|---|---|
| FYSPRT (Full Year SFY2024) | $75,000.00 | |
| 5071 - Full FY amount available provider cost of monitoring CR/LRA State Hospital discharged individual | $63,000.00 | |
| Governor's Housing/Homeless Initiative -Rental Voucher and Bridge Program | $50,000.00 | |
| **Total** | **$188,000.00** | |

Table 5: Salish RSA Trueblood Enhanced Services (12 months) Reimbursement via A-19

| Fund Source | Total FY2024 | Amended 6 Month Amount |
|---|---|---|
| Enhanced Crisis Stabilization/Crisis Triage | $125,000.00 | $125,000.00 |

**Explanations**

All proviso dollars are GF-S funds. Outlined below, are explanations of the provisos and dedicated accounts applicable **to all regions that receive the specific proviso**:

- **Juvenile Drug Court:** Funding to provide alcohol and drug treatment services to juvenile offenders who are under the supervision of a juvenile drug court.
- **State Drug Court:** Funding to provide alcohol and drug treatment services to offenders who are under the supervision of a drug court.
- **Jail Services:** Funding to provide mental health services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate access to programs that offer mental health service upon mentally ill offenders' release from confinement. This includes efforts to expedite applications for new or re- instated Medicaid benefits.
- **WA - Program for Assertive Community Treatment (WA - PACT)/Additional PACT/1109:** Funds received per the budget proviso for development and initial operation of high-intensity programs for active community treatment WA- PACT teams.
- **Detention Decision Review:** Funds that support the cost of reviewing a DCR's decision whether to detain or not detain an individual under the State's involuntary commitment statutes.
- **Criminal Justice Treatment Account (CJTA):** Funds received, through a designated account in the State treasury, for expenditure on: a) SUD treatment and treatment support services for offenders with an addition of a SUD that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; b: the provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program.
- **CJTA Therapeutic Drug Court:** Funding to set up of new therapeutic courts for cities or counties or for the expansion of services being provided to an already existing therapeutic court that engages in evidence-based practices, to include medication assisted treatment in jail settings pursuant to RCW 71.24.580.
- **Assisted Outpatient Treatment:** Funds received to support Assisted Outpatient Treatment (AOT). AOT is an order for Less Restrictive Alternative Treatment for up to ninety days from the date of judgment and does not include inpatient treatment.
- **Dedicated Cannabis Account (DCA):** Funding to provide a) outpatient and residential SUD treatment for youth and children; b) PPW case management, housing supports and residential treatment program; c) contracts for specialized fetal alcohol services; d) youth drug courts; and e) programs that support intervention, treatment, and recovery support services for middle school and high school aged students. All new program services must direct at least eighty-five percent of funding to evidence-based on research-based programs and practices.

- **ITA Non-Medicaid – Mobile Crisis (5480 Proviso):** Funding that began in 2013, to provide additional local mental health services to reduce the need for hospitalization under the Involuntary Treatment Act in accordance with regional plans approved by DBHR.

- **Secure Detoxification:** Funding for implementation of new requirements of RCW 71.05, RCW 71.34 and RCW 71.24 effective April 1, 2018, such as evaluation and treatment by a SUDP, acute and subacute detoxification services, and discharge assistance provided by a SUDP in accordance with this Contract.

- **Crisis Triage/Stabilization and Step-Down Transitional Residential:** Funding originally allocated under SSB 5883 2017, Section 204(e) and Section 204(r) for operational costs and services provided within these facilities.

- **Behavioral Health Enhancements (one-time payment):** Funding for the implementation of regional enhancement plans originally funded under ESSB 6032 and continued in ESHB 1109.SL Section 215(23).

- **Discharge Planners (one-time payment):** These are funds received for a position solely responsible for discharge planning.

- **Trueblood Misdemeanor Diversion Funds:** These are funds for non-Medicaid costs associated with serving individuals in crisis triage, outpatient restoration, Forensic PATH, Forensic HARPS, or other programs that divert individuals with behavioral health disorders from the criminal justice system.

- **Behavioral Health Advisory Board (BHAB):** Specific General Fund allocation to support a regional BHAB.

- **SB 5092(65) Added Crisis Teams/including Child Crisis Teams**: Funds to support the purchase of new mobile crisis team capacity or enhancing existing mobile crisis staffing and to add or enhance youth/child Mobile crisis teams.

- **SB 5476 Blake Recovery Nav Admin. – SUD Regional Administrator:** Funds to support the regional administrator position responsible for assuring compliance with the recovery navigator program standards, including staffing standards.

- **SB 5476 Blake decision Navigator Program –** Funds available to implement the recovery navigator plan that meets program requirements including demonstrating the ability to fully comply with statewide program standards.

- **SB 5071 - Full FY amount available - Provider cost of monitoring CR/LRA State Hospital discharged individual** – Funds to support the treatment services for individuals released from a state hospital in accordance with RCW 10.77.086(4), competency restoration. BH-ASOs may submit an A-19, not to exceed $9,000 per Individual. Amounts are statewide pooled funds and are limited to funds available.

- **MHBG American Rescue Plan Act (ARPA) (BH-ASO) Peer Pathfinders Transition from Incarceration Pilot** – Funds to support the Peer Pathfinders Transition from Incarceration Pilot Program intended to serve individuals exiting correctional facilities in Washington state who have either a serious mental illness or co-occurring conditions.

- **MHBG ARPA Enhancement Treatment - Crisis Services** – Funds to supplement non-Medicaid individuals and non-Medicaid crisis services and systems.

- **MHBG ARPA Enhancement Mental Health Services non - Medicaid services and individuals** - Funds to supplement non-Medicaid individuals and non-Medicaid mental health services that meet MHBG requirements.

- **MHBG Co-Responder funds** - Funds to support grants to law enforcement and other first responders to include a mental health professional on the team of personnel responding to emergencies within regions.

- **SABG Co-Responder funds** - Funds to support grants to law enforcement and other first responders to include a mental health professional on the team of personnel responding to emergencies within regions.

- **MHBG ARPA Enhancement - Peer Bridger Participant Relief Funds** – Peer Bridger Participants Relief Funds to assist Individual's with engaging, re-engaging, and supporting service retention aligned/associated with continuing in treatment for mental health and/or SUD.

- **MHBG ARPA Enhancement - Addition of Certified Peer Counselor to BHASO Mobile Crisis Response Teams** – FBG stimulus funds for Contractor to enhance mobile crisis services by adding certified peer counselors.

- **SABG ARPA BH-ASO Treatment Funding** - Funds to supplement non-Medicaid individuals and non-Medicaid Substance Use Disorder services that meet federal block grant requirements.

- **SABG ARPA Peer Pathfinders Transition from Incarceration Pilot** - Funds to support Funds to support the Peer Pathfinders Transition from Incarceration Pilot Program intended to serve Individuals who are exiting correctional facilities in Washington state who have a substance use disorder or co-occurring condition.

- **HB 1773 AOT LRA/LRO FTE Coordinator to ASO** - Funds for each BH-ASO to employ or subcontract an assisted outpatient treatment program coordinator. The Contractor will use funding provided in FY2023 to hire and train the BH-ASO assisted outpatient treatment coordinator to oversee system coordination and legal compliance for assisted outpatient treatment under RCW 71.05.148 and RCW 71.34.755.

- **HB 1773 AOT LRA/LRO Service and Hearing funds -** Added funding for Treatment and Hearing costs specific to enhanced AOT LRA/LRO Program.

- **Governor's Housing/Homeless Initiative**- Rental Vouchers and Bridge Program Funds To create a rental voucher and bridge program and implement strategies to reduce instances where an individual leaves a state operated behavioral or private behavioral health facility directly into homelessness. Contractors must prioritize this funding for individuals being discharged from state operated behavioral health facilities.

- **Room & Board**: Funding is provided solely for the authority to increase resources for behavioral health administrative service organizations and managed care organizations for the increased costs of room and board for behavioral health inpatient and residential services provided in nonhospital facilities.

- **988 Enhanced Crisis funding (Proviso 112)** Amounts for preparing for Endorsement of Crisis teams and standards associated to SAMSHA and 988 bill to go into effect sometime before July 2024. Appropriations are provided solely for the authority to expand and enhance regional crisis services. These amounts must be used to expand services provided by mobile crisis teams and community-based crisis teams either endorsed or seeking endorsement pursuant to standards adopted by the authority. Beginning in fiscal year 2025, the legislature intends to direct amounts within this subsection to be used for performance payments to mobile rapid response teams and

community-based crisis teams that receive endorsements pursuant to Engrossed Second Substitute House Bill No. 201134 (988 system).

**Outlined below are explanation for provisos or new funding applicable to specific regions:**

- **ITA 180 Day Commitment Hearings:** Funding to conduct 180-day commitment hearings.
- **Assisted Outpatient Treatment (AOT) Pilot:** Funding for pilot programs in Pierce and Yakima counties to implement AOT.
- **Spokane: Acute Care Diversion:** Funding to implement services to reduce the utilization and census at Eastern State Hospital.
- **MH Enhancement – Mt Carmel (Alliance):** Funding for the Alliance E&T in Stevens County.
- **MH Enhancement-Telecare:** Funding for Telecare E&T in King County.
- **Long-Term Civil Commitment Beds:** This funding is for court costs and transportation costs related to the provision of long-term inpatient care beds as defined in RCW 71.24.025 through community hospitals or freestanding evaluation and treatment facilities.
- **Trueblood Enhanced Crisis Stabilization/Crisis Triage Spokane, Carelon, King, Thurston Mason, and Salish -** Trueblood funding – Amounts are for enhancing services in Stabilization/Crisis Triage facility for identified Trueblood population. Includes Emergency Housing Vouchers for King County
- **Enhanced Mobile Crisis Team funds specific to teams stood up by Trueblood.** Funds are used to continue teams stood up by Trueblood funding. Funding is to be incorporated into Mobile Crisis Team requirements, 5092 Crisis Team requirements and 988 enhanced Crisis Team requirements, where appropriate. (Spokane, King, Pierce, SW)
- **King County ASO - CCORS** -Funding to maintain children's crisis outreach response system services previously funded through DCYF.
- **King County King County BHASO medication opioid**. King county behavioral health administrative services organization to expand medication for opioid 5use disorder treatment services in King County.
- **Youth Inpatient Navigators – 8 Regions: Salish, Greater Columbia, and Carelon (SW, NC,) Great Rivers, Spokane. Pierce is direct contract and Thurston Mason is ARPA funds only.** Funds to contract for Youth Inpatient Navigator Services in 8 regions of the state.
- **Homeless Outreach Stabilization and Transition (HOST) programs in SW, Pierce, North Sound, Thurston Mason, and Spokane**. Funds for The Homeless Outreach Stabilization and Transition (HOST) program provides outreach-based treatment services to individuals with serious behavioral health challenges including substance use disorder (SUD). Multidisciplinary teams can provide SUD, medical, rehabilitative, and peer services in the field to individuals who lack consistent access to these vital services.
- **New Journey First Episode Psychosis**: Funds provided to support Non-Medicaid client's portion of provider team costs offering the New Journey First Episode Psychosis Program.
- **MRSS-Mobile Response and Stabilization Services - Federal Grant:** This federal grant funding is provided for the enhancement of existing Mobile Crisis Response (MCR)

services already contracted through Carelon (Pierce) & Spokane BH-ASOs to help align current systems with the Mobile Response and Stabilization Services (MRSS) model.

- **Kitsap Crisis Triage Services: Funding** is provided solely for the authority to contract on a one-time basis with the Salish behavioral health administrative services organization serving Kitsap County for crisis triage services in the county that are not being reimbursed through the Medicaid program.

- **Snohomish county BHASO crisis -** 32 bed: Funds are provided solely for the authority to contract on a one-time basis with the North Sound behavioral health 1administrative services organization serving Snohomish County for start-up costs in a new 32-bed community recovery center in Lynnwood that will provide crisis services to Medicaid and other low-income residents.

- **Behavioral Health Housing**: Behavioral Health Housing 3 ASO pilots (proviso 86) Funds are provided solely for a targeted grant program to three behavioral health administrative services organizations (SW, King, NS) to transition persons who are either being diverted from criminal prosecution to behavioral health treatment services or are in need of housing upon discharge from crisis stabilization services. The authority must provide an opportunity for all the behavioral health administrative service organizations to submit plans for consideration.

# Exhibit D-1
## Service Area Matrix

| County | BH-ASO |
|---|---|
| ADAMS | Spokane |
| ASOTIN | Greater Columbia |
| BENTON | Greater Columbia |
| CHELAN | NCWA - Carelon Behavioral Health |
| CLALLAM | Salish |
| CLARK | SWWA - Carelon Behavioral Health |
| COLUMBIA | Greater Columbia |
| COWLITZ | Great Rivers |
| DOUGLAS | NCWA - Carelon Behavioral Health |
| FERRY | Spokane |
| FRANKLIN | Greater Columbia |
| GARFIELD | Greater Columbia |
| GRANT | NCWA - Carelon Behavioral Health |
| GRAYS HARBOR | Great Rivers |
| ISLAND | North Sound |
| JEFFERSON | Salish |
| KING | King |
| KITSAP | Salish |
| KITTITAS | Greater Columbia |
| KLICKITAT | SWWA – Carelon Behavioral Health |
| LEWIS | Great Rivers |
| LINCOLN | Spokane |
| MASON | Thurston-Mason |
| OKANOGAN | NCWA – Carelon Behavioral Health |
| PACIFIC | Great Rivers |
| PEND OREILLE | Spokane |
| PIERCE | Pierce – Carelon Behavioral Health |
| SAN JUAN | North Sound |
| SKAGIT | North Sound |
| SKAMANIA | SWWA – Carelon |
| SNOHOMISH | North Sound |
| SPOKANE | Spokane |
| STEVENS | Spokane |
| THURSTON | Thurston-Mason |
| WAHKIAKUM | Great Rivers |
| WALLA WALLA | Greater Columbia |
| WHATCOM | North Sound |
| WHITMAN | Greater Columbia |
| YAKIMA | Greater Columbia |

# Exhibit G-1
# Peer Bridger Program

## 1) Peer Bridger Program Overview

The Peer Bridger Program is intended to serve those who are currently at Western State Hospital (WSH), Eastern State Hospital (ESH), Evaluation and Treatment centers or community hospitals with inpatient mental health beds and have had a lengthy hospitalization or a history of frequent, multiple hospitalizations. Participation in the program is voluntary. The Peer Bridgers will offer Peer Bridger services to engage Individuals in planning their discharge. Hospital staff and the IMC/BH-ASO Hospital Liaisons will help the Peer Bridgers identify potential participants.

Peer Bridgers will be required to outreach to each Individual after admission. If requested by the Individual, a Peer Bridger will work with Individuals throughout hospitalization and discharge planning process.

The state hospital discharge transition team may include the Peer Bridger who with the consent of the Individual to identify the strengths, needs, preferences, capabilities, and interests of the Individual and to devising ways to meet them in the most integrated setting appropriate for the Individual.

The Peer Bridger will transition from spending time on social support and begin offering assistance with independent living skills, coping skills and community adjustment skills. The hand-off between the Peer Bridger and the community behavioral health provider who is providing mental health services will be gradual and based on the Individual's needs and their person-centered plan. The anticipated duration of in-community Peer Bridger services is 120 days with extensions granted by the BH-ASO on a case-by-case basis.

The Peer Bridger is not a case manager, discharge planner or a crisis worker. However, the Peer Bridger can bring the Individual's perspective into the provision of those services.

## 2) Peer Bridger Program Duties

a) Each Behavioral Health Service Organization is allocated a certain number of Peer Bridger FTEs by HCA/DBHR. If the regions' Peer Bridger team(s) are not fully staffed, monthly invoices will be prorated. The Peer Bridger will work with an average of 6 to 15 program Individuals. Prior to hospital discharge the majority of the work will be inside the state or local psychiatric hospitals or Evaluation and Treatment facilities. Post-discharge activities will be in the community. Peer Bridgers shall routinely engage and interact with potential program participants.

b) Current allocation of Peer Bridger FTEs are detailed as follows in the outline below:

| Region | Number of Peer Bridgers |
|---|---|
| Great Rivers BHASO | 2 |
| Greater Columbia BHASO | 3 |
| King BHASO | 4 |
| Pierce BHASO | 3 |
| North Central BHASO | 1 |
| North Sound BHASO | 3 |
| Salish BHASO | 2 |
| Spokane BHASO | 3 |
| Thurston/Mason BHASO | 3 |
| Southwest BHASO | 3 |

i) The Contractor shall contract with an agency licensed as a Community Behavioral Agency by DOH to provide recovery support services.

ii) After being recruited, and prior to beginning hospital related activities, the Peer Bridger or Peer Bridger team will:

(1) Participate in statewide Peer Bridger Orientation and training.

(2) Participate in statewide specialized training as requested by the inpatient settings.

(3) Complete required non-disclosure, Acknowledgement of Health Care Screening for Contractors and other required forms, as requested by the inpatient setting.

c) The same Peer Bridger shall work directly with Individuals and potential Individuals and follow the Individuals into the community setting to ensure consistency with the "bridging" process. After discharge, the time spent between the community and the inpatient setting shall be adjusted to respond to Individuals in the hospital and Individuals in the community. In conjunction with the MCO/BH-ASO Hospital Liaisons and State Hospital Peer Bridger Liaison (identified during orientation), the Peer Bridger will work to engage potential Individuals. These Individuals may:

i) Have been on the hospital "referred for active discharge planning"; or

ii) Have had multiple state hospitalizations or involuntary hospitalizations; or

iii) Have hospital stays of over one year; or

iv) Be Individuals whom hospital staff and/or the Hospital Liaison have been unable to engage in their own discharge planning;

v) Require additional assistance to discharge and/or need support in the community; or

vi) Be civilly committed or be Individuals who will be converted from forensic to civil commitment.

d) Examples of Peer Bridger engagement activities may include:

i) Interacting with potential participants.

ii) Developing a trusting relationship with participants.

iii) Promoting a sense of self-direction and self-advocacy.

iv) Sharing their experiences in recovery.

v) Helping motivate through sharing the strengths and challenges of their own illness.

vi) Considering the Individual's medical issues and helping them develop wellness plans they can pursue in accordance with their physician recommendations.

vii) Helping the Individual plan how they will successfully manage their life in the community.

viii) Educating Individuals about resources in their home community.

ix) Join with the Individual (when requested by the Individual) in treatment team meetings. Help to convey the Individual's perspectives and assist the Individual with understanding the process.

e) The Peer Bridger shall support the Individual in discharge planning to include the following:

i) Function as a member of the Individual's hospital discharge planning efforts.

ii) Identify Individual-perceived barriers to discharge, assist the Individual with working through barriers and assure the Individual that they will be supported throughout the process.

iii) Coordinating in conjunction with discharge planning efforts for the Individual to travel back to his or her community.

iv) The Peer Bridgers shall conduct routine hospital-based engagement groups for any individual willing to participate.

v) The Peer Bridgers shall be available periodically on treatment malls or wards and at evening groups.

f) Peer Bridger team shall:

i) Participate in monthly statewide Peer Bridger Program administrative support conference calls. At least one Peer Bridger per region shall attend.

ii) Participate in Peer Bridger Training events scheduled by HCA.

iii) Complete the current DBHR Peer Bridger report/log, submit log to HCA via secured email every month, enter program enrollment start and stop dates into Behavioral Health Data System (BHDS), and enter encounters using the rehabilitation case management code.

iv) Participate in hospital and IMC/BH-ASO Peer Bridger training.

v) Coordinate activities with the IMC/BH-ASO hospital liaison.

vi) Attend and participate in Peer Bridger team coordination meetings as directed by HCA.

vii) Meet the documentation requirements of the inpatient setting and their employer.

g) Community-based post-discharge activities will include:

i) The frequency and duration of community-based Peer Bridger services will be determined by the Individual's needs, the service level required to help the individual stay safely in the community and caseload prioritization. Peer Bridger services will be decreased when the Individual is receiving behavioral health treatment and peer services from a behavioral health agency or when the Individual no longer wants the Peer Bridger's support. The Peer Bridger shall facilitate a "warm hand-off" to the behavioral health agency chosen by the Individual. Warm hand-off activities may include:

(1) Being present and supportive during the Individual's first appointment and during the intake evaluation, primary provider or prescriber appointments, etc.

(2) Helping the Individual complete any necessary paperwork for receiving Behavioral Health services.

(3) Supporting the Individual's self-advocacy in the development of their own community treatment plan and treatment activities.

ii) The Peer Bridger may assist the Individual in developing a crisis plan with the Individual's behavioral health service agency. The Peer Bridger may be identified as a non-crisis resource in the plan.

iii) The Peer Bridger shall:

(1) Attempt to connect the Individual with natural support resources and the local recovery community and attend meetings as allowed.

(2) Help the Individual develop skills to facilitate trust-based relationships, develop strategies for maintaining wellness and develop skills to support relationships.

(3) Assist the Individual in developing a life structure, including skills for daily living such as visits to coffee shops, use of local transportation, opening a bank account, work effectively with a payee if needed, understand benefits, budget planning, shopping and meal preparation, access leisure activities, find a church or faith home, attain and maintain housing, etc.

(4) Help the Individual develop skills to schedule, track and attend appointments with providers.

(5) Help the Individual develop skills for self-advocacy so that the Individual can better define his or her treatment plan and communicate clearly with professionals such as psychiatric prescribers, primary care doctors, etc. The Peer Bridger shall help Individuals prepare for appointments and identify questions or comments the Individual might have for the provider as needed.

(6) Explore supported employment that addresses the following:

(a) Employment goals and how they relate to recovery.

(b) The availability of additional training and education to help the Individual become employable.

(c) The array of employment programs and supported employment opportunities available within the region.

h) Peer Bridgers should demonstrate that recovery is possible and model the ten components of recovery as defined in the SAMHSA Consensus Statement on Mental Health Recovery (http://store.samhsa.gov/shin/content/SMA05-4129/SMA05-4129.pdf).

i) The Peer Bridger team, including Peer Bridger Supervisor will:

i) Participate in monthly, statewide Peer Bridger Program administrative support conference calls.

ii) Participate in bi-annual Peer Bridger Training events scheduled by DBHR.

iii) Ensure that Peer Bridgers complete tracking logs monthly and submit logs to DBHR via secured or encrypted emails.

iv) Coordinate and communicate Peer Bridger team schedules for participation at the inpatient settings with Peer Bridger coordinator.

v) Participate in scheduled supervisory sessions to address topics that align with HCA Peer Bridger training such as ethics, personal bias, self-care, and safety.

j) The Peer Bridger Job Description must contain the following elements:

i) Required Qualifications

(1) Lived experience of mental health recovery and the willingness to share his/her own experiences.

(2) Ability to work flexible hours.

(3) Valid Washington Driver's license or the ability to travel via public transportation.

(4) Ability to meet timely documentation requirements.

(5) Ability to work in a cooperative and collaborative manner as a team member with Hospital staff, MCO/BH-ASO staff, and program Individuals.

(6) Strong written and verbal communication skills.

(7) General office and computer experience.

(8) Washington Certified Peer Specialist with at least two years' experience working as a peer.

(9) Dress professionally and appropriately.

ii) Desired Qualifications

(1) Ability and experience working with people from diverse cultures.

(2) Experience with state hospital system.

(3) Ability to form trusting and reciprocal relationships.

# Schedule C
## Trueblood Enhanced Crisis Stabilization/Crisis Triage
## Salish Region Behavioral Health Administration Services Organization (BH-ASO)

**Purpose:** The Contractor shall ensure provision of short-term behavioral health assistance within a secure crisis triage/crisis stabilization facility OR community-based crisis services for individuals identified as potential Trueblood Class Members experiencing crisis related symptoms. Trueblood class members are adults that have been detained in city and county jails and are awaiting competency evaluation or restoration services and/or individuals who have previously received competency and restoration services and have been released and remain at-risk for re-arrest or re-institutionalization or individuals that have the potential of becoming class members. The Contractor will also ensure provision of support and assessment of mental wellness for individuals transported to the facility by law enforcement, as well as for those that may be served in the community by crisis outreach or other behavioral health providers.

For those individuals served within a crisis stabilization center, which are deemed as either homeless or living in inadequate housing arrangements can be offered an emergency hotel/motel voucher if it is determined by the Contractor to meet the needs of the individual and the individual will be referred to Housing and Recovery through Peer Services (HARPS), Forensic Housing and Recovery through Peer Services (FHARPS), or other supportive housing programs in the region.

The Contractor must provide the services and staff, and otherwise do all things necessary for or incidental to the performance of work in the region (county or counties), as set forth herein.

1. The Contractor will ensure that the enhancement to crisis triage/stabilization services are in line with the language in the Trueblood et al. v. DSHS settlement agreement.
2. Enhancements are funded to create overall capacity for crisis stabilization units and/or crisis services in the Phase 3 Salish region.
3. The Contractor will not use funds for services and programs that are covered under the capitation rate for Medicaid-covered services to Medicaid enrollees.
4. The Quarterly Enhanced Crisis Stabilization/Crisis Triage (QECST) report will be submitted to HCA by the last day of the month following the end of each quarterly reporting period. The report is due April 30, 2024 (January-March), July 30, 2024 (April-June), October 31, 2024 (July-September), January 31, 2025 (October-December), April 30, 2025 (January-March), and June 30, 2025 (Aril-June) to hcabhaso@hca.wa.gov. The report will identify the progression of services and the utilization of crisis enhancement funds for the quarterly payment for this Contract.
5. **Community Awareness and Outreach**: The Contractor will ensure community outreach and education focusing on creating public awareness of the services available at the crisis triage/ stabilization facility in the form of outreach materials and community engagement strategies providing instruction on how to request services.
6. This contract is cost reimbursement based on funds utilized, with pre-approval by the HCA Trueblood Program Supervisor and invoiced through the A19 with backup documentation to support expenditures.

7. **Consideration.** Total consideration payable to Contractor for satisfactory performance of the work under this Contract is up to a maximum of $375,000 (there is up to $125,000 allowable January through June 2024 and up to $250,000 allowable July 2024 through June 2025) including all expenses and will be based upon receipt and acceptance of reports and back up documentation. Salish Region BHASO must obtain pre-approval of the utilization of the crisis enhancement funds.

| Goal # | Task | Performance Measure / Deliverables | SFY 24 | SFY 25 |
|---|---|---|---|---|
| | | | | |
| 1 | Allowable utilization may include, but not be limited to:<br>a) Staff hiring and retention bonuses.<br>b) Community and/or facility-based staff increased wages.<br>c) Training for staff working in community-based crisis response teams and/or crisis stabilization facilities.<br>d) Identify steps and activities that increase law enforcement officers diverting people experiencing a behavioral health crisis | Based on budgeted cost to provide crisis enhancement funds, reconciled by actual cost with valid supporting cost documentation through A-19.<br><br>Requires reports intended to provide insights to program success and barriers and success for potential Trueblood class members.<br><br>Requires quarterly submission of:<br>• documented A-19,<br>• completion of HCA Quarterly Enhanced Crisis Stabilization/Crisis Triage report. | Up to an average of $56,818.50 for each quarter for this contract period<br>With a maximum contract amount of $113,637. | Up to an average $56,818.25 per quarter for this contract period.<br>With a maximum contract amount of $227,273. |

| Goal # | Task | Performance Measure / Deliverables | SFY 24 | SFY 25 |
|---|---|---|---|---|
| | from jail and/or arrest.<br>e) Technology improvements<br>f) One-time vehicle purchase (up to $35,000)<br>g) Other uses of these funds are allowable with the pre-approval of the HCA program manager | | | |
| **Maximum State Fiscal Year Totals:** | | | **$113,637** | **$227,273** |
| **ASO Admin Expense at 10% of Contracted Services:** | | | **$11,363** | **$22,727** |
| **Total Amount for each SFY:** | | | **$125,000** | **$250,000** |
| **Total Contract Maximum Consideration (SFY 24 and SFY 25):** | | | **$375,000** | |