BOARD OF COUNTY COMMISSIONERS AGENDA

240 NW Vancouver Ave, Room 18,
Stevenson, WA 98648
Tuesday, April 23rd, 2024

Commissioner meetings are open to public attendance with limited available seating. If you would like to attend remotely, you may do so by using the following ZOOM login information:
To Join by Phone with Audio Only, Dial: 1 346 248 7799
Meeting ID: 889 0632 1210
Join Zoom Meeting with Audio and Video: https://us02web.zoom.us/j/88906321210

Written comments are accepted until noon on the day before the meeting. If you wish written comments to be listed on the posted agenda, they need to be submitted to the Clerk of the Board by noon on the Wednesday preceding the Tuesday/Wednesday meeting. If written comments are received after noon the day before the meeting, they will be held for the following meeting. Please email comments and public comment questions to the Clerk of the Board at sackos@co.skamania.wa.us. Please note, when a holiday falls on Monday, the regular meeting is held on Wednesday of that week.

Tuesday, April 23rd, 2024

9:00 AM Staff Reports

9:30 PM Call to Order
Pledge of Allegiance
Public Comment (3 minutes per speaker)

Consent Agenda: Items will be considered and approved on a single motion. Any Commissioner may, by request, remove an item from the agenda prior to approval.

1. Minutes for meeting April 16th, 2024.
2. Contract with Lueders Pyrotechnics, LLC to produce the 4th of July fireworks display at the Skamania County Fair and Timber Carnival.
3. Re-appointment of Kristy McCaskell to the Homeless Housing Council as a Real Estate representative.
4. Agreement amendment #19 with Carelon Behavioral Health, Inc. to expand and update the terms and funding for Skamania services.
5. Agreement renewal with Community Health Plan of Washington for behavioral health services.

Voucher Approval
Payroll Approval

WSU Extension Report with Extension Director Hannah Brause

BOCC Meeting Updates

10:00 AM Department Head Reports

Note: Agenda subject to change. Times listed are estimates only. The Commission reserves the right to move agenda items as needed and during the meeting and may add and act on any item not included in the above agenda. Minutes are available at www.skamaniacounty.org on the Commissioners' web page. If necessary, the Board may hold executive sessions on scheduled meeting days. Board of Commissioner meetings are recorded, and audio may be heard at www.skamaniacounty.org.

10:30 AM Safety Committee Report

10:45 AM Workshop with Financial Management Group, Elected Officials, Department Heads, and Managers to discuss County finances

11:15 AM Department of Natural Resources updates with District Manager Brian Poehlein and Region Manager Scott Sargent

Adjourn

Information: Thursday, April 25th, 2024

5:30 PM The Veterans Advisory Board will be holding a meeting in the Commissioners' meeting room.

Note: Agenda subject to change. Times listed are estimates only. The Commission reserves the right to move agenda items as needed and during the meeting and may add and act on any item not included in the above agenda. Minutes are available at www.skamaniacounty.org on the Commissioners' web page. If necessary, the Board may hold executive sessions on scheduled meeting days. Board of Commissioner meetings are recorded, and audio may be heard at www.skamaniacounty.org.

BOARD OF SKAMANIA COUNTY COMMISSIONERS
Skamania County Courthouse
240 NW Vancouver Ave. Lower Level, Room 18
Stevenson, WA 98648
Minutes for Meeting of April 16th, 2024

The Commissioners' business meeting was called to order at 9:30 a.m. on Tuesday, April 16th, 2024, at the Commissioners' Meeting Room, 240 NW Vancouver Avenue in Stevenson, Washington with Commissioners T.W. Lannen, Richard Mahar, and Asa Leckie, Chair, present.

The Pledge of the Allegiance was led by Adam Kick, Prosecuting Attorney.

Public comment was provided by Staci Patton, west-end resident, regarding National Crime Victims' Week and Mary Repar, Stevenson resident, regarding the Courthouse lawn.

The Chair announced that the presentation of a retirement clock to Deputy Chris Helton was cancelled.

Commissioner Lannen moved, seconded by Commissioner Mahar, and the motion carried unanimously to amend the agenda to add the consideration of a contract with BerryDunn Consulting.

Commissioner Lannen moved, seconded by Commissioner Mahar, and the motion carried unanimously to approve the National Crime Victim's Rights Week Proclamation.

Commissioner Mahar moved, seconded by Commissioner Lannen, and the motion carried unanimously to approve the Consent Agenda as follows:

1. Minutes for meeting February 27th, 2024.
2. Minutes for meeting March 5th, 2024.
3. Contract renewal with BTG Holding Group, Inc DBA Infrastructure Software services for software support for Community Health.
4. Interlocal agreement with Skamania County Public Hospital District for safety and health training.
5. Contract renewal with Solutions Yes, LLC for county-wide printers/copiers lease and service contract.
6. Authorization to accept grant funding from the Washington Association of Sheriffs and Police Chiefs grant program for assistance in purchasing radar units for traffic enforcement.
7. Agreement for grant funding from the Washington Office of Secretary of State to help increase information security for elections.

Commissioner Mahar moved, seconded by Commissioner Lannen, and the motion carried unanimously to approve vouchers for the period dated April 16th, 2024, totaling $454,661.55 with the Current Expense amount of $210,093.69, covering warrant numbers 197671 through 197759.

The Board reported on various meetings they attended.

The meeting recessed at 9:52 a.m. and reconvened the same day at 10:00 a.m. with Commissioners T.W. Lannen, Richard Mahar, and Asa Leckie, Chair, present.

The Board met for Department Head reports:

- David Waymire, Public Works Director, reported on Engineering, County Road, Building Division, Community Development, ER&R, Solid Waste, Information Technology, Building and Grounds, and the Wind River Business Park.

- Tamara Cissell, Community Health Director, reported on Behavioral Health, Public Health, Developmental Disabilities, and Housing.

The Board met with Chris Awaad for the County Forester report.

The meeting recessed at 10:20 a.m. and reconvened the same day at 10:46 a.m. with Commissioners T.W. Lannen, Richard Mahar, and Asa Leckie, Chair, present.

The Board met with County staff and BerryDunn Consulting to discuss software for the county.

The Board came out of the workshop and Commissioner Lannen moved, seconded by Commissioner Mahar, and the motion carried unanimously to approve the contract with BerryDunn Associates for consultation services.

The meeting recessed at 11:12 a.m. and reconvened the same day at 1:30 p.m. with Commissioner Richard Mahar and Commissioner Asa Leckie, Chair, present. Commissioner T.W. Lannen was absent.

The Board met with American Legion Post 122 Chaplain Larry Haas, Post 122 Commander Michelle Crittenden, and Post 122 Vice-Commander regarding posting a Prisoner of War (POW)/Missing in Action (MIA) display on the lower level of the Courthouse.

The meeting recessed at 2:07 p.m. and reconvened the same day at 2:20 p.m. with Commissioner Richard Mahar and Commissioner Asa Leckie, Chair, present. Commissioner T.W. Lannen was absent.

The Board met with Director of Equity and Inclusion Sasha Bentley and Co-Directors of Civic Engagement Cristian Olivares and Ben Noble for WAGAP updates.

The meeting recessed at 2:56 p.m. and reconvened the same day at 5:34 p.m. with Commissioner Richard Mahar and Commissioner Asa Leckie, Chair, present. Commissioner T.W. Lannen was absent.

The Board held a public hearing to consider and take public testimony regarding Ordinance 2024-01, amending the Skamania County Code Title 15, Chapter 15.18 flood damage. Building Official Arnold Bell provided a staff report. There was no public testimony. No final action was taken.

Commissioner Mahar moved, Commissioner Leckie, Chair, stepped down and seconded, and the motion carried unanimously to adjourn the Skamania County Board of Commissioners meeting for Tuesday, April 16th, 2024.

The meeting adjourned at 5:42 p.m.

ATTEST:

BOARD OF COMMISSIONERS
SKAMANIA COUNTY, WASHINGTON

_____
Asa Leckie, Chair

_____
Richard Mahar, Commissioner

_____
Lisa Sackos, Clerk of the Board

_____
T.W. Lannen, Commissioner

COMMISSIONER'S AGENDA ITEM COMMENTARY

SUBMITTED BY	Community Events Department Signature
AGENDA DATE	04/23/2024
SUBJECT	Contract – Lueders Pyrotechnics LLC
ACTION REQUESTED	Approve contract

SUMMARY/BACKGROUND
This is the contract with our local fireworks vendor to produce the 4th of July fireworks display.

FISCAL IMPACT
Community Events and Recreation applied for Lodging Tax to cover all expenses pertaining to the 4th of July event

RECOMMENDATION
The Skamania County Board of Commissioners signs the contract

LIST ATTACHMENTS
Facesheet
Contract with Lueders Pyrotechnics LLC

COUNTY FACE SHEET FOR CONTRACTS/LEASES/AGREEMENTS

1. Contract Number _____

2. Contract Status: (Check appropriate box) ☒ Original ☐ Renewal ☐ Amendment

3. Contractor Information:

Contractor: Lueders Pyrotechnics LLC
Contact Person: Ray Lueders
Title: Manager
Address: 11271 Wind River Hwy
Address: Carson, Wa 98610
Phone: 509-427-5985

4. Brief description of purpose of the contract and County's contracted duties:
This contract will pay for a fireworks show to be produced on the4th of July and during the Skamania County Fair and Timber Carnival

5. Term of Contract: From:4/23/2024 To: 12/31/24

6. Contract Award Process: (Check appropriate box)

General Purchase of materials, equipment or supplies - RCW 36.32.245 & 39.04.190

☐ Exempt (Purchase is $2,500 or less upon order of the Board of Commissioners
☐ Informal Bid Process (Formal Quotes between $2,500 and $25,000)
☐ Formal Sealed Bid Process (Purchase is over $25,000)
☐ Other Exempt (explain and provide RCW)_____

Public Works Construction & Improvements Projects – RCW 36.32.250 & 39.04.155 (Public Works, B&G, Capital Improvements Only)

☐ Small Works Roster (PW projects up to $200,000)
☐ Exempt (PW projects less than $10,000 upon order of the Board of Commissioners)

7.

Amount Budgeted in Current Year:	$11,945	
Amount Not Budgeted in Current Year	$	Source:
Total Non-County Funds Committed:	$11,945	Source: Lodging Tax
Total County Funds Committed:	$0	
TOTAL FUNDS COMITTED:	$11,945	

8. County Contact Person: Name: Alex Hays
Title: Program Manager

9. Department Approval: _____
Department Head or Elected Official Signature

10. Special Comments: _____

_____

SKAMANIA COUNTY - PROFESSIONAL SERVICE CONTRACT BETWEEN SKAMANIA COUNTY AND LUEDERS PYROTECHNICS LLC

THIS CONTRACT, by and between **SKAMANIA COUNTY,** a municipal corporation, hereinafter referred to as the "**COUNTY**", and **LUEDERS PYROTECHNICS LLC,** hereinafter referred to as the "**CONTRACTOR**",

WITNESSETH THAT:

1. **AUTHORITY TO CONTRACT**

A. The **CONTRACTOR** covenants that the person whose signature appears as the representative of the **CONTRACTOR** on the signature page of this contract is the **CONTRACTOR**'S contracting officer and is authorized to sign on behalf of the **CONTRACTOR** and, in addition, to bind the **CONTRACTOR** in any subsequent dealings with regard to this contract, such as modifications, amendments, or change orders.

B. The **CONTRACTOR** covenants that all licenses, tax I.D. Nos., bonds, industrial insurance accounts, or other matters required of the **CONTRACTOR** by federal, state, or local governments in order to enable the **CONTRACTOR** to do the business contemplated by this agreement, have been acquired by the **CONTRACTOR** and are in full force and effect.

C. The **COUNTY** represents that the services contracted for herein have been, or will be, appropriately budgeted for and that the **COUNTY** has the authority to contract for such services; that the contracting officer for the **COUNTY** is Alex Hays; provided that changes that require a change in the amount of the contract price, shall require the approval of the Skamania County Board of Commissioners.

2. **INDEPENDENT CONTRACTOR STATUS**

A. The parties intend the **CONTRACTOR** to be an independent contractor, responsible for its own employer/employee benefits such as Workman's Compensation, Social Security, Unemployment, and health and welfare insurance. The parties agree that the **CONTRACTOR**'s personal labor is not the essence of this contract; that the **CONTRACTOR** will own and supply its own equipment necessary to perform this contract; that the **CONTRACTOR** will employ its own employees; and that, except as to defining the work and setting the parameters of the work, the **CONTRACTOR** shall be free from control or direction of the **COUNTY** over the performance of such services.

B. The **CONTRACTOR** represents that it is capable of providing the services contracted for herein; that it is the usual business of the **CONTRACTOR** to provide such services.

3. **SERVICES TO BE RENDERED**

A. The work to be performed by the **CONTRACTOR** consists of those services that are fully described in the contract documents marked Attachment A, consisting of a total of 2 pages which has been initialed by the parties, attached hereto, and by this reference incorporated herein.

B. Amendments, modifications, or change orders to this contract must be in writing and signed by the parties designated in this contract to be the contracting officers; provided that, change orders affecting the total contract price must be signed by the Board of Commissioners for the **COUNTY**.

4. **TERMS OF CONTRACT**

The contract shall begin on 4/09/2024 and terminate on 12/31/2024 ; PROVIDED that, in the event this contract is a personal services contract, not exempt under Chapter 39 of the Revised Code of Washington, this contract shall not be effective until the requirements of said statute have been met. The County may terminate this contract earlier upon five (5) days' written notice.

5. **PERFORMANCE AND PAYMENT BONDS (If Applicable)**

Per RCW 39.08.010, the Contractor shall provide a non-corporate surety bond for performance and payment guarantee in the full amount of the contract or in lieu of the bond, the County, at the request of the contractor, may retain fifty percent of the contract amount for a period of thirty days after the date of final acceptance, or until receipt of all necessary releases from the department of revenue and the department of labor and industries and settlement of any liens filed under chapter 60.28 RCW, whichever is later and applicable. Said bonds shall be delivered to the County business office prior to the commencement of work and not later than fifteen (15) calendar days after notification of award of bid.

6. **PAYMENTS FOR SERVICES**

A. The consideration for the services to be performed by the **CONTRACTOR** shall not exceed $11,945, including Washington sales tax, and shall be paid as outlined below or in Attachment A.

B. Payment on the account of the contracted services shall be made not more than monthly, based on submission by the **CONTRACTOR** to the **COUNTY**'s contracting officer of reports and invoices describing the services performed in sufficient detail to enable the **COUNTY**'s contracting officer to adequately determine the services for which payment is sought. Payment is due within thirty (30) days of submission of accepted detailed invoice.

C. The **CONTRACTOR** agrees that funds received from the **COUNTY** can be

expended for only public purposes and the **CONTRACTOR** will keep identifiable financial and performance books and records of all funds received pursuant to this contract from the **COUNTY** detailing the receipts and expenditures of such funds; that these detailed accounting records shall be made available at all reasonable times to any county, state, or federal auditor, whose duties include auditing these funds.

7. **INSURANCE**

The **CONTRACTOR** agrees to save the **COUNTY** harmless from any liability that might otherwise attach to the **COUNTY** arising out of any activities of the **CONTRACTOR** pursuant to this contract and caused by the **CONTRACTOR**'S negligence. The **CONTRACTOR** further agrees to provide the **COUNTY** with evidence of general liability insurance naming the **COUNTY, its elected and appointed official, agents, employees, and volunteers** as an additionally insured party in the amount of $1,000,000.

8. **INDEMNIFICATION**

Contractor agrees to indemnify and hold harmless the County and its respective employees, agents, licensees and representatives, from and against any and all suits, claims, actions, losses, costs, penalties, damages, attorneys' fees and all other costs of defense of whatever kind or nature arising out of injuries of or death of any and all persons (including Subcontractors, agents, licensees or representatives, and any of their employees) or damage of or destruction of any property (including, without limitation, Owner's property, Contractor's property, or any Subcontractor's property) in any manner caused by, resulting from, incident to, connected with or arising out of Contractor's performance of its work, unless such injury, death or damage is caused by the sole negligence of the County.

In any situation where the damage, loss or injury is caused by the concurrent negligence of the Contractor or its agents and employees and the County or its agents or employees, then the Contractor expressly and specifically agrees to hold the County harmless to the extent of the Contractor or its agents' and employees' concurrent negligence.

The Contractor specifically waives its immunity as against Skamania County under Title 51 RCW (Industrial insurance statute) and acknowledges that this waiver of immunity was mutually and expressly negotiated by the parties, and expressly agrees that this promise to indemnify and hold harmless applies to all claims filed by and/or injuries to the Contractor's own employees against the County. This provision is not intended to benefit any third parties.

If a Subcontractor is used, then the Contractor shall ensure that all Subcontracts also provide that the Contractor or Subcontractor will waive its immunity under Title 51 RCW.

9. **GOVERNING LAW**

The parties agree that this contract shall be governed by the laws of the State of Washington and that venue for any action pursuant to this contract, either interpreting the contract or

enforcing a provision of the contract, or attempting to rescind or alter the contract, shall be brought in Skamania County, Washington; that the prevailing party shall be entitled to all costs, including reimbursement for attorney's fees at a reasonable rate.

10. **ASSIGNABILITY**

The **CONTRACTOR** shall not assign nor transfer any interest in this contract.

11. **EQUAL EMPLOYMENT OPPORTUNITY**

A. The **CONTRACTOR** shall not discriminate on the basis of race, color religion, sex, national origin, age, disability, marital or veteran status, political affiliation, or any other legally protected status in employment or the provision of services.

B. The **CONTRACTOR** shall not, on the grounds of race, color, sex, religion, national origin, creed, age, or disability:

(1) Deny an individual any services or other benefits provided under this agreement.

(2) Provide any service(s) or other benefits to an individual which are different or are provided in a different manner from those provided to others under this agreement.

(3) Subject an individual to unlawful segregation, separate treatment, or discriminatory treatment in any manner related to the receipt of any service(s), and/or the use of the contractor's facilities, or other benefits provided under this agreement.

(4) Deny any individual an opportunity to participate in any program provided by this agreement through the provision of services or otherwise, or afford an opportunity to do so which is different from that afforded others under this agreement. The **CONTRACTOR**, in determining (1) the types of services or other benefits to be provided or (2) the class of individuals to whom, or the situation in which, such services or other benefits will be provided or (3) the class of individuals to be afforded an opportunity to participate in any services or other benefits, will not utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, sex, religion, national origin, creed, age, or disability.

12. **NONCOMPLIANCE WITH NONDISCRIMINATION PLAN**

In the event of the **CONTRACTOR**'s noncompliance or refusal to comply with the above nondiscrimination plan, this contract may be rescinded, canceled, or terminated in whole or in part, and the contractor may be declared ineligible for further contracts with the **COUNTY**. The **COUNTY** shall, however, give the **CONTRACTOR** reasonable time to cure this noncompliance. Any dispute may be resolved with the "Disputes" procedure set

forth herein.

13. **DISPUTES**

Except as otherwise provided in this contract, when a genuine dispute arises over an issue related to the contract between the **COUNTY** and the **CONTRACTOR** and it cannot be resolved, either party may submit a request for a dispute resolution to the Board of County Commissioners. The parties agree that this resolution process shall precede any action in a judicial and quasi-judicial tribunal. A party's request for a dispute resolution must:

a. be in writing; and
b. state the disputed issues; and
c. state the relative positions of the parties; and
d. state the **CONTRACTOR's** name, address, and the **COUNTY** department the contract is with; and
e. be mailed to the Board of Commissioners, P.O. Box 790, Stevenson, Washington 98648, within thirty (30) calendar days after the party could reasonably be expected to have knowledge of the issue which he/she now disputes. This dispute resolution process constitutes the sole administrative remedy available under this contract.

14. **WAGE AND HOUR COMPLIANCE**

The **CONTRACTOR** shall comply with all applicable federal and state provisions concerning wages and conditions of employment, fringe benefits, overtime, etc., as now exists or is hereafter enacted during the term of this contract, and shall save the County harmless from all actions, claims, demands, and expenses arising out of the **CONTRACTOR'S** failure to so comply.

15. **DEFAULT/TERMINATION/DAMAGES**

A. The parties hereto agree that TIME IS OF THE ESSENCE of this contract.

B. If the **CONTRACTOR** shall fail to fulfill in a timely manner any of the covenants of this agreement, the **COUNTY** shall have the right to terminate this agreement by giving the **CONTRACTOR** seven (7) days' notice, in writing, of the **COUNTY's** intent to terminate and the reasons for said termination. And in the event of any such termination the **CONTRACTOR** shall be liable for the difference between the original contract and the replacement or cover contract as well as all administrative costs directly related to the replacement contract; that in such event the **COUNTY** may withhold from any amounts due the **CONTRACTOR** for such work or completed services any balances due the Contractor, and said amounts shall be used to totally or partially offset the **COUNTY's** damages as a result of the **CONTRACTOR's** breach to the extent they are adequate.

C. Either party may cancel the contract, without fault, by giving the other party 20 days written notice.

16. **OWNERSHIP OF WORK PRODUCTS**

Upon completion of the project or termination for whatever reason, all finished and unfinished documents, data, studies, drawings, service maps, models, photographs, and other work product resulting from this agreement shall become the **COUNTY**'s property.

IN WITNESS WHEREOF, the **COUNTY** has caused this Contract to be duly executed on its behalf, and thereafter the **CONTRACTOR** has caused the same to be duly executed on its behalf.

DATED: _____, **20**___.

SKAMANIA COUNTY
BOARD OF COMMISSIONERS

_____	_____
Chairman	**Date**
_____	_____
Commissioner	**Date**
_____	_____
Commissioner	**Date**

APPROVED AS TO FORM ONLY:

_____
Prosecuting Attorney

Ray Lueders

_____
Owner

ATTEST:

_____
Clerk of the Board

_____
Date

Attachment A
SUSPENSION & DEBARMENT CERTIFICATION

Definitions: COUNTY shall mean **Skamania County**
CONTRACTOR shall mean **Lueders Pyrotechnics LLC**

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion:

This certification is required by the regulations at Title 2 Code of Federal Regulations Part 180 for all lower tier (subcontracting) transactions.

The CONTRACTOR certifies, by signing this agreement, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. The prospective lower tier participant shall provide immediate written notice to the Community Events Program Manager if at any time the CONTRACTOR learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

Should the CONTRACTOR enter into a covered transaction with another person at the next lower tier (subcontract), the CONTRACTOR agrees by signing this agreement that it will verify that the person with whom it intends to do business is not excluded or disqualified. The CONTRACTOR will do this by:

(a) Checking the federal Excluded Parties List System (EPLS); or
(b) Collecting a certification from that person; or
(c) Adding a clause or condition to the contract with that person

The CONTRACTOR agrees by signing this agreement that it shall not knowingly enter into any lower tier transaction (subcontract) with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which the transaction originated. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction (subcontract) that is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous.

The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered. If it is later determined that the CONTRACTOR knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

		4/23/24	
Contractor	**Date**	**Skamania County**	**Date**

Contractor and County Guidelines

1. Contractor shall produce a firework display for the County, hereinafter referred to as "Display", at the Skamania County Fairgrounds, Stevenson WA, 98648. The Display shall be fired on July 4th, 2024, at approximately 10:00 PM. An alternate date, acceptable to both parties, shall be used if the original firing date and time stated above are canceled due to inclement weather.

2. Contractor shall produce the display as a service to the County. Contractor shall provide the materials, equipment, and labor as required by law, for the successful completion of the Display. Contractor shall not subcontract any portion of this contract to third parties.

3. County agrees, to provide Contractor with a suitable site to stage the display, which must be clear of any and all people, vehicles and/or structures, acceptable to the Contractor, and any local authority having jurisdiction, to accommodate the normal firing and fallout of debris from the Display. The County shall allow sufficient time and access to the Contractor prior to Display to safely set up the Display on site and ensure that all safety precautions are followed.

4. The County agrees, to provide suitable barriers adequate to prevent any access to the Display site by members of the general public or persons not specifically approved by Contractor, Temporary barricades or fencing will be set up by the County with consultation of Contractor. To the extent allowed by law, any claim arising from injury to unauthorized persons or damages to property left in the Display area, arising out of the negligence of the County are the sole responsibility of the County. To the extent allowed by law, The County agrees to hold the Contractor harmless from any such claim unless the Contractor does not follow any mandatory safety precautions provided in this agreement or Attachment thereto.

5. Contractor shall not fire the Display if the wind speed exceeds twenty miles per hour, or if for any other reason the Contractor determines that firing the Display is unsafe due to weather or other conditions; if so instructed not to by any local authority having jurisdiction; or, if the unplanned proximity of people or property should enter the Display site in violation of any mandatory safety precautions in this agreement or attachment. Contractor shall attempt to fire the Display at such a time as conditions warrant a safe Display. There shall be no refund for effects not fired after arrival on Display site by the Contractor, but services or materials purchased for event can be moved to a future agreed Display.

6. The County agrees to indemnify and hold harmless the Contractor and its respective employees, agents, and representatives, from and against any and all suites, claims, actions, losses, costs, penalties, damages, attorney's fees and all other costs of defense of whatever kind of nature arising out of injuries of or death of any and all persons or damage of or destruction of any property, the County's property, in any manner caused by, resulting from, incident to, connected with or arising out of the Contractor's performance of its work, unless such injury, death or damage is caused by the sole gross negligence of the Contractor.

7. County shall have the option to cancel the Display at any time. If the County cancels 20 days or less from the display event date, then the Contractor will receive payment for 100% of the

labor and supplies incurred at the time of the canceling. The County and the Contractor can arrange to use the firework supplies for future events if the Display date is canceled for any reason. If the Contractor does not choose to produce future events for the County, then any supplies purchased for the use of the Display will be transferred to County or subrecipients equipped to properly store the used fireworks for future events.

8. County may elect to set a rainout or inclement weather Display date. This date must be established at the time of this Agreement being signed and agreed upon by County and Contractor. The date agreed upon will be the week of New Years.

9. This contract shall be governed by the laws of the State of Washington. It is agreed that any court of competent jurisdiction within Skamania County, Washington shall be proper venue for an action. Should such action be brought to enforce or interpret the terms or provisions of this Agreement, each party shall bear its own attorney fees and costs.

10. Nothing in this Agreement shall be construed as forming a partnership, joint venture, agency or any form of legal relationship, other than contractual, between the Contractor and the County. Neither party shall be held responsible for any Agreements or obligations not expressly provided for herein and shall be severally responsible for their own separate debts and obligations.

11. The Contractor will not start assembling the display until at least 3 weeks prior to the event. If the Display has been assembled and the County shuts down the event for any reason, the Display cannot be taken apart without compromising the integrity and safety of the product and will not receive any products back and will take all products as a loss if an agreed backup date has not been secured.

Payment Schedule:

Upon receipt of an invoice and W9 from the Contractor, the County will process the payment to not exceed the amount outlined in 6A of the contract.

COMMISSIONER'S AGENDA ITEM COMMENTARY

SUBMITTED BY	Community Health Department	Signature 
AGENDA DATE	BOCC, 04/23/2024	
SUBJECT	Skamania County Homeless Housing Council Advisory Board	
ACTION REQUESTED	Approval/Signature	

SUMMARY/BACKGROUND

The one (1) attached letter has been submitted by the Homeless Housing Council requesting that Kristy McCaskell be re-appointed and continue serving on the Board for another (2) two-year term as set forth in Resolution 2007-13.

FISCAL IMPACT

None

RECOMMENDATION

Sign

LIST ATTACHMENTS

Agenda Commentary
Letter of Request for re-appointment from:

Kristy McCaskell: Real-Estate

Date: April 12, 2024

Board of Commissioners
PO Box 790
Stevenson, WA 98648

Dear Commissioners:

I would like to serve on the Skamania County Homeless Housing Council because:

I care deeply about our community & our housing issues.

For this reason, I request that my term be extended for another (2) two years.

For this reason, I would like to be appointed to serve on the Homeless Housing Council.

While serving in this position, I am representing real Estate (Mental Health, Substance Abuse, Government Agency, etc), which enables me to contribute to crucial discussions regarding how housing issues are addressed in Skamania County. I feel that my opinions are/will be considered and that the time I spend with the board is valued.

Thank you for the opportunity to make a difference. Please consider my membership with the Skamania County Homeless Housing Council.

Sincerely,

Name: Kristy McCaskell
Address: 7042 E. Loop Rd.
Stevenson, Wa. 98648
Phone: 702-480-4302
Email: Kmccaskell@windermere.com

Dated this _____ day of _____2024.

ATTEST:

BOARD OF COMMISSIONERS
SKAMANIA COUNTY, WASHINGTON

_____
Asa Leckie, Chairman

_____
Richard Mahar, Commissioner

_____
Lisa Sackos, Clerk of the Board

_____
T.W. Lannen, Commissioner

Aye ____
Nay ____
Abstain ____
Absent ____

COMMISSIONER'S AGENDA ITEM COMMENTARY

SUBMITTED BY	Community Health Department	Signature
AGENDA DATE	BOCC, 4/23/2024	
SUBJECT	Carelon Behavioral Health, Inc. ~~Beacon Health Options (Value Options)~~ Amendment 19 to insurance contract for services	
ACTION REQUESTED	Signature	

SUMMARY/BACKGROUND

Amends insurance contract for services with Carelon Behavioral Health, Inc. ~~Beacon Health Options (a.k.a. Value Options)~~ to expand and update the terms and funding for Skamania services. .

FISCAL IMPACT

REVENUE CONTRACT

Cost reimbursement, Capacity and Fee for Service payments for services provided

RECOMMENDATION

Sign

LIST ATTACHMENTS

Face Sheet
Contract Amendment

SPECIAL INSTRUCTIONS

Please email signed contract signature page to Kirstin Peterson, Kirstin.peterson@carelon.com

COUNTY FACE SHEET FOR CONTRACTS/LEASES/AGREEMENTS

1. Contract Number

2. Contract Status: (Check appropriate box) ☐ Original ☐ Renewal ☒ Amendment #19

3. Contractor Information:

Contractor:	~~Beacon Health Options, Inc.~~ Carelon Behavioral Health Inc
Contact:	Kirstin Peterson
Address:	1220 Main Street, 4th Floor
Address:	Vancouver WA 98660
Phone:	360-216-3020
Email:	Kirstin.peterson@carelon.com

4. Brief description of purpose of the contract and County's contracted duties:

Amends insurance contract for services with ~~Beacon Health Options (a.k.a. Value Options)~~ Carelon Behavioral Health Inc., to expand and update the terms and funding for Skamania services.

5. Term of Contract: From: July 1, 2016 To: December 31, 2024

6. Contract Award Process: (Check appropriate box) **NA/Revenue Contract**
General Purchase of materials, equipment or supplies - RCW 36.32.245 & 39.04.190

☐ Exempt (Purchase is $2,500 or less upon order of the Board of Commissioners
☐ Informal Bid Process (Formal Quotes between $2,500 and $25,000)
☐ Formal Sealed Bid Process (Purchase is over $25,000)
☐ This contract was awarded under RCW 39.29 or Skamania County Code _____. Please provide a summary of the competitive process by which this contract was awarded or the exemption and why it applies. _____

_____

Public Works Construction & Improvements Projects – RCW 36.32.250 & 39.04.155 (Public Works, B&G, Capital Improvements Only)

☐ Small Works Roster (PW projects up to $200,000)
☐ Exempt (PW projects less than $10,000 upon order of the Board of Commissioners)

7. Original Contract Amount: $ Fee for Service & Cost Reimbursement
Amendment Amount: $ Fee for Service & Cost Reimbursement
Source: Beacon Health

TOTAL FUNDS ANTICIPATED: $ To be determined

8. County Contact Person: Name: Tamara Cissell
Title: Director

9. Department Approval: _____
Department Head or Elected Official Signature

Special Comments:

Please send signed PDF of signature page to Kirstin Peterson at Kirstin.peterson@carelon.com

AMENDMENT #19 TO
CARELON FACILITY AGREEMENT

This nineteenth amendment ("Amendment") amends the Carelon Facility Agreement ("Agreement") entered into by Carelon Behavioral Health, Inc. ("Carelon") and Skamania County dba Skamania County Community Health ("Facility"). Unless otherwise defined herein, all capitalized terms used in this Amendment shall have the same meaning as set forth in the Agreement.

WHEREAS, the Agreement permits amendments to the Agreement by Carelon and Facility; and

WHEREAS, Carelon and Facility desire to amend the Agreement to make certain changes to it.

NOW, THEREFORE, in consideration of the promises and mutual covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Agreement is hereby amended as follows, **effective January 1, 2024**:

1. Exhibit A.A18 Facility Location(s) & Practitioners, Services & Payment is removed in its entirety and replaced with Exhibit A.A19 Facility Location(s) & Practitioners, Services & Payment.

2. Exhibit A-1.A17 SWRG Rate Schedule is removed in its entirety and replaced with Exhibit A-1.A19 SWRG Mobile Crisis and Designated Crisis Responder Rate Schedule.

3. Exhibit A-2.A17 SWJT Rate Schedule is removed in its entirety and replaced with Exhibit A-2.A19 SWJT Jail Transition Services Rate Schedule.

4. Exhibit A-3.A18 SWGF SWMH Outpatient Mental Health Rate Schedule is removed in its entirety and replaced with Exhibit A-3.A19 SWGF Outpatient Mental Health Rate Schedule.

5. Exhibit A-4.A17 SWSA Rate Schedule is removed in its entirety and replaced with Exhibit A-4.A19 SWGF Outpatient Substance Use Disorder Rate Schedule

6. Exhibit B-2.A18 Maximum Contract Amounts is removed in its entirety and replaced with Exhibit B-2.A19 Maximum Contract Amounts.

7. Exhibit B-4.A18 Crisis Program Provisions (Mobile Crisis and Designated Crisis Responder) is removed in its entirety and replaced with Exhibit B-4.A19 Crisis Program Provisions (Mobile Crisis and Designated Crisis Responder).

8. Exhibit B-6.A18 Jail Transition Program Provisions is removed in its entirety and replaced with Exhibit B-6.A19 Jail Transition Program Provisions.

9. Exhibit B-7.A18 Mental Health Program Provisions is removed in its entirety and replaced with Exhibit B-7.A19 Mental Health Program Provisions.

10. Exhibit B-8.A18 Washington State Health Care Authority Specific Provisions is removed in its entirety and replaced with Exhibit B-8.A19 Washington State Health Care Authority Specific Provisions.

11. Exhibit B-11.A18 Substance Use Disorder Program Provisions is removed in its entirety and replaced with Exhibit B-11.A19 Substance Use Disorder Program Provisions.

12. Exhibit B-25.A18 Reporting Provisions is removed in its entirety and replaced with Exhibit B-25.A19 Reporting Provisions.

13. This Amendment shall be effective upon the date set forth by Carelon following signature by both Carelon and Facility.

14. Except as amended herein, all other terms and conditions of the Agreement shall remain in full force and effect without modification.

15. Scope of work pursuant with contract terms between Carelon and Health Care Authority as dictated in contract amendment dated January 1, 2024.

Facility: Skamania County

Address: PO Box 1492, Stevenson, WA 98648

NPI: 1821175456

Intending to be legally bound, the parties have caused their authorized representatives to execute this Agreement effective as of the date set forth by Carelon below.

Skamania County:	**Carelon Behavioral Health, Inc.:**
Signature	Signature
Date	Date
Print Name & Title	Print Name & Title

Federal Tax Identification Number: 91-6001363

Address for Notice:	**Address for Notice:**
Skamania County 6315 S 19th Street Tacoma, WA, 98466-6217	Carelon Behavioral Health, Inc. P.O. Box 989 Latham, NY 12110-6402 Attn: National Provider Network Operations

Please do NOT write below this line. For Carelon office use ONLY.

EFFECTIVE DATE: **January 1, 2024**

Negotiated by: Kirstin Peterson
Print Name

Provider Network Manager

Date Received by Carelon

Please check if included: ☐ _____ ☐ _____

I: Facility Location(s) & Practitioners.

(1) The list of those Facility locations and Practitioners who are or will be rendering available Covered Services to Eligible Individuals under this Agreement is set out in the most recently approved credentialing documentation.

II: Facility Services.

(1) All Behavioral Health Services: (a) available from Facility and/or Practitioners pursuant to their respective licensure or certification; (b) for which Facility and/or Practitioners have been credentialed pursuant to Carelon's credentialing/re-credentialing policies and procedures; and (c) for which there is a corresponding rate schedule herein.

III: Rate Schedules & Payment.

(1) The parties agree that:

(a) Payment amounts for Covered Services shall be in accordance with the Rate Schedule(s) attached hereto and incorporated herein by reference;

(b) The date of receipt of a claim is the date Carelon, or Payor, receives the claim, as indicated by its date stamp on the claim;

(c) The date of payment is the date of the check or other form of payment;

(d) The per diem payment rates listed in attached Rate Schedules are inclusive, including without limitation, facility, supplies, materials, drugs, equipment, x-ray, laboratory (technical, facility) and other diagnostic fees, , operating room (where applicable), nurses and other Facility employees and permitted contracted entities and individuals; and

(e) Inpatient days commence at 12:00 midnight**, however no payment is due for the date of discharge.**

(f) Crisis stabilization services are considered inpatient services with the length of stay calculated per the Health Care Authority's (HCA) Inpatient Hospital billing guide. When admit and discharge are on same day one per diem unit will be paid.

(2) No payment in addition to the applicable per diem rate for Covered Services above will be made for: (a) any outpatient services rendered in the emergency room of Facility prior to an inpatient admission; or (b) any outpatient observation services rendered prior to an inpatient admission.

Exhibit A-1.A19
SWRG Mobile Rapid Response Crisis Team and Designated Crisis Responder Rate Schedule

This Exhibit contain the Service Codes and billing rates that are allowed under the SWRG fund code. Following the Rate Schedule is a table listing modifiers and their descriptions as well as a key to abbreviations that may be used in this Rate Schedule.

Please consult the current Service Encounter Reporting Instructions (SERI) for modifier definitions and uses.

Definitions

1. Payment Type:

    a. Fee for Service (FFS): Claims submitted for health care payments, also known as the Fee for Service (FFS) payment type, must be cleanly submitted within current Washington State Health Care Authority timely filing requirements in the format outlined in this Rate Schedule.

    b. Prepaid: Prepaid claims submitted for health care reporting purposes, also known as the Prepaid payment type, must be cleanly submitted to Carelon monthly in the format outlined in this Rate Schedule. Payment for services provided will be made according to the Payment Method identified in Exhibit B-2 Maximum Contract Amounts.

SWRG Rate Schedule.A19: Mobile Rapid Response Crisis Team and Designated Crisis Responder (DCR)

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Required	Place of Service (POS)	Payment Type
99075	N/A	N/A	Medical Testimony	H9				$0.01	UN (1 per encounter)	No	11, 12, 21, 23, 27, 51, 53, 56, 99	Prepaid
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HA	HK			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HA	HK	XE		$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HA	XE			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HA				$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HB	HK			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72 99	Prepaid
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HB	HK	XE		$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72 99	Prepaid

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Required	Place of Service (POS)	Payment Type
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HB				$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72 99	Prepaid
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HB	XE			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72 99	Prepaid
H2011	N/A	N/A	Crisis intervention services, per 15 minutes	UB	HB			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72 99	Prepaid
H2011	N/A	N/A	Crisis intervention services, per 15 minutes	HB				$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72 99	Prepaid
H2011	N/A	N/A	Crisis intervention services, per 15 minutes	HB	HK			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2011	N/A	N/A	Crisis intervention services, per 15 minutes	HA				$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2011	N/A	N/A	Crisis intervention services, per 15 minutes	HA	HK			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2011	N/A	N/A	Crisis intervention services, per 15 minutes	HA	HK	XE		$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2011	N/A	N/A	Crisis intervention services, per 15 minutes	HA	XE			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2011	N/A	N/A	Crisis intervention services, per 15 minutes	HB	XE			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72 99	Prepaid
H2011	N/A	N/A	ITA Investigation DCR Use Only	HW				$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2011	N/A	N/A	ITA Investigation DCR Use Only	HW	HK			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Required	Place of Service (POS)	Payment Type
H2011	N/A	N/A	ITA Investigation DCR Use Only	HW	XE			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2011	N/A	N/A	ITA Investigation DCR Use Only	HW	HK	XE		$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2011	N/A	N/A	Crisis intervention services, per 15 minutes	UB	HA			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2019	N/A	N/A	Therapeutic behavioral services	HA	HK			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2019	N/A	N/A	Therapeutic behavioral services	HA	HK	XE		$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2019	N/A	N/A	Therapeutic behavioral services	HA	XE			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2019	N/A	N/A	Therapeutic behavioral services	HA				$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2019	N/A	N/A	Therapeutic Behavioral Services	HB				$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2019	N/A	N/A	Therapeutic Behavioral Services	HB	XE			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2019	N/A	N/A	Therapeutic Behavioral Services	HB	HK			$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid
H2019	N/A	N/A	Therapeutic Behavioral Services	HB	HK	XE		$0.01	UN (1=15 minutes; 1 or more)	No	02, 03, 04, 06, 09, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 27, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72, 99	Prepaid

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Required	Place of Service (POS)	Payment Type
T1013	N/A	N/A	Sign Lang/Oral Interpreter Services (Note: submit prepaid claims for reporting and invoice for reimbursement)					$0.01	UN (1= 15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13,15, 19, 22, 27, 32, 33, 34, 53, *57, 62, 71, 72	Prepaid
T1013	N/A	N/A	Sign Lang/Oral Interpreter Services (Note: submit prepaid claims for reporting and invoice for reimbursement)	XE				$0.01	UN (1= 15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13,15, 19, 22, 27, 32, 33, 34, 53, *57, 62, 71, 72	Prepaid

This Exhibit contain the Service Codes and billing rates that are allowed under the SWJT fund code. Following the Rate Schedule is a table listing modifiers and their descriptions as well as a key to abbreviations that may be used in this Rate Schedule.

Please consult the current Service Encounter Reporting Instructions (SERI) for modifier definitions and uses.

Definitions

1. Payment Type:

    a. Fee for Service (FFS): Claims submitted for health care payments, also known as the Fee for Service (FFS) payment type, must be cleanly submitted within current Washington State Health Care Authority timely filing requirements in the format outlined in this Rate Schedule.

    b. Prepaid: Prepaid claims submitted for health care reporting purposes, also known as the Prepaid payment type, must be cleanly submitted to Carelon monthly in the format outlined in this Rate Schedule. Payment for services provided will be made according to the Payment Method identified in Exhibit B-2 Maximum Contract Amounts.

SWJT Rate Schedule.A19: Jail Transition Services

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Required	Place of Service (POS)	Payment Type
T1013	N/A	N/A	Sign Lang/Oral Interpreter Services (Note: submit prepaid claims for reporting and invoice for reimbursement)					$0.01	UN (1= 15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13,15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	Prepaid
T1013	N/A	N/A	Sign Lang/Oral Interpreter Services (Note: submit prepaid claims for reporting and invoice for reimbursement)	XE				$0.01	UN (1= 15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13,15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	Prepaid
T2038	N/A	N/A	Community transition waiver/services, per service					$0.01	UN (1=15 minutes; 1 or more)	No	02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	Prepaid

This Exhibit contain the Service Codes and billing rates that are allowed under the SWGF fund code. Following the Rate Schedule is a table listing modifiers and their descriptions as well as a key to abbreviations that may be used in this Rate Schedule.

Please consult the current Service Encounter Reporting Instructions (SERI) for modifier definitions and uses.

Definitions

1. Payment Type:

    a. Fee for Service (FFS): Claims submitted for health care payments, also known as the Fee for Service (FFS) payment type, must be cleanly submitted within current Washington State Health Care Authority timely filing requirements in the format outlined in this Rate Schedule.

    b. Prepaid: Prepaid claims submitted for health care reporting purposes, also known as the Prepaid payment type, must be cleanly submitted to Carelon monthly in the format outlined in this Rate Schedule. Payment for services provided will be made according to the Payment Method identified in Exhibit B-2 Maximum Contract Amounts.

SWGF Rate Schedule.A19: Outpatient Mental Health Services

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Requir	Place of Service (POS)	Payme nt Type
90791	N/A	90785	Psychiatric diagnostic evaluation	52				$199.26	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90791	N/A	90785	Psychiatric diagnostic evaluation	53				$199.26	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90791	N/A	90785	Psychiatric diagnostic evaluation					$199.26	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90792	N/A	90785	Psychiatric diagnostic evaluation w/medical services	52				$465.47 MD/DO $258.55 NP	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90792	N/A	90785	Psychiatric diagnostic evaluation w/medical services	53				$465.47 MD/DO $258.55 NP	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90792	N/A	90785	Psychiatric diagnostic evaluation w/medical services					$465.47 MD/DO $258.55 NP	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90832	N/A	90785	Psychotherapy w/patient and/or family member, 30 minutes					$79.70	UN (1= 16-37 minutes; 1 per encounter)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90832	N/A	90785	Psychotherapy w/patient and/or family member, 30 minutes	XE				$79.70	UN (1= 16-37 minutes; 1 per encounter)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Requir	Place of Service (POS)	Payme nt Type
90834	N/A	90785	Psychotherapy w/patient and/or family member, 45 minutes					$124.22	UN (1= 38-52 minutes; 1 per encounter)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90834	N/A	90785	Psychotherapy w/patient and/or family member, 45 minutes	XE				$124.22	UN (1= 38-52 minutes; 1 per encounter)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90837	G2212	90785	Psychotherapy w/patient and/or family member, 60 minutes					$159.40	UN (1=53 68 minutes; 2 per encounter)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90837	G2212	90785	Psychotherapy w/patient and/or family member, 60 minutes	XE				$159.40	UN (1=53 68 minutes; 2 per encounter)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90846	N/A	N/A	Family psychotherapy w/o patient					$31.37	UN (1=15 minutes; 1 or more)	No	03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90846	N/A	N/A	Family psychotherapy w/o patient	XE				$31.37	UN (1=15 minutes; 1 or more)	No	03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90846	N/A	N/A	Family psychotherapy w/o patient	HK				$31.37	UN (1=15 minutes; 1 or more)	No	03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90846	N/A	N/A	Family psychotherapy w/o patient	HK	XE			$31.37	UN (1=15 minutes; 1 or more)	No	03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90847	N/A	N/A	Family psychotherapy w/ patient present					$35.38	UN (1=15 minutes; 1 or more)	No	03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90847	N/A	N/A	Family psychotherapy w/ patient present	XE				$35.38	UN (1=15 minutes; 1 or more)	No	03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90847	N/A	N/A	Family psychotherapy w/o patient	HK				$35.38	UN (1=15 minutes; 1 or more)	No	03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90847	N/A	N/A	Family psychotherapy w/o patient	HK	XE			$35.38	UN (1=15 minutes; 1 or more)	No	03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90849	N/A	N/A	Multifamily group psychotherapy					$42.35	UN (1=15 minutes; 1 or more)	No	09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90849	N/A	N/A	Multifamily group psychotherapy	XE				$42.35	UN (1=15 minutes; 1 or more)	No	09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90853	N/A	90785	Group Psychotherapy					$41.26	UN (1=15 minutes; 1 or more)	No	09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
90853	N/A	90785	Group Psychotherapy	XE				$41.26	UN (1=15 minutes; 1 or more)	No	09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96372	N/A	N/A	Injection for ther/proph/diag purposes SQ or IM					$59.81	UN (1 per ENC)	No	11, 12, 53, 56, *57	FFS
99202	90833 90836 90838	90785	Office/OP visit, new patient, straightforward MDM, 15 minutes must be met or exceeded	52				$85.82	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

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99202	90833 90836 90838	90785	Office/OP visit, new patient, straightforward MDM, 15 minutes must be met or exceeded	53				$85.82	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99202	90833 90836 90838	90785	Office/OP visit, new patient, straightforward MDM, 15 minutes must be met or exceeded					$85.82	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99203	90833 90836 90838	90785	Office/OP visit, new patient, low MDM, 30 minutes must be met or exceeded	52				$128.32	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99203	90833 90836 90838	90785	Office/OP visit, new patient, low MDM, 30 minutes must be met or exceeded	53				$128.32	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99203	90833 90836 90838	90785	Office/OP visit, new patient, low MDM, 30 minutes must be met or exceeded					$128.32	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99204	90833 90836 90838	90785	Office/OP visit, new patient, moderate MDM; 45 minutes must be met or exceeded	52				$184.59	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99204	90833 90836 90838	90785	Office/OP visit, new patient, moderate MDM; 45 minutes must be met or exceeded	53				$184.59	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99204	90833 90836 90838	90785	Office/OP visit, new patient, moderate MDM; 45 minutes must be met or exceeded					$184.59	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99205	G2212	90785	Office/OP visit, new patient, high MDM; 60 minutes must be met or exceeded	52				$465.47 MD/DO $258.55 NP	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99205	G2212	90785	Office/OP visit, new patient, high MDM; 60 minutes must be met or exceeded	53				$465.47 MD/DO $258.55 NP	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99205	G2212	90785	Office/OP visit, new patient, high MDM; 60 minutes must be met or exceeded					$465.47 MD/DO $258.55 NP	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99211	90833 90836 90838	90785	Office/OP visit, established patient, may not require physician/QHP, minimal presenting problem					$38.07 MD/DO $21.55 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99211	90833 90836 90838	90785	Office/OP visit, established patient, may not require physician/QHP, minimal presenting problem	25				$38.07 MD/DO $21.55 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99212	90833 90836 90838	90785	Office/OP visit, established patient, straightforward MDM, 10-19 minutes total time of encounter					$76.14 MD/DO $43.07 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99212	90833 90836 90838	90785	Office/OP visit, established patient, straightforward MDM, 10-19 minutes total time of encounter	25				$76.14 MD/DO $43.07 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99213	90833 90836 90838	90785	Office/OP visit, established patient, low MDM, 20-29 minutes total time of encounter					$112.98 MD/DO $64.64 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99213	90833 90836 90838	90785	Office/OP visit, established patient, low MDM, 20-29 minutes total time of encounter	25				$112.98 MD/DO $64.64 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

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99214	90833 90836 90838	90785	Office/OP visit, established patient, moderate MDM, 30-39 minutes total time of encounter					$190.36 MD/DO $107.73 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99214	90833 90836 90838	90785	Office/OP visit, established patient, moderate MDM, 30-39 minutes total time of encounter	25				$190.36 MD/DO $107.73 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99215	G2212	90785	Office/OP visit, established patient, high MDM, 40-54 minutes total time of encounter					$304.57 MD/DO $173.26 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99215	G2212	90785	Office/OP visit, established patient, high MDM, 40-54 minutes total time of encounter	25				$304.57 MD/DO $173.26 NP	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99304	N/A	90785	Initial visit at nursing facility E/M, per day, low severity, 25 minutes w/patient and/or family/caretaker	52				$99.90	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99304	N/A	90785	Initial visit at nursing facility E/M, per day, low severity, 25 minutes w/patient and/or family/caretaker	53				$99.90	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99304	N/A	90785	Initial visit at nursing facility E/M, per day, low severity, 25 minutes w/patient and/or family/caretaker					$99.90	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99305	N/A	90785	Initial visit at nursing facility E/M, per day, moderate severity, 35 minutes w/patient and/or family/caretaker	52				$132.62	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99305	N/A	90785	Initial visit at nursing facility E/M, per day, moderate severity, 35 minutes w/patient and/or family/caretaker	53				$132.62	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99305	N/A	90785	Initial visit at nursing facility E/M, per day, moderate severity, 35 minutes w/patient and/or family/caretaker					$132.62	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99306	G0317	90785	Initial visit at nursing facility E/M, per day, high severity, 45 minutes w/patient and/or family/caretaker	52				$163.06	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99306	G0317	90785	Initial visit at nursing facility E/M, per day, high severity, 45 minutes w/patient and/or family/caretaker	53				$163.06	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99306	G0317	90785	Initial visit at nursing facility E/M, per day, high severity, 45 minutes w/patient and/or family/caretaker					$163.06	UN (1 per ENC)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99307	N/A	90785	Subseqt. nursing facility visit, per day, E&M (patient stable, recovering, or improving; 10 mins w/ the PT and/or fam. or caregiver must be met or exceeded)					$51.67	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99307	N/A	90785	Subseqt. nursing facility visit, per day, E&M (patient stable, recovering, or improving; 10 mins w/ the PT and/or fam. or caregiver must be met or exceeded)	25				$51.67	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

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99308	N/A	90785	Subsequent nursing facility visit, per day, E&M (patient is responding inadequately to therapy or has developed a minor complication; 15 mins w/ the PT and/or fam. or caregiver must be met or exceeded)					$86.12	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99308	N/A	90785	Subsequent nursing facility visit, per day, E&M (patient is responding inadequately to therapy or has developed a minor complication; 15 mins w/ the PT and/or fam. or caregiver must be met or exceeded)	25				$86.12	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99309	N/A	90785	Subsequent nursing facility visit, per day, E&M (patient has developed a significant complication or a significant new prob.; 25 mins w/ the PT and/or fam. or caregiver must be met or exceeded)					$120.57	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99309	N/A	90785	Subsequent nursing facility visit, per day, E&M (patient has developed a significant complication or a significant new prob.; 25 mins w/ the PT and/or fam. or caregiver must be met or exceeded)	25				$120.57	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99310	G0317	90785	Subsequent nursing facility visit, per day, E&M (patient may be unstable or may have developed a significant new problem requiring immediate physician attention; 35 mins w/ the PT and/or fam. or caregiver must be met or exceeded)					$151.01	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99310	G0317	90785	Subsequent nursing facility visit, per day, E&M (patient may be unstable or may have developed a significant new problem requiring immediate physician attention; 35 mins w/ the PT and/or fam. or caregiver must be met or exceeded)	25				$151.01	UN (1 per ENC)	No	*02, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
99341	N/A	90785	Home visit for new patient E/M, low severity, 20 minutes face-face w/patient and/or family	52				$41.31	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99341	N/A	90785	Home visit for new patient E/M, low severity, 20 minutes face-face w/patient and/or family	53				$41.31	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99341	N/A	90785	Home visit for new patient E/M, low severity, 20 minutes face-face w/patient and/or family	HK				$41.31	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99341	N/A	90785	Home visit for new patient E/M, low severity, 20 minutes face-face w/patient and/or family					$41.31	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99342	N/A	90785	Home visit for new patient E/M, moderate severity, 30 minutes face-face w/patient and/or family	52				$59.43	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS

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99342	N/A	90785	Home visit for new patient E/M, moderate severity, 30 minutes face-face w/patient and/or family	53				$59.43	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99342	N/A	90785	Home visit for new patient E/M, moderate severity, 30 minutes face-face w/patient and/or family	HK				$59.43	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99342	N/A	90785	Home visit for new patient E/M, moderate severity, 30 minutes face-face w/patient and/or family					$59.43	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99344	N/A	90785	Home visit for new patient E/M, high severity, 60 minutes face-face w/patient and/or family	52				$136.45	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99344	N/A	90785	Home visit for new patient E/M, high severity, 60 minutes face-face w/patient and/or family	53				$136.45	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99344	N/A	90785	Home visit for new patient E/M, high severity, 60 minutes face-face w/patient and/or family	HK				$136.45	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99344	N/A	90785	Home visit for new patient E/M, high severity, 60 minutes face-face w/patient and/or family					$136.45	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99345	G0318	90785	Home visit for new patient E/M, unstable or has developed a significant new problem requiring immediate physician attention, 75 minutes face-face w/patient and/or family	52				$165.51	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99345	G0318	90785	Home visit for new patient E/M, unstable or has developed a significant new problem requiring immediate physician attention, 75 minutes face-face w/patient and/or family	53				$165.51	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99345	G0318	90785	Home visit for new patient E/M, unstable or has developed a significant new problem requiring immediate physician attention, 75 minutes face-face w/patient and/or family	HK				$165.51	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99345	G0318	90785	Home visit for new patient E/M, unstable or has developed a significant new problem requiring immediate physician attention, 75 minutes face-face w/patient and/or family					$165.51	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99347	90833 90836 90838	90785	Home or residence visit for establ. PT E&M (problem(s) are self- limited or minor; 20 mins are spent face - face w/ the PT and/or fam must be met or exceeded)					$41.58	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99347	90833 90836 90838	90785	Home or residence visit for establ. PT E&M (problem(s) are self- limited or minor; 20 mins are spent face - face w/ the PT and/or fam must be met or exceeded)	25				$41.58	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99348	90833 90836 90838	90785	Home or residence visit for estab. PT E&M (problems(s) of low to moderate severity; 30 mins spent face - face w/ the PT and/or fam must be met or exceeded)					$63.16	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99348	90833 90836 90838	90785	Home or residence visit for estab. PT E&M (problems(s) of low to moderate severity; 30 mins spent face - face w/ the PT and/or fam must be met or exceeded)	25				$63.16	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS

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99349	90833 90836 90838	90785	Home or residence visit for estab. PT E&M (problem(s) of moderate to high severity; 40 mins spent face - face w/ the PT and/or fam must be met or exceeded)					$96.20	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99349	90833 90836 90838	90785	Home or residence visit for estab. PT E&M (problem(s) of moderate to high severity; 40 mins spent face - face w/ the PT and/or fam must be met or exceeded)	25				$96.20	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99350	90833 90836 90838	90785	Home or residence visit for estab. PT. E&M (problem(s) of moderate to high severity. The patient may be unstable or may have developed a significant new prob. Req. immediate MD attention; 60 mins spent face - face w/ the PT and/or fam must be met or exceeded)					$133.25	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
99350	90833 90836 90838	90785	Home or residence visit for estab. PT. E&M (problem(s) of moderate to high severity. The patient may be unstable or may have developed a significant new prob. Req. immediate MD attention; 60 mins spent face - face w/ the PT and/or fam must be met or exceeded)	25				$133.25	UN (1 per ENC)	No	12, 13, 15, 32, 33, 34, 99	FFS
Add on 90833	N/A	90785	Psychotherapy, w/ PT and/or fam. mem., approx. 30 minutes, performed w/ an E/M code					$45.10	UN (1= 16-37 minutes; 1 per encounter)	N/A	Same as Primary CPT / Rev Code	FFS
Add on 90836	N/A	90785	Psychotherapy approx. 45 minutes w/ PT and/or fam. mem.; performed w/ an E/M service					$57.11	UN (1= 38-52 minutes; 1 per encounter)	N/A	Same as Primary CPT / Rev Code	FFS
Add on 90838	N/A	90785	Psychotherapy approx. 60 minutes w/ PT and/or fam. mem.; performed w/ an E/M service					$75.74	UN (1=53 68 minutes; 1 per encounter)	N/A	Same as Primary CPT / Rev Code	FFS
Add on 90785	N/A	N/A	Interactive complexity					$9.34	UN (1 per ENC)	N/A	Same as Primary CPT / Rev Code	FFS
Add on G0317	N/A	90785	Prolonged nursing facility visit, each additional 15 minutes by the physician or other qualified professional with or without patient contact					$22.23	UN (1 = 15 min.)	N/A	*02, 03, 09, *10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
Add on G0318	N/A	90785	Prolonged home or residence visit, each additional 15 minutes by the physician or other qualified professional with or without patient contact					$21.76	UN (1 = 15 min.)	N/A	12, 13, 15, 32, 33, 34, 99	FFS
Add on G2212	N/A	N/A	Prolonged office/OP visit, each additional 15 minutes					$23.03	UN (1 = 15 min.)	N/A	Same as Primary CPT / Rev Code	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	HK				$39.86	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Requir	Place of Service (POS)	Payment Type
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	HK	XE			$39.86	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes					$39.86	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	XE				$39.86	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0023	N/A	N/A	Behavioral Health Care Coordination and Community Integration (formally RCM)	XE				$113.93	UN (1 per encounter)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Care Coordination and Community Integration (formally RCM)					$113.93	UN (1 per encounter)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service (Intake)	U9				$113.93	UN (1 per encounter)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service (Intake)	U9	52			$113.93	UN (1 per encounter)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service (Intake)	U9	53			$113.93	UN (1 per encounter)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0025	N/A	N/A	BH prev. educ. services (delivery of services with target population to affect knowledge, attitude and/or behavior)					$10.36	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0025	N/A	N/A	BH prev. educ. services (delivery of services with target population to affect knowledge, attitude and/or behavior)	XE				$10.36	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0031	N/A	N/A	MH health assessment by non-MD	52				$49.15	UN (1= 15minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0031	N/A	N/A	MH health assessment by non-MD	53				$49.15	UN (1= 15minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0031	N/A	90785	MH health assessment by non-MD	HK				$49.15	UN (1= 15minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0031	N/A	90785	MH health assessment by non-MD					$49.15	UN (1= 15minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0032	N/A	N/A	MH services plan dev by non-MD	HT				$158.61	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0032	N/A	N/A	MH services plan dev by non-MD	HT	XE			$158.61	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0032	N/A	N/A	MH services plan dev by non-MD					$158.61	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0032	N/A	N/A	MH services plan dev by non-MD	XE				$158.61	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0033	N/A	N/A	Oral Medication administration direct observation					$11.02	UN (1=15 minutes; 1 or more)	No	04, 11, 12, 15, 13, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0033	N/A	N/A	Oral Medication administration direct observation	XE				$11.02	UN (1=15 minutes; 1 or more)	No	04, 11, 12, 15, 13, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Requir	Place of Service (POS)	Payme nt Type
H0034	N/A	N/A	Medication training and support, per 15 minutes					$10.10	UN (1=15 minutes; 1 or more)	No	04, 11, 12, 15, 13, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0034	N/A	N/A	Medication training and support, per 15 minutes	XE				$10.10	UN (1=15 minutes; 1 or more)	No	04, 11, 12, 15, 13, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0035	N/A	N/A	Mental health partial hospitalization, treatment, less than 24 hours	HK				$135.20	UN (1= a day; 1 per encounter)	Ye s	03, 11, 19, 22, 50, 51, 52, 53, 56, *57, 99	FFS
H0035	N/A	N/A	Mental health partial hospitalization, treatment, less than 24 hours	HK	HH			$135.20	UN (1= a day; 1 per encounter)	Ye s	03, 11, 19, 22, 50, 51, 52, 53, 56, *57, 99	FFS
H0035	N/A	N/A	Mental health partial hospitalization, treatment, less than 24 hours	HK	U6			$135.20	UN (1= a day; 1 per encounter)	Ye s	03, 11, 19, 22, 50, 51, 52, 53, 56, *57, 99	FFS
H0035	N/A	N/A	Mental health partial hospitalization, treatment, less than 24 hours	HK	HA			$135.20	UN (1= a day; 1 per encounter)	Ye s	03, 11, 19, 22, 50, 51, 52, 53, 56, *57, 99	FFS
H0036	N/A	N/A	Community psychotherapy face-face supplemental treatment, per 15 minutes	HK				$8.80	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0036	N/A	N/A	Community psychotherapy face-face supplemental treatment, per 15 minutes	HK	XE			$8.80	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0036	N/A	N/A	Community psychotherapy face-face supplemental treatment, per 15 minutes					$8.80	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0036	N/A	N/A	Community psychotherapy face-face supplemental treatment, per 15 minutes	XE				$8.80	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0038	N/A	N/A	Self-help/peer services, per 15 minutes					$33.26	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57, 99	FFS
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	XE				$33.26	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57, 99	FFS
H0046	N/A	N/A	Mental health services, NOS, less than 15 minutes	HK				$44.80	UN (1=<15 minutes; 1 per encounter)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0046	N/A	N/A	Mental health services, NOS, less than 15 minutes	HK	XE			$44.80	UN (1=<15 minutes; 1 per encounter)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0046	N/A	N/A	Mental health services, NOS	UB				$44.80	UN (1=<15 minutes; 1 per encounter)	No	03, 04, 06, 09, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72 99	FFS
H0046	N/A	N/A	Mental health services, NOS, less than 15 minutes					$44.80	UN (1=<15 minutes; 1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0046	N/A	N/A	Mental health services, NOS, less than 15 minutes	XE				$44.80	UN (1=<15 minutes; 1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2012	N/A	N/A	Behavioral Health Day Treatment, per hour					$17.04	UN (1= hour; 1 or more)	Ye s	11, 15, 19, 22, 53, 99	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Requir	Place of Service (POS)	Payme nt Type
H2012	N/A	N/A	Behavioral Health Day Treatment, per hour	HH				$17.04	UN (1= hour; 1 or more)	Ye s	11, 15, 19, 22, 53, 99	FFS
H2012	N/A	N/A	Behavioral Health Day Treatment, per hour	HH	XE			$17.04	UN (1= hour; 1 or more)	Ye s	11, 15, 19, 22, 53, 99	FFS
H2012	N/A	N/A	Behavioral Health Day Treatment, per hour	XE				$17.04	UN (1= hour; 1 or more)	Ye s	11, 15, 19, 22, 53, 99	FFS
H2014	N/A	N/A	Skills training and development, per 15 minutes					$18.18	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2014	N/A	N/A	Skills training and development, per 15 minutes	XE				$18.18	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2015	N/A	N/A	Comprehensive community support services, per 15 minutes	XE				$42.37	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2015	N/A	N/A	Comprehensive community support services, per 15 minutes					$42.37	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2017	N/A	N/A	Psychosocial rehabilitation services, per 15 minutes					$18.22	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2017	N/A	N/A	Psychosocial rehabilitation services, per 15 minutes	XE				$18.22	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2021	N/A	N/A	Comm. based wraparound services, per 15 min					$33.26	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2021	N/A	N/A	Comm. based wraparound services, per 15 min	XE				$33.26	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2022	N/A	N/A	Community wraparound service, per diem					$55.51	UN (1=a day; 1 per encounter) All-Inclusive per diem	No	03, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2023	N/A	N/A	Supported employ, per 15 min					$33.26	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2023	N/A	N/A	Supported employ, per 15 min	XE				$33.26	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2025	N/A	N/A	Supported maintenance employ, per 15 min					$33.26	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2025	N/A	N/A	Supported maintenance employ, per 15 min	XE				$33.26	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2027	N/A	N/A	Psycho-education service, per 15 minutes					$18.35	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2027	N/A	N/A	Psycho-education service, per 15 minutes	XE				$18.35	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Requir	Place of Service (POS)	Payment Type
H2031	N/A	N/A	MH clubhouse services, per diem					$27.80	UN (1= a day; 1 or more) All-Inclusive per diem	Yes	11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H2033	N/A	90785	Multisystem therapy for juveniles, per 15 minutes					$21.49	UN (1=15 minutes; 1 or more)	No	03, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
S9446	N/A	N/A	PT educ., not otherwise classified, by non- physician provider, in group setting, per session					$19.04	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
S9446	N/A	N/A	PT educ., not otherwise classified, by non- physician provider, in group setting, per session	XE				$19.04	UN (1=15 minutes; 1 or more)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
S9480	N/A	N/A	Intensive OP psychiatric services, per diem	HK				$38.78	UN (1=a day; 1 per encounter) All-Inclusive per diem	No	03, 11, 19, 22, 53, *57, 99	FFS
S9480	N/A	N/A	Intensive OP psychiatric services, per diem	HK	HH			$38.78	UN (1=a day; 1 per encounter) All-Inclusive per diem	No	03, 11, 19, 22, 53, *57, 99	FFS
S9480	N/A	N/A	Intensive OP psychiatric services, per diem	HK	U6			$38.78	UN (1=a day; 1 per encounter) All-Inclusive per diem	No	03, 11, 19, 22, 53, *57, 99	FFS
S9480	N/A	N/A	Intensive OP psychiatric services, per diem	HK	HA			$38.78	UN (1=a day; 1 per encounter) All-Inclusive per diem	No	03, 11, 19, 22, 53, *57, 99	FFS
S9484	N/A	N/A	Crisis intervention, per hour	HK				$80.30	UN (1=1 hour; 1 or more)	No	11, 12, 15, 23, 53, 99	FFS
S9484	N/A	N/A	Crisis intervention, per hour	HK	XE			$80.30	UN (1=1 hour; 1 or more)	No	11, 12, 15, 23, 53, 99	FFS
S9484	N/A	N/A	Crisis intervention, per hour					$80.30	UN (1=1 hour; 1 or more)	No	02, 10, 11, 12, 15, 23, 53, 99	FFS
S9484	N/A	N/A	Crisis intervention, per hour	XE				$80.30	UN (1=1 hour; 1 or more)	No	02, 10, 11, 12, 15, 23, 53, 99	FFS
T1001	N/A	N/A	Nursing assessment / evaluation					$25.76	UN (1 per ENC)	No	03, 09, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
T1013	N/A	N/A	Sign Lang/Oral Interpreter Services (Note: submit prepaid claims for reporting and invoice for reimbursement)					$0.01	UN (1= 15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13,15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	Prepaid
T1013	N/A	N/A	Sign Lang/Oral Interpreter Services (Note: submit prepaid claims for reporting and invoice for reimbursement)	XE				$0.01	UN (1= 15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13,15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	Prepaid

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Requir	Place of Service (POS)	Payme nt Type
T1023	N/A	N/A	Program intake assessment screening to determine appropriateness of an individual for participation in a special program, project or treatment protocol, per encounter					$28.49	UN (1=15 minutes; 1 or more)	No	03, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
T1023	N/A	N/A	Program intake assessment screening to determine appropriateness of an individual for participation in a special program, project or treatment protocol, per encounter	XE				$28.49	UN (1=15 minutes; 1 or more)	No	03, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

Exhibit A-4.A19
SWGF Outpatient Substance Use Disorder Rate Schedule

This Exhibit contain the Service Codes and billing rates that are allowed under the SWGF fund code. Following the Rate Schedule is a table listing modifiers and their descriptions as well as a key to abbreviations that may be used in this Rate Schedule.

Please see Exhibit B-11 Substance Use Disorder Provisions for services without an associated Service Code that can be submitted via cost reimbursement invoice with prior approval from the Beacon Account Partnership Director for your Regional Service Area (RSA).

Please consult the current Service Encounter Reporting Instructions (SERI) for modifier definitions and uses.

Definitions

1. Payment Type:

    a. Fee for Service (FFS): Claims submitted for health care payments, also known as the Fee for Service (FFS) payment type, must be cleanly submitted within current Washington State Health Care Authority timely filing requirements in the format outlined in this Rate Schedule.

    b. Prepaid: Prepaid claims submitted for health care reporting purposes, also known as the Prepaid payment type, must be cleanly submitted to Carelon monthly in the format outlined in this Rate Schedule. Payment for services provided will be made according to the Payment Method identified in Exhibit B-2 Maximum Contract Amounts.

SWGF Rate Schedule.A19: Outpatient Substance Use Disorder (SUD)

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Require	Place of Service (POS)	Payment Type
96164	96165	N/A	BH Intervention w/ grp (2 or more) face to face, first 30 minutes	HD	U5			$36.18 Y $31.04 A	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96164	96165	N/A	BH Intervention w/ grp (2 or more) face to face, first 30 minutes	HD	U5	XE		$36.18 Y $31.04 A	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96164	96165	N/A	BH Intervention w/ grp (2 or more) face to face, first 30 minutes	HD				$36.18 Y $31.04 A	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96164	96165	N/A	BH Intervention w/ grp (2 or more) face to face, first 30 minutes	HD	XE			$36.18 Y $31.04 A	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96164	96165	N/A	BH Intervention w/ grp (2 or more) face to face, first 30 minutes	U5				$36.18 Y $31.04 A	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96164	96165	N/A	BH Intervention w/ grp (2 or more) face to face, first 30 minutes	U5	XE			$36.18 Y $31.04 A	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Require	Place of Service (POS)	Payment Type
96164	96165	N/A	BH Intervention w/ grp (2 or more) face to face, first 30 minutes					$36.18 Y $31.04 A	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96164	96165	N/A	BH Intervention w/ grp (2 or more) face to face, first 30 minutes	XE				$36.18 Y $31.04 A	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96167	96168	N/A	BH Intervention w/ family & patient face to face, first 30 minutes	HD				$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96167	96168	N/A	BH Intervention w/ family & patient face to face, first 30 minutes	HD	XE			$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96167	96168	N/A	BH Intervention w/ family & patient face to face, first 30 minutes	HD	U5			$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96167	96168	N/A	BH Intervention w/ family & patient face to face, first 30 minutes	HD	U5	XE		$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96167	96168	N/A	BH Intervention w/ family & patient face to face, first 30 minutes	U5				$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96167	96168	N/A	BH Intervention w/ family & patient face to face, first 30 minutes	U5	XE			$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96167	96168	N/A	BH Intervention w/ family & patient face to face, first 30 minutes					$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96167	96168	N/A	BH Intervention w/ family & patient face to face, first 30 minutes	XE				$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96170	96171	N/A	BH Intervention w/ family, no patient, face to face, first 30 minutes	HD				$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96170	96171	N/A	BH Intervention w/ family, no patient, face to face, first 30 minutes	HD	XE			$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96170	96171	N/A	BH Intervention w/ family, no patient, face to face, first 30 minutes	HD	U5			$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96170	96171	N/A	BH Intervention w/ family, no patient, face to face, first 30 minutes	HD	U5	XE		$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96170	96171	N/A	BH Intervention w/ family, no patient, face to face, first 30 minutes	U5				$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Require	Place of Service (POS)	Payment Type
96170	96171	N/A	BH Intervention w/ family, no patient, face to face, first 30 minutes	U5	XE			$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96170	96171	N/A	BH Intervention w/ family, no patient, face to face, first 30 minutes					$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
96170	96171	N/A	BH Intervention w/ family, no patient, face to face, first 30 minutes	XE				$62.70	UN (1=30 minutes)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
Add on 96165	N/A	N/A	Behav. Hlth Intrvtn. w/ grp (2 or more), face-to-face; each additional 15 minutes					$13.59 Y $11.81 A	UN (1=15 minutes; 1 or more)	N/A	Same as Primary CTP / Rev Code	FFS
Add on 96168	N/A	N/A	Behav. Hlth Intrvtn. w/ fam. & pt. face to face, each additional 15 minutes					$31.34	UN (1=15 minutes; 1 or more)	N/A	Same as Primary CTP / Rev Code	FFS
Add on 96171	N/A	N/A	Behav.Hlth. Intrvtn. w/ fam; no pt, face to face, each additional 15 minutes					$31.34	UN (1=15 minutes; 1 or more)	N/A	Same as Primary CTP / Rev Code	FFS
H0001	N/A	N/A	Alcohol/drug assessment	52				$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	53				$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	HD				$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	HD	U5			$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	HD	U5	52		$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	HD	U5	53		$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	HD	52			$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	HD	53			$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	U5	52			$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	U5	53			$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment	U5				$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0001	N/A	N/A	Alcohol/drug assessment					$42.83	UN (1=15 minutes; 1 or more)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Require	Place of Service (POS)	Payment Type
H0003	N/A	N/A	Presumptive Drug Class Screening (analysis completed onsite by provider and billed by provider)					$25.84	UN (1 per UA)	No	03, 09, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	HD	U5			$37.32	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	HD	U5	XE		$37.32	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	HD				$37.32	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	HD	XE			$37.32	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	U5				$37.32	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	U5	XE			$37.32	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes					$37.32	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0004	N/A	N/A	BH counseling and therapy, per 15 minutes	XE				$37.32	UN (1=15 minutes; 1 or more)	No	*02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0020	N/A	N/A	Alcohol/drug services; MAT admin. /dispense services by a licensed program	HD				$20.42	Unit (1 per encounter)	No	11, 15, 19, 22, 53, 57	FFS
H0020	N/A	N/A	Alcohol/drug services; MAT admin. /dispense services by a licensed program	TF	HD			$20.42	Unit (1 per encounter)	No	11, 19, 22, 53, 57	FFS
H0020	N/A	N/A	Alcohol/drug services; MAT admin. /dispense services by a licensed program	HD	U5			$20.42	Unit (1 per encounter)	No	11, 15, 19, 22, 53, 57	FFS
H0020	N/A	N/A	Alcohol/drug services; MAT admin. /dispense services by a licensed program	TF	HD	U5		$20.42	Unit (1 per encounter)	No	11, 15, 19, 22, 53, 57	FFS
H0020	N/A	N/A	Alcohol/drug services; MAT admin. /dispense services by a licensed program	U5				$20.42	Unit (1 per encounter)	No	11, 15, 19, 22, 53, 57	FFS
H0020	N/A	N/A	Alcohol/drug services; MAT admin. /dispense services by a licensed program	TF	U5			$20.42	Unit (1 per encounter)	No	11, 15, 19, 22, 53, 57	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Require	Place of Service (POS)	Payment Type
H0020	N/A	N/A	Alcohol/drug services; MAT admin. /dispense services by a licensed program					$20.42	Unit (1 per encounter)	No	11, 15, 19, 22, 53, 57	FFS
H0020	N/A	N/A	Alcohol/drug services; MAT admin. /dispense services by a licensed program	TF				$20.42	Unit (1 per encounter)	No	11, 15, 19, 22, 53, 57	FFS
H0020	N/A	N/A	Alcohol/drug services; MAT admin. /dispense services by a licensed program	TF	XE			$20.42	Unit (1 per encounter)	No	11, 15, 19, 22, 53, 57	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service	HW				$113.93	UN (1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 21, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service	HW	HD	U5		$113.93	UN (1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 21, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service	HW	U5			$113.93	UN (1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 21, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service	HW	XE			$113.93	UN (1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 21, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service	HW	HD	XE		$113.93	UN (1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 21, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service	HW	HD	U5	XE	$113.93	UN (1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 21, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Outreach Service	HW	U5	XE		$113.93	UN (1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 21, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Care Coordination and Community Integration (formally RCM)	XE				$113.93	UN (1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0023	N/A	N/A	Behavioral Health Care Coordination and Community Integration (formally RCM)					$113.93	UN (1 per encounter)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72, 99	FFS
H0025	N/A	N/A	Behavior Health Prevention Education	HD				$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0025	N/A	N/A	Behavior Health Prevention Education	HD	XE			$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0025	N/A	N/A	Behavior Health Prevention Education	HD	U5			$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Require	Place of Service (POS)	Payment Type
H0025	N/A	N/A	Behavior Health Prevention Education	HD	U5	XE		$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0025	N/A	N/A	Behavior Health Prevention Education	U5				$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0025	N/A	N/A	Behavior Health Prevention Education	U5	XE			$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0025	N/A	N/A	Behavior Health Prevention Education	U5	HD			$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0025	N/A	N/A	Behavior Health Prevention Education	U5	HD	XE		$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0025	N/A	N/A	Behavior Health Prevention Education					$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0025	N/A	N/A	Behavior Health Prevention Education	XE				$19.38	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0026	N/A	N/A	Alcohol / drug prevention	HD	U5			$14.54	UN (1 per encounter)	No	02, 03, 10, 15, 99	FFS
H0026	N/A	N/A	Alcohol / drug prevention	HD	U5	XE		$14.54	UN (1 per encounter)	No	02, 03, 10, 15, 99	FFS
H0026	N/A	N/A	Alcohol / drug prevention	HD				$14.54	UN (1 per encounter)	No	02, 03, 10, 15, 99	FFS
H0026	N/A	N/A	Alcohol / drug prevention	U5				$14.54	UN (1 per encounter)	No	02, 03, 10, 15, 99	FFS
H0026	N/A	N/A	Alcohol / drug prevention					$14.54	UN (1 per encounter)	No	02, 03, 10, 15, 99	FFS
H0038	N/A	N/A	Self-help/peer services, per 15 minutes					$15.89	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57, 99	FFS
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	XE				$15.89	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57, 99	FFS
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HD	U5			$15.89	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57	FFS
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HD	U5	XE		$15.89	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57	FFS
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HD				$15.89	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57	FFS
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	HD	XE			$15.89	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57	FFS
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	U5				$15.89	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Require	Place of Service (POS)	Payment Type
H0038	N/A	N/A	Self-help/peer services, per 15 minutes	U5	XE			$15.89	UN (1=15 minutes; 1 or more)	No	11, 12, 15, 16, 53, *57	FFS
H0046	N/A	N/A	Mental health services, NOS, less than 15 minutes	UB				$36.24	UN (1=<15 minutes; 1 per encounter)	No	03, 04, 06, 09, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 31, 32, 51, 53, 55, 56, *57, 62, 71, 72 99	FFS
H0047	N/A	N/A	Alcohol / drug abuse svc, NOS	HD	U5			$36.24	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0047	N/A	N/A	Alcohol / drug abuse svc, NOS	HD	U5	XE		$36.24	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0047	N/A	N/A	Alcohol / drug abuse svc, NOS	HD				$36.24	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0047	N/A	N/A	Alcohol / drug abuse svc, NOS	HD	XE			$36.24	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0047	N/A	N/A	Alcohol / drug abuse svc, NOS	U5				$36.24	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0047	N/A	N/A	Alcohol / drug abuse svc, NOS	U5	XE			$36.24	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0047	N/A	N/A	Alcohol / drug abuse svc, NOS					$36.24	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0047	N/A	N/A	Alcohol / drug abuse svc, NOS	XE				$36.24	UN (1 per encounter)	No	02, 03, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0050	N/A	N/A	Alcohol/drug services, per 15 minutes	HD				$28.62	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0050	N/A	N/A	Alcohol/drug services, per 15 minutes	HD	XE			$28.62	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0050	N/A	N/A	Alcohol/drug services, per 15 minutes	HD	U5			$28.62	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0050	N/A	N/A	Alcohol/drug services, per 15 minutes	HD	U5	XE		$28.62	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0050	N/A	N/A	Alcohol/drug services, per 15 minutes	U5				$28.62	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS

Service Code	Allowed Add On Code(s)	Interactive Complexity Add On Code	Service Description SWGF	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate per Unit	Allowed Billing Unit	Auth Require	Place of Service (POS)	Payment Type
H0050	N/A	N/A	Alcohol/drug services, per 15 minutes	U5	XE			$28.62	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0050	N/A	N/A	Alcohol/drug services, per 15 minutes					$28.62	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
H0050	N/A	N/A	Alcohol/drug services, per 15 minutes	XE				$28.62	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	FFS
T1013	N/A	N/A	Sign Lang/Oral Interpreter Services (Note: submit prepaid claims for reporting and invoice for reimbursement)					$0.01	UN (1= 15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13,15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	Prepaid
T1013	N/A	N/A	Sign Lang/Oral Interpreter Services (Note: submit prepaid claims for reporting and invoice for reimbursement)	XE				$0.01	UN (1= 15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13,15, 19, 22, 32, 33, 34, 53, *57, 62, 71, 72	Prepaid
T1016	N/A	N/A	Case management, each 15 minutes	HD				$15.04	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
T1016	N/A	N/A	Case management, each 15 minutes	HD	XE			$15.04	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
T1016	N/A	N/A	Case management, each 15 minutes	U5				$15.04	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
T1016	N/A	N/A	Case management, each 15 minutes	U5	XE			$15.04	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
T1016	N/A	N/A	Case management, each 15 minutes					$15.04	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS
T1016	N/A	N/A	Case management, each 15 minutes	XE				$15.04	UN (1=15 minutes; 1 or more)	No	02, 03, 09, 10, 11, 12, 13, 15, 19, 22, 53, 57, 71, 72	FFS

Carelon shall have no obligation to pay for costs or claims in excess of the amounts listed below for the identified periods, unless this Exhibit is amended pursuant to the terms of the Agreement.

I: General Provisions.

(1) Whenever in this Exhibit B-2 the term "Facility" is used to describe an obligation or duty, such obligation or duty will also be the responsibility of each individual licensed health care practitioner, Facility, and provider employed or owned by or under contract with Facility, as the context may require.

(2) Facility agrees:

a. Capital Purchases made using funds in this agreement are to be utilized explicitly for the funded program under which the purchase was made. Assets for this program will be used at the level of 90% specifically. De minimus use will be allowed. If the program funding is discontinued, the State of Washington can decide to re-purpose the assets for the benefit of this or other programs. Capital purchases may include technology and transportation and other costs associated with operations.

i. Capital purchases $5,000 and over must receive prior approval from Carelon.

ii. When vehicle purchases are approved, a vehicle usage policy must be submitted to Carelon for approval.

1. The vehicle usage policy shall include maintenance of a Vehicle Usage Log to track, at a minimum, the following data: trip date, driver identification, passenger identification, and destination.

2. Facility agrees, at its sole expense, to obtain and maintain the following vehicle insurance:

a. Comprehensive motor vehicle coverage subject to limits of at least $1,000,000 for any one person, $1,000,000 for any one accident for bodily injury, and $1,000,000 for property damage, and uninsured motorist.

b. A Transportation Log shall be kept, separate from any Vehicle Usage Log, to track public transportation provided to Carelon eligible individuals funded under this agreement. When utilized, a copy of the Transportation Log shall be included with the monthly invoice.

i. The Transportation Log shall include a client ID, the date of purchase, the type of transportation purchased, the cost and the fund source.

II: Definitions.

(1) Claims, also known as Fee for Service (FFS) payment type, means an attempt to cause a health care payer to make a health care payment for a specified health care service.

(2) Prepaid claims, also known as the Prepaid payment type, means the transmission of information equivalent to a health care claim for a specified health care service for the purpose of health care reporting.

(3) Payment Method:

a. Fee for Service (FFS) means the Facility will submit clean claims within timely filing limits to receive payment for direct services provided.

b. Prepaid:

i. Capacity means the Facility will submit monthly invoices to Carelon for the funding period total divided by the number of months in the funding period and will also submit prepaid claims to document all direct services provided. Direct Services are those details in the current Rate Schedule(s). Prepaid claims must be submitted monthly for the previous month.

ii. Cost Reimbursement means the Facility will submit monthly invoices to Carelon for the deliverable, performance measure, or actual costs to be reimbursed up to the contract maximum and will also submit prepaid claims to document all direct services provided. Direct services are those detailed in the current Rate Schedule(s). Prepaid claims must be submitted monthly for the previous month. At a minimum, invoices should include itemization of staff time (hourly rate x items charged), overhead, supplies, deliverables, etc.

iii. Staffing means the Facility will submit monthly invoices to Carelon for the funding period total divided by the number of months in the funding period to obtain reimbursement for the funded staff. Invoices should not be submitted for vacant funded positions. If invoices are submitted for vacant funded positions they will not be paid. At a minimum, invoices should include the name and FTE for each position invoiced.

1. If funded staff provide direct services for which there is a service code in the Facility's rate schedule(s), that service code shall not be submitted to Carelon for FFS reimbursement. The service code shall be submitted as a prepaid claim for reporting purpose.

2. With prior approval, funds may be used for recruiting costs to fill vacant funded positions.

(4) Timely Filing Limit:

a. For all fund codes except Federal Block Grant (FBG), timely filing limit means Facility will submit FFS claims within current Washington State Health Care Authority timely filing requirements.

b. For FBG fund codes, timely filing limit means:

i. Mental Health Block Grant (MHBG),Substance Abuse Block Grant (SABG), MHBG American Rescue Plan Act (ARPA), and SABG ARPA FFS claims must be submitted by July 10, 2024 for dates of service betweenJuly 1, 2023 to December 31, 2023.

(5) Transportation Log means a log kept when public transportation such as bus passes, Uber, Lyft, or Taxis are provided to Carelon Eligible individuals funded under this agreement.

(6) Vehicle Usage Log means a log that tracks the usage of vehicles purchased with Carelon funds.

III: Maximum Contract Amounts.

(1) The following table outlines the maximum amounts funded under this contract for the stated period. Unspent funds from the first 6-month period may be spent in the second 6-month period. Unspent funds do not carry over after June 30, 2024.

(2) Monitoring Facility spending against the funds allocated in this Amendment is the responsibility of Facility. Carelon supports this responsibility by providing Facility with periodic Finance Memos that include payments made by Carelon to Facility and any remaining funds available for that fiscal year.

(3) Invoices shall be submitted monthly within 20 calendar days of the end of the month being billed. **Invoices not received within these timeframes may be denied for payment.**

a. Payment may be withheld if contractual obligations, including but not limited to the timely provision of required reports, are not met.

b. Invoices shall be submitted to the following email address, which is monitored multiple times each day: **BehavioralHealth_WAASO@carelon.com**.

(4) Behavioral Health Workforce Investment Program:

a. When dollars are allocated in the Maximum Contract Amounts table below for BH Workforce Investment Programs, the Facility must submit a final report on program outcomes. The final report is due when the funds have been expended ,or at the end of the current fiscal year, whichever comes first.

Table 1.A19 Skamania County
Maximum Contract Amounts
July 1, 2023 – June 30, 2024

Program or Service	Exhibit	Payment Method	Fund Source	Fund Code	Funding Period		
					July 2023 – Dec 2023	Jan 2024 – June 2024*	Total FY23/24
Workforce Investment (Base Amount)	B-2	Cost Reimbursement	Non-Medicaid State	N/A	$12,500	$14,375	$26,875
Mobile Crisis and Designated Crisis Responder Services	B-4	Capacity	Non-Medicaid State	SWRG	$8,016	$9,218	$17,234
			Medicaid		$8,650	$9,948	$18,598
Jail Transition Program	B-6	Capacity	Jail Services	SWJT	$1,272	$1,272	$2,544
Outpatient Mental Health Treatment	B-7	Fee For Service	Non-Medicaid State	SWGF	$1,365	$1,569	$2,934
Outpatient Substance Use Disorder (SUD) Treatment	B-11		Non-Medicaid State	SWGF	$1,365	$1,569	$2,934
						Grand Total	**$71,118**

**** Contingent upon Carelon's receipt of signed HCA Amendment confirming funding for this period.***

Exhibit B-4.A19

Crisis Program Provisions (Mobile Rapid Response Crisis Team (MRRCT) and Designated Crisis Responder)

This Exhibit contains additional provisions applicable to Covered Services rendered to Eligible Individuals (as defined below) covered under Crisis Program Provisions (as defined below) offered and/or administered by Washington State Health Care Authority (HCA). In the event of any conflict between the provisions of the Agreement (including Exhibit B-8), and this Exhibit B-4 and subject to the provisions set out in Exhibit B-4, the provisions of this Exhibit control as related to services rendered to individuals receiving Crisis Program Services.

I: General Provisions.

(1) Whenever in this Exhibit B-4 the term "Facility" is used to describe an obligation or duty, such obligation or duty will also be the responsibility of each individual licensed health care practitioner, Facility, and provider employed or owned by or under contract with Facility, as the context may require.

(2) Facility agrees:

a. Facility shall provide crisis intervention services in accordance with WAC 246-341; as well as the Carelon Level of Care Guidelines which are incorporated herein by reference.

b. Facility agrees to participate in MRRCT dispatch technology solutions and follow Carelon approved participation standards and guidelines.

c. Facility shall review and update Crisis Connections' standard Crisis Team Information Form on a monthly basis.

d. Crisis System Operations Requirements

i. Crisis Services shall be available 24 hours a day, seven (7) days a week.

ii. Crisis teams will respond in the following timeframes:

1. Triage calls within 15 minutes or less of initial request

2. Crisis services provided are available within two hours of contact for emergent, within 24 hours for an urgent behavioral health situation. Best practice is a response within 60 minutes for all call types.

iii. The goal for each MRRCT is to have the capacity to provide community-based services in the community 24 hours per day, seven days per week, 365 days per year with a two-person team (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.

iv. Implementation must include the following elements:

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

2. Each team will require at a minimum, a Mental Health Professional (MHP) 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 MHP is available 24/7 for any MHCP or peer to contact for consultation, this MHP does not have to be the supervisor.

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

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

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

    b. HCA sponsored Certified Crisis Intervention Specialist – II (CCIS-II) EDGE Approach training by July 1, 2024.

v. 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:

    1. Responders will provide developmentally appropriate services.

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

    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.

vi. 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.

e. MRRCT Outreach goals should:

i. 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.

ii. Support Individuals, youth, and families by providing trauma informed care.

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

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

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

f. Crisis System Staffing Requirements

i. Facility shall ensure compliance with applicable staffing requirements of WAC 246-341.

ii. Facility shall ensure they have sufficient staff available, including DCRs, to respond to requests for Crisis Services and ITA services, as applicable.

iii. Facility shall comply with DCR qualification requirements in accordance with Chapters 71.05 and 71.34 RCW and WAC 246-341-0901 and WAC 246-341-0912, and shall incorporate the statewide DCR Protocols, listed on the HCA website, into the practice of DCRs.

iv. DCRs must be designated by the county or other authority authorized in rule. DCR designation shall be documented in:

1. Credentialing rosters submitted to Carelon must include verification that the DCRs are authorized as such by the county or other authorized authority.

2. Monthly attestations confirming whether the DCR designation remains valid.

v. Facility shall ensure that staff are available for consultation 24 hours a day, seven (7) days a week who have expertise in Behavioral Health conditions pertaining to children and families.

vi. Facility shall have at least one Substance Use Disorder Professional (SUDP) and one Certified Peer Counselor (CPC) with experience providing Behavioral Health crisis support available for consultation by phone or on site. CPC's shall be available during regular Business Hours. Per WAC 246-341-0901, SUDP's shall be available 24 hours a day, 7 days a week.

vii. Facility shall have established ITA services policies and procedures, as applicable, that implement WAC 246-341-0901 and the following requirements:

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.

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./

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.

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.

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.

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.

7. Facility shall provide a wireless telephone or comparable device to every DCR or crisis worker, who participates in home visits to provide Crisis Services.

g. Facilities shall provide MRRCT outreach services in accordance with WAC 246-341 hereafter referred to as MRRCT Intervention services consistent with MRRCT technical specifications as well as the Carelon Level of Care Guidelines which are incorporated herein by reference.

h. If applicable, Facility shall provide Involuntary Treatment Act Services (ITA) in a manner that includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with WAC 246-341-0912 Chapters 71.05 RCW, 71.34 RCW, and 71.24.300 RCW. Crisis Services become Involuntary Treatment Act Services when a Designated Crisis Responder (DCR) determines an individual must be evaluated for involuntary treatment. The decision making authority of the DCR must be independent of Carelon's administration. Services 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. ITA services continue until the end of the involuntary commitment.

i. Facility shall respond in a full and timely manner to law enforcement inquiries regarding an Individual's eligibility to possess a firearm under RCW 9.41.040(2)(a)(ii).

j. Facility shall coordinate interventions with other community resources, including regional Managed Care Organization (MCO) when applicable, to provide an array of stabilization and recovery services and avoid unnecessary hospitalizations. For Individuals who are American Indian/Alaska Native (AI/AN), assist in connecting the Individual to services available from a Tribal government or Indian Health Care Provider (IHCP).

k. All contracted crisis providers under this Exhibit are delegated crisis providers under the following Managed Care Organization (MCO) networks: CCCWA, CHPW AH, AGPWA, Molina's Medicaid network and United's Washington Medicaid Network.

II: Definitions.

(1) Certified Peer Counselor (CPC): Individuals who: have self-identified as a consumer of behavioral health services, or are a parent or legal guardian of a child (under the age of 18) with lived experience with mental health or substance use services; have received specialized training provided/contracted by HCA's Division of Behavioral Health and Recovery (DBHR); have passed a written/oral test, which includes both written and oral components of the training; have passed a Washington State background check; have been certified by DBHR; and are a registered Agency Affiliated Counselor with the Department of Health (DOH).

(2) Co-responder: Teams consisting of first responder(s) and behavioral health professional(s) to engage with Individuals experiencing behavioral health crises.

(3) Conditional Release (CR): When a treating Facility determines that an Individual committed to an inpatient treatment Facility can be appropriately treated by outpatient treatment in the community prior to the end of the commitment period, the Individual may be discharged under a CR. A CR differs from a less restrictive order in that the CR is filed with the court, as opposed to being ordered by the court. The length of the CR is the amount of time that remains on the current inpatient commitment order.

(4) Crisis Hotline: This is the 24/7 regional crisis line that is available to all individuals in the region and serves as the front door to the crisis system.

(5) Crisis Program: The program is the provision of those crisis services further described within this Exhibit B-4 which are reimbursable pursuant to the contract between Carelon and the Washington State Health Care Authority.

(6) 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.

(7) Cultural Humility: The continuous application in professional practice of self-reflection and self-critique, learning from patients, and partnership building, with an awareness of the limited ability to understand the patient's worldview, culture(s), and communities.

(8) Culturally Appropriate Care: Health care services provided with Cultural Humility and an understanding of the patient's culture and community, and informed by Historical Trauma and the resulting cycle of Adverse Childhood Experiences (ACEs).

(9) Designated Crisis Responder (DCR): Means a person designated by the County or other authority authorized in rule, to perform the civil commitment duties described in Chapter 71.05 RCW.

(10) Eligible Individuals: For purposes of this Exhibit B-4, medically necessary Crisis Services will be available to all individuals who present with a need for Crisis Services in the Regional Service Area regardless of insurance status, ability to pay, county of residence, or level of income.

(11) Evaluation and Treatment (E&T) Facility: Means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency E&T, outpatient care, and timely and appropriate inpatient care to individuals suffering from a behavioral health disorder and who are at risk of harm or are gravely disabled, and which is licensed or certified as such by DOH. (RCW 71.05.020)

(12) First Responders: Means individuals with specialized training who are among the first to arrive and provide assistance at the scene of an emergency. First responders typically include law enforcement officers, firefighters, medical and hospital emergency rooms, and 911 call centers.

(13) Involuntary Treatment Act (ITA): Allows for individuals to be committed by court order to a hospital or facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to 120 hours, but, if necessary, individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days of inpatient involuntary treatment or outpatient involuntary treatment (RCW 71.05.180, 71.05.230 and 71.05.290).

(14) Involuntary Treatment Act Services: Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals civilly committed under the ITA in accordance with Chapters 71.05 and 71.34 RCW and RCW 71.24.300.

(15) Less Restrictive Alternative (LRA) Treatment: Means a program of individualized treatment in a less restrictive setting than inpatient treatment that include the services described in RCW 71.05.585.

(16) Less Restrictive Alternative (LRA) Treatment Order: If a court determines that an Individual committed to an inpatient Facility meets criteria for further treatment but finds that treatment in a less restrictive setting is a more appropriate placement and is in the best interest of the Individual or others, an LRA order may be issued. The LRA order remands the Individual to outpatient treatment by a Behavioral Health service provider in the community who is responsible for monitoring and providing LRA treatment. The Individual must receive at least a minimum set of services and follow the conditions outlined in the LRA order. The length of an LRA order is usually 90 or 180 days but in certain cases can be for up to one year. (RCW 71.05.320). An LRA order may be extended by a court.

(17) Mental Health Care Provider: Means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years' experience in the mental health or related fields. Additionally, this person would be supervised by a provider who meets the definition of a mental health professional and be an Agency Affiliated Counselor.

(18) Mental Health Professional (MHP): Means:

a. A psychiatrist, psychologist, psychiatric nurse, psychiatric nurse practitioner, physician assistant supervised by a psychiatrist, or social worker as defined in RCW 71.05.020;

b. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such persons shall have, in addition, at least two years of experience in direct

treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional;

c. A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;

d. A person who is licensed by DOH as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;

e. A person who has an approved exception to perform the duties of a Mental Health Professional; or

f. A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional.

(19) Mobile Crisis Intervention Program Technical Specifications: This a set of documents that describes in detail contracted program expectations for adult mobile crisis intervention (AMCI) and youth mobile crisis intervention (YMCI). It is a supplement to the Washington Provider Service Instruction Manual. It is available on Carelon's Washington website

(20) 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 serves 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.

(21) 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.

(22) Substance Use Disorder Professional (SUDP): An individual who is certified according to RCW 18.205.020 and the certification requirements of WAC 246-811-030 to provide SUD services.

(23) Triage: The sorting and allocation of treatment to patients according to the urgency of their need for care.

(24) Urgent Behavioral Health Situation: Means a behavioral health condition that requires attention and assessment within 24-hours, but which does not place the Individual in immediate danger to self or others and the Individual is able to cooperate with treatment.

(25) Withdrawal Management (previously known as detoxification): Care and treatment in a residential or hospital setting of persons intoxicated or incapacitated by alcohol or other drugs during the period in which the person is recovering from the transitory effects of intoxication or withdrawal. Acute detoxification provides medical care and physician supervision; subacute detoxification is non-medical.

III. Services. Facility agrees to:

(1) Interpreter services for Individuals in crisis over-the-telephone.

a. Facility will submit prepaid claim codes for interpretation provided over-the-phone to Individuals in crisis.

b. Reimbursable Services must meet the following criteria:

i. The Individuals must be Medicaid eligible on the date the service took place;

ii. The Individual received a Medicaid covered service by a servicing provider that has a Core Provider Agreement with HCA;

iii. The Interpretation requests must be for urgent same day events, necessary to assist Individuals determined to be in crisis;

iv. Services must be provided by a qualified interpreter as described by Section 1557 of the Affordable Care Act; and

v. The prepaid claim must be submitted to Carelon within forty-five (45) calendar days of the date of service.

c. Do not submit prepaid claim codes for administrative activities including but not limited to: scheduling or reminder calls, scheduled events, and appointments scheduled more than 24-hours in advance.

i. Scheduled events, or appointments scheduled more than 24-hours in advance must use the HCA Interpreter Services program. If the coordinating entity is unable to find an interpreter for the health care provider, the health care provider must provide interpreter services, seeking an outside resource.

(2) Deliver crisis response and intervention services, referral and linkage services to all individuals located in the designated Regional Service Area/County in accordance with CFR 42, WAC 246-341, current DCR protocols set out by the Division of Behavioral Health and Recovery (DBHR) (or its successor), and any other documents incorporated by reference.

(3) The Facility will implement the requirements of 2007-2008 Substitute House Bill 1456, including the provision of secondary personnel when deemed necessary by acting Crisis Supervisor, provision by Facility of a wireless telephone or comparable device for the purpose of emergency communication, and annual training on safety and violence prevention topics described in RCW 49.19.030 for all who work directly with clients. This act is known as the Marty Smith law.

(4) Crisis Services shall be delivered as follows:

a. Stabilize Individuals as quickly as possible and assist them in returning to a level of functioning that no longer qualifies them for Crisis Services.

b. Provide solution-focused, person-centered, and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, institutionalization, or out of home placement.

c. Coordinate closely with regional MCOs, community court system, Department of Corrections (DOC), jail-based staff, First Responders, criminal justice system, inpatient/residential service providers, Tribal governments, ICHPs, and outpatient behavioral health providers to include processes to improve access to timely and appropriate treatment for Individuals with current and or prior criminal justice involvement.

d. Engage the Individual in the development and implementation of crisis prevention plans to reduce unnecessary crisis system utilization and maintain the Individual's stability.

e. Develop and implement strategies to assess and improve the crisis system over time.

(5) Core MRRCT services the Facility shall provide include:

a. Coordination with co-responders within the region.

b. A comprehensive crisis assessment, including a mental status exam, crisis precipitants, behavioral health and physical health history, medication history and compliance, safety/risk issues with the individual and / or caregiver(s) / natural supports, and functioning at home, work, and community.

c. Providing support, information, understanding and consultation to caregiver(s) / natural supports who are likely experiencing (normal, but often overwhelming) stress, concern, and exhaustion so that they are best equipped to participate in the intervention, make decisions, and support their loved one.

d. Discussing and activating caregiver / natural support strengths and resources to identify how such strengths and resources impact their ability to care for the individual's behavioral health needs.

e. Assessing the individual's behavior and the responses of caregiver(s)/natural support and others to the individual's behavior

f. Identifying current providers, including state agency involvement.

g. Attempt to obtain Release of Information (ROIs) and document stakeholder coordination in the clinical record.

h. Ensure that all calls, services, appropriate coordination with Tribes and IHPCs, and outcomes are documented.

i. Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the individual and caregiver(s).

j. Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support.

k. Psychiatric consultation and urgent psychopharmacology intervention (if current prescribing provider cannot be reached immediately or if no current provider exists), as needed, from an on-call psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist.

l. Confirm whether the Individual has a Crisis Alert on file and get access to any risk management / safety plans, if available. If the Individual does not already have one, develop risk management / safety plan.

m. Provide crisis intervention, including solution-focused crisis counseling and brief interventions that address behavior and safety.

n. Referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

o. For adults who are receiving Program for Assertive Community Treatment (PACT) or similar program, or youth who are receiving Wraparound with Intensive Services (WISe) or similar program, MRRCT staff shall coordinate with the individual's care coordinator throughout the delivery of the MRRCT service.

p. The MRRCT shall coordinate with the individual's primary care provider, any other care management program, or other behavioral health providers providing services to the individual throughout the delivery of the MRRCT service.

q. Crisis Services (Behavioral Health) are not intended for the purposes of accessing respite, out-of-home placement, or outpatient treatment or to supplant existing front-line responses for adults receiving services from a primary provider (e.g. primary care, PACT, residential, etc.).

(6) Following completion of a Mobile Crisis Intervention, if the MRRCT clinician determines that DCR intervention may be medically necessary, the clinician will manage referrals and coordination of care.

a. MRRCT and DCR programs must coordinate and communicate daily to ensure effective community response management.

b. MRRCTs shall be utilized whenever possible to provide the initial response in order to maximize the efficiency

of limited DCR resources by helping to ensure DCRs respond to cases specific to RCW 71.05 .

(7) If the Facility provides DCR services, core services include:

a. Deliver Involuntary Treatment Act Services including all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with WAC 246-341-0912 , Chapter 71.05 RCW, 71.34 RCW and 71.24.300 RCW. The decision-making authority of the DCR shall be independent of Carelon Behavioral Health, Inc.

i. The Facility will have a process in place to determine if an individual is impaired due to the presence of substances in their system.

ii. The Facility will perform functions necessary for facilitation of voluntary psychiatric inpatient care and least restrictive alternative care, including all necessary documentation and administrative functions.

iii. The Facility shall implement a plan to provide appropriate treatment services to the Individual, which may include the development of Least Restrictive Alternatives (LRAs), or relapse prevention programs reasonably calculated to reduce demand for involuntary detentions to E&T facilities and Secure Withdrawal Management and Stabilization facilities.

iv. The Facility will monitor and track all individuals placed on Least Restrictive Alternatives (LRAs) and Conditional Release (CR) in the county/region in accordance with RCW 71.05.320, RCW 71.05.340, and RCW 71.05.585 respectively, and submit monthly updates to Carelon, using the template provided by Carelon. Updates shall include information on LRA treatment from the treatment provider.

v. The Facility shall report to HCA and Carelon when it is determined an Individual meets detention criteria under RCW 71.05.150, 71.05.153, 71.34.700 or 71.34.710 and there are no beds available at the Evaluation and Treatment Facility, Secure Withdrawal Management and Stabilization facility, psychiatric unit, or under a single bed certification, and the DCR was not able to arrange for a less restrictive alternative for the Individual.

vi. When the DCR determines an Individual meets detention criteria, the investigation has been completed and when no bed is available, the DCR shall submit an Unavailable Detention Facilities report (No Bed Report) to HCA and Carelon within 24 hours. The report shall include the following:

1. The date and time the investigation was completed;

2. A list of facilities that refused to admit the Individual;

3. Information sufficient to identify the Individual, including name and age or date of birth;

4. The identity of the responsible BH-ASO and MCO, if applicable;

5. The county in which the person met detention criteria; and

6. Other reporting elements deemed necessary or supportive by HCA.

vii. When a DCR submits a No Bed Report due to the lack of an involuntary treatment bed, a face-to-face re-assessment is conducted each day by the DCR or Mental Health Professional (MHP) employed by the crisis provider to verify that the person continues to require involuntary treatment. If a bed is still not available, the DCR sends a new Unavailable Detention Facilities Report (No Bed Report) to HCA and Carelon and the DCR or MHP works to develop a safety plan to help the person meet their health and safety needs, which includes the DCR or MHP continuing to search for an involuntary treatment bed or appropriate less restrictive alternative to meet the individual's current crisis.

b. The Facility will respond in person when requested by community stakeholders and providers unless: (1) there are significant safety issues identified, documented, and reported to Carelon; and / or (2) the requesting stakeholder or provider agree that a face-to-face response is not required.

c. The Facility will have clinicians available 24/7 who have expertise in behavioral health issues pertaining to adults, children, and families.

d. The Facility's community response time will be no longer than 2 hours or as mandated by WAC and RCW.

e. The Facility will seek less restrictive alternatives for all individuals served, with effort made to maintain an individual in their community, and voluntary placement when a higher level of care is clinically indicated. The Facility may provide crisis and community stabilization services, in accordance with WAC 246-341-0915, to stabilize individuals and assist them in returning to a level of functioning. These services may include brief counseling, skill building, case management, check-ins by phone or in person and other supportive services including engagement with family and significant others for support.

f. The Facility will coordinate with the outpatient provider system, including the MCO when appropriate, and participate in treatment planning and treatment team meetings when requested.

g. The Facility may provide targeted, short term interventions including next day immediate access to outpatient services and/or follow up care. These services may include the following:

i. Face to face therapeutic response

ii. Telephonic psychiatric consultation

iii. Solution focused crisis counseling, including teaching of coping and behavior management skills, mediation, parent/family support and psychoeducation

iv. Telephonic support to individual and family

v. Collateral contacts

(8) Facility will execute and maintain inter-agency agreements or memorandum of understanding (MOU) documenting the provision of applicable crisis services (Mobile Rapid Response Crisis Team, Designated Crisis Responder) with applicable key partner organizations including but not limited to school districts, child welfare, law enforcement, emergency services, hospitals, providers, etc.

(9) Partner with Carelon to organize and facilitate community forum(s), on an agreed upon frequency, for the purposes of obtaining feedback about crisis services, identifying service gaps, and ensuring crisis services are responsive to the unique needs of communities within the region.

(10) Implement a client satisfaction survey for individuals served through crisis services and report data to Carelon and at agreed upon community forums. Results from the client satisfaction survey will inform quality improvement initiatives and program development goals.

IV. Reporting Requirements are detailed in Exhibit B-25

This Exhibit contains additional provisions applicable to Covered Services rendered to Eligible Individuals (as defined below) covered under Jail Transition Program (as defined below) offered and/or administered by Washington State Health Care Authority (HCA). In the event of any conflict between the provisions of the Agreement (including Exhibit B-8), and this Exhibit B-6 and subject to the provisions set out in Exhibit B-6, the provisions of this Exhibit control as related to services rendered to individuals receiving Jail Transition Program services.

I: General Provisions.

(1) Whenever in this Exhibit B-6 the term "Facility" is used to describe an obligation or duty, such obligation or duty will also be the responsibility of each individual licensed health care practitioner, Facility, and provider employed or owned by or under contract with Facility, as the context may require.

(2) Facility agrees:

a. These services are intended to facilitate access to mental health services upon mentally ill offenders' release from confinement, including expediting applications for new or re-instated Medicaid benefits.

b. To 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 managed care organizations or the FFS Medicaid Program.

c. To coordinate with local and Tribal law enforcement, courts and jail personnel to they meet the needs of Individuals detained in city, county, tribal, and regional jails.

d. The Individuals eligible for these services include individuals incarcerated in a local jail who meet the criteria of the state priority population (RCW 71.24), and the Washington State Department of Social and Health Services' (DSHS) current Access to Care Standards ("Eligible Incarcerated Individuals").

II: Definitions.

(1) Continuity of Care: Means the provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one setting as the Individual transitions between: Facility to home; Facility to Facility; providers or service areas; managed care Contractors; and Medicaid fee for-service (FFS) and managed care arrangements.

(2) Cultural Humility: The continuous application in professional practice of self-reflection and self-critique, learning from patients, and partnership building, with an awareness of the limited ability to understand the patient's worldview, culture(s), and communities.

(3) Culturally Appropriate Care: Health care services provided with Cultural Humility and an understanding of the patient's culture and community, and informed by Historical Trauma and the resulting cycle of Adverse Childhood Experiences (ACEs).

(4) Eligible Individual: For purposes of this Exhibit B-6, Eligible Individual means any individual confined in a county or city jail eligible to receive services through the Jail Transition Program offered by the Washington State Health Care Authority.

(5) 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.

(6) Jail Transition Program: Means 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.

(7) Mental Health Professional (MHP): Means:

a. A psychiatrist, psychologist, psychiatric nurse, psychiatric nurse practitioner, physician assistant supervised by a psychiatrist, or social worker as defined in RCW 71.05.020;

b. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such persons shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional;

c. A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;

d. A person who is licensed by DOH as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;

e. A person who has an approved exception to perform the duties of a Mental Health Professional; or

f. A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional.

III. Services. Facility agrees to:

(1) Facility shall identify and provide the transition services described in this Exhibit to individuals with mental illness to expedite and facilitate their return to the community. Prerelease services are only eligible to individuals pending discharge. Individuals are eligible for post release services up to, but no longer than, 90 days post release.

a. Pre-release services shall include:

i. Mental health and Substance Use Disorder (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.

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

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

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

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

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

b. The Facility may also use JTS funds, if sufficient, to facilitate any of the following:

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

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

iii. Inter-local agreements with juvenile detention facilities.

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

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

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

(3) Facility shall assist individuals with mental illness in completing and submitting applications for medical assistance to the local Community Services Office (CSO) prior to release from jail.

(4) The Facility shall operate according to their own written protocols for service provision.

VI. Reporting Requirements are detailed in Exhibit B-25.

This Exhibit contains additional provisions applicable to Covered Services rendered to Eligible Individuals (as defined below) covered under the Mental Health Program (as defined below) offered and/or administered by Washington State Health Care Authority (HCA). In the event of any conflict between the provisions of the Agreement (including Exhibit B-8), and this Exhibit B-7 and subject to the provisions set out in Exhibit B-7, the provisions of this Exhibit control as related to services rendered to individuals receiving Mental Health Program services.

I: General Provisions.

(1) Whenever in this Exhibit B-7 the term "Facility" is used to describe an obligation or duty, such obligation or duty will also be the responsibility of each individual licensed health care practitioner, Facility, and provider employed or owned by or under contract with Facility, as the context may require.

(2) Facility agrees:

a. Facility shall provide mental health services in accordance with the Carelon Level of Care Guidelines , which are incorporated herein by reference.

b. Follow all rules and regulations of CFDA 93.958 for provision of services for the Block Grants for Community Mental Health (MHBG) program when funding is used. For the purposes of this contract, the Facility is designated a subrecipient.

c. In accordance with WAC 246-341, provide mental health services, residential services (licensed under WAC 246-337), and crisis stabilization services. Provide services to individuals on a least restrictive alternative (LRA) or conditional release (CR) in accordance with RCW 71.05.

II: Definitions.

(1) Continuity of Care: Means the provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one setting as the Individual transitions between: Facility to home; Facility to Facility; providers or service areas; managed care Contractors; and Medicaid fee for-service (FFS) and managed care arrangements.

(2) Cultural Humility: The continuous application in professional practice of self-reflection and self-critique, learning from patients, and partnership building, with an awareness of the limited ability to understand the patient's worldview, culture(s), and communities.

(3) Culturally Appropriate Care: Health care services provided with Cultural Humility and an understanding of the patient's culture and community, and informed by Historical Trauma and the resulting cycle of Adverse Childhood Experiences (ACEs).

(4) Eligible Individuals: For purposes of this Exhibit B-7, Eligible Individual means any non-Medicaid individual eligible to receive services through the Mental Health Program offered by the Washington State Health Care Authority.

(5) Medication Management: 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.

(6) Medically Necessary Services: A requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Individual that endanger life, cause suffering of pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client

Individual requesting the service. "Course of treatment" may include mere observation or, where appropriate, no treatment at all

(7) Mental Health Block Grant (MHBG): Means those funds granted by the Secretary of HHS, through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), to states to establish or expand an organized community-based system for providing mental health services for adults with Serious Mental Illness (SMI) and children who are seriously emotionally disturbed (SED).

(8) Mental Health Block Grant (MHBG) Program: The program is the provision of those MHBG services further described within this Exhibit B-7 which are reimbursable pursuant to the contract between Carelon and the Washington State Health Care Authority.

(9) Mental Health Program: The program is the provision of those mental health services further described within this Exhibit B-7 which are reimbursable pursuant to the contract between Carelon and the Washington Health Care Authority.

III. Services. Facility agrees to:

(1) Actively work with Carelon Utilization Management staff to submit invoice billing to the State to be applied to Medicaid spenddown.

(2) The Facility shall provide medically necessary mental health services to Eligible Individuals. Facility shall provide services at the appropriate level, frequency and duration.

(3) In addition, Facility shall:

a. Operate according to Carelon approved written protocols for service provision;

b. Provide education and support to help the individual and family recognize, understand, and respond to the individual's needs;

c. Provide linkages to the individual's primary care physician as well as other community services including ongoing care coordination as needed.

d. Provide strength-based mental health treatment services that match each individual's mental health needs with an appropriate intensity and array of services in the natural environment (outside a Community Mental Health Clinic and/or office).

e. Provide only the authorized level of service to an individual. If Facility anticipates based on a clinical assessment that an individual will require a higher level or type of service than previously authorized, Facility shall timely request a change of authorization type in accordance with Carelon policies and procedures.

(4) If Facility is providing crisis triage and stabilization services, they must receive training in crisis triage and management for Individuals of all ages and behavioral health conditions, including SMI, SUDs, and co-occurring disorders.

(5) If Facility receives a referral for a non-Medicaid LRA ordered service, the referral must be prioritized. Staff will coordinate and collaborate with superior courts, contractors providing services to persons released on assisted outpatient treatment orders, and other stakeholders within their region. Updates must be provided as required in the LRA.

(6) When a Transition Team appointment is accepted from the court, for individuals that meet criteria for civil commitment with a Special Finding of Violent Offence under RCW 71.05.280(3)(b) or individuals that meet criteria for Not Guilty by Reason of Insanity (NGRI) under RCW 10.77.010(6), and RCW 10.77.030, the Facility agrees to assign a Care Coordinator to take part in the team.

a. If Facility conducts a mental health intake assessment prior to the individual's discharge, an invoice should be

sent to Carelon, regardless of whether the individual will discharge with Medicaid.

(7) If Facility receives MHBG funding, the Facility shall:

a. Facility may use block grant funds to help Individuals satisfy cost-sharing requirements for MHBG-authorized mental health services. The Facility must ensure that:

i. The provider is a recipient of block grant funds;

ii. Cost-sharing is for a block grant authorized service;

iii. Payments are in accordance with MHBG laws and regulations;

iv. Cost-sharing payments are made directly to the provider of the service; and

v. A report is provided to Carelon upon request that identifies:

1. The number of Individuals provided cost-sharing assistance;

2. The total dollars paid out for cost-sharing; and

3. Providers who received cost-sharing funds.

b. Deliver MHBG services as described in the regional MHBG Project Plan for the current fiscal year approved by Carelon and the Health Care Authority.

c. Provide MHBG services to promote recovery for an adult with a SMI and resiliency for SED children in accordance with federal and state requirements.

d. Ensure that MHBG funds are used only for services to individuals who are not enrolled in Medicaid or for services that are not covered by Medicaid as described in the following table:

Benefits	Services	Use MHBG Funds	Use Medicaid
Individual is not a Medicaid recipient	Any Allowable Type	Yes	No
Individual is a Medicaid recipient	Allowed under Medicaid	No	Yes
Individual is a Medicaid recipient	Not Allowed under Medicaid	Yes	No

e. MHBG funds may not be used to pay for services provided prior to the execution of this Exhibit, or to pay in advance of service delivery. All contracts and amendments must be in writing and executed by both parties prior to any services being provided.

f. Participate in annual peer review by individuals with expertise in the field of mental health treatment when requested by HCA (42 U.S.C. 300x-53 (a) and 45 C.R.R. 96.136, MHBG Service Provisions).

g. Send a representative to the regional Behavioral Health Advisory Board (BHAB) meetings to report on program data and results.

h. Participate in quarterly check-in meetings with Carelon to provide program updates and share successes/ barriers.

(8) If Facility is providing Outpatient Mental Health Services, they must be provided by staff with appropriate credentials as defined by WAC 246-341-0515.

(9) If Facility is providing Residential Supervised Living Services, as authorized by Carelon, the following shall be included:

a. Must provide 24 hours per day, 7 days per week supervision of all residents by licensed staff

b. Must provide a multi-disciplinary licensed staff (i.e. social worker, counselors, nurses etc.)

c. Must have written admission and discharge criteria

d. Must provide a full range of social and recreational therapies

e. Must provide individualized treatment plans

f. Must provide a structured program at least 5 days per week or as clinically indicated to support successful discharge and reduce risk for recidivism as documented in the treatment plan.

g. Must require and/or encourage family involvement in treatment

h. Must provide emergency psychiatric/medical services on-site or by contract

i. Must receive oversight from a Medical or Clinical Program Director

j. Must conduct criminal background check on all staff

k. Must have a documented patient visit with a prescriber within 72 hours of admission and at least 1 time every 30 days thereafter or as clinically indicated and documented in the treatment plan

l. Services require authorization by Carelon Care Managers

(10) If Facility is providing Residential Treatment Services, as authorized by Carelon, the following shall be included:

a. Must provide 24 hours per day, 7 days per week supervision of all residents by licensed staff

b. Must provide a multi-disciplinary licensed staff (i.e. social worker, counselors, nurses etc.)

c. Must have written admission and discharge criteria

d. Must provide a full range of social and recreational therapies

e. Must provide individualized treatment plans

f. Must provide a full range of treatment programming 7 days per week, with structured programming provided a minimum of 6 hours per day

g. Must require and/or encourage family involvement in treatment

h. Must provide emergency psychiatric/medical services on-site or by contract

i. Must receive oversight from a Medical or Clinical Program Director

j. Must conduct criminal background check on all staff

k. Must have a documented patient visit with a prescriber at least 1 time per week

l. Services require authorization by Carelon Care Managers

(11) If Facility is providing Intensive Outpatient (IOP) services the following shall be included:

a. Must have a written program narrative

b. Must provide individualized treatment plans

c. Must have written procedures for handling medical/psychiatric emergencies

d. Must provide or make available any structured recovery support groups

e. Must have the supervision of a licensed clinician

f. Must have written admission and discharge criteria

g. Must have a written schedule of program activities

h. Must provide services at least 3 hours per day, 3 to 5 days per week

(12) If Facility is providing Partial Hospitalization services, as authorized by Carelon, the following shall be included:

a. Must be under the supervision of a physician.

b. Must have written admission and discharge criteria.

c. Must provide physician medication management.

d. Staffing must include psychiatry, nursing, psychology, and social work.

e. Must provide individualized treatment plans.

f. Must provide a full program schedule to include individual and group therapy.

g. Must operate at least 5 days per week and at least a minimum of 4-6 hours per day.

h. Must receive oversight from a Medical or licensed Program Director.

i. Must have a documented patient visit with a prescriber at least 1 time per week

j. Services require authorization by Carelon Care Managers

(13) If the Facility is providing Crisis Stabilization Services (facility based), as authorized by Carelon, the following shall be included:

a. Medication Management

b. Psychoeducation

c. Skills Teaching

d. Supportive Counseling

e. Coordination with outside services

f. Discharge Planning

g. Room and Board

h. Must be provided 24 hours per day/7 days per week.

i. May be provided prior to an intake evaluation.

j. Shall not exceed 14 days

k. Services require authorization by Carelon Care Managers.

(14) Facility staff must develop a discharge plan for all Eligible Individuals. For individuals not authorized for continuation of crisis stabilization services, the Facility shall also provide a referral to a Community Mental Health Agency for outpatient services.

IV. Reporting Requirements are detailed in Exhibit B-25

In addition to the obligations set forth elsewhere in this Agreement, Carelon and Facility agree to comply with the following requirements with respect to Covered Services rendered to Eligible Individuals subject to Carelon's contract with the Washington Health Care Authority. In the event of any conflict between the provisions of the Agreement and this Exhibit B-8, the provisions of this Exhibit control as related to Washington State Health Care Authority Specific Provisions. Capitalized terms used but not defined in this Exhibit B-8 shall have the meanings set forth in the Agreement.

I: Hold Harmless.

(1) Facility hereby agrees that in no event, including, but not limited to nonpayment by Carelon, or Payor, Carelon's insolvency or the insolvency of Payor, or breach of this contract will Facility bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an Eligible Individual or person acting on their behalf, other than Carelon or Payor, for Covered Services provided pursuant to this contract. This provision does not prohibit collection of deductibles, copayments, coinsurance, and/or payment for non-covered services, which have not otherwise been paid by a primary or secondary issuer in accordance with regulatory standards for coordination of benefits.

(2) Facility agrees, in the event of Carelon or Payor's insolvency, to continue to provide the services promised in this contract to Eligible Individuals for the duration of the period for which payments were made or until the Eligible Individual's discharge from inpatient facilities, whichever time is greater when both apply.

(3) Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member's Plan.

(4) Facility may not bill the Eligible Individual for Covered Services (except for deductibles, copayments, or coinsurance) where Carelon or Payor denies payments because the provider or Facility has failed to comply with the terms or conditions of this Agreement.

(5) Facility further agrees (i) that the provisions of (1), (2), (3), and (4) of this subsection shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Eligible Individuals, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Facility and Eligible Individuals or persons acting on their behalf.

(6) In addition to the requirements of Section 3.5 of the Agreement, when Facility contracts with Practitioners to provide covered services to Eligible Individuals with the expectation of receiving payment directly or indirectly from Carelon or Payor such Practitioners must agree to abide by the provisions of (1), (2), (3), (4), and (5) of this subsection.

(7) Facility acknowledges that Facility or its Practitioners that willfully collect or attempt to collect an amount from an Eligible Individual knowing that collection to be in violation of this Agreement constitutes a class C felony under RCW 48.80.030(5).

II: Amendments.

(1) Notwithstanding Sections 5.4(b) and 11.2 of the Agreement, Facility must be given reasonable notice of not less than sixty (60) days of changes that affect Facility or its Practitioners' compensation or that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice must be provided as soon as possible. Notice to Facility is considered notice to its Practitioners under this Agreement.

a. Subject to any termination and continuity of care provisions of the Agreement, Facility may terminate the Agreement without penalty if Facility does not agree with the changes, subject to the requirements in Article VIII of the Agreement

b. A material amendment to the Agreement may be rejected by Facility. The rejection will not affect the terms of the existing Agreement. A material amendment has the same meaning as in RCW 48.39.005.

(2) No change to the Agreement may be made retroactive without the express written consent of the Facility.

III: Practitioner Relationships and Communication.

(1) Carelon will not in any way preclude or discourage Facility from informing Eligible Individuals of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the individual's Plan. Carelon will not prohibit, discourage, or penalize Facility or its Practitioners otherwise practicing in compliance with the law from advocating on behalf of an Eligible Individual with Carelon, a Payor, or a Plan. Nothing in this section shall be construed to authorize Facility to bind Carelon or Payor to pay for any service.

(2) Carelon will not preclude or discourage Eligible Individuals or those paying for their coverage from discussing the comparative merits of different Payors or Plans with Facility or its Practitioners. This prohibition specifically includes prohibiting or limiting Facility participating in those discussions even if critical of Carelon, a Payor or a Plan.

(3) Carelon will not penalize Facility because Facility, in good faith, reports to state or federal authorities any act or practice by Carelon that jeopardizes an individual's health or welfare or that may violate state or federal law.

(4) Communication

(1) Nothing under this Agreement prohibits, or otherwise restricts, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an individual who is their patient, for the following:

a. The individual's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

b. Any information the individual needs in order to decide among all relevant treatment options.

c. The risks, benefits, and consequences of treatment or non-treatment.

d. The individual's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

IV. Confidentiality of Health Records.

(1) In addition to the other requirements of the Agreement, Facility will make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Eligible Individuals subject to applicable state and federal laws related to the confidentiality of medical or health records.

(2) Information about Individuals, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and Regulations.

V. Discrimination Prohibited.

(1) Carelon is responsible for ensuring that Facility and its Practitioners furnish Covered Services to each Eligible Individuals without regard to the individual's enrollment in a Plan as a private purchaser of a Plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the Facility should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions

VI. Dispute Resolution.

(1) Notwithstanding those provisions in Article X of the Agreement, the parties are not required to engage in binding arbitration;

however, parties agree to otherwise follow the dispute resolution process prior to judicial remedies. Facility has thirty days after the action giving rise to a dispute to complain and initiate the dispute resolution process. Carelon shall render a decision on Facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, Carelon must render a decision within sixty (60) days of the complaint.

VII. Payments.:

(1) Carelon shall pay Facility as soon as practical but at a minimum

a. Carelon shall pay ninety-five percent (95%) of the monthly volume of Clean Claims within thirty (30) days of receipt. For purposes of this Section VII, Clean Claim means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

b. Carelon shall pay or deny ninety-five percent (95%) of all claims within sixty days of receipt by Carelon and ninety-nine percent (99%) of all claims within ninety (90) calendar days of receipt, except as otherwise agreed to in writing by the parties on a claim-by-claim basis.

c. The receipt date of a claim is the date that Carelon receives either written or electronic notice of the claim. Carelon shall have a reasonable method for responding to inquiries about claims.

d. In the event that Carelon fails to meet the requirements set forth in this Section 7, Carelon shall pay interest on undenied and unpaid Clean Claims more than sixty-one (61) days old until such time as Carelon meets requirements of subsections 7 (a) and 7 (b). Interest shall be assessed at the rate of one percent (1%) per month and shall be calculated monthly as simple interest prorated for any portion of the month. In the event that interest is due and payable to the Facility, Carelon shall add the interest payable to the amount of the claim in question without the necessity of Provider submitting an additional claim. Any interests paid under this Section shall not be applied by Carelon to an individual's deductible, copayment, coinsurance or other individual's cost share obligation.

e. Denial of a claim by Carelon shall include specific reason that the claim was denied. If the denial was based on medical necessity, then Carelon shall, upon the request of Facility, disclose the supporting basis for the denial.

f. Carelon's Provider Dispute Resolution (PDR) Process can be utilized for claims that deny for administrative, non-clinical reasons as outlined in the WA State ASO Provider Handbook: Supplement.

g. The provisions of this Section 7 shall not apply to claims for which there is substantial evidence of fraud or misrepresentation by Facility or to instances in which Carelon has not been granted reasonable access to information under Facility's control.

h. Carelon and Facility are not required to comply with the provisions of this Section 7, if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

(2) Carelon shall comply with terms and conditions of payment outlined in WAC 284-170-431.

(3) Carelon is the payor of last resort, therefore Facility agrees to:

a. Make reasonable efforts to determine if individuals being served have insurance or health coverage other than through Payor, including conducting a benefit inquiry in the ProviderOne system, and promptly report any duplicate coverage to Carelon;

b. Ensure that services and benefits available under this Contract shall be secondary to all other coverage

c. Attempt to recover any third-party resources available to individuals, including pursuit of FFS Medicaid funds provided for AI/AN Individuals who did not opt into managed care, and make all records available for audit and review.

VIII: Accountability & Oversight.

(1) Regardless of any provision to the contrary, Washington State Health Care Authority (herein also referred to as 'Payor') or their respective designees, oversee and monitor the provision of services to individuals on an on-going basis and remain accountable and responsible for compliance with the terms and conditions of their respective Contract, regardless of the provisions of the Agreement or any delegation of administrative activities or functions to Carelon.

IX. Compliance.

(1) The Facility shall maintain Policy and Procedures that demonstrate compliance with contractual requirements and provide copies upon request.

(2) Comply with all applicable state and federal laws, rules, and regulations related to services rendered to Eligible individuals, and applicable requirements of the Carelon and Washington State Health Care Authority Contract.

(3) Comply with Carelon's Program Integrity requirements and HCA approved Program Integrity policies and procedures.

(4) Implement procedures to screen employees, contractors, subcontractors, volunteers, and Board of Directors to ensure individuals are not excluded from participation in Federal programs. Screening will be completed upon hire and monthly thereafter.

a. Facility agrees to immediately disclose to Carelon Behavioral Health any exclusion or other event which makes them ineligible to perform work related directly or indirectly to Federal health care programs.

b. Facility will submit a completed monthly attestation regarding exclusionary checks to Carelon Behavioral Health no later than the 10th of each month.

c. Facility will make evidence of monthly checks available upon request.

(5) Guard against Fraud, Waste and Abuse by creating a Compliance Plan that includes:

a. Implementing written policies, procedures and standards of conduct, including whistleblower protection

b. Designating a Compliance Officer and Compliance Committee

c. Conducting effective ongoing training and education of employees and volunteers

d. Developing effective lines of communication

e. Enforcing standards though well-publicized disciplinary guidelines

f. Conducting internal monitoring and auditing

g. Responding promptly to detected offenses and developing corrective actions;

(6) Participate in Carelon required or HCA sponsored Quality Improvement activities.

(7) Keep records necessary to adequately document services provided in a manner consistent with state and federal laws and regulations.

(8) Provide Carelon and/or Payors with timely access to records, information and data necessary for Carelon and/or Payors to meet their respective obligations under their Contract;

(9) Submit all reports and clinical information required by Carelon and/or Payors that may be required by Contract(s) and to ensure the quality, appropriateness and timeliness of contracted services;

(10) Notify Carelon when a Washington State entity performs any audit related to the activities contained in this contract, and submit any report and corrective action plan related to the audit to Carelon.

X. Audit/Access to Records.

(1) Facility shall comply with all applicable required audits, including those requested by Carelon, authority to conduct a Facility inspection, and the federal Office of Management and Budget (OMB) Super Circular, 2 C.F.R. 200.501 and 45 C.F.R. 75.501 audits.

(2) Facility shall maintain all financial, medical, and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles or other comprehensive basis of accounting (OCBOA) that is prescribed by the State Auditor's Office under the authority of Washington State Law, chapter 43.09 RCW. Other records shall be maintained as necessary to clearly reflect all actions taken by the Facility related to this Contract.

(3) Upon request, the Facility shall allow HCA or any authorized state or federal agency or authorized representative, access to all records pertaining to this Contract, including computerized data stored by the Facility. The Facility shall provide and furnish the records at no cost to the requesting agency.

(4) On-Site and Virtual Inspections

a. The Facility must provide any record or data pertaining to this Contract including, but not limited to:

i. Medical records;

ii. Billing records;

iii. Financial records;

iv. Any record related to services rendered, quality, appropriateness, and timeliness of service; and

v. Any record relevant to an administrative, civil or criminal investigation or prosecution.

b. Upon request, the Facility shall assist in such review, including the provision of complete copies of records.

c. The Facility must provide access to its premises and the records requested to any state or federal agency or entity, including, but not limited to: HCA, OIG, MFCD, Office of the Comptroller of the Treasury, whether the visitation is announced or unannounced.

(5) Carelon may not access medical records unrelated to Eligible Individuals served under this contract. Except that this provision shall not limit Carelon's or Payor's right to ask for and receive information relating to the ability of the Facility to deliver health care services that meet the accepted standards of medical care prevalent in the community.

(6) Access to medical records for the purpose of audit by Carelon, or the Payors is limited to only that necessary to perform the audit.

(7) The billing audit rights granted to Carelon and the Payors are reciprocal so that Facility may audit the denial of its claims.

XI. Miscellaneous.

(1) Compliance with law. Carelon and Facility shall comply with all applicable Washington laws governing this Agreement and the provision of Covered Services to Eligible Individuals. In the event that any applicable Washington law conflicts with the terms of this Exhibit B-8, such terms shall be deemed amended to the extent necessary for consistency with the applicable Washington law.

(2) Conflicts or inconsistencies. In the event of any conflict or inconsistency between the terms of this Exhibit B-8 and the terms in any other section of the Agreement including other Exhibit Bs, then this Exhibit B-8 shall control; provided however, that if Carelon and Facility are capable of complying with both the requirements of such other section and this Exhibit B-8, nothing herein shall be construed as waiving the obligations of Carelon or Facility under such other section.

XII. Additional Provisions Required of the Washington State Health Care Authority (HCA).

(1) Facility shall not subcontract services identified in this contract without the express permission of Carelon Behavioral Health. Carelon will respond in a timely manner to subcontracting requests and clearly communicate feedback about potential subcontractor(s) and subcontract language. In the event subcontracting is approved, all requirements contained in this contract must be included in any subcontract .

(2) The Facility shall inform, post, and guarantee that each Individual has the following rights:

a. To information regarding the Individual's behavioral health status.

b. To receive all information regarding behavioral health treatment options including any alternative or self-administered treatment, in a culturally-competent manner.

c. To receive information about the risks, benefits, and consequences of behavioral health treatment (including the option of no treatment).

d. To participate in decisions regarding their behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions.

e. To be treated with respect and with due consideration for their dignity and privacy.

f. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

g. To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. Part 164.

h. To be free to exercise their rights and to ensure that to do so does not adversely affect the way the Facility treats the Individual.

(3) The Facility shall ensure Individual self-determination by:

a. Obtaining informed consent prior to treatment from Individuals, or persons authorized to consent on behalf of an Individual, as described in RCW 7.70.065;

b. Patient consent is required for telemedicine per RCW 48.43.735. Failure to obtain consent could result in disciplinary action against the provider.

c. Complying with the provisions of the Natural Death Act (Chapter 70.122 RCW) and state rules concerning Advance Directives (WAC 182-501-0125); and,

d. When appropriate, informing Individuals of their right to make anatomical gifts (Chapter 68.64 RCW).

(4) Facility shall use the Integrated Co-Occurring Disorder Screening Tool (GAIN-SS found at https://www.hca.wa.gov/billers-providers-partners/program-information-providers/contractor-and-provider-resources for all services except DCR services, and shall train staff that will be using the tool(s) to address the screening and assessment process, the tool, and quadrant placement. Failure to implement and maintain the process may result in corrective action.

(5) Ensure that all services and activities provided under this Contract shall be designed and delivered in a manner sensitive to the needs of the diverse population.

(6) Initiate actions to develop or improve access, retention, and cultural relevance of treatment, relapse prevention or other appropriate services, for ethnic minorities and other diverse populations in need of services under this Contract as identified in their needs assessment.

(7) Participate in training when requested by the HCA. Exceptions must be in writing and include a plan for how the required information shall be provided to staff.

(8) The Facility shall assure equal access for all Individuals when oral or written language creates a barrier to such access.

a. Oral Information:

i. Provide interpreter services free of change for Individuals with a preferred language other than English. This includes the provision of interpreters for Individuals who are Deaf, DeafBlind, or Hard of Hearing. This includes oral interpretation Sign Language (SL), and the use of Auxiliary Aids and Services as defined in section C(i). below (42 C.F.R. § 438.10(d)(4)). Interpreter services shall be provided for all interactions between such Individuals and the Facility including, but not limited to:

1. Customer service;

2. All appointments with any Provider for any covered service; and

3. All steps necessary to file Grievances and Appeals.

b. Written Information:

i. The Facility shall provide all generally available and Individual-specific written materials in a language and format which may be understood by each Individual in each of the prevalent languages that are spoken by 5 percent or more of the population of the RSA based on information obtained from HCA.

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

1. Translating the material into the Individual's preferred reading language;

2. Providing the material in an audio format in the Individual's preferred language;

3. Having an interpreter read the material to the Individual in the Individual's preferred language.

4. Providing the material in another alternative medium or format acceptable to the Individual. The Contractor shall document the Individual's acceptance of the material in an alternative medium or format; or

5. Providing the material in English, if the Facility documents the Individual's preference for receiving material in English.

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

c. Auxiliary Aids and Services

i. Auxiliary Aids and Services means services or devices that enable Individuals with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the benefits, programs or activities conducted by the Facility. Auxiliary Aids and Services includes:

1. Qualified interpreters onsite or through video remote interpreting (VRI), note takers, real-time computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons, videotext displays, or other effective methods of making aurally delivered materials available to Individuals with hearing impairments;

2. Qualified readers, taped texts, audio recordings, Brailled materials, large print materials, or other effective methods of making visually delivered materials available to Individuals with visual impairments;

(9) The following provisions are required by (i) federal statutes and regulations applicable to medical assistance programs for the indigent, (ii) state statutes and regulations applicable to medical assistance programs for the indigent, or (iii) contracts and agreements between the Health Plan and the state agencies responsible for regulating risk-based medical assistance programs for the indigent. These provisions shall be automatically modified to conform to subsequent amendments to such statutes, regulations, and agreements. Further, any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

(10) Facility shall provide reasonable access to facilities and financial and medical records for duly authorized representatives of the CMS, HCA, Department of Social & Health Services ("DSHS") or the Department of Health & Human Services ("DHHS") for audit purposes and immediate access for Medicaid fraud investigators.

(11) Facility shall investigate and disclose to Carelon and HCA immediately upon becoming aware of any person in their employment who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act since the inception of those programs.

(12) Facility shall require nondiscrimination in employment and Individual services.

(13) Facility shall conduct criminal background checks and maintain related policies and procedures and personnel files consistent with requirements in RCW 43.43 and, WAC 246-341.

(14) Facility shall completely and accurately report prepaid claim data to Carelon. Facility shall have the capacity to submit all required data to enable Carelon to meet the requirements in the Encounter Data Transaction Guide published by HCA.

(15) Facility shall comply with Carelon's fraud and abuse policies and procedures.

(16) Facility shall not assign this Agreement without Carelon's written agreement.

(17) Facility shall comply with any term or condition of Carelon's contracts with HCA that is applicable to the services to be performed by Facility.

(18) Facility shall accept payment from Carelon as payment in full and shall not request payment from HCA or any Eligible

Individual for Covered Services performed under this Agreement.

(19) Facility agrees to hold harmless HCA and its employees, CMS and its employees, and all enrollees served under the terms of this Agreement in the event of non-payment by Carelon. Facility 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 Facility, its agents, officers, employees or contractors.

(20) If, at any time, Carelon determines that Facility is deficient in the performance of its obligations under the Agreement, Carelon may require Facility to develop and submit a Corrective Action Plan (CAP) that is designed to correct such deficiency.

a. Carelon shall approve, disapprove, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency.

b. Facility shall, upon approval of Carelon, immediately implement the corrective action plan, as approved or modified by Carelon.

c. Facility's failure to implement any corrective action plan may, in the sole discretion of Carelon, be considered breach of the Agreement, subject to any and all contractual remedies including termination of the Agreement with or without notice.

(21) Facility shall make reasonable accommodation for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all Covered Services and shall assure physical and communication barriers shall not inhibit enrollees with disabilities from obtaining Covered Services.

(22) Facility shall comply with all Program Integrity provisions as documented in Carelon's Provider Manual and as set forth by 42 CFR 438.608 and Carelon's contracts with HCA.

(23) With the exception of crisis services and HOST, Facility shall ensure that all persons receiving services under this Agreement are screened for financial eligibility. Specifically, Facility shall:

a. Capture sufficient demographic, financial, and other information to support eligibility decisions and reporting requirements.

b. Check Medicaid eligibility, including conducting a benefit inquiry in the ProviderOne system, prior to each service delivery.

c. Conduct an inquiry regarding each Eligible Individual' s continued financial eligibility no less than once each month.

d. Document the evidence of each financial screening in the individual's records.

e. Update funding information when the funding source changes.

f. To be eligible for any non-crisis behavioral health service under this Agreement, an individual must meet: (i) the financial eligibility criteria; and (ii) the clinical or program eligibility criteria for the service . For services in which medical necessity criteria applies, all services must be medically necessary.

g. Funding for services where medical necessity does not apply can only be used under the follow circumstances:

i. Based on available resources

1. Service type(s) allowable by fund source

2. Individual meets financial eligibility criteria

ii. Based on identified treatment need

1. Individual meets criteria for the fund source where specified

2. Individual meets service criteria

3. Services that directly support an Individual's progress in treatment

4. Services are identified within the Individual's treatment plan.

h. Financial eligibility criteria for non-crisis behavioral health services are as follows:

i. Does not qualify for Medicaid.

ii. Gross monthly income (adjusted for family size) that does not exceed 220% of the Federal Poverty Guidelines,

iii. ***And*** meet one of the following criteria:

1. Are uninsured

2. Have insurance, but are unable to meet the co-pay or deductible for services

3. Are using excessive SUD or mental health crisis services due to inability to access non-crisis behavioral health services

4. Have more than 5 visits over 6 months to the emergency department, withdrawal management facility, or the sobering center due to a SUD

(24) Facility may offer a sliding scale fee schedule to Individuals who are not eligible for Medicaid coverage that takes into consideration an Individual's circumstances and ability to pay. If the Facility selects to develop a fee schedule, the fee schedule must comply with the following and must be reviewed and approved by Carelon:

a. Put the sliding fee schedule in writing that is non-discriminatory;

b. Include language in the sliding fee schedule that no Individual shall be denied services due to inability to pay;

c. Provide signage and information to Individuals to educate them on the sliding fee schedule;

d. Protect Individual's privacy in assessing fees;

e. Maintain records to account for each Individual's visit and any charges incurred;

f. Charge Individuals at or below 100 percent of Federal Poverty Level (FPL) a nominal fee or no fee at all. The Federal Poverty Guidelines can be found at https://aspe.hhs.gov/poverty-guidelines; and,

g. Develop at least three (3) incremental amounts on the sliding fee scale for Individuals between 101 to 220 percent FPL.

h. Facility will reduce the amount billed to Carelon by any sliding fee schedule amounts collected from Eligible Individuals.

(25) Facility shall provide continuing education to client facing staff on Carelon funded services and eligibility and keep records documenting participation. Education shall be provided annually at a minimum.

(26) In compliance with RCW 71.32 pertaining to mental health advance directive for behavioral health care, Facility shall:

a. The Facility shall maintain a written Mental Health Advance Directive (MHAD) policy and procedure that respects an Individual's Advance Directive. Policy and procedures must comply with Chapter 71.32 RCW.

b. Inform all individuals of their right to a mental health advance directive and provide technical assistance to those who express an interest in developing and maintaining a mental health advance directive

c. Maintain current copies of any mental health advance directive in the individual's utilization records.

d. Inform individuals that complaints concerning noncompliance with a mental health advance directive should be referred to the Washington State Department of Health by calling 1-360-236-2620 or by following the written instructions contained in the mental health benefit booklet.

(27) The Facility shall implement a Grievance process that complies with WAC 182-538C-110. The Facility shall:

a. Grievance means an expression of dissatisfaction about any matter other than an Action. Action means the denial or limited authorization of a Contracted Service based on medical necessity. Possible subjects for grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Individual's rights regardless of whether remedial action is requested. Grievance includes an Individual's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

b. Inform Individuals of their right to file a Grievance or Appeal in the case of:

i. Denial or termination of service related to medical necessity determinations

ii. Failure to act upon a request for services with reasonable promptness

c. Ensure that termination of this contract shall not be grounds for an Appeal, Administrative Hearing, or a Grievance for individuals if similar services are immediately available in the service area.

(28) The Facility shall ensure that the hours of operation for individuals served under this contract with Carelon are no less than the hours of operation offered to any other individual.

(29) If the Facility is a **faith-based organization (FBO), it shall** meet the requirements of 42 CFR Part 54 as follows:

a. Individuals requesting or receiving SUD services shall be provided with a choice of SUD treatment providers.

b. The FBO shall facilitate a referral to an alternative provider within a reasonable time frame when requested by the recipient of services. The FBO shall report to the Contractor all referrals made to alternative providers.

c. The FBO shall provide individuals served with a notice of their rights.

d. The FBO provides individuals served with a summary of services that includes any inherently religious activities.

e. Funds received from the FBO must be segregated in a manner consistent with federal regulation

f. No funds may be expended for religious activities

(30) Critical Incident Reporting.

a. Facility shall submit a Critical Incident report for the following incidents to Carelon:

i. To an individual receiving services funded by this contract and occurred within the Facility:

1. Abuse, neglect, or sexual/ financial exploitation perpetrated by staff;

2. Physical or sexual assault perpetrated by another client; and

3. Death.

ii. By an individual receiving services funded by this contract, with a behavioral health diagnosis, or history of behavioral health treatment within the previous 365 days. Acts allegedly committed, to include:

1. Homicide or attempted homicide;

2. Arson;

3. Assault or action resulting in serious bodily harm which has the potential to cause prolonged disability or death;

4. Kidnapping; and

5. Sexual Assault

iii. Unauthorized leave from a behavioral health facility during an involuntary detention, when funded by this contract.

iv. Incident posing a credible threat to the individual receiving services safety.

v. Poisoning or overdose that was unintentional, or the intention was unknown.

vi. Attempted or completed suicide.

vii. Any event involving an individual that has attracted or is likely to attract media coverage, when receiving services funded by this contract.

b. All critical incidents shall be reported within 1 business day of becoming aware of the incident.

(31) For providers in twenty-four (24) hour settings, a requirement to provide discharge planning services which shall, at a minimum:

a. Coordinate a community-based discharge plan for each individual served under this Agreement beginning at intake in order to procure the best available recovery plan and environment for the individual. Discharge planning shall apply to all individuals regardless of length of stay or whether they complete treatment.

b. 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.

c. Establish referral relationships with assessment entities, outpatient providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of referents in treatment activities.

d. Coordinate, as needed, with Department of Behavioral Health and Rehabilitation (DBHR) prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including the Division of Children and Family Services, the Community Services Division including Community Service Offices (CSOs), Tribal governments and Non-Tribal IHCPs.

e. Coordinate services to financially-Eligible Individuals who are in need of medical services.

(32) Performance Evaluation. Carelon shall:

a. At its discretion, upon reasonable notice during normal business hours, perform periodic programmatic and financial reviews. These may include on-site inspections and audits by Carelon or its agents of the records of Provider relating to the provision of contracted services.

b. Provide reasonable notice to Provider prior to any on-site visit to conduct an audit, and further notify Provider of any records Carelon wishes to review.

c. Review and evaluate Provider for its successful performance of all contractual obligations and its compliance with the terms of the Agreement.

d. Inform Provider of the results of any performance evaluations and of any dissatisfaction with Provider's performance, and reserve the right to demand a corrective action plan or to terminate the Agreement.

(33) Loss of Program Authorization

a. Should any part of the work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which authority has been withdrawn, or which is the subject of a legislative repeal), Facility must do no work on that part after the effective date of the loss of program authority. If Facility works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Facility will not be paid for that work. If Facility was paid in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work must be returned. However, if Facility worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to Facility, Facility may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

(34) Facility shall create and maintain a business continuity and disaster recovery plan that ensures timely reinstitution of the Individual information system following total loss of the primary system or a substantial loss of functionality. The plan shall include the following:

a. A mission or scope statement

b. Information services disaster recovery person(s)

c. Provision for back up of key personnel, emergency procedures, and emergency telephone numbers

d. Procedures for effective communication, application inventory and business recovery priorities, and hardware and software vendor lists

e. Documentation of updated system and operations and a process for frequent back up of systems and data

f. Off-site storage of system and data backups and ability to recover data and systems from back-up files

g. Designated recovery options

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

(35) Facility shall submit an annual certification statement indicating there is an up to date business continuity disaster plan in place. Certification must be received by December 31 of each contract year to **BehavioralHealth_WAASO@carelon.com.**

(36) If a Facility receives FBG funds, an annual fiscal review will be conducted regardless of reimbursement methodology. The Facility shall provide Carelon with requested documentation to comply with fiscal review requirements. Requested documents may include, but are not limited to, the following:

a. An accounting of FBG expenditures by revenue source.

b. Confirmation that no expenditures were made for items prohibited by this Contract.

c. Confirmation that expenditures were made only for the purposes stated in this Contract, and for services that were actually provided.

d. FBG funds cannot be used for the following:

i. Construction and/or renovation.

ii. Capital assets or the accumulation of operating reserve accounts.

iii. Equipment costs over $5,000.

iv. Cash payments to Consumers

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

vi. Promotional items, which include but are not limited to clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags.

(37) Debarment and Suspension

a. The undersigned (authorized official signing for the contracting organization) certifies to the best of his or her knowledge and belief, that the contractor, defined as the primary participant in accordance with 45 CFR Part 76, and its principals: are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency have not within a 3-year period preceding this contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in Section 2 of this certification; and have not within a 3- year period preceding this contract had one or more public transactions

(Federal, State, or local) terminated for cause or default.

b. Should the Contractor or Subrecipient not be able to provide this certification, an explanation as to why should be placed after the assurances page in the contract.

(38) Certification Regarding Lobbying

a. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative Contracts from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative Contract. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative Contract must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative Contracts EXCEEDING $100,000 in total costs (45 CFR Part 93).

b. The undersigned (authorized official signing for the contracting organization) certifies, to the best of his or her knowledge and belief, that:

   i. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative Contract, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative Contract.

   ii. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative Contract, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

   iii. The undersigned shall require that the language of this certification be included in the award documents for all subcontracts at all tiers (including subcontracts, subcontracts, and contracts under grants, loans and cooperative Contracts) and that all sub-recipients shall certify and disclose accordingly.

c. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

(39) Certification Regarding Environmental Tobacco Smoke

a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

c. By signing the certification, the undersigned certifies that the contracting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

(40) For each publication that results from SAMHSA grant-supported activities, the Facility must include an acknowledgment of grant support using one of the following statements:

a. "This publication was made possible by Grant Number (MHBG 93.958 or SABG 93.959) from SAMHSA."

b. "The project described was supported by Grant Number (MHBG 93.958 or SABG 93.959) from SAMHSA."

c. Facility also must include a disclaimer stating the following:

i. "Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the SAMHSA."

XIII. Documents Incorporated by Reference.

(1) Each of the documents listed below are incorporated by this reference into this Contract as though fully set forth herein, including any amendments, modifications or supplements thereto. All services shall be provided in accordance with these documents and legal authorities:

a. Carelon's contracts, program agreements, exhibits, amendments, and any other agreements with the Washington State Health Care Authority;

b. The Medicaid State Plan and the 1915(b) Medicaid Waiver;

c. The Health Care Authority policies, the State Medicaid Manual (SMM) as applicable, the BARS Manual and any applicable BARS Supplemental Instructions;

d. State laws and regulations including the Revised Code of Washington and the Washington Administrative Code;

e. Carelon External Policies and Procedures, including Carelon's Provider Handbook and Washington State ASO Provider Handbook: Supplemental Appendix;

f. CPT Manual, HCPC Manual, and Washington State Service Encounter Reporting Instructions;

g. The Code of Federal Regulations Title 45 CFR and Title 42 CFR;

h. Title XIX and Title XXI of the Social Security Act.

i. Title VI of the Civil Rights Act of 1964.

j. Title IX of the Education Amendments of 1972, regarding any education programs and activities.

k. The Age Discrimination Act of 1975.

l. The Rehabilitation Act of 1973.

m. The Budget Deficit Reduction Act of 2005.

n. The Washington Medicaid False Claims Act and Federal False Claims Act (FCA).

o. The Health Insurance Portability and Accountability Act (HIPAA).

p. The American Recovery and Reinvestment Act (ARRA).

q. The Patient Protection and Affordable Care Act (PPACA or ACA).

r. The Health Care and Education Reconciliation Act (HCERA).

s. The Mental Health Parity and Addiction Equity Act (MHPAEA) and final rule.

t. 21 C.F.R. Food and Drugs, Chapter 1 Subchapter C – Drugs – General.

u. Senate Bill 6312 (Chapter 225. Laws of 2014) State Purchasing of Mental Health and Chemical Dependency Treatment Services.

v. All federal and state professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including but not limited to:

i. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
ii. Those specified in Title 18 RCW for professional licensing.

w. Equal Employment Opportunity (EEO) Provisions.

x. All federal and state nondiscrimination laws and Regulations.

y. Americans with Disabilities Act (ADA): The Contractor shall make reasonable accommodation for Individuals with disabilities, in accord with the ADA, for all Contracted Services and shall assure physical and communication barriers shall not inhibit Individuals with disabilities from obtaining Contracted Services.

z. Any other requirements associated with the receipt of federal funds, and,

aa. Any services provided to an Individual enrolled in Medicaid are subject to applicable Medicaid rules.

IX. Term & Termination.

(1) In addition to and notwithstanding the provisions set forth in the Agreement:

a. This Agreement may be terminated by either party for any reason upon ninety (90) days written notice to the other party.

b. Any Exhibit may be suspended or terminated by Carelon immediately upon written notice if:

i. Facility is disqualified, terminated, suspended, debarred, or otherwise excluded from or ineligible for participation under the program or any other state or federal government-sponsored health program; or

ii. The Agreement is terminated or not renewed.

X. Confidential Information.

(1) Nothing contained in the Carelon Facility Agreement or associated Exhibits shall be construed as prohibiting Facility from

sharing information with the public as required by federal, state or local law.

This Exhibit contains additional provisions applicable to Covered Services rendered to Eligible Individuals (as defined below) covered under Substance Use Disorder (SUD) Program (as defined below) offered and/or administered by Washington State Health Care Authority (HCA). In the event of any conflict between the provisions of the Agreement (including Exhibit B-8), and this Exhibit B-11 and subject to the provisions set out in Exhibit B-11, the provisions of this Exhibit control as related to services rendered to individuals receiving SUD Program services.

I: General Provisions.

(1) Whenever in this Exhibit B-11 the term "Facility" is used to describe an obligation or duty, such obligation or duty will also be the responsibility of each individual licensed health care practitioner, Facility, and provider employed or owned by or under contract with Facility, as the context may require.

(2) Facility agrees:

a. Facility shall provide substance use disorder services in accordance with the Carelon Level of Care Guidelines and under the Carelon Service Instruction Manual, which are incorporated herein by reference.

b. Follow all rules and regulations of CFDA 93.959 for provision of services for the Substance Abuse Prevention and Treatment Block Grant (SABG) program when funding is used. For the purposes of this contract, the Facility is designated a subrecipient.

c. Facility shall provide alcohol and drug treatment services per RCW 71.24 as described in the Services below.

d. If applicable, Facility shall provide alcohol and drug treatment services pursuant to the Dedicated Cannabis Account DCA program provisions as promulgated by the Washington State Health Care Authority when that funding is used.

i. DCA funds shall be used to fund SUD treatment services for youth living at or below 220 percent of the federal poverty level, without insurance coverage or who are seeking services independent of their parent/guardian;

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

e. If applicable, provide Outpatient Treatment Services in accordance with WAC 246-341 for Specialty Court or CJTA eligible patients. Specifically, Facility shall:

i. Provide services to individuals with an addiction or a substance abuse problem that, if not treated, would result in addiction, against whom a prosecuting attorney in Washington State has filed charges.

ii. In accordance with RCW 2.30.040, counties are required to provide a dollar-for-dollar participation match for CJTA funded services for Individuals who are under the supervision of a therapeutic court.

1. No more than 10 percent of the total CJTA funds can be used for the following treatment support services combined:

a. Transportation; and

b. Child Care Services.

iii. The Facility, under the provisions of this contract and in accordance with RCW 71.24.580(9), will abide by the following guidelines related to CJTA funding that supports therapeutic courts: The Facility shall have policy and procedures in place that:

1. Allow Individuals at any point in their course of treatment to be prescribed any medication approved the by the FDA for the treatment of SUD.

2. Do not deny admission into therapeutic court programs and related services for Individuals who are prescribed any medication approved by the FDA for the treatment of SUD; and

3. Do not mandate titration of any medication approved by the FDA for the treatment of SUD, as a condition of individual being admitted into the program, continuing in the program, or graduating from the program; with the understanding that decisions concerning medication adjustment are made solely between the Individual and their prescribing providers.

4. Coordinates care with agencies that are able to provide or facilitate the induction of any medication approved by the FDA for the treatment of SUD.

iv. CJTA funding shall be used to supplement, not supplant, other federal, state, and local funds used for SUD treatment per RCW 71.24.580(8).

II: Definitions.

(1) American Society of Addiction Medicine Level of Care Guidelines (ASAM Guidelines): Means a professional society dedicated to increasing access and improving the quality addiction treatment. ASAM Guidelines are a set of criteria promulgated by ASAM used for determining treatment placement, continued stay and transfer/discharge of individuals with addiction conditions.

(2) Behavioral Health Medical Director: means a physician licensed in Washington State to practice medicine, oversee operations, set policies, and help to make informed medical/behavioral health decisions.

(3) Brief Intervention for SUD: Means a time limited, structured behavioral intervention using techniques such as evidence-based motivational interviewing, and referral to treatment services when indicated. Services may be provided at sites exterior to treatment facilities such as hospitals, medical clinics, schools or other non-traditional settings.

(4) Certified Peer Counselor (CPC): Means individuals who: have self-identified as a consumer of behavioral health services, or are a parent or legal guardian of a child (under the age of 18) with lived experience with mental health or substance use services, have received specialized training provided/contracted by HCA, Division of Behavioral Health and Recovery (DBHR); have passed a written/oral test, which includes both written and oral components of the training; have passed a Washington State background check; have been certified by DBHR; and are a registered Agency Affiliated Counselor with the Department of Health (DOH)..

(5) Clinically Managed Residential Withdrawal Management: (sometimes referred to as "social setting detoxification" or "social detox") means an organized service that may be delivered by appropriately trained staff, who provide 24-hour supervision, observation, and support for Individuals who are intoxicated or experiencing withdrawal. This level is characterized by its emphasis on peer and social support rather than medical and nursing care. This level provides care for Individuals whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support: however, the full resources of a Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management services are not necessary. ASAM 3.2-WM.

(6) Criminal Justice Treatment Account (CJTA): Means an account created by the state for expenditure on the following: a) SUD treatment and treatment support services for offenders with a SUD that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; and b) the provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program (RCW

71.24.580)..

(7) Continuity of Care: Means the provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one setting as the Individual transitions between: Facility to home; Facility to Facility; providers or service areas; managed care Contractors; and Medicaid fee for-service (FFS) and managed care arrangements.

(8) 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.

(9) Cultural Humility: The continuous application in professional practice of self-reflection and self-critique, learning from patients, and partnership building, with an awareness of the limited ability to understand the patient's worldview, culture(s), and communities.

(10) Culturally Appropriate Care: Health care services provided with Cultural Humility and an understanding of the patient's culture and community, and informed by Historical Trauma and the resulting cycle of Adverse Childhood Experiences (ACEs).

(11) Eligible Individuals: For purposes of this Exhibit B-11, Eligible Individual means any non-Medicaid individual eligible to receive services through the SUD Program offered by the Washington State Health Care Authority, and for SABG funded services not covered by Medicaid, any Medicaid individual.

(12) Outreach & Engagement: Means identification of hard -to-reach Individuals with a possible SUD and/or Severe Mental Illness (SMI) and engagement of these Individuals in assessment and ongoing treatment services as necessary.

(13) Intake Evaluation, Assessment, and Screenings (Substance Use or Problem Gambling Disorder): Also referred to as " SUD assessment" means a comprehensive evaluation of a 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.

(14) Interim Services: Means services to individuals who are currently waiting to enter a treatment program to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease.

(15) Inpatient/Residential Substance Use Treatment Services: Means rehabilitative services, including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward Individuals who are harmfully affected by the use of mood-altering chemicals or have been diagnosed with a Substance Use Disorder (SUD). Techniques have a goal of abstinence (assisting in their Recovery) for Individuals with SUDs. Provided in certified residential treatment facilities with sixteen (16) beds or less. Residential treatment services require additional program-

specific certification by DOH, and include: Intensive inpatient services; Recovery house treatment services; Long-term residential treatment services; and youth residential services.

(16) Intensive Inpatient Residential Services: Means a concentrated program of SUD treatment, individual and group counseling, education, and related activities including room and board in a 24-hour-a-day supervised Facility in accordance with WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 3.5)

(17) Intensive Outpatient SUD Treatment: means services provided in a non-residential intensive patient centered outpatient program for treatment of SUD (The service as described satisfies the level of intensity in ASAM Level 2.1).

(18) Long-Term Care Residential SUD Services: Means the care and treatment of chronically impaired individuals diagnosed with substance use disorder with impaired self-maintenance capabilities including personal care services and a concentrated program of substance use disorder treatment, individual and group counseling, education, vocational guidance counseling and related activities for individuals diagnosed with substance use disorder, excluding room and board in a twenty-four-hour-a-day, supervised facility accordance with WAC 246-341. (The service as described satisfies the level of intensity in ASAM Level 3.3.)

(19) Medically Necessary Services: A requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Individual that endanger life, cause suffering of pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client Individual requesting the service. "Course of treatment" may include mere observation or, where appropriate, no treatment at all

(20) Medication Assisted Treatment (MAT): Means the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUDs.

(21) Medically Monitored Inpatient Withdrawal Management: Means an organized service delivered by medical and nursing professionals, which provides for 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to Individuals whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. ASAM 3.7-WM.

(22) Opioid Substitution Treatment: Means assessment and treatment to opioid dependent patients. Services include prescribing and dispensing of an approved medication, as specified in 212 CFR Part 291, for opioid substitution services in accordance with WAC 246-341. Both withdrawal management and maintenance are included, as well as physical exams, clinical evaluations, individual or group therapy for the primary patient and their family or significant others. Additional services include guidance counseling, family planning and educational and vocational information. (The service as described satisfies the level of intensity in ASAM Level 1).

(23) Pregnant and Post-Partum Women (PPW): Means: (i) women who are pregnant; (ii) women who are postpartum during the first year after pregnancy completion regardless of the outcome of the pregnancy or placement of children; or (iii) women who are parenting children, including those attempting to gain custody of children supervised by the Department of Children, youth and Families (DCYF).

(24) Pregnant, Post-Partum or Parenting (PPW) Women's Housing Support Services: Means the costs incurred to provide support services provided to PPW individuals with children under the age of six (6) in a transitional residential housing program designed exclusively for this population.

(25) Recovery House Residential Treatment: Means a program of care and treatment with social, vocational, and recreational activities designed to aid individuals diagnosed with substance use disorder in the adjustment to abstinence (assisting in their Recovery) and to aid in job training, reentry to employment, or other types of community activities, excluding room and board in a twenty-four-hour-a-day supervised facility in accordance with WAC 246-341. (The service as described satisfies the level of intensity in ASAM Level 3.1).

(26) Recovery Support Services: Means a broad range of non-clinical services that assist individuals and families to initiate, stabilize, and maintain long-term Recovery from behavioral health disorders including mental illness and substance use disorders.

(27) Sobering Services: Means short-term (less than 24 consecutive hours) emergency shelter, screening, and referral services to Individuals who are intoxicated or in active withdrawal.

(28) Substance Abuse Block Grant (SABG) Block Grant: Means the Federal Substance Abuse Block Grant Program authorized by Section 1921 of Title XIX, Part B, Subpart II and III of the Public Health Service Act.

(29) Substance Use Disorder Professional (SUDP): Means an individual who is certified according to chapter 18.205 RCW and the certification requirements of WAC 246-811-030 to provide Substance Use Disorder (SUD) services.

(30) Substance Use Disorder (SUD) Program: The program is the provision of those SUD services further described within this Exhibit B-11 which are reimbursable pursuant to the contract between Carelon and the Washington State Health Care Authority.

(31) Youth: Means a person from age thirteen (13) through seventeen (17). Specific programs may assign a different age range for youth.

(32) Waiting List: Means a list of Eligible Individuals who qualify for SABG-funded services for whom services have not been scheduled due to lack of capacity.

III. Services. Facility agrees to:

(1) Facility may use block grant funds to help Individuals satisfy cost-sharing requirements for SABG-authorized SUD services. The Facility must ensure that:

a. The provider is a recipient of block grant funds;

b. Cost-sharing is for a block grant authorized service;

c. Payments are in accordance with SABG laws and regulations;

d. Cost-sharing payments are made directly to the provider of the service; and

e. A report is provided to Carelon upon request that identifies:

i. The number of Individuals provided cost-sharing assistance;

ii. The total dollars paid out for cost-sharing; and

iii. Providers who received cost-sharing funds.

(2) Services in the table below are allowable as defined by the HCA when utilizing funds in the priority identified when that funding is received. Facilities seeking reimbursement for providing services without an associated Fee for Service (FFS) billing code in Facility's rate schedule, shall confirm such services are part of the current regional SABG Project Plan and obtain approval from the Account Partnership Director before submission of a cost reimbursement invoice.

Allowable Services Table

Service	CJTA-Drug Court: 1st Priority for qualifying nonviolent offender	DCA: 1st priority for youth or perinatal women	SABG: 1st priority for non-offender adults or services not covered by DCA	GFS: Default funding after all others
Assessment	X*	X	X	X
Engagement and Referral	X		X	X
Alcohol/Drug Information School (ADIS)		X	X	X
Interim Services	X	X	X	X
Outreach and Engagement at $40/hour. Time shall be calculated in 15 minute units.	X	X	X	X
Crisis Services			X	X
Sobering Services	X		X	X
Involuntary Commitment Investigations and Treatment	X		X	X
Therapeutic Interventions for Children		X	X	X
Transportation	X	X	X	X
Childcare Services provided by licensed childcare providers	X	X	X	X
PPW Housing Support Services		X	X	X
Family Hardship				X
Recovery Support Services	X	X	X	X
Continuing Education			X	X
Urinalysis	X	X	X	X
Employment services and job training	X		X	X
Relapse prevention	X	X	X	X
Family/marriage education	X		X	X
Peer-to-peer services, mentoring and coaching	X	X	X	X
Self-help and support groups	X		X	X
Housing support services (rent and/or deposits)	X		X	X
Life skills	X		X	X
Education	X		X	X
Parent education and child development	X		X	X
Naloxone	X		X	X

*includes assessments done while in jail

(3) If Facility is providing Inpatient Medically Monitored Intensive Inpatient Detoxification Services (Level 3.7), as authorized by Carelon, the following shall be included:

a. Must provide 24hr/7 days per week medically-monitored services

b. 24-hour nursing care with physician availability

c. Must accept admissions 24hrs/7 days per week.

d. Must have written admission and discharge criteria.

e. Must provide medical diagnostic services on-site or by contract.

f. Must provide a full range of treatment programming 7 days per week.

g. Must provide individualized treatment plans.

h. Must provide emergency psychiatric/medical services on-site or by contract.

i. Must require and/or encourage family involvement in treatment.

j. Must provide structured recovery support groups.

k. Must have an Addictionologist either on staff or contracted or Medical Director must have three (3) years' experience treating substance abuse patients as evidenced in resume.

l. Must receive oversight from a Medical Director.

(4) If Facility is providing Intensive Outpatient services, the following shall be included:

a. Must have a written program narrative.

b. Must provide individualized treatment plans.

c. Must have written procedures for handling medical/psychiatric emergencies.

d. Must provide or make available any structured recovery support groups.

e. Must have the supervision of a licensed clinician.

f. Must have written admission and discharge criteria.

g. Must have a written schedule of program activities.

h. Must provide services at least 3hrs per day, 3 to 5 days per week.

(5) If Facility is providing Clinically Managed High Intensity Residential Services (Level 3.5), authorized by Carelon, the following shall be included:

a. Must provide 24hr/7 days per week coverage by licensed staff.

b. Must accept admissions 24hrs/7 days per week.

c. Must have written admission and discharge criteria.

d. Must provide medical diagnostic services on-site or by contract.

e. Must provide a full range of treatment programming 7 days per week.

f. Must provide individualized treatment plans.

g. Must provide emergency psychiatric/medical services on-site or by contract.

h. Must require and/or encourage family involvement in treatment.

i. Must provide structured recovery support groups and aftercare.

j. Must have an Addictionologist either on staff or contracted or Medical Director must have three (3) years' experience treating substance abuse patients as evidenced in resume.

k. Must receive oversight from a Medical Director.

(6) For all engagement and outreach services provided prior to an intake, the Facility shall:

a. If more than three engagement and outreach services provided in a 90-day period to the same person and an intake has not been provided, the Facility shall ensure a note is included in the chart indicating why individual has not received an intake.

b. Facility should track outcomes of outreach and engagement in converting individuals into ongoing treatment.

(7) For SABG funded services, the Facility shall ensure the following:

a. As a Facility receiving funding under the Block Grant and providing services required by CFR Title 45, Section 96.959, Facility shall make every effort, including the establishment of systems for eligibility determination, billing, and collection, to:

i. Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX. Additional programs include any State compensation program, other public assistance program for medical expenses, grant programs, private health insurance, or any other benefit program; and

ii. Secure payments from individuals for services in accordance with their ability to pay.

b. Meet the needs of priority populations, in priority order below, as identified in the SABG or by HCA, including but not limited to:

i. Pregnant individuals injecting drugs.

iii. Pregnant individuals with SUD.

iv. Women with dependent children.

v. Individuals who are injecting drugs or substances.

vi. The following additional priority populations, in no particular order:

1. Postpartum women (up to one year, regardless of pregnancy outcome).

2. Patients transitioning from residential care to outpatient care.

3. Youth.

4. Offenders

c. Within available resources, ensure that SABG services are not denied to any Eligible Individual regardless of:

i. The individual's drug(s) of choice.

ii. The fact that the individual is taking FDA approved medically-prescribed medications.

iii. The fact that the individual is using over the counter nicotine cessation medications or actively

participating in a nicotine replacement therapy regimen

d. Deliver SABG services as described in the regional SABG Project Plan for the current fiscal year approved by Carelon and the Health Care Authority.

e. Ensure that SABG funds are used only for services to individuals who are not enrolled in Medicaid or for services that are not covered by Medicaid as described in the following table:

Benefits	Services	Use SABG Funds	Use Medicaid
Individual is not a Medicaid recipient	Any Allowable Type	Yes	No
Individual is a Medicaid recipient	Allowed under Medicaid	No	Yes
Individual is a Medicaid recipient	Not Allowed under Medicaid	Yes	No

f. Have protocols for maintaining waiting lists and providing interim services for SABG priority population individuals, as defined in this Contract, who are eligible to receive services but for whom SUD treatment services are not available due to limitations in provider capacity or available resources.

    i. The waiting list interim record must include:

        1. Application form that includes the applicant's full name (last, first and middle initial), birth date, gender, race (including Spanish/Hispanic origin), Social Security Number, address and phone number

        2. A unique individual identifier for each individual

        3. Service plan record noting proposed treatment modalities, tentative treatment dates

        4. Record of all contacts and referrals.

g. Ensure interim services are provided by for pregnant and parenting women and intravenous drug users.

h. Interim services shall be made available within forty-eight (48) hours of seeking treatment for pregnant and parenting women and intravenous drug users.

    i. Admission to treatment services for the intravenous drug user shall be provided within fourteen (14) days after the patient makes the request, regardless of funding source.

    ii. If there is no treatment capacity within fourteen (14) days of the initial patient request, the Facility shall have up to one hundred twenty (120) days, after the date of such request, to admit the patient into treatment. Interim services must be documented in the system platform designated by the HCA and include, at a minimum:

        1. Counseling on the effects of alcohol and drug use on the fetus for the pregnant patient.

        2. Prenatal care for the pregnant patient.

        3. Human immunodeficiency virus (HIV) and tuberculosis (TB) education.

        4. HIV or TB treatment services if necessary for an intravenous drug user.

5. The interim service documentation requirement is specifically for the admission of priority populations with any funding source; and any patient being served with SABG Block Grant funds.

i. A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of detoxification, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within twenty-four (24) hours.

j. Facility shall notify Carelon, in writing, when the Facility is at ninety (90) percent capacity and must maintain records using the Capacity Management Form, in accordance with (42 USC 300-23 and 42 USC 300X 27).

k. SABG funds may not be used to pay for services provided prior to the execution of this Exhibit, or to pay in advance of service delivery. All contracts and amendments must be in writing and executed by both parties prior to any services being provided

l. Participate in annual peer review by individuals with expertise in the field of drug abuse treatment when requested by HCA (42 U.S.C. 300x-53 (a) and 45 C.R.R. 96.136)

m. Send a representative to the regional Behavioral Health Advisory Board (BHAB) meetings to report on program data and results.

n. Participate in quarterly check-in meetings with Carelon to provide program updates and share successes/ barriers.

o. Facility shall ensure compliance with tuberculosis screening, testing and referral, in accordance with (42 USC 300x-24(a) and 45 CFR 96.127), in the following manner:

i. Coordinating with other public entities to make tuberculosis services available to each Eligible Individual receiving SABG-funded SUD treatment.

ii. The services will include tuberculosis counseling, testing, and providing for or referring infected with tuberculosis for appropriate medical evaluation and treatment.

iii. In the case of an Eligible Individual in need of treatment service who is denied admission to the tuberculosis program on the basis of lack of capacity, the Facility will refer the Eligible Individual to another provider of tuberculosis services.

iv. Contract for case management activities to ensure the Eligible Individuals receive tuberculosis services.

(8) Charitable Choice Requirements of 42 CFR Part 54 are followed and Faith-Based Organizations (FBO) are provided opportunities to compete with traditional alcohol/drug abuse treatment providers for funding.

a. Contracted FBOs are required to meet the requirements of 42 C.F.R. Part 54 as follows:

i. Eligible Individuals requesting or receiving SUD services shall be provided with a choice of SUD treatment providers.

ii. The FBO shall facilitate a referral to an alternative Facility within a reasonable time frame when requested by the recipient of service

iii. The FBO shall report to Carelon all referrals made to alternative providers.

iv. The FBO shall provide Eligible Individuals with a notice of their rights.

v. The FBO provides Eligible Individuals with a summary of services that includes any religious activities.

vi. Funds received from the FBO must be segregated in a manner consistent with federal Regulations.

vii. No funds may be expended for religious activities.

(9) Prior Authorization is required for all residential services.

(10) Facility may provide the following services, as authorized by Carelon, using funds from the Designated Cannabis Account (DCA) when that funding is used:

a. Substance Use Disorder Outpatient youth treatment utilizing individual, group and family treatment modalities

b. Assessment

c. Residential Treatment Services – Youth

(11) When DCA funding is used, Facility shall participate in quarterly check-in meetings with Carelon to provide program updates and share successes/ barriers.

(12) When CJTA funding is used, Facility shall have participated in the development and implementation of any local CJTA plans established under RCW 71.24.580(6) developed by the CJTA panel and approved by HCA and/or the CJTA Panel in accordance with 71.24.580(5)(b).

(13) When CJTA funding is used for treatment in the jail:

a. CJTA funding used for this purpose may not supplant any locally funded programs within a city, county, or tribal jail.

b. SUD treatment service provided in jail may include, but are not limited to the following:

i. Engaging Individuals in SUD treatment

ii. Referral to SUD services;

iii. Administration of Medications for the treatment of SUDs including Opioid Use Disorder to include the following

1. Screening for medications for SUDs

2. Cost of medications for SUDs

3. Administration of medications for SUDs

iv. Coordinating care;

v. Continuity of Care; and

vi. Transition planning

IV. Reporting Requirements are detailed in Exhibit B-25.

Exhibit B-25.A19
Reporting Provisions

This Exhibit contains additional provisions applicable to reporting on Covered Services offered and/or administered by Washington State Health Care Authority (HCA). In the event of any conflict between the provisions of the Agreement (including Exhibit B-8), and this Exhibit B-25 and subject to the provisions set out in Exhibit B-25, the provisions of this Exhibit control as related to reporting on services rendered to individuals receiving Covered Services.

I: General Provisions.

(1) Whenever in this Exhibit B-25 the term "Facility" is used to describe an obligation or duty, such obligation or duty will also be the responsibility of each individual licensed health care practitioner, Facility, and provider employed or owned by or under contract with Facility, as the context may require.

II: Global Reporting Requirements

(1) HCA reporting templates are located at: https://www.hca.wa.gov/billers-providers-partners/program-information-providers/model-managed-care-contracts.

(2) Provision of required reports is a condition for payment.

(3) Facility will use Carelon's Provider Connects portal to register Eligible Individuals for services to ensure they are assigned a unique ID. Registrations must include, but are not limited to, appropriate start date and fund assignment for prepaid claims/ claims reporting. For those with Medicaid, the individual's Provider One ID must be provided so proper allocation of cost can be distinguished for the Payor.

a. Funding registration ends after one year. Individuals continuing to receive services must be re-registered.

(4) Facility must submit complete and accurate reports and data required under this Contract that complies with HCA Service Encounter Reporting Instructions (SERI) Guide, HCA Encounter Data Reporting Guide (EDRG), and Behavioral Health Supplemental Data (BHSD) transactions that comply with the most current Behavioral Health Data System (BHDS) Guide. Behavioral Health Supplemental Transactions related to services provided to Individuals must be submitted within thirty (30) calendar days from the date of service or event.

a. Data quality will be measured for each individual transaction as outlined in the BHDS Guide. Error ratios that exceed 1 percent for each separate transaction may result in corrective actions up to and including sanctions.

b. Data quality error corrections must be made within 2 weeks of notification.

(5) Unless there is an established SFTP site with Carelon, reports should be submitted to the following email address, which is monitored multiple times each day: **BehavioralHealth_WAASO@carelon.com**. The name of the report should be included in the email subject line.

(6) Facility will submit a completed monthly attestation regarding exclusionary checks to Carelon Behavioral Health no later than the 10th of each month.

(7) Facility must provide claims and/or prepaid claim codes to Carelon for reporting to the Washington State Health Care Authority in accordance with the Rate Schedules in this Contract. For all fund codes except Federal Block Grant (FBG), claims submitted for health care payments, also known as the Fee for Service (FFS) payment type, must be submitted within current Washington State Health Care Authority timely filing requirements or they will be denied for timely filing. For FBG fund codes, claims must be submitted by July 10 for the prior reporting period (July 1 – January 31). Prepaid claims submitted for health care reporting purposes, also known as the Prepaid payment type, must be submitted to Carelon monthly for the previous month. Claims and prepaid claim submissions are used to reconcile services provided and directly impact future rate setting and/or funding available in the RSA. Failure to submit claims and/or prepaid claims for services

rendered as outlined in your rate schedule(s) may result in future budget reductions.

(8) Failure to meet reporting requirements may result in a Corrective Action Plan (CAP).

III: If Facility is providing services outlined in Exhibit B-4 Crisis Program Provisions, the following additional reporting requirements apply.

(1) When reporting prepaid claims, the fund code and, for those with Medicaid, the individual's Provider One ID, must be provided so proper allocation of cost can be distinguished for the Payor.

(2) Facility must collect and report to Carelon all applicable transactions described in the Health Care Authority (HCA) most current Behavioral Health Data System (BHDS) Guide, including but not limited to the following within 24 hours:

a. Demographics 020.08

b. DCR Investigation 160.05

c. ITA Hearing 162.05

(3) Facility shall submit Daily Crisis Logs that provide summary of all crisis interventions, including but not limited to, core demographics, date of contact, referral reason, intervention provided, outcome, follow up services to be provided, and recommendations for further clinical care coordination by MCO or Carelon. Facility shall enter the Eligible Individual's Carelon assigned identification number in the field titled "Client ID".

(4) Facility shall obtain and provide to Carelon monthly updates on all LRA/CR orders in their county(ies) by the 20th day of the month.

(5) Facility shall develop a client satisfaction process and provide an annual report to Carelon with an analysis of results and recommendations for improvement. At a minimum, the report shall include: the process used, number of clients who participated, results, and actions taken or to be taken to improve client satisfaction. Annual report is due by July 30 for the previous contract year.

(6) Facility will provide a quarterly report of progress towards execution and/or maintenance of inter-agency agreements/MOUs including the following information: organizations with executed agreements and maintenance status, organizations in discussion and status of discussions, organizations not yet approached and plans for engagement. Reports are due by the 20th day of the month following the end of the quarter.

(7) Facility shall report dashboard data monthly to Carelon to fulfill reporting requirements to key stakeholders and the HCA, including but not limited to, the elements outlined in the following Crisis Dashboard Reporting Elements tables when those services are provided by the Facility:

a. Data must be submitted by the 10th day of the following month.

b. Definitions of each element as well as formatting requirements will be provided by Carelon upon request or when there is a change to an element or formatting.

(9) When the DCR determines an Individual meets detention criteria, the investigation has been completed and when no bed is available, the DCR shall submit an Unavailable Detention Facilities report (No Bed Report) to HCA and Carelon within 24 hours. The report shall include the following:

a. The date and time the investigation was completed;

b. A list of facilities that refused to admit the Individual;

c. Information sufficient to identify the Individual, including name and age or date of birth;

d. The identity of the responsible BH-ASO and MCO, if applicable;

e. The county in which the person met detention criteria; and

f. Other reporting elements deemed necessary or supportive by HCA.

(10) When a Single Bed Certification is used:

a. The Single Bed Certification documentation shall be submitted to HCA and Carelon within 24 hours.

b. The Single Bed Certification Log shall be provided to Carelon daily, using the Carelon standard template, for each day individuals are on a Single Bed Certification.

Crisis Dashboard Reporting Elements

Data	Reported by	
Key **IP = In Person** **TH = Telehealth**	**MRRCT (Adult/Youth) Responses that do not require a DCR**	**DCR**
Referral Source		
Regional Crisis Line	X	X
MRRCT		X
Law Enforcement (**Sheena's Law**)		X
Warm hand off in clinic or brought over to facility		X
Family Member Petition (**Joel's Law**)		X
Co-responder Team		X
Jail or Juvenile Detention		X
Other (provide details)		
Total number referrals received	X	X
Response Time		
For Initial Dispatch (average minutes)	X	X
From Request to Face-to-Face Arrival (average minutes)	X	X
% encounters in initial 2-person response	X	
Emergent (respond within 2 hours)	X	X
Urgent (as scheduled within 24 hours), defined as:	X	X
By next judicial day for someone in secure setting	Definitions provided for information only, subcategory reporting of Urgent response times not currently required.	
No more than 6 hours post medical clearance: ER observation, refused voluntary treatment		
Brought by Peace Officer, up to 12 hours post medical clearance: crisis stabilization, E&T, hospital ED, triage, secure detox, SUD		
Within 3 hours must be assessed; determination within 12 hours of notice		
Up to 12 hours to evaluate minors (13 + years old) brought to E&T, hospital ER, secure detox		

Data	Reported by	
Key **IP = In Person** **TH = Telehealth**	**MRRCT (Adult/Youth) Responses that do not require a DCR**	**DCR**
Location of Intervention		
Community	X	X
ER/Hospital		X
Jail or Juvenile Detention		X
Other (provide details)	X	X
Placement		
# Unavailable bed reports		X
# Single Bed Certs		X
# Out of County Placements		X
Outcomes		
Phone Consult Only: Inappropriate Referral	X	
Phone Consult Only: Refused Service/Declined IP Response (individual or family)	X	
Refer to Community Stabilization (TH or IP)	X	
Refer to DCR (TH or IP)	X	
Resolved (TH or IP): # result in Referral to 7-day Crisis CM Services	X	
Resolved (TH or IP): % seen in 7 day CM follow-up	X	
Resolved (TH or IP): Follow-up contact made within 24 hours	X	
Resolved (TH or IP): Seen by follow-up PCP/OP in 7 days	X	
# Face-to-Face crisis contacts (TH or OP)	X	
% diverted from Higher Level of Care (HLOC)	X	
% with unplanned contact/return to crisis system	X	X
Results in Referral to OP Treatment		X
Results in Referral to Voluntary IP Treatment		X
Results in Detention under ITA: MH Detention		X
Results in Detention under ITA: Referral to AOT, LRA, CR		X
Results in Detention under ITA: SUD Detention (**Ricky's Law**)		X
Referred to Law Enforcement		X
Unable to Contact / Refused Service	X	X
Other or No Further Steps		X
Total number of ITA Investigations		X
Total number of ITA Investigations Conducted via TH		X
Total number unique individuals served	X	X
Court Hearing Outcomes		
# 14-day hearing outcomes		X
# 90-day hearing outcomes		X
# 180-day hearing outcomes		X
# LRA/CR in place		X
Individuals monitored during reporting period		X

Data	Reported by	
Key **IP = In Person** **TH = Telehealth**	**MRRCT (Adult/Youth) Responses that do not require a DCR**	**DCR**
Individual unique ID #		X
Type of Service Provided		X
Start and End dates		X
Treatment Provider and Phone #		X
Health insurance coverage		X
# LRA/CR revoked		X

IV: If Facility is providing services outlined in Exhibit B-6 Jail Transition Program Provisions, the following additional reporting requirements apply.

(1) When reporting prepaid claims, the fund code and, for those with Medicaid (active or suspended), the individual's Provider One ID, must be provided so proper allocation of cost can be distinguished for the payer.

(2) Submit an Annual Jail Transition Service report due by July 20th of each year, for services provided in the prior state fiscal year. The report will include the following:

a. Number of Jail Transition Services provided;

b. Number of Individuals served with Jail Transition funding;

c. Narrative describing Jail Transition Services provided;

d. Narrative describing barriers to providing Jail Transition Services; and

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

(3) Facility and Carelon will agree to any additional acceptable data and reporting system to properly transmit needed data and services to the state.

V: If Facility is providing services outlined in Exhibit B-7 Mental Health Program Provisions, the following additional reporting requirements apply.

(1) If Facility is providing Crisis Triage/Stabilization services, report monthly on the number of admissions, average length of stay, number diverted to other resources/services, and number of denials for each location due by the 10th of the following month.

(2) For all MHBG funded services:

a. Using the template provided by Carelon, the Facility shall submit a MHBG Monthly Service Report by the 20th of each month. The Monthly Service Report is not required when services are reimbursed through Fee for Service claims.

b. Using the template provided by Carelon, the Contractor shall submit an MHBG Annual Progress Report by July

VI: If Facility is providing services outlined in Exhibit B-11 Substance Use Disorder Program Provisions, the following additional reporting requirements apply.

(1) If Facility is providing Outreach and Engagement services as detailed in the Allowable Services Table, a detailed accounting must be included with the invoice for these hourly services. Detail shall include location, date, topic, and number of attendees for community education events and/or a de-identified spreadsheet of encounters to document outreach and engagement to individuals using the template provided by Carelon.

(2) For all SABG funded services:

a. On a quarterly basis, on the 20th of the month following the close of the quarter, Facility shall submit the SABG Capacity Management Form.

b. Using the template provided by Carelon, the Facility shall submit a SABG Monthly Service Report by the 20th of each month. The Monthly Service Report is not required when services are reimbursed through Fee for Service claims.

c. Using the template provided by Carelon, the Facility shall submit an SABG Annual Progress Report by July 1.

(3) For all CJTA funded services:

a. Facility will provide all data necessary to inform the development and monitor the implementation of any local HCA approved CJTA plans.

b. Facility will submit a quarterly CJTA Quarterly Progress Report. The report is due on January 15 (October-December), April 15 (January-March), July 15 (April-June), and October 15 (July-September).. CJTA Quarterly Progress Report must include the following program elements:

i. Number of Individuals served under CJTA funding for that time period;

ii. Barriers to providing services to the criminal justice population;

iii. Strategies to overcome the identified barriers;

iv. Training and technical assistance needs;

v. Success stories or narratives from Individuals receiving CJTA services; and

vi. If a Therapeutic Court provides CJTA funded services: the number of admissions of Individuals into the program who were either already on medications for opioid use disorder, referred to a prescriber of medications for opioid use disorder, or were provided information regarding medications for opioid use disorder.

(4) For all DCA funded services:

a. Facility will submit a quarterly DCA Progress Report using the template provided by Carelon, by the 20th of the month following the close of the quarter.

COMMISSIONER'S AGENDA ITEM COMMENTARY

SUBMITTED BY	Community Health Department
AGENDA DATE	BOCC, 4/23/2024
SUBJECT	CHPW Behavioral Health Services Contract
ACTION REQUESTED	Signature

Signature

SUMMARY/BACKGROUND

Renews agreement to receive payment from CHPW for Behavioral Health Services.

FISCAL IMPACT

FEE FOR SERVICES REVENUE CONTRACT - TBD

RECOMMENDATION

Sign

LIST ATTACHMENTS

Face Sheet
Agreement

COUNTY FACE SHEET FOR CONTRACTS/LEASES/AGREEMENTS

1. Contract Number _____

2. Contract Status: (Check appropriate box) ☐ Original ☒ Renewal ☐ Amendment

3. Contractor Information:

Contractor:	**Community Health Plan of Washington**
Contact:	Cathy Neiman
Email:	cathy.neiman@chpw.org
Phone:	206-613-8974

4. Brief description of purpose of the contract and County's contracted duties:
Renews Agreement with Health Plan to provide Behavioral Health services

5. Term of Contract: From: January 1, 2024 To: Ongoing

6. Contract Award Process: (Check appropriate box)
General Purchase of materials, equipment or supplies - RCW 36.32.245 & 39.04.190

☒ Exempt (Purchase is $2,500 or less upon order of the Board of Commissioners
☐ Informal Bid Process (Formal Quotes between $2,500 and $25,000)
☐ Formal Sealed Bid Process (Purchase is over $25,000)
☐ This contract was awarded under RCW 39.29 or Skamania County Code _____. Please provide a summary of the competitive process by which this contract was awarded or the exemption and why it applies.

_____

_____

Public Works Construction & Improvements Projects – RCW 36.32.250 & 39.04.155 (Public Works, B&G, Capital Improvements Only)

☐ Small Works Roster (PW projects up to $200,000)
☐ Exempt (PW projects less than $10,000 upon order of the Board of Commissioners)

7.

Amount Budgeted in Current Year:	$	
Amount Not Budgeted in Current Year	$	Source:
Total Non-County Funds Committed:	$TBD	Source: Revenue Contract
TOTAL FUNDS COMMITTED:	$TBD	Fee For Services

8. County Contact Person: Name: Allen Esaacson
Title: Data & Finance Manager

9. Department Approval: _____
Department Head or Elected Official Signature

Special Comments:
Please email signed copy to Cathy Neiman at cathy.neiman@chpw.org

COMMUNITY HEALTH PLAN OF WASHINGTON
PROVIDER AGREEMENT

This Agreement ("Agreement") is made by and between **Community Health Plan of Washington** ("CHPW"), a not for profit Washington Corporation, and **Skamania County Community Health** ("Contractor") and is effective **January 1, 2024** ("Effective Date").

RECITALS

A. Community Health Plan of Washington ("CHPW") is a 501(c)(4) tax exempt entity, accredited by the National Committee on Quality Assurance ("NCQA") and certified as a health care services contractor, organized and operating under the laws of the State of Washington to provide or arrange for provision of covered health care services to individuals enrolled in its Benefit Plans ("Members");

B. CHPW arranges for provision of covered health services to Members pursuant to its contracts with state and federal agencies, including Washington State Health Care Authority ("HCA"), and Centers for Medicare and Medicaid Services ("CMS"), that sponsor various health programs (collectively, "state and federal sponsored health programs");

C. Contractor has employed or contracted with duly licensed providers of health care services located in the State(s) in which it provides health care services and has met CHPW's criteria to be a provider of health care services for Members; and

D. CHPW desires to contract with Contractor to provide Covered Services to Members pursuant to this Agreement and CHPW Benefit Plans, and Contractor desires to contract with CHPW to provide such services. This Agreement is written in compliance with 42 CFR 434.6.

NOW, THEREFORE, in consideration of the recitals, mutual promises, covenants, and agreements set forth herein, both parties agree as follows:

AGREEMENT

1. DEFINITIONS

The following definitions shall apply to this Agreement, except to the extent that they may be superseded by definitions that are specific to a particular health benefit plan on the applicable Benefit Plan Exhibit in Exhibit B and/or available at www.CHPW.org.

1.1 "Agreement" means this Provider Agreement, entered into between CHPW and Contractor, with all amendments, schedules and exhibits hereto.

1.2 "Benefit Plan" means a healthcare benefit product, defined by the applicable plan sponsor, which is offered or administered by CHPW for the payment of Covered Services provided to Members, including without limitation state and federal sponsored health programs. Each Benefit Plan is governed by one or more Benefit Plan Exhibits as indicated on Exhibit B.

1.3 "CHPW Health Benefit Exchange Product" (also referred to as "the CHPW Exchange Product" or "CHPW HBE Product") means those health benefit programs offered and sold by CHPW to individuals or groups who obtain health coverage through the Washington Health Benefit Exchange.

1.4 "Clean Claim" means a reimbursement claim for provision of Covered Services submitted by Contractor to CHPW that is (i) in the form required by CHPW, (ii) complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Administrative Simplification for Electronic Data Interface, and (iii) has no defect or impropriety that may prevent timely or accurate payment of the claim such as failure to include necessary substantiating documentation, encounter data or documentation of particular circumstances requiring special treatment.

1.5 "Contracted Participating Provider" is an individual or entity that is a duly licensed, certified or registered health care provider, is employed or subcontracted by or otherwise associated with Contractor, and who, upon credentialing by CHPW, becomes a Participating Provider.

1.6 "Copayments, Coinsurance and Deductibles" (also referred to as "Cost Sharing") are payments a Member may be required to make to Contractor in accordance with the conditions of the Member's Benefit Plan.

1.7 "Covered Services" are the Medically Necessary health care services that are reimbursable under a Member's Benefit Plan.

1.8 "Critical Incident" means a situation or occurrence that places a Member at risk for potential harm or causes harm to a Member. Examples include homicide (attempted or completed), suicide (attempted or completed), the unexpected death of a Member, or the abuse, neglect, or exploitation of a Member by an employee or volunteer.

1.9 "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in

serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

1.10 "Emergency Services" means inpatient and outpatient services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition.

1.11 "Health Benefit Exchange" (also referred to as "the Exchange" or "HBE") means the Washington health benefit exchange established in RCW 43.71.020, et seq., the Health Benefit Exchange Act and regulated by the Washington State Office of the Insurance Commissioner ("OIC").

1.12 "Individual with Special Health Care Needs" ("ISHCN") means a Member who meets the diagnostic and risk score criteria for Health Home Services, or is a child with special health care needs, or has a chronic or disabling condition that: (i) has a biologic, psychologic, or cognitive basis; (ii) is likely to continue for more than one year; and (iii) causes either significant limitation in areas of physical, cognitive, or emotional functions, or dependency on medical or assistive devices to minimize limitations of function or activities.

1.13 "Medically Necessary" means a service or supply which meets all of the following criteria:

1.13.1 is consistent with the symptoms or diagnosis and treatment of the Member's condition;

1.13.2 is the most appropriate supply or level of service that is essential to the Member's needs and meets the recognized standards of medical care;

1.13.3 when applied to a Member inpatient, cannot be safely provided to the Member in a less restrictive setting;

1.13.4 is not experimental or investigative;

1.13.5 is consistent with good medical practice;

1.13.6 is not provided primarily for the convenience of the Member, Contractor or Contracted Participating Provider; and

1.13.7 is the most cost-effective of the alternative levels of service or supplies that are adequate and available.

1.14 "Member" is an individual enrolled in a Benefit Plan, who is entitled to receive Covered Services pursuant to that Benefit Plan.

1.15 "Non-Participating Provider" means a professional health care provider, facility, or legal entity that does not have a written agreement with CHPW to participate in CHPW's Provider Network and has not been credentialed by CHPW but may provide health care services to Members upon referral and prior authorization.

1.16 "Participating Provider" means an individual healthcare practitioner or entity that is duly licensed, certified, and/or registered by the appropriate state or other governmental board or agency, is credentialed by CHPW or its delegate, and under a written agreement with CHPW that is current at the time Covered Services are rendered. Participating Providers are collectively referred to as CHPW's "Provider Network".

1.17 "Primary Care Provider" or "PCP" means a Participating Provider who is responsible for (i) providing primary health care, (ii) initiating referrals for specialist and inpatient care, and (iii) supervising, coordinating and maintaining continuity of Members' health care.

1.18 "*Provider Manual*" refers to applicable CHPW manuals, policies and procedures, and documents, as periodically revised, including those that refer to Program Integrity requirements, credentialing, utilization management, prior authorization requirements, claims, and encounter submission, payment, drug formulary, and Participating Provider lists. The *Provider Manual* and associated information are available to Contractor online through www.CHPW.org.

1.19 "Provider Preventable Condition" is an umbrella term for acquired conditions (hospital and nonhospital) identified by the HCA for nonpayment to ensure the high quality of medical services provided to Apple Health enrollees. Provider Preventable Condition(s) includes Other Provider Preventable Conditions and Health Care-Acquired Conditions, as those terms are defined in WAC 182-502-0022.

1.20 "Service Area" means those geographic areas in which CHPW is contracted to provide Covered Services to Members.

1.21 **"**Urgently Needed Services" means Covered Services, other than Emergency Services, that are provided without a written referral when a Member is experiencing an Urgent Medical Condition and is either (i) temporarily absent from CHPW's Service Area or CHPW's Provider Network is temporarily unavailable or inaccessible, or (ii) when it is unreasonable, under the circumstances, for the Member to obtain such services through CHPW Participating Providers.

1.22 "Urgent Medical Condition" means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity such that if services are not received within 24 hours of the request, the individual's situation is likely to deteriorate to the point that Emergency Services are necessary.

1.23 **Additional Definitions.** Additional definitions pertinent to CHPW's state sponsored health benefit plans are available at www.CHPW.org.

2. OBLIGATIONS OF CONTRACTOR

2.1 **Engagement.** CHPW hereby engages Contractor to participate in CHPW's Provider Network, and Contractor hereby accepts such engagement pursuant to the terms and conditions hereunder.

2.2 Contractor and Contracted Participating Providers, Licenses and Credentialing.

2.2.1 Contractor shall select each individual Contracted Participating Provider in accordance with Contractor's written procedures, which shall include consideration of the individual's professional qualifications, experience, and ability to deliver efficient, effective health care services to Members. Each Contracted Participating Provider who provides Covered Services to Medicare Advantage Members must be a Certified Medicare Provider.

2.2.2 Contractor shall cooperate and comply with CHPW credentialing criteria and verification procedures for Participating Providers. Contractor represents and warrants that each of its Contracted Participating Providers is fully qualified and duly licensed and/or certified by the appropriate state or other governmental board or agency to provide healthcare services within the scope of the Contracted Participating Provider's license. Contractor and Contracted Participating Providers shall maintain such license(s) and/or certification(s) in good standing. Contractor will provide prompt written notice to CHPW of any changes in the license or certification of any of its Contracted Participating Providers, any legal or governmental action, or any other situation which may adversely impair the Contracted Participating Provider's ability to provide Covered Services to Members pursuant to this Agreement, in no case longer than five (5) days after Contractor becoming aware of any such circumstances.

2.2.3 Contractor shall provide an accurate list of Contracted Participating Providers with status designations as "employed by Contractor" or "subcontracted with Contractor" in Exhibit A. Contractor shall promptly notify CHPW in writing of changes in its list of Contracted Participating Providers and/or their status designations by providing a revised Exhibit A in accordance with the procedures outlined in the *Provider Manual*, and in no case more than thirty (30) days after a change becomes effective.

2.2.4 Contractor shall orient Contracted Participating Providers, employees and subcontractors to the applicable terms of this Agreement, the *Provider Manual*, and to other areas specifically designated by CHPW, including Member rights, marketing, enrollment and disenrollment procedures, risk management, customer service, claims preparation and authorizations, hospital admission notification and certification, transfer and discharge procedures.

2.2.5 In performing its duties hereunder, Contractor shall require its Contracted Participating Providers to comply with all applicable terms of this Agreement and the Benefit Plans listed on Exhibit B, and applicable requirements of the *Provider Manual*, as amended by CHPW from time to time at its sole discretion.

2.2.6 Contractor shall ensure that Contracted Participating Providers participate in continuing education programs required by law. Contractor shall participate in and cooperate with CHPW's education and training programs for Contracted Participating Providers and for Members.

2.2.7 CHPW may terminate a Contracted Participating Provider's participation upon thirty (30) days' notice to Contractor due to a violation of the terms of this Agreement, and immediately upon a Contracted Participating Provider's failure to maintain compliance with CHPW's credentialing requirements. A Contracted Participating Provider's exercise of any rights they may possess to appeal such termination shall not change the effective date of such termination.

2.2.8 Contractor represents and warrants that neither it nor its Contracted Participating Providers is or has been excluded from participation in any state or federally funded health care program, including Medicare and Medicaid. Contractor shall promptly notify CHPW of any threatened, proposed, or actual exclusion of Contractor, a key employee or a Contracted Participating Provider from any state or federally funded health care program.

2.2.9 Contractor shall have and maintain for the term of this Agreement all necessary licenses, certifications, permits, and other permissions required by law for the performance of its obligations hereunder. Contractor shall notify CHPW immediately in the event of a change in the status of Contractor's required licenses, certifications, or other required permissions. Contractor's loss or suspension of licensure or its exclusion from any federally funded health care program, including Medicare and Medicaid, shall constitute cause for immediate termination pursuant to Section 6.2 of this Agreement.

2.3 Services.

2.3.1 Contractor has service locations and Contracted Participating Providers listed on Exhibit A attached hereto. Subject to Section 2.4.7, Contractor shall notify CHPW in writing within sixty (60) days of changes in its list of locations, Contracted Participating Providers and their status as employees or subcontractors. The process for updating Exhibit A is contained in the *Provider Manual.*

2.3.2 Contractor shall provide or arrange for provision of efficient and effective Covered Services through its Contracted Participating Providers to Members of those Benefit Plans identified on Exhibit B. Covered Services shall be Medically Necessary and appropriate to each Member's clinical condition in accordance with the *Provider Manual*, industry standards, accreditation requirements, and applicable state and federal laws and regulations.

2.3.3 Contractor shall participate in and cooperate with CHPW's education and training programs for Participating Providers and for Members.

2.3.4 Contractor shall provide all Covered Services hereunder to Members in the same manner and timeliness as such services are made available to non-Members, without regard to an individual's participation in private health care coverage or in a publicly funded Benefit Plan, in accordance with this Agreement and industry standards.

2.3.5 Before providing Covered Services, other than screening and treatment for Emergency Medical Conditions, Contractor shall verify each Member's eligibility either electronically at www.CHPW.org, as set forth in the *Provider Manual,* or by calling CHPW's Customer Service Department at the telephone number printed on the back of Member's CHPW identification card.

2.3.6 Contractor shall not delegate the provision of Covered Services without CHPW's prior written approval. To the extent Contractor subcontracts provision of any Covered Services, such subcontracts shall be in writing and include a requirement for compliance with all provisions of this Agreement, including without limitation the credentialing, insurance and hold harmless sections.

2.3.7 If Contractor provides primary care services, Contractor shall assure that each Member is assigned to a PCP Participating Provider.

2.3.7.1 In consultation with other appropriate health care professionals such as care managers, community health workers or community-based care managers, PCPs shall provide, coordinate, and supervise health care to meet the needs of each Member, including initiation and coordination of referrals for medically necessary specialty care.

2.3.7.2 In consultation with other appropriate health care professionals, PCPs shall assess and develop individualized treatment plans for Members meeting the definition of an Individual with Special Health Care Needs. Such treatment plans shall ensure the integration of appropriate clinical and non-clinical disciplines and services in the overall plan of care.

2.3.8 Each Contracted Participating Provider shall exercise independent medical judgment and control over his/her professional services. Nothing herein shall give CHPW authority over Contracted Participating Provider's medical judgment or direct the means by which s/he practices within the scope of his/her licensed, certified, and/or registered practice.

2.3.9 Each Participating Provider is responsible for their relationship with each Member the Participating Provider treats, and for the quality of health care services provided to Members. Contractor shall be solely responsible to each Member for medical care provided.

2.3.10 Contractor shall assist CHPW with the transfer of any Member who has selected a Contracted Participating Provider and is receiving Emergency Services or other authorized care from a non-participating facility to a participating facility at which the Contracted Participating Provider or another suitable Participating Provider has admitting privileges in accordance with the CHPW Medical Director's determination of the medical acceptability of such transfer.

2.3.11 To the extent that Contractor's PCPs have capacity, Contractor's PCPs shall accept enrollment of any Member at CHPW's request. Contractors providing primary care services may close enrollment of new Members due to lack of capacity, after providing forty-five (45) days written notice to CHPW and with written approval from CHPW, which shall not be unreasonably withheld. Contractor's enrollment of Members shall not be closed if enrollment remains open to other plans or lines of business.

2.3.12 Contractor shall cooperate with, participate in, and provide information and data necessary to support, CHPW's Care Coordination activities and to meet HCA care coordination obligations.

2.3.13 Critical Incident Reporting. Contractor shall provide immediate notification to CHPW of any Critical Incident involving a Member. Notification shall be made during the business day on which Contractor becomes aware of the Critical Incident. If Contractor becomes aware of a Critical Incident involving a Member after business hours, Contractor shall provide notice to CHPW as soon as possible the next business day. Contractor shall provide to CHPW all available information related to a Critical Incident at the time of notification, including: a description of the event, including the date and time of the incident, the incident location, incident type, information about the individuals involved in the incident and the nature of their

involvement, the Member's or other involved individuals' service history with Contractor, steps taken by Contractor to minimize potential or actual harm, and any legally required notification made by Contractor. Upon CHPW's request and as additional information becomes available, Contractor shall update the information provided to CHPW regarding the Critical Incident and, if requested by CHPW, Contractor shall prepare a written report regarding the Critical Incident, including any actions taken in response to the incident, the purpose for which such actions were taken, any implications to Contractor's delivery system, and efforts designed to prevent or lessen the possibility of future similar incidents.

2.3.14 Discharge Planning Services. If Contractor provides Covered Services in twenty-four (24) hour care settings, Contractor must provide discharge planning services, which shall include, at a minimum:

2.3.14.1 Coordination of a community-based discharge plan for each Member, beginning at intake, and regardless of length of stay or whether the Member completes treatment;

2.3.14.2 Coordination of information with the referring entity, including ensuring the exchange of assessment, admission, treatment progress, and continuing care information, where applicable. Contact with the referring entity must be made within the first week of residential treatment, where applicable;

2.3.14.3 As applicable, establishment of referral relationships with assessment entities, outpatient providers, vocational or employment services, and courts, which specify aftercare expectations and services, including procedure(s) for involvement of entities making referrals in treatment activities;

2.3.14.4 As applicable, coordination with appropriate community resources and services, including, for example, DBHR prevention services, vocational services, services available through the DSHS Children's and Economic Services Administrations, and/or housing services and supports; and

2.3.14.5 Coordination of medical services, as needed, for eligible Members.

2.3.15 Behavioral Health Screening and Assessment. If Contractor provides Behavioral Health services, Contractor shall utilize the Global Appraisal of Individual Needs-Short Screener (GAIN-SS) and assessment process, including use of the quadrant placement. If the results of the GAIN-SS are indicative of the presence of a co-occurring disorder, Contractor shall consider this information in the development of the Member's treatment plan, including appropriate referrals. In addition, Contractor shall implement, and maintain throughout the term of this Agreement, the Integrated Co-Occurring Disorder Screening and Assessment process, including training for applicable staff. If Contractor fails to implement or maintain this process, CHPW shall require and monitor Contractor's compliance with a corrective action plan designed to ensure compliance with the requirements of this Section.

2.4 Member Access to Services.

2.4.1 Contractor shall provide Members with access to Covered Services on the same basis as such services are made available to individuals who are not Members.

2.4.2 A PCP Participating Provider must provide Members with 24-hour-a-day, seven-days-a-week access by phone to a health care professional for the purpose of rendering medical advice concerning emergent, urgent or routine medical conditions, and for authorizing Emergency Medical Services and out of area urgent care services. Such advice shall be provided by a health care professional licensed to practice independently or a physician's assistant.

2.4.3 A specialty care Participating Provider must provide Members with 24-hour-a-day, seven-days-a-week access by phone to a health care professional for the purpose of rendering medical advice concerning emergent, urgent or routine medical conditions. Such advice shall be provided by a health care professional licensed to practice independently or a physician's assistant

2.4.4 Contractor shall maintain an appointment system for Members' prompt access to health care in compliance with the following appointment wait time standards:

- To the extent applicable, transitional healthcare by a PCP available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.
- To the extent applicable, transitional health care by a home care nurse or home care registered counselor within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by a Member's PCP or as part of the discharge plan.
- Non-symptomatic (i.e., preventative care) – 30 calendar days.
- Non-urgent, symptomatic (i.e., routine care) – 10 calendar days.
- Urgent – 24 hours.
- Emergency care access – 24/7 provided at area Hospital Emergency Departments.

In the event that CMS, HCA, or another applicable state or federal authority, enact more stringent appointment wait time standards, Contractor shall adopt and abide by the most stringent standard(s) applicable for all CHPW Members. CHPW shall monitor Contractor's compliance with applicable appointment wait time standards and may take corrective action in the event Contractor fails to comply.

2.4.5 At least annually and upon CHPW request, Contractor shall provide to CHPW a report on its capacity for additional primary care enrollment or capacity to provide specialty Services.

2.4.6 Contractor shall provide CHPW at least one hundred twenty (120) calendar days written notice before Contractor, any Contractor location, or any Contracted Participating Provider ceases providing Covered Services to Members.

2.4.7 If a Contracted Participating Provider's participation with CHPW is discontinued by either party, Members undergoing an active course of treatment (including treatment for second or third trimester pregnancy and postpartum care) with a terminated Contracted Participating Provider, shall be given the option to continue such treatment with the terminated Contracted Participating Provider for ninety (90) days following the effective date of the Contracted Participating Provider's termination or completion of the active course of treatment, whichever occurs first. A Member who is receiving inpatient care on the effective date of Contracted Participating Provider's termination shall continue receiving Services from the terminated Contracted Participating Provider until the Member has been discharged from inpatient treatment or transferred to another Participating Provider. CHPW shall reimburse Contractor in accordance with the reimbursement rate provided herein for any Covered Services rendered in accordance with this Section after the effective termination date. Contractor shall work with the terminating Contracted Participating Provider and impacted Member(s) to develop a reasonable transition plan. This Section 2.4.7 shall not apply to Contracted Participating Providers terminated for incompetence, unprofessional conduct, or loss of license or exclusion from Medicare or Medicaid.

2.4.8 Termination of Contracted Primary Care Provider(s). CHPW shall provide written notice to each Member affected by the termination or cessation of practice of the Member's Contracted PCP at least thirty (30) calendar days prior to the effective date of such termination or cessation. Such notice shall include the PCP's name, effective date of termination, the procedure for selecting another PCP, and an offer to assist the Member to select a new PCP.

2.4.9 Termination of Contracted Specialty Care Provider or Specialty Group. Contracted specialty groups and individual specialists shall provide timely written notice to Members of pending termination or cessation of their practice. Notwithstanding the foregoing, CHPW shall be responsible to notify in writing each Member affected by termination or cessation of a specialty group's or individual specialist's practice. CHPW shall provide such notice to affected Members prior to the effective date of such termination or cessation of practice.

2.4.10 Contractor shall give CHPW at least ninety (90) calendar days written notice before opening any additional sites or satellite facilities that are not currently listed on Exhibit A. Within sixty (60) calendar days of receiving the notice, CHPW shall approve or disapprove in writing the use of such locations for providing Covered Services to Members.

2.4.11 CHPW will monitor Member access to and availability of Contracted Participating Providers and inform Contractor of significant concerns and Member complaints about access to or availability of Covered Services. If a CHPW access study shows excessive Member wait times for appointments, CHPW may suspend further enrollment or referrals of Members with Contractor until capacity improves and another access study shows acceptable wait times.

2.5 Member Rights.

2.5.1 Contractor and Contracted Participating Providers shall in all instances obtain informed consent prior to treatment.

2.5.1.1 Without regard to Benefit Plan limitations or cost, Contractor and Contracted Participating Providers shall communicate freely and openly with Members (i) about their health status, and treatment alternatives (including

medication treatment options); (ii) about their rights to participate in treatment decisions (including refusing treatment); and (iii) providing them with relevant information to assist them in making informed decisions about their health care.

2.5.1.2 If applicable, Contractor shall assure that all sterilizations and hysterectomies performed for Members are in compliance with 42 CFR 441 Subpart F, and that the Washington State Health Care Authority ("HCA") Sterilization Consent form HCA 13-364 or its equivalent is used. No payment shall be made under state sponsored Benefit Plans for sterilization procedures and hysterectomies that do not comply with the requirements of this paragraph.

2.5.1.3 Contractor shall comply with the Natural Death Act, HCA, CMS and other applicable rules concerning advance directives and, when appropriate, inform Members or their representatives of their right to make anatomical gifts. Contractor shall assure that the existence of an Advanced Directive is documented in each Member's record in compliance with the Patient Self-Determination Act of 1990.

2.5.2 Contractor shall provide care in a culturally competent manner and shall provide or arrange for interpretive services for each Member who is hearing impaired, or whose oral or written language creates a barrier to access, for all contacts between Contractor and Member including appointments for provision of Covered Services, emergent and urgent services, telephone contacts, and assistance with all steps necessary to file Member complaints and appeals. Contractor shall assure that all generally available written materials provided to Members are developed at the 6th grade reading level, translated into the Member's primary reading language, or audibly in the Member's primary language or provided in an alternative medium or format acceptable to the Member and approved by CHPW.

2.6 Utilization Review and Quality Assurance.

2.6.1 Contractor shall maintain a quality improvement system (i) tailored to the nature and types of Covered Services provided hereunder, (ii) which affords quality control for health care provided, including Covered Services, and (iii) provides for free exchange of information between CHPW and Contractor.

2.6.2 Contractor shall comply with, and cooperate and participate in, utilization review, applicable Performance Improvement Projects ("PIPs") and PIP requirements, quality improvement, quality assurance programs, necessity of care evaluations, coordination of benefit activities, health care coding reviews and cost containment activities, as set forth in the *Provider Manual* and as CHPW deems necessary, including concurrent and retrospective reviews, audits and/or reviews by independent quality improvement organizations and accreditation agencies.

2.6.2.1 Contractor shall cooperate with CHPW's collection, production and distribution of comparative data for quality assurance and utilization review. CHPW may use such data regarding Contractor and its Contracted Participating Providers' performance in activities such as quality improvement, public reporting to consumers, preferred status designations and other activities that promote transparency to consumers and Members.

2.6.2.2 Contractor shall cooperate and communicate freely with CHPW regarding quality issues and notify CHPW of any Member's medical situation or special health care needs that may benefit from case management in accordance with the conditions of the Members' Benefit Plans and the *Provider Manual.*

2.7 Member Complaint Procedures. Contractor shall cooperate and comply with CHPW's Member complaint and appeals procedures as set forth in the *Provider Manual*, for resolution of any Member complaints or appeals that may arise from Contractor's provision of services, or CHPW's denial of coverage, under this Agreement. Contractor shall notify CHPW of Member complaint or appeal that it receives and the subsequent resolution. Contractor shall cooperate with CHPW in the investigation and resolution of Member complaints or appeals received by CHPW regarding Contractor or a Contracted Participating Provider's provision of services.

2.8 Record Keeping and Access. Contractor shall prepare, maintain, and retain accurate Member health records including appropriate medical, administrative and financial records related to this Agreement and to Covered Services provided hereunder in accordance with the *Provider Manual*, industry standards, applicable state and federal sponsored health programs, and applicable federal and state statutes and regulations. Such records shall be maintained for the maximum period required by federal or state law as set forth in Section 5.5, below. CHPW shall have continued access to Contractor's records necessary for CHPW to perform its obligations hereunder, to administer its Benefit Plans, and to comply with federal or state law or regulations and applicable accreditation requirements. CHPW prefers electronic copies of such information, data and records, but Contractor may provide hard copies at its own expense.

2.9 Member Copayments, Coinsurance, Deductibles.

2.9.1 Contractor shall collect and may retain Member Cost Sharing amounts authorized under the applicable Member's Benefit Plan for Covered Services.

2.9.2 Copayments that Contractor charges a Member hereunder shall not exceed the actual cost of providing the associated Covered Services.

2.9.3 Members enrolled in a CHPW Medicare Advantage Special Needs Plan and for whom a state provides coverage ("Dual Eligible Enrollees") will not be required to pay any Cost Sharing Amounts for Services covered by Medicare Parts A or B, when the applicable state Medicaid Program is required to pay.

2.9.3.1 In lieu of collecting such Cost Sharing Amounts under the Medicare Advantage Benefit Plan, Contractor may either (i) bill such Cost Sharing Amounts to the appropriate state Medicaid source, or (ii) forego collecting Cost Sharing Amounts and accept the Medicare Advantage Benefit Plan reimbursement as payment in full.

2.9.3.2 Contractor may determine that a Member is a Dual Eligible Enrollee by reviewing plan information on the Member's ID card, or through CHPW's electronic provider portal(s).

2.10 Non-Covered Services. Contractor and Contracted Participating Providers shall notify Members of their personal financial obligations for non-Covered Services before rendering such

services. Contractor and Contracted Participating Providers shall not bill a Member for non-Covered Services unless the Member has, prior to the provision of non-Covered Services, signed a written acknowledgement and acceptance of financial responsibility after full written disclosure of (i) Contractor's intent to bill Member for non-Covered Services, and (ii) the non-liability of CHPW for such non-Covered Services.

2.11 Hold Harmless and Insolvency.

2.11.1 In no event, including, but not limited, to non-payment by CHPW, CHPW insolvency, or breach of this Agreement, shall Contractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member, a person acting on a Member's behalf, or HCA for Services provided under this Agreement. This provision shall not prohibit Contractor's collection of copayments, coinsurance and deductibles, or fees for non-covered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from a Member in accordance with the terms of Member's Benefit Plan.

2.11.2 In the event of CHPW's insolvency, Contractor shall continue to provide the Services promised under this Agreement to Members for the duration of the period for which premiums on behalf of Members were paid to CHPW or until Member is discharged from inpatient facilities, whichever time is greater.

2.11.3 Notwithstanding any other provision herein, nothing in this Agreement shall be construed to modify the rights and benefits contained in a Member's Benefit Plan.

2.11.4 Contractor may not bill Members for Covered Services (except for copayments, coinsurance and deductibles) when CHPW denies payment because Contractor failed to comply with the terms of this Agreement.

2.11.5 If Contractor contracts with other care providers who are not Participating Providers, and who agree to provide Covered Services to Members with the expectation of receiving payment directly or indirectly from CHPW, such providers must agree in writing to abide by the provisions of this Section 2.11.

2.11.6 Contractor further agrees that this Section 2.11 shall survive termination of this Agreement regardless of the cause giving rise to such termination, and shall be construed to be for the benefit of CHPW Members. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Contractor and Members or persons acting on a Member's behalf.

2.11.7 If Contractor willfully collects or attempts to collect an amount from a Member under any of the provisions outlined above, the act will constitute a class C felony under RCW 48.80.030(5).

2.12 Referrals and Authorizations.

2.12.1 Contractor shall not refer a Member to a Non-Participating Provider without prior written authorization from CHPW, except when necessary in the case of Emergency Services or

Urgently Needed Services. Contractor must notify CHPW of referrals for Emergency Services or Urgently Needed Services by the next business day.

2.12.2 Contractor shall cooperate and comply with prior authorization, hospital admission and certification procedures required by the then current *Provider Manual.*

2.12.3 Consistent with applicable law and the *Provider Manual*, Contractor shall use best efforts to refer Members to other Participating Providers for appropriate, Medically Necessary Covered Services when such Services are not available from Contractor.

2.12.4 To the extent that Contractor is billing for pharmacy claims, Contractor shall be subject to the *Provider Manual* terms with regard to prior authorization procedures including policies regarding emergency fill authorizations.

2.13 Insurance Requirements.

2.13.1 Contractor shall maintain the insurance coverage limits set forth below, to cover all of Contractor's Services under this Agreement, in the minimum amounts specified in this Section, except as otherwise agreed:

2.13.1.1 Professional liability coverage, including negligence and errors and omissions coverage, with a minimum limit of One Million Dollars ($1,000,000) per occurrence, and Three Million Dollars ($3,000,000) annual aggregate. These limits must apply per Contracted Participating Provider, and shall not be shared amongst Contractor's Contracted Participating Providers.

2.13.1.2 Commercial and comprehensive general liability coverage, with a minimum limit of One Million Dollars ($1,000,000) per occurrence, and One Million Dollars ($1,000,000) annual aggregate.

2.13.1.3 Applicable state statutory limits for workers compensation.

2.13.1.4 Other usual or customary insurance coverage, or an equivalent program of self-insurance, applicable to the work being performed and the Services Contractor provides under this Agreement, and acceptable to CHPW.

2.13.1.5 To the extent applicable, coverage for Federally Qualified Health Centers under the Federal Torts Claims Act will be deemed to meet the requirements of this Section 2.9.

2.13.2 By requiring insurance herein, CHPW does not represent that coverage and limits will necessarily be adequate to protect Contractor. Such coverage and limits shall not be deemed as a limitation on Contractor's liability under the indemnities granted to CHPW herein.

2.13.3 Contractor will promptly notify CHPW of any cancellation, reduction, or other material change in the amount or scope of Contractor's required coverage. Upon CHPW's request, Contractor will furnish to CHPW a certificate of insurance evidencing all of the policies of insurance and limits required hereunder.

2.13.4 All policies maintained by Contractor shall be primary with respect to any insurance maintained by CHPW. Failure to maintain the required insurance constitutes cause for termination of the Agreement.

2.13.5 The requirements of this Section 2.9 shall survive termination or expiration of this Agreement.

2.14 Administrative Matters. In performing its duties hereunder, Contractor shall comply, and require its Contracted Participating Providers to comply, with applicable requirements of the *Provider Manual* that CHPW may amend from time to time at its sole discretion. Without limiting the generality of the foregoing:

2.14.1 Contractor shall comply with RCW 48.135 concerning Insurance Fraud Reporting and notify CHPW's Compliance Department of all incidents or occasions of suspected fraud, waste or abuse involving Services provided to a Member. Contractor shall report a suspected incident of fraud, waste or abuse, including a credible allegation of fraud, within five (5) business days of the date Contractor first becomes aware of, or is on notice of, such activity. The obligation to report suspected fraud, waste or abuse shall apply whether the suspected conduct was perpetrated by Contractor, Contractor's employee, agent, or subcontractor, or Member. Contractor shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against suspected fraud, waste or abuse. Upon request by CHPW or the State, Contractor shall confer with the appropriate State agency prior to or during any investigation into suspected fraud, waste or abuse. For purposes of this section, the terms fraud and abuse shall have the same meaning as provided for in 42 CFR §455.2.

2.14.1.1 CHPW shall not penalize Contractor because Contractor, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare or that may violate state or federal law.

2.14.1.2 Contractor will maintain policies and procedures that require its managers, officers, and directors, who are involved in work that relates to Members, to complete and sign a Conflict of Interest Statement upon hiring or appointment, and annually thereafter, and to report potential conflicts of interest that may arise.[1]

2.15 Audio Only Telemedicine. In accordance with Washington state law, if a provider intends to bill a patient or CHPW for an audio-only telemedicine service, the provider must obtain the patient's consent for the billing in advance of the service being delivered. A provider's failure to obtain such consent may result in disciplinary action against the provider. Effective January 1, 2023, providers must also have an "established relationship" with the patient to bill for audio-only telemedicine services.

[1] A conflict of interest may arise if a person or a member of his/her family has an existing or potential interest or relationship that impairs or appears to impair the person's independent judgment.

2.15.1 For purposes of this Section, "established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services, and:

2.15.1.1 For Covered Services included in the essential health benefits category of mental health and substance use disorder services, including behavioral health treatment: (i) within the past three years, the Member has had at least one in-person appointment or at least one real-time interactive appointment using both audio and video technology with the provider providing audio-only telemedicine, or with a provider employed at the same medical group or at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or (ii) the Member was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment or at least one real-time interactive appointment using both audio and video technology, with the Member and has provided relevant medical information to the provider providing audio-only telemedicine.

2.15.1.2 For any other Covered Service: (i) within the past two years, the Member has had at least one in-person appointment or, until July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine, or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or (ii) the Member was referred to the provider providing audio-only telemedicine by another provider who has had, within the past two years, at least one in-person appointment or, until July 1, 2024, at least one real-time interactive appointment using both audio and video technology with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine.

3. OBLIGATIONS OF CHPW

3.1 Reimbursement. CHPW shall reimburse Contractor for Covered Services it has provided to Members in accordance with this Agreement, the *Provider Manual*, and applicable state and federal law, regulation, guidance and instruction.

3.2 Eligibility. CHPW or its designee shall confirm a Member's eligibility for Covered Services upon Contractor's request.

3.3 Identification Cards. CHPW shall provide an identification card to each Member. The card will display status of membership with CHPW, Member's name, Benefit Plan identification number, name of Primary Care Clinic, copayment amounts, telephone number for prior approval authorization requests and notifications, and the claims address.

3.4 Data Requirements. CHPW shall provide Contractor with claim, encounter, and referral format requirements.

3.5 CHPW Insurance Coverage. CHPW shall maintain general comprehensive liability insurance in the amounts of $1,000,000 per occurrence and $3,000,000 in the aggregate and will provide Contractor evidence of such coverage upon request.

3.6 Provider Manual.

3.6.1 CHPW shall maintain and make accessible to Contractor its *Provider Manual* and associated information, policies and procedures, on its website, www.CHPW.org. The *Provider Manual* covers topics such as utilization review, general benefits information, quality assessment and improvement programs, credentialing, grievance procedures, billing and data reporting requirements, reimbursement terms and other relevant information.

3.6.2 CHPW may revise and update the Provider Manual from time to time. CHPW will provide Contractor not less than sixty (60) days' notice of a change that substantially affects Contractor's reimbursement or Covered Service delivery, unless changes to federal or state law or regulations or other circumstances make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to the termination and continuity of care provisions in Section VI., below, Contractor may terminate this Agreement, as set forth in Section 6.3, below, if the change is unacceptable to Contractor. If there are any conflicts between the Provider Manual and this Agreement, this Agreement shall prevail.

3.7 Non-Discouragement.

3.7.1 CHPW shall not in any way preclude or discourage Contractor from informing Members about healthcare they require, including various treatment options and whether, in Contractor's view, such care is consistent with medical necessity, medical appropriateness, or coverage under the Member's Benefit Plan. CHPW shall not prohibit, discourage or penalize Contractor from legally advocating on behalf of a Member with CHPW. Nothing in this Section 3.7, however, shall be construed to authorize Contractor to bind CHPW to pay for any service.

3.7.2 CHPW shall not preclude or discourage Contractor, Members, or those paying for their coverage, from discussing the comparative merits of different health carriers, even if such discussion is critical of CHPW.

3.7.3 Notwithstanding any other provision herein, CHPW shall not prohibit, directly or indirectly, any Member from freely contracting at any time to obtain any health care services outside a CHPW Benefit Plan on any terms or conditions a Member chooses. Nothing herein, however, shall be construed to bind CHPW to pay for services delivered outside a CHPW Benefit Plan.

3.8 Notification. CHPW will notify Provider of any adverse benefit determination that involves the pre-service denial of a treatment or procedure request by Provider.

3.9 Prescription Drug Utilization Management. In accordance with RCW 48.43.420, CHPW maintains a prescription drug utilization management program applicable to any Health Benefit Exchange Benefit Plans covered under this Agreement, including a clear, readily accessible, and convenient process to request an exception. Detailed information can be found on CHPW's website at https://www.cascadeselect.org/member-center/member-resources/prescription-drug-coverage/.

4. BILLING AND REIMBURSEMENT

4.1 Requirements.

4.1.1 For all billing and reimbursement activities, the parties shall comply with applicable billing instructions, practices and policy guidelines referenced herein, and as published and periodically updated in the *Provider Manual* and, as applicable, with HCA and CMS instructions and coverage/non-coverage determinations. If there is a conflict between the substance or interpretation of HCA billing instructions or guidelines and the *Provider Manual*, the *Provider Manual* shall control. If there is a conflict between the substance or interpretation of CMS instructions or determinations on coverage and the *Provider Manual*, the CMS instructions or determinations shall control.

4.2 Claims and Encounter Submission.

4.2.1 Contractor shall comply with the claims, encounter reporting, payment, and billing procedures set forth in the *Provider Manual,* and shall submit Clean Claims for Covered Services rendered to the address set forth on the Member's identification card in nationally approved standard formats, and through a CHPW approved clearinghouse. Contractor shall use best efforts to submit claims/encounters electronically. Without limiting the generality of the foregoing, encounters shall be submitted within thirty (30) days of the end of the month in which the service was rendered. Except as otherwise stated, Contractor shall use best efforts to submit claims/encounters electronically.

4.2.2 Upon request, Contractor shall furnish all information reasonably required by CHPW to substantiate the provision of and charges for Covered Services, at no charge to CHPW. Claim approval and payment for claims or encounters are contingent upon CHPW's receipt of complete and accurate information from Contractor.

4.2.2.1 CHPW's prior authorization through prospective and/or concurrent review does not guarantee payment.

4.2.2.2 CHPW reserves the right to assure, through audit and retrospective evaluation of a Member's documented medical care, and based on the information available to the attending physician or ordering provider at the time services were provided, that those services were Medically Necessary and claims were accurately coded. Such review or audit may result in denial of claims for services on the basis of medical Necessity or errors in claims submission and may adversely impact payment.

4.2.2.3 If it is determined that all or part of the payment of a claim for Services, other than Emergency Services, was based on information that, in the opinion of CHPW, is significantly different from the information that was available at the time of CHPW or its designee's original certification that the Member was eligible for the Covered Services authorized or provided, CHPW may request a refund.

4.2.3 CHPW shall not pay a claim received (i) more than three hundred and sixty-five (365) calendar days after the date a Covered Service was rendered, or (ii) more than sixty (60) calendar days after Contractor first receives notice that CHPW is a secondary payer under applicable coordination of benefit procedures.

4.3 Reimbursement.

4.3.1 CHPW shall reimburse Contractor for timely submitted Clean Claims for Covered Services Contractor provides to Members in accordance with this Section 4 and the applicable Benefit Plan Exhibit(s) in Exhibit B. Contractor shall accept such reimbursement, plus any applicable Cost Sharing Amounts, as payment in full for such Covered Services.

4.3.2 CHPW shall not pay a claim received (i) more than three hundred and sixty-five (365) calendar days after the date a Covered Service was rendered or the date of discharge, whichever is later or (ii) more than sixty (60) calendar days after Contractor first receives notice that CHPW is a secondary payer under applicable coordination of benefit procedures.

4.3.3 CHPW reserves the right to change the reimbursement rates set forth on each Benefit Plan Exhibit by written notice to Contractor in accordance with changes in rates paid by applicable federal, state, or other third-party payers. Such reimbursement shall be accepted by Contractor as payment in full.

4.3.3.1 CHPW will provide Contractor at least sixty (60) days' notice of changes that affect Contractor's reimbursement rates pursuant to Section 7.6.1 below, unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Contractor may terminate this Agreement pursuant to Section 6.3 if it does not agree with the changes.

4.3.3.2 The parties acknowledge that configuring new rates into CHPW's reimbursement system to begin paying claims at a new rate requires up to 30 days. In situations where federal or state rate changes do not allow CHPW to provide 60 days' advance notice to Contractor, new rates will be implemented on the later of the date CHPW has completed configuring its system, or on the published effective date of the new rates. Where a change allows for 60 days' notice, the new rates will be implemented on the published effective date of the rate change.

4.3.3.3 CHPW will apply new rates only to claims received on and after the implementation date described in the previous Section. If such action results in a substantial negative impact to either party, the impacted party may request that the parties negotiate a settlement payment in lieu of retroactive adjustment of individual claims.

4.3.4 CHPW shall deny or recover payment(s) to Contractor related to the treatment of a Provider Preventable Condition. At the request or direction of the HCA, the Washington State Medicaid Fraud Control Unit ("MFCU"), or a state or federal law enforcement agency, CHPW may suspend part of or all payments related to a credible allegation of fraud, as determined by the requesting or directing agency.

4.3.5 Except as agreed to by the parties on a claim-by-claim basis, CHPW shall pay not less than ninety-five percent (95%) of all Clean Claims received from Contractor within thirty (30) days of receipt, and pay or deny ninety-five percent (95%) of all claims received from Contractor within sixty (60) days of receipt. A Clean Claim is "received" on the date CHPW receives either written or electronic notice of the claim. For state sponsored Benefit Plans, if CHPW fails to meet its obligations in this paragraph, CHPW shall pay Contractor interest at the rate of one percent (1%) per month of the contract amount of all unpaid Clean Claims that have not been denied and which have aged sixty one (61) or more days, until such time as CHPW is again in compliance with the requirements of this Section.

4.3.6 If Contractor is a chiropractic provider, CHPW will reimburse Contractor for services deemed by CHPW to be Medically Necessary if (i) the service is a Covered chiropractic health care Service, (ii) provided by Contractor or the Contractor's employee in accordance with applicable state law, and (iii) Contractor has otherwise complied with the terms and conditions of this Agreement.

4.4 Coordination of Benefits and Third-Party Payment.

4.4.1 Contractor will cooperate with CHPW's coordination of benefits, subrogation and third-party payment policies as set forth herein and in the *Provider Manual*. CHPW will not unreasonably delay payment of a claim by reason of the application of its coordination of benefits policies.

4.4.2 Contractor shall promptly notify CHPW if it becomes aware that a Member has a subrogation claim or right to reimbursement from a third-party, and shall assist CHPW in arranging for assignment of such right to CHPW for collection. Contractor shall also notify CHPW of Members that may approach stop-loss deductibles, have other insurance coverage available, or be eligible for Social Security coverage.

4.4.3 Except as otherwise required by Chapter 284-51 WAC, under no circumstances shall CHPW reimburse Contractor any amount greater than that provided for under this Agreement. If Contractor has received payment from another coverage plan or entity that has primary payment responsibility under coordination of benefits rules, and that payment is equal to or greater than the rates set forth herein, Contractor may not seek additional reimbursement from CHPW. In addition, Contractor shall promptly refund to CHPW any amount CHPW has already paid to Contractor which, when added to amounts paid by another coverage plan or third party for the same Covered Services, are in excess of the rates set forth in this Agreement.

4.4.4 With regard to state sponsored Benefit Plans, payment for Services and benefits shall be secondary to any other medical coverage exception in accord with the applicable rules of WAC 284-51-205(1)(a). CHPW shall not refuse or reduce Services provided hereunder solely due

to the existence of similar benefits under another health care contract. CHPW shall pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties.

4.5 Retrospective Review and Recovery Rights.

4.5.1 CHPW reserves the right to assure through audit and retrospective evaluation of a Member's documented medical care that, based on the information available to the attending physician or order provider at the time services were provided, services provided were Medically Necessary and claims were accurately coded. Such review or audit may result in denial of claims for services on the basis of Medical Necessity or errors in claims submission and may adversely impact payment.

4.5.1.1 CHPW may retrospectively deny a claim (a) if it is determined that prior authorization was based upon a material misrepresentation by Contractor or a Contracted Participating Provider, and/or (b) if information provided to CHPW is materially different from information that was reasonably available at the time of the original determination

4.5.2 Any payments made to Contractor by CHPW that are determined to be inappropriate in accordance with applicable law, or to which Contractor is not entitled under the terms of this Agreement or the *Provider Manual*, shall be considered an overpayment. Overpayments shall be refunded to CHPW within thirty (30) days of the date Contractor is notified of the overpayment or within sixty (60) days of identification of an overpayment by Contractor, whichever is earlier. Alternatively, CHPW may, in its discretion, immediately offset or recoup any and all overpayments or other amounts owed by Contractor to CHPW against amounts owed by CHPW to Contractor.

4.5.3 Contractor agrees that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Contractor. Notwithstanding the foregoing, except in the case of fraud, CHPW may not request (a) a refund of a payment previously made to satisfy a claim unless CHPW does so in writing within twenty-four (24) months (or within thirty (30) months for reasons related to coordination of benefits) in accordance with RCW 48.43.600 or (b) payment of a contested refund sooner that six (6) months after receipt of the request. This section is not applicable to subrogation claims.

4.5.4 Except in the case of fraud, Contractor may not request payment from CHPW to satisfy a claim unless it does so in writing within twenty-four (24) months after the date the claim was denied or payment intended to satisfy the claim was made. In the case of coordination of benefits, Contractor must request any additional balances owed from CHPW within thirty (30) months after original payment was made. Additional payment cannot be requested any sooner than six (6) months after request is made. This section is not applicable to subrogation claims.

5. MUTUAL OBLIGATIONS

5.1 Independent Contractors. CHPW and Contractor are independent entities. No provision of this Agreement is intended to create, nor shall be construed to create, any relationship other than that of independent entities contracting with each other solely for the purpose of effecting this Agreement. Neither party nor any of its respective employees and subcontractors shall be construed to be the principal, agent, employee, or representative of the other party.

5.2 Representatives. Each party shall designate a representative who is responsible for coordination and communication between Contractor and CHPW in performance of this Agreement, including review of the *Provider Manual* and subsequent updates. Each party's representative and their respective contact information are set forth in Exhibit E, attached hereto and incorporated herein. Each party shall promptly notify the other in writing pursuant to Section 7.6 of any changes to the party's designated representative or their contact information.

5.3 Compliance.

5.3.1 Each party shall comply in all material respects with requirements of applicable federal and state laws and regulations, the terms of this Agreement and applicable terms and conditions set forth in the CHPW's contracts with state and federal agencies obligating it to administer all or some of the Benefit Plans referred to herein, including:

5.3.1.1 Applicable Medicare laws, regulations, and CMS Instructions;
5.3.1.2 Title VI of the Civil rights Act of 1964 implemented by regulations at 45 CFR 84;
5.3.1.3 The Age Discrimination Act of 1975, implemented by regulations at 45 CFR 91;
5.3.1.4 The Rehabilitation Act of 1973;
5.3.1.5 The Americans with Disabilities Act;
5.3.1.6 The False Claims Act (32 U.S.C. §3729 et seq.);
5.3.1.7 The Anti-kickback Statute (Section 1128B(b) of the Social Security Act);
5.3.1.8 Other laws applicable to recipients of federal funds;
5.3.1.9 Applicable federal and state laws that pertain to enrollee rights; and
5.3.1.10 As applicable, additional provisions included in a Benefit Plan Exhibit in Exhibit B, including but not limited to Medicaid Additional Provisions set forth in Exhibit B-1-B, attached hereto and incorporated herein, and Medicare Advantage Additional Provisions set forth in Exhibit B-2-B, attached hereto and incorporated herein.

5.3.2 Each party agrees to require that all subcontracts related to this Agreement will be written and will specify that the subcontractor must also comply with terms of this Agreement and any applicable federal and state laws, regulations and requirements.

5.3.3 As a condition to entering into this Agreement, and in compliance with 42 CFR 455.101-106, Contractor shall provide to CHPW a completed, accurate Disclosure of or Change in Ownership and Control Interest form. Contractor shall promptly provide updates to the Disclosure of or Change in Ownership and Control Interest form when information on the current form changes. Failure to provide a complete accurate form or updates to it shall be deemed a material breach of this Agreement.

5.4 Confidentiality and Privacy.

5.4.1 All information provided by a party in the process of negotiation or performance of this Agreement, identified by a party as confidential or proprietary, including reimbursement rates, fee schedules, and Member and CHPW group information, is confidential and shall not be disclosed to any third person or entity in any format without the express prior written consent of providing party. This provision shall not preclude duly authorized and appropriate access to records in order to allow billing and quality assurance review with respect to Covered Services delivered under this Agreement. Upon termination of this Agreement, any information identified by either party as confidential or proprietary shall be returned or otherwise disposed of as mutually agreed to by the parties. This section shall survive termination of the Agreement.

5.4.2 Each party is a covered entity and in performing this Agreement, each party may have access to and receive from the other party Protected Health Information ("PHI") as those terms are defined under HIPAA, and Chapter 70.02 RCW, the Uniform Health Care Information Act.

5.4.2.1 Each party shall maintain the confidentiality of PHI and shall not use or disclose Member PHI except as necessary to carry out the terms and conditions of this Agreement or as permitted or required by federal or state law or regulations.

5.4.2.2 Each party shall implement a documented health information system and a privacy security program that includes administrative, technical and physical safe guards designed to prevent the accidental or unauthorized use or disclosure of Member PHI and medical records. The information system and the privacy and security program shall, at a minimum, comply with applicable HIPAA regulations regarding the privacy and security of PHI, including but not limited to 42 CFR § 438.242; 45 CFR § 164.306(a); and 45 CFR § 162.200 as well as the HIPAA privacy provisions in Title 13 of the American Recovery and Reinvestment Act of 2009 ("ARRA") including the Health Information Technology for Economic and Clinical Health ("HITECH") Act.

5.4.2.3 This Section 5.4 shall be interpreted as broadly as necessary to implement and comply with applicable current and future HIPAA requirements, and resolve any ambiguity in favor of a meaning that complies and is consistent with HIPAA requirements.

5.4.3 Each party shall comply with 42 CFR Part 2, as applicable. If Contractor is a "Part 2 program" as defined under 42 CFR §2.11, Contractor shall obtain signed written consent, which complies with the requirements of 42 CFR Part 2, from each Member prior to disclosing the Member's Patient Identifying Information to CHPW. For the purposes of this section "Patient Identifying Information" shall have the same meaning as under 42 CFR §2.11. Such consent shall explicitly name CHPW as an authorized recipient of the Member's Patient Identifying Information. Contractor shall maintain copies of each Member's consent form in accordance with Section 5.5. CHPW reserves the right to audit Contractor's records to ensure compliance with this Section.

5.4.4 This Section 5.4 shall survive termination of the Agreement.

5.5 Record Retention, Access and Audits.

5.5.1 Each party shall cooperate and assist in providing access to records reasonably required or permitted for inspection, evaluation and audit as set forth herein.

5.5.2 Consistent with industry standards and applicable state and federal law and regulations, including OIC regulations, each party or its authorized representative(s) may, during normal business hours and upon giving reasonable notice to the other party, audit, examine and inspect (to the extent necessary to perform the audit) the other party's books and records, including medical and financial records and electronically stored data, related to this Agreement, transactions between CHPW and Contractor hereunder, and to surveys and audits for accreditation and compliance.

5.5.3 Each party shall retain and protect all applicable books and records for at least ten (10) years after termination of this Agreement. Each party acknowledges that certain government agencies, including the Secretary of the Department of Health and Human Services (HHS) and the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, have the right to inspect and audit each party's books and records for ten (10) years beyond the termination of this Agreement, or until the completion of any governmental audit that pertains to such books and records, whichever is later, unless: (i) HHS determines there is special need to retain a particular record or group of records for a longer period and notifies the party at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by either party, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) HHS determines that there is a reasonable possibility of fraud or similar fault, in which HHS may inspect, evaluate, and audit either party at any time. Without limiting the foregoing, following the commencement of any audit by a government agency, the party subject to the audit shall retain its relevant books and records until completion of said audit. This Section shall survive termination of this Agreement for the period of time required by state and federal law. Contractor shall provide copies of all such records to the auditing agency at Contractor's cost.

5.5.4 Pursuant to 42 CFR 422.504(e)(2), CMS may access Contractor's records (including medical records) that are to be used for risk-adjustment data validation (RADV) purposes to determine amounts payable under a Medicare Advantage contract.

5.6 Marketing.

5.6.1 CHPW may use Contractor's name for publication in its directory of clinics and providers, and to otherwise carry out the terms of this Agreement. At its discretion, Contractor shall display CHPW-approved signs and material related to provision of services, participate in CHPW-approved marketing programs for its products and perform other marketing duties CHPW may request.

5.6.2 Contractor shall obtain prior written approval for any publication or distribution of promotional materials using the CHPW name or logo. Unless such material requires review and approval by HCA or CMS, CHPW shall decide whether to approve the materials within fifteen (15) working days of the submission of the material to CHPW.

5.6.3 Contractor shall not engage in direct and/or indirect door-to-door, telephonic, or other cold-call marketing of enrollment with Members or potential Members. Member information and marketing materials must be developed at the 6th grade reading level and require prior written approval of CHPW.

5.7 Dispute Resolution.

5.7.1 If a dispute between CHPW and Contractor arises with regard to performance or interpretation of any of the terms of this Agreement, the parties shall first meet informally in good faith to attempt to resolve the dispute. The complaining party shall send written notice to the other party expressly referencing the provisions of this Section 5.7 and the nature of the dispute. The parties shall meet and in good faith work to resolve the dispute.

5.7.2 If a dispute is not resolved informally within thirty (30) days of receipt of the notice described in Section 5.7.1, either party may send written notice to the other requesting formal consideration of the disputed matter and describing its position on the disputed matter. The party receiving such request shall review the matter and send a written response, describing its position on the matter and the basis for its position, to the requesting party within thirty (30) days of receipt of the request for formal consideration. Where the party receiving the request for formal consideration fails to respond within thirty (30) days of receipt, the requesting party may proceed as if the request has been rejected.

5.7.3 Where a request for informal or formal resolution fails to result in resolution of a dispute, the parties may agree to non-binding mediation, conducted under the mediation rules of the American Health Lawyers Association, or another mutually agreed organization. The mediator's fees shall be born in equal shares by the parties. All other related costs incurred shall be the sole responsibility of the party incurring the cost.

5.7.4 If the parties cannot resolve the matter through non-binding mediation either party may initiate an action in any Superior Court of competent jurisdiction in King County, Washington.

5.8 Responsibility for Own Acts. Each party shall be responsible for its own acts and omissions and shall be liable for payment of that portion of any and all legal claims, liabilities, injuries, suits, demands, or expenses of any kinds that may result from or arise out of any alleged malfeasance or neglect caused by said party, its employees, agents or subcontractors. If a claim is made against both parties, each party shall cooperate in the defense and cause its insurers to do likewise. Each party shall, however, retain the right to take any action it believes necessary to protect its own interests.

5.9 Indemnification.

5.9.1 Each party agrees to indemnify and hold harmless (and at such party's request, defend) the other party, its directors, officers, employees and agents from any third party claims, judgments, damages, costs, suits, losses, or liabilities (including reasonable attorney's fees) arising solely and exclusively out of the negligence, wrongful act or omission, or breach of this Agreement by such indemnifying party, or any of its respective officers, directors, agents or employees.

5.9.2 CHPW shall not be liable to Members for any act of malpractice on the part of Contracted Participating Providers. Contractor shall indemnify, defend, and hold harmless CHPW from any such liability. The indemnity in the immediately preceding sentence shall not apply to any alleged act of independent liability on the part of CHPW, or any of its employees or agents.

6. TERM OF AGREEMENT AND TERMINATION

6.1 **Term.** This Agreement shall take effect on the date specified on page one as the Effective Date, and shall remain in force for an initial term of twelve (12) months from the effective date. Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless written notice of intent not to renew is given at least one hundred twenty (120) days prior to the expiration date of any such annual term, or unless otherwise terminated as provided hereunder.

6.2 **Termination upon Breach.** Either party may terminate this Agreement if (i) it believes the other party has committed a material breach of the Agreement, (ii) it gives the breaching party written notice describing the breach and (iii) such breach is not corrected, or a corrective action plan approved by both parties is not in place, within thirty (30) days following the written notice. Further, this Agreement may be terminated immediately if a party or any of its Directors, Officers, Owners or employees is excluded from participation in a state or federally sponsored health program, is convicted of a crime, has its license or certification revoked, or fails to accurately complete or timely return the Disclosure of or Change in Ownership and Control Interest Form.

6.3 **Termination without Cause.** Either party may terminate this Agreement without cause upon at least one hundred twenty (120) days' advance written notice to the other party given pursuant to Section 7.6 below.

6.4 **Continuing Responsibilities upon Termination.** Neither party shall be released from obligations hereunder prior to the effective termination date of the Agreement. Contractor shall cooperate with and assist CHPW in working with affected Members to develop a reasonable transition plan.

6.5 **Member Notification.** Whether the termination was for cause or without cause, CHPW will make a good faith effort to ensure that written notice of termination is provided at least thirty (30) days prior to the effective date of the termination, or immediately for a termination for cause that results in less than thirty (30) days' notice, to all Members who are patients seen on a regular basis by a specialist, by a provider for whom the Member has a standing referral, or by a primary care provider.

7. MISCELLANEOUS

7.1 **Assignment.** Contractor may not assign its duties, rights, or obligations under this Agreement without prior written approval of CHPW, which shall not be unreasonably withheld, and, in regard to state sponsored Benefit Plans, the approval of HCA.

7.2 Discrimination. Neither party shall discriminate against any person because of race, color, national origin, ancestry, religion, gender, marital status, age, sexual orientation, presence of physical or mental handicaps, and any other reason(s) prohibited by law, in the provision of services or in employment practices.

7.3 Washington State Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Washington irrespective of choice-of-law principles, except to the extent pre-empted by federal law. Venue for any action or proceeding related to this Agreement shall be in King County, Washington.

7.4 Amendments.

7.4.1 CHPW may immediately amend this Agreement upon written notice to Contractor to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement.

7.4.2 CHPW may additionally amend this Agreement on sixty (60) days written notice to Contractor. Contractor's failure to object in writing within sixty (60) days of receipt of such amendment shall constitute Contractor's acceptance thereof. If the amendment is a "material amendment" as defined in RCW 48.39.005, Contractor shall have the right to reject the amendment and such rejection will not affect the existing terms of the Agreement.

7.5 Third-Party Beneficiaries. Notwithstanding that benefits arising from this Agreement may inure to a Member or other third party, the parties hereto intend that no third-party shall be a Third-Party Beneficiary of the obligations assumed by either party to this Agreement and no such person shall have the right to enforce any such obligation.

7.6 Notice.

7.6.1 All notices or other communications, except notice of termination, required or permitted to be given hereunder shall be in writing and deemed to have been delivered to a party upon: (i) personal delivery to that party; (ii) electronically confirmed delivery by facsimile to the telephone number provided by the party for such purposes; (iii) electronic mail transmission to the electronic mailbox provided by the party for such purposes; (iv) upon deposit for overnight delivery with a bonded courier holding itself out to the public as providing such services, with charges prepaid; or (v) four (4) business days following deposit with the United States Postal Service, postage prepaid, and in any case addressed to the party as set forth below, or to another address that the party provides by notice to the other party.

7.6.2 Notice of termination shall be in writing and deemed to have been delivered to a party upon deposit for overnight delivery with a bonded courier holding itself out to the public as providing such services, with charges prepaid and signature receipt required; or deposit with the United States Postal Service, postage prepaid and certified mail or return receipt requested, and in any case addressed to the person set forth below, or to another address that the party provides by notice to the other party.

Community Health Plan of Washington	Skamania County Community Health
ATTN: Director, Network Management & Strategy 1111 Third Avenue, Suite 400 Seattle, WA 98101-3292 FAX: (206) 613-5018 Email: Cathy.Neiman@CHPW.org	ATTN: Allen Esaacson 710 SW Rock Creek Drive Stevenson, WA 98648 FAX: Email: allene@co.skamania.wa.us

7.7 **Force Majeure.** Neither party shall be considered to be in breach of this Agreement if its failure to comply is occasioned by an act of God, declared local or national emergency, public health crisis including without limitation a WHO- or CDC-designated pandemic, act of a governmental authority responding to an act of God or other declared emergency or public health crisis, or the result of a strike, lockout or other labor dispute.

7.8 Payment of Federal Funds.

7.8.1 Neither party shall make any specific payment, directly or indirectly, to a physician or physician group, or other health care provider, as an incentive to reduce or limit Medically Necessary Services furnished to a particular Member. Indirect payments may include offerings of monetary value (*e.g.* stock options, or waivers of debt) measured in the present or future.

7.8.2 Each party shall remain in good standing with applicable regulatory agencies and shall comply with applicable federal and state laws and regulations. Each party, in fulfilling its obligations hereunder, acknowledges that it is subject to certain laws that are applicable to individuals and entities receiving federal funds. Each party agrees to inform all related entities, contractors, and subcontractors that payments that they receive are, in whole or in part, from federal funds.

7.9 Construction.

7.9.1 Entire Agreement. This Agreement, with exhibits attached hereto, constitutes the entire agreement between the parties with respect to its subject matter and supersedes any and all previous or contemporaneous agreements and understandings regarding such subject matter.

7.9.2 Construction and Applicability of Certain Laws and Regulations.

7.9.2.1 Nothing in this Agreement modifies any benefits, terms, or conditions contained in a Member's Benefit Plan. In the event of a conflict between this Agreement and the benefits, terms, and conditions of a Member's Benefit Plan, the benefits, terms or conditions contained in the Member's Benefit Plan shall govern.

7.9.2.2 In addition to the applicable terms of this Agreement, as to the state sponsored Benefits Plans offered by CHPW through its contracts with HCA, and listed in Exhibit B, the contract between the HCA and CHPW, as well as applicable laws and regulations, shall govern construction.

7.9.2.3 In addition to the applicable terms of this Agreement, as to Medicare Advantage Plans listed on Exhibit B, applicable laws and regulations as well as the CMS-CHPW Contract, CMS guidance and instructions shall govern construction.

7.9.2.4 In addition to the applicable terms of this Agreement, as to the Health Benefit Exchange Products listed on Exhibit B, applicable laws and regulations including those from the Washington Health Benefit Exchange, the Health Benefit Exchange Act including the 2012 regular session laws, chapter 87, Affordable Care Act Implementation and regulations adopted pursuant to RCW 43.71 and the OIC shall govern construction.

7.9.2.5 With regard to this Agreement in general, ambiguities shall be reasonably construed in accordance with all relevant circumstances and shall not be construed against either party, irrespective of which party is deemed to have authored the ambiguous provision. The captions and headings appearing herein are for reference only and will not be considered in construing this Agreement. As used herein, "including" means "including without limitation". If any provision hereof is held invalid or unenforceable, such provision will be amended to achieve as nearly as possible the same economic and operational effect as the original provision, and the remainder of this Agreement will remain in full force and effect. Waiver by either party of the breach of any provision hereof by the other party will not operate or be construed as a waiver of any subsequent, similar or other breach by the breaching party. The rights of each party granted herein are in addition to any others that a party may be entitled to by law, shall be construed as cumulative, and no such right is exclusive of any others or of any right or priority allowed by law. Whether specifically identified or not, obligations of the parties hereunder, that, by their nature or content would continue beyond the expiration or termination of this Agreement, shall survive such expiration or termination, and the statute of limitations shall not begin to run until the time such obligations have been fulfilled. This Agreement may be executed in any number of counterparts, each of which will be an original and all of which together will constitute one and the same instrument.

// signature page follows //

The undersigned have executed this Agreement as of the date and year written below.

Community Health Plan of Washington	**Skamania County Community Health**
1111 Third Avenue, Suite 400 Seattle, WA 98101-3292 Phone: (206) 521-8833	710 SW Rock Creek Drive Stevenson, WA 98648 Phone: (50) 427-3856
Sign: _____	Sign: _____
Name: Erin Hafer	Name: _____
Title: Vice President, Delivery and Health System Innovation & Community Partnership	Title: _____
Date: _____	Date: _____

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EXHIBIT A
CONTRACT LOCATIONS AND PARTICIPATING PROVIDERS

GROUP CONTRACT INFORMATION			
Group Legal Name	Skamania County Community Health		
Group DBA Name			
Group TIN/(EIN)	916001363	**Group NPI**	

1. Please complete the following Location Roster for all locations to be covered under this Agreement:

LOCATION to be LINKED to CONTRACT						
Location A	**Location Name**					
	Street Address 1					
	Street Address 2					
	City		**State**		**Zip**	
	Office Phone		**Office Fax**			
	TIN: Same as above?	**Yes** O	No O			
	NPI: Same as above?	**Yes** O	No O			

LOCATION to be LINKED to CONTRACT						
Location B	**Location Name**					
	Street Address 1					
	Street Address 2					
	City		**State**		**Zip**	
	Office Phone		**Office Fax**			
	TIN: Same as above?	Yes O	No O			
	NPI: Same as above?	Yes O	No O			

LOCATION to be LINKED to CONTRACT						
Location C	**Location Name**					
	Street Address 1					
	Street Address 2					
	City		**State**		**Zip**	
	Office Phone		**Office Fax**			
	TIN: Same as above?	Yes O	No O			
	NPI: Same as above?	Yes O	No O			

2. Please complete the following Provider Roster as requested below for all Contracted Participating Providers at each Contractor Location.

INDIVIDUAL PROVIDERS to be LINKED to CONTRACT						
	Provider Name (First Last)	Accreditation	NPI	Location(s)	Active w/CHPW	Cred App
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						

3. Whenever there are changes to any of the information on this Exhibit A, Contractor may submit changes online via webforms as hyperlinked below, to have information accurately updated across all CHPW systems and applications – as well as our Provider Directory:

   a. Clinic & Group Changes Form

   b. Individual Provider Add, Change & Term Form

EXHIBIT B
BENEFIT PLANS

CHPW Benefit Plans. The following are the Benefit Plans offered by Community Health Plan of Washington that may be subject to this Agreement. The following Benefit Plans are designated as either "Included" or "Not Included" for purposes of this Agreement, and any Benefit Plan that is "Included" is accompanied by one or more Plan Exhibits, as indicated, that will control with regard to services delivered to Members of that Benefit Plan.

Benefit Plan Controls. Nothing in this Exhibit B, or the Agreement, will have the effect of modifying any benefit, term, or condition of a Benefit Plan. In the event of a conflict between the Agreement and a Benefit Plan, the benefits, terms, and condition of the Benefit Plan will govern with respect to Covered Services provided to Members enrolled in the Benefit Plan.

Amendments. Consistent with Section 7.4 of the Agreement, *Amendments*, CHPW may add Benefit Plans, or otherwise make changes to this Exhibit B (e.g. termination of a Benefit Plan), by notifying Contractor in writing of such addition(s) or change(s), and Contractor shall not unreasonably withhold its consent to participate in additional Benefit Plan(s) or accept such change(s). If Contractor fails to object in writing within sixty days of its receipt of such notice, Contractor will be deemed to have agreed to inclusion of the additional Benefit Plan(s).

1. **Medicaid Plans** — **Included**

   Washington Apple Health Integrated Managed Care Plans
   Includes Behavioral Health Services Only, where applicable

   Network Name: CHPW AH Network

   - ☒ Exhibit B-1-A – Medicaid Reimbursement Rates
   - ☒ Exhibit B-1-B – Medicaid Required Provisions
   - ☐ Exhibit B-1-C – Medicaid Value Based Payment Arrangement
   - ☐ Exhibit B-1-D – Medicaid CHIP Managed Care Addendum for IHCP's

2. **Medicare Advantage (MA) Plans**

   Medicare Advantage and Medicare Advantage Prescription Drug Plans offered by CHPW. — **Not Included**

   Network Name: CHPW MA Network

2. **Medicare Advantage (MA) Plans** (Continued)

Medicare Advantage Special Needs Plans offered by CHPW. **Not Included**

Network Name: CHPW SNP Network

- ☐ Exhibit B-2-A – Medicare Advantage Reimbursement Rates
- ☐ Exhibit B-2-B – Medicare Advantage Required Provisions
- ☐ Exhibit B-2-C – Medicare Advantage Value Based Payment Arrangement

3. **CHPW Affiliated Health Benefit Exchange Plans**

CHPW Affiliated Health Benefit Exchange Plans may be offered by CHPW or its affiliate, Community Health Network of Washington.

Network Name: CHPW Cascade Care Affiliate Network

"Cascade Care" Standard *and* "Cascade Select" Public Option Plans. **Not Included**

- ☐ Exhibit B-4-A – CHPW Health Benefit Exchange Reimbursement Rates
- ☐ Exhibit B-4-B – CHPW Health Benefit Exchange Required Provisions
- ☐ Exhibit B-4-D – CHPW Health Benefit Exchange QHP Addendum for IHCP's

Effective Date: January 1, 2024
(CHPW TO COMPLETE)

EXHIBIT B-1-A
MEDICAID
REIMBURSEMENT RATES

1. **Rates.** Subject to the terms and conditions of the Agreement, reimbursement rates for Covered Services billed under Contractor's tax ID number for the Apple Health program shall be the lesser of billed charges or the following and will be less any applicable Cost Sharing Amounts:

   Network Name: CHPW AH Network

   ☐ **N/A%** of HCA's Fee Schedule.

   ☐ Alternative Treatment Benefit Services (*Acupuncture, Chiropractic, and Massage Therapy services covered under CHPW's Apple Health Alternative Treatment Benefit, as set forth in CHPW's Alternative Treatment Billing Guideline*):

   N/A% of CMS Physician Fee Schedule.

   ☐ The Rates set forth in Schedule(s) [A][B] for the Covered Services described therein.

   ☐ The Rates set forth in Schedule(s) [A][B] for the Covered Services described therein; for all other Covered Services:

   N/A% of CHPW's [insert Fee Schedule] Fee Schedule.

   ☒ The Rates set forth in Schedule A for the Covered Services described therein; for all other Covered Services:

   100% of HCA's Fee Schedule.

2. **Payment.** All payments under this Agreement shall be made in accordance with the terms of this Agreement, the *Provider Manual* and the applicable billing instructions and policy guidelines published and periodically updated by applicable state and federal agencies as set forth in Section 4 of the Agreement.

   Treatment Benefit is subject to CHPW's Alternative Treatment Billing Guideline ("Guideline"). Alternative Treatment Benefit services are part of a combined benefit, and are subject to an annual visit maximum, as set forth in the Guideline. Claims for services rendered in excess of the annual visit maximum will be denied. Contractor is responsible for confirming how many visits each Member has used and how many remain eligible for reimbursement.

Effective Date: January 1, 2024
(CHPW TO COMPLETE)

SCHEDULE A TO EXHIBIT B-1-A
BEHAVIORAL HEALTH SERVICES
FEE FOR SERVICE REIMBURSEMENT RATES
Network Name: CHPW AH Network

1. **Fee for Service Reimbursement**. Subject to the terms and conditions of the Agreement, reimbursement rates for Covered Behavioral Health Services billed under Contractor's tax ID number for the Apple Health program shall be the lesser of billed charges or the following and will be less any applicable Cost Sharing Amounts.

   A. **Covered Behavioral Health Services.**

   ☒ Contractor will be reimbursed at the rates set below for the Covered Services described in the table, and at **225%** of CHPW's IMC Mental Health Fee Schedule and **225%** of CHPW's IMC Pierce County Substance Use Disorder Fee Schedule for all Covered Services contained therein.

   ☒ Covered Services not specifically identified herein or on the applicable Fee Schedule, Contractor will be reimbursed at **100%** of HCA's Fee Schedule.

BEHAVIORAL HEALTH SERVICES	CPT/HCPCS CODE	UNIT	REIMBURSEMENT
Drug Test(s), Presumptive, Direct Optical Observation, SUD	80305	Per Unit	$31.75/unit
Drug Test(s), Presumptive, Direct Optical Observation, SUD	80306	Per Unit	$43.18/unit
Drug Test(s), Presumptive, Instrument Chemistry Analyzers, SUD	80307	Per Unit	$80.96/unit
Case Management – Mental Health, and SUD	T1016	15-minutes	$50.85/unit

2. **Payment.** All payments hereunder shall be made in accordance with the terms of the Agreement, the *Provider Manual,* applicable billing instructions and policy guidelines published and periodically updated by applicable state and federal agencies, including the current Service Encounter Reporting Instructions (SERI) published by the HCA.

   In the event that Contractor believes its annual FFS compensation under this Schedule A is materially different, on an annual basis, when compared to Contractor's compensation under Exhibit C-2 to the parties' prior provider agreement (which was in effect from May 1, 2020 through December 31, 2023), CHPW and Contractor shall meet and attempt to negotiate in

good faith an appropriate financial reconciliation reflective of CHPW Member utilization.

3. **Limitations.** Contractor's compensation for Covered Services that are not covered by Medicaid, and are paid from General Fund State ("GFS" or "State Only") funds, are subject to the availability of such funds.

Effective Date: January 1, 2024
(CHPW TO COMPLETE)

EXHIBIT B-1-B
MEDICAID
REQUIRED PROVISIONS

Community Health Plan of Washington ("CHPW") has contracted with the Washington State Health Care Authority ("HCA") to arrange for the provision of fully integrated physical and behavioral health care services to Members under the Apple Health Medicaid Program. The Contract between CHPW and HCA (the "State Contract") requires that specific terms and conditions be incorporated into agreements between CHPW and its participating providers and subcontractors.

This Exhibit B-1-B ("this Exhibit") is intended to supplement the Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to Members as it pertains to the Apple Health Program. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Exhibit, this Exhibit shall govern as to the Apple Health Program.

Contractor agrees and understands that Covered Services shall be provided in accordance with the State Contract(s), Payor requirements, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To the extent Contractor is unclear about Contractor's duties and obligations, Contractor shall request clarification from CHPW.

Definitions. The following definitions apply to this Exhibit B-1-B:
Capitalized terms used and not otherwise defined herein shall have the meanings given to them in the Agreement or the State Contract. The definitions listed below will supersede any meanings contained elsewhere in the Agreement with regard to this Exhibit.
Apple Health Program: the Medicaid integrated managed care program known as Apple Health.

Behavioral Health Supplemental Transaction ("BHST"): non-encounter data submissions outlined in the HCA's Behavioral Health Supplemental Transaction Data Guide, which include supplemental data, including additional demographic and social determinant data, as well as service episode and outcome data necessary for federal Substance Abuse and Mental Services Administration (SAMHSA) block grant reporting and other state reporting needs.

HCA: the State of Washington Health Care Authority and its employees and authorized agents.

Medically Necessary: health care services that: (a) are reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the Member that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction; and (b) are not more costly than any other equally effective or more conservative course of treatment available or suitable for the Member requesting the service. Such services shall include services related to the Member's ability to achieve age-appropriate growth and development.

Member: an individual enrolled in Apple Health and entitled to receive Covered Services pursuant to that Benefit Plan.

Physician's Orders for Life Sustaining Treatment ("POLST"): a set of guidelines and protocols for how emergency medical personnel shall respond when summoned to the site of an injury or illness for the treatment of a person who has signed a written directive or durable power of attorney requesting that he or she not receive futile emergency medical treatment, in accordance with RCW 43.70.480.

Primary Care Provider or PCP: a Participating Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to pediatricians, family practitioners, general practitioners, internists, naturopathic physicians, medical residents (under the supervision of a teaching physician), physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (nurse practitioners), as designated by CHPW. The definition of PCP is inclusive of primary care physician as it is used in 42 C.F.R. § 438. All Federal requirements applicable to primary care physicians will also be applicable to PCPs as the term is used in this Exhibit.

State: the state of Washington.

State Contract(s): the applicable contract(s) between HCA and CHPW under which CHPW agrees to provide or arrange for services related to the Apple Health Program, including any exhibits, attachments, documents, or materials incorporated by reference.

Contractor Agreement Requirements. The parties agree to the following terms and conditions:

1. ***CHPW Remains Legally Responsible.*** Nothing herein shall be construed to delegate legal responsibility to HCA for any work performed under the Agreement, nor for oversight of any functions and/or responsibilities delegated to Contractor.

2. ***HCA Enrolled Provider.*** Contractor shall enroll with the HCA and maintain such enrollment for the term of this Agreement. Contractor will ensure that their enrollment is effective prior to the first date Contractor provides Covered Services to an Apple Health Member.

3. ***Compliance with Applicable Law.*** Contractor shall comply with all Applicable Law. For purposes of this Exhibit, Applicable Law shall specifically include those laws and regulations as set forth in the State Contract, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Mental Health Parity and Addiction Equity Act ("MHPAEA") and final rule, state laws and regulations regarding mental and behavioral health and substance use disorder services, the Federal Drug and Alcohol Confidentiality Laws in 42 C.F.R. Part 2, 42 U.S.C. §§ 1396a(a)(43) (early and periodic screening, diagnostic, and treatment services ("EPSDT")), 1396d(r) (definition of EPSDT), and 42 C.F.R. § 438.3(l) (choice of network provider).

4. ***Compliance with State Contract.*** Contractor shall comply with any term or condition of the State Contract that is applicable to the services to be performed under the Agreement, including but not limited to the Performance Improvement Project requirements of the State Contract and the prohibition on direct and/or indirect door-to-door, telephonic, or other cold-call marketing.

5. ***Policies and Procedures.*** Contractor shall comply with CHPW's policies and procedures, including, but not limited to, credentialing and recredentialing, utilization management, fraud and abuse, authorization of services, quality improvement activities and provider payment suspensions. Contractor shall comply with the Program Integrity requirements of the State Contract, as well as CHPW's program integrity policies and procedures. Without limiting the generality of the foregoing, Contractor shall comply with the Program Integrity requirements in Section 1902(a)(68) of the Social Security Act, 42 C.F.R. § 438.610, 42 C.F.R. § 455, 42 C.F.R. § 1000 through 1008, and Chapter 182-502A WAC. Further, Contractor shall be subject to ongoing analysis of utilization, claims, billing and/or encounter data to detect overpayment, which analysis shall include audits and investigations of Contractor. To the extent that Contractor is delegated authority for authorization of services, Contractor shall comply with all Utilization Management requirements described in the State Contract.

6. ***Debarment Certification.*** Contractor represents and warrants that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any State or federal department or agency from participating in transactions. Contractor shall immediately notify CHPW in writing if, during the term of the Agreement, (a) Contractor becomes debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded, or (b) Contractor or any of Contractor's employees are subject to disciplinary action against accreditation, certification, license and/or registration.

7. ***Records.*** Contractor shall maintain all financial, billing, medical and other records pertinent to the Agreement, including but not limited to records related to services rendered, quality, appropriateness, and timeliness of service, any administrative, civil or criminal investigation or prosecution. All financial records shall follow generally accepted accounting principles. Other records shall be maintained as necessary to clearly reflect all actions taken by Contractor related to the Agreement.

All records and reports relating to the Agreement shall be retained by Contractor for a minimum of ten (10) years after final payment is made under the Agreement. However, when an inspection, audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of ten (10) years following resolution of such action.

8. ***Inspection.*** Contractor shall fully cooperate with and permit State, including HCA, MFCU and state auditor, CMS, auditors from the federal Government Accountability Office, federal Office of the Inspector General, federal Office of Management and Budget, the Office of the Inspector General, the Comptroller General, and their designees, to access, inspect and audit any books, records, contracts, or documents of Contractor that pertain to any aspect of services and activities performed, including any computerized data stored by Contractor, and shall permit inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, at any time whether such visit is announced or unannounced. Contractor shall make copies of records and shall deliver them to the requestor, without cost, within thirty

(30) calendar days of request. The right for the parties named above to audit, access and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS or the federal Office of the Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the federal Office of the Inspector General may inspect, evaluate, and audit the subcontractor at any time.

9. ***Interpreter Services.*** Contractor shall provide interpreter services, free of charge, for all interactions with Members or potential Members, including but not limited to: (a) customer service, (b) all appointments with any provider for any Covered Service, (c) emergency services, and (d) all steps necessary to file grievances and appeals including requests for Independent Review of CHPW decisions.

10. ***Marketing Materials.*** All information to be provided to Members, e.g. marketing materials, must be accurate, not misleading, comprehensible to its intended audience, designed to provide the greatest degree of understanding, and written at a sixth (6th) grade reading level, in addition to any other requirements imposed by CHPW based on the nature of the materials. Such materials must generally be approved by CHPW prior to use and must comply with the State Contract.

11. ***Coordination of Benefits.*** Services and benefits available under the Agreement shall be secondary to any other medical coverage, except in accordance with Chapter 284-51 WAC, as applicable. CHPW shall not refuse or reduce services provided under the Agreement solely due to the existence of similar benefits under any other health care contract, except in accord with applicable coordination of benefits rules in WAC 284-51. CHPW shall provide prenatal care and preventive pediatric care and then seek reimbursement from third parties.

12. ***Subcontracting.*** Contractor may not subcontract any services under the Apple Health Program without the prior written consent of CHPW. Any subcontract entered into by Contractor must be in writing consistent with 42 C.F.R. § 434.6, and all Contractor requirements contained in this Exhibit must be propagated downward into any other lower tiered subcontracts.

13. ***Reasonable Accommodations for Disabilities.*** Contractor shall cooperate with CHPW to make reasonable accommodation for Members with disabilities, in accordance with the Americans with Disabilities Act, for all Covered Services and shall assure physical and communication barriers shall not inhibit Members with disabilities from obtaining Covered Services.

14. ***Surgical Health and Safety.*** If Contractor is a hospital, ambulatory care surgery center, or office-based surgery site, Contractor shall endorse and adopt procedures for verifying the correct patient, the correct procedure and the correct surgical site that meet or exceed those set forth in the Universal Protocol™ development by the Joint Commission or other similar standards.

15. ***Practice Guidelines.*** Contractor shall comply with applicable physical and behavioral health practice guidelines adopted by CHPW.

16. ***Supervision of Behavioral Health Care Providers.*** If applicable under the behavioral health practice guidelines, Contractor will receive payment for the supervision of behavioral

health providers whose license or certification restricts them to working under supervision, effective as of the first day of the term following August 2019.

17. ***Timely Access to Care.*** Contractor shall offer access to care comparable to that offered to commercial enrollees or if Contractor serves only Medicaid enrollees, then comparable to Medicaid fee-for-service.

18. ***Hours of Operation.*** Contractor's hours of operation for Members shall be no less than the hours of operation offered to any other of Contractor's patients.

19. ***Administrative Simplification.*** Unless otherwise directed by CHPW, Contractor shall use and follow the most recent updated versions of: Current Procedural Terminology ("CPT"); International Classification of Diseases ("ICD"); Healthcare Common Procedure Coding System ("HCPCS"); CMS Relative Value Units ("RVUs"); CMS billing instructions and rules; The Diagnostic and Statistical Manual of Mental Disorders; NCPDP Telecommunication Standard D.O.; and Medi-Span® Master Drug Data or any other nationally recognized drug database with approval by HCA.

20. ***Claims Payment Standards.*** Except as otherwise allowed under Applicable Law, or unless otherwise agreed by the Parties in writing on a claim-by-claim basis, CHPW shall meet the following minimum standards for timeliness of payment: ninety-five percent (95%) of Clean Claims shall be paid or denied within thirty (30) calendar days of receipt of the paper or electronic claim; ninety-five percent (95%) of all claims shall be paid or denied within sixty (60) calendar days of receipt of the paper or electronic claim; and ninety-nine percent (99%) of Clean Claims shall be paid or denied within ninety (90) calendar days of receipt.

21. ***Appointment Wait Time Standards.*** As applicable, Contractor shall meet the following appointment wait time standards with respect to Members:

20.1 Transitional healthcare services by a PCP shall be available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.

20.2 Transitional healthcare services by a home care nurse, a home care Mental Health Professional or other Behavioral Health Professional shall be available within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health care, if ordered by the Member's PCP or as part of the discharge plan;

20.3 Preventive care office visits shall be available from the Member's PCP within thirty (30) calendar days; available

20.4 Routine care office visits shall be available from the Member's PCP within ten (10) calendar days, including behavioral health services from a behavioral health provider;

20.5 Urgent, symptomatic office visits shall be available from the Member's primary care, behavioral health or another provider within twenty-four (24) hours;

20.6 Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week; and

20.7 Second opinion appointments specifically described in the State Contract must occur within thirty (30) calendar days of the request, unless the Member requests a postponement of the second opinion to a date later than thirty (30) calendar days.

CHPW shall monitor Contractor's compliance with this Section. In the event Contractor fails to comply with the applicable appointment wait time standards set forth in this Section, Contractor shall comply with CHPW's procedures for corrective action. Nothing in this Section prohibits Contractor from conducting assessments in alternate settings, such as the Member's home or within an institutional setting.

22. ***24/7 Availability***. To the extent applicable, Contractor shall make the following services available twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days a year by a toll-free telephone number:

21.1 Medical and behavioral health advice for Members from licensed health care professionals;

21.2 Triage concerning the emergent, urgent or routine nature of medical and behavioral health conditions by licensed health care professionals; and

21.3 The toll-free line staff must be able to make a warm handoff to the regional crisis line.

23. ***Health Information Systems***. Contractor shall maintain a health information system that complies with the requirements of 42 C.F.R. § 438.242 and provides the information necessary to meet CHPW's obligations under the State Contract. Contractor shall:

22.1 Collect, analyze, integrate, and report data. The system must provide information on areas that include but are not limited to utilization, grievance and appeals, and terminations of enrollment for other than loss of Medicaid eligibility; and

22.2 Ensure data provided to CHPW is accurate and complete by: (a) Verifying the accuracy and timeliness of reported data; (b) Screening the data for completeness, logic, and consistency; and (c) Collecting service information on standardized formats to the extent feasible and appropriate.

24. ***Release of Necessary Information***. Contractor acknowledges and agrees to release to CHPW any information necessary to perform any of CHPW's obligations under the State Contract.

25. ***Encounter Data Reporting***. Contractor shall submit complete, accurate and timely encounter data to CHPW in accordance with current encounter submission guidelines published by HCA or as otherwise specified by CHPW. Contractor represents and warrants that it has the capacity to submit all data required by HCA to enable CHPW to meet the reporting requirements in the Encounter Data Reporting Guide published by HCA.

26. ***Behavioral Health Supplemental Transaction Reporting.*** If Contractor is a behavioral health agency, Contractor shall submit complete, accurate and timely BHST data to CHPW or its designee in accordance with the current guidelines published by HCA or as otherwise specified by CHPW. Contractor represents and warrants that is has the capacity to submit all data required by HCA to enable CHPW to meet the reporting requirements in the Behavioral Health Supplemental Transaction Data Guide published by HCA.

27. ***Clinical Data Repository.*** If Contractor utilizes a certified electronic health record system (EHR), Contractor is required to submit automated exports of standard CCD/CCDA, or subsequent ONC-specified standard healthcare transactions, from Contractor's EHR to HCA's Clinical Data Repository (CDR) via the State Health Information Exchange (HIE), as specified by HCA.

28. ***Credible Allegations of Fraud.*** Contractor shall refer credible allegations of fraud to HCA and the Medicaid Fraud Control Unit as described in Subsection 12.6 of the State Contract, or its successor.

29. ***Subrogation.*** Contractor agrees to subrogate to the State for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims Contractor has or may have against any entity or individual that directly or indirectly receives funds under the State Contract including, but not limited to, any Health Care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products or services. For the purposes of this Section, "subrogation" means the right of any State government entity or local law enforcement to stand in the place of Contractor in the collection against a third party.

30. ***Limitations on Referrals.*** Contractor referrals may be limited to Participating Providers except in the following circumstances: (a) Emergency services; (b) Services provided outside the Service Areas as necessary to provide Medically Necessary services; (c) When a Member has other primary comparable physical and/or behavioral health coverage, as necessary to coordinate benefits; and (d) Within the Service Areas, as defined in the Service Areas provisions of the Enrollment Section of the State Contract, Contractor shall cover Members for all physical and/or behavioral health necessary services.

31. ***High Categorical Risk Providers.*** Providers that are deemed to be "high categorical risk," including prospective (newly enrolling) home health agencies and prospective (newly enrolling) durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers or such other categories of providers as defined under 42 C.F.R. § 424.518, shall be enrolled in and screened by Medicare, in addition to complying with CHPW's policies and procedures regarding credentialing and recredentialing. Such providers shall revalidate Medicare enrollment every three (3) years in compliance with 42 C.F.R. § 424.515. Notwithstanding the foregoing, Infant In-Home Phototherapy Providers that meet CHPW's certification requirements are not required to be enrolled in Medicare.

32. ***HCA Approval for Assignment.*** Contractor acknowledges and agrees that no assignment of the Agreement shall take effect without the prior written agreement of HCA.

33. ***Quality Improvement System.*** Contractor shall maintain a quality improvement system tailored to the nature and type of Covered Services provided hereunder, which affords quality control for such services, including but not limited to the accessibility of Medically Necessary services, and which provides for a free exchange of information with CHPW to assist CHPW in complying with the requirements of the State Contract. Providers that are PCPs or specialty care providers shall comply with all quality improvement activities of the CHPW.

34. ***Records of Delegated Activities.*** As applicable to services rendered under the Agreement, Contractor shall have a means to keep records necessary to adequately document services provided to Members for any and all delegated activities including quality improvement, utilization management, Member's rights and responsibilities, Health Homes, and credentialing and re-credentialing.

35. ***Payment in Full and Member Charges.*** Contractor agrees to accept payment from CHPW as payment in full. Contractor shall not request payment from HCA or any Member for Covered Services provided under the Agreement, and shall comply with WAC 182-502-0160 requirements applicable to providers. Contractor shall report to CHPW any instance in which a Member is charged for services. Contractor shall repay to a Member any inappropriate charges paid by such Member, or shall reimburse CHPW to the extent CHPW repays such inappropriate charges to the Member.

36. ***HCA and Member Hold Harmless.*** Contractor agrees to hold harmless HCA and its employees, and all Members in the event of non-payment by CHPW. Contractor further agrees to indemnify and hold harmless HCA and its employees against (a) 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 Contractor, its agents, officers, employees or contractors, and (b) any damages related to Contractor's unauthorized use or release of Personal Information or PHI of Members.

37. ***Termination Provision.*** Either Party to this Exhibit may terminate this Exhibit upon ninety (90) days advance written notice to the other Party. Notwithstanding the foregoing, in the event that (a) Contractor is excluded from participation in the Medicaid program, CHPW may immediately terminate the Agreement or this Exhibit upon written notice to Contractor, and may immediately recover any payments for goods or services that benefit excluded individuals or entities; or (b) HCA or Medicare has taken any action to revoke Contractor's privileges for cause, and Contractor has exhausted all applicable appeal rights or the timeline for appeal has expired. "For cause" may include but is not limited to reasons related to fraud, integrity or quality.

38. ***Provider Appeal Rights.*** If Contractor provides physician services, Contractor may exercise any appeal rights pursuant to Chapter 284-170 WAC to challenge CHPW's failure to cover a service.

39. ***CHPW Oversight and Corrective Action.*** Contractor acknowledges and agrees that CHPW shall conduct ongoing monitoring and periodic formal review that is consistent with applicable industry standards and the regulations of the Washington State Office of the Insurance Commissioner, if any. Such formal review shall be completed no less than once every three (3) years or more often if specified, and will identify any deficiencies or areas of improvement and

provide for corrective action of any such deficiencies. Such review shall include an evaluation to ensure that services furnished by Contractor to individuals with special health care needs are appropriate to the Member's needs. Inadequate performance under the Agreement will be subject to the revocation of delegation or imposition of sanctions in accordance with the dispute resolution process detailed in the Agreement.

40. ***Member Self-Referral.*** Contractor acknowledges that Members have a right to self-refer for:

39.1 Family planning services and supplies, and sexually-transmitted disease screening and treatment services provided at participating or non-Participating Providers, including but not limited to family planning agencies;

39.2 Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through and if provided by a local health department;

39.3 Immunizations, sexually transmitted disease screening, family planning and behavioral health services through and if provided by a school-based health center;

39.4 All services received by American Indian or Alaska Native Members under the Special Provisions for American Indians and Alaska Natives Subsection of the State Contract; and

39.5 Crisis Response Services, including crisis intervention; crisis respite; investigation and detention services; and, evaluation and treatment services. Self-referrals can also be made for assessment and intake for behavioral health services.

41. ***Delegated Administrative Services Agreement.*** In the event that the Agreement delegates administrative functions to Contractor, the Parties agree that they shall enter into a delegated administrative services agreement that contains all provisions required pursuant to the State Contract.

42. ***Confidential Member Information.*** Contractor shall keep information about Members, including their medical records, confidential in a manner consistent with Applicable Law.

43. ***Member Rights.*** Contractor shall comply with any Applicable Law that pertain to Members' rights and shall protect and promote those rights when furnishing services to Members. Contractor shall guarantee each Member the rights set forth below. Each Member must be free to exercise these rights and the exercise of these rights must not adversely affect the way CHPW or Contractor treats the Member. These rights include:

42.1 To be treated with respect and with consideration for Member's dignity and privacy;

42.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's ability to understand;

42.3 To participate in decisions regarding Member's health care, including the right to refuse treatment;

42.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

42.5 To request and receive a copy of their medical records, and to request that they be amended or corrected in accordance with Applicable Law; and

42.6 To choose a behavioral Health Care Provider.

44. ***Background Checks.*** Contractor shall require a criminal history background check through the Washington State Patrol for employees and volunteers of Contractor who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults. Further, Contractor shall maintain related policies and procedures and personnel files consistent with requirements in Chapter 43.43 RCW, Chapters 388-877 WAC and Chapter 388-06A WAC.

45. ***Cultural Considerations.*** If applicable, Contractor shall participate in and cooperate with CHPW's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

46. ***Member Self-Determination.*** Contractor shall (a) obtain informed consent prior to treatment from all Members, or from persons authorized to consent on behalf of Members as described in RCW 7.70.065, (b) comply with the provisions of the Natural Death Act (Chapter 70.122 RCW) and Applicable Law and rules concerning advance directives and POLST (eg., WAC 182-501-0125 and 42 C.F.R. § 417.436), and (c) when appropriate, inform Members of their right to make anatomical gifts pursuant to Chapter 68.64 RCW.

47. ***Advance Directives and POLST.*** Contractor shall ensure that whether a Member has executed an advance directive or POLST shall be indicated in a prominent part of such Member's medical records, and Contractor shall not provision care or otherwise discriminate against a Member based on whether the Member has executed an advance directive or POLST.

48. ***Mental Health Advance Directives.*** Contractor shall comply with Chapter 71.32 RCW (Mental Health Advance Directives).

49. ***Behavioral Health Services.*** If Contractor provides behavioral health services, Contractor must use GAIN-SS and assessment process that includes use of the quadrant placement. Failure to implement and maintain the Integrated Co-Occurring Disorder Screening and Assessment process will result in corrective action.

50. ***Health Home Surety Bond.*** If Contractor is a home health agency, Contractor represents and warrants that it is in compliance with the surety bond requirements of federal law (Section 4708(d) of the Balanced Budget Act of 1997 and 42 C.F.R. § 441.16).

51. ***Physician Incentive Plan.*** If Contractor is at financial risk, as defined in the Substantial Financial Risk or Risk provisions in the State Contract, Contractor shall be subject to solvency

requirements that provide assurance of Contractor's ability to meet its obligations. Such requirements shall be regularly monitored and enforced.

If Contractor makes payment to any physician under a Physician Incentive Plan, such plan shall meet all applicable requirements under the State Contract, including but not limited to disclosure requirements and stop-loss protection. No payment to Contractor, or by Contractor to a provider, under a Physician Incentive Plan shall, directly or indirectly, be an inducement to reduce or limit Medically Necessary Services provided to an individual Member.

52. ***Information on Ownership and Control.*** Failure to comply with the terms of this Section shall be deemed a material breach of the Agreement.

52.1 If Contractor is not an individual practitioner or a group of practitioners, Contractor shall disclose the following information to CHPW upon Agreement execution, upon request during the re-validation of enrollment process under 42 C.F.R. § 455.414, and within thirty-five (35) business days after any change in ownership of Contractor:

52.1.1 The name and address of any person (individual or corporation) with an ownership or control interest in Contractor;

52.1.2 If Contractor is a corporate entity, the primary business address, every business location, and P.O. Box address;

52.1.3 If Contractor has corporate ownership, the tax identification number of the corporate owner(s);

52.1.4 If Contractor is an individual, date of birth and Social Security Number;

52.1.5 If Contractor has a five percent (5%) ownership interest in any of its subcontractors, the tax identification number of the subcontractor(s);

52.1.6 Whether any person with an ownership or control interest in Contractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in Contractor;

52.1.7 If Contractor has a five percent (5%) ownership interest in any of its subcontractors, whether any person with an ownership or control interest in such subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in Contractor; and

52.1.8 Whether any person with an ownership or control interest in Contractor also has an ownership or control interest in any other Medicaid provider, in the State's fiscal provider or in any Managed Care entity.

52.2 Upon the request of CHPW or HCA, Contractor shall furnish to HCA, within thirty-five (35) calendar days of a request, full and complete business transaction information as follows:

52.2.1 The ownership of any subcontractor with whom Contractor has had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the previous twelve (12) month period ending on the date of the request; and

52.2.2 Any significant business transaction between Contractor and any wholly owned supplier or any subcontractor during the previous five (5) year period ending on the date of the request.

Contractor shall provide any further information needed or reasonably requested by CHPW for the purpose of satisfying CHPW's HCA reporting requirements under the State Contract, or for the purpose of verifying or screening for exclusion from federal or state health care programs, or for conviction of various criminal or civil offences, among the individuals or entities who have an ownership or control interest in, or who are a managing employee of, Contractor.

52.3 Upon request, Contractor shall furnish to the Washington Secretary of State, the Secretary of the US Department of Health and Human Services, the Inspector General of the US Department of Health and Human Services, the Washington State Auditor, the Comptroller of the Currency, and HCA a description of the transaction between Contractor and a party in interest (as defined in Section 1318(b) of the Public Health Service Act) within thirty-five (35) calendar days of the request, including the following transactions:

52.3.1 Any sale or exchange, or leasing of any property between Contractor and such a party;

52.3.2 Any furnishing for consideration of goods, services (including management services), or facilities between Contractor and such a party but not including salaries paid to employees for services provided in the normal course of their employment; and

52.3.3 Any lending of money or other extension of credit between Contractor and such a party.

53. ***Information on Persons Convicted of Crimes.*** Contractor shall investigate and disclose to CHPW, at Agreement execution or renewal, and upon request by CHPW of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs and who is:

53.1 A person who has an ownership or control interest in Contractor;

53.2 An agent or person who has been delegated the authority to obligate or act on behalf of Contractor; and

53.3 An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, Contractor.

54. ***Maternity Newborn Length of Stay; Sterilizations and Hysterectomies.*** All hospital delivery maternity care provided under the Agreement shall be in accord with RCW 48.43.115.

All sterilizations and hysterectomies provided under the Agreement shall be in compliance with 42 C.F.R. § 441 Subpart F, and Contractor shall use a Consent for Sterilization form (HHS-687) or its equivalent in connection therewith. A hysterectomy requires the Hysterectomy Consent and Patient Information form (HCA 13-365).

55. ***Grievance and Appeals.*** CHPW shall maintain a grievance and appeals system in accordance with the requirements of the State Contract, and CHPW shall provide the following information regarding CHPW's grievance and appeal system to Contractor:

55.1 The toll-free numbers to file oral grievances and appeals;

55.2 The availability of assistance in filing a grievance or appeal, including informing the Member about ombuds services and how to access those services;

55.3 The Member's right to request continuation of Medicaid benefits during an appeal or hearing and, if the CHPW's Adverse Benefit Determination is upheld, that the Member may be responsible to pay for the continued benefits;

55.4 The Member's right to file grievances and appeals and their requirements and timeframes for filing;

55.5 The Member's right to a hearing, how to obtain a hearing and representation rules at a hearing; and

55.6 Contractor may file a grievance or request an adjudicative proceeding on behalf of a Member in accordance with the State Contract.

EXHIBIT D
ACKNOWLEDGEMENT OF REVIEW OF PROVIDER MANUAL

Contractor hereby acknowledges review of CHPW's *Provider Manual* and acknowledges that the *Provider Manual* was made available to Contractor for review prior to Contractor's decision to enter into this Agreement. The *Provider Manual* is available at CHPW's website at www.CHPW.org.

Date of Review: _____

Initials of Contractor's Authorized Representative: _____

Effective Date: January 1, 2024
(CHPW TO COMPLETE)

EXHIBIT E
CONTRACT REPRESENTATIVES AND CONTACT INFORMATION

Skamania County Community Health					
Contact Name					
Contact Title					
Mailing Address 1					
Mailing Address 2					
City		**State**		**Zip**	
Phone			**Fax**		
Email					

COMMUNITY HEALTH PLAN of WASHINGTON (CHPW)					
ATTN: Provider Contracting Department					
Mailing Address	1111 Third Avenue, Suite 400				
City	Seattle	**State**	WA	**Zip**	98101-3292
Email	Provider.Contracting@CHPW.org				

ATTN: Provider Relations Department					
Mailing Address	1111 Third Avenue, Suite 400				
City	Seattle	**State**	WA	**Zip**	98101-3292
Phone	(206) 521-8833		**Fax**	(206) 613 - 5018	
Email	Provider.Relations@CHPW.org				

ATTN: Contract Administrator					
Name	Doug Porter				
Mailing Address	1111 Third Avenue, Suite 400				
City	Seattle	**State**	WA	**Zip**	98101-3292
Phone	(206) 652-7184		**Fax**	(206) 613 - 5018	
Email	doug.porter@chpw.org				

SAFETY COMMITTEE REPORT TO BOARD OF COMMISSIONERS

April 23, 2024
7:30am, Human Resource Office
Bottom floor of County Courthouse

1. Chairman's Safety Report
2. Old Business
3. New Business

2024-E-001

A Buildings and Grounds employee reported that they were driving county vehicle home, a vehicle was stuck in their driveway, when attempting to go up their steep driveway the vehicle started to slide and ran into the parked vehicle.

The Safety Committee agrees with the Supervisor that the accident was preventable and recommends that the employee puts chains on.

2024-E-002

A Public Works employee was backing vehicle out of the shop. The employee was demonstrating how to release the new vehicles mechanical parking brake. Employee attempted to put vehicle in park, opened the door and too foot off the brake with the door opened. The vehicle moved backwards and got caught on a stack of tires.

The safety committee agrees with the supervisor that this was preventable, and the employee needs to be more aware.

2024-E-003

A Solid Waste employee was pushing garbage, a piece of wood got stuck in the tire tread, jamming it into the finder well, busting it.

The safety committee agrees with the supervisor that this was unpreventable due to the nature of the work and that this could happen in the work environment every day.

2024-E-004

A Solid Waste employee had a huge pile of garbage over 20 feet tall. The employee was manipulating the pile to pack it into the trailer. The bucket was being raised and lowered to do this, when the bucket was raising up, an object came under the bucket and speared the air cooler for the AC.

The safety committee disagrees with the Supervisor. The Supervisor listed that it was an unpreventable incident, and the Safety Committee believes that the incident was preventable by the county, the equipment needs metal guards instead of plastic guards. Equipment could be modified for the type of work the equipment is being used for.

2024-1001

Community Health employee became ill due to being exposed to COVID by co-worker. Employee works in a shared office with two other individuals.

Safety Committee disagrees with the Supervisor. The Supervisor listed that it was preventable. The Safety Committee voted that it was unpreventable because the employee that did test positive had no symptoms when they supposably exposed others in their office.