Washington State Health Care Authority	**CONTRACT AMENDMENT BEHAVIORAL HEALTH – ADMINSTRATIVE SERVICES ORGANIZATION**	HCA Contract No.: K8346 Amendment No.: 02 Kitsap County No: KC-343-25-B

THIS AMENDMENT TO THE BEHAVIORAL HEALTH – ADMINISTRATIVE SERVICES ORGANIZATION CONTRACT is between the Washington State Health Care Authority and the party whose name appears below, and is effective as of the date set forth below.

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

AMENDMENT START DATE	**AMENDMENT END DATE**	**CONTRACT END DATE**
January 1, 2026	June 30, 2027	June 30, 2027
PRIOR MAXIMUM CONTRACT AMOUNT $10,470,545.00	**AMOUNT OF INCREASE** $7,302,766.00	**TOTAL MAXIMUM CONTRACT AMOUNT** $17,773,311.00

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

WHEREAS, HCA and Contractor wish to amend the Contract to 1) update requirements and provide editorial changes to the BH-ASO Contract to ensure clarity of Contract expectations; and 2) revise Exhibit A-1, Non-Medicaid Funding Allocation.

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

1. The Total Maximum Contract Amount for this Contract is increased by $7,302,766.00, from $10,470,545.00 to $17,773,311.00.

2. Section 1, Definitions, a new subsection 1.15 Assisted Outpatient Treatment (AOT), is added as follows:

   1.15 Assisted Outpatient Treatment (AOT)

   "Assisted Outpatient Treatment (AOT)" means the practice of providing community-based Behavioral Health treatment under civil court order, as a means of: (1) motivating an Individual with a Behavioral Health disorder who struggles with voluntary treatment adherence to engage fully with their treatment plan; and (2) focusing the attention of treatment providers on the need to work diligently to keep the person engaged in effective treatment. An AOT Program is an organized, systematic effort within a Behavioral Health system to ensure that AOT will be made available to those who need it to live safely in the community.

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

3. Section 1, Definitions, 1.25 Behavioral Health Professional, is amended to read as follows:

1.25 Behavioral Health Professional

"Behavioral Health Professional" means a licensed physician, board certified or board eligible in Psychiatry or Child and Adolescent Psychiatry, Addiction Medicine or Addiction Psychiatry, licensed doctoral level psychologist and psychological associate, Psychiatric Advanced Registered Nurse Practitioner (ARNP), or a licensed pharmacist.

4. Section 1, Definitions, 1.34 Certified Peer Specialist (CPS) is renamed 1.34 Certified Peer Support Specialist (CPSS) and is amended to read as follows:

1.34 Certified Peer Support Specialist (CPSS)

"Certified Peer Support Specialist (CPSS)" means a person who meets the certification requirements as set forth in RCW 18.420.050 and is certified under chapter 18.420 RCW to engage in the practice of Peer Support Services.

5. Section 1, Definitions, 1.35 Certified Specialist Trainee (CPST) is renamed 1.35 Certified Peer Support Specialist Trainee (CPSST) and amended to read as follows:

1.35 Certified Peer Support Specialist Trainee (CPSST)

"Certified Peer Support Specialist Trainee (CPSST)" means a person who meets the certification requirements as set forth in RCW 18.420.060 and is working toward the supervised experience requirements to become a Certified Peer Specialist under chapter 18.420 RCW.

6. Section 1, Definitions, 1.40 Clinically Managed Residential Withdrawal Management (ASAM 3.2 WM) is renamed 1.40 Clinically Managed Residential Withdrawal Management and amended to read as follows:

1.40 Clinically Managed Residential Withdrawal Management

"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, but, the full resources of a Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management services are not necessary. The service as described satisfies the level of intensity in ASAM Level 3.2 WM.

7. Section 1, Definitions, 1.86 Global Appraisal of Individual Needs Short Screener (GAIN SS), is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

8. Section 1, Definitions, 1.92 Health Care Professional, is amended to read as follows:

1.92 Health Care Professional

"Health Care Professional" means a physician or any of the following acting within his or her scope of practice; an applied behavior analyst, certified registered dietician, naturopath, podiatrist, optometrist, optician, osteopath, chiropractor, psychologist, psychological associate, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered

or practical nurse (including nurse practitioner or clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed midwife, licensed social worker (advanced or independent clinical license or associate), licensed mental health counselor, licensed mental health counselor associate, licensed marriage and family therapist, licensed marriage and family therapist associate, registered respiratory therapist, pharmacist, and certified respiratory therapy technician.

9. Section 1, Definitions, 1.123 Medically Monitored Inpatient Withdrawal Management (ASAM 3.7 WM) is renamed 1.123 Medically Monitored Inpatient Withdrawal Management and amended to read as follows:

1.123 Medically Monitored Inpatient Withdrawal Management

"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. The service as described satisfies the level of intensity in ASAM Level 3.7 WM.

10. Section 1, Definitions, 1.132 Mobile Rapid Response Crisis Team (MRRCT), is amended to read as follows:

1.132 Mobile Rapid Response Crisis Team (MRRCT)

"Mobile Rapid Response Crisis Team (MRRCT)" means a team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for Individuals who experiencing a Behavioral Health crisis that meet standards for response times established by the HCA. As a best practice to the extent practicable based on workforce availability, MRCCTs may include Certified Peer Counselors until December 31, 2026. Beginning July 1, 2025, MRRCTs may also include Certified Peer Support Specialists and Certified Peer Support Specialist Trainees. MRRCTs teams that primarily serve children, youth, and families follow the Mobile Response and Stabilization Services (MRSS) model and may refer to themselves as an MRSS team or as a child, youth, and family MRRCT.

11. Section 1, Definitions, 1.148 Peer Bridger, is amended to read as follows:

1.148 Peer Bridger

"Peer Bridger" means a trained individual who offers peer services to participants in state hospitals and inpatient mental health facilities prior to discharge and after their return to their communities. The Peer Bridger must be an employee of a Behavioral Health agency licensed by DOH that provides Recovery services. Until December 31, 2026, a Peer Bridger is a Certified Peer Counselor, and also beginning July 1, 2025, a Peer Bridger may be a Certified Peer Support Specialist or Certified Peer Support Specialist Trainee.

12. Section 1, Definitions, 1.149 Peer Support Services, is amended to read as follows:

1.149 Peer Support Services

"Peer Support Services" means scheduled activities that promote wellness, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services provided by Certified Peer Counselors, Certified Peer Support Specialists, and Certified Peer Support Specialist Trainees

as noted in the Individuals' Individualized Service Plan (ISP), or without an ISP when provided during/post crisis episode. In this service, model skills in recovery and self-management to help Individuals meet their self-identified goals.

13. Section 1, Definitions, 1.169 Serious Emotional Disturbance (SED), is amended to read as follows:

    1.169 Serious Emotional Disturbance (SED)

    "Serious Emotional Disturbance (SED)" means a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) that results in functional impairment which substantially interferes with or limits a child's role or functioning in family, school, or community activities.

14. Section 1, Definitions, 1.187 Tribal Crisis Coordination Protocols for Coordination with Tribes and non-Tribal IHCPs is renamed 1.187 Tribal Crisis Coordination Protocols for Tribes and non-Tribal IHCPs and amended to read as follows:

    1.187 Tribal Crisis Coordination Protocols for Tribes and non-Tribal IHCPs

    "Tribal Crisis Coordination Protocols for Tribes and non-Tribal IHCPs" means the protocols that HCA and a Tribe or non-Tribal IHCP develop and agree on, with input from the Contractor, for the coordination of Crisis Services (including involuntary commitment assessment), Care Coordination, and discharge and transition planning. See Subsection 21.2, Crisis Coordination for Tribes and non-Tribal IHCPs.

15. Section 2, General Terms and Conditions, 2.2 Administrative Simplification, subsection 2.2.1 is amended to read as follows:

    2.2.1 To maximize understanding, communication, and administrative economy among all Contractors, their Subcontractors, governmental entities, and Individuals, the Contractor shall use and follow the most recent updated versions of:

        2.2.1.1 Current Procedural Terminology (CPT).

        2.2.1.2 International Classification of Diseases (ICD).

        2.2.1.3 Healthcare Common Procedure Coding System (HCPCS).

        2.2.1.4 The Diagnostic and Statistical Manual of Mental Disorders.

        2.2.1.5 The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5).

        2.2.1.6 National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard D.O.

        2.2.1.7 Medi-Span® Master Drug Data Base or other nationally recognized drug data base with approval by HCA.

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

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

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

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

6.1.6.3 Assist the state in expanding community-based alternatives for Crisis Stabilization, such as MRRCT outreach or Crisis residential and respite beds; and

6.1.6.4 Assist the state in expanding community-based, Recovery oriented services, use of Peer Support Services and research- and Evidence-Based Practices.

17. Section 9, Subcontracts, 9.3 Required Provisions, subsection 9.3.1 is amended to read as follows:

9.3.1 Subcontracts shall be in writing and available to HCA upon request. All Subcontracts shall contain the following provisions in addition to applicable provisions contained in this Contract:

9.3.1.1 Identification of the parties of the Subcontract and their legal basis for operation in the state of Washington.

9.3.1.2 The process for revoking Delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

9.3.1.3 Procedures and specific criteria for terminating the Subcontract.

9.3.1.4 Identification of the services to be performed by the Subcontractor and which of those services may be Subcontracted by the Subcontractor. If the Contractor allows the Subcontractor to further Subcontract, all Subcontractor requirements contained in this Contract must be propagated downward into any other lower-tiered Subcontracts (45 C.F.R. § 92.35).

9.3.1.5 Reimbursement rates and procedures for services provided under the Subcontract, including the use of the Contractor's own fee schedule for all services provided, except for psychiatric inpatient services provided in a community hospital.

9.3.1.6 Release any information necessary to the Contractor to perform any of its obligations under this Contract.

9.3.1.7 Reasonable access to facilities, financial records, and medical records for duly-authorized representatives of HCA or DOH for audit purposes and immediate access for Medicaid Fraud investigators.

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

9.3.1.8.1 The Contractor shall work with IHCPs to develop a mechanism to collect reports and data that will minimize duplication of reporting for IHCPs that submit reports and data to HCA without using the Contractor's processes or systems.

9.3.1.9 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA-approved Program Integrity policies and procedures.

9.3.1.10 The requirement to refer potential allegations of Fraud to HCA and as described in Section 13 of this Contract.

9.3.1.11 A requirement to comply with applicable state and federal statutes, rules, and Regulations set forth in this Contract.

9.3.1.12 A requirement to comply with any term or condition of this Contract that is applicable to the services to be performed under the Subcontract.

9.3.1.13 Comply with Tribal Crisis Coordination Protocols.

9.3.1.14 A requirement to have all Subcontractors that are Behavioral Health Service Providers accept Tribal court orders from Tribes located within the state on the same basis as state court orders (RCW 71.34.312(2) and RCW 71.05.337(2)).

9.3.1.15 Comply with the definition of Medical Clearance under RCW 71.05.020 and include IHCPs among individuals qualified to determine that an Individual is medically stable and ready for referral to the DCR or Facility.

9.3.1.16 Not to require Medical Clearance prior to investigation by the DCR for an Individual presenting in the community (chapter 71.05 RCW).

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

The Contractor's Subcontracts shall contain the following provisions:

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

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

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

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

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

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

9.5.4.1 Coordinate a community-based discharge plan for each Individual served under this Contract beginning at intake. Discharge planning shall apply to all Individuals regardless of length of stay or whether or not they complete treatment.

9.5.4.2 Coordinate exchange of assessment, admission, treatment progress, and continuing care information with the referring entity, including IHCPs as appropriate. Contact with the referral agency shall be made within the first week of residential treatment.

9.5.4.3 Comply with the requirements for discharge planning defined in this Contract and in accordance with chapters 71.05 and 71.34 RCW, including Facility discharge notification to Tribes and appropriate Care Coordination with IHCP if the Facility has reason to know that an Individual is AI/AN and access health services at an IHCP.

9.5.4.4 Establish referral relationships with assessment entities, outpatient Providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of entities making referrals in treatment activities.

9.5.4.5 Coordinate as needed with DBHR prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate; including DCYF, DSHS Economic Services Administration (ESA), Community Services Offices (CSOs), Tribal governments, and non-Tribal IHCPs.

9.5.4.6 Coordinate services to financially eligible Individuals who are in need of medical services.

9.5.5 A requirement that residential treatment Providers ensure that priority admission is given to the populations, including American Indians and Alaska Natives, identified in this Contract.

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

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

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

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

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

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

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

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

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

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

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

9.5.15 Requirements for nondiscrimination in employment and Individual services.

9.5.16 Protocols for screening for Debarment and suspension of certification.

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

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

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

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

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

9.5.20.2 The FBO shall facilitate a referral to an alternative Provider within a reasonable time frame when requested by the recipient of services.

9.5.20.3 The FBO shall report to the Contractor all referrals made to alternative Providers.

9.5.20.4 The FBO shall provide Individuals with a notice of their rights.

9.5.20.5 The FBO provides Individuals with a summary of services that includes any religious activities.

9.5.20.6 Funds received from the FBO must be segregated in a manner consistent with federal Regulations.

9.5.20.7 No funds may be expended for religious activities.

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

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

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

9.5.22.1 Assigned responsibilities.

9.5.22.2 Delegated activities.

9.5.22.3 A mechanism for evaluation.

9.5.22.4 Corrective action policy and procedure.

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

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

9.5.25 A 90-day termination notice provision.

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

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

9.5.27.1 The Contractor shall ensure that Subcontractors have complied with data submission requirements established by HCA for all services funded under the Contract.

9.5.27.2 The Contractor shall ensure that the Subcontractor updates individual funding information when the funding source changes.

9.5.27.3 The Contractor shall maintain written or electronic records of all Subcontractor monitoring activities and make them available to HCA upon request.

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

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

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

9.5.28.1.2 If a Subcontractor is not subject to OMB Super Circular, the Contractor shall perform subrecipient monitoring in compliance with federal requirements.

9.5.29 The Contractor shall document and confirm in writing all Single Case Agreements with Providers. The agreement shall include:

9.5.29.1 The description of the services;

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

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

9.5.29.4 Any other specifics of the negotiated rate.

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

9.5.31 The Contractor shall maintain a record of the Single Case Agreements for a period of six (6) years.

9.5.32 A requirement to comply with the Tribal Crisis Coordination Protocols as defined in Section 1, Definitions of this Contract.

9.5.33 Comply with the Tribal Crisis Coordination Protocols. Until these protocols are completed and agreed upon, the Contractor shall use the most recent annual plan for providing Crisis and ITA evaluation on Tribal Lands that was agreed upon by the Contractor and the Tribe. If the most recent annual plan is not available, the Contractor shall use the current HCA guidance template: Protocols for Coordination with Tribes and Non-Tribal IHCPs.

9.5.34 A requirement to have all Subcontractors that are Behavioral Health Service Providers accept Tribal court orders from Tribes located within the state on the same basis as state court orders (RCW 71.34.312(2) and RCW 71.05.337(2)).

9.5.35 Comply with the definition of Medical Clearance under RCW 71.05.020 and include IHCPs among individuals qualified to determine that an Individual is medically stable and ready for referral to the DCR or Facility.

9.5.36 Not to require Medical Clearance prior to investigation by the DCR for an Individual presenting in the community (chapter 71.05 RCW).

19. Section 9, Subcontracts, 9.9 Provider Education, subsection 9.9.1 is amended to read as follows:

9.9.1 The Contractor shall inform GFS and FBG Providers in writing regarding these requirements:

9.9.1.1 Contracted Services for Individuals served under this Contract.

9.9.1.2 Coordination of care requirements.

9.9.1.3 HCA and the Contractor's policies and procedures as related to this Contract.

9.9.1.4 Data Interpretation.

9.9.1.5 Requirements for Utilization Management (UM) decision making, procedure coding, and submitting claims for GFS and FBG funded services.

9.9.1.6 Care management staff who can assist in care transitions and care management activity.

9.9.1.7 Program Integrity requirements.

9.9.1.8 Ensure Contractor sponsored Certified Peer Support Specialist trainings are offered in accordance with DBHR policies. Policy requirements include the use of DBHR approved curriculum, trainers, testers, and applicants.

9.9.1.9 The Protocols for Coordination with Tribes and non-Tribal IHCPs applicable to the Individual's Tribe or Indian Health Care Provider in any region.

20. Section 12, Utilization Management (UM) Program and Authorization of Services, 12.1 Utilization Management Requirements, subsection 12.1.7 is amended to read as follows:

12.1.7 Actions including any decision to authorize a service in an amount, duration or scope that is less than requested shall be conducted by:

12.1.7.1 A physician that is board-certified or board-eligible in Psychiatry or Child and Adolescent Psychiatry;

12.1.7.2 A physician that is board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry; or

12.1.7.3 A licensed, doctoral level clinical psychologist or psychological associate.

21. Section 13, Program Integrity, 13.4 Referring of Allegations of Potential Fraud and Invoking Provider Payment Suspensions, subsection 13.4.1 is amended to read as follows:

13.4.1 When the Contractor suspects that potential Fraud exists, the Contractor shall make a Fraud referral to HCA within five (5) Business Days of the determination and stop any further action including, overpayment issuance, collection, or any other steps. The referral must be emailed to HCA at HotTips@hca.wa.gov. The Contractor shall report using the WA Fraud Referral Form.

22. Section 14, Grievance and Appeal System, 14.1 General Requirements, subsection 14.1.7 is amended to read as follows:

14.1.7 With respect to any decisions described in subsection 14.1.6, the Contractor shall ensure that the Health Care Professional making such decisions:

14.1.7.1 Has clinical expertise in treating the Individual's condition or disease that is age appropriate (e.g., a board-certified Child and Adolescent Psychiatrist for a child Individual);

14.1.7.2 A physician that is board-certified or board-eligible in Psychiatry or Child or Adolescent Psychiatry if the Grievance or Appeal is related to inpatient level of care denials for psychiatric treatment;

14.1.7.3 A physician that is board-certified or board-eligible in Addiction Medicine or a Sub-specialty in Addiction Psychiatry if the Grievance or Appeal is related to inpatient level of care denials for SUD treatment; or

14.1.7.4 Are one or more of the following, as appropriate, if a clinical Grievance or Appeal is not related to inpatient level of care denials for psychiatric or SUD treatment:

14.1.7.4.1 Physicians that are board-certified or board-eligible in Psychiatry, Addiction Medicine or Addiction Psychiatry;

14.1.7.4.2 Licensed, doctoral level clinical psychologists or psychological associates; or

14.1.7.4.3 Pharmacists.

23. Section 15, Care Management and Coordination, 15.4 Care Coordination and Continuity of Care: State Hospitals and Long-Term Civil Commitment (LTCC) Facilities, subsection 15.4.4 Peer Birder Program is amended to read as follows:

15.4.4 Peer Bridger Program

15.4.4.1 The Contractor shall develop and implement a Peer Bridger program staffed by at least one or more Peer Bridger(s) based on FTE allocation table in Exhibit A in each region and in collaboration with the MCOs in the region to facilitate and increase the number of state hospital discharges and promote continuity of services when an Individual returns to the community. Services shall be delivered equitably to Individuals assigned to the MCOs and the Contractor. BH-ASO regions may begin utilizing Peer Bridgers for local psychiatric inpatient discharges. The program shall follow Peer Bridger program standards found in the Peer Bridger Manual.

15.4.4.2 The Contractor shall ensure that the Peer Bridger is allowed to attend treatment activities with the Individual during the 120-day period following discharge if requested by the Individual. Examples of activities include but are not limited to intake evaluations, prescriber appointments, treatment planning, etc. This may be extended on a case-by-case basis.

15.4.4.3 Data reporting. The Contractor shall:

15.4.4.3.1 Submit to HCA the Peer Bridger Monthly Report by the fifteenth (15) calendar day of the month following the month being reported, for each region, on the template provided by HCA;

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

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

24. Section 17, Scope of Services – Crisis System, 17.4 Crisis System Operational Requirement, subsection 17.4.8 is amended to read as follows:

17.4.8 The Contractor shall establish protocols for providing information about and referral to other available services and resources for Individuals who do not meet criteria for Medicaid or GFS/FBG services (e.g., homeless shelters, domestic violence programs, Recovery Support Services). Protocols shall align with the Tribal Crisis Coordination Protocols.

25. Section 18, Designated Crisis Responder (DCR) and Involuntary Treatment Act (ITA), 18.2 Tribal Designated Crisis Responders, a new subsection 18.2.1 is added as follows:

18.2.1 The Contractor will enable any Tribal DCR, whether appointed by the Contractor, by the courts within the region, or by HCA, to shadow with and receive on-the-job training and technical assistance from a DCR employed by a DCR Provider agency that is contracted with the Contractor.

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

26. Section 19, Mobile Rapid Response Crisis Team (MRRCT), 19.1 Mobile Rapid Response Crisis Team Required Elements, is amended to read as follows:

19.1.1 The Contractor will work to ensure a minimum of one CPC or CPSS is included in MRRCT following the program guidelines as workforce allows.

19.1.1.1 CPCs and CPSSs will be required to complete the HCA Crisis Awareness and Communication in Peer Support continuing education training for peers working in crisis response.

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

19.1.2 Each BH ASO will have a minimum of one adult MRRCT and one children, Youth, and family MRRCT in the region and continue to work on increasing capacity.

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

19.1.2.2 The Contractors in regions King, Spokane, Pierce and Southwest shall build MRCCT's to ensure non-Medicaid Individuals who have been diagnosed with a Behavioral Health condition and who cycle through the criminal court system that are within the identified resources in Exhibit A, Funding Allocation (formerly line item Enhanced Mobile Crisis Team (Trueblood) funds).

19.1.2.2.1 Funding must be used to address the following requirements:

19.1.2.2.1.1 To decrease response time to Individuals experiencing a Behavioral Health crisis who are involved with the legal system.

19.1.2.2.1.2 To support the integration of MCR services with Co-responders, law enforcement and other First Responder teams to assist with the diversion of Individual from incarceration.

19.1.2.2.1.3 To divert hospitalizations and/or incarceration by offering a timely response to crisis when initiated.

19.1.2.2.1.4 Assisting with law enforcement by supporting handoffs.

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

19.1.2.4 Implementation elements:

19.1.2.4.1 Each team will adhere to the HCA Crisis team model as described in the MRRCT Best Practice Guide. Youth MRRCT will follow the MRSS model in the HCA MRRCT Best Practice Guide.

19.1.2.4.2 On the initial Crisis outreach service each team follows best practice guidance, as workforce allows to include at a minimum, a Mental Health Professional, or a Mental Health Care Provider to provide clinical assessment and a peer trained in Crisis Services, responding jointly. Mental Health Care Provider (MHCPs), with WAC 246-341-0302 exemption, can respond jointly with a peer in place of an MHP, as long as at least one Mental Health Professional is available 24/7 for any MHCP or peer to contact for consultation. This Mental Health Professional does not have to be the supervisor. Additional outreach and follow-up may include two staff as needed and when clinically appropriate to ensure the safety of the responder and the Individual as staffing allows.

19.1.2.4.3 MRRCT may provide additional in-home stabilization after the initial 72-hour crisis intervention as needed for up to eight weeks to ensure the least restrictive care is used to stabilize Individuals in the community.

19.1.2.4.4 All peers must complete the HCA-sponsored Crisis Awareness and Communication in Peer Support training.

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

19.1.2.4.5.1 HCA-approved certified crisis intervention specialist training;

19.1.2.4.5.2 Trainings in Trauma Informed Care, De-escalation Techniques, and Harm Reduction; and

19.1.2.4.5.3 MRRCT shall follow the established Tribal Crisis Coordination Protocols established between the HCA and the Tribe.

27. Section 19, Mobile Rapid Response Crisis Team (MRRCT), 19.2 Mobile Rapid Response Crisis Team Endorsement, subsection 19.2.1 is amended to read as follows:

19.2.1 The Contractor shall maintain a contract with any MRRCT or Community-based Crisis Team (CBCT) that receives an Endorsement from HCA. The Contractor will report any issues or concerns related to the Endorsement teams fulfilling the contract terms to HCA.

19.2.1.1 The Contractor will ensure their contracts with endorsed teams contain the following:

19.2.1.1.1 Funding for the enhanced case rate for endorsed teams;

19.2.1.1.2 Mechanism to make supplemental performance payments to an endorsed team that responds to Behavioral Health Emergencies and meets the response times described in RCW 71.24.903 for rural, suburban, and urban areas;

19.2.1.1.3 The ability collect identified Endorsement related data and service encounters; and

19.2.1.1.4 Inclusion of the endorsed team in regional dispatch protocols as the primary responder to calls defined as a Behavioral Health Emergency in chapter 182-140 WAC for their service area.

19.2.1.2 The Contractor will monitor Providers annually to ensure compliance with the Endorsement standards in chapter 182-140 WAC.

19.2.1.2.1 The Contractor will notify the HCA in writing within seven (7) calendar days if a Provider is presumed to be out of compliance with the endorsement standards;

19.2.1.2.2 The Contractor will conduct formal inspections of Providers within sixty (60) calendar days that are presumed to be out of compliance with the Endorsement standards;

19.2.1.2.3 The Contractor must notify HCA within fourteen (14) calendar days upon completion of the inspection if an endorsed team is determined to be out of compliance with the Endorsement standards; and

19.2.1.2.4 The Contractor shall submit a report that details their completion of the annual monitoring to HCABHASO@hca.wa.gov by October 31. The report must include information on how the Contractor ensured Provider maintained compliance with chapter 182-140 WAC including staffing standards, training standards, transportation, equipment, and communication standards.

19.2.1.3 Being endorsed makes teams eligible for performance payments. The choice not to become endorsed does not change a team's obligation to comply with any standards adopted by HCA related to MRRCTs.

19.2.1.3.1 Nothing in the Endorsement standards shall be construed to alter or interfere with MRRCT standards in the contract nor any requirements in the Contract between the Contractor and HCA.

19.2.1.3.2 The Contractor will submit all data from the MRRCT BHDS transaction to HCA no later than ten (10) calendar days after month end to ensure HCA can determine when an endorsed team meets response time standards and approve payment for the supplemental performance payments.

19.2.1.4 The Contractor shall pass on the full endorsement payment received from the MCO and HCA to the Providers who met endorsement standards as outlined in chapter 182-140 WAC. HCA payments to the Contractor will include payment for Non-Medicaid Clients, Fee-For-Service clients and the non-Medicaid portion for managed care clients. The MCO payment to the Contractor will include the Medicaid portion for the managed care clients.

19.2.1.4.1 HCA will provide information to the Contractor to facilitate payments to the endorsed MRRCTs and CBCTs. The supplemental rates will be published to HCA's website.

19.2.1.4.2 HCA will reconcile performance payments and adjust funding accordingly in the next 6-month contract period.

28. Section 20, Assisted Outpatient Treatment (AOT) and Least Restrictive Alternative (LRA), 20.1 Less Restrictive Alternative Standards, is amended to read as follows:

20.1 Less Restrictive Alternative Standards

20.1.1 Assisted Outpatient Treatment (AOT) shall be provided to those who are identified as meeting the need. The Contractor shall employ an AOT designated program coordinator. The BHASO coordinator will oversee system coordination and legal compliance for AOT under RCW 71.05.148 and RCW 71.34.755.

20.1.1.1 The coordinator shall work with HCA AOT program staff, Regional ITA courts, AOT Providers, and community partners to develop program requirements and best practices, policy, and procedures. Work with regional partners to implement and sustain the AOT program within the region.

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

20.1.1.3 The Contractor must provide notice to the Tribe and IHCP regarding the filing of an AOT petition concerning a person who is an AI/AN who receives medical or Behavioral Health services from a Tribe within the state of Washington.

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

20.1.1.4.1 In accordance with RCW 71.34.710 and RCW 71.05.150, notification shall be made in person or by telephonic or electronic communication to the Tribal contact as soon as possible, but before the hearing and no later than 24 hours from the time the petition is served upon the Individual and the Individual's guardian.

20.1.1.4.2 In accordance with RCW 71.34.710 and RCW 71.05.150, the notice to the Tribe or Indian health care provider must include a copy of the petition, together with any orders issued by the court and a notice of the Tribe's right to intervene.

20.1.1.4.3 In accordance with RCW 71.05.203 and chapter 71.34 RCW, the Contractor will, upon request, disclose the date of a Designated Crisis Responder investigation under chapter 71.05 or 71.34 RCW to an immediate family member, guardian, or conservator, or a federally recognized Indian Tribe if the Individual is a member of such tribe, of a person to assist in the preparation of a petition under RCW 71.05.201.

20.1.1.5 The Contractor will complete the quarterly AOT report and submit to HCABHASO@hca.wa.gov. Reports are due: February 15 (October through December); May 15 (January through March); August 15 (April through June); and November 15 (July through September).

20.1.1.6 AOT coordinators shall:

20.1.1.6.1 Attend monthly AOT coordinator meetings as directed by HCA;

20.1.1.6.2 Participate in quarterly AOT coordinator meetings as directed by HCA; and

20.1.1.6.3 Attend the Treatment Advocacy Center (TAC) monthly scheduled meetings.

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

20.1.2.1 Tracking responsibility includes notification to the Individual's MCO of the order for LRA Treatment so that the MCO can Coordinate LRA Treatment services.

20.1.2.1.1 The MCO is responsible for coordinating care with the Individual and the treatment Provider for the provision of LRA Treatment services;

20.1.2.1.2 The MCO is responsible to monitor or purchase monitoring services for Individuals receiving LRA Treatment services; and

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

20.1.2.2 For Individuals not enrolled in a Managed Care plan, the Contractor is responsible for coordinating LRA Treatment services with the Individual and the LRA Treatment Provider for the following:

20.1.2.2.1 Unfunded Individuals;

20.1.2.2.2 Individuals who are not covered by the Medicaid FFS program; and

20.1.2.2.3 Individuals who are covered by commercial insurance.

20.1.2.3 The Contractor will monitor or purchase monitoring services for Individuals receiving LRA Treatment services.

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

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

29. Section 21, External Entities and Tribal, 21.2 Crisis Coordination for Tribes and non-Tribal IHCPs, is amended to read as follows:

21.2 Crisis Coordination for Tribes and non-Tribal IHCPs

21.2.1 Upon request from HCA or the Tribe and non-Tribal IHCP, the Contractor shall participate in meetings with Tribes and non-Tribal IHCPs, facilitated by HCA, to develop the Tribal Crisis Coordination Protocols.

21.2.2 The Contractor will comply with the Tribal Crisis Coordination Protocols as defined in Section 1, Definitions, of this Contract applicable to Individuals served by a Tribal IHCP for any region when they are completed and agreed upon for each Tribe or non-Tribal IHCP. Until these protocols are completed and agreed upon, the Contractor shall use the most recent annual plan for providing Crisis and ITA evaluation on Tribal Lands that was agreed upon by the Contractor and the Tribe. If the most recent annual plan is not available, the Contractor shall use the current HCA guidance template Protocols for Coordination with Tribes and Non-Tribal IHCPs.

21.2.3 The Contractor, in partnership with HCA, will participate in HCA convened meetings to develop and revise protocols for the coordination of Crisis Services (including involuntary commitment assessment), Care Coordination, and discharge and transition planning as part of HCA's government-to-government relationship with each of the Tribes under chapter 43.376 RCW and various federal requirements and as part of HCA's meet-and-confer relationship with each non-Tribal IHCP under HCA policy. Protocols are applicable to multiple regions as applicable to individual served. With respect to Crisis and involuntary commitment assessment services, these protocols will include at a minimum a description of the procedures or processes for:

21.2.3.1 DCRs access to Tribal Lands to provide services, including Crisis response and involuntary commitment assessment;

21.2.3.2 Providing services on Tribal Lands in the evening, holidays, or weekends if different than during business hours;

21.2.3.3 Notifying Tribal authorities when Crisis Services are provided on Tribal Land, especially on weekends, holidays or after business hours, including who is notified and timeframes for the notification;

21.2.3.4 How DCRs will coordinate with Tribal mental health and/or SUD Providers, Tribal law enforcement, Tribal Crisis Services, Tribal DCRs, and others identified in the protocols, including coordination and debriefing with any Tribal mental health or SUD Providers after a Crisis Service has been provided;

21.2.3.5 When a DCR determines whether to detain or not for involuntary commitment; and

21.2.3.6 If ITA evaluations cannot be conducted on Tribal Land, how and by whom Individuals will be transported to non-Tribal Lands for involuntary commitment assessment and detention and/or to a licensed Evaluation and Treatment Facility.

21.2.4 HCA will provide the Contractor with a copy of each set of Protocols applicable to the Contractor's RSA as soon as they are agreed upon by the Tribe or non-Tribal IHCP.

21.2.5 The Contractor will ensure that all Subcontractors comply with the Tribal Crisis Coordination Protocols.

30. Section 24, Criminal Justice Treatment Account (CJTA), 24.1 CJTA Funding Guidelines, subsection 24.1.3 is amended to read as follows:

24.1.3 Therapeutic Drug Court and CJTA Base Funding are consolidated into a single CJTA funding source.

31. Section 27, Peer Pathfinders Transition from Incarceration Pilot Program, is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

32. Section 28, Family Youth System Partner Round Table (FYSPRT), 28.1 General Requirements, subsection 28.1.3 is amended to read as follows:

    28.1.3 In alignment with System of Care values and principles outlined in the Regional FYSPRT manual, include Regional FYSPRT Tri-leads and Youth/young adult, family, and system partner meeting participants in all aspects of the Regional FYSPRT work, including development, promotion, implementation, evaluation, and budgeting.

33. Section 28, Family Youth System Partner Round Table (FYSPRT), 28.1 General Requirements, subsection 28.1.6 is amended to read as follows:

    28.1.6 Convene a minimum of ten Regional FYSPRT meetings, in person or virtually, in the calendar year. Meeting agenda and materials must be made publicly available on the Regional FYSPRT's webpage prior to the meeting. The meetings shall:

        28.1.6.1 Follow the Regional FYSPRT meeting protocol found in the Regional FYSPRT manual; and

        28.1.6.2 Include a review of WISe data or WISe reports at two meetings per calendar year to identify the strengths and needs related to WISe in the RSA. Include a plan to address identified need(s) as a meeting agenda item, work plan goal or other method in the quarterly report.

34. Section 28, Family Youth System Partner Round Table (FYSPRT), 28.1 General Requirements, subsection 28.1.9 is amended to read as follows:

    28.1.9 Maintain Regional FYSPRT webpage, reviewed, and updated a minimum of once per quarter, that includes:

        28.1.9.1 Point of contact, name, email, and phone number;

        28.1.9.2 Regional meeting agendas and past meeting notes;

        28.1.9.3 Dates, locations, and times of upcoming Regional FYSPRT meetings, including information on travel reimbursement, child care, and other meeting supports. If the meeting is online, include information about how to join;

        28.1.9.4 The Regional FYSPRT Charter;

        28.1.9.5 Policies and procedures (may also be addressed in the Regional FYSPRT Charter);

        28.1.9.6 How to propose an agenda item for a future Regional FYSPRT meeting;

        28.1.9.7 Results of the needs assessment;

        28.1.9.8 The work plan; and

        28.1.9.9 Links to relevant regional/statewide resources and information.

35. Section 30, Behavioral Health Advisory Board (BHAB), 30.1 BHAB Requirements, subsection 30.1.3 is amended to read as follows:

    30.1.3 The BHAB will:

        30.1.3.1 Solicit and use the input of Individuals with mental health and/or SUD to improve Behavioral Health services delivery in the region;

30.1.3.2 Provide quality improvement feedback to key Tribal governments, IHCPs, and stakeholders and other interested parties defined by HCA. The Contractor shall document the activities and provide to HCA upon request; and

30.1.3.3 Approve the annual SUPTRS and MHBG expenditure plan for the region and provide documentation of the approval in MHBG and SUPTRS project plan submitted to HCA.

36. Section 32, Recovery Navigator Program, 32.1 Substance Use Disorder Regional Recovery Navigator Administrator, subsection 32.1.1 is amended to read as follows:

32.1.1 The Contractor must have a SUD regional administrator for the Recovery Navigator Program. The regional administrator shall be responsible for assuring compliance with the updated Recovery Navigator Uniform Program Standards.

37. Section 32, Recovery Navigator Program, 32.2 Recovery Navigators Plan, is amended to read as follows:

32.2 Recovery Navigators Plan

32.2.1 In accordance with the current Uniform Program Standards, each navigator program must maintain enough appropriately trained personnel which must include individuals with lived experience with SUD to the extent possible. The SUD Regional Recovery Navigator Administrator must assure that staff conducting intake and referral services, and field assessments are paid a livable and competitive wage and have appropriate training and receive continuing education.

32.2.2 The Recovery Navigator Program shall provide services to Youth and adults with Behavioral Health conditions who are referred to the program from diverse sources including but not limited to:

32.2.2.1 Law enforcement;

32.2.2.2 Court systems;

32.2.2.3 Community-based outreach;

32.2.2.4 Intake and referral services;

32.2.2.5 Comprehensive assessment;

32.2.2.6 Connection to services; and

32.2.2.7 Warm Handoffs to treatment and Recovery Support Services along the continuum of care.

32.2.3 Additional services to be provided as appropriate include but not limited to:

32.2.3.1 Long-term intensive case management.

32.2.3.2 Recovery coaching.

32.2.3.3 Recovery Support Services.

32.2.3.3.1 Flexible Participant Funds may be used to cover a participant's modest and variable needs within available funding.

32.2.3.4 Treatment.

32.2.4 The Contractor shall update their Recovery Navigator Plan to reflect the updated Recovery Navigator Uniform Program Standards no later than January 5, 2026.

32.2.5 Each Recovery Navigator Program must submit quarterly reports to the Recovery Navigator Program Managed File Transfer (MFT) site (https://mft.wa.gov/webclient/Login.xhtml) using the Recovery Navigator Program data collection workbook. Recovery Navigator Program administrators are responsible for ensuring a data Validation review is completed on all Provider's quarterly reports before submitting them to the MFT. Workbook corrections will be completed as requested. The quarterly reports are due on the last day of the month following the end of each quarter. Reports are due: January 31 (October through December); April 30 (January through March); July 31 (April through June); and October 31 (July through September).

32.2.6 The Contractor shall participate in technical assistance provided by the LEAD National Support Bureau/Washington State Expansion Team for their Recovery Navigator Program as needed. Technical assistance topics will depend on each Contractor's identified needs. Technical assistance can be provided virtually, by phone, email, or in-person. The Contractor may also receive technical assistance from HCA staff as needed.

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

32.2.7.1 Bi-monthly technical assistance with HCA;

32.2.7.2 Meetings every other month hosted by HCA; and

32.2.7.3 HCA hosted trainings.

38. Section 34, Youth Behavioral Health Navigator Program (YBHNP), 34.1 General Requirements, subsection 34.1.1 is amended to read as follows:

34.1.1 The Youth Behavioral Health Navigator Program (YBHNP) is intended to establish and strengthen collaborative communication, identify community resources, provide Care Coordination, consultation, community outreach and offer multidisciplinary team (MDTs) when clinically indicated with the goal to improve access to and coordination of services for children, Youth, and families/caregivers experiencing difficulty accessing Behavioral Health care.

39. Section 36, Reports/Deliverables, 36.1 Templates, is amended to read as follows:

36.1 Templates

36.1.1 Templates for all reports that the Contractor is required to submit to HCA are hereby incorporated by reference into this Contract. HCA may update the templates from time to time, and any such updated templates will also be incorporated by reference into this Contract. The report templates are located at: https://www.hca.wa.gov/billers-providers-partners/program-information-providers/model-managed-care-contracts. All deliverables must be named and submitted using the naming convention identified on the HCA reports template page. Documents and email subject headings to utilize the same naming convention. The Contractor may email HCA at any time to confirm the most recent version of any template to HCABHASO@hca.wa.gov.

36.1.1.1 Report templates include:

36.1.1.1.1 Assisted Outpatient Treatment Quarterly Report

36.1.1.1.2 Behavioral Health Data System - Behavioral Health Agency Quarterly Submission Report

36.1.1.1.3 Bureau of Justice Assistance quarterly report (Carelon only)

36.1.1.1.4 Children's Crisis Outreach Responses System/Intensive Stabilization Services (CCORS/ISS) Report (King only)

36.1.1.1.5 Community Behavioral Health Enhancement (CBHE) Funds Quarterly Report

36.1.1.1.6 Co-Responder Report

36.1.1.1.7 Criminal Justice Treatment Account (CJTA) Quarterly Progress Report

36.1.1.1.8 Crisis System Metrics Report

36.1.1.1.9 Crisis Triage/Stabilization and increasing Psychiatric Bed Capacity Report

36.1.1.1.10 Data Shared with External Entities Report

36.1.1.1.11 E&T Discharge Planner Report

36.1.1.1.12 Substance Use Prevention, Treatment and Recovery Services (SUPTRS) and MHBG Annual Progress Report

36.1.1.1.13 FYSPRT Gift Card Purchase and Distribution Tracker

36.1.1.1.14 Grievance, Adverse Authorization Determination, and Appeals

36.1.1.1.15 HOST Monthly Status Report (Carelon (Pierce and Southwest), King, North Sound, Spokane, Thurston/Mason (Schedule E)

36.1.1.1.16 Juvenile Cout Treatment Program Quarterly Report

36.1.1.1.17 Mental Health Block Grant (MHBG) Project Plan

36.1.1.1.18 Mobile Rapid Response Crisis (MRRC) Team Report

36.1.1.1.19 Non-Medicaid Expenditure Report

36.1.1.1.20 Non-Medicaid Spending Plan

36.1.1.1.21 Peer Bridger Participant Treatment Engagement Resources Monthly Report

36.1.1.1.22 Peer Bridger Monthly Report

36.1.1.1.23 Recovery Navigator Program Quarterly Report

36.1.1.1.24 Regional Crisis Forum Report

36.1.1.1.25 Semi-Annual Trueblood Misdemeanor Diversion Fund Report

36.1.1.1.26 Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant Capacity Management Report

36.1.1.1.27 Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant Project Plan

36.1.1.1.28 Supplemental Data Daily Submission Notification

36.1.1.1.29 Supplemental Data Monthly Certification Letter

36.1.1.1.30 Systems of Care Mobile Response and Stabilization Services (MRSS) (Carelon only) (Schedule A)

36.1.1.1.31 Trueblood Enhanced Crisis Stabilization/Crisis Triage Quarterly Report (Carelon, King, Salish, Thurston/Mason and Spokane only)

36.1.1.1.32 Trueblood Enhanced Crisis Stabilization/Triage Services Staff Details (Carelon, King, Salish, Thurston/Mason and Spokane only)

36.1.1.1.33 Trueblood Lifeline Connections Transportation

36.1.1.1.34 Youth Behavioral Health Navigator Quarterly Tracking

36.1.1.1.35 Youth Behavioral Health Navigator Quarterly Report

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

41. This Amendment will be effective as January 1, 2026 ("Effective Date").

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

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

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

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
	ORAN, ROOT Chair	3/9/26
HCA SIGNATURE	**PRINTED NAME AND TITLE**	**DATE SIGNED**
Signed by: Annette Schuffenhauer 4E259ECAE7C2450...	Annette Schuffenhauer Chief Legal Officer	3/13/2026

Exhibit A-2: Non-Medicaid Funding Allocation
Kitsap County (dba Salish Behavioral Health Administrative Services Organization)

This Exhibit addresses non-Medicaid funds in the Salish RSA for the provision of crisis services and non-crisis behavioral health services for January 1, 2026, through June 30, 2026, of state fiscal year (SFY) 2026. Amounts can be utilized during SFY ending June 30, 2026, unless otherwise noted.

MHBG and SUPTRS funds will be administered by the Contractor in accordance with the plans developed locally for each grant. Block grant funding in Table 2 is shown for the full SFY 2026.

Table 1: Salish RSA January - June SFY 2026 GF-S Funding

Fund Source	Monthly	Total 6 Months	Amended 6 Month Amount
Flexible GF-S	$593,940	$3,563,640	
Shift Flexible to GF-S funds from PACT, DCA, BHAB, & YIN	One Time Shift	$1,223,382	$1,223,382
PACT	$19,006	$114,036	
Shift PACT funds to GFS	One Time Shift	-$430,322	-$430,322
Jail Services	$8,386	$50,316	
MH Sentencing Alternatives 153	$1,344	$8,064	
ITA - Non-Medicaid funding	$13,605	$81,630	
Detention Decision Review	$2,291	$13,746	
Crisis Triage/Stabilization	$37,167	$223,002	
Long-Term Civil Commitment Court Costs	$1,499	$8,994	
Trueblood Misdemeanor Diversion	$10,940	$65,640	
DCA - Dedicated Cannabis Account	$18,880	$113,280	
Shift DCA - Dedicated Cannabis Account funds to GFS	One Time Shift	-$408,612	-$408,612
CJTA	$43,709	$262,253	
CJTA State Drug Court	$17,573	$105,438	
Secure Detox	$8,466	$50,796	
Behavioral Health Advisory Board	$3,333	$19,998	
Shift Behavioral Health Advisory Board funds to GFS	One Time Shift	-$37,861	-$37,861
New Journey First Episode Psychosis	$4,164	$24,984	
Room & Board	$1,163	$6,978	
Kitsap crisis triage services BHASO	One Time Adj.	-$124,998	-$124,998
Discharge Planners	$8,941	$53,646	
BH Service Enhancements	$19,159	$114,954	
5092(65) Added Crisis Teams/including child crisis teams	$97,350	$584,100	
Youth Stabilization Crisis Teams	$15,282	$91,692	
Recovery Navigator Program	$69,705	$418,230	
Recovery Navigator Lead Admin	$5,833	$34,998	
Youth Inpatient Navigators	$33,708	$202,248	
Shift Youth Inpatient Navigators funds to GFS	One Time Shift	-$346,587	-$346,587
Client Services in New Crisis Stabilization Facility	$9,726	$58,356	

Client Services in Facilities	$37,369	$224,208		
Crisis Endorsement Teams	One-Time 6 months payment	$932,537		
Total	**$1,082,538**	**$7,302,766**		**-$124,998**

Table 2: Salish RSA SFY 2026 Block Grant Funding (12 months) Reimbursement via A-19

Fund Source	Total FY2026	Amended 6 Month Amount
MHBG (Full Year SFY2026)	$329,354	
MHBG Co-Responder (Full year SFY2026)	$75,000	
Peer Bridger Full Year SFY2026 (FED Block Grant)	$86,857	
SUPTRS (Full Year SFY2026)	$1,132,110	
SUPTRS Co-Responder (Full Year SFY2026)	$25,000	
Total	**$1,648,321**	

Table 3: Salish RSA ARPA Grant Funding (Utilization until September 30, 2025) Reimbursement via A-19

Fund Source	Total FY2026	Amended 6 Month Amount

Table 4: Salish RSA - SFY 2026 Budgeted Program funds to be Reimbursement via A-19

Fund Source	Total FY2026	Amended 6 Month Amount
FYSPRT (Full Year SFY2026)	$75,000	
Peer Bridger (Full Year SFY2026)	$95,314	
5071 - Full FY amount available Provider cost of monitoring CR/LRA State Hospital discharged individual	$63,000	
Governor's Housing/Homeless Initiative -Rental Voucher and Bridge Program	$25,000	
Total	**$258,314**	

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

Fund Source	Total FY2026	Amended 6 Month Amount
Enhanced Crisis Stabilization/Crisis Triage	$250,000	

Table 6: Maximum Agreement Calculation		Amended 6 Month Amount
Table 1 July – June SFY2026	$13,880,128	-$124,998
Table 2,3,4,5 New Available funds during SFY2026	$3,893,183	$0
Total	**$17,773,311**	**-$124,998**

Explanations

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

- **Juvenile Drug Court:** Funding to provide alcohol and drug treatment services to juvenile offenders who are under the supervision of a juvenile drug court.
- **State Drug Court:** Funding to provide alcohol and drug treatment services to offenders who are under the supervision of a drug court.
- **Jail Services:** Funding to provide mental health services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate access to programs that offer mental health service upon mentally ill offenders' release from confinement. This includes efforts to expedite applications for new or re- instated Medicaid benefits.
- **WA - Program for Assertive Community Treatment (WA - PACT)/Additional PACT/1109:** Funds received per the budget proviso for development and initial operation of high-intensity programs for active community treatment WA- PACT teams.
- **Detention Decision Review:** Funds that support the cost of reviewing a DCR's decision whether to detain or not detain an individual under the state's involuntary commitment statutes.
- **Criminal Justice Treatment Account (CJTA):** Funds received, through a designated account in the State treasury, for expenditure on: a) SUD treatment and treatment support services for offenders with an addition of a SUD that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; b) the provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program.

- **CJTA Therapeutic Drug Court:** Funding to set up new therapeutic courts for cities or counties or for the expansion of services being provided to an already existing therapeutic court that engages in evidence-based practices, to include medication assisted treatment in jail settings pursuant to RCW 71.24.580.

- **Assisted Outpatient Treatment:** Funds received to support Assisted Outpatient Treatment (AOT). AOT is an order for Less Restrictive Alternative Treatment for up to ninety days from the date of judgment and does not include inpatient treatment.

- **Dedicated Cannabis Account (DCA):** Funding to provide a) outpatient and residential SUD treatment for youth and children; b) PPW case management, housing supports and residential treatment program; c) contracts for specialized fetal alcohol services; d) youth drug courts; and e) programs that support intervention, treatment, and recovery support services for middle school and high school aged students. All new program services must direct at least eighty-five percent of funding to evidence-based on research-based programs and practices.

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

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

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

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

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

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

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

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

- **SB 5476 Blake Recovery Nav Admin. – SUD Regional Administrator:** Funds to

support the regional administrator position responsible for assuring compliance with the recovery navigator program standards, including staffing standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **988 Enhanced Crisis funding (Proviso 112)** Amounts for preparing for Endorsement of Crisis teams and standards associated to SAMSHA and 988 bill to go into effect sometime before July 2024. Appropriations are provided solely for HCA to expand and enhance regional crisis services. These amounts must be used to expand services provided by mobile crisis teams and community-based crisis teams either endorsed or seeking endorsement pursuant to standards adopted by HCA. Beginning in fiscal year 2026, the legislature intends to direct amounts within this subsection to be used for performance payments to mobile rapid response teams and community-based crisis teams that receive endorsements pursuant to Engrossed Second Substitute House Bill No. 201134 (988 system). Funds cannot be used for building, leasehold improvements, or other capital building costs. Funds may not be used for capital expenditures except those listed below.

  Allowable costs:

  - Hiring or retaining staff to expand services as needed.
  - Purchasing vehicles and/or equipment for the vehicles.
  - Purchasing communication equipment and/or computer equipment for outreach.
  - Onboarding new providers to address gaps in coverage for outreach.

- **988 Endorsement Team Crisis Funding Amounts received are for Endorsed Team Program expenses**. The Contractor shall pass on the full endorsement and performance payment received from the MCO and HCA to the providers who met endorsement standards as outlined in chapter 182-140 WAC. HCA payments to the Contractor will include payment for Non-Medicaid Clients, ASO Admin and Fee-For-Service clients. The MCO payment to the Contractor will include the Medicaid portion for the managed care clients. HCA will provide information to the Contractor to facilitate payments to the endorsed MRRCTs and CBCTs. The comprehensive payment structure that includes the endorsement and performance rates will be published to HCA's website. HCA will reconcile performance payments and adjust funding accordingly in the next 6-month contract period.

- **MH Sentencing Alternatives 153** Funding regarding MH Disposition Alternative. Provides funding for: Follow up to ensure a local treatment provider has accepted the

individual on the MH Disposition Alternative into services and is able to provide follow up treatment and ensure adherence to the treatment plan and the requirements of the sentencing alternative, including reporting to the court.

- **Youth Inpatient Navigators –** Funds to contract for Youth Inpatient Navigator Services in 9 regions of the state. 10 Regions: Salish, Greater Columbia, and Carelon (SW, NC,) Great Rivers, Spokane, King, NS, Thurston Mason. Pierce is HCA direct contract and Thurston Mason has ARPA funds.
- **Client Services in New Crisis Stabilization Facility & Client Services in Facilities -** Funding is for non-Medicaid Client service utilization of these facilities. The New Crisis Stabilization funding is intended for ASO regional and neighboring non-Medicaid client use of new Crisis Stabilization facilities. This funding can also be used for ASO non-Medicaid client utilization of any Bed/Chair related services. Client Services in Facility funding is intended for ASO non-Medicaid client utilization of any Bed/Chair related services.

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

- **ITA 180 Day Commitment Hearings:** Funding to conduct 180-day commitment hearings.
- **Assisted Outpatient Treatment (AOT) Pilot:** Funding for pilot programs in Pierce and Yakima counties to implement AOT.
- **Spokane: Acute Care Diversion:** Funding to implement services to reduce the utilization and census at Eastern State Hospital.
- **MH Enhancement – Mt Carmel (Alliance):** Funding for the Alliance E&T in Stevens County.
- **MH Enhancement-Telecare:** Funding for Telecare E&T in King County.
- **Long-Term Civil Commitment Beds:** This funding is for court costs and transportation costs related to the provision of long-term inpatient care beds as defined in RCW 71.24.025 through community hospitals or freestanding evaluation and treatment facilities.
- **Trueblood Enhanced Crisis Stabilization/Crisis Triage Spokane, Carelon, King, Thurston Mason, and Salish -** Trueblood funding – Amounts are for enhancing services in Stabilization/Crisis Triage facility for identified Trueblood population. Includes Emergency Housing Vouchers for King County.
- **Enhanced Mobile Crisis Team funds specific to teams stood up by Trueblood.** Funds are used to continue teams stood up by Trueblood funding. Funding is to be incorporated into Mobile Crisis Team requirements, 5092 Crisis Team requirements and 988 enhanced Crisis Team requirements, where appropriate. (Spokane, King, Pierce, SW).
- **King County ASO - CCORS** -Funding to maintain children's crisis outreach response system services previously funded through DCYF.

- **King County King County BHASO medication opioid**. King county behavioral health administrative services organization to expand medication for opioid 5use disorder treatment services in King County.

- **Youth Inpatient Navigators – 8 Regions: Salish, Greater Columbia, and Carelon (SW, NC,) Great Rivers, Spokane. Pierce is a direct contract, and Thurston Mason is ARPA funds only.** Funds to contract for Youth Inpatient Navigator Services in 8 regions of the state.

- **Homeless Outreach Stabilization and Transition (HOST) programs in SW, Pierce, North Sound, Thurston Mason, and Spokane**. Funds for The Homeless Outreach Stabilization and Transition (HOST) program provides outreach-based treatment services to individuals with serious behavioral health challenges including substance use disorder (SUD). Multidisciplinary teams can provide SUD, medical, rehabilitative, and peer services in the field to individuals who lack consistent access to these vital services.

- **New Journey First Episode Psychosis**: Funds provided to support Non-Medicaid client's portion of provider team costs offering the New Journey First Episode Psychosis Program.

- **MRSS-Mobile Response and Stabilization Services - Federal Grant:** This federal grant funding is provided for the enhancement of existing Mobile Crisis Response (MCR) services already contracted through Carelon (Pierce) & Spokane BH-ASOs to help align current systems with the Mobile Response and Stabilization Services (MRSS) model.

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

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

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

- **Youth Stabilization Crisis Teams –** Funding to add 3 FTEs staff to Youth Crisis teams.

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