Washington State Health Care Authority	**CONTRACT AMENDMENT BEHAVIORAL HEALTH – ADMINSTRATIVE SERVICES ORGANIZATION**	HCA Contract No.: K8344 Amendment No.: 05

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)**
Greater Columbia Behavioral Health, LLC	
CONTRACTOR ADDRESS 101 N. Edison Street Kennewick, WA 99336	**WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)** 604-294-453

AMENDMENT START DATE	**AMENDMENT END DATE**	**CONTRACT END DATE**
July 1, 2026	June 30, 2027	June 30, 2027
PRIOR MAXIMUM CONTRACT AMOUNT $30,546,886.00	**AMOUNT OF INCREASE** $15,283,631.00	**TOTAL MAXIMUM CONTRACT AMOUNT** $45,830,517.00

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

WHEREAS, HCA and Contractor wish to amend the Contract to 1) update requirements and provide editorial changes to the BH-ASO Contract to ensure clarity of Contract expectations; 2) revise Exhibit A-4, Non-Medicaid Funding Allocation to add state fiscal year (SFY) 2027 funding; 3) update Exhibit G-1, Federal Subaward Identification, Attachment A, to add MHBG federal funding; and 4) update Exhibit G-1, Federal Subaward Identification, Attachment B, to add SUPTRS federal funding.

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

1. The Total Maximum Contract Amount for this Contract is increased by $15,283,631, from 30,546,886 to $45,830,517.

2. Section 1, Definitions, 1.36 Certified Peer Support Specialist Trainee (CPSST), is amended to read as follows:

   1.36 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 Support Specialist under chapter 18.420 RCW.

3. Section 1, Definitions, 1.46 Community Mental Health Agency (CMHA), is deleted in its entirety. All remaining subsections are subsequently renumbered and internal references updated accordingly.

4. Section 1, Definitions, 1.95 Health Disparities, is amended to read as follows:

   1.95 Health Disparities

"Health Disparities" means the preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

5. Section 1, Definitions, 1.105 Institute for Mental Disease (IMD), is renamed as 1.105 Institution for Mental Disease (IMD) and amended to read as follows:

   1.105 Institution for Mental Disease (IMD)

   "Institution for Mental Disease (IMD)" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

6. Section 1, Definitions, 1.111 Involuntary Treatment Act (ITA), is amended to read as follows:

   1.111 Involuntary Treatment Act (ITA)

   "Involuntary Treatment Act (ITA)" means state laws that allow for individuals to be committed by court order to a 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, RCW 71.05.230 and RCW 71.05.290).

7. Section 1, Definitions, 1.112 Involuntary Treatment Act (ITA) Services, is amended to read as follows:

   1.112 Involuntary Treatment Act (ITA) Services

   "Involuntary Treatment Act (ITA) Services" includes all services and Administrative Functions required for the evaluation and treatment of Individuals civilly committed under the ITA in accordance with chapters 71.05, 71.24 and 71.34 RCW.

8. Section 1, Definitions, 1.115 Less Restrictive Alternative (LRA) Treatment, is removed in its entirety. The definition of Less Restrictive Alternative (LRA) found in subsection 1.114 is the official definition. All remaining subsections are subsequently renumbered and internal references updated accordingly.

9. Section 1, Definitions, 1.114 Less Restrictive Alternative (LRA) Treatment, is amended to read as follows:

   1.114 Less Restrictive Alternative (LRA) Treatment

   "Less Restrictive Alternative (LRA) Treatment" means 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 order may be issued. The order remands the Individual to outpatient treatment by a Behavioral Health Service Provider (BHSP) in the community who is responsible for providing Treatment. The Individual must receive at least the minimum set of services described in RCW 71.05.585 and follow the conditions outlined in the order. Less restrictive treatment includes treatment pursuant to a less restrictive alternative (LRA) treatment order under RCW 71.05.240 (90-day) or RCW 71.05.320 (90-day, 180-day, 365-day); treatment pursuant to a conditional release under RCW 71.05.340 (90-day, 180-day); and treatment pursuant to an assisted outpatient treatment order under RCW 71.05.148 (up to 18-months). Additional less restrictive

alternative treatment can be sought via petition in consultation with DCR services (CR to LRA or AOT/LRA to LRA or AOT/AOT to AOT).

10. Section 1, Definitions, 1.133 Mobile Rapid Response Crisis Team (MRRCT), is amended to read as follows:

    1.133 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, 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, 1.149 Peer Bridger, is amended to read as follows:

    1.149 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. A Peer Bridger may be a Certified Peer Counselor (until December 31, 2026), Certified Peer Support Specialist or Certified Peer Support Specialist Trainee.

12. Section 1, Definitions, 1.150 Peer Support Services, is amended to read as follows:

    1.150 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 (until December 31, 2026), 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, a new subsection 1.159 Purchased and Referred Care Program, is added as follows:

    1.159 Purchased and Referred Care Program

    "Purchased and Referred Care Program" means Indian Health Services for medical/dental/behavioral health care provided away from an IHS or Tribal health care facility. The Tribe oversees referral, coordination, and payment for any Purchased and Referred Care funded service. Tribal Purchased and Referred Care dollars are always the payor of last resort, in accordance with 42 C.F.R. § 136.61.

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

14. Section 1, Definitions, 1.168 Secure Withdrawal Management and Stabilization Facility (SWMSF), is renamed as 1.168 Secure Withdrawal Management and Stabilization (SWMS) Facility, and is amended to read as follows:

    1.168 Secure Withdrawal Management and Stabilization (SWMS) Facility

"Secure Withdrawal Management and Stabilization (SWMS) Facility" means a facility operated by either a public or private agency as defined in RCW 71.05.020 that provides evaluation and treatment to individuals detained for SUD ITA. This service does not include the cost of Room and Board.

15. Section 2, General Terms and Conditions, 2.6 Compliance with Applicable Law, subsection 2.62 is amended to read as follows:

2.6.2 A provision of this Contract that is stricter than such laws or Regulations will not be deemed a conflict. Applicable laws and Regulations include, but are not limited to:

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

2.6.2.2 Title VI of the Civil Rights Act of 1964.

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

2.6.2.4 The Age Discrimination Act of 1975.

2.6.2.5 The Rehabilitation Act of 1973.

2.6.2.6 The Budget Deficit Reduction Act of 2005.

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

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

2.6.2.9 The American Recovery and Reinvestment Act (ARRA).

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

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

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

2.6.2.13 21 C.F.R. Food and Drugs, Chapter 1 Subchapter C – Drugs – General.

2.6.2.14 42 C.F.R. Subchapter A, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records.

2.6.2.15 42 C.F.R. Subchapter A, Part 8 – Certification of Opioid Treatment Programs.

2.6.2.16 45 C.F.R. Part 96 Block Grants.

2.6.2.17 45 C.F.R. § 96.126 Capacity of Treatment for Intravenous Substance Abusers who Receive Services under Block Grant funding.

2.6.2.18 Chapter 70.02 RCW Medical Records – Health Care Information Access and Disclosure.

2.6.2.19 Chapter 71.05 RCW Behavioral Health Disorders.

2.6.2.20 Chapter 71.24 RCW Community Behavioral Health Services Act.

2.6.2.21 Chapter 71.34 RCW Behavioral Health Services for Minors.

2.6.2.22 Chapter 246-341 WAC.

2.6.2.23 Chapter 43.20A RCW Department of Social and Health Services (DSHS).

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

2.6.2.25 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:

2.6.2.25.1 All applicable standards, orders, or requirements issued under Section 508 of the Clean Water Act (33 U.S.C. § 1368), Section 306 of the Clean Air Act (42 U.S.C. § 7606, Executive Order 11738, and Environmental Protection Agency (EPA) Regulations (40 C.F.R. Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to HCA, DHHS, and the EPA.

2.6.2.25.2 Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.

2.6.2.25.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

2.6.2.25.4 Those specified in Title 18 RCW for professional licensing.

2.6.2.26 Industrial Insurance – Title 51 RCW.

2.6.2.27 Reporting of abuse as required by RCW 26.44.030.

2.6.2.28 Equal Employment Opportunity (EEO) Provisions.

2.6.2.29 Copeland Anti-Kickback Act.

2.6.2.30 Davis-Bacon Act.

2.6.2.31 Byrd Anti-Lobbying Amendment.

2.6.2.32 All federal and state nondiscrimination laws and Regulations.

2.6.2.33 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.

2.6.2.34 Any other requirements associated with the receipt of federal funds.

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

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

6.1.3 The Contractor must submit a quarterly Combined Provider Submission report using the most recent template provided by HCA. This report shall include quarterly evidence that the Contractor has adequate Provider network capacity and contracted service Providers to deliver services to serve the population in the Contractor's RSA. Reports shall be submitted no later than the fifteenth of the first month for the current reporting quarter. Reports are due: January 15 (January through March); April 15 (April through June); July 15 (July through September); and October 15 (October through December). Submit reports to HCABHASO@hca.wa.gov. The first quarterly report is due October 15, 2026.

17. Section 6, Access to Care and Provider Network, 6.1 Network Capacity, a new subsection 6.1.4 is added to read as follows:

6.1.4 The network must have sufficient capacity to serve the RSA and include, at a minimum:

6.1.4.1 24/7/365 Telephone Crisis Intervention;

6.1.4.2 Designated Crisis Responder (DCR);

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

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

6.1.4.5 Staff to provide MRRCT outreach in the RSA; and

6.1.4.6 In-home stabilization, and Facility-based Crisis Stabilization Services including 23-Hour CRC.

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

18. Section 6, Access to Care and Provider Network, 6.1 Network Capacity, a new subsection 6.1.5 is added as follows:

6.1.5 If the Contractor fails to provide evidence of or HCA is unable to validate contracts with a sufficient number of Providers, HCA may terminate this Contract.

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

19. Section 6, Access to Care and Provider Network, 6.1 Network Capacity, subsection 6.1.8 is amended to read as follows:

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

6.1.8.1 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;

6.1.8.2 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;

6.1.8.3 Assist the state in expanding community-based alternatives for Crisis Stabilization, such as MRRCT outreach or Crisis residential and respite beds, in-home stabilization, Facility-based Crisis Stabilization, including 23-Hour CRC; and

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

20. Section 6, Access to Care and Provider Network, 6.4 Customer Service, subsection 6.4.4 is amended to read as follows:

6.4.4 The Contractor shall staff its customer services line and provide Individuals in Crisis with access to qualified clinicians without placing the Individual on hold. The clinician shall assess the Crisis and warm transfer the call to the regional Crisis call center to deploy a DCR or MRRCT, call 911, resolve the crisis on the phone, or refer the Individual for services or to his or her Provider.

21. Section 7, Quality Assessment and Performance Improvement, 7.4 Critical Incident Reporting is amended to read as follows:

7.4 Critical Incident Reporting

The Contractor shall communicate with the appropriate MCO and HCA when the Contractor becomes aware of an incident for a Medicaid Enrollee and to HCA when the Contractor becomes aware of an incident related to an Individual who is receiving BH-ASO funded services and not enrolled in a Medicaid managed care plan.

22. Section 7, Quality Assessment and Performance Improvement, 7.4 Critical Incident Reporting, 7.4.2 Individual Critical Incident Reporting, subsection 7.4.2.1 is amended to read as follows:

7.4.2.1 The Contractor shall submit an Individual Critical Incident report for the following incidents that occur:

7.4.2.1.1 To an Individual receiving BH-ASO funded services and occurred within a contracted Behavioral Health facility (inpatient psychiatric, Behavioral Health agencies), FQHC, or by independent Behavioral Health Provider:

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

7.4.2.1.1.2 Physical or sexual assault perpetrated by another individual; and

7.4.2.1.1.3 Death.

7.4.2.1.2 By an Individual receiving BH-ASO funded services, with a Behavioral Health diagnosis, or history of Behavioral Health treatment within the previous 365 days. Acts allegedly committed, to include:

7.4.2.1.2.1 Homicide or attempted homicide;

7.4.2.1.2.2 Arson;

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

7.4.2.1.2.4 Kidnapping; and

7.4.2.1.2.5 Sexual assault.

7.4.2.1.3 Unauthorized leave during an involuntary investigation or detention, when funded by the Contractor.

7.4.2.1.4 Any event involving an Individual that has attracted or is likely to attract media coverage, when funded by the Contractor. (The Contractor shall include the link to the source of the media, as available).

23. Section 7, Quality Assessment and Performance Improvement, 7.5 Health Information Systems is amended to read as follows:

7.5 Health Information Systems

The Contractor shall establish and maintain, and shall require Subcontractors to maintain, a health information system that complies with the requirements of the Office of the Chief Information Officer (OCIO) Security Standard SEC-02-01-S, and the Data, Security and Confidentiality Exhibit, and provides the information necessary to meet the Contractor's obligations under this Contract. OCIO Security Standards are available at: https://ocio.wa.gov.

The Contractor shall have in place mechanisms to verify the health information received from Subcontractors. The Contractor shall:

7.5.1 Collect, analyze, integrate, and report data. The system must provide information on areas including, but not limited to utilization, and fund availability by service type and fund source.

7.5.2 Ensure data received from Providers is accurate and complete by:

7.5.2.1 Verifying the accuracy and timeliness of reported data;

7.5.2.2 Screening the data for completeness, logic, and consistency; and

7.5.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.

7.5.3 Make all collected data available to HCA upon request, to the extent permitted by the HIPAA Privacy Rule (42 C.F.R. Part 2, 45 C.F.R. Part 160; 45 C.F.R. 164, Subparts A and E; and RCW 70.02.005).

7.5.4 Establish and maintain protocols to support timely and accurate data exchange with any Subcontractor that will perform any delegated functions under the Contract. Adding information to the portal shall not be a barrier to providing a necessary Crisis Service.

7.5.5 Establish and maintain web-based portals with appropriate security features that allow referrals, requests for Prior Authorizations, claims/encounters submission, and claims/encounters status updates.

7.5.6 Have information systems that enable paperless submission, automated processing, and status updates for Prior Authorization and other utilization management related requests.

7.5.7 Maintain Behavioral Health content on a website that meets the following minimum requirements.

7.5.7.1 Public and secure access via multi-level portals for providing web-based training, standard reporting, and data access for the effective management and evaluation of the performance of the Contract and the service delivery system as described under this Contract.

7.5.7.2 The Contractor shall organize the website to allow for easy access of information by Individuals, family members, network Providers, stakeholders, and the public in compliance with the ADA. The Contractor shall include on its website, at a minimum, the following information, or links:

7.5.7.2.1 Hours of operations;

7.5.7.2.2 How to access information on Contracted Services and toll-free Crisis telephone numbers;

7.5.7.2.3 Telecommunications device for the deaf/text telephone numbers;

7.5.7.2.4 Information on the right to choose a qualified Behavioral Health service Provider, including IHCPs, when available and Medically Necessary; and

7.5.7.2.5 An overview of the range of Behavioral Health services being provided.

24. Section 7, Quality Assessment and Performance Improvement, 7.9 Data Quality Standards and Error Correction for Behavioral Health Supplemental Data, subsection 7.9.4 is amended to read as follows:

7.9.4 HCA shall perform supplemental transaction data quality reviews to ensure receipt of complete and accurate supplemental data for program administration and for matching supplemental transactions in the BHDS to encounters within the ProviderOne system.

7.9.4.1 Data quality shall be measured for each individual transaction as outlined in the BHDG. Error ratios that exceed 10 percent for each separate transaction may result in corrective actions up to and including sanctions.

7.9.4.1.1 HCA reserves the right to reevaluate the error ratio percentage and adjust the percentage when warranted. HCA will provide written notice to the Contractor with a minimum of ninety (90) calendar days prior to any changes.

7.9.4.2 Errors corrected as a result of error report review by the Contractor or as a result of an HCA data quality review must be submitted within sixty (60) calendar days from notification by HCA.

7.9.4.3 The Contractor shall, upon receipt of a data quality notice from HCA, inform subcontractors about any changes needed to ensure correct reporting of services.

7.9.4.4 If the Contractor requires more than sixty (60) calendar days to make corrections and resubmit identified supplemental transactions, then written notice must be submitted by the Contractor to HCA including reason for delay and date of completion. The Contractor shall notify HCA at mmishelp@hca.wa.gov or the specific email listed in the notification sent by HCA, and HCA will provide a final decision to the request in writing.

25. Section 9, Subcontracts, 9.11 Coordination of Benefits (COB) and Subrogation of Rights of Third-Party Liability, 9.11.1 Coordination of Benefits is amended to read as follows:

9.11.1 Coordination of Benefits:

9.11.1.1 The services and benefits available under this Contract shall be secondary to any other coverage, with the exception of coverage funded by the Indian Health Services, including

Purchased and Referred Care dollars, which are the payer of last resort under 42 C.F.R. § 136.61.

9.11.1.2 Nothing in this Section negates any of the Contractor's responsibilities under this Contract. The Contractor shall:

9.11.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable COB rules in chapter 284-51 WAC.

9.11.1.2.2 Attempt to recover any third-party resources available to Individuals and make all records pertaining to COB collections for Individuals available for audit and review.

9.11.1.2.3 Pay claims for Contracted Services when probable third-party liability has not been established or the third-party benefits are not available to pay a claim at the time it is filed.

9.11.1.2.4 Coordinate with out-of-network Providers with respect to payment to ensure the cost to Individuals is no greater than it would be if the services were furnished within the network.

9.11.1.2.5 Communicate the requirements of this Section to Subcontractors that provide services under the terms of this Contract and assure compliance with them.

9.11.1.2.6 Ensure subcontracts require the pursuit and reporting of all third-party revenue related to services provided under this agreement, including pursuit of FFS Medicaid funds provided for AI/AN Individuals who did not opt into managed care.

9.11.1.2.7 Coordinate with Tribes or IHCPs when appropriate to ensure proper consideration of third-party liability, including plans funded by Purchased and Referred Care Program dollars.

26. Section 9, Subcontracts, 9.12 Sliding Fee Schedule, subsection 9.12.2 is amended to read as follows:

9.12.2 In developing sliding fee schedules, Providers must comply with the following:

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

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

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

9.12.2.4 Protect Individual's privacy in assessing fees;

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

9.12.2.6 Charge Individuals at or below 100 percent of the FPL a nominal fee or no fee at all; and

9.12.2.7 Develop at least three incremental amounts on the sliding fee scale for Individuals between 101 to 220 percent of the FPL.

9.12.2.8 Ensure coordination with Tribes, when appropriate, prior to development of a payment plan, for AI/AN Individuals who may be eligible for Tribal Purchased and Referred Care Program dollars, and ensure amounts charged do not exceed the amount they would be charged in subsections 9.12.2.6 or 9.12.2.7 of this Contract.

27. Section 11, Individual Rights and Protections, 11.3 Mental Health Advance Directive (MHAD), a new subsection 11.3.5 is added to read as follows:

11.3.5 The Contractor shall ensure coordination with Tribally developed MHAD's, as applicable.

28. Section 12, Utilization Management (UM) Program and Authorization of Services, 12.4 Time frames for Authorization Decisions, subsection 12.4.2 is amended to read as follows:

12.4.2 The Contractor shall provide for the following timeframes for authorization decisions and notices:

12.4.2.1 For denial of payment that may result in payment liability for the Individual, at the time of any Action or Adverse Authorization Determination affecting the claim;

12.4.2.2 For termination, suspension, or reduction of previously authorized Contracted Services, ten (10) calendar days prior to such termination, suspension, or reduction, unless the criteria stated in 42 C.F.R. §§ 431.213 and 431.214 are met; and

12.4.2.3 Standard authorizations for planned or elective service determinations: The authorization decisions are to be made, and notices of Adverse Authorization Determinations are to be provided as expeditiously as the Individual's condition requires. The Contractor must make a decision to approve, deny, or request additional information from the Provider within five (5) calendar days of the original receipt of the request. If additional information is required and requested, the Contractor must give the Provider five (5) calendar days to submit the information and then approve or deny the request within four (4) calendar days of the receipt of the additional information.

12.4.2.3.1 An extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances:

12.4.2.3.1.1 The Individual or the Provider requests the extension; or

12.4.2.3.1.2 The Contractor justifies and documents a need for additional information and how the extension is in the Individual's interest.

12.4.2.3.2 If the Contractor extends the timeframe past fourteen (14) calendar days of the receipt of the request for service:

12.4.2.3.2.1 The Contractor shall provide the Individual written notice within three (3) Business Days of the Contractor's decision to extend the timeframe. The notice shall include the reason for the decision to extend the timeframe and inform the Individual of the right to file a Grievance if he or she disagrees with that decision; and

12.4.2.3.2.2 The Contractor shall issue and carry out its determination as expeditiously as the Individual's condition requires, and no later than the date the extension expires.

12.4.2.4 Expedited Authorization Decisions: For timeframes for authorization decisions not described in inpatient authorizations or standard authorizations, or cases in which a Provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the Individual's life or health, or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Individual's condition requires.

12.4.2.4.1 The Contractor will make the decision within two (2) calendar days if the information provided is sufficient; or request additional information within one (1) calendar day if the information provided is not sufficient to approve or deny the request. The Contractor must give the Provider two (2) calendar days to submit the requested information and then approve or deny the request within two (2) calendar days.

12.4.2.4.2 The Contractor may extend the expedited time period by up to ten (10) calendar days under the following circumstances:

12.4.2.4.2.1 The Individual requests the extension; or

12.4.2.4.2.2 The Contractor justifies and documents a need for additional information and how the extension is in the Individual's interest.

12.4.2.5 Concurrent Review Authorizations: The Contractor must make its determination within one (1) Business Day of receipt of the request for authorization.

12.4.2.5.1 Requests to extend concurrent care review authorization determinations may be extended to within three (3) Business Days of the request of the authorization if the Contractor has made at least one attempt to obtain needed clinical information within the initial one (1) Business Day after the request for authorization of additional days or services.

12.4.2.5.2 Notification of the Concurrent Review determination shall be made within one (1) Business Day of the Contractor's decision.

12.4.2.6 For post-service authorizations, the Contractor shall make its determination within thirty (30) calendar days of receipt of the authorization request.

12.4.2.6.1 The Contractor shall notify the Individual, the requesting Provider, and the facility in writing within three (3) Business Days of the Contractor's determination.

12.4.2.6.2 When post-service authorizations are approved, they become effective the date the service was first administered.

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

14.1 General Requirements

The Contractor shall have a Grievance and Appeal System that includes a Grievance Process, an Appeal Process, and access to the Administrative Hearing process for Contracted Services in accordance with WAC 182-538C-110.

NOTE: Provider claim disputes initiated by the Provider are not subject to this Section.

14.1.1 The Contractor shall have policies and procedures addressing the Grievance and Appeal System, which comply with the requirements of this Contract. HCA must approve, in writing, all Grievance and Appeal System policies and procedures and related notices to Individuals regarding the Grievance and Appeal System.

14.1.2 The Contractor shall give Individuals any reasonable assistance necessary in completing forms and other procedural steps for Grievances and Appeals. The Contractor shall provide information about the availability of Behavioral Health advocate services to assist the Individual.

14.1.3 The Contractor shall cooperate with any representative authorized in writing by the Individual.

14.1.4 The Contractor shall consider all information submitted by the Individual or his/her authorized representative.

14.1.5 The Contractor shall ensure that decision makers on Grievances and Appeals were not involved in previous levels of review or decision-making.

14.1.6 Decisions regarding Grievances and Appeals shall be made by Health Care Professionals with clinical expertise in treating the Individual's condition or disease if any of the following apply:

14.1.6.1 The Individual is appealing an Action.

14.1.6.2 The Grievance or Appeal involves any clinical issues.

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.

30. Section 14, Grievance and Appeal System, 14.2 Grievance Process is amended to read as follows:

14.2 Grievance Process

The following requirements are specific to the Grievance Process:

14.2.1 Only an Individual or the Individual's authorized representative may file a Grievance with the Contractor. A Provider may not file a Grievance on behalf of an Individual unless the Provider is acting on behalf of the Individual and with the Individual's written consent.

14.2.1.1 The Contractor shall request the Individual's written consent should a Provider file a Grievance on behalf of an Individual without the Individual's written consent.

14.2.2 The Contractor shall accept, document, record, and process Grievances forwarded by HCA.

14.2.3 The Contractor shall provide a written response to HCA within three (3) Business Days to any constituent Grievance. For the purposes of this subsection, "constituent Grievance" means a complaint or request for information from any elected official or agency director or designee.

14.2.4 The Contractor shall acknowledge receipt of each Grievance, either orally or in writing within two (2) Business Days.

14.2.5 The Contractor shall investigate and resolve all Grievances whether received orally or in writing. The Contractor shall not require an Individual or his/her authorized representative to provide written follow-up for a Grievance the Contractor received orally.

14.2.6 The Contractor shall complete the disposition of a Grievance and notice to the affected parties as expeditiously as the Individual's health condition requires, but no later than forty-five (45) calendar days from receipt of the Grievance.

14.2.7 The notification may be made orally or in writing for Grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

14.2.8 Individuals do not have the right to an Administrative Hearing regarding the disposition of a Grievance.

31. Section 14, Grievance and Appeal System, 14.3 Appeal Process is amended to read as follows:

14.3 Appeal Process

The following requirements are specific to the Appeal Process:

14.3.1 For Appeals of standard service authorization decisions, an Individual, or a Provider acting on behalf of the Individual, must file an Appeal, either orally or in writing, within sixty (60) calendar days of the date on the Contractor's Notice of Action. This also applies to an Individual's request for an expedited Appeal.

14.3.2 An Individual, the Individual's authorized representative, or a Provider acting on behalf of the Individual and with the Individual's written consent, may Appeal a Contractor Action.

14.3.2.1 If a Provider has requested an Appeal on behalf of an Individual, but without the Individual's written consent, the Contractor shall not dismiss the Appeal without first attempting to contact the Individual within five (5) calendar days of the Provider's request, informing the Individual that an Appeal has been made on the Individual's behalf, and then asking if the Individual would like to continue the Appeal.

14.3.2.2 If the Individual wants to continue the Appeal, the Contractor shall obtain from the Individual a written consent for the Appeal. If the Individual does not wish to continue the Appeal, the Contractor shall formally dismiss the Appeal, in writing, with appropriate Appeal rights and by delivering a copy of the dismissal to the Provider as well as the Individual.

14.3.2.3 For expedited Appeals, the Contractor may bypass the requirement for the Individual's written consent and obtain the Individual's oral consent. The Individual's oral consent shall be documented in the Contractor's records.

14.3.3 If HCA receives a request to Appeal an Action of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the Individual with information that a Provider filed an Appeal.

14.3.4 The Contractor shall acknowledge in writing, the receipt of each Appeal. The Contractor shall provide the written notice to both the Individual and requesting Provider within three (3) calendar days of receipt of the Appeal.

14.3.5 The Appeal Process shall provide the Individual a reasonable opportunity to present evidence, and allegations of fact or law in writing. The Contractor shall inform the Individual of the limited time available for this in the case of expedited resolution.

14.3.6 The Appeal Process shall provide the Individual and the Individual's representative opportunity, before and during the Appeals process, to examine the Individual's case file, including medical records, and any other documents and records considered during the Appeal Process.

14.3.7 The Appeal Process shall include as parties to the Appeal, the Individual and the Individual's authorized representative, or the legal representative of the deceased Individual's estate.

14.3.8 In any Appeal of an Action by a Subcontractor, the Contractor or its Subcontractor shall apply the Contractor's own standards, protocols, or other criteria that pertain to authorizing specific services.

14.3.9 The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Individual's health condition requires, within the following timeframes:

14.3.9.1 For standard resolution of Appeals and for Appeals for termination, suspension or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the Appeal, unless the Contractor notifies the Individual that an extension is necessary to complete the Appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for Appeal;

14.3.9.2 For any extension not requested by an Individual, the Contractor must give the Individual written notice of the reason for the delay; or

14.3.9.3 For expedited resolution of Appeals or Appeals of Behavioral Health drug authorization decisions, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the Appeal.

14.3.9.4 Standard Appeal timeframes apply to post-service denials.

14.3.10 The Contractor shall provide notice of resolution of the Appeal in a language and format which is easily understood by the Individual. The notice of the resolution of the Appeal shall:

14.3.10.1 Be in writing and sent to the Individual and the requesting Provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice;

14.3.10.2 Include the date completed and reasons for the determination; and

14.3.10.3 Include a written statement of the reasons for the decision, including how the requesting Provider or Individual may obtain the review or decision-making criteria.

14.3.11 For Appeals not resolved wholly in favor of the Individual:

14.3.11.1 Include information on the Individual's right to request an Administrative Hearing and how to do so.

32. Section 14, Grievance and Appeal System, 14.4 Expedited Appeals Process, subsection 14.4.3 is amended to read as follows:

14.4.3 The Contractor shall make a decision on the Individual's request for an expedited Appeal or Appeals of a concurrent review determination and provide written notice, as expeditiously as the Individual's health condition requires, no later than three (3) calendar days after the Contractor receives the Appeal. The Contractor shall also make reasonable efforts to provide oral notice.

33. Section 15, Care Management and Coordination, 15.4 Care Coordination and Continuity of Care: State Hospitals and Long Term Civil Commitment (LTCC) Facilities, is renamed as 15.4 Care Coordination and Continuity of Care: Adult Involuntary Treatment, and is amended to read as follows:

15.4 Care Coordination and Continuity of Care: Adult Involuntary Treatment

15.4.1 Admission and Discharge Planning for involuntary treatment.

15.4.1.1 The Contractor shall ensure Individuals are medically cleared, prior to admission to involuntary treatment and coordinate for provision of medical treatment as necessary when informed of the admission in advance.

15.4.1.2 The Contractor shall use best efforts to divert admissions and expedite discharges by using alternative community resources and Behavioral Health services, within Available Resources.

15.4.1.2.1 If the Contractor is aware an Individual identifies as AI/AN, the Contractor shall use best efforts to include the Tribe and/or IHCP in diverting admission or expediting discharges using Care Coordination.

15.4.1.3 The Contractor shall monitor, and track Individuals discharged from inpatient hospitalizations on LRA treatment under RCW 71.05.320 to ensure compliance with LRA requirements. The Contractor will document LRA tracking. The Contractor's tracking documentation will include a log with the following:

15.4.1.3.1 Name of Individuals on an LRA;

15.4.1.3.2 Date of LRA order;

15.4.1.3.3 Identification of enrollment (indicate all):

15.4.1.3.3.1 If for an MCO enrollee, name of the responsible MCO; and

15.4.1.3.3.2 If an Individual identifies as AI/AN, name of the responsible Tribe and/or IHCP;

15.4.1.3.4 Date the Contractor made notification to MCO/Tribe and/or IHCP of an Individual on an LRA;

15.4.1.3.5 Name of the staff notified at MCO, Tribe and/or IHCP;

15.4.1.3.6 If the Contractor did not notify the responsible MCO, Tribe and/or IHCP this information will be recorded on the Contractor's tracking log; and

15.4.1.3.7 The Contractor will state on the tracking log if the BHSP, providing LRA Treatment, is included within the LRA order.

15.4.1.4 The Contractor shall offer Behavioral Health services to Individuals who are ineligible for Medicaid to ensure compliance with LRA treatment requirements.

15.4.1.5 The Contractor shall respond to requests for participation, implementation, and tracking of Individuals receiving services on Conditional Release consistent with requirements for LRA Treatment services as described in RCW 71.05.340. LRA Treatment must be provided regardless of Available Resources.

15.4.1.5.1 If the Individual is enrolled in Managed Care plan, the MCO will cover the services.

15.4.1.5.2 If the Individual is Medicaid FFS, Medicaid will cover the services.

15.4.1.5.3 If the Individual is covered by commercial insurance, the insurance carrier will purchase the care.

15.4.1.5.4 If the Individual is non-insured, the Contractor will be responsible for purchasing the LRA Treatment services.

15.4.1.6 Individuals residing in the Contractor's RSA prior to admission, and discharging to another RSA, will do so according to the agreement established between the receiving RSA and the Contractor. The agreements shall include:

15.4.1.6.1 Specific roles and responsibilities of the parties related to transitions between the community and involuntary inpatient facility;

15.4.1.6.2 Collaborative discharge planning and coordination with cross-system partners such as residential facilities, community mental health or SUD Providers; and

15.4.1.6.3 Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's service area.

15.4.1.7 When Individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the Contractor shall:

15.4.1.7.1 Coordinate with DSHS and any residential Provider to develop a crisis plan to support the placement;

15.4.1.7.2 Coordinate with DSHS and any residential Provider in the development of a treatment plan that supports the viability of the DSHS placement when the Individual meets access to care criteria; and

15.4.1.7.3 Coordinate with Tribal governments and/or IHCPs for AI/AN Individuals, with client consent, when the Contractor has knowledge that the Individual is AI/AN and receives health care services from a Tribe and/or IHCP in Washington State.

15.4.1.8 The Contractor shall provide the following services for AI/AN Individuals in the FFS Medicaid Program who have opted out of Medicaid managed care, in coordination with the Individual's IHCP, if applicable:

15.4.1.8.1 Crisis Services and related coordination of care;

15.4.1.8.2 Involuntary commitment evaluation services;

15.4.1.8.3 Services related to inpatient discharge and transitions of care; and

15.4.1.8.4 Assistance in identifying services and resources for Individuals with voluntary admission.

15.4.2 Coordination and Discharge Planning for State Hospitals and State Facilities.

15.4.2.1 The Contractor shall meet the requirements of the state hospital and state facility MOU.

15.4.2.2 Utilization of state hospital beds.

15.4.2.2.1 The Contractor will be assigned Individuals for discharge planning purposes in accordance with agency assignment process within each RSA in which the Contractor operates;

15.4.2.2.2 The Contractor will be responsible for coordinating discharge for the Individuals assigned and, until discharged; and

15.4.2.2.3 The Contractor may not enter into any agreement or make other arrangements for use of state hospital beds outside of this Contract.

15.4.2.3 The Contractor shall work as a member of the State Hospital Discharge and State Facility Transition Team to identify potential discharge options and resolve barriers to discharge for Individuals assigned to the Contractor. The Contractor shall:

15.4.2.3.1 Begin linking Individuals to appropriate community providers as soon after admission as possible to support timely discharge;

15.4.2.3.2 Notify and collaborate with Tribes and/or IHCPs if the Contractor has reason to know that an Individual is AI/AN and accessing health services at an IHCP.

15.4.2.3.3 Participate in discharge planning which supports timely discharge in accordance with the Individual's preferences, including the Individual's choice to live in their own home or in the most integrated community setting appropriate for their needs;

15.4.2.3.4 Participate in the development of discharge plans using a person-centered process that includes documentation reflecting the Individual's treatment goals, clinical needs, linkages to timely appropriate behavioral and primary health care, and the individual's informed choice, including geographic preferences and housing preferences, prior to discharge.

15.4.2.3.5 Ensure that appropriate and timely referrals are made to community-based services and supports, including supportive housing, PACT, and vocational supports. Services provided are within Available Resources;

15.4.2.3.6 Make referrals and transfers of case information to other discharge planning individuals and service providers within seven (7) Business Days of the event that made the referral or transfer appropriate;

15.4.2.3.7 Ensure that prescriber and other Provider appointments are scheduled to occur within seven (7) calendar days of Individual's discharge and communicated back to the facility, including for patients discharging from the state forensic units. Services provided are within Available Resources;

15.4.2.3.8 Work with state hospital social workers to ensure that discharge related activities or meetings (i.e., pre-placement visits to potential facilities or housing, interviews with post discharge service providers and Individuals, and engagement with Behavioral Health programs and providers) are scheduled within seven (7) calendar days of the determination by the discharge planning team that the visit or meeting is necessary or useful; and

15.4.2.3.9 Request a discharge barriers consult in all cases where there are barriers to timely discharge of an Individual to the most integrated community setting appropriate.

15.4.2.4 For the purposes of this Section, 'integrated community setting' means a setting that typically includes the following characteristics:

15.4.2.4.1 It supports the Individual's access to the greater community, including opportunities to work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community. The degree of access supported shall be similar to the access enjoyed by individuals not receiving support services;

15.4.2.4.2 It is in the Individual's own home or is another setting that is selected by the Individual;

15.4.2.4.3 It ensures an Individual's rights to privacy, dignity, respect, and freedom from coercion and restraint;

15.4.2.4.4 It optimizes an Individual's initiative, autonomy, and independence in making life choices, including in daily activities, physical environment, and personal associations; and

15.4.2.4.5 It facilitates Individual choice regarding services and supports and who provides them.

15.4.2.5 The Contractor shall ensure provision of Behavioral Health agencies as part of Transition Teams, Laws of 2021, Chapter 263 (Engrossed Second Substitute Senate Bill 5071) when requested by DSHS pertaining to Individuals that meet criteria for civil commitment in accordance with RCW 71.05.280(3)(b) and Individuals that meet criteria for Not Guilty by Reason of Insanity (NGRI) under RCW 10.77.400 and .550. These Transition Teams are a collaboration between DSHS, DOC, and BHAs to provide for closer monitoring and multidisciplinary for Individuals with underlying violent crimes that are at special level of risk.

15.4.2.5.1 Authority for treatment of services for Individuals released from a state hospital on Civil LRA in accordance with RCW 71.05.280(3)(b) pursuant to RCW 10.77.645(4) and (7), related to competency restoration and Forensic NGRI conditional release according to RCW 10.77.550(3)(c) and (4)(a). The Contractor may submit an A19, not to exceed $9,000 without prior written approval from HCA, for transition teams services and treatment services provided to non-Medicaid individuals released from a state hospital in accordance with RCW 71.05.320 or who are found not guilty by reason of insanity (NGRI).

15.4.2.6 Authority for treatment of services for Individuals released from a state hospital in accordance with RCW 10.77.645(4), competency restoration and RCW 10.77.550(3)(c) NGRI conditional release orders. The Contractor may submit an A19 to HCABHASO@hca.wa.gov, not to exceed $9,000 without prior written approval from HCA, for transition teams services and treatment services provided to non-Medicaid individuals released from a state hospital in accordance with RCW 71.05.320 or who are found not guilty by reason of insanity (NGRI).

15.4.3 Coordination and Discharge Planning with LTCC Facilities

15.4.3.1 The Contractor shall coordinate with the LTCC facilities to receive admission and discharge notifications, and changes in Individual Medicaid eligibility and MCO enrollment.

15.4.3.2 The Contractor shall participate in team meetings or case reviews according to LTCC facility policy and procedures in order to engage Individuals early and ongoing in discharge planning support. The Contractor shall coordinate with LTCC facilities to receive the information on how the Contractor should participate in team meetings or case reviews.

15.4.3.3 If the Individual is AI/AN and accessing services at a Tribe or an IHCP, the Contractor shall coordinate services with their IHCP and consult with the Tribal member and Tribal assisters for Medicaid eligibility and Managed Care enrollment.

15.4.3.4 When the Contractor's discharge team knows or has reason to know that an Individual discharging is AI/AN and receives medical or Behavioral Health services from a Tribe

within a state, the discharge staff/team shall ensure they provide notification of the Individuals' discharge, subject to federal laws and regulations, to the Tribal DCR crisis responder office or the Tribal contact. Coordinate with IHCPs when appropriate to ensure proper consideration of payment of third-party liability, including plans funded by the Indian Health Services, including Purchased and Referred Care.

15.4.3.5 A Facility providing SUD services must attempt to obtain a release of information before discharge to meet the notification requirements under chapters 71.05 and 71.34 RCW.

15.4.3.6 The Contractor shall participate in a Quarterly Learning Collaborative meeting with other BH-ASOs, MCOs and LTCC facility staff across the state to discuss barriers and/or challenges with admissions or discharge planning processes, to share Care Coordination best practices and participate in educational opportunities. Quarterly Learning Collaboration activities include the following:

15.4.3.6.1 The Contractor shall work with other BH-ASOs and MCOs to identify representative(s) to co-lead with representative LTCC staff, to organize and conduct these meetings;

15.4.3.6.2 The Contractor shall work with other BH-ASOs, MCOs and LTCC facility staff to assess LTCC utilization data to support quality improvement and reduce recidivism;

15.4.3.6.3 The Contractor shall work with other BH-ASOs, MCOs and LTCC facility staff to develop initial LTCC Discharge Coordination Guidelines that will delineate discharge planning responsibilities for LTCC facilities, BH-ASOs, and MCOs by October 31, 2023, and annually review and revise as required; and

15.4.3.6.4 The Contractor shall coordinate with the LTCC facilities and assist with the elements of the discharge planning process as agreed upon in the Learning Collaborative and outlined in LTCC Discharge Coordination Guidelines.

15.4.3.7 The Contractor shall track those Individuals in each Facility who were ready to discharge and were not discharged within fourteen (14) calendar days, will track for patient recidivism, and will analyze for trends, gaps in services and potential solutions. The Contractor will work with other BH-ASOs, MCOs and LTCC facility staff through the Quarterly Learning Collaborative to review the status of the program including but not limited to quality, access, timeliness of discharges, recidivism, and Care Coordination, and will identify concerns and plans to address concerns. The Contractor along with other BH-ASOs and MCOs will ensure that minutes from the Quarterly Learning Collaborative meetings are submitted to HCA at hcamcprograms@hca.wa.gov by the last calendar day of the month following each quarter.

15.4.3.8 The Contractor shall provide Care Coordination support for Individuals who have discharged from LTCC facilities, for a minimum of one hundred eighty (180) calendar days post discharge unless Individual declines or opts out. The Contractor shall track those Individuals who receive Care Coordination services, length of time receiving Care Coordination services, and those who opted out or declined, and shall provide this information upon request by HCA.

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.

34. Section 15, Care Management and Coordination, 15.5 Care Coordination: Filing of an Unavailable Detention Facilities Report, subsection 15.5.1 is amended to read as follows:

15.5.1 The Contractor shall ensure its DCRs report to HCA when it is determined an Individual meets detention criteria under RCW 71.05.150 and .153, RCW 71.34.700 or RCW 71.34.710 and there are no beds available at the Evaluation and Treatment Facility, SWMS, psychiatric unit, or under a single bed certification, and the DCR was not able to arrange for a less restrictive alternative for the Individual.

35. Section 15, Care Management and Coordination, 15.5 Care Coordination: Filing of an Unavailable Detention Facilities Report, subsection 15.5.4 is amended to read as follows:

15.5.4 Upon notification by HCA that a No Bed Report has been filed on an Individual, the Contractor must attempt to engage the Individual in appropriate services for which the Individual is eligible and report back within seven (7) calendar days to HCA. The report must include a description of all attempts to engage the Individual, any plans made with the Individual to receive treatment, and all plans to contact the Individual on future dates about the treatment plan from this encounter. If the Contractor identifies an individual accesses services at an IHCP, the Contractor and Subcontractor shall follow the Tribal Crisis Coordination Protocols. The Contractor may contact the Individual’s insurance Provider or treatment Providers including IHCP, as applicable, to ensure services are provided.

36. Section 15, Care Management and Coordination, 15.5 Care Coordination: Filing of an Unavailable Detention Facilities Report, subsection 15.5.5 is amended to read as follows:

    15.5.5 The Contractor shall implement a plan to provide appropriate treatment services to the Individual, which may include the development of LRAs or relapse prevention programs reasonably calculated to reduce demand for involuntary detentions to E&T Facilities, and SWMS.

37. Section 15, Care Management and Coordination, 15.6 Care Coordination and Continuity of Care: Evaluation and Treatment (E&T) Facilities, subsection 15.6.4 is amended to read as follows:

    15.6.4 When the Contractor's discharge team knows or has reason to know that an Individual discharging is AI/AN and receives medical or Behavioral Health services from a Tribe within a state, the discharge staff/team shall ensure they provide notification of the Individual's discharge, subject to federal laws and regulations, to the Tribal DCR crisis responder office or the Tribal contact listed in the Tribal Crisis Coordination Protocols, 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 Office of Tribal Affairs guidance template "Navigating a Crisis without a Tribal Crisis Coordination Protocol" at: https://www.hca.wa.gov/assets/program/navigating-a-crisis-without-a-tribal-crisis-protocol-202509_0.pdf. Coordinate with IHCPs when appropriate to ensure proper consideration of payment of third-party liability, including plans funded by the Indian Health Services, including Purchased and Referred Care.

        15.6.4.1 A Facility providing SUD services must attempt to obtain a release of information before discharge to meet the notification requirements under chapters 71.05 and 71.34 RCW.

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

    16.1 Special Provisions Regarding Behavioral Health Crisis Services

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

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

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

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

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

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

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

16.1.5.2 A Children's Specialist.

16.1.5.3 An Addictions Specialist.

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

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

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

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

16.1.9.1 Crisis Stabilization staff shall have training in Crisis triage and management for Individuals of all ages and Behavioral Health conditions, including SMI, SED, SUDs, and co-occurring disorders.

39. Section 17, Scope of Services – Crisis System, 17.1 Crisis System General Requirements, subsection 17.1.1 is amended to read as follows:

17.1.1 The Contractor must provide 24-hour a day, seven (7) days a week crisis behavioral health services to Individuals who are within the Contractor's RSAs and report they are experiencing a crisis.

17.1.1.1 Crisis response shall occur within one hour of a referral for Behavioral Health Emergency, within two hours of a referral for an Emergent Care crisis and within 24 hours of a referral for an Urgent Behavioral Health Situation crisis.

17.1.1.2 Youth MRRCT team crisis response shall occur within one hour of a referral for Behavioral Health Emergency, and for all other referrals shall occur within two hours or may be scheduled within 24 hours at the convenience of the family.

17.1.1.3 Maintain crisis network adequacy as defined in Section 6.1 of this Contract.

17.1.1.4 Youth MRRCT shall follow System of Care (SOC) principles; family and Youth driven, care is delivered to them in their preferred environments, and culturally and linguistically responsive.

40. Section 17, Scope of Services – Crisis System, 17.2 Community Information and Education, subsection 17.2.1 is amended to read as follows:

17.2.1 The Contractor shall develop and implement a Community Information and Education Plan (CIEP) that educates and informs Tribes and community stakeholders about the Crisis system. Community

stakeholders shall include residents of the RSA, health care Providers, First Responders, Public Safety Answering Points, the criminal justice system, educational systems, Youth facing system partners, emergency departments, and faith-based organizations.

17.2.1.1 An updated CIEP shall be provided to HCA by January 31 of each year.

17.2.1.2 The CIEP and any plan updates shall be submitted to HCA at HCABHASO@hca.wa.gov.

41. Section 17, Scope of Services – Crisis System, 17.3 Crisis System Staffing Requirements, is amended to read as follows:

17.3.1 The Contractor shall ensure Provider compliance with applicable staffing requirements of chapter 246-341 WAC.

17.3.2 The Contractor shall ensure Providers have clinicians available for consultation 24 hours a day, seven (7) days a week who have expertise in Behavioral Health conditions pertaining to children and families.

17.3.3 All Crisis call center staff operating regional crisis lines must complete HCA's MRSS 101 training.

17.3.4 The Contractor shall ensure Providers have at least one SUDP and one CPC (until December 31, 2026) or CPSS with experience providing Behavioral Health Crisis support available for consultation by phone or on-site during regular Business Hours.

42. Section 17, Scope of Services – Crisis System, 17.4 Crisis System Operational Requirement, subsection 17.4.1 is amended to read as follows:

17.4.1 The Contractor will establish comprehensive Regional Crisis Protocols for dispatching MRRCT and Community Based Crisis Teams. The Regional Crisis Protocols must memorialize expectations, understandings, lines of communication, and strategies for optimizing Crisis response within Available Resources. The Regional Crisis Protocols must describe how partners, Tribal governments, and stakeholders will share information, including real-time information sharing between 988 contact hubs, regional Crisis lines and Public Safety Answering Points. Submit the Regional Protocols to HCABHASO@hca.wa.gov.

17.4.1.1 The Regional Crisis Protocols should be updated as needed. The Contractor must notify HCA if changes are made to the Regional Crisis Protocol within thirty (30) calendar days of the change.

17.4.1.2 The Regional Crisis Protocols must be reviewed, updated and resubmitted to HCA at a minimum every three (3) years or when updated.

43. Section 17, Scope of Services – Crisis System, 17.4 Crisis System Operational Requirement, subsection 17.4.3 is amended to read as follows:

17.4.3 The Contractor shall coordinate with the 988 Suicide and Crisis Line, Native & Strong Provider in their region to ensure these appointments are accessible to uninsured individual callers who meet the criteria outlined in the next day appointment assessment tool.

44. Section 17, Scope of Services – Crisis System, 17.4 Crisis System Operational Requirement, subsection 17.4.4 is amended to read as follows:

17.4.4 The Contractor, in partnership with HCA, shall convene an annual crisis continuum of care forum with participation from partners serving RSAs, including MCOs, Behavioral Health Providers, mobile rapid

response crisis teams, 988 call center hubs, Public Safety Answering Points, counties, Tribes, IHCPs, and other regional partners to identify and develop collaborative regional-based solutions. The Contractor shall submit the Regional Crisis Forum report to HCA including recommendations that may include capital infrastructure requests, local capacity building, or community investments including joint funding opportunities, innovative and scalable pilot initiatives, or other funder and stakeholder partnerships. The Regional Crisis Forum report is due annually on August 15. Submit the Regional Crisis Forum report to HCABHASO@hca.wa.gov.

45. Section 17, Scope of Services – Crisis System, 17.4 Crisis System Operational Requirement, subsection 17.4.7 is amended to read as follows:

17.4.7 The Contractor shall establish registration processes for non-Medicaid Individuals utilizing Crisis Services to maintain demographic and clinical information and establish a medical record/tracking system to manage their Crisis care, and utilization.

46. Section 18, Designated Crisis Responder (DCR) and Involuntary Treatment Act (ITA), 18.1 DCR and ITA Services is amended to read as follows:

18.1 DCR and ITA Services

18.1.1 ITA Services shall include all services and Administrative Functions required for the evaluation of involuntary detention or involuntary treatment of Individuals in accordance with chapters 71.05, 71.24 and 71.34 RCW.

18.1.1.1 Requirements include payment for all Behavioral Health services ordered by the court for Individuals ineligible for Medicaid, and ITA court costs and Transportation to and from for court hearings.

18.1.1.1.1 When the Contractor submits requests to HCA for public defense services under RCW 71.05.110, HCA shall reduce the funding provided to the Contractor equivalent to HCA's expenses in contracting with the Washington State Office of Public Defense for that representation. The Contractor may still seek reimbursement from the BH-ASO that serves the Individual's county of residence who is the subject of the civil commitment case.

18.1.1.2 Crisis Services become ITA Services when a DCR determines an Individual must be evaluated for involuntary treatment. ITA Services continue until the end of the Involuntary Commitment and may be outpatient or inpatient.

18.1.1.3 ITA decision-making authority of the DCR must be independent of the Contractor.

18.1.2 The Contractor shall ensure Providers have sufficient staff available, including DCRs, to respond to requests for Crisis Services and ITA Services.

18.1.2.1 The Contractor shall submit a DCR Office Contact Information report quarterly or immediately if changes occur using the most recent template provided by HCA. All elements within the report shall be completed by the Contractor. Reports are due January 15 (January through March); April 15 (April through June); July 15 (July through September); and October 15 (October through December) or immediately when changes occur. The first report is due July 15, 2026. Submit reports to HCA at HCABHASO@hca.wa.gov.

18.1.3 The Contractor shall ensure Provider compliance with DCR qualification requirements in accordance with chapters 71.05 and 71.34 RCW and WAC 246-341-0912. The Contractor shall ensure Provider compliance with provisions of Involuntary Treatment Act/DCR services in accordance with chapters 71.05 and 71.34 RCW, along with chapter 246-341 WAC, and the DCR Protocols. The Contractor will monitor annually for compliance with Involuntary Treatment Act/DCR services.

18.1.4 The Contractor shall ensure Providers of ITA Services establish policies and procedures that implement the following requirements:

18.1.4.1 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 first responder or second individual trained under RCW 71.05.720 on safety and violence prevention topics accompanies them.

18.1.4.2 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.

18.1.4.3 HCA Crisis Academy training in:

18.1.4.3.1 Mobile Response and Stabilization Services (MRSS) which includes MRSS 101 and MRSS 102;

18.1.4.3.2 Youth crisis responder which includes developmentally appropriate trauma-informed approach, developmentally appropriate de-escalation and developmentally appropriate harm reduction;

18.1.4.3.3 Adult crisis responder which includes trauma-informed approach, de-escalation and harm reduction;

18.1.4.3.4 Trauma-informed approach for DCRs; and

18.1.4.3.5 HCA En Route Northwest training for Family Initiated Treatment (FIT).

18.1.4.4 The second individual who responds may be a Mental Health Professional, a SUDP, or a mental health Provider who has received training required in RCW 71.05.720 as identified under RCW 49.19.030 for health care settings. A First Responder may be a second for safety.

18.1.4.5 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.

18.1.4.6 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.

18.1.4.7 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.

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

18.1.4.9 Behavioral Health ITA Services shall be provided in accordance with RCW 71.05, RCW 71.24, RCW 71.34, and WAC 246-341-0912. Services shall include investigation and evaluation activities, management of the court case findings and legal proceedings in order to ensure the due process rights of the Individuals who are detained for involuntary treatment. The Contractor shall reimburse the county for direct costs associated with providing judicial services for civil commitment and shall provide for evaluation and treatment services as ordered by the court for Individuals who are not eligible for Medicaid, including Individuals detained by a DCR. Reimbursement for judicial services shall be provided per civil commitment case at a rate to be determined based on an independent assessment of the county's actual direct costs. This assessment must be based on an average of the expenditures for judicial services within the county over the past three years. In the event that a baseline cannot be established because there is no significant history of similar cases within the county, the reimbursement rate shall be equal to 80 percent of the median reimbursement rate of counties included in the independent assessment.

18.1.4.10 Services provided in Involuntary Treatment facilities such as E&T and SWMS Facilities, must be licensed and certified by DOH. These facilities must have adequate staff to provide a safe and secure environment for the staff, patients, and the community. The facilities will provide assessment and treatment services to limit the duration of involuntary treatment until the Individual can be discharged back to their home community to continue their treatment without the loss of their civil liberties. The treatment shall be Evidence-Based Practices to include supportive housing, supported employment, Pharmacological services, psycho-social classes, withdrawal management as needed, access to a traditional cultural healer to be present during their involuntary treatment evaluation in accordance with RCW 71.05.150; discharge planning, and Warm Handoff to follow-up treatment including any LRA care ordered by the court.

47. 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 Mobile Rapid Response Crisis Team Required Elements

19.1.1 The Contractor will work to ensure a minimum of one CPC (until December 31, 2026) 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 endorsed teams, 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 for 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 coordination 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 MHP supervisor to provide clinical oversight and supervision of all staff, at all times 24/7.

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 shall follow 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 All MRRCT's 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 The Crisis is defined by the Individual, including adults, Youth, young adults and/or the parent or caregiver.

19.1.2.4.5 Youth MRRCT will minimally include all elements in this Section and the following:

19.1.2.4.5.1 Youth MRRCT will follow System of Care principles; family and youth driven. Care is delivered to them, and culturally and linguistically responsive.

19.1.2.4.5.2 Services are delivered in-person, in home or community settings wherever the Youth is located. Teams will support and maintain the Youth in their current living situation whenever possible, reducing the need for out-of-home placements, inpatient care, hospital boarding and residential interventions.

19.1.2.4.5.3 Teams are intentionally inclusive of family/caregivers and natural support throughout the intervention whenever possible and in alignment with RCW 71.34.530.

19.1.2.4.5.4 Teams will intentionally partner with Youth serving systems and must be responsive to referrals to support diversion from emergency departments or unnecessary contact with law enforcement. If Youth do enter the emergency department or a 23-hour Crisis Relief Center, teams shall partner with those entities to promote safe discharge home whenever clinically indicated with the support of an MRSS episode of care by providing crisis intervention, safety planning and in-home stabilization. However, MRSS teams will not be responsible for finding out of home placement, or monitoring, or monitoring Youth in temporary placements.

19.1.3 MRRCT Required Training.

19.1.3.1 All individuals providing MRRCT services, whether newly hired or currently employed, are required to complete all trainings specified in subsection 19.1.3:

19.1.3.1.1 All MRRCT's shall complete HCA LMS MRSS 101 and 102 modules;

19.1.3.1.2 HCA-approved certified crisis intervention specialist training;

19.1.3.1.3 HCA LMS Trainings in Trauma Informed Care, de-escalation techniques, and harm reduction. MRRCT's that serve Youth will complete the three developmentally appropriate LMS modules outlined in 19.1.3.1.1; and

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

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

19.1.5 The required elements for all BH-ASO contracted mobile crisis Providers as defined in Section 19 of this Contract will be incorporated into the Contractor's subcontracts by September 1, 2026.

48. Section 19, Mobile Rapid Response Crisis Team (MRRCT), 19.2 Mobile Rapid Response Crisis Team Endorsement, subsection 19.2.1, a new subsection 19.2.1.5 is added to read as follows:

19.2.1.5 Electric vans for 988 Behavioral Health Crisis response and suicide prevention.

19.2.1.5.1 The BH-ASO will distribute funds to MRRCTs, and CBC teams endorsed under RCW 71.24.903 (endorsed Providers) for the purchase of electric vans to support 988 Behavioral Health Crisis response and suicide prevention. For the purposes of this subsection, a van is defined as an electric vehicle with a capacity for six or more passengers.

19.2.1.5.1.1 Ensure this is reported within the Non-Medicaid Spending Plan as identified in Section 5 of this Contract.

19.2.1.5.1.2 In determining how the funds will be distributed among the applicable endorsed Providers, the BH-ASO must ensure the following is considered:

19.2.1.5.1.2.1 The needs of specific cities and counties, prioritizing areas with higher identified needs for Behavioral Health Crisis Services.

19.2.1.5.1.2.2 How the electric van will enhance the endorsed Provider's ability to respond to and transport people experiencing significant Behavioral Health Emergencies to a location that will provide the appropriate level of crisis stabilization services.

19.2.1.5.1.2.3 How the electric van will increase the number of people served and/or a Providers ability to improve current response times. E.g., improving ability to reach more rural areas, and a reduced timeframe for providing in-person rapid responses will enhance the endorsed Provider's ability to provide endorsement level services, including meeting the statutory response times.

19.2.1.5.2 The funds must be used to purchase electric vans, related necessary equipment, and to support associated costs needed to operationalize the van, e.g., installation of charging station, purchase and installation of electrical service upgrade as needed to support the charger, delivery or transport costs from dealer/manufacturer to the endorsed Provider, etc.

19.2.1.5.2.1 The funds must also ensure the electric van meets the requirements as identified in WAC 182-140-0100(3)(a).

19.2.1.5.3 These funds do not allow for the purchase of non-electric hybrid, or plug-in hybrid vehicles. The fund must not be used for ongoing maintenance costs and/or ongoing operational costs. The funds may not be used for capital expenditures except those listed below:

19.2.1.5.3.1 Purchasing electric vans and/or necessary equipment for the electric vans.

49. Section 20, Assisted Outpatient Treatment (AOT) and Least Restrictive Alternative (LRA) is renamed as 'Less Restrictive Alternative (LRA) Court, Including Assisted Outpatient Treatment (AOT)' and is amended to read as follows:

20 LESS RESTRICTIVE ALTERNATIVE (LRA) COURT, INCLUDING ASSISTED OUTPATIENT TREATMENT (A0T)

20.1 Less Restrictive Alternative Standards

20.1.1 The Contractor is to be aware that 'Less Restrictive Alternative (LRA) court orders' is broad terminology which includes the following involuntary treatment court orders: Less Restrictive Alternative (LRA) or less restrictive order (LRO), Conditional Release (CR), and Assisted Outpatient (AOT).

20.1.2 LRA Treatment Services shall include all services and Administrative Functions required for the treatment of Individuals on LRA court orders in accordance with chapters 71.05 and 71.34 RCW, and WAC 246-341-0805.

20.1.3 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 defined in Section 15 of this Contract.

20.1.3.1 The Contractor will track or purchase services for tracking Individuals on LRA Treatment court orders.

20.1.3.2 Tracking treatment services will include reporting non-compliance with the appropriate DCR Provider.

20.1.4 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 tracking service.

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

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

20.1.5.2 The MCO is responsible to purchase treatment services for Individuals receiving LRA Treatment services; and

20.1.5.3 Treatment services will include coordination with the appropriate DCR Provider, including non-compliance.

20.1.6 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:

20.1.6.1 Unfunded Individuals;

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

20.1.6.3 Individuals who are covered by commercial insurance.

20.2 Assisted Outpatient Treatment (AOT)

20.2.1 Assisted Outpatient Treatment (AOT) shall be provided to those who are identified as meeting the need. The Contractor shall employ a designated BH-ASO AOT coordinator. The BH-ASO AOT coordinator will oversee system coordination and legal compliance for AOT under RCW 71.05.148 and RCW 71.34.815.

20.2.1.1 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. Policies and procedures shall address goal of improving treatment engagement, reducing Crisis and hospitalizations, decreasing criminal justice involvement, promoting community stability and supporting long term Recovery as defined in SAMHSA national guidelines.

20.2.1.2 The Contractor shall have an AOT program in at least one county in Contractor's region in operation by March 31, 2027. AOT program shall include the ability to evaluate referrals, file petitions, a court to monitor an Individual and a Provider to provide wraparound treatment services. Work with regional partners to implement and sustain the AOT program within the region.

20.2.1.3 The Contractors shall show growth of AOT participation year after year through December 31, 2029.

20.2.1.4 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.

20.2.1.5 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.

20.2.1.6 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.

20.2.1.6.1 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.

20.2.1.6.2 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.

20.2.1.6.3 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.

20.2.1.7 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).

20.2.1.8 BH-ASO AOT coordinators shall:

20.2.1.8.1 Attend monthly AOT coordinator meetings as directed by HCA; and

20.2.1.8.2 Participate in quarterly AOT coordinator meetings as directed by HCA.

50. Section 21, External Entities and Tribal, 21.2 Crisis Coordination and non-Tribal IHCPs, subsection 21.2.2 is amended to read as follows:

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 Office of Tribal Affairs guidance template "Navigating a Crisis without a Tribal Crisis Coordination Protocol" at: https://www.hca.wa.gov/assets/program/navigating-a-crisis-without-a-tribal-crisis-protocol-202509_0.pdf.

51. Section 23, Juvenile Court Treatment Program, 23.1 Juvenile Court Treatment Program Requirements, is amended to read as follows:

23.1 Juvenile Court Treatment Program Requirements

23.1.1 In RSAs where funding is provided, the Contractor shall support Individuals involved with a region's Juvenile Drug Court (JDC), or other juvenile court treatment program, to provide the following services:

23.1.1.1 A SUD assessment;

23.1.1.2 SUD and mental health treatment and counseling as appropriate which may include Evidence-Based Practices such as Functional Family Therapy and Aggression Replacement Training;

23.1.1.3 A comprehensive case management plan which is individually tailored, culturally appropriate, developmentally and gender appropriate, and which includes educational goals that draw on the strengths and address the needs of the Individual;

23.1.1.4 Track attendance, completion of activities, and offer incentives for compliance; and

23.1.1.5 Engagement of the community to broaden the support structure and better ensure success such as, but not limited to referrals to mentors, support groups, and pro-social activities.

23.1.1.6 Coordination with Tribal courts and Tribal BH services for Individuals seeking connection to Tribal communities and/or culturally attuned care by IHCPs.

23.1.2 The Contractor will submit the quarterly Juvenile Court Treatment Program Report within forty-five (45) calendar days of the state fiscal quarter end using the most current version of the Juvenile Court Treatment Program reporting template.

52. Section 24, Criminal Justice Treatment Account (CJTA), 24.1 CJTA Funding Guidelines, subsection 24.1.7 is amended to read as follows:

24.1.7 The Contractor shall dedicate a minimum of 30 percent of the CJTA funds for innovative projects that meet any or all of the following conditions:

24.1.7.1 An acknowledged evidence or research based best practice or treatment strategy that can be documented in published research; or

24.1.7.2 An approach utilizing either traditional, promising, or best practices to treat significantly underserved and marginalized population(s) and populations who are disproportionately affected by involvement in the criminal legal system; or

24.1.7.3 A regional project conducted in partnership with at least one other entity serving the RSA such as the AH-IMC MCOs operating in the RSA or the ACH.

24.1.7.4 Utilization of CJTA funding for housing support services are prohibited from using simultaneous sources of funding for both the same housing expenses and same Individual.

53. Section 24, Criminal Justice Treatment Account (CJTA), 24.2 Allowable Expenditures under CJTA is amended to read as follows:

24.2 Allowable Expenditures under CJTA

24.2.1 Services that can be provided using CJTA funds are:

24.2.1.1 Brief Intervention (any level, assessment not required);

24.2.1.2 Clinically Managed Residential Withdrawal Management (ASAM Level 3.2WM);

24.2.1.3 Outpatient Services (ASAM Level 1);

24.2.1.4 Intensive Outpatient Services (ASAM Level 2.1);

24.2.1.5 Opioid Treatment Program (ASAM Level 1);

24.2.1.6 Clinically Managed High Intensity Residential Services (ASAM Level 3.5);

24.2.1.7 Clinically Managed Population-Specific High-Intensity Residential Services;

24.2.1.8 Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1);

24.2.1.9 Assessments, including assessments completed while in jail;

24.2.1.10 Interim Services;

24.2.1.11 Community Outreach;

24.2.1.12 Involuntary Commitment Investigations and Treatment;

24.2.1.13 Room and Board (Residential Treatment Only);

24.2.1.14 Transportation;

24.2.1.15 Child Care Services;

24.2.1.16 Urinalysis;

24.2.1.17 Case Management; and

24.2.1.18 Treatment in the jail:

24.2.1.18.1 The Contractor may not use more than 30 percent of their total annual allocation for providing treatment services in jail.

24.2.1.18.1.1 The Contractor may request an exception to this funding limit within their strategic plan submitted per subsection 24.3.1 of this Contract.

24.2.1.18.2 SUD treatment services provided in jail may include, but are not limited to the following:

24.2.1.18.2.1 Engaging Individuals in SUD treatment;

24.2.1.18.2.2 Referral to SUD services;

24.2.1.18.2.3 Administration of medications for the treatment of SUDs, including Opioid Use Disorder, to include the following:

24.2.1.18.2.3.1 Screening for medications for SUDs;

24.2.1.18.2.3.2 Cost of medications for SUDs; and

24.2.1.18.2.3.3 Administration of medications for SUDs.

24.2.1.18.3 Coordinating care;

24.2.1.18.4 Continuity of Care; and

24.2.1.18.5 Transition planning.

24.2.1.19 Employment services and job training;

24.2.1.20 Relapse prevention;

24.2.1.21 Family and marriage education;

24.2.1.22 Peer-to-peer services, mentoring and coaching;

24.2.1.23 Self-help and support groups;

24.2.1.24 Housing support services (rent and deposits);

24.2.1.25 Utilization of CJTA funding to cover the costs of housing, within Available Resources, must present the Individual with options for recovery residences of approved recovery residences maintained by the authority under RCW 41.05.760. The Contractor is prohibited from requiring Individuals to stay in a single specific approved recovery residence(s) when utilizing CJTA funds to pay for housing in that region and must offer choice giving strong consideration to adding options when an Individual prefers a residence not currently utilized.

24.2.1.26 Life skills;

24.2.1.27 Education; and

24.2.1.28 Parent education and child development.

24.2.2 SUD treatments services and treatment support services for non-violent offenders within a drug court program may be continued for one hundred eighty (180) calendar days following graduation from the drug court program.

54. Section 24, Criminal Justice Treatment Account (CJTA), 24.3 CJTA Strategic Plan is renamed as 'CJTA Strategic Biennial Plan' and is amended to read as follows:

24.3 CJTA Strategic Biennial Plan

24.3.1 The CJTA Strategic Biennial Plan is due every two years on October 1 of every odd year.

24.3.1.1 The Contractor must coordinate with the local legislative authority for the county or counties in its RSA in order to facilitate the planning requirement as described in RCW 71.24.580(6). The CJTA Strategic Biennial Plan shall:

24.3.1.1.1 Describe in detail how SUD treatment and support services will be delivered within the region;

24.3.1.1.2 Provide in detail how the Contractor and Subcontractors shall coordinate with local Tribal Behavioral Health agencies and IHCP to meet the needs of AI/AN Individuals who may be receiving allowable CJTA funded services. The Contractor and Subcontractors shall support the coordination with Tribal courts and Tribal BH services for Individuals seeking connection to Tribal communities and/or culturally attuned care by IHCP's. This portion of the plan will specifically address how CJTA funded therapeutic courts will allow flexibility in AI/AN Individuals to receive treatment services through their Tribal Behavioral Health agency.

24.3.1.1.3 Address the CJTA Account Match Requirement from subsection 24.1.4 of this Contract;

24.3.1.1.4 Include details on innovative projects as referenced in subsection 24.1.7 of this Contract, including the following:

24.3.1.1.4.1 Describe the project and how it will be consistent with the strategic plan;

24.3.1.1.4.2 Describe how the project will enhance treatment services for eligible Individuals identified in RCW 71.24.580(1)(a) - (b);

24.3.1.1.4.3 Describe how the project will incorporate best practices and treatment strategies while addressing underserved populations;

24.3.1.1.4.4 Indicate the number of Individuals who were served using innovative funds; and

24.3.1.1.4.5 Detail the original goals and objectives of the project.

24.3.1.2 If applicable, the CJTA Strategic Biennial Plan will indicate a plan of action for meeting the requirements in Subsection 24.5 of this Contract.

24.3.1.3 All plans must include a budget and budget narrative that categorizes how much funding will be used for various SUD-related initiatives.

24.3.1.4 Completed plans must be submitted to HCA and the CJTA Panel established in RCW 71.24.580(5)(b), for review and approval. Once approved, the Contractor must implement its plan as written.

55. Section 28, Family Youth System Partner Round Table (FYSPRT), 28.1 General Requirements, Subsection 28.1.1 is amended to read as follows:

28.1.1 FYSPRT support shall be provided within the identified resources in Exhibit A and reported in accordance with this Section. Funding identified in Exhibit A is to support FYSPRT deliverables outlined in this Contract including:

28.1.1.1 Travel support for Youth/young adult and family participants to attend in-person FYSPRT meetings;

28.1.1.2 Meeting support;

28.1.1.3 Projects or strategies outlined in the work plan, including travel to events, conferences, and trainings; and

28.1.1.4 MHBG funds for FYSPRT to be used for compensating Tri-Leads for activities related to the role of the Regional FYSPRT Tri-Lead as outlined in the Regional FYSPRT manual (including the voluntary quarterly Tri-Lead call);

28.1.1.4.1 All funds not used to compensate Tri-Leads shall be put towards outreach and engagement efforts for Youth and families, travel and meeting support and for the Regional FYSPRT as connected to the contract deliverables and the Regional FYSPRT manual.

56. Section 28, Family Youth System Partner Round Table (FYSPRT), 28.1 General Requirements, Subsection 28.1.4 is amended to read as follows:

    28.1.4 Consistent with the Regional FYSPRT manual, the Contractor will continue to develop, promote, and support each Regional FYSPRT by providing administrative and staff support for FYSPRT deliverables as outlined in this Section, including but not limited to:

        28.1.4.1 Community Outreach and Engagement efforts to publicize the work of the FYSPRTs;

        28.1.4.2 Recruit members;

        28.1.4.3 Fiscal management;

        28.1.4.4 Arranging meeting space; and

        28.1.4.5 Other administrative support necessary for the operation of the Regional FYSPRT.

57. Section 28, Family Youth System Partner Round Table (FYSPRT), 28.1 General Requirements, Subsection 28.1.8 is amended to read as follows:

    28.1.8 Review the Regional FYSPRT charter during a minimum of one meeting per calendar year to ensure that the charter shows how the Regional FYSPRTs are connected to legislative groups, including the recurring gaps and needs form process and how Statewide FYSPRT meeting notes and information will be conveyed to Regional FYSPRT members.

58. Section 28, Family Youth System Partner Round Table (FYSPRT), 28.1 General Requirements, Subsection 28.1.10 is amended to read as follows:

    28.1.10 Participation in state-level activities, to include:

        28.1.10.1 Identification of Regional Tri-Leads to participate as members of the Statewide FYSPRT, including attending meetings and responding to surveys and emails;

        28.1.10.2 Provision of travel support for all Regional Tri-Leads to attend the Statewide FYSPRT meetings, if in person with the requirement that at least two of the three Tri-Leads attend each Statewide FYSPRT meeting within Available Resources;

        28.1.10.3 Provide support for Regional FYSPRT Youth/young adult Tri-Lead(s) to participate as members of the Statewide Behavioral Health Youth Network (Youth Network) activities, trainings, or meetings a minimum of once per quarter and attend other Youth/young adult-run organization or program events and activities as determined by regional needs or as requested by HCA within Available Resources;

        28.1.10.4 Provide support for Regional FYSPRT Family Tri-Lead(s) to participate as members of the Washington Behavioral Health Statewide Family Network activities, trainings, or meetings a minimum of once per quarter and attend other family-run organization or program events and activities as determined by regional needs or requested by HCA and within Available Resources; and

        28.1.10.5 Provide support for Regional FYSPRT Tri-Lead(s) to participate in the voluntary quarterly Tri-Lead call Available Resources.

59. Section 28, Family Youth System Partner Round Table (FYSPRT), 28.1 General Requirements, Subsection 28.1.12 is amended to read as follows:

28.1.12 Beginning July 1, 2026, the quarterly reports shall be submitted within forty-five (45) calendar days following the end of the state fiscal quarter; February 15 (October – December), May 15 (January – March), August 15 (April – June), and November 15 (July – September) and must be submitted to HCABHASO@hca.wa.gov. Quarterly reports must include the following:

28.1.12.1 A quarterly report summarizing the progress or completion of FYSPRT deliverables outlined in the FYSPRT section of this Contract, identifying any barriers and plans to address barriers;

28.1.12.2 A quarterly update on work plan completed for subsection 28.1.7 showing progress on goals, action steps, those assigned, and timeline for completion in the work plan. The work plan must include a clearly identifiable revision date on the document;

28.1.12.3 Sign-in sheets showing percentage of Youth/young adult and family in attendance; if below the benchmark of 51 percent, note the percentage in the quarterly report and identify three strategies to increase Youth/young adult and family participation to 51 percent in the next quarter;

28.1.12.4 Meeting notes;

28.1.12.5 A link to the required Regional FYSPRT webpage materials;

28.1.12.6 Tri-Lead attendance at Statewide FYSPRT meetings;

28.1.12.7 FYSPRT Gift Card Purchase and Distribution Tracker;

28.1.12.7.1 Gift card purchases and distribution must be tracked on the FYSPRT Gift Card Purchase and Distribution Tracker template provided by HCA and shall include documentation of the date of purchase, date of distribution, name of participant receiving the gift card, the county of residence of the gift card receiver, amount of gift card, and purpose of the gift card. The tracker will include the total dollar amount of gift cards on hand and the total dollar amount of gift cards distributed for the quarter being reported and the state fiscal year;

28.1.12.7.2 If Youth/young adult, family, and system partners are compensated by an employer to attend FYSPRT meetings, they are not eligible for meeting support. System partners are not eligible for monetary gifts or raffle items supplied by FYSPRT dollars;

28.1.12.7.3 Gift cards provided by the Contractor (or their Subcontractor) shall be used for travel support, meeting support, compensation and other expenses related to participation in the FYSPRT as outlined in this Section, the Regional FYSPRT manual or in the Regional FYSPRT work plan goals/strategies. HCA reserves the right to request supporting documentation.

28.1.12.8 Youth/youth adult and family travel to FYSPRT meetings, including participation and meeting support, shall include documentation of the date of travel/meeting support, name of participant, the purpose of the expense, and the amount of the expense being reimbursed;

28.1.12.9 Conference and training attendance, travel, and related expenses that are paid for using FYSPRT dollars shall be identified in the work plan and be connected to a work plan goal or strategy. Travel needs to be in alignment with the current per diem rate (https://www.gsa.gov/travel/plan-book/per-diem-rates). If airline tickets are being purchased for travel, they need to be purchased more than fourteen (14) calendar days before the travel occurs. When submitting for reimbursement, include itemized documentation per attendee and submit with the A19.

28.1.12.10 Youth/young adult and family travel to FYSPRT meetings, including participation, meeting support, and conference and training expenses must be billed in the quarter in which the expense occurred. Documentation shall be submitted with the A19 in alignment with the Contractor's policies and shall be billed quarterly on the A19; and

28.1.12.11 A19 shall be submitted within forty-five (45) calendar days of the end of each state fiscal quarter February 15 (October – December), May 15 (January – March), August 15 (April – June), and November 15 (July – September) and must be submitted to HCABHASO@hca.wa.gov.

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

32.1 Substance Use Disorder Regional Recovery Navigator Administrator

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.

32.1.2 The SUD Regional Recovery Navigator Administrator will develop a Regional Resource Assessment for their region which captures existing local, state, and federally funded community-based access points. This resource assessment will map out existing agencies and relative funding sources which include, but are not limited to the following programs:

32.1.2.1 Designated Crisis Responders;

32.1.2.2 Mobile Crisis Teams;

32.1.2.3 Diversion and deflection programs (e.g., Co-responder, Mental Health Field Response team, Law Enforcement Assisted Diversion (LEAD), Arrest and Jail Alternatives, etc.) which currently are funded and operational within their region.

32.1.2.4 Community-based harm reduction and outreach services;

32.1.2.5 Low-barrier Medications for Opioid Use Disorder programs;

32.1.2.6 Crisis Stabilization Facilities;

32.1.2.7 Street Medicine programs;

32.1.2.8 Opioid Treatment Networks or Hub and Spoke Medication for Opioid Use Disorder (MOUD) programs;

32.1.2.9 Any peer-based program which embeds peer support specialists in community-based programming; and

32.1.2.10 The Regional Resource Assessment will consider areas such as Transportation and telehealth while identifying geographical areas where there are service gaps.

32.1.3 The SUD Regional Recovery Navigator Administrator will work with local law enforcement organizations to determine which city, county, and Tribal law enforcement departments are operating within their regions.

32.1.4 The SUD Regional Recovery Navigator Administrator will work closely with the Accountable Communities of Health, local health jurisdiction, local behavioral advisory committee, local and Tribal law enforcement, and any other community-driven stakeholder groups while executing the requirements of the position.

61. 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 Recovery Navigator Program must maintain 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 as indicated in the Uniform Program Standards. Examples of referrals sources include but are not limited to:

32.2.2.1 Law enforcement;

32.2.2.2 Court systems;

32.2.2.3 Community-based organizations;

32.2.2.4 Social contact referral from law enforcement;

32.2.2.5 Harm reduction programs; and

32.2.2.6 Healthcare provider.

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). The Contractor shall coordinate with HCA on any updated versions of the data collection workbook to determine the appropriate effective date.

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 and/or funded trainings.

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

34.1 General Requirements

34.1.1 The Youth Behavioral Health Navigator Program (YBHNP) is intended to establish and strengthen collaborative communication, identify community resources, including culturally appropriate resources and 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 experiencing difficulty accessing Behavioral Health care.

34.1.2 Children and Youth boarding in emergency departments due to lack of placement options will be given priority access to this program and MDTs.

63. Section 34, Youth Behavioral Health Navigator Program (YBHNP), 34.2 Supports in Navigating Access to Behavioral Health Resources, Subsection 34.2.1 is amended to read as follows:

34.2.1 The Contractor will identify and hire program staff to meet the minimum requirements, including:

34.2.1.1 Experience in group facilitation.

34.2.1.2 Experience with Care Coordination.

34.2.1.3 Experience with advocacy and outreach.

34.2.1.4 Knowledge of family systems.

34.2.1.5 Experience with communication and documentation.

34.2.1.6 Knowledge of community, Tribal and regional resources, Behavioral Health funding, state law, and policies related to pediatric Behavioral Health.

34.2.1.7 Ability to perform data collection and creation of public records.

64. Section 34, Youth Behavioral Health Navigator Program (YBHNP), 34.4 Technical Support, Subsection 34.4.2 is amended to read as follows:

34.4.2 The Contractor will participate in technical assistance (TA) support and learning collaboratives as needed to support the development of the YBHNP including Tribal health care services, culturally attuned care, and Care Coordination with Tribes and IHCPs for services to AI/An Individuals.

65. Section 36, Reports/Deliverables, 36.1 Templates, Subsection 36.1.1 is amended to read as follows:

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 Combined Provider Submission

36.1.1.1.6 Community Behavioral Health Enhancement (CBHE) Funds Quarterly Report

36.1.1.1.7 Co-Responder Report

36.1.1.1.8 Criminal Justice Treatment Account (CJTA) Quarterly Progress Report

36.1.1.1.9 Crisis System Metrics Report

36.1.1.1.10 Crisis Triage/Stabilization and Increasing Psychiatric Bed Capacity Report

36.1.1.1.11 Data Shared with External Entities Report

36.1.1.1.12 Designated Crisis Responder (DCR) Office Contact Information

36.1.1.1.13 E&T Discharge Planner Report

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

36.1.1.1.15 FYSPRT Gift Card Purchase and Distribution Tracker

36.1.1.1.16 Grievance, Adverse Authorization Determination, and Appeals

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

36.1.1.1.18 Juvenile Court Treatment Program Quarterly Report

36.1.1.1.19 Mental Health Block Grant (MHBG) Project Plan

36.1.1.1.20 Mobile Rapid Response Crisis (MRRC) Team Report

36.1.1.1.21 Non-Medicaid Expenditure Report

36.1.1.1.22 Non-Medicaid Spending Plan

36.1.1.1.23 Peer Bridger Participant Treatment Engagement Resources Monthly Report

36.1.1.1.24 Peer Bridger Monthly Report

36.1.1.1.25 Recovery Navigator Program Quarterly Report

36.1.1.1.26 Regional Crisis Forum Report

36.1.1.1.27 Semi-Annual Trueblood Misdemeanor Diversion Fund Report

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

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

36.1.1.1.30 Supplemental Data Daily Submission Notification

36.1.1.1.31 Supplemental Data Monthly Certification Letter

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

36.1.1.1.33 Trueblood Enhanced Crisis Services Narrative Quarterly Report (Carelon, King, Salish, Thurston/Mason and Spokane only)

36.1.1.1.34 Trueblood Enhanced Crisis Staff Details (Carelon, King, Salish, Thurston/Mason and Spokane only)

36.1.1.1.35 Trueblood Lifeline Connections Transportation

36.1.1.1.36 Youth Behavioral Health Navigator Quarterly Tracking

36.1.1.1.37 Youth Behavioral Health Navigator Quarterly Report

66. Exhibit A-5, Non-Medicaid Funding Allocation, supersedes and replaces Exhibit A-4 and is attached hereto and incorporated herein.

67. Exhibit G-1, Federal Subaward Identification, Attachment A-1, supersedes and replaces Attachment A and is attached hereto and incorporated herein.

68. Exhibit G-1, Federal Subaward Identification, Attachment B-1, supersedes and replaces Attachment B and is attached hereto and incorporated herein.

69. This Amendment will be effective as of July 1, 2026 (“Effective Date”).

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

71. 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 Karen Richardson	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

Exhibit A-5: Non-Medicaid Funding Allocation
Greater Columbia Behavioral Health

This Exhibit addresses non-Medicaid funds in the Greater Columbia RSA for the provision of crisis services and non-crisis behavioral health services for July 1, 2026, through December 31, 2026, of state fiscal year (SFY) 2027. Amounts can be utilized during SFY ending June 30, 2027, 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 2027.

Table 1: Greater Columbia RSA July - December SFY 2027 GF-S Funding

Fund Source	Monthly	Total 6 Months	Amended 6 Month Amount
Flexible GF-S	1,142,480.00	6,854,880.00	
5092(65) Added Crisis Teams/including child crisis teams	74,323.00	445,938.00	
Behavioral Health Advisory Board	3,333.00	19,998.00	
BH Service Enhancements	36,928.00	221,568.00	
CJTA	100,770.00	604,620.00	
Client Services in Facilities	36,797.00	220,782.00	
Client Services in New Crisis Stabilization Facility	74,864.00	449,184.00	
Crisis Endorsement Teams	One Time Payment (Six Months)	166,387.00	
Crisis Stabilization Facilities Start-up and Ops	168,842.00	1,013,052.00	
Crisis Triage/Stabilization	21,038.00	126,228.00	
DCA - Dedicated Cannabis Account	21,869.00	131,214.00	
Detention Decision Review	3,051.00	18,306.00	
Discharge Planners	11,921.00	71,526.00	
Electric Vans	One Time Annual Payment	116,666.00	
ITA - Non-Medicaid funding	27,950.00	167,700.00	
Jail Services	20,427.00	122,562.00	
Long-Term Civil Commitment Court Costs	11,741.00	70,446.00	
MH Sentencing Alternatives 153	2,638.00	15,828.00	
New Journey First Episode Psychosis	8,327.00	49,962.00	
PACT	59,891.00	359,346.00	
Recovery Navigator Lead Admin	5,833.00	34,998.00	
Recovery Navigator Program	142,707.00	856,242.00	
Room & Board	2,239.00	13,434.00	
Secure Detox	26,889.00	161,334.00	
Step-Down Transitional Residential	8,500.00	51,000.00	
Trueblood Misdemeanor Diversion	7,722.00	46,332.00	
Youth Inpatient Navigators	33,500.00	201,000.00	
Youth Stabilization Crisis Teams	15,282.00	91,692.00	
Total	**2,069,862.00**	**12,702,225.00**	**-**

Table 2: Greater Columbia RSA SFY 2027 Grant Funding (12 months)

Fund Source	Total FY27	Amended 6 Month Amount
MHBG (Full Year SFY2027)	644,948.00	
MHBG FYSPRT	25,000.00	
Peer Bridger (Full Year SFY2027) (Fed Block Grant)	130,286.00	
SUPTRS (Full Year SFY2027)	1,531,901.00	
Total	**2,332,135.00**	-

Table 3: Greater Columbia RSA - SFY2027 Budgeted Program funds to be Reimbursement via A-19

Fund Source	Total FY27	Amended 6 Month Amount
5071 - Full FY amount available Provider cost of monitoring CR/LRA State Hospital discharged individual	6,300.00	
FYSPRT (Full Year SFY2027)	75,000.00	
Governor's Housing/Homeless Initiative -Rental Voucher and Bridge Program	25,000.00	
Peer Bridger (Full Year SFY2027)	142,971.00	
Total	**249,271.00**	-

Table 4: Maximum Agreement Calculation

Fund Source	Total July - December FY27	Amended 6 Month Amount
Table 1	12,702,225.00	-
Tables 2, 3	2,581,406.00	-
Total	**15,283,631.00**	-

Explanations

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

- **Juvenile Drug Court:** Funding to provide alcohol and drug treatment services to juvenile offenders who are under the supervision of a juvenile drug court.

- **State Drug Court:** Funding to provide alcohol and drug treatment services to offenders who are under the supervision of a drug court.

- **Jail Services:** Funding to provide mental health services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate access to programs that offer mental health service upon mentally ill offenders' release from confinement. This includes efforts to expedite applications for new or re-instated Medicaid benefits.

- **WA - Program for Assertive Community Treatment (WA - PACT)/Additional PACT/1109:** Funds received per the budget proviso for development and initial operation of high-intensity programs for active community treatment WA- PACT teams.

- **Detention Decision Review:** Funds that support the cost of reviewing a DCR's decision whether to detain or not detain an individual under the state's involuntary commitment statutes.

- **Criminal Justice Treatment Account (CJTA):** Funds received, through a designated account in the State treasury, for expenditure on: a) SUD treatment and treatment support services for offenders with an addition of a SUD that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; b) the provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program.

- **CJTA Therapeutic Drug Court:** Funding to set up 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 2025, the legislature intends to direct amounts within this subsection to be used for performance payments to mobile rapid response teams and community-based crisis teams that receive endorsements pursuant to Engrossed Second Substitute House Bill No. 201134 (988 system). 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.

- **MHBH FYSPRT -** MHBG funds for FYSPRT to be used for compensating Tri-Leads for activities related to the role of the Regional FYSPRT Tri-lead (including the Quarterly Tri-Lead call). All funds not used to compensate Tri-Leads shall be put towards outreach and engagement efforts for youth and families and travel and meeting support.

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) and 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.

- **Crisis stabilization facilities Start-up and Ops -** Funding to support the provision of crisis stabilization services to uninsured or underinsured individuals in facilities licensed as a Crisis Stabilization Unit or a 23-Hour Crisis Relief Center.

- **Electric Vans -** Electric vans for 988 behavioral health crisis response and suicide prevention (Proviso 76) Amounts for the purchase of electric vans for 988 behavioral health crisis response and suicide prevention mobile rapid response crisis teams and community-based crisis teams endorsed under RCW 71.24.903. These amounts must be used to purchase electric vans and associated equipment necessary to enhance the statewide behavioral health crisis response system and ensure individuals experiencing a crisis have access to help easily in their regions. Purchased electric vans must meet endorsement vehicle requirements as outlined in WAC 182-140-0100.
    - Funds cannot be used for ongoing maintenance costs and/or ongoing operational costs. Funds may not be used for capital expenditures except those listed below.
        - Allowable costs:
            - Purchasing electric vans and/or equipment for the electric vans.

Exhibit G-1
Attachment A-1
Federal Subaward Identification
K8344

1.	Federal Awarding Agency	Dept. of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA)
2.	Federal Award Identification Number (FAIN)	B09SM090369
3.	Federal Award Date	02/03/2025
4.	Assistance Listing Number and Title	93.958 Block Grants for Community Mental Health Services
5.	Is the Award for Research and Development?	☐ Yes ☒ No
6.	Contact Information for HCA's Awarding Official	Teesha Kirschbaum, Assistant Director WA State Health Care Authority Division of Behavioral Health and Recovery Teesha.kirschbaum@hca.wa.gov 360-725-5925
7.	Subrecipient name (as it appears in SAM.gov)	Greater Columbia Behavioral
8.	Subrecipient's Unique Entity Identifier (UEI)	NBCXS9LEL1N5
9.	Subaward Project Description	Behavioral Health Administrative Service Organization
10.	Primary Place of Performance	90630-5897
11.	Subaward Period of Performance	07/01/2025 – 06/30/2027
12.	Amount of Federal Funds Obligated by this Action	$800,234.00
13.	Total Amount of Federal Funds Obligated by HCA to the Subrecipient, including this Action	$1,575,468.00
14.	Indirect Cost Rate for the Federal Award (including if the de minimis rate is charged)	de minimus (15%)

This Contract is subject to 2 CFR Chapter 1, Part 170 Reporting Sub-Award and Executive Compensation Information. The authorized representative for the Subrecipient identified above must answer the questions below. If you have questions or need assistance, please contact subrecipientmonitoring@hca.wa.gov.

1. Did the Subrecipient receive (1) 80% or more of its annual gross revenue from federal contracts, subcontracts, grants, loans, subgrants, and/or cooperative agreements; **and** (2) $25,000,000 or more in annual gross revenues from federal contracts, subcontracts, grants, loans, subgrants, and/or cooperative agreements?

   ☐ YES ☐ NO

2. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   ☐ YES ☐ NO

Exhibit G-1
Attachment B-1
Federal Subaward Identification
K8344

1.	Federal Awarding Agency	Dept. of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA)
2.	Federal Award Identification Number (FAIN)	B08TI088142-01
3.	Federal Award Date	02/24/2025
4.	Assistance Listing Number and Title	93.959 Block Grants for Prevention and Treatment of Substance Abuse
5.	Is the Award for Research and Development?	☐ Yes ☒ No
6.	Contact Information for HCA's Awarding Official	Teesha Kirschbaum, Assistant Director WA State Health Care Authority Division of Behavioral Health and Recovery Teesha.kirschbaum@hca.wa.gov 360-725-5925
7.	Subrecipient name (as it appears in SAM.gov)	Greater Columbia Behavioral
8.	Subrecipient's Unique Entity Identifier (UEI)	NBCXS9LEL1N5
9.	Subaward Project Description	Behavioral Health Administrative Service Organization
10.	Primary Place of Performance	90630-5897
11.	Subaward Period of Performance	07/01/2025 – 06/30/2027
12.	Amount of Federal Funds Obligated by this Action	$1,531,901.00
13.	Total Amount of Federal Funds Obligated by HCA to the Subrecipient, including this Action	$3,063,802.00
14.	Indirect Cost Rate for the Federal Award (including if the de minimis rate is charged)	de minimus (15%)

This Contract is subject to 2 CFR Chapter 1, Part 170 Reporting Sub-Award and Executive Compensation Information. The authorized representative for the Subrecipient identified above must answer the questions below. If you have questions or need assistance, please contact subrecipientmonitoring@hca.wa.gov.

1. Did the Subrecipient receive (1) 80% or more of its annual gross revenue from federal contracts, subcontracts, grants, loans, subgrants, and/or cooperative agreements; **and** (2) $25,000,000 or more in annual gross revenues from federal contracts, subcontracts, grants, loans, subgrants, and/or cooperative agreements?

   ☐ YES ☐ NO

2. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   ☐ YES ☐ NO