Proposal for a Section 1915(b) Capitated Waiver Program
Waiver Renewal

Requested effective date October 1, 2010

Washington State Integrated Community Mental Health Program
October 1, 2010 through September 30, 2012

Submitted by:
Washington State
Department of Social and Health Services
Health and Recovery Services Administration
Douglas Porter, Assistant Secretary

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Center for Medicaid and
State Operations

Table of Contents

Appendices (TO BE SUBMITTED ALONG WITH COST EFFECTIVENESS INFORMATION)

PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM
Waiver Renewal Submittal
Section A. GENERAL INFORMATION

The **State of Washington** requests a waiver under the authority of Section 1915(b)(1) of the Act. The waiver program will be operated directly by the Medicaid agency.

Effective Dates: This waiver renewal is requested for a period of 2 years; effective October 1, 2010 and ending September 30, 2012.

The waiver program is called Integrated Community Mental Health Program.

State Contact: The State contact person for this waiver is Cynthia LaBrec, who can be reached by telephone at (360) 725-2029 or e-mail at Cynthia.LaBrec@dshs.wa.gov.

I. Statutory Authority

a. **Section 1915(b)(1):** The State's waiver program is authorized under Section 1915(b)(1) of the Act, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.

b. **Other Statutory Authority:** The State is also relying upon authority provided in the following section(s) of the Act:

1. ___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.IV.b Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2. _X__ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

   Please list in Section A.IV .d.1 and Appendix D.III additional services to be provided under the waiver, which are not covered under the State plan. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval.

   New Section: In response to direction from CMS, the State has developed the "Action

Plan for Implementation of Consistent b(3) Services in Section 1915(b) Capitated Waiver Program" to describe how the State will ensure that all 1915(b)(3) services provided to PIHP enrollees are provided consistently throughout the State. The "Action Plan for Implementation of Consistent b(3) Services in Section 1915(b) Capitated Waiver Program" is attached to this document as Attachment A.IV.d.2.

3. **_X_ 1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

c. Sections Waived. Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

1. **___ Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

2. **_X_ Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3. **_X_ Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO, PIHP or PAHP.

4. **_X_ Section 1902(a)(4)** – To permit the State to mandate beneficiaries into a single PIHP or PAHP.

5. **_X_ Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their CMS Regional Office to identify required submission items from this format.

Section 438.52 *Non-competitive Procurement - The Health and Recovery Services Administration (HRSA) continues to rely on its agreement with the Centers for Medicare and Medicaid Services that the Regional Support Networks (RSN) have the first opportunity to contract to operate the PIHP for outpatient mental health services and community mental health inpatient services.*

Pursuant to the State's Community Mental Health Services Act (RCW 71.24. which defines RSN as "a county authority or group of county authorities or other entity recognized by the secretary in contract

in a defined region"), county-based Regional Support Networks (RSNs) administer all community mental health services funded by the state. Under the State's Involuntary Treatment Statutes (RCW 71.05 and RCW 71.34), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Additionally, under other state statutes, the counties play a key role in chemical dependency treatment as well as services for people with developmental disabilities. All RSNs must meet the certification requirements of RCW 71.24 and the requirements of RCW 48.44 (the insurance code), as applicable.

If an RSN chooses not to participate, or is unable to meet required qualifications, HRSA will secure an alternate contractor. This would be done as covered in the contingency plan submitted to CMS to avoid disruption of care for consumers.

Section 438.52 *Choice – All individuals eligible for Medicaid are mandatorily enrolled in a single PIHP covering a specific catchment area. The state requests authority to waive 438.52.*

II. Background

[Required] Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any program changes either planned or anticipated during the requested renewal period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.

Brief Summary

The former Mental Health Division (MHD) began delivering mental health services under a 1915(b) waiver in 1993, for outpatient mental health services and in 1997 for integrated community mental health. The first opportunity to demonstrate qualification and enter into capitated managed mental health care contracts was provided to county-based Regional Support Networks (RSNs). This opportunity was granted based on the RSN's agreement to enter into a full-risk capitation contract at an actuarially sound rate. RSNs were also required to demonstrate capacity to meet program and fiscal requirements.

The State's Community Mental Health Services Act, RCW 71.24.030. (20) – Defines Regional Support Network as "a county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region."

RSNs administer funding appropriated by the Washington state legislature for both inpatient and outpatient mental health services. As Prepaid Inpatient Health Plans, the RSNs contract for direct services, provide utilization management and other administrative functions, and develop quality

improvement and enrollee protections for all Medicaid clients enrolled in the RSN system. In Washington, 12 Regional Support Networks are comprised of county entities, the 13th – the Pierce County RSN – is operated by OptumHealth, a for profit behavioral health entity.

The capitated managed mental health system gives the RSN the ability to design an integrated system of mental health care and, as necessary, subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing quality service delivery which is age and culturally competent. This ability established the ability to control the rate of financial growth and improved mental health service outcomes; however, does not relieve the RSNs of ultimate responsibility for compliance with state and federal requirements. RSNs may impose additional requirements on subcontractors as needed to affect appropriate management oversight and flexibility in addressing local needs.

The Regional Support Networks also work cooperatively with Healthy Options managed care organizations to ensure coordinated care for enrollees. Healthy Options is Washington's managed care program that serves TANF enrollees – There are currently six managed care organizations (MCO) under contract to cover a full array of medical services as well as a limited mental health benefit.

The state requires RSNs and Healthy Options MCOs to work cooperatively to manage enrollees receiving services from both systems in the most efficient and effective way possible. The RSNs and MCOs also coordinate to transition enrollees who have received the maximum mental health services under the benefit administered by the MCOs and are moving to the mental health system to receive their mental health care.

In mid-2009, the Mental Health Division was merged with the Division of Alcohol and Substance Abuse to form the Division of Behavioral Health and Recovery Services (DBHR). All program and policy functions are conducted by DBHR. Administrative functions, including the waiver development, RSN contracting and External Quality Review and monitoring were incorporated into the Division of Healthcare Services. Both divisions reside in the Health and Recovery Services Administration (HRSA) of the Department of Social and Health Services.

The purpose of this waiver renewal is to continue to:

1) *Promote age, culturally, and linguistically competent coordination of comprehensive mental health services with regionally managed care through Prepaid Inpatient Health Plans (PIHP);*
2) *Provide community mental health rehabilitation services and community psychiatric inpatient care in a seamless manner, providing continuity and integrated care for persons served by the public mental health system; and*
3) *Support recovery and reintegration to the community for persons with mental illness.*

***Mission Statement**: The mission of Washington State's mental health system is to ensure that people of all ages experiencing mental illness can better manage their illness, achieve their personal goals, and live, work and participate in their community.*

The mission of the Health and Recovery Services Administration is to administer a public mental health system that

promotes recovery and resiliency as well as personal and public safety.

We are committed to taking action consistent with these values:

1. *We value the strengths and assets of consumers and their families, and seek to include their participation in decision-making and policy setting.*
2. *We respect and celebrate the cultural and other diverse qualities of each consumer.*
3. *We work in partnership with allied community providers to deliver quality, individualized supports and services.*
4. *We treat people with respect, equality, courtesy and fairness.*

Significant Legislation

The 2008 and 2009 legislatures passed several major bills related to the mental health system. While it is premature to predict the full impact on the mental health system, the bills promote increased public safety, accountability, coordination of care and a culture of recovery.

2008

SHB 2654 *calls for strategies for the development and funding of consumer and family-run services, including possible changes to the state plan and federal waiver via a report to the Legislature by January 2009.*

SB 2674 *will modify credentialing standards for counselors and creates eight new categories for full-credentialed and pre-credentialed health professionals.*

SB 6404 *establishes a process by which the Department can replace a managing entity that voluntarily chooses to no longer continue as the RSN operator and allows for additional entities to serve as an RSN.*

2009

HB 1300 *will provide for access to mental health treatment history information to: (1) law enforcement, (2) public health officials, (3) the Indeterminate Sentencing Review Board, and (4) jail personnel; specifies what information may be released and the purposes for which it may be released.*

HB 1349 *will provide additional grounds to renew court orders for less restrictive treatment.*

HB1373 *will strengthen equitable access to appropriate and effective children's mental health services by including specific mental health professionals who are state regulated to provide mental health services to children, youth and families if properly supervised and reinforces federal early periodic screening, diagnosis and treatment requirements related to the receipt of medically necessary services identified through developmental screening.*

HB 1498 *will expand provisions governing firearms possession by persons who have been involuntarily*

committed.

HB 1589 *will require that that the court venue relating to petitions for modification or revocation of conditional release shall be in the county in which the petition is filed.*

HB 2025 *will broaden the instances where by mental health treatment records can be shared without a patient's consent.*

SB 5433 *will allow counties that pass sales and use tax for chemical dependency or mental health treatment services as established in 2005 via SB 5763 to partially and temporarily use those funds to supplant existing funding heretofore prohibited.*

Stakeholder involvement includes:

- ***The Office of Consumer Partnerships*** *(OCP), meets quarterly with consumers, families and advocates. Frequent and consistent communication assures an accurate understanding of the points of view of consumers and other family members, which is then incorporated into the workings of the public mental health system. The OCP Director continues to meet with consumer groups to develop yearly work plans. HRSA contracts with family advocacy groups statewide for education and advocacy purposes. These groups are also very visible during the state's legislative session.*

- *The SHB2654 Work Group, composed of consumers and advocates from an across the state, met, with support from TriWest Group, to develop a report that more fully includes consumer and peer organizations as treatment options for mental health consumers. The group also recommended that language recognizing properly credentialed Certified Consumer and Family Run Organizations as eligible providers of Peer Support and select (b)(3) services be incorporated into the waiver, which will be accomplished in the next waiver amendment to allow time for development and dissemination of proposed language.*

- *HRSA supports family and youth voice. The Division of Behavioral Health and Recovery (DBHR) partners with the Mental Health Transformation Grant in supporting a "Family Liaison" who is active across the state in:*
    - *Providing trainings, such as "Parent-Professional Partnerships", trainings on Tribal issues and other community trainings in wraparound services,*
    - *Responding to parents who need help navigating the public mental health system and*
    - *Cataloging services and resources available to parents and children.*

- *This federal fiscal year, HRSA is supporting a number of parent organizations across the state as they expand their reach to parents and work to incorporate youth voice in the development of special projects and activities. "**Washington Dads**" is one such fledgling organization whose model has received national exposure, and recently obtained its 501c3 status.*

- *HRSA provides funding for and helps to organize an annual "**Connector Conference**," for which parent*

partners have leadership roles in training and supporting parents who are "new" to the public mental health system. "Connector Grants" are awarded for parent-run events and projects. These broad informal networks of parents are available to each other throughout the year.

- ***Youth 'n Action** is a nationally recognized model for youth empowerment developed in WA that has brought youth leadership squarely into planning for child, youth and family mental health, particularly in regards to youth in transition. In the coming year, Youth'n Action will be supported by HRSA in three pilot sites and will be participating in a statewide strategic planning process for youth voice.*

- *Consumers and family members comprise 51% of the state Mental Health Planning and Advisory Council (MHPAC). This council includes representatives who are advocates for children, adults and older adults with mental illness, RSNs, service providers and representatives of allied systems. The council meets at least eight (8) times a year and actively participates in HRSA planning and evaluation activities.*

- *HRSA, in partnership with the DSHS office of Indian Policy Service and Supports (IPSS), has reinstituted the Tribal Mental Health Workgroup. The purpose of this workgroup is to improve collaboration between HRSA and the Tribes, address policy issues and concerns and to improve tribal mental health services.*

- *Staff of the newly formed Division of Behavioral Health and Recovery staff the co-occurring disorders interagency committee (CODIAC) made up of representatives from state agencies, mental health and chemical dependency providers, and consumers from both systems. This group addresses co-occurring mental illness and substance related disorders, system and treatment issues.*

- *HRSA meets with the Washington Community Mental Health Council (WCMHC) monthly. This provider organization represents 85% of the community mental health agencies providing services under subcontract with the RSNs. Directors from DBHR and the Division of Healthcare Services attend regularly, as well as the Secretary of DSHS, members of the Mental Health Transformation Grant and legislative staff as requested. HRSA also receives input from the community mental health agencies that do not belong to the WCMHC but subcontract with the RSNs.*

III. General Description of the Waiver Program

a. **Type of Delivery Systems:** The State will be entering into the following types of contracts with an MCO, PIHP, or PAHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g. a PIHP program for a mental health carve out is "other risk," but just checking the relevant items under "2" will not convey that information fully).

1. ___ **Risk-Comprehensive (fully-capitated—MCOs or HIOs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or

more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

(a)__ The contractor is at-risk for inpatient hospital services and any one of the following services:

i.___ Outpatient hospital services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services, and
ix.___ Home Health services.

(b)__ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a).

2. **_X_ Partial Risk (PIHP/PAHP):** Other risk contracts are those that have a scope of risk that is less than comprehensive. The contractors in these programs are either PIHPs or PAHPs (e.g., a PIHP for mental health/substance abuse). References in this preprint to PIHPs/PAHPs generally apply to these other risk entities. For PIHPs, please check either (a) or (b); if (b) is chosen, please check the services that apply. For PAHPs, please check (b), and indicate the services that apply.

(a)__ The contractor is a PIHP at-risk for all inpatient hospital services,
or

(b)__ The contractor is a PIHP or PAHP at-risk for two or fewer of the below services ((i) through (x)).

i._**X**_ Outpatient hospital services,
PIHPs are responsible for community mental health rehabilitation services.
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services
ix.___ Home Health services.
x._**X**_ Other: ___ dental

___ transportation
__X__ a subset of inpatient hospital services (e.g. only mental health admissions). *PIHPs are responsible for community mental health inpatient admissions.*

3. ___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., a PIHP contract where the State performs a cost-settlement process at the end of the year). Please provide a brief narrative description of non-risk model, which will be implemented by the State.

4. ___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

b. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to CMS):

1. _X_ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

2. ____Other (please list in the table below):

Regardless of whether item 1 or 2 is checked above, in the chart below please list the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PIHP, PAHP, HIO, or other entity) with which the State will contract:

City/County/Region	Name of Entity*	Type of Entity (MCO, PIHP, PAHP, HIO, or other entity)
Chelan, Douglas	Chelan/ Douglas Regional Support Network	PIHP
Clark	Clark County Regional Support Network	PIHP
Grays Harbor	Grays Harbor Regional Support Network	PIHP
Asotin, Garfield, Klickitat, Kittitas, Yakima, Benton, Franklin, Skamania, Walla Walla, Columbia, Whitman	Greater Columbia Behavioral Health Regional Support Network	PIHP
King	King County Regional Support Network	PIHP
Adams, Grant, Okanogan Stevens, Lincoln, Pend Orielle, Ferry	North Central Regional Support Network	PIHP
Skagit, San Juan, Island, Snohomish, Whatcom	North Sound Regional Support Network	PIHP
Clallam, Jefferson, Kitsap	Peninsula Regional Support Network	PIHP
Cowlitz	Southwest Regional Support Network	PIHP

City/County/Region	Name of Entity*	Type of Entity (MCO, PIHP, PAHP, HIO, or other entity)
Pierce	OptumHealth	PIHP
Spokane	Spokane Regional Support Network	PIHP
Thurston, Mason	Thurston Mason Regional Support Network	PIHP
Lewis, Pacific, Wahkiakum	Timberlands Regional Support Network	PIHP

*The State should list the actual names of the contracting entities. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

- **Requirement for Choice:** Section 1932(a)(3) of the Act and 42 CFR 438.52 require the State to permit individuals to choose from not less than two managed care entities.

  1. ___ This model has a choice of managed care entities.
     (a)__ At least one MCO and PCCM (please use the combined PCCM Capitated Waiver Renewal Preprint)
     (b)__ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM Waiver Renewal preprint)
     (c)__ Two or more MCOs
     (d)__ At least one PIHP or PAHP and a combination of the above entities

  2. ___ This model is an HIO.

  3. ___ The State is opting to use the exception for rural area residents in Section 1932(a)(3) and 42 CFR 438.52(b). Please list the areas of the State in which the rural exception applies:

  4. **X** The State is requesting a waiver of 1902(a)(4) to permit the State to mandate beneficiaries into a single PIHP/PAHP.

     The State mandates enrollment into a single PIHP for each geographic area.

c. Waiver Population Included: The waiver program includes the following targeted groups of beneficiaries. Check all items that apply:

1. **X** Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2. **X** Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC) .

3. **X** Blind/Disabled Children and Related Populations (SSI)

4. **X** Blind/Disabled Adults and Related Populations (SSI)

5. **X** Aged and Related Populations (Please specify: SSI, QMB Plus, SLMB Plus, and all state

buy in.)

6. **X** Foster Care Children

7. **X** Title XXI SCHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8.___ Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.

9. **X** Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)

i. ___ Children with special needs due to physical and/ or mental illnesses,
ii. ___ Older adults,
iii. ___Foster care children,
iv. ___Homeless individuals,
v. **X** Individuals with serious and persistent mental illness and/or substance abuse.
vi. ___Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii. __ Other (please list):

Please see Attachment A.III.d. - Access to Care Standards Eligibility Requirements for Authorization of services for Medicaid eligibles. Access to Care Standards became effective August 1, 2003.

The PIHPs are expected to meet the mental health needs of the consumers they serve. They are encouraged to provide innovative and flexible supports. Services are provided by a community mental health agency that is licensed and/or certified by the state. All services are to be provided by or under the supervision of a mental health professional.

According to 42 CFR 438 Section 2, Definitions, "Health care professional means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician."

The above definition is specific to physical health providers – this waiver describes a managed care system for mental health services, thus the definition of health care professional has been modified in past waiver applications to include the definition mental health professional.

In addition to the definition specified in 42 CFR 438.2, HRSA requests the definition be expanded to include Mental Health Professional and mental health specialists as described in Washington Administrative Code (WAC) 388-85-0150, or its successor under this waiver. This will allow the public

mental health system to continue to have qualified staff perform authorization to mental health service, second opinion, grievance and appeal functions appropriate to their scope of practice and experience, and allow the effective use of mental health professionals.

Attachment A.III.d.

Access to Care Standards – 1/1/06

Eligibility Requirements for Authorization of Services for Medicaid Adults & Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult & Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

*** = *Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).

Access to Care Standards – 1/1/06

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*** = *Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Functional Impairment **<u>Must be the result of a mental illness.</u>**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate serious functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)

Access to Care Standards – 1/1/06

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* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

*** = *Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Supports & Environment*	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One</u>, individuals may be referred for the following treatment: * Individual Treatment * Medication Monitoring * Peer Support The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

*** =** ***Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to twelve months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of an emotional disorder or a mental illness.**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 60 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 50 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need

Access to Care Standards – 1/1/06

Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

*** = *Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)
Supports & Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.

Access to Care Standards – 1/1/06

Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

*** =** ***Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Minimum Modality Set	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:** * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment * Family Supports The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	**Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One,</u> individuals may be referred for the following treatment:** * Individual Treatment * Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults & Medicaid Older Adults
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for eligibility.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
	DEMENTIA	
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance	B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance	B
290.40	Vascular Dementia Uncomplicated	B
290.41	Vascular Dementia With Delirium	B
290.42	Vascular Dementia With Delusions	B
290.43	Vascular Dementia With Depressed Mood	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	B
294.10	Dementia Due to... (*Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance	B
294.11	Dementia Due to... (*Indicate the General Medical Condition not listed above)* With Behavioral Disturbance	B
---.--	Substance-Induced Persisting Dementia (*refer to Substance-related Disorders for substance specific codes)*	B
---.--	Dementia Due to Multiple Etiologies	B
294.8	Dementia NOS	B
	OTHER COGNITIVE DISORDERS	
294.9	Cognitive Disorder NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS **DEPRESSIVE DISORDERS**	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment).

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children & Youth
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely

emotionally disturbed child in RCW 71.24 and RCW 71.05. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for coverage.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B
307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A

	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A

296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A

300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be

substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]

* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness
* At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
* Child is under six years of age and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:
    1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers).
    2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

End of Attachment A.III.d.

d. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1. **_X_** Have Medicare coverage, except for purposes of Medicaid-only services (pure QMB, pure SLMB, expanded SLMB, qualified disables and working individuals[QDWI]);

2. ___ Have medical insurance other than Medicaid;

3. ___ are residing in a nursing facility;

4. **_X_** are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5. ___ are enrolled in another Medicaid managed care program;

6. ___ have an eligibility period that is less than 3 months;

7. **_X_** are in a poverty level eligibility category for pregnant women.

Women who are eligible for family planning services only have a S program code matched with either a P or a Z.

8. ___ are American Indian or Alaskan Native;

9. ___ participate in a home and community-based waiver;

10. __ receive services through the State's Title XXI CHIP program;

11.__ have an eligibility period that is only retroactive;

12. _X_ are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in l. above are listed here (Please explain further in Section F. Special Populations if necessary);

i. ___ Children with special needs due to physical and/ or mental illnesses,
ii. ___ Older adults,
iii. ___ Foster care children,
iv. **_X_** Homeless individuals *for whom no Medicaid reimbursement is received*,
v. ___ Individuals with serious and persistent mental illness and/or substance abuse,
vi. ___Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii. **_X_** Other (please list): *The following client groups are excluded from the capitation system and their mental health services are paid through other means:*

- *Residents of state psychiatric hospitals;*
- *Children in the Children's Long Term Inpatient Program;*
- *Persons enrolled in the Program for All Inclusive Care for the Elderly (PACE) program; and*
- *Persons enrolled in the Washington Medicaid Integration Partnership (WMIP) – WMIP enrollees may "opt out" of the program and continue to receive mental health services from the Regional Support Network.*

13. __ have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:

e. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

f. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is**

to be submitted to CMS at least 3 months prior to the end of the waiver period. [Please refer to SMM 2111 and CMS's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1. ___ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to CMS as required.

2. _X_ Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State that an Independent Assessment is needed in the waiver approval letter.

IV. Program Impact

In the following informational sections, please complete the required information to describe your program.

a. **Marketing** including indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general) and direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). *Information to potential enrollees and enrollees (i.e., member handbooks), is addressed in Section H.*

Previous Waiver Period

1. ___ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements, as well as results of the monitoring. [Reference: items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint, or items A.III.a Upcoming Waiver Period of 1999 Waiver Renewal preprint].

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period.

1. _X_ The State does not permit direct or indirect MCO//PIHP/PAHP marketing (go to item "b. Enrollment/Disenrollment")
2. ___ The State permits indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general). Please list types of indirect marketing permitted.
3. ___ The State permits direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4.___ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

5.___ The State permits MCOs/PIHP/PAHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6.___ The State requires MCO/PIHP/PAHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

The State has chosen these languages because (check those that apply):

i. __ The languages comprise all prevalent languages in the MCO/PIHP/PAHP service area.

ii.__ The languages comprise all languages in the MCO/PIHP/PAHP service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

7.___ The State requires MCO/PIHP/PAHP marketing materials to be translated into alternative formats for those with visual impairments.

8. **Required Marketing Elements**: Listed below is a description of requirements that the State must meet under the waiver program (items a through g). If an item is not checked, please explain why.

Marketing requirements do not apply for the following reasons:

- *The state provides an enrollment handbook to all eligible Medicaid clients.*
- *Enrollment in this waiver program is mandatory and automatic for Medicaid eligibles. There is no disenrollment.*
- *RSNs must serve all enrollees who meet medical necessity including Access to Care Standards*
- *There is a single PIHP for each geographical area.*

The State:

(a)__ Ensures that all marketing materials are prior approved by the State

(b)__ Ensures that marketing materials do not contain false or misleading information

(c)__ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of marketing materials

(d)__ Ensures that the MCO/PIHP/PAHP distributes marketing materials to its entire service area

(e)__ Ensures that the MCO/PIHP/PAHP does not offer the sale of any other type of insurance product as an enticement to enrollment.

(f)___ Ensures that the MCO/PIHP/PAHP does not conduct directly or indirectly, door-

to-door, telephonic, or other forms of "cold-call" marketing.

(g)__ Ensures that the MCO/PIHP/PAHP does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

b. Enrollment/Disenrollment:

Previous Waiver Period

1. [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements. Please include the results from those monitoring efforts for the previous waiver period. (Reference items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint; items A.III.b Upcoming Waiver Period of 9/23/99 Waiver Renewal).

Disenrollment has been waived for the community mental health program beginning in August 2003. The state has mandatory enrollment and does not operate an alternate fee-for-service system. All areas of the state are covered by the Waivered mental health managed care program.

Upcoming Waiver Period - Please describe the State's enrollment process for MCOs/PIHPs/PAHPs by checking the applicable items below.

1. ___ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

2.___ **Administration of Enrollment Process**:

(a)__ State staffs conduct the enrollment process.

(b)__ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request the authority in 1915(b)(2) in Section A.I.b.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: _____

ii. Procurement method:

(A). ____Competitive

(B). ____Sole source

iii. Please list the functions that the contractor will perform:

(c)__ State allows MCOs/PIHPs/PAHPs to enroll beneficiaries. Please describe the

process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)__**X**__ Mandatory for populations in Section A.III.c.

(b)__ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(c)___ Other (please describe):

4**. Enrollment:**

(a)__ The State will make counseling regarding their MCO/PIHP/PAHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

(b)__ Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PIHPs/PAHPs and providers based on their medical needs. Please describe.

(c)__ Enrollees will notify the State/enrollment broker of their choice of plan by:
i. ___ mail
ii.___ phone
iii.___ in person at ____
iv.___ other (please describe):

(d) **NA - mandatory enrollment** [Required] There will be an open enrollment period during which the MCO/PIHP/PAHP will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).

(e)__ Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.

(f)___ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g)__ If a potential enrollee does not select a plan within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have____days/month(s) to choose a plan.
ii. Please describe the auto-assignment process and/or algorithm. What

factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PIHP/PAHP that includes their current provider or to an MCO/PIHP/PAHP that is capable of serving their particular needs?

(h)__ The State provides guaranteed eligibility of ____ months for all MCO enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i)__ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

5. **Disenrollment:**

(a)__ The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs.
i. ___ Enrollee submits request to State
ii. ___ Enrollee submits request to MCO/PIHP/PAHP. The plan may approve the request, or refer it to the State plan may not disapprove the request).
iii. ___ Enrollee must seek redress through MCO/PIHP/PAHP grievance procedure before determination will be made on disenrollment request
iv. ___ [Required] Regardless of whether plan or State makes determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

(b)**_X_** The State does not allow enrollees to disenroll from the only available PIHP/PAHP.

(c)__ The State monitors and tracks disenrollments and transfers between MCOs/PIHPs/PAHPs. Please describe the tracking and analysis:

(d)__ The State has a lock-in period of ____ months (up to 12 months permitted). If so, the following are required:
i.___ MCO/PIHP/PAHP enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO/PIHP/PAHP.
ii.___ MCO/PIHP/PAHP enrollees must be notified of their ability to disenroll or change MCOs/PIHPs/PAHPs at the end of their enrollment period at least 60 days before the end of that period.
iii.___ MCO/PIHP/PAHP enrollees who have the following good cause reasons for disenrollment are allowed to disenroll during the lock-in period:
A. __ [Required] Enrollee moves out of plan area

B. __ [Required] Plan does not, because of moral or religious objections, cover the service the enrollee seeks
C. __ [Required] Enrollee needs related services; not all services available in network, and enrollee's provider determines that receiving services separately would subject enrollee to unnecessary risk
D. __ [Required] Poor quality of care
E. __ [Required] Lack of access to covered services
F. __ [Required] Lack of access to providers experienced in dealing with enrollee's health care needs
G. ___ Other: (please list)

iv. __ [Required] Ensure access to State fair hearing process for any enrollee dissatisfied with determination that there is not good cause for disenrollment.

(e)__ The State does not have a lock-in, and enrollees in MCOs/PIHPs/PAHPs are allowed to terminate or change their enrollment without cause at any time.

(f) __ [Optional] A beneficiary who is disenrolled from an MCO/PIHP/PAHP solely due to loss of eligibility for two months or less may be automatically re-enrolled with the same MCO/PIHP/PAHP.

6. **MCO/PIHP/PAHP Disenrollment of Enrollees**: If the State permits MCOs/PIHPs/PAHPs to request disenrollment of enrollees, please check items below that apply:

(a)__ [Required] The MCO/PIHP/PAHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status, utilization of medical services, diminished mental capacity, and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee. Please describe the reasons for which the MCO/PIHP/PAHP can request reassignment of an enrollee:

(b)__ The State reviews and approves all MCO/PIHP/PAHP-initiated requests for enrollee transfers or disenrollments.

(c)__ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP to remove the enrollee from its membership.

(d)__ The enrollee remains a member of the MCO/PIHP/PAHP until another MCO/PIHP/PAHP is chosen or assigned.

c. Entity Type Or Specific Waiver Requirements

Upcoming Waiver Period -- Please describe the entity type or specific waiver requirements for

the upcoming two-year period.

1. **X** **Required MCO/PIHP/PAHP Elements:** MCOs/PIHPs/PAHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR Parts 434 and 438 et seq. *Unless waived*

2. **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting authority under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

3.

(a) X The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i. X Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan.

Note: The state's current mental health system is administered via a managed care program; the standards for access and quality of services meet the same degree of rigor that is contained in the State's Medicaid State Plan.

ii. **X** MCO/PIHP/PAHP must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver.

iii. **X** MCO/PIHP/PAHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv.___ Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

v. **X** There are no restrictions that discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing services.

3. The State has selected/will select the MCOs/PIHPs/PAHPs that will operate under the waiver in the following manner:

(a) The State has used/will use a competitive procurement process. Please describe.

(b)__ The State has used/will use an open cooperative procurement process in which any qualifying MCO/PIHP/PAHP may participate that complies with federal

procurement requirements and 45 CFR Section 74.

(c) **X** The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

4. **X** Per Section 1932(d) of the Act and 42 CFR 438.58, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO/PIHP/PAHP contracts and the default enrollment process established for MCOs/PIHPs/PAHPs.

d. Services
Previous Waiver Period

1. **X** [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. Please include the results from those monitoring efforts for the previous waiver period. [Reference: items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint, items A.III.d. Upcoming Waiver Period of 9/23/99 Waiver Renewal Preprint]

HRSA monitors services in a variety of ways:

- *Annual on-site monitoring activities conducted by our External Quality Review Organization, Accumentra Health;*
- *Annual site reviews by HRSA contract monitoring staff – these visits alternate between contract monitoring and certification updates on a yearly basis;*
- *Submission of contractually required reporting to Contract Monitoring staff by the PIHPs, including expenditure reports, encounter data, grievances and appeals;*
- *Meetings with stakeholders as described;*
- *Client satisfaction surveys.*

The 2009 EQRO report was submitted to CMS Region X in December, 2009 The report can be accessed at: http://www1.dshs.wa.gov/Mentalhealth/publications.shtml .

HRSA regularly conducts child and adult satisfaction surveys as well as provider surveys to assess the use of evidence based services. Results of current and past consumer and provider surveys may be found at http://depts.washington.edu/washinst/Reports/Reports.html.

In addition, HRSA regularly participates in performance management activities within a variety of levels of government within Washington State. This includes reporting and

analytics of mental health performance data through the following forums:

- *Quarterly reporting for the Governor's Management, Accountability and Performance Office;*
- *Quarterly reporting to the Office of Financial Management's Performance Tracking System;*
- *Monthly reporting for the Department of Social and Health Services Executive Management Information System;*
- *Participation in a variety of studies through the DSHS Research and Data Analysis Division to analyze clients who use services from multiple DSHS programs.*

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period.

1. _X__ Please list in Appendix D.2.S the Medicaid services MCOs/PIHPs/PAHPs will be responsible for delivering, prescribing, or referring. Instructions for this Appendix can be found in Section D. Cost Effectiveness, III. Instructions for Appendices.

Section A.IV .d.1 - (b)(3) Services

Supported employment is a service for Medicaid enrollees who are not currently receiving federally funded vocational services such as those provided through the Department of Vocational Rehabilitation. Services include:

- *An assessment of work history, skills, training, education, and personal career goals.*
- *Information about how employment will affect income and benefits the consumer is receiving because of their disability.*
- *Preparation skills such as resume development and interview skills.*
- *Involvement with consumers served in creating and revising individualized job and career development plans that include:*
  - *(a) Consumer strengths*
  - *(b) Consumer abilities*
  - *(c) Consumer preferences*
  - *(d) Consumer's desired outcomes*
- *Assistance in locating employment opportunities consistent with the consumer's strengths, abilities, preferences, and desired outcomes.*
- *Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.*
- *Services are provided by or under the supervision of a mental health professional.*
- *Other supportive employment services that cannot legally be provided by a vocational rehabilitation program, such as extended services defined under the federal Rehabilitation Act.*

Respite Care is a service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than

the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional. Respite under this waiver is only available to those consumers who do not have this coverage under some other federal program.

Mental Health Clubhouse: A service specifically contracted by the PIHP to provide a consumer directed program to Medicaid enrollees. These services provided at a clubhouse may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must be certified by HRSA. The Mental Health Clubhouse must operate at least ten hours a week outside normal business hours Monday through Friday, or anytime on Saturday or Sunday based on the needs of clubhouse members. An exception to the distance standards is granted for clubhouse services.

Clubhouse Services include the following:

- *Opportunities to work within the clubhouse, which contributes to the operation and enhancement of the clubhouse community.*
- *Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness.*
- *Assistance with employment opportunities, housing, transportation, education and benefits planning.*
- *Opportunities for socialization activities.*

2. **Emergency Services (Required)**. The State must ensure enrollees in MCOs/PIHPs/PAHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

   (a)__ The State has a more stringent definition of emergency medical condition for MCOs/PIHPs/PAHPs than the definition above. Please describe.

   The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

   (b)__ The State ensures enrollee access to emergency services by requiring the MCO/PIHP/PAHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

(c)__ The State ensures enrollee access to emergency services by including in the contract with MCOs/PIHPs/PAHPs a requirement to cover and pay for the following: *Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PIHPs/PAHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.*

i.___ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

ii.___ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii.___ Subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

iv.___ Continued emergency services until the enrollee can be safely discharged or transferred,

v.___ Post-stabilization services which are pre-authorized by the MCO/PIHP/PAHP, or were not pre-authorized, but the MCO/PIHP/PAHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PIHP/PAHP contacts the emergency room and takes responsibility for the enrollee.

(d) The State also assures the following additional requirements are met:

i.__ The MCO/PIHP/PAHP may not limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms;

ii. __ The MCO/PIHP/PAHP may not refuse to cover emergency services based on the provider not notifying the enrollee's PCP or plan of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services;

iii. __ The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO/PIHP/PAHP.

(e) _X_ The MCO/PIHP/PAHP does not cover emergency services.

3. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO/PIHP/PAHP staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program.

(a)__ Enrollees are informed that family planning services will not be restricted under the waiver.

(b)__ Non-network family planning services are reimbursed in the following manner:

i.___ The MCO/PIHP/PAHP will be required to reimburse non-network family planning services

ii.___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers

iii.___The State will pay for all family planning services, provided by both network as well as non-network providers

iv.___ The State pays for non-network services and capitated rates were set accordingly.

v.___ Other (please explain):

(c) _X_ Family planning services are not included under the waiver.

4. **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PIHPs/PAHPs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following services:

(a) ___ [Required for rural exception to choice]
- The service or type of provider is not available in the plan;
- for up to 60 days if provider is not part of the network but is the main source of care and is given opportunity to join network but declines;
- MCO/PIHP/PAHP or provider does not, because of moral or religious objections, provide a covered service; provider determines enrollee needs related service not available in network and receiving service separately would subject enrollee to unnecessary risk.

(b) ___ [Required if women's routine` and preventive care is a covered service] Female enrollees must have direct access to women's health specialist within the network for covered care related to women's routine and preventive care. (Please note whether self-referral is allowed only to network providers or also to non-network providers.)

(c) **_X_** Other: (please identify)

Each PIHP has an integrated crisis system, which is accessible 24 hours/7days a week with responses from individuals, rather than recorded messages. This crisis system

includes the following: crisis intervention; crisis respite; investigation and detention services; and evaluation and treatment services.

Crisis response services are provided in the following manner:

- *Toll free numbers that ensure access to crisis services, including people who may not have the funds to utilize a public pay phone. If these numbers are not toll free but accept collect charges it must be stated so in the public telephone directory. Services for non-English speaking and hearing impaired enrollees must also be in place.*
- *Enrollees have unrestricted access to the crisis response system, without establishing medical necessity for the first contact, and without reference to the enrollee's ongoing service coverage under a particular RSN.*
- *Triage with local hospitals to reduce unnecessary utilization of the Emergency Department (ED) through working agreements with local evaluation and treatment facilities. The agreements ensure that enrollees who request mental health services inappropriately from the ED are directed to the crisis response system. The agreements also establish how people served in the ED may be referred for Designated Mental Health Professional evaluation for possible involuntary treatment. While ED visits not resulting in admission are not covered by this waiver, inpatient services for enrollees admitted through the ED are covered provided the designated professional person for the consumer's county of residence has conducted a pre-admission certification and conditions of medical necessity are met.*

5. **X** **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PIHP/PAHP to track, coordinate, and monitor services to which an enrollee can self-refer:

PIHPs must report crisis services provided to the HRSA/CIS system. Crisis services are monitored by HRSA and the PIHPs on an ongoing basis. Additionally, the transition from crisis services to routine services is monitored to ensure compliance with Access to Care Standards. If a client accessing crisis response is already receiving services from the PIHP, Washington Administrative Code requires access to the client's individual service plan on a 24/7 basis.
As described above, crisis phone services must be available to Limited English Speaking clients, as well as American Indian/Alaska Natives (AI/AN).

6. **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)__ The program is **voluntary**, and the enrollee can disenroll at any time if he or she

desires access to FQHC services. The MCO/PIHP/PAHP is not required to provide FQHC services to the enrollee during the enrollment period.

(b) **X** The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PIHP/PAHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP he or she selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available.

Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP with a participating FQHC:

Currently there are FQHCs contracting for mental health services in the public mental health system and will continue participating in the waiver system if they so choose. The PIHPs are required to contract with at least one FQHC in their service area if the FQHC requests. The FQHC is accessed the same as any other CMHA in the RSN service area.

(c)__ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

(a) **X** The State requires MCOs/PIHPs/PAHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.

The PIHPs are required to submit the data as they would for any child being served according to the requirements of the data dictionary attached as Attachment C.VI.b. There is a simple data flag if the child is referred in through an EPSDT screen. Of the 63,415 children served in the outpatient mental health system from April 1, 2007 through March 31, 2009, there were 14,706 unduplicated consumers flagged as being referred to mental health services through an EPSDT screen.

(b)__ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual screening rates, including behavioral components, for previous waiver period. (Please note*: CMS requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data reported in the CMS 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.)

Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

(c) __ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?

(d)__ Immunizations are covered under this waiver, and managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

(e)_**X**_ Mechanisms are in place to coordinate school services with those provided by the MCO/PIHP/PAHP. Please describe and clarify the aspects of school services that are coordinated including IEPs, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

Regional Support Networks are required by contract to provide cross-system coordination for children, youth and the families who are receiving services through more than one DSHS services system. Coordination with other DSHS program areas is expected as part of treatment planning. The team may include key providers, the child/youth and family, schools and natural supports.

A copy of the IEP of those children/youth who have one is required as part of the clinical record for any child served in the mental health system (WAC 388-865-0425(7)(a). Participation with the child's school is expected and, as necessary or recommended, mental health services may be conducted in natural settings such as schools.

(f)_**X**_ Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided by the MCO/PIHP/PAHP. Please describe.

Children/youth who do not have a primary care provider and/or who have not had an EPSDT screen are provided information on how to obtain either or both. Any child/youth being treated in the mental health system who is in need to other healthcare services, such as a well child checkup, dental services, or substance abuse counseling are referred to the proper provider and/or the primary care provider. All CMHAs have developed working relationships with medical and other service providers in their communities.

Section B. ACCESS AND CAPACITY

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are

furnished within a reasonable distance from the residences of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

I. Timely Access Standards

Upcoming Waiver Period -- Please describe the State's availability standards for the upcoming waiver period.

a. **Availability Standards**: The State has established maximum distance and/or travel time requirements, given clients' normal means of transportation, for MCO/PIHP/PAHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6.**_X_** Mental Health (please describe your standard):

The PIHPs ensure that when enrollees must travel to service sites, they are accessible per the following standards: 1) in rural areas, service sites are within a 30-minute commute time; 2) in large rural geographic areas service sites are accessible within a 90-minute commute time; 3) in urban areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed 90 minutes each way;

Travel standards do not apply: a) for clubhouse activities; b) when the enrollee chooses to use service sites that require travel beyond the travel standards; c) to psychiatric inpatient services including Evaluation & Treatment; d) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages, delayed ferry service).

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Other providers (please describe your standard):

b. **Appointment Scheduling** (Appointment scheduling means the time before an enrollee can

acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PIHP/PAHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6.__**X**__ Mental Health (please describe your standard):

A request for services is defined as the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an enrollee or the person authorized to consent to treatment for that enrollee. Urgent and Emergent medically necessary mental health services (e.g. crisis services, stabilization services) may be accessed without intake evaluations and/or other screening and assessment processes.

The determination of eligibility for authorization to service shall be based on the Access to Care Standards. Authorization shall not take more than fourteen calendar days following initiation of an intake evaluation, unless the enrollee, CMHA, or PIHP requests an extension. An extension of up to 14 additional calendar days is possible upon request by the enrollee or the CMHA, or the PIHP justifies (to MHD upon request) a need for additional information and how the extension is in the enrollee's interest.

The PIHP must have written policy and procedure to ensure consistent application of requests within the service area. The PIHP must monitor the use and pattern of extensions and apply corrective action where necessary. Urgent and emergent medically necessary mental health services (e.g. crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes

An intake evaluation appointment must be available and offered to every enrollee within 10 working days of the request for services.

A total of 28 calendar days from request for services to first routine services appointment offered will be the normal time period expected unless a 14-day extension to the authorization process is requested as described above.

Emergent mental health services occur within 2 hours of the request for services from any source.

Urgent mental health services occur within 24 hours of the request for services from any source.

The following are the contract definitions:

Emergent Care: *service provided for a person that, if not provided, would likely result in the need for hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.*

Urgent Care*: service provided for a person approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.*

Routine Care: *service provided for a person authorized to receive services as defined in the Access to Care Standards. Routine Care is designed to alleviate symptoms, to stabilize, sustain, and facilitate progress toward mental health on a non emergent and non urgent basis.*

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Urgent care (please describe your standard):

10.___Other providers (please describe your standard):

c. In-Office Waiting Times: The State has established standards for in-office waiting times for MCO/PIHP/PAHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6.**_X_** Mental Health (please describe your standard):

For those services that do occur in the office, the wait time for a consumer should be minimal. There are times when it may be necessary and acceptable for a consumer to wait, however, a consumer should not have to wait over an hour beyond the scheduled appointment time.

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.__ Other providers (please describe your standard):

II. Access and Availability Monitoring: Enrollee access to care will be monitored by the State, as part of

each MCO/PIHP/PAHP's Quality Assessment and Performance Improvement program, annual external quality review (EQR), and (if applicable) Independent Assessments (IA).

Previous Waiver Period

a. X [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PIHP/PAHP access and availability in the previous two year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint; item B.II Upcoming Waiver Period, 9/23/99 Waiver Renewal Preprint].

The statewide EQRO report for 2009 was sent to CMS, Region X, in December 2009.

Upcoming Waiver Period -- Check below any of the following (a-o) that the State will also utilize to monitor access: *Monitoring will take place using the three mandatory EQR protocols to the extent these issues are covered in the protocols*

a. X Measurement of access to services during and after a MCO/PIHP/PAHP's regular office hours to assure 24 hour accessibility, 7 days a week *(*e.g., PCPs' 24-hour accessibility will be monitored through random calls to PCPs during regular and after office hours).

It should be noted here that PCPs are not utilized in the community mental health system – random calls to Community Mental Health Agencies take the place of random calls to PCPs.

b. X Determination of enrollee knowledge on the use of managed care programs.

This is determined through involvement with the Office of Consumer Partnerships, National Alliance for the Mentally Ill, and the Mental Health Planning and Advisory Council.

c. X Ensure that services are provided in a culturally competent manner to all enrollees, and the MCO/PIHP/PAHP participates in any State efforts to promote the delivery of services in a culturally competent manner.

d.___ Review of access to emergency or family planning services without prior authorization

e. X Review of denials of referral requests

f.___ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

g. X Periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a sample of enrollees. Corrective actions taken on deficiencies found are also planned.

Individual RSNs will be compared against their own results and not statewide. They are expected to maintain or improve their results.

h.___ Measurement of enrollee requests for disenrollment from a MCO/PIHP/PAHP due to access issues

i. X Tracking of complaints/grievances concerning access issues.

j.___ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)

k.___ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

l. During monitoring, the State will look for the following indications of access problems.

1.__ Long waiting periods to obtain services from a PCP.
2.__ Denial of referral requests when enrollees believe referrals to specialists are medically necessary.
3.__ Enrollee confusion about how to obtain services not covered under the waiver.
4.__ Lack of access to services after PCP's regular office hours.
5.___ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
6.__ Lack of access to emergency or family planning services.
7.__ Frequent recipient requests to change a specific PCP.
8.__ Other indications (please describe):

m.__ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

n. X Monitoring the provider network showing that there will be providers within the distance/travel times standards.

The PIHP shall ensure that when enrollees must travel to service sites, they are accessible per the following standards: 1) in rural areas, service sites are within a 30-minute commute time; 2) in large rural geographic areas service sites are accessible within a 90-minute commute time; 3) in urban areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed 90 minutes each way;

Travel standards do not apply: a) for clubhouse activities; b) when the enrollee chooses to use service sites that require travel beyond the travel standards; c) to psychiatric inpatient services including E & T; d) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages, delayed ferry service).

o.__ The incentives, sanctions, and enforcement related to the access and availability standards above.

p.___ Other (please explain):

III. Capacity Standards

Previous Waiver Period

a. X [Required] MCO/PIHP/PAHP Capacity Standards. The State ensured that the number of providers under the waiver remained adequate to assure access to all services covered under the contract. Please describe the results of this monitoring.

The PIHP currently contracts with licensed CMHAs for the provision of mental health services. HRSA is the licensor of CMHAs and also certifies inpatient beds for involuntary treatment. The number of CMHAs providing services has remained fairly consistent throughout the waiver since 1993. There have been some mergers or sales in the outpatient system but this has not reduced overall capacity.

Since each PIHP serves a specific geographic area, HRSA requires assurances from each PIHP that they will guarantee a sufficient number of service sites, both in and out of facility, to assure enrollees have convenient access to service locations as expressed in the availability standards. In addition, under the rehabilitation services options, most services, especially crisis services, are provided out of the facility (e.g., enrollee's residence or in other community settings that are comfortable to the enrollee).

The PIHP will continue to provide inpatient service through community psychiatric inpatient hospitals and will purchase service capacity for adults and children to ensure that services are as close to the enrollee's community as possible so long as it is clinically indicated. The contract with the PIHP stipulates that resource management of acute inpatient care shall be performed under the general oversight of a physician. A physician must review any denial of a request for voluntary inpatient authorization.

The state will allow the PIHPs to submit a regional plan for direct contracting with psychiatric hospital providers. Any contract between a PIHP and local hospital must contain the provision of collaboration for emergency admissions to non-contracted hospitals and the transfer of enrollees to contracted hospitals. The state allows exceptions to this, if the transfer would cause harm to the enrollee, or there is no psychiatric hospital unit within reasonable travel time of the residence of the immediate family member who helps with the personal needs of the enrollee. Each PIHP needs to ensure that Medicaid enrollees who have other insurance but have exhausted their benefits will receive continuity of care.

Any PIHP that develops a direct psychiatric hospital contract network will be required to develop a plan that ensures hospitals and physicians will be provided orientation to the prepaid inpatient health plan. All contracts between a PIHP and community hospital will have a grievance procedure for enrollees, which will be made available to them. If a PIHP develops a direct contract network, the state will require them to show that they have a capacity (combined in-network and out-of network providers) of at least 110% of their actual utilization for the prior year. The plan must be submitted to HRSA 90 days in advance for approval.

b. NA [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate. Please describe the results of this monitoring.
Enrollment in the community mental health system is mandatory; however, HRSA monitors adequate availability of providers on an ongoing basis.

Upcoming Waiver Period -- Please describe the capacity standards for the upcoming two year period.

a. MCO/PIHP/PAHP Capacity Standards

1.___ The State has set enrollment limits for the MCO/PIHP/PAHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

2.___ The State monitors to ensure that there are adequate open panels within the MCO/PIHP/PAHP. Please describe how often and how the monitoring takes place.

3. **X** [Required] The State ensures that the number of providers under the waiver is adequate to assure access to all services covered under the contract. Please describe how the State will ensure that provider capacity will be adequate.

By contract, the PIHPs must ensure adequate capacity to serve the entire Medicaid population in their service area that has been determined to have a medical necessity for mental health services. The PIHPs are responsible for the resource and utilization management of the system and are required in contract to submit changes that result in reduced capacity to HRSA prior to the change. HRSA monitors grievance and satisfaction as elements of capacity.

b. PCP Capacity Standards

1.___ The State has set capacity standards for PCPs within the MCO/PIHP/PAHP expressed in the following terms (In the case of a PIHP/PAHP, a PCP may be defined as a case manager or gatekeeper):

i.___ PCP to enrollee ratio
ii.___ Maximum PCP capacity
iii.__ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans

2. **X** The State ensures adequate geographic distribution of PCPs within MCO/PIHPs/PAHPs. Please explain.

Each RSN must ensure adequate capacity to serve the Medicaid population.

3. X The State designates the type of providers that can serve as PCPs. Please list these provider types.

Please Note: Mental Health services in the PIHP are not provided by PCPs, but by Mental Health Professionals, including: *psychiatrists, psychologists, psychiatric nurses, or social workers.*

c. Specialist Capacity Standards

1. _X_ The State has set capacity standards for specialty services. Please explain.

Mental health services are a specialty service. Services must be provided by or under the supervision of a mental health professional. WAC has additional requirements for mental health services for Children, Ethnic Minority, Geriatric and Disability Mental Health Specialists as described in 388-865-0150 and 388-865-405(5). By contract, the PIHP must comply with WAC and have the capacity and staff to meet the needs of the population.

2.___ The State requires particular specialist types to be included in the MCO/PIHP/PAHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. specialty to enrollee ratio. If specialists types are not involved in the MCO/PIHP/PAHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

IV. Capacity Monitoring

Previous Waiver Period

a. X [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring the MCO/PIHP/PAHP capacity in the previous two year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint; item B.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

HRSA continues to monitor the number of licensed CMHAs, grievance and fair hearing data and issues identified on the MHSIP satisfaction survey with regards to access, quality and appropriateness.

There are approximately 161 licensed and certified CMHAs contracting with the RSNs. The number is approximate because of multiple locations of various providers.

Upcoming Waiver Period --
Please indicate which of the following activities the State employs:

a. X Periodic comparison of the number and types of Medicaid providers before and after the waiver.

b.___ Measurement of referral rates to specialists.

c.___ Provider-to-enrollee ratios

d.___ Periodic MCO/PIHP/PAHP reports on provider network

e.___ Measurement of enrollee requests for disenrollment from a plan due to capacity issues

f. **X** Tracking of complaints/grievances concerning capacity issues

g.___ Geographic Mapping (please explain)

i.___ Tracking of termination rates of PCPs

j.___ Review of reasons for PCP termination

k. **X** Consumer Experience Survey, including persons with special needs,

l.__ Other (Please explain):

V. Coordination and Continuity of Care Standards

Upcoming Waiver Period -- Check any of the following that the State requires of the MCO/PIHP/PAHP:

a.___ Primary Care and Coordination

(i)__ [Required] Implement procedures to deliver primary care to and coordinate health care service for all enrollees.
See (iv)
(ii)__ [Required] Ensure each enrollee has an ongoing source of primary care appropriate to his or her needs, and a person or entity who is primarily responsible for coordinating the enrollee's health care services.
See (iv)
(iii)___ [Required] Coordinate the services the MCO/PIHP/PAHP furnishes to the enrollee with services the enrollee receives from any other MCO/PIHP/PAHP.
See (iv)
(iv)__ [Required] Ensure that in the process of coordinating care, each enrollees' privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

(iv) **X** The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the primary care requirements of 42 CFR 438.208. Please explain.

Providers in the mental health system do not meet the definition of Primary Care Provider. The PIHPs are required to provide continuity of care between inpatient and outpatient mental health services and are also required to refer Medicaid enrollees to their physical health care provider when they are in need of physical health care. The PIHPs are also required to work in partnership with other Medicaid managed care

programs within the state when appropriate and asked.

b.___ Additional services for enrollees with special health care needs.

(i)_**X**_ [Required] Identification. The state has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

In previous waiver periods, the State negotiated with CMS to all the State to define all Medicaid clients with serious mental illness or children with a serious emotional disturbance as special needs clients and to treat these clients accordingly when providing mental health services through the PIHP system.

(ii)_X_ [Required] Assessment. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate *mental* health care professionals, to assess each enrollee identified by the state to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

All enrollees are provided an intake assessment upon request for services.

(iii)_X_ [Required] Treatment Plans. For enrollees with special health care needs who need a course of *mental health* treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1._**X**_ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee

It should be noted that in the context of Managed Mental Health services, the Mental Health Professional takes the place of the Primary Care Provider in developing a treatment plan. The treatment plan is developed collaboratively with the consumer and other people identified by the consumer as his or her support system. The treatment plan is developed within thirty days of starting community support services. The service plan should be in language and terminology that is easily understood by consumers and their family, and include goals that are measurable.

2**.**_**X**_Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3._**X**_ In accord with any applicable state quality assurance and utilization review standards.

(iv)_**X**_ [Required] Direct access to specialists. If treatment plan or regular care monitoring is needed, MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access

specialists as appropriate for enrollee's condition and identified needs.

In a mental health managed care program, all enrollees are considered to have special health care needs and have access to needed specialty services. PIHPs are required to coordinate care with other Medicaid managed care systems and with allied social service systems upon request. Please see description of coordination of services.

(iv) **X** The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 42 CFR 438.208.

VI. Coordination and Continuity of Care Monitoring

Previous Waiver Period

a. X [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in 1995 preprint; item B.VI. Upcoming Waiver Period, 1999 Renewal Waiver Preprint.].

The QA & I team, through both the onsite contract monitoring of the PIHP and through licensing review, monitors that treatment plans are being developed with the participation of the consumer and their natural support system. The team looks for quotes of both the consumer and those whom they have identified as being an integral part of their treatment. HRSA requires the plan to be written in language easily understood by consumers. When reviewing treatment plans, the team looks for abbreviations, overly complicated clinical descriptions, etc. The team also reviews for coordination of services when required (Protocols for children and older adults) and consultation with children, geriatric, ethnic minority and disabled mental health specialists.

Currently the MHSIP survey monitors satisfaction with participation in treatment and treatment planning. Please see the survey results on the web at http://depts.washington.edu/washinst/.

c. X [Required for all elements checked in the previous waiver submittal if this is a PIHP/PAHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PIHP/PAHP providers were educated about how to detect MH/SA problems for both children and adults and where to refer consumers once the problems were identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PIHP/PAHP providers. Please describe how this issue was addressed in the PIHP/PAHP program.

Providers in the mental health, medical and chemical dependency fields are required to conduct the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) – a self reporting tool designed to assist in the comprehensive screening for substance abuse and mental illness.

The RSNs work with both Healthy Options providers and other physicians around children, adults, and older adults with regards to mental illness, pharmacy and cross-system care. These contractors and sub-contractors work closely together and do cross-system training on access/referral to services, symptoms, reactions, and integrated planning.

Additionally, effective in July of 2009, the former Mental Health Division and Division of Alcohol and Substance Abuse merged to form the Division of Behavioral Health and Recovery (DBHR), and are now co-located in the same building. The Division of Healthcare Services, which is responsible for the Healthy Options program, as well as fee for service authorizations, is also located in this building and efforts are ongoing to further integrate behavioral health and medical services for all enrollees.

d. **X** [Required if this is a PIHP/PAHP mental health, substance abuse, or developmentally disabled population waiver] Please describe how pharmacy services prescribed to program enrollees were monitored in this waiver program.

Medication management and medication monitoring is provided through CMHAs. These services include the prescribing and/or administering and reviewing of medications and their side effects. This service is rendered face-to-face by a person licensed to perform such services. Service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy. Medication monitoring is face to face cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. This service also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual.

As part of the case record review QA & I staff looks at prescriptions to ensure the medications are prescribed by a qualified physician or an ARNP with prescriptive authority and that the prescriptions are reviewed/monitored on at least a three month cycle. Monitoring would/could include side effects, lab tests, etc. The team also notes in the case record review the results of medication monitoring, compliance and positive outcomes noted.

The QA & I team also review medication storage at the CMHA as part of the ADA/federal requirement walk around per WAC 388-865-0458.

Additionally, HRSA staff monitors prescription drugs in various ways:

- *Edits and audits are put into the payment system to prevent inappropriate payments;*
- *Post-payment reviews look for billing errors such as: Package Size, Rounding, and Quantity Errors;*
- *Neural net models are utilized to compare providers to their Washington peers enabling us to detect aberrant billing patterns;*
- *Reports and queries are available in the Decision Support System (DSS) for utilization review;*

- *On-site audits are conducted by HRSA auditing staff.*

Upcoming Waiver Period -- Please describe how standards for continuity and coordination of care will be monitored in the upcoming two year period.

a. How often and through what means does the State monitor the coordination and continuity standards checked above in Item B.V?

This will continue to be monitored through the use of the required EQRO protocols and according to those schedules and by the QA & I on-site contract monitoring.

b. Specify below which providers are excluded from the capitated waiver and how the State explicitly requires the MCO/PIHP/PAHP to coordinate health care services with them:

1.___ Mental Health Providers (please describe how the State ensures coordination exists):

2._**X**_ Substance Abuse Providers (please describe how the State ensures coordination exists):

3._**X**_ Local Health Departments (please describe how the State ensures coordination exists):

4._**X**_ Dental Providers (please describe how the State ensures coordination exists):

5._**X**_Transportation Providers (please describe how the State ensures coordination exists):

6._**X**_ HCBS (1915c) Service (please describe how the State ensures coordination exists):

7._**X**_ Developmental Disabilities (please describe how the State ensures coordination exists):

8._**X**_ Title V Providers (please describe how the State ensures coordination exists):

9.___ Women, Infants and Children (WIC) program

10._**X**_ Indian Health Services providers

11.__ FQHCs and RHCs not included in the program's networks

12._X_Other (please describe):

RSNs have working partnerships with a variety of other community services to provide coordinated care for their shared consumers. The RSNs and CMHAs are required to participate in multi-system coordination efforts whenever possible. They are required to refer consumers to alternate or additional services that the CMHA or the consumer's individual Mental Health Care Provider believes the consumer needs to complete or aid in the recovery process. HRSA, as part of the umbrella agency of DSHS, monitors coordination efforts through meetings with other divisions within the Department, through our work with the Indian Policy Advisory Committee, and stakeholder meetings with both the Office of the Superintendent of Public Instruction and

the Department of Health.

RSN contracts have the following coordination requirements:
The Contractor must participate in the coordination of mental health services with other systems of care when clinically indicated. The Contractor must:

- *Maintain MHD approved service protocols developed with the DSHS Children's Administration and DSHS Aging and Disability Services Administration.*
- *Maintain the existing working Agreement with the DSHS Juvenile Rehabilitation Administration (JRA) addressing the coordination of services for enrollees that are released from JRA facilities.*
- *Maintain the relationship between the Contractor and Healthy Option plans in the service area through a Memorandum of Understanding.*
- *Maintain the relationship between the Contractor and the DSHS Division of Vocational Rehabilitation (DVR) office in the service area.*
- *Comply with published directives from MHD when the Contractor or its subcontractors are unable to resolve local disputes with other service systems (Healthy Options, other DSHS administrations as provided by MHD) regarding service or cost responsibilities.*

RSNs are additionally required to collaborate with tribal mental health providers to ensure coordination of services, and appropriate placement of tribal consumers in inpatient treatment if necessary. RSNs also coordinate with tribal mental health systems to ensure appropriate discharge planning from inpatient treatment facilities', and are required to provide crisis services.

Section C. QUALITY OF CARE AND SERVICES

A Section 1915(b) Waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, MCOs, PIHPs, and PAHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies: -- This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a.___ Summarize the results of or include as an attachment reports from the External Quality Review Organization, results from performance improvement projects, and other monitoring reports from the previous waiver period. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint, item C.1 Upcoming Waiver Period, 1999 Waver Renewal Preprint].

The 2009 EQRO report was submitted to CMS Region X in December 2009.

b.___ Intermediate sanctions were imposed during the previous waiver period. Please describe.

Upcoming Waiver Period -- Please check any of the items below that the State requires.

a. X [Required] The State has a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. Please indicate if the strategy has already been submitted to CMS. If not, please attach a copy (Attachment C.1.a).
The state has a CMS approved quality strategy in place, which was submitted in June, 2007. The Division of Healthcare Services is currently in the process of developing an integrated quality strategy for health and behavioral health, with an anticipated completion date of June, 2010.

b. X [Required] The State must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.

c. X [Required] The State must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy as needed.

d. X [Required] The State must arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to the services delivered under each MCO and PIHP contract. Note: EQR for PIHPs is required beginning 8/14/03.

1. Please specify the name of the entity: *Accumentra Health*
The entity type is:

   (a) X A Peer Review Organization (PRO);
   (b) ____ A private accreditation organization approved by CMS;
   (c) ____ A PRO-like entity approved by CMS.

4. Please describe the scope of work for the External Quality Review Organization (EQRO):

   RSN-specific portion of the statewide EQRO RFP has identified mental health services issues such as
   - *conducting a monitoring review to determine PIHP compliance with Standards;*
   - *annual validation of PIHP Performance Improvement Projects (PIPs) and Performance Measures (PMs); Encounter Data Validation Study for PIHPs;*
   - *completion of an Information System Capability Assessment (ISCA);*
   - *conduct two activities designed to provide performance measure data, in 2008 conduct a clinical records review to assess quality of care and in 2009 conduct a study of quality management activities and report how the PIHP uses collected data, monitors results and service verification to strengthen its ongoing quality management program. The assessment will include the degree to which mental health services:*
     - *are driven by and incorporate enrollee and family voice;*
     - *are culturally and linguistically competent;*
     - *are age appropriate;*
     - *are provided in the least restrictive environment;*

- *assist enrollees' progress towards recovery and resiliency; and*
- *promote continuity in service and integration with other formal/informal systems and settings.*

e. **X** The State includes required internal quality assessment and performance improvement (QAPI) standards in its contracts with MCOs and PIHPs.

f.__ The State monitors, on a continuous basis, MCO/PIHP adherence to the State standards, through the following mechanisms (check all that apply):

1.__ Reviews and approves each MCO's/PIHP's written QAPI. Such review shall take place prior to the State's execution of the contract with the MCO/PIHP.

2. **X** [Required] Reviews the impact and effectiveness of each MCO's/PIHP's written QAPI at least annually.

3. **X** Conducts monitoring activities using (check all that apply):

(a) **X** State Medicaid agency personnel

(b)__ Other State government personnel (please specify):

(c) **X** A non-State agency contractor (please specify): *Accumentra Health*

4.__ Other (please specify):

g. NA for PIHP[Required] The State has established intermediate sanctions that it may impose.

h. **X** [Required] The State has standards in the State QAPI, at least as stringent as those required in 42 CFR 438 Subpart D for access to care, structure and operations, and measurement and improvement .

II. Access Standards

Coverage and Authorization of Services

Previous Waiver Period

a. **X** [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint, item C.II Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

PIHPs are required to provide services comparable in scope and intensity to the state plan rehabilitation services and community inpatient services for adults and children. PIHPs must also

ensure system capacity to provide a full range of mental health services to meet the individual enrollee's needs in a way that allows for seamless coordination and continuity of mental health services that create the least amount of disruption in the enrollee's life and supports recovery and reintegration to their community.

HRSA monitors services in a variety of ways. In addition to the annual on-site monitoring activities of the EQRO and HRSA contract monitoring staff, there are the meetings with stakeholders as described, additional monitoring through the Information System, monitoring of complaints and grievances, and satisfaction surveys.

The 2009 EQRO report was submitted to CMS Region X in December 2009. The report can be accessed at: http://www1.dshs.wa.gov/Mentalhealth/publications.shtml.

A performance Indicator report may be found at http:www.mhd-pi.com/layout.asp?.

HRSA regularly conducts child and adult satisfaction surveys as well as provider surveys to assess the use of evidence based services. Results of current and past consumer and provider surveys may be found at http://depts.washington.edu/washinst/Reports/Reports.html.

Upcoming Waiver Period -- Please check any of the following processes and procedures that the State requires to ensure that MCOs, PIHPs, and/or PAHPs meet coverage and authorization requirements.

Contracts with MCOs, PIHPs, and PAHPs:

a. X [Required] Identify, define and specify the amount, duration and scope of each service offered, differentiating those services that may be available to special needs populations only, as appropriate. Note: These services may not be furnished in an amount, duration, and scope that is less than the amount, duration, and scope for the same services under the State Plan.

b. X [Required] Require that the MCO, PIHP, or PAHP may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;

c. X [Required] Include a definition of "medically necessary services". This definition can be no more restrictive than that used in the State Plan. Please list that specification or definition:

***"Medical necessity"** or **"medically necessary"** - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause a physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate, no treatment at all.*

Additionally, the individual must be determined to: 1) have a mental illness covered by Washington State for public mental health services; 2) the individual's impairment(s) and corresponding need(s) must be the result of a mental illness; 3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support cannot address the individual's unmet need.

d. **X** [Required] Include written policies and procedures for the processing of requests for initial and continuing authorizations of services.

e. **X** [Required] Require that the MCO, PIHP, and PAHP have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

f. **X** [Required] Require that the MCO,PIHP, and PAHP consult with the requesting provider when appropriate.

g. **X** [Required] Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope, that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

h. **X** [Required] Require that, for standard authorization decisions, notice is provided as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days. The timeframe may be extended up to an additional 14 days if the enrollee or provider requests an extension or if the MCO, PIHP, and PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

i. **X** [Required] Require that the MCO,PIHP, or PIHP make an expedited authorization decision no later than 3 working days after receipt of the request for service. The timeframe may be extended up to 14 days if the enrollee *or the MHCP* requests an extension or if the MCO, PIHP, or PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

Mental health access standards are more stringent than this requirement. They are 2 hours for emergent, 24 hours for urgent and 14 days for routine.

j.___ Other (please describe):

III. Structure and Operation Standards

Provider Selection

Previous Waiver Period

[Required for all related items checked in previous waiver request] Please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

HRSA has not noted any significant problem around retention or selection of Mental Health

Professionals in the CMHA's.

Upcoming Waiver Period

The State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow. Please check any of the following processes or procedures that the State includes in its policy.

a. **X** [Required] Each MCO, PIHP, PAHP must develop and implement a documented process for selection and retention of providers.

b. **X** [Required] Each MCO, PIHP, PAHP must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment solely on the basis of the population served or condition treated.

c.____ Each MCO, PIHP, PAHP must have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

d.___ Each MCO, PIHP, PAHP must have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1.___ Initial credentialing

2.___ Performance indicators, including those obtained through the following (check all that apply):
(a) X The quality assessment and performance improvement program;
(b) X The utilization management system;
(c) X The grievance system;
(d) X Enrollee satisfaction surveys *are issued separately by HRSA and not the PIHPs or the CMHAs.*
(e) X Other MCO/PIHP/PAHP activities as specified by the State.

e.___ Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State _____

f.___ Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g.___ Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

h. _X_ Other (please describe):

The PIHPs only contract with Licensed Community Mental Health Agencies for the provision of state plan services.

IV. Subcontractual Relationships and Delegation

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint, item C.IV Upcoming Waiver period, 1999 Waiver Renewal Preprint].

The EQRO reviewed samples of model subcontracts from each of the 13 RSNs and found them to generally be in compliance with requirements. If the samples were found to contain deficiencies the RSNs were required to submit corrective action plans and amend their subcontracts.

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs, PIHPs, and PAHPs oversee and are accountable for any delegated functions.

Where any functions are delegated by MCOs, PIHPs, or PAHPs, the State Medicaid Agency:

a.___ Reviews and approves (check all that apply):
1.___ All subcontracts with individual providers or groups

2.___ All model subcontracts and addendum

3.___ All subcontracted reimbursement rates

4.___ Other (please describe):

b. **_X_** [Required] Monitors to ensure that MCOs, PIHPs, and PAHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

c. **_X_** [Required] Requires agreements to be in writing and to specify the delegated activities.

d. **_X_** [Required] Requires agreements to specify reporting requirements.

e. **_X_** [Required] Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

f. **_X_** [Required] Ensures that MCOs, PIHPs, and PAHPs monitor the performance of the entity on an ongoing basis.

g. **X** [Required] Monitors to ensures that MCOs, PIHPs, and PAHPs formally review the entity's performance according to a periodic schedule established by the State.

h. **X** [Required] Ensures that MCOs, PIHPs, and PAHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

i. **X** [Required] Requires MCOs, PIHPs, and PAHPs to take corrective action if any deficiencies or areas for improvement are identified.

j.___ Other (please explain):

V. Measurement and Improvement Standards

Practice Guidelines
Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint].

In the last five years, much work has been done to research and identify practice guidelines and evidence-based practices and their value to service recipients and the provider field. The EQRO monitored practice guidelines in 2005 and found it was new concept to the majority of the PIHPs.

The 2006 EQRO review showed much improvement from the previous two years. At least two practice guidelines and/or evidence based practices (EBPs) had been adopted by all 13 PIHPs. The majority of PIHPs have moved beyond locally developed guidelines to nationally validated guidelines and EBPs.

The 2009 EQRO found that eight (8) RSNs fully met the standard for Practice Guidelines; three (3) RSNs substantially met the standard and one RSN partially met the standard. Nine of the 12 RSNs used clinical record review to monitor contracted providers' implementation of their practice guidelines.

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that MCOs, PIHPs, and PAHPs adopt and disseminate practice guidelines.

a. **X** [Required] Guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

b. **X** [Required] Guidelines consider the needs of the MCO's, PIHP's or PAHP's enrollees.

c. **X** [Required] Guidelines are developed in consultation with contracting *mental* health professionals.

d. X [Required] Guidelines are reviewed and updated periodically.

e. X [Required] Guidelines are disseminated to all affected providers and, upon request to enrollees and potential enrollees.

f. X [Required] Guidelines are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g. X Other (please explain): *EBPs may be used when the practice guideline standards (above) are met*.

Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a. **X** [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint, item C.VII Upcoming Waiver Period, 1999 Waiver Renewal Preprint]. Please break down monitoring results by subpopulations if available.

The QAPI compliance areas are included in the EQRO report submitted to CMS in December 2009.

b. X The State or its MCOs and PIHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two year period.

All PIHPs are evaluated on two sets of performance improvement measurements included in their contract: core performance measures and regional performance measures. The core performance measures are established statewide and required of all PIHPs. For these measures, the state calculates the baseline, defines the measurement, establishes the annual improvement target, and provides the quarterly and annual reports to each PIHP. Regional performance measures are developed, calculated, tracked and reported by the PIHP. They are responsible to collect and manage the data necessary to support the measurement activities, including establishing the baseline, determining demonstrable improvement target, tracking change in performance over time, and reporting the annual findings to the state. The aim of the regional performance measurement is to allow the PIHP to develop a quantitative, regional understanding of the healthcare and service delivery system, to establish meaningful and relevant measures unique to its population and geographic service area, to maximize the collection of data at the local level, and to foster innovation and partnership between the PIHP and network providers.

The current core performance measures are made up of 3 service provision measures and 2 data quality measures. The service provision measures are:

- *A routine outpatient service must be offered to a Medicaid client within seven (7) days of discharge from a psychiatric inpatient hospital or Evaluation and Treatment (E&T) facility. This is calculated as a percentage of discharges from community psychiatric inpatient hospitals and E&Ts with a routine outpatient service within seven (7) days, divided by the total number of discharges from community psychiatric inpatient hospitals and E&Ts.*

- *Time from a request for service to a routine service offered shall be within 28 days. This is calculated as a percentage of Medicaid clients who received a routine service within 28 days of the service request, divided by the total number of Medicaid clients who requested, authorized and received routine services.*

- *Time from a service request to an intake service shall be within 14 days. This is calculated as a percentage of Medicaid clients who received an intake service within 14 days of the service request, divided by the total number of Medicaid clients who requested services and received intake services.*

The data quality measures are:
Consumer Periodics (made up of various outcome measures such as employment status, housing, whether the client is in school part or full time, etc) are required to be submitted to the state per contract. A timeliness of submission measure is calculated as a percentage of the number of Consumer Periodics that are successfully submitted within 60 days, divided by the total number of Consumer Periodics submitted in the reporting period.

Outpatient encounters are also required to besubmitted to the state within 60 days of the close of the month in which the services were provided (i.e., service month). This measure is

calculated as a percentage of the number of outpatient encounters successfully submitted within 60 days after the services month, divided by the total number of outpatient encounters in the reporting period.

For regional performance measures, PIHPs are required to develop a minimum of three (3) measures. These are chosen by the PIHP but cannot be the same as the core performance measures nor currently calculated statewide or optional indicators from the Performance Improvement Project (PIP) by the PIHP. Regional measures cannot not be deleted or modified, once the baseline and target have been established by the PIHP. Measures are to be chosen based on local relevance, clinical consensus, and research evidence and with input from each PIHP's local Mental Health Advisory Board. The state encourages PIHPs to develop their measures that reflect these areas:

- *Access and Availability*
- *Care Coordination and Continuity*
- *Effectiveness of Care*
- *Quality of Care*
- *Hope, Recovery, and Resiliency*
- *Empowerment and Shared Decision Making*
- *Self Direction*
- *Cultural Competency*
- *Health and Safety Measures*
- *Consumer Health Status and Functioning*
- *Community Integration and Peer Support*
- *Quality of Life and Outcomes*
- *Promising and Evidence-Based Practices*
- *Provider effectiveness and satisfaction*
- *Integrated Programs and Systems Integration*

Each PIHP must submit their measures for state review by a particular date. They also must calculate the baseline measurement and submit their calculation methodology to the state for review. PIHPs must submit annual improvement targets and a performance report to the state for review and acceptance.

In addition to these core contract measures, the state collects data on a variety of other performance indicators to meet SAMHSA requirements for reporting of Uniform Reporting System and National Outcome Measures and reports on these additional indicators are

available to State and PIHP staff through a web based reporting system.

The results of the PIPs conducted by the PIHPs are included in the EQRO report submitted to CMS in December, 2009.

The state and the PIHP have been participating with SAMHSA, CMHS, as part of the data infrastructure grant. The report may be found at http://www1.dshs.wa.gov/mentalhealth .

Upcoming Waiver Period- The State must require that each MCO and PIHP have an ongoing QAPI for the services it furnishes to its enrollees.

a. **_X_** [Required] The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's QAPI. This review includes:
QAPI compliance areas are in the EQRO report submitted to CMS in December, 2009.

1. _X_ The MCO's and PIHP's performance on the standard measures on which it is required to report.

Through the participation of the state with SAMHSA on the data infrastructure grant there will be data shown for each of the 13 RSNs. As it is with the states and the data infrastructure grant the RSNs will be measured against themselves and not against each other.

2.___ The results of each MCO's and PIHP's performance improvement projects.

b. ___Please check any of the following processes and procedures that the State includes as a requirement for MCO and PIHP QAPIs

Each MCO and PIHP must have:

1 X A policy making body which oversees the QAPI

2.___ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3 X Active participation by providers and consumers

4 X Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5.___ Other (please describe):

c. **_X_** [Required] Each MCO and PIHP must have in effect mechanisms to detect both underutilization and overutilization of services. Please describe these mechanisms:

The PIHP must have documented procedures to identify at the RSN level over and under utilization and shall monitor for over-utilization and under-utilization of services and ensure that resource management and utilization management activities are not structured in such a way as

to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary mental health services to any enrollee. Care management focuses on access, referrals, oversight of care coordination, utilization review, resource management, risk management, and quality improvement. These activities must be performed by a Mental Health Professional.

d. **_X_** [Required] Each MCO and PIHP must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs**.** Please describe these mechanisms:

Please see our response to special health care needs above.

e. _X_ [Required] Each MCO and PIHP must measure and report to the State its performance, using standard measures required by the State. Please list or attach the standard measures currently required.

Please see Attachment C.VI.b. - Data Dictionary and the Performance Indicator Report which may be found on HRSA's website which is http://www1.dshs.wa.gov/mentalhealth .

Performance Improvement Projects

f. _X_ [Required] Each MCO and PIHP must conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

g _X_ Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

h. _X_ [Required] Each MCO and PIHP must report the status and results of each project to the State as requested.

Please list or attach the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

Following is a list of clinical and nonclinical PIPs currently being conducted, by RSN:

CCRSN: Clark County RSN
Clinical: Employment Outcomes for Adult Consumers
Nonclinical: Timeliness of Access to Outpatient Services

CDRSN: Chelan Douglas RSN
Clinical: Metabolic Syndrome Screening and Intervention

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments After Psychiatric Hospitalization

GCBH: Greater Columbia Behavioral Health

Clinical: Impact of Implementing the PACT Model on the Use of Inpatient Treatment

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments after Psychiatric Hospitalization

GHRSN: Grays Harbor RSN

Clinical: Improving Treatment Outcomes for Adults Diagnosed with a New Episode of Major Depressive Disorder

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments after Psychiatric Hospitalization

KCRSN: King County RSN

Clinical: Metabolic Syndrome Screening and Intervention

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments after Psychiatric Hospitalization

NCWRSN: North Central Washington RSN

Clinical: Improved Delivery of Non-Crisis Outpatient Appointments after Psychiatric Hospitalization

Nonclinical: Improved Access to Services – Intakes Provided within 14 Days of a Service Request

NSMHA: North Sound Mental Health Administration

Clinical: Decrease in the Days to First Prescriber Appointment After Request for Service

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments after Psychiatric Hospitalization

PRSN: Peninsula RSN

Clinical: Metabolic Syndrome Screening and Intervention

Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments after Psychiatric Hospitalization

SCRSN: Spokane County RSN

Clinical: Implementing an Evidence-Based Practice

Nonclinical: Reduced Errors in Service Encounter Reporting Through Consistent Interpretation of Reporting Guidelines

SWRSN: South West RSN

Clinical: Using Assertive Community Treatment to Decrease Consumer Hospital Utilization
Nonclinical: Improved Delivery of Non-Crisis Outpatient Appointments after Psychiatric Hospitalization

TMRSN: Thurston-Mason RSN
Clinical: Multisystemic Therapy
Nonclinical: Improved Rates of Medicaid Adults Seen for a Non-Crisis Outpatient Appointment within 7 Days of Discharge from a Psychiatric Inpatient Level of Care

TRSN: Timberlands RSN
Clinical: Not Submitted
Nonclinical: Improving Coordination of Care with Primary Care Providers

Because the OptumHealth (Pierce County) RSN officially began serving Pierce County in July of 2009, they have not yet been reviewed to monitor Performance Improvement Projects. OptumHealth will be reviewed in 2010 to ensure compliance with contract requirements around PIPs.

Monitoring & Implementing Improvement Strategies: All RSNs are required to develop and implement a quality improvement plan to improve or sustain the indicator and make this plan available to HRSA for review and monitoring

i. **X** [Required] Each MCO and PIHP must measure performance using objective quality indicators.

j. **X** [Required] Each MCO and PIHP must implement system interventions to achieve improvement in quality.

k. **X** [Required] Each MCO and PIHP must formally evaluate the effectiveness of the interventions.

l. **X** Each MCO and PIHP must correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

m. **X** MCOs or PIHPs are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

n.___ Each MCO and PIHP must select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

o.___ Each MCO and PIHP must select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

p.___ Each MCO and PIHP must provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

q.___ Each MCO and PIHP must establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

r.___ Each MCO and PIHP must use a sampling methodology that ensures that results are accurate and reflective of the MCO's or PIHP's enrolled Medicaid population.

s.___ Each MCO and PIHP must use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

t.___ Each MCO and PIHP must ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

u.___ Other (please describe):

VI. Mental Health Information Systems

Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

The RSNs now submit data within acceptable standards. The Information System Data and Evaluation Committee (ISDEC) continues to meet and facilitate data quality improvements. HRSA and the RSNs are now HIPAA compliant and use standard transactions and national code sets for encounter reporting.

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs and PIHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program.

The State requires that MCO and PIHP systems:

a. X [Required] Provide information on:

1. **X** Utilization;

2. **X** Grievances and appeals;

3.___ Disenrollment for reasons other than loss of Medicaid eligibility.

b. X [Required] Collect data on enrollee and provider characteristics as specified by

the State. *The Data dictionary is available on request.*

c. **X** Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO/PIHP is capable of (please check all that apply):

Please see the data dictionary above

1. **X** [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees

2. **X** [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors

3. **X** [Required] Verifying the accuracy and timeliness of data

4. **X** [Required] Screening data for completeness, logic and consistency

5. **X** [Required] Collecting service information in standardized formats to the extent feasible and appropriate

6. ___ Other (please describe):

d. ___ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1. ___ Health services (please specify frequency and provide a description of the data and/or content of the reports)

2. ___ Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports)

3. ___ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)

4. ___ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

e. **X** Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAPI.

f. **X** Ensure that information and data received from providers are accurate, timely and complete.

g. **X** Allow the State agency to monitor the performance of MCOs/PIHPs using systematic, ongoing collection and analysis of valid and reliable data.

h.___ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i.__X_ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs/PIHPs.

State contracts with PIHPs require encounters to be submitted to the state within 60 days of the close of the month in which the services were provided (i.e., service month). A performance measure in the contract requires that PIHPs achieve a compliance rate of 95% for timeliness of submission within 60 days. A report on the compliance rate is provided to management and to each PIHP quarterly. This report also tracks numbers of encounters submitted, to provide an indication of any deviation from typical submission rates and to flag any PIHPs that have not submitted any encounters in a given time frame.

As encounters are processed into the database, edits in the database manage accuracy and completeness, in part by rejecting encounters that do not contain acceptable values such as procedure codes, date of service, client identifier, duration of service, location where service was provided, and procedure code modifiers as required by the state plan. The PIHP contract also requires that any rejected encounters be corrected and resubmitted within 30 days of original submission.

The external quality review organization coordinates with the state for encounter validation activities that provide a level of oversight regarding completeness and accuracy of encounter reporting. As well, the encounter validation activities provide a level of oversight about the degree of match between encounters that are recorded in client's medical record and those reported in the information system.

In 2010, PIHP encounter data reporting is transitioning from a custom database to a new MMIS system, known as Provider One. This new system will shift PIHP encounter data reporting from the current information system and will integrate information in ProviderOne for all services provided to Medicaid clients. This will ultimately improve efforts to analyze and report on service utilization and facilitate efforts to improve integration of care. It will also enhance our ability to measure the impact of services and/or policy changes, and allow better risk profiling and enhanced quality improvement activities.

However, additional non-encounter data reported by the PIHPs, used for performance and outcome measures, is not planned to be reported through Provider One but will continue to be reported to the custom database. This will necessitate a significant redesign and reformatting. A project team is implementing infrastructure changes and the creation of linkages and programming to regenerate the existing structure so that encounters and associated client data can be matched for use in reporting.

The state hosts bi-monthly meetings with PIHP IT and Quality Managers, along with provider representatives, to discuss data quality issues, review monitoring reports, provide technical specifications to meet contract requirements for encounter submission and to improve encounter data quality. The group is also an advisory body to review and suggest changes to all technical documents such as data dictionaries, encounter reporting guides that provide guidance for encounter reporting to the state.

j.__X_ The State uses information collected from MCOs/PIHPs as a tool to monitor and evaluate

MCOs/PIHPs (i.e. report cards). Please describe.

Information collected from PIHPs includes both encounters and other performance and outcome data at the client level. Since the data reporting requirements for PIHPs is the same in the PIHP contract as it is for the block grant contract, we are able to apply the same data quality processes to a larger data set. That data is used for internal management reports, for decision support and planning purposes and for executive and legislative reports on system performance. Further, this data is used by the umbrella social service agency, the Department of Social and Health Services' (the Agency) Research and Data Analysis Division, to provide research and policy reports on treatment, performance and outcome trends. This division can link the clients served by the PIHP to other department services such as chemical dependency treatment, state cash assistance, all medical services paid for by Medicaid, including prescriptions for medications, emergency room visits, etc, to provide more comprehensive views and analysis of what services clients are getting.

PIHP-supplied data is also used for to provide reports through a web-based ad hoc reporting system that provides a number of developed reports that can be run with various parameters of age groups, state geographic regions, ethnicities etc to provide specific reports of interest. This system is available to internal staff, PIHP staff as well as their subcontractors, upon vetting a request for a login. This year a subset of these reports will also be available to the general public, to provide a broader stakeholder group with access to performance and outcome data.

Much of the data collected in both the PIHP and the block grant contracts is used to report to CMS via the URS/NOMS reporting tables, specifically based on the client funding.

During the past year the Agency has integrated the mental health and chemical dependency divisions into one "behavioral health" division. Much of this data is also being used in the on-going planning process of integrated treatment goals for clients and to inform the funding and contracting directions to provide better care.

Administrative data sets are provided to external contractors such as actuarial firms, for rate setting activities, to a quality review organization (EQRO) to provide an independent encounter validation review and for other advisory activities.

k.___ The State uses information collected from MCOs/PIHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PHPs and/or providers). Please describe.

l.___ Other (please describe):

Section D – Cost-Effectiveness

Cost Effectiveness Information and appendices are provided in a separate document.

Section E. FRAUD AND ABUSE

States must promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PIHPs/PAHPs have certain provisions in place.

Previous Waiver Period

WA 1915(b) Renewal
Effective date: September 1, 2010

a. [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period. [Reference: items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint, item E.I Upcoming Waiver Period, 1999 Waiver Renewal Preprint)]

The State Auditor monitors and reported no findings of Fraud and Abuse. The EQRO found no evidence of fraud and abuse in their reviews.

Upcoming Waiver Period -- Please check all items below which apply, and describe any other measures the State takes.

I. State Mechanisms

a. X The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PIHP/PAHP, by the State's claims processing system).

b.___ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

c. X The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

The State auditor monitors for fraud and abuse. These reports have been submitted to CMS over the course of the waiver. There have been no findings.

d. X The State has a specific process for informing MCOs/PIHPs/PAHPs of fraud and abuse requirements under this waiver. If so, please describe.
The contract with the PIHP includes the marked terms from II. b. below.

e.___ Other (please describe):

II. MCO/PIHP/PAHP Fraud Provisions

a. X [Required for MCOs/PIHPs if State payments based on data submitted by MCO/PIHP, e.g. encounter data] MCO/PIHP must certify data as follows:

(i) data is accurate, complete, and truthful based on best knowledge, information, and belief

(ii) certification is made by plan CEO, CFO, or individual delegated to sign for, and reports to, plan CEO or CFO

(iii) certification is submitted concurrently with data

b. **_X_** [Required for MCO/PIHPs]The State requires MCOs/PIHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Plan includes:
(i) **_X_** Written polices that articulate commitment to comply with all applicable Federal and State laws
(ii) **_X_** Designation of compliance officer and committee
(iii) **_X_** Effective training and education for compliance officer and plan employees
(iv) **_X_** Enforcement of standards through well-publicized disciplinary guidelines
(v) **_X_** Provision for internal monitoring and auditing
(vi) **_X_** Provision for prompt response to detected offence, and corrective action initiative related to MCO/PIHP contract

c. **_X_** [Required for MCOs/PIHPs/PAHPs] The plan is prohibited from having affiliations with an individual who was, or is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation.

d. **_X_** The State requires MCOs/PIHPs/PAHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.

Section F. SPECIAL POPULATIONS

States may wish to refer to the October 1998 CMS document entitled "Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

Previous Waiver Period

a. [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint, item F.I. Upcoming Waiver Period, 1999 Renewal Waiver Preprint].

b. Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

Upcoming Waiver Period -- Please check all items that apply to the State.

a. X The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals (with Medicaid), Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.

For the purpose of this waiver, "populations with special health care needs" is defined as Medicaid clients with serious and persistent mental illness.

b. X There are special populations included in this waiver program.
Please list the populations.

Per CMS definition, Children, adults and older adults with mental illness or serious emotional disturbance.

c. X The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies that serve special needs consumers, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

The PIHP contract includes the requirement for cross-system coordination for all children who are involved in multiple system. These plans are developed by the RSN in collaboration with their local or regional system partners, approved and signed by the respective regional administrator.
Treatment plans reflect this coordination, which involves intersystem collaboration with key DSHS agencies involved with the client and family as well as school, CLIP, family partners, etc. For children this requirement includes EPSDT coordination with any DSHS child serving agency, with whom a child/youth is involved, including a process for participation by the agency in the development of a cross-system Individual Service Plan when indicated under EPSDT.

RSN Allied System Coordination Plans must be developed with each of the following programs:

- *Aging and Disability Services Administration (ADSA) (this includes Developmental Disability Services for adults and children)*
- *Chemical Dependency and Substance Abuse services*
- *Children's Administration*
- *Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Healthy Options Plans*
- *Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections)*
- *Division of Vocational Rehabilitation*
- *Juvenile Rehabilitation Administration*

Each region is allowed to develop their own format, but must adhere to the following required elements. These plans are updated as needed according to contract and/or request by one or more systems due to internal and/or community changes. These agreements provide a foundation for coordinating effective treatment planning and case management.

The RSN Contract Allied System Coordination Agreement must contain all of the following elements:

- *Clarification of roles and responsibilities of the allied systems in serving multi-system consumers.*
- *Processes for the sharing of information related to eligibility, access and authorization.*
- *Identification of needed local resources, including initiatives to address those needs.*
- *A process for facilitation of community reintegration from out-of-home placements (e.g. State hospitals, Children's Long- term Inpatient facilities, Juvenile Rehabilitation Administration facilities, foster care, nursing homes, acute inpatient settings) for consumers of all ages.*
- *A process or format to address disputes related to service or payment responsibility.*
- *A process to evaluate progress in cross-system coordination and integration of services.*

d.___ The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1.___ Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)
2.___ State/local funding sources
3.___ Other (please describe):

e.___ The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the waiver in the following areas:

1.___ Access to services (please describe):
2.___ Quality of Care (please describe):
3.___ Coordination of care (please describe):
4.___ Enrollee satisfaction (please describe):
5.___ Other (please describe):

f. X The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.

HRSA's QA & I team reviews new (provisional license) agencies for ADA compliance. They request the latest self-assessment for ADA compliance and look for any corrective actions. If they are county or RSN contractors, QA &I staff ask to see their latest review activities on this issue. If the agency can't provide documentation of ADA evaluation, QA&I staff then look about to see if there are any major access barriers (disabled parking, rails in bathrooms, wheel chair accessible, etc.).

g. X The State has specific performance measures and performance improvement projects for the populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance indicators and performance improvement projects:

Please see the Division of Behavioral Health and Recovery website at http://www1.dshs.wa.gov/mentalhealth and the WIMIRT website http://depts.washington.edu/washinst.

II. State Requirements for MCOs/PIHPs/PAHPs

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint, item F.II. Upcoming Waiver Period, 1999 Renewal Waiver Preprint].

Upcoming Waiver Period Please check all the items that apply to the State or MCO/PIHP/PAHP.

a.___ The State has required care coordination/case management services the MCO/PIHP/PAHP shall provide for individuals with special health care needs. Please describe by population.

b.___ As part of its criteria for contracting with an MCO/PIHP/PAHP, the State assesses the MCO/PIHP/PAHP's skill and experience level in accommodating people with special needs. Please describe by population.

c.___ The State requires MCOs/PIHPs/PAHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population.

d.___ The State has provisions in contracts with MCOs/PIHPs/PAHPs that allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If not checked, please explain by population.

e.___ The State collects or requires MCOs/PIHPs/PAHPs to collect population-specific data for special populations. Please describe by population.

f.___ The State requires MCOs/PIHPs/PAHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.

1. Please note any services marked in Appendix D.2.S that are for special needs populations only by population.

2. Please note any unique definitions of "medically necessary services" for special needs populations by population.

3. Please note any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State's Title V agency for any special needs children who qualify for Title V assistance?

g.___ The State requires MCOs/PIHPs/PAHPs to identify individuals with complex or serious medical conditions in the following ways:

1.___ An initial and/or ongoing assessment of those conditions
2.___ The identification of medical procedures to address and/or monitor the conditions.
3.___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
4.___ Other (please describe):

h.___ The State specifies requirements of the MCO/PIHPs/PAHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

Section G. APPEALS, GRIEVANCES, AND FAIR HEARINGS

MCOs/PIHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

States, MCOs, PIHPs, and PAHPs are required to provide Medicaid enrollees with access to the State hearing process as required under 42 CFR 431 Subpart E, including:

- *Informing Medicaid enrollees about their hearing rights in a manner that assures notice at the time of an action;*
- *Ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if the State takes action without the advance notice and as required in accordance with State Policy on hearings. The state must also inform enrollees of the procedures by which benefits can be continued or reinstated; and*
- *Other requirements for fair hearings found in 42 CFR 431 Subpart E.*

I. Definitions (MCO/PIHP):

Upcoming Waiver Period --

a. **X** [Required]The definition of action in the case of an MCO/PIHP means:

- ✓ Denial or limited authorization of a requested service, including the type or level of service;
- ✓ The reduction, suspension, or termination of a previously authorized service;
- ✓ The denial, in whole or in part, of a payment for a service;
- ✓ The failure to provide services in a timely manner;
- ✓ The failure to act within timeframes required by 42 CFR 438.408(b);
- ✓ For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

b. **X** Appeal means a request for a review of an action.

c. **X** Grievance means an expression of dissatisfaction about any matter other than an action.

b. Please describe any special processes that the State has for persons with special needs.

II. Grievance Systems Requirements (MCO/PIHP):

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to appeals, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint, item G.II 1999 Upcoming Waiver Renewal Preprint]. Also, please provide summary information on the types of appeals, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Strategy.

HRSA has monitored grievance and fair hearings for the last several years. The current template and instructions for use in reporting complaints (not included in the table below), grievances and fair hearings was implemented in October, 2001. Data for adults and for children were combined on a one page summary report, to be submitted to MHD. In addition to reports of cases and occurrences of various types (e.g. dignity and respect), RSNs are expected to report the corresponding resolutions to the occurrences of types of grievances and fair hearings.

RSNs vary in their ability to conduct analyses of raw data. Some of them have incorporated use of complaint data into their ongoing quality monitoring and management processes.

The PIHPs have gained a better understanding of their responsibility when a denial of service is initiated due to an enrolled consumer not meeting the definition of medical necessity for service.

b. Please mark any of the following that apply:

1.___ A hotline was maintained which handles any type of inquiry, complaint, or problem.

2.**_X_** Following this section is a list or chart of the number and types of complaints and/or (not required per BBA and CMS) grievances handled during the waiver period.

October 2007 through September 2008

Adult (21 Yrs. and over)	PIHP Grievances	Fair Hearings
Access to Outpatient	5	0
Dignity and Respect	6	0
Quality/ Appropriateness	4	1
Phone calls not returned	1	0
Service -- Intensity, Not Available, Coordination	5	6
Consumer Rights	9	3
Physicians & Medications	1	0
Financial & Admin Svs	0	0

Children (0-20 Yrs.)	PIHP Grievances	Fair Hearing
Access to Outpatient	0	0
Dignity and Respect	0	0
Quality/ Appropriateness	0	0
Phone calls not returned	0	0
Service -- Intensity, Not Available, Coordination	0	0
Consumer Rights	0	0
Physicians & Medications	3	0
Financial & Admin Svs	0	0

Transportation	0	0
Emergency Services	0	1
Access to Inpatient	1	0
Violation of Confidentiality	0	0
Participation in Treatment	3	1
Other	2	1
Total	**37**	**13**

Transportation	0	0
Emergency Services	0	0
Access to Inpatient	0	0
Violation of Confidentiality	0	0
Participation in Treatment	0	0
Other	0	0
Total	**3**	**0**

October 2008 through September 2009

Adult (21 Yrs. and over)	**PIHP Grievances**	**Fair Hearings**
Access to Outpatient	5	0
Dignity and Respect	6	0
Quality/ Appropriateness	4	1
Phone calls not returned	1	0
Service -- Intensity, Not Available, Coordination	5	6
Consumer Rights	9	3
Physicians & Medications	1	0
Financial & Admin Svs	0	0
Transportation	0	0
Emergency Services	0	1
Access to Inpatient	1	0
Violation of Confidentiality	0	0
Participation in Treatment	3	1
Other	2	1
Total	**37**	**13**

Children (0-20 Yrs.)	**PIHP Grievances**	**Fair Hearing**
Access to Outpatient	0	0
Dignity and Respect	0	0
Quality/ Appropriateness	0	0
Phone calls not returned	0	0
Service -- Intensity, Not Available, Coordination	0	0
Consumer Rights	0	0
Physicians & Medications	3	0
Financial & Admin Svs	0	0
Transportation	0	0
Emergency Services	0	0
Access to Inpatient	0	0
Violation of Confidentiality	0	0
Participation in Treatment	0	0
Other	0	0
Total	**3**	**0**

3. **X** There is consumer involvement in the grievance process. Please describe.
Consumers have the right to seek the services of Ombuds. Ombuds are required to be consumers or past consumers of mental health or family members of consumers of mental health. Consumers may also use other representation if they choose.

Upcoming Waiver Period -- Please check requirements in effect for MCO/PIHP grievance

processes.

a. Required Appeals, Grievances, and Fair Hearings Elements for MCOs/PIHPs:

1. **X** MCO/PIHPs have a system in place for enrollees that include a grievance process, an appeals process, and access to the State's fair hearing process.

2. **X** An MCO/PIHP enrollee can request a State fair hearing under the State's Fair Hearing process. The State permits
(A)__ direct access without first exhausting the MCO/PIHP grievance process

(B) **X** exhaustion of MCO/PIHP grievance process before a State fair hearing can be accessed. With regard to specific mental health grievance, the state requires the consumer to exhaust grievances at the lowest level possible; first at the community mental health agency, then the PIHP level and then fair hearing with a maximum time frame for resolution of 30 days at each level.

Per DSHS rules a consumer may access a fair hearing at any time for issues with regard to DSHS rules.

3. **X** Enrollees are informed about their State fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.

4. **X** The state specifies a time frame that is no less than 20 days and does not exceed 90 days from the date of action for the enrollee to request an appeal or fair hearing. Specify the time frame *20 days.*

5. **X** [Optional] The State has time frames for resolution of grievances. Specify the time frame set by the State *90 days.*

The regional support network must have in place a system for reviewing and resolving consumer grievances. The process must comply with WAC 388-865-0255 or its successor.

6. **X** The MCO/PIHP issues a written notice of all actions. Notices meet the requirements of 42 CFR 438.404 for language, format, content, and timing.

7. **X** The MCO/PIHP acknowledges receipt of each appeal and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PHPs to acknowledge complaints and grievances, please specify: *Initial acknowledgement may be by telephone, with written acknowledgement within five working days of receipt of the appeal or grievance.*

8. **X** The MCO/PIHP gives enrollees assistance completing forms or other assistance necessary in filing appeals or grievances (or as appeals and grievances are being resolved).

9. **X** The MCO/PIHP ensures individuals who make decisions were not involved in previous levels of decision making.

10. **X** The MCO/PIHP ensures individuals who make decisions are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease.

11. **X** The MCO/PIHP ensures the special requirements for appeal, i.e. on oral inquiries, reasonable opportunity to present evidence; ability to examine case file, and inclusion of parties to appeal in 42 CFR 438.406(b) are met.

12. **X** Timeframes for resolution:

(a) **X** Grievances are *investigated and* resolved within 30 days (may not exceed 90 days from date of receipt by MCO/PIHP)

(b) **X** Standard appeals are resolved in 45 days (may not exceed 45 days from date of receipt by MCO/PIHP).

(c) **X** Expedited appeals are resolved in 3 days (may be no more than 3 working days from date of receipt by MCO/PIHP, unless extended).

13. **X** Timeframes for resolution may be extended for up to 14 calendar days if it meets the requirements of 42 CFR 438.408(c).

14. **X** The MCO/PIHP notifies the enrollee in writing of the appeals decision and, if not favorable to the enrollee, the right to request a State fair hearing, including rights to continuation of benefits. The format and content of the notice meet the requirements of 42 CFR 438.408(d)-(e).

15. **X** The MCO/PIHP complies with the requirements on availability of and parties to State fair hearings in 42 CFR 438.408(f).

16. **X** The MCO/PIHP maintains an expedited review process for appeals when it is determined that the standard resolution timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. This includes the prohibitions on punitive actions, and action following denial of request for expedited resolution in 42 CFR 438.410.

17. **X** The MCO/PIHP informs the enrollee of any applicable mechanism for resolving the issue external to the MCO's/PIHP's own processes (e.g. independent state review mechanism).

18. **X** MCOs/PIHPs maintain a log of all appeals and grievances and their resolution.

19. **X** The State reviews information on each MCO/PIHP's appeals as art of the State quality strategy.

20. **X** The State and/or MCO/PIHP have ombuds programs to assist enrollees in the appeals, grievance, and fair hearing process.

21.___Other (please specify):

III. PAHP Requirements

1.__ [Optional] PAHPs have an internal grievance system. Please describe.

2.__ [Required] PAHP enrollees have access to the State fair hearing process.

Section H. ENROLLEE INFORMATION AND RIGHTS

This section describes the process for informing enrollees and potential enrollees about the waiver program, and protecting their rights once enrolled. Marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.IV.a).

I. Information – Understandable; Language; Format

Previous Waiver Period

a. [Required] Please provide copies of the brochure and informational materials for potential enrollees explaining the program and ~~how to enroll~~ *mandatory enrollment*.

The Benefit Booklet is updated on HRSA's web page as we are made aware of changes. The Benefit Booklet attached as Attached H.I.a. has been updated to reflect changes in provider location and contact information, as well as to clarify information provided in the previous handbook.

Attachment H. I. a.

Washington Public Mental Health

Benefits Booklet

For People Enrolled in Medicaid

Division of Behavioral Health and Recovery's Office of Consumer Partnerships

Call 1-800-446-0259

TRANSLATION PAGE

Division of Behavioral Health and Recovery's Office of Consumer Partnerships
Call 1-800-446-0259

Dear Medicaid Recipient,

Children and adults enrolled in Medicaid may be eligible for mental health services as well as medical coverage. This benefits booklet will help answer many questions about these services including:

- How to get mental health services and what to do in an emergency.
- Mental health services available under the Medicaid Mental Health Program run by the Health and Recovery Services Administration (HRSA).
- Your rights when you receive help.
- How you and your family members can be involved in helping us provide better services.
- Information about medical care.
- What to do when you aren't satisfied.

For more information on the public mental health system run by HRSA, you may want to look at the laws and rules. You can look in the Revised Code of Washington (RCW) Chapters 71.05, 71.24, 71.34 and the Washington Administrative Code (WAC) 388-865-(0100-0600). You can find these on the internet at http://www.leg.wa.gov/pages/home.aspx.

Mental health information is also available at The Division of Behavioral Health and Recovery's internet site at http://www1.dshs.wa.gov/mentalhealth.

Besides the information provided in this booklet, there are people who can help you find other mental health services that may be available. You may call 1-800-562-3022. There are instructions inside this booklet on how to use this telephone number. They can also direct you to other information on the internet.

Health and Recovery Services Administration

Table of Contents

Important Numbers

If there is a life-threatening emergency, please call 9-1-1.
24-Hour Mental Health Crisis Line Phone Numbers by County:

ADAMS	COLLECT – OTHELLO 1-509-488-5611, COLLECT – RITZVILLE 1-509-659-4357
ASOTIN	1-888-475-5665
BENTON-FRANKLIN	1-800-783-0544, 1-509-783-0500
CHELAN	1-800-852-2923, 1-509-662-7105(8:00 – 5:00 MON – FRI)
CLALLAM	1-360-374-6177, 1-360-374-5011
CLARK	1-800-626-8137, 1-360-696-9560
COLUMBIA	1-866-382-1164
COWLITZ	1-800-803-8833, 1-360-425-6064
DOUGLAS	1-800-852-2823, 1-509-662-7105
FERRY	1-866-268--5105
GARFIELD	1-888-475-5665
GRANT	TTY/TDD COLLECT 1-509-765-1717, 1-877-467-4303
GRAYS HARBOR	1-800-685-6556
ISLAND	1-800-584-3578
JEFFERSON	1-360-385-0321
KING	1-866-427-4747, 1-206-461-3222

KITSAP	1-360-479-3033, 1-800-843-4793
KITTITAS	1-509-925-9861, 1-509-925-4168 (AFTER HOURS)
KLICKITAT	1-800-572-8122
LEWIS	1-800-559-6696, 1-360-748-6696 #1
LINCOLN	1-888-380-6823
MASON	1-800-627-2211, 1-360-586-2800, YOUTH: 1-360-586-2777
OKANOGAN	1-509-826-6191, #2
PEND OREILLE	1-509-826-6191, #2
PIERCE	1-800-576-7764
SAN JUAN	1-800-584-3578
SKAGIT	1-800-584-3578
SKAMANIA	1-509-427-3850, #1
SNOHOMISH	1-800-584-3578, 1-425-258-4357
SPOKANE	1-877-678-4428, 1-509-838-4428
STEVENS	1-888-380-6823
THURSTON	1-800-627-2211, 1-360-586-2800, YOUTH: 1-360-586-2777
WAHKIAKUM	1-800-635-5989, #1
WALLA WALLA	1-509-522-4278
WHATCOM	1-800-584-3578

WHITMAN	1-866-871-6385
YAKIMA	1-509-575-4200 OR 1-800-572-8122

Important Resources

Medical Care
1-800-562-3022, 7:00 am to 5:30 pm Monday through Friday
You will need your Services card when you use this number

You can also email customerinquiry@dshs.wa.gov for information if you are unable to get through the telephone number during busy call hours. You will need your Services card number in your email, and will receive a response in 24 – 48 hours.

http://hrsa.dshs.wa.gov/HealthyOptions

Alcohol or Substance Abuse
Division of Behavioral Health and Recovery
1-877-301-4557 or http://www1.dshs.wa.gov/dasa/

Aging and Disabilities Services
1-800-422-3263 or http://www.aasa.dshs.wa.gov

Medicaid Transportation Information
1-800-562-3022 or customerinquiry@dshs.wa.gov
This is the same information for Medical Care above.

Office of Civil Rights
http://www.hhs.gov/ocr

Office of Administrative Hearings
PO Box 42489
Olympia, WA 98504
1-800-583-8271

Information about Services

Who is eligible for public mental health services?
People who receive a Services card can get medically necessary mental health services at no cost.

The Regional Support Networks (RSNs) contract with Community Mental Health Agencies (CMHAs) to provide mental health services. You have to meet medical necessity and have an illness covered by our program. Sometimes you will hear this called the *Access to Care Standards*.

If you do not meet the *Access to Care Standards*, you may be eligible for mental health services provided by other parts of the Department of Social and Health Services (DSHS).

You can call 1-800-562-3022 to find out more.

Who provides services covered under this booklet?
The Washington State public mental health system, run by the Health and Recovery Services Administration (HRSA), has 13 RSNs. Each RSN is made up of one or more counties. Everyone on Medicaid is enrolled in the RSN.

Except for Crisis Services, most mental health services must be authorized by the RSN in your area. You may only go to an RSN contracted agency for covered services. A list of agencies begins on page 19.

You may have to pay for services if you go to a mental health provider that is not on the agency list.

REGIONAL SUPPORT NETWORK	COUNTIES SERVED
CHELAN-DOUGLAS RSN	CHELAN, DOUGLAS
CLARK COUNTY RSN	CLARK
GRAYS HARBOR RSN	GRAYS HARBOR
GREATER COLUMBIA RSN	ASOTIN, BENTON, COLUMBIA, FRANKLIN, GARFIELD, KITTITAS, KLICKITAT, SKAMANIA, WALLA WALLA, WHITMAN, YAKIMA
KING COUNTY RSN	KING
NORTH CENTRAL WASHINGTON RSN	ADAMS, GRANT, OKANOGAN, FERRY, LINCOLN, PEND OREILLE, STEVENS
NORTH SOUND RSN	ISLAND, SAN JUAN, SKAGIT, SNOHOMISH, WHATCOM
PENINSULA RSN	CLALLAM, JEFFERSON, KITSAP
PIERCE RSN	PIERCE
SOUTHWEST RSN	COWLITZ
SPOKANE COUNTY RSN	SPOKANE
THURSTON-MASON RSN	MASON, THURSTON
TIMBERLANDS RSN	LEWIS, PACIFIC, WAHKIAKUM

How can I get mental health services?

If you think that you need mental health services, you can call or go to your RSN or to a covered agency in the

community where you live to schedule an appointment for an intake evaluation. The intake evaluation is used to decide medical necessity and what mental health services you may need.

The RSN will provide easily understood information on mental health and applying for services. If needed, this will be in languages other than English.

What happens at an intake evaluation?
A mental health professional will meet with you to determine if you have a covered mental illness. This is called a clinical assessment and decides medical necessity. This may take more than one visit.

This service is at no cost to anyone on Medicaid.

The mental health professional will talk with you about your strengths and needs. They will ask questions about your goals. They might talk to you about your history and culture. They will ask about substance abuse issues, other medical issues and other questions about your life.

If after that meeting, they agree with you that services will help improve, stabilize or keep your illness from getting worse, you are eligible for services.

Once eligible, you will develop an individual service plan with your mental health care provider. You will also get a Notice of Determination letter that tells you what services are approved and for how long.

How do I get care in an emergency?
Mental health crisis and post-stabilization services are available to assist you if you have a sudden or severe mental health problem that needs treatment right away. If you think you have an emergency, no matter where you are, call 911 or go to the nearest emergency room. You **do not** need an intake evaluation before you receive these services and there is no charge to you for these services.

What if I need to be in a hospital for mental health care?
If you think you may need to be admitted to a hospital for mental health treatment, contact your mental health care provider or the crisis line immediately. Mental health treatment in a hospital is a covered service for Medicaid enrollees. Hospital care must be approved in advance by the RSN or you may be billed for the services.

What services are available to me as a Medicaid enrollee?
You, your mental health care provider, and others you want to invite, will make a plan that is only for you. The "individual service plan" will build on your personal, family and community strength and will honor your age, culture, and beliefs.

Here is a list of the kinds of services you have a right to get if they are part of your plan:

- **Brief Intervention Treatment** – short term counseling that is solution-focused on a specific problem

- **Day Support** – intensive program to learn or assist you with independent living skills
- **Family Treatment** – family centered counseling to help everyone get along and solve problems
- **Evaluation and Treatment/Community Hospitalization** – inpatient care, in a hospital or facility. You **do not** need an intake evaluation before this service.
- **Group Treatment Services** – counseling that offers a chance to learn from people with similar needs
- **High Intensity Treatment** – services that are provided by a team to help you meet your goals in your individual service plan
- **Individual Treatment Services** – counseling and/or other activities designed to help you meet your goals in your service plan
- **Intake Evaluation** – meeting to help identify your needs and goals. It helps you and your mental health care provider to decide other services. The first service you get unless you have had a crisis service.
- **Medication Management** – licensed staff who prescribe you medicine and talk to you about side effects
- **Medication Monitoring** – service to help you to remember to take your medicine correctly
- **Mental Health Services Provided in Residential Settings** – services provided where you live
- **Peer Support** – support, activities, and other nonprofessional services provided by trained mental health consumers who are in recovery to help you learn to cope, plan, and work toward recovery. These services are provided to compliment professional services such as psychiatry and medication management.
- **Psychological Assessment** – help with diagnosis, evaluation and treatment planning
- **Rehabilitation Case Management** – coordination with your inpatient mental health services, outpatient mental health services, and physical care services. This might be part of your intake evaluation**.**
- **Special Population Evaluation** – services provided to you by someone with special training in working with children, older adults or those from a minority background to help set treatment goals
- **Stabilization Services** – provided in your home or home-like setting to help prevent a hospital stay. You **do not** need an intake evaluation before this service.
- **Therapeutic Psychoeducation** – education about mental illness, mental health treatment choice, medicine and recovery

These services may be available in your RSN:

- **Respite Care –** temporary replacement of a caregiver of someone with a mental illness in order for the caregiver to rest.
- **Supported Employment -** services that help people with mental illnesses find and keep employment within their communities.
- **Mental Health Clubhouse -** a place designed to assist someone to recover from a mental illness by involving them in meaningful activities that encourage and support them to take control of their lives.
- **Other services –** your mental health care provider may also help you connect with services such as housing, healthcare, and employment.

For more detailed information, please call the RSN in your community.

May I choose my mental health care provider?
You may choose a mental health care provider at the agency where you receive services. If you don't choose a mental health care provider, one will be assigned to you. You have the right to change mental health care providers during the first 30 days. You can also ask for a change once a year without a reason.

How can I access medical care that is covered by Medicaid?
If you have Medicaid Fee for Service (FFS) benefits, you can go to any doctor who is contracted with DSHS. Contact the doctor to see if they are a Medicaid Provider before making an appointment. If you need more help or information to find a doctor or clinic in your area you may call this toll free number: 1-800-562-3022.

Be sure to take your Services card to your medical appointment so your doctor may determine your benefits.

If you are enrolled in managed care under Healthy Options/Children's Health Insurance Program (HO/CHIP) your plan's number is listed below. You can call your plan and request care. If you need more help or information to find a doctor or clinic in your area you may call 1-800-562-3022 or go to http://hrsa.dshs.wa.gov/healthyoptions/newho/client/planlinks.htm.

Be sure to take your plan ID card as well as your Services card to your medical appointment so your doctor may determine your benefits.

For children from birth to 21 years of age, EPSDT health screenings are available. The health screening could identify other health needs you might have. The doctor can then make a referral for follow-up.

PLAN NAME	**TOLL- FREE NUMBERS**
ASURIS NORTHWEST HEALTH	1-866-240-9560
COLUMBIA UNITED PROVIDERS	1-800-315-7862
COMMUNITY HEALTH PLAN OF WASHINGTON	1-800-440-1561
GROUP HEALTH COOPERATIVE	1-888-901-4636
MOLINA HEALTHCARE OF WASHINGTON, INC.	1-800-869-7165
REGENCE BLUESHIELD	1-800-669-8791
IF YOU WANT TO ENROLL OR CHANGE YOUR PLAN CALL	IF YOU WANT TO CHANGE YOUR DOCTOR, PLEASE CALL

DSHS AT 1-800-562-3022	YOUR PLAN DIRECTLY.

What other mental health care is covered by Medicaid?
If you do not meet Access to Care Standards for RSN services but need mental health care, you may access these services through other parts of DSHS. You can get this information by calling 1-800-562-3022 or by calling your managed care plan.

Do I have to pay for any mental health services?
Usually not…. but if you get care from a provider who is not contracted with your RSN, you may have to pay. If you ask for a service that is not covered, or not medically necessary, you may have to pay. If you are not sure about the provider or the services, please check with your RSN.

What if I get a bill?
You should not receive a bill for services that are covered by Medicaid unless you get services that were not authorized.

If you get a bill, contact the billing office of the agency that sent you the bill. Tell them you are covered by Medicaid and ask them to explain the bill.

If this does not fix the problem you can contact your mental health care provider, your RSN or the Ombuds for more help.

What if I need transportation for medical care?
In many cases Medicaid will pay for transportation to a health related service appointment. If you need help finding transportation call this toll-free number: 1-800-562-3022.

Are there member satisfaction surveys?
Once a year, HRSA does a survey to see how you or your family member feel about the services you received. You do not have to take part in the survey. If you are contacted please take the time to respond. Your voice is the best way to improve the system.

Your Rights as a Person Receiving Public Mental Health Services

What are my rights as a person receiving public mental health services in the community?

- To be treated with respect and dignity
- To have your privacy protected
- To help develop a plan of care with services to meet your needs
- To participate in decisions regarding your mental health care
- To receive services in a barrier-free location (accessible)
- To request information about names, location, phones, and languages for local agencies
- To receive the amount and duration of services you need
- To request information about the structure and operation of the RSN
- To services within two hours for emergent care and 24 hours for urgent care
- To be free from use of seclusion or restraints
- To receive age and culturally appropriate services
- To be provided a certified interpreter and translated material at no cost to you
- To understand available treatment options and alternatives
- To refuse any proposed treatment
- To receive care that does not discriminate against you (e.g. age, race, type of illness)
- To be free of any sexual exploitation or harassment
- To receive an explanation of all medications prescribed and possible side effects
- To make an advance directive, that states your choices and preferences for mental health care
- To receive quality services which are medically necessary
- To have a second opinion from a mental health professional
- To file a grievance with your agency or RSN
- To file a RSN appeal based on a RSN written Notice of Action
- To choose a mental health care provider or choose one for your child who is under 13 years of age
- To change mental health care providers during the first 90 days, and sometimes more often
- To file a request for an administrative (fair) hearing
- To request and receive a copy of your medical records and ask for changes. You will be told the cost for copying
- Be free from retaliation
- Request and receive policies and procedures of the RSN and Community Mental Health Agencies (CMHAs) as they pertain to your rights

You may also contact the Office of Civil Rights for more information at http://www.hhs.gov/ocr.

Mental Health Advanced Directives

What is a mental health advance directive?
A mental health advance directive is a written document that describes what you want to happen if you become so ill by mental illness that your judgment is affected or if you are unable to communicate. It tells others about what treatment you want or don't want. It can identify a person to whom you have given the authority to make decisions on your behalf.

If you have a physical health care advance directive you should share that with your mental health care provider so they know your wishes.

How do I complete a mental health advance directive?
A model "fill-in-the-blanks" form is available on the DSHS web site, http://www1.dshs.wa.gov/mentalhealth. Your CMHA, your mental health care provider, or your Ombuds may also have copies of the form. You may also call the Office of Consumer Partnerships at 1-800-446-0259.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Rights for Children

What is EPSDT for children?
EPSDT is a health program for children with Medicaid coverage, including foster children, and provides links to other services. With EPSDT, children can get regular health checkups. If your child needs to get medical care for a problem that is found during the check up, Medicaid will also pay for medically necessary follow-up care. Every child from birth to 21 years of age who has Medicaid coverage can get regular health checkups. During this EPSDT health visit your child may be referred for a mental health assessment either through the RSN or as part of your child's health plan. You will get an intake evaluation when you are sent to the RSN.

When should children get a checkup?
Children should receive their first health exam as soon as you get your Services card. After the first exam:

- Children two to six years old should get a checkup once a year.
- Children age seven through 20 should get a checkup every other year.
- Children under age two, consult with your primary care provider about how often to get a checkup.

A referral for mental health assessment could occur at any of these visits. Once there is an appointment with a mental health professional, the primary care provider is notified by the mental health professional so they can work together on a plan of care.

If mental health care is already being received, the mental health care provider will ask if regular health exams are also being received. If not, a referral will be made for a primary care physician or a telephone number will be offered in order to find a primary care physician for regular health exams. A referral for a "Healthy Child Screening" may also be made.

Medicaid will also cover some dental and eye screening under EPSDT.

What if my child or I need a dentist?
Limited dental coverage is available to Medicaid enrollees. To find a dentist, call the local dental society in your area. It will be listed in the yellow pages under "Dentist Referral" or call 1-800-562-3022.

Grievance and Appeals

What can I do if I am not happy with my services?
You can tell the Community Mental Health Agency (CMHA). If that doesn't help you can:

- Contact Ombuds services;
- File a Grievance;
- File an Appeal if you receive a written Notice of Action from your RSN; and/or
- Request an Administrative (Fair) Hearing

Who can help me with Grievances, Appeals or Administrative (Fair) Hearings?
Each RSN has an Ombuds service that can assist you with a grievance, an appeal, or the state administrative fair hearing process. The Ombuds help resolve concerns about mental health services.

EXAMPLE: YOU FEEL THAT SOMEONE AT THE CMHA WAS RUDE TO YOU AND YOU WANT TO KNOW WHAT YOU CAN DO:

- **YOU CAN TELL SOMEONE AT THE AGENCY**
- **YOU CAN TALK TO THE OMBUDS**
- **YOU CAN HAVE THE OMBUDS HELP YOU FILE A GRIEVANCE AT THE CMHA OR RSN LEVEL**
- **YOU CAN ASK FOR AN ADMINISTRATIVE (FAIR) HEARING THROUGH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS. THE OMBUDS CAN ALSO HELP YOU WITH THIS**

The Ombuds service phone numbers are listed for each RSN on page 18. A CMHA or the RSN can also help you contact the Ombuds.

How do I file a Grievance?
Here are the steps in the grievance process:

1. To file a Grievance, contact the CMHA where you receive services or the RSN in your community.
2. You may ask for help with your Grievance. The Ombuds service is free to you. You may choose someone else to help if you wish. Interpreter and TTY/TTD services are there to help, if needed.
3. You may file a Grievance with a telephone call or in writing. If you start with a telephone call, you must send a letter within seven days. The Ombuds can help you with this.
   Please include in your letter:
   - **your name;**
   - **how to best contact you;**
   - **the problem;**
   - **what you want to solve the problem; and**

- **your signature**

4. When a CMHA or RSN receives the Grievance, they will let you know either by telling you or sending a letter within one working day. If they tell you, they must also send you a letter within five working days.
5. Your Grievance will be reviewed by people who have not been involved before with the issue(s). If your Grievance is about mental health treatment, a qualified mental health care professional will be part of the review.
6. You will receive a letter telling you the decision.
7. If you start the process at the CMHA and you are not happy with their decision, you can go to the RSN. You have five calendar days from when you get the CMHA's decision to talk with the RSN.
8. There are timelines that must be followed by the CMHA and the RSN. Normally this is 30 days from the time you make the request. You may ask for an additional 14 calendar days for the RSN to respond if you think it is in your best interest. The RSN also may ask for up to 14 additional days to make a decision if they need more information and it is in your best interest. You will be told the reason for the delay.
9. You will receive a letter with the RSN's decision about your Grievance.
10. If you do not receive a letter within the timeframes in the rules, or you disagree with the RSN, you may file a request for an Administrative (Fair) Hearing.

What is an action?
An Action is a denial, suspension, reduction, or termination of your services.

What is a Denial?
The decision not to offer an intake evaluation is a denial. The decision by the RSN not to authorize Medicaid mental health services that are requested for you by a CMHA is a denial.

What does a Suspension, Reduction or Termination mean?
This occurs when an RSN makes a decision to change your mental health services to less than what was originally agreed upon.

What kind of decision is not an Action?
An Action can only come from the RSN:

EXAMPLE OF WHAT ARE NOT ACTIONS:

- **YOU AND YOUR MENTAL HEALTH CARE PROVIDER MAKE CHANGES TO YOUR INDIVIDUAL SERVICE PLAN.**
- **YOUR MEDICATION MANAGEMENT SERVICE IS CHANGED TO YOUR PRIMARY CARE PHYSICIAN.**

If a mental health professional does not request ongoing mental health services after an intake, you will get a "Notice of Determination".
This is a letter that explains to you why the decision was made. It will remind you about:

- your right to a second opinion and how to get the second opinion;
- information about the availability of other services under EPSDT for enrollees under 21 and their legal representative; and
- your right to file a grievance or request an Administrative (Fair) Hearing and how to do so.

How do I file an appeal?

1. To start an Appeal, contact the RSN that sent you the Notice of Action. The Appeal must be requested within 20 days of getting the Notice of Action or the date the Action takes place. If your Appeal is about services you are getting, you can ask for the services to continue until your Appeal is decided. If you do this, your request for an Appeal must be made within 10 days from the date the RSN mailed the Notice of Action, or the date the Action takes place.
2. The Ombuds can help with your Appeal. You may have help from your CMHA or anyone else you want.
    - Interpreter and TTY/TTD services are available and free.
3. You may start an Appeal with a phone call or in writing. Please include:
    - your name;
    - how to reach you;
    - the reason for the Appeal;
    - any information you wish to submit to support your request, and,
    - your signature.
4. You may ask for a faster (expedited) Appeal process if you or your mental health care provider feel that this is better for your mental health. If you ask for a faster process your RSN will decide within three working days. If the RSN takes longer, you will be told why.
5. When the RSN gets the request for an Appeal, they will tell you or write to you within one working day. If they tell you, they must send a letter within five working days.
6. During the Appeal process, you and anyone you give permission can look at your mental health records to help.
7. Your Appeal will be reviewed by someone who is trained and has not been involved with your treatment.
8. While your Appeal is being decided, you may ask to continue your services, if:
    - The Appeal is filed within 10 days.
    - The services are covered Medicaid mental health services.
    - The Appeal involves the reduction, suspension, or termination of services that the CMHA states you need.
    - Your approval for Medicaid mental health services is current.

    IMPORTANT NOTE: If the Appeal decision is not in your favor, you may have to pay for the services you received during the Appeal.
9. Your RSN will decide your Appeal within 45 days from the day you started it. They may ask for up to 14 more days. This is so they make the best decision and have time to get more information. The delay

must be in your best interest. You will be notified of the reason for the delay.

10. The RSN will send you a written Appeal decision.

What is an Administrative (Fair) Hearing?

An Administrative or Fair Hearing is the same process. It has two names in the Federal and State laws. An Administrative Law Judge (ALJ) makes decisions in Administrative (Fair) Hearings. They will decide if a Washington Administrative Code (WAC), or state law, has been violated. If so, the judge can order a corrective action plan if needed. The decision of the ALJ must be followed by the RSN.

You may request an Administrative Hearing if you believe:

- A Washington Administrative Code (WAC), which is a state rule, has been broken.
- You are not satisfied with the result of your Appeal at the RSN.

You only have 20 days of the <u>original</u> date of the decision of your Appeal from the RSN to file an administrative or fair hearing.

The request for the administrative or fair hearing must go to the Office of Administrative Hearings (OAH). OAH is **not** a part of DSHS, HRSA, or the RSN. It is an independent state agency. You may call OAH at 1-800-583-8271 or send your request to:

Office of Administrative Hearings
PO Box 42489
Olympia, WA 98504

Your case will be assigned to the OAH closest to your home.

You may have an Ombuds help you with the hearing at no cost. You may also hire your own lawyer or anyone else to represent you, but you will have to pay for the cost of your representation.

During the hearing, you will have a chance to talk with others who are involved with your concerns.

Sometimes issues are resolved between you and the CMHA or the RSN before the hearing date.

Ombuds Services Contact Information

RSN OR HOSPITAL	TELEPHONE NUMBER
CHELAN-DOUGLAS RSN	1-800-346-4529 OR 1-509-886-0700
CLARK COUNTY RSN	1-866-666-5070 OR 1-360-397-8470
GRAYS HARBOR RSN	1-866-439-3064 OR 1-503-468-3509
GREATER COLUMBIA RSN	1-800-257-0660 OR 1-509-783-7333
KING COUNTY RSN	1-800-790-8049 #3
NORTH CENTRAL WASHINGTON RSN	1-800-346-4529 OR 1-509-766-2568, EXT. 314
NORTH SOUND RSN	1-888-336-6164 OR 1-360-416-7004
PIERCE COUNTY RSN (OPTUMHEALTH)	1-800-531-0508 OR 1-253-798-6123
PENINSULA RSN	1-888-377-8174 OR 1-360-692-1582
SOUTHWEST RSN	1-866-731-7403 OR 360414-0237
SPOKANE COUNTY RSN	1-866-814-3904 OR 1-509-477-4666
THURSTON-MASON RSN	1-800-658-4105 OR 1-360-867-2556
TIMBERLANDS RSN	1-866-439-3064 OR 1-503-468-3509
WMIP/MOLINA	1-800-869-7175 EXT. 141113 OR 1-425-424-1113

EASTERN STATE HOSPITAL PATIENT ADVOCATE	1-509-565-4520
WESTERN STATE HOSPITAL DIRECTOR OF CONSUMER AFFAIRS	1-253-879-7996

Regional Support Networks by County with Contracted Community Mental Health Agencies

Chelan-Douglas RSN
636 Valley Mall Parkway, Suite 200
East Wenatchee, WA 98802-4875
Web: http://www.cdrsn.org
Public Phone 509-886-6318 or Toll Free 1-877-563-3678

Authorized Community Mental Health Agencies

Catholic Family & Child Services: 509-662-6761
640 S. Mission Wenatchee, WA 98801-2263
Alternative languages available: Spanish

Children's Home Society: 509-663-0034
1014 Walla Walla Avenue, Wenatchee, WA 98801-1523
Alternative languages available: Spanish

Columbia Valley Community Health/Behavior Health Services – Adults:
509-662-7195 or Toll Free 888-424-6124

701 N. Miller Street, Wenatchee, WA 98801-2086

Columbia Valley Community Health/Behavior Health Services – Children
509-662-4296
504 Orondo St., Wenatchee WA 98801

Clark County RSN
PO BOX 5000
Vancouver, WA 98666-5000
CCRSN Web: www.clark.wa.gov/mental-health
Public Phone: 360-397-2130 or Toll Free 1-800-410-1910

Authorized Community Mental Health Agencies

Catholic Community Services: 360-567-2211
9300 NE Oak view Dr., #B, 2nd floor, Vancouver WA 98662
Alternative languages available: French, Russian and Spanish

Children's Center: 360-699-2244
415 W 11th Street, Vancouver, WA 98666-0484
Alternative languages available: Russian and Spanish
Children's Home Society: 360-695-1325
309 W 12th Street, Vancouver, WA 98666-0605

Columbia River Mental Health Services: 360-993-3000
6926 E. Fourth Plain Boulevard, Vancouver, WA 98661-7254
Alternative languages available: American Sign Language, Cambodian, Chinese, French, German, Korean, Laotian, Russian, Spanish, Tagalog, Taiwanese, Thai and Vietnamese

Community Services Northwest: 360-397-8484
1601 E Fourth Plain Blvd., Vancouver WA 98668-1845

Family Solutions: 360-695-0115
1104 Main Street, Suite 500, Vancouver, WA 98660-2972
Alternative languages available: Spanish

Lifeline Connections: 360-397-8246
PO Box 1678, Vancouver, WA 98668-1678

Sea Mar Community Health Center: 360-566-4432
7410 E Delaware Lane, Vancouver, WA 98663

Southwest Washington Medical Center: 360-696-5300
3400 Main Street, Vancouver, WA 98668-1600

Grays Harbor County RSN
2109 Sumner Avenue, Suite 203
Aberdeen, WA 98520-3699
Web: www.ghphss.org
Public Phone: 360-532-8665 x 477 or Toll Free 1-800-464-7277

Authorized Community Mental Health Agencies

Behavioral Health Resources: 360-482-5358
575 E Main Street, Suite C, Elma, WA 98541-9551
Alternative languages available: Spanish

Behavioral Health Resources: 360-538-9290
205 8th Street, Hoquiam, WA 98550-2507
Alternative languages available: Spanish

Sea Mar Counseling Social Services: 360-538-1461
1813 Sumner St. Aberdeen WA 98520
Alternative languages available: Spanish

Grays Harbor Crisis Clinic: 360-532-4357
615 8th Street, Hoquiam, WA 98550

Greater Columbia Behavioral Health RSN
Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Skamania, Walla Walla, Whitman and Yakima Counties and the Yakima Nation
101 N. Edison Street, Kennewick WA 99336-1958
Web: http;//www.gcbh.org
Public Phone: 509-735-8681 or Toll Free 1-800-795-9296

Authorized Community Mental Health Agencies

Benton/Franklin Counties Crisis Response Unit: 509-783-0500
2635 W. Deschutes Avenue, Kennewick WA 99336-3004
Alternative languages available: Spanish

Blue Mountain Counseling: 509-382-1164
221 E. Washington, Dayton, WA 99328

Catholic Family and Child Services: 509-965-7100
5301 Tieton Drive, Suite "C", Yakima WA 98908-3478
Alternative languages available: Spanish

Catholic Family and Child Services-Richland: 509-946-4645

2139 Van Glesen, Richland WA 99353

Central WA Comprehensive Mental Health-Yakima: 509-575-4084
402 S. Fourth Avenue, Yakima, WA 98907-0959
Alternative languages available: Spanish

Central WA Comprehensive Mental Health-Ellensburg: 509-925-9861
220 W. 4th Avenue, Ellensburg, WA 98926

Central WA Comprehensive Mental Health-Goldendale: 509-773-5801
112 W. Main Street, Goldendale, WA 98620

Central WA Comprehensive Mental Health-Sunnyside: 509-837-2089
1319 Saul Road S., Sunnyside, WA 98944

Central WA Comprehensive Mental Health-White Salmon: 509-493-3400
251 Rhine Village Drive, White Salmon, WA 98672

Lourdes Counseling Center: 509-943-9104
1175 Carondelet Drive, Richland WA 99352-3396
Alternative languages available: Fijian, Hindi, Meman, Punjabi, Spanish and Urdu
Lutheran Community Services Northwest: 509-735-6446
3321 W. Kennewick Avenue, Suite 150, Kennewick, WA 99336-2959

Nueva Esperanza Community Counseling center-La Clinica: 509-545-6506
720 W. Court Street, Suite 8, Pasco, WA 99301-4178
Alternative languages available: Spanish and Toisan

Palouse River Counseling Center: 509-334-1133
340 NE Maple, Pullman WA 99163
Quality Behavioral Health: 509-758-9941
900 7th Street, Clarkston, WA 99403-2058

Skamania County Counseling Center: 509-427-3850
683 SW Rock Creek Drive, Stevenson WA 98648

Walla Walla County Crisis Response Unit: 509-524-2920
310 W. Poplar, Walla Walla, WA 99362
Alternative languages available: Spanish

Yakima Valley Farm Workers Clinic Behavioral Health Services: 509-453-1344
918 E. Mead Avenue, Yakima, WA 98903-3720
Alternative languages available: Spanish

King County RSN
401 5th Avenue, Suite 400
Seattle, WA 98104-1598
Web: http://www.metrokc.gov/dshs/mhd/mhp/guide.htm
Public Phone: 206-263-9000 or 1-800-790-8049

Authorized Community Mental Health Agencies

Asian Counseling & Referral Services: 206-695-7600
3639 Martin Luther King Jr. Way S., Seattle WA 98144
Alternative languages available: Cambodian, Cantonese, Chiuchow, French, H'mong, Ilocano, Japanese, Korean, Loa, Mandarin, Mien, Samoan, Tagalog, Taglish, Thai, Taiwanese, toishanese, Vietnamese

Children's Hospital & Regional Medical Center Front Desk: 206-987-5572
4800 Sand Point Way NE, Seattle, WA 98105-0371 Intake (New patients only): 206-987-2000
Alternative languages available: ASL, Interpreters used for any languages available on request

Community House Mental Health: 206-322-2387
431 Boylston avenue E., Seattle, WA 98102-4903
Alternative languages available: Spanish
Community Psychiatric Clinic: 206-461-3614
11000 Lake City Way NE, Seattle WA 98125-6748
Alternative languages available: Chinese, French, German, Japanese, Spanish and Tagalog

Consejo Counseling & Referral Services: 206-461-4880
3808 S. Angeline Street, Seattle WA 98118-1712
Alternative languages available: Spanish

Downtown Emergency Service Center: 206-464-1570
515 – 3rd Avenue, Seattle WA 98104
Alternative languages available: Spanish

Evergreen Healthcare: 206-923-6300 or Toll Free 1-800-548-0558
2414 SW Andover Street D-120, Seattle, WA 98106

Harborview Mental Health Services: 206-744-9600
325 9th Avenue, BOX 359797 Seattle WA 98104
Alternative languages available: French, Ilocano, Spanish and Tagalog

NAVOS Mental Health Solutions: 206-933-7000
2600 SW Holden St., Seattle, WA 98126-3505
Alternative languages available: Interpreters for any language available on request

Sea Mar Community Health Center: 206-766-6976

10001 17th Place S., Seattle, WA 98168
Alternative languages available: Spanish, Interpreters provided upon request including ASL

Seattle Children's Home: 206-283-3300
2142 10th Avenue W., Seattle, WA 98119-2899
Alternative languages available: ASL, Greek, Spanish and Vietnamese

Seattle Counseling Service for Sexual Minorities: 206-323-1768
1216 Pine St., Suite 300, Seattle, WA 98101
Alternative languages: Cambodian, Chinese, Korean, Laotian, Russian, Spanish, Vietnamese. Language Line used for inbound calls and interpreters for sessions.

Sound Mental Health: 206-302-2200 TTY: 206-302-2209
1600 E. Olive St., Seattle, WA 98122-2799
Branches also available in North Seattle, Bellevue, Redmond, Renton, Kent, Auburn and Snoqualmie
Alternative languages available: ASL, Interpreters provide upon request including ASL

Therapeutic Health Services, Central Youth & Family Services Branch: 206-322-7676
1901 Martin Luther King Jr. Way S., Seattle, WA 98144
Alternative languages available: Uses CTS Language Link at 1-800-535-7749

Therapeutic Health Services, Eastside Branch: 425-757-7892
1412 140th Place NE., Bellevue, WA 98007
Alternative languages available: Uses CTS Language Link at 1-800-535-7749

Therapeutic Health Services, Rainier Beach: 206-723-1980
5802-Rainier Avenue S., Seattle WA 98118
Alternative languages available: Uses CTS Language Link at 1-800-535-7749

Therapeutic Health Services, Seneca Branch: 206-323-0934
1305 Seneca Street, Seattle, WA 98101
Alternative languages available: Uses CTS Language Link at 1-800-535-7749

Therapeutic Health Services, Shoreline Branch: 206-546-9766
16715 Aurora Avenue, Suite 102, Shoreline WA 98133
Alternative languages available: Uses CTS Language Link at 1-800-535-7749
Therapeutic Health Service, Summit Branch: 206-323-0930
1116 Summit Avenue, Seattle, WA 98101
Alternative languages available: Uses CTS Language Link at 1-800-535-7749

Valley Cities Counseling & Consultation: 253-939-4055
2704 "I" street NE, Auburn WA 98002-2498
Alternative languages available: Dynamic Language Center (for all languages including ASL) 1-800-682-8242

Valley Cities Counseling & Consultation-Federal Way: 253-661-6634
33301 1st Way South, Federal Way, WA 98003-6252
Alternative languages available: Dynamic Language Center (for all languages including ASL) 1-800-682-8242

Valley Cities Counseling & Consultation-Kent: 253-250-9350
325 W Gowe St., Kent WA 98032-5892

Valley Cities Counseling & Consultation-Kent: 253-520-9350
923 Powell Ave. SW Suite 100, Renton, WA 98055

YMCA Mental Health Services: 206-382-5340 or 1-800-760-5340
909 Fourth Avenue, Seattle, WA 98104
Alternative languages available: Uses Language Link for spoken languages. Also provides interpreters for ASL

North Central Washington RSN

Adams, Grant, Okanogan, Ferry, Lincoln, Pend Oreille and Stevens Counties
119 Basin Street SW, Ephrata, WA 98823
Public Phone: 509-754-6577 or Toll Free 1-800-251-5350

Authorized Community Mental Health Agencies

Community Counseling Services of Adams County: 509-488-5611
425 East Main, Suite 600, Othello, WA 99344-1003
Alternative languages available: Spanish

Community Counseling Services of Adams County-Ritzville: 509-659-4357
120 W. Main, Ritzville, WA 99169

Grant Mental Healthcare: 509-765-9239
840 East Plum Street, Moses Lake, WA 98837-0160
Alternative languages available: Spanish

Grant Mental Healthcare-Grand Coulee: 509-633-1471
322 Fortuyn Road, Grand Coulee, WA 99133

Grant Mental Healthcare-Quincy: 509-787-4466
203 south Central Avenue, Quincy, WA 98848

Okanogan Behavioral Healthcare and Medical Clinic, Inc.: 509-826-6191

1007 Koala Drive, Omak, WA 98841-3208
Alternative languages available: Spanish

Pend Oreille County Counseling Services: 509-447-5651
105 South Garden Avenue, Newport, WA 99156

Northeast Washington Alliance Counseling Services: 509-684-4597 or 1-866-708-4597 TTY: 509-684-7565
165 E. Hawthorne Avenue, Colville WA 99114-2629

Northeast Washington Alliance Counseling Services: Davenport: 509-725-3001 or Toll Free 1-888-725-3001
1211 Merriam, Davenport, WA 99122

Northeast Washington Alliance Counseling Services: Chewelah: 509-935-4808
Municipal Bldg., E. Clay & 2nd, Room 201, Chewelah WA 99109

Northeast Washington Alliance Counseling Services: Nine Mile Falls: 509-262-0396 or 1-866-708-4597
6176-B, Highway 291, Suite 203, Nine Mile Falls, WA 99026

Northeast Washington Alliance Counseling Services: Republic: 509-775-3341 or 1-866-807-7131
42 Klondike Road, Republic, WA 99166-9701

North Sound Mental Health RSN
Island, San Juan, Skagit, Snohomish and Whatcom Counties.
117 N. 1st Street, Suite 8, Mount Vernon, WA 98273-2858
Web: http://www.nsmha.org
Public Phone: 360-416-7013 or Toll Free 1-800-684-3555
Regional Access System for Outpatient Services for North Sound Region: 1-888-693-7200

Authorized Community Mental Health Agencies

Bridgeways: 425-513-8213 or 1-877-355-8668
1220 75th Street SW, Everett, WA 98203

Catholic Community Services-Skagit County: 360-856-3054 or 1-888-504-9992
160 Cascade Pl. Ste. 201, Burlington WA 98233-3126

Catholic Community Services-Snohomish County: 425-257-2111 or Toll Free 1-888-504-9992
1918 Everett, WA 98201

Catholic Community Services-Whatcom County: 360-676-2164 or Toll Free 1-888-504-9992
1133 Railroad Avenue, Bellingham, WA 98225

Compass Health-Snohomish County: 425-349-6200 or 1-800-457-9303
4526 Federal Avenue, Everett, WA 98203-8810

Alternative languages available: American Sign Language, Arabic, Bosnian, Cambodian, Cantonese, Farsi, French, Japanese, Korean, Mandarin, Romanian, Russian, Spanish, Tagolog, and Ukrania

Compass Health-Island County: 360-678-5555 or 1-800-457-9303
105 NW First St. Coupeville, WA 98239
Alternative Languages available: Spanish

Compass Health-San Juan County: 360-378-2669 or 1-800-457-9303
520 Spring St., Friday Harbor, WA 98250
Alternative languages available: Spanish

Compass Health-Skagit County: 360-419-3500 or 1-800-457-9303
1220 Memorial Hwy, Mount Vernon, WA 98273, Spanish Available
Interfaith Community Health Center: 360-676-6177 or 1-877-235-6850
220 Unity St,. Bellingham WA 98225
Alternative Languages available: Spanish

Lake Whatcom Residential and Treatment Center: 360-676-6000 or Toll Free 1-888-676-6002
609 A North Shore Drive, Bellingham, WA 98226-4414

Sea Mar Counseling and Social Services Bellingham: 360-734-5458
4455 Cordata Pkwy, Bellingham, WA 98226-8037

Sea Mar Counseling and Social Services, Everett: 425-347-5415 or 1-866-923-2312
5007 Claremont Way Everett WA 98203

Sea Mar Counseling and Social Services, Mount Vernon: 360-428-8912 or 1-866-923-2312
1010 E. College Way, Mount Vernon WA 98273

Sunrise Services Inc.-Skagit County: 360-336-3762 or 1-888-774-9658
PO Box 1790 Mount Vernon, WA 98273
Alternative languages available: Spanish

Sunrise Services Inc. –Snohomish County: 425-347-3149 or 1-888-774-9658
PO Box 2569, Everett WA 98213
Alternative languages available: Spanish

Volunteers of America: 425-259-3191 or 1-888-693-7200
2802 Broadway, Everett WA 98201

Whatcom Counseling & Psychiatric Clinic: 360-676-2220 or 1-888-311-0120
3645 E. McLeod road, Bellingham, WA 98226-8799

Peninsula RSN
Clallam, Jefferson and Kitsap Counties
614 Division Street, MS 23
Port Orchard, WA 98366-4676
Public Phone: 360-337-4886 or Toll Free 1-800-525-5637

Authorized Community Mental Health Agencies

Jefferson Mental Health Services: 360-385-0321
884 West Park Avenue, Port Townsend, WA 98368-0565
Kitsap Mental Health Services: 360-405-4010
5455 Almira Drive, Bremerton, WA 98311-8331
Alternative languages available: Japanese, Spanish and Tagalog

Peninsula Community Mental Health Center: 360-457-0431
118 East 8th Street, Port Angeles, WA 98362-6129

West End Outreach Services: 360-374-5011
530 Bogachiel Way, Forks, WA 98331-9120
Alternative languages available: Spanish

Pierce County RSN
3315 S 23rd St., Suite 310
Tacoma WA 98418
Public Phone: 253-292-4200 or Toll Free 1-800-673-6256

Authorized Community Mental Health Agencies

Mobile Outreach Crisis Services: 1-800576-7764
3580 Pacific Avenue, Tacoma, WA 98418-7915

Crisis Intervention Teams Tacoma/Peninsula Area: 253-396-5089
Lakewood/Southwest Pierce County Area: 253-584-8933
Puyallup/East Pierce County Area: 253-445-8125 or 1-888-445-8125

Asian Counseling Services: 253-697-8650
4301 South Pine Street, Suite 456, Tacoma WA 98409
Alternative languages available: Many Asian Languages spoken

Catholic Community Services: 253-759-9544
5410 N 44th Street, Tacoma WA 98407-3799
Counseling: 253-502-2696
1323 S. Yakima St., Tacoma WA 98407
Alternative languages available: American Sign Language, Cambodian, Chamorro, Dagaari, French, German, Korean, Nigerian, Norwegian, Romanian, Shona, Spanish, Swedish, and Tagalog

Comprehensive Mental Health: (Tacoma/Peninsula Area)
(Adults/Older Adults)1-253-396-5000
514 S 13th Street, Tacoma WA 98402
(Children/Families)-1-253-396-5800
1201 S. Proctor Street, Suite 1, Tacoma WA 98405-2095
Alternative languages available: American Sign Language, Cantonese, Farsi, German, Hindi, Italian, Mandarin, Palauan, Punjabi, Russian, Samoan, Spanish, Swahili, Tagalog, Ukrainian and Vietnamese

Good Samaritan Community Health Services: (Puyallup/East Pierce County) 253-445-8120
325 E. Pioneer, Puyallup, WA 98372-3265
Alternative languages available: American Sign Language, Cambodian, French, German, Korean, Mandarin, Samoan, Spanish, Taiwanese, Thai, and Vietnamese

Greater Lakes Mental Healthcare: (Lakewood/Southwest Pierce County) 253-581-7020
9330 59th Avenue SW, Lakewood, WA 984499-6600
Alternative languages available: American Sign Language, Arabic, German, Korean, Spanish, and Tagalog

Kwawachee Counseling Center of the Puyallup Tribal Health Authority: 253-593-0247
2209 E. 32nd Street, Tacoma WA 98404-4997

Pierce County Residential Treatment Facility:
3580 Pacific Avenue, Tacoma WA98418-7915
Evaluation & Treatment: 253-798-4443
Crisis Triage: 253-798-4357
Detox: 253-789-4430

Sea Mar Counseling and Social Services: 253-396-1643
1112 S. Cushman Avenue, Tacoma WA 98405-3631
Alternative languages available: Spanish

Southwest RSN
1952 9th Avenue, Longview WA 98632-4045
Web: http://www.cowlitzcounty.org/humanservices/swrsn.htm
Public Phone: 1-360-501-1201 or Toll Free 1-800-347-6092

Authorized Community Mental Health Agencies

Center for Behavioral Solutions: 360-414-2280
600 Broadway, Longview WA 98632-3256
Alternative languages available: Spanish

Lower Columbia Mental Health Center: 360-423-0203
921 14th Avenue, Longview WA 98632-2316
Alternative languages available: Filipino, German, Russian and Spanish

Youth and Family Link: 360-423-6741
907 Douglas, Longview WA 98632

Spokane County RSN
312 West 8th Avenue, 3rd floor, Spokane WA 99204-2506
Web: http://www.spokanecounty.org/mentalhealth
Public Phone: 509-477-5722 or Toll Free 1-800-273-5864

Authorized Community Mental Health Agencies

Catholic Charities Counseling Program: 509-242-2308
12 E. 5th Avenue, Spokane WA 99210

Children's Home Society Washington: 509-747-4174
2323 N. Discovery Place, Spokane Valley WA 99216
Alternative languages available: Spanish

Family Service Spokane: 509-838-4128
7 South Howard Street, Suite 321, Spokane WA 99201

Lutheran Community Services: Northwest 509-747-8224
210 West Sprague Avenue, Spokane WA 99201

Partners with Families and Children-Spokane: 509-473-4810
613 South Washington Street, Spokane WA 99204

Passages Family Support Program/Volunteers of America: 509-892-9241
525 West Second Avenue, Spokane WA 99201

Spokane County Supportive Living Program: 509-477-4388
1725 North Ash Street, Spokane WA 99205
Alternative languages available: Spanish

Spokane Mental Health: 509-838-4651
107 South Division Street, Spokane WA 99202
Alternative languages available: American Sign Language, German, Tagalog, and Spanish

The N.A.T.I.V.E. Project 509-325-5502
1803 W. Maxwell Avenue, Spokane WA 99201

Thurston-Mason RSN
412 Lilly Road NE
Olympia WA 98507
Public Phone: 360-786-5830 or Toll Free 1-800-658-4105
TDD 360-786-5602 or Toll Free 1-800-658-4105
Web: http://www.co.thurston.wa.us/health/ssrsn

Authorized Community Mental Health Agencies

Behavioral Health Resources: 360-704-7107 or 1-800-825-4820
3857 Martin Way East, Olympia WA 98506
Alternative languages available: ASL, Cantonese, French, German, Spanish, Vietnamese

Behavioral Health Resources-Lacey: 360-704-7170 or 1-800-825-4820
4422 Sixth Avenue SE, Lacey WA 98503

Behavioral Health Resources-Shelton: 360-426-1696 or 1-800-825-4820
110 W "K", Shelton WA 98584

Providence St. Peter Hospital Outpatient Services (Older Adult): 360-493-7060
413 Lilly Rd NE, Olympia WA 98506

Evaluation & Treatment Facility: 360-528-2590 or Toll Free: 1-800-270-0041
3436 Mary Elder Rd NE, Olympia WA 98506
Crisis Resolution Services: 360-754-1338

Sea Mar Community Health Center: 360-570-8258

409 Custer Way, Suite D, Tumwater WA 98501

Timberlands RSN

Lewis, Pacific and Wahkiakum Counties
PO Box 217, Cathlamet WA 98612-0217
Public Phone: 360-795-3118 or Toll Free 1-800-392-6298

Authorized Community Mental Health Agencies

Cascade Mental Health Care: 360-748-6696 or Toll Free 1-800-559-6696
135 W Main, Chehalis WA 98531

Cascade Mental Health Care: Child & Adolescent Program) 360-330-9044 or 1-800-559-6696
2428 Reynolds Avenue, Centralia WA 98531

Wahkiakum County Mental Health Services: 360-795-8630 or Toll Free 1-800-635-5989
42 Elochoman Valley Road, Cathlamet WA 98612

Willapa Long Beach Office: Willapa Behavioral Health 360-642-3787 or Toll Free 1-800-884-2298
1107 North Pacific Hwy, Long Beach WA 98631

Willapa South Bend Office: Willapa Behavioral Health: 360-942-2303 or 1-800-884-2298
300 Ocean Avenue, Raymond Wa 98577

Definitions

Action: (1) The denial or limited authorization by the Regional Support Network (RSN) of a requested service by the Community Mental Health Agency (CMHA) for you, including the type or level of service;

(2) The reduction, suspension, or termination by the RSN of a service you have been getting;

(3) The denial by the RSN, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner; and/or

(5) The failure of the RSN to act within the timeframes in the rules.

Appeal: The process used when you request review of an Action.

Crisis Services: Evaluation and treatment of a mental health crisis that is available to all Medicaid enrollees. Crisis services are available on a 24-hour basis. Crisis services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a Mental Health Professional.

Enrollee: **A person who is on Medicaid.**

Emergent care: **Services provided for a person that, if not provided, would likely result in the need for crisis intervention or for hospital evaluation due to concerns of danger to self, others, or grave disability.**

Grievance: If you are voicing that you are dissatisfied about anything that is not an Action, as "Action" is defined in this section. (Possible grievances include, but are not limited to, the quality of care or services, rudeness of a provider or employee, or failure to respect your rights).

Medically Necessary or Medical Necessity: A term for describing a requested service which is reasonably expected to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. Course of treatment may include mere observation, or where appropriate, no treatment at all.

Additionally, the individual must be determined to 1) have a mental illness covered by Washington State public mental health services; 2) the individual's impairment(s) and corresponding need(s) must be the result of a mental illness; 3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is

expected to benefit from the intervention; and 5) any other formal or informal system or support can not address the individual's unmet need.

Mental Health Professional: **An individual who meets the standards defined in Washington State law. The standards are based on how much education the person has and how much experience the person has in mental health. Most mental health professionals have a Master's Degree and at least two years experience in treating mental health issues.**

Psychiatrists, psychologists, psychiatric nurses and social workers are all mental health professionals.

Mental Health Care Provider (MHCP): **The individual with the primary responsibility for helping you to develop and complete an individualized plan for mental health rehabilitation services.**

Ombuds Service**: A free and confidential service to help you when you have a complaint related to your mental health services. The person at the Ombuds service will help you resolve your complaint or problem at the lowest possible level. This service can also help you find other consumer advocates. The Ombuds service is independent of the Regional Support Network (RSN). The ombuds can also help you when your complaint is not resolved and you need to file a grievance, appeal, or an administrative (fair) hearing.**

Ombuds: A person who can help you when you need to file or would like to avoid filing a grievance, appeal, or an administrative (fair) hearing.

Recovery: The belief that everyone has the capacity to improve their quality of life. Recovery looks different for everyone and a person with a mental illness can have an improved quality of living in a community while reaching the best possible level of functioning and well-being.

Regional Support Network (RSN): County or groups of counties responsible for local public mental health services.

Request for Service: The time when services are sought or applied for through a telephone call, walk in or written request by the enrollee or those defined as family or upon receipt of an Early Periodic Screening Diagnosis and Treatment (EPSDT) referral by a Physician, Advanced Registered Nurse Practitioner (ARNP), Physician Assistant, trained public health nurse or Registered Nurse.

Stabilization Services: Services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis. These services are provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional.

Urgent Care: Service provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

End of Attachment H.I.a.

Upcoming Waiver Period -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items that apply to the State or MCO/PIHP/PAHP. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a. X [Required] The State will ensure that materials provided to potential enrollees and enrollees by the State, the enrollment broker, and the MCO/PIHP/PAHP are in a manner and format that may be easily understandable.

HRSA makes the above information available at the first point of approval of Medicaid eligibility - the Community Service Office (CSO), including the list of relevant contact information for both the state and the RSN. Additionally, in the letter from DSHS received by each new Medicaid enrollee there is a paragraph explaining their mental health benefit and how to access mental health services. That section reads: "Mental illness affects many of us at some time in our lives. As a part of your Medicaid coverage, you can get mental health services such as: case management; therapy; medication management; hospitalization or crisis services, should you need them. Look in the phone book for crisis service numbers. Other mental health services are available to you through a Regional Support Network. Ask your worker how to contact them."

This information is again available through the Community Mental Health Agencies, the RSN offices, through the Involuntary Detention process if this is an enrollee's first contact with the mental health system, on the Division of Behavioral Health and Recovery's website and/or by calling HRSA's 1-800 number.

b. X Potential enrollee and enrollee materials will be translated into the prevalent languages listed below (If the State does not require written materials be translated, please explain):

The State defines prevalent non-English languages as: (check any that apply):

1.__ Spoken by significant number of potential enrollees and enrollees.

2. **X** *The languages spoken by approximately 5% percent or more of the potential enrollee/enrollee population which is currently limited to Spanish.*

3.____ Other (please explain):

The Department of Social and Health Services, the single state agency, identifies and translates the benefit booklet into the following languages.

Cambodian, Chinese, Korean, Laotian, Russian, Spanish, Vietnamese

c. X [Required] Oral translation services are available to all potential enrollees and enrollees, regardless of language.

d. X [Required] The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program. Please describe.

The State has produced the required informational materials for consumers and conducts surveys of consumers and stakeholders to determine to their knowledge of managed care.

e. X [Required] Each MCO/PIHP will have a mechanism in place to help potential enrollees and enrollees understand the requirements and benefits of the plan. Please describe.

The State has produced the required informational materials for consumers. The PIHP is required to have more specific information with regard to authorization of services and level of care information and it must be in an easily understood format for consumers.

f. X The State's and MCO/PIHP/PAHP information materials are available *when requested* in alternative formats that takes into consideration the special needs of those, for example, with visual impairments.

II. Potential Enrollee Information

Not applicable under this waiver - all Medicaid eligible are enrolled.

Upcoming Waiver Period -- This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a.___[Required] Timing. The State or its contractor will provide the required information:

(i) at the time the potential enrollee becomes eligible to enrollee in a voluntary program, or is first required to enrollee in a mandatory program.

(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs/PIHPs/PAHPs.

b. Content The State and/or its enrollment broker provides the following information to potential enrollees.

1.___ Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities

2.___ An initial notification letter

3.___ A form for enrollment in the waiver program and selection of a plan

4.___ Comparative information about plans

5.___ Information on how to obtain counseling on choice of MCOs/PHPs

6.___ A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);

7.__ A health risk assessment form to identify conditions requiring immediate attention.

8.__ [Required] General information about:
(i)__Basic features of managed care;
(ii)__Which populations are excluded from enrollment, subject to mandatory enrollment; or eligible for voluntary enrollment
(iii)__MCO/PIHP/PAHP responsibilities for coordination of care

9.__ [Required] Specific information about each MCO/PIHP/PAHP (a summary may be provided, but State must provide detailed information upon request):
(i)__Benefits covered
(ii)__Cost sharing (if any)
(iii)__Service area
(iv)__ Names, locations, telephone numbers of, and non-English language(s) spoken by contracted providers, and identification of providers not accepting new patients (at a minimum: primary care physicians, specialists, and hospitals)
(v)__ Benefits available under state plan but not covered contract, including how and where to obtain; cost sharing; and how transportation provided. For counseling/referral service that MCO/PIHP/PAHP does not provide, State must provide information.

10.__ Other items (please explain):

III. Enrollee Information

a. The State has designated the following as responsible for providing required information to enrollees:
(i)_**X**_ the State or its contractor
(ii)__ the MCO/PIHP/PAHP

b.__ [Required] Timing. The State, its contractor, or the MCO/PIHP/PAHP must provide the information to enrollees as follows:

1. **_X_** For new enrollees, all required information within a reasonable time after the MCO/PIHP/PAHP receives notice of beneficiary's enrollment.

2**. _X_** For existing enrollees:

(A) State must notify of disenrollment rights at least annually, and if there is a lock-in, by no less than 60 days before the start of each enrollment period. N/A

(B) Notify all enrollees of right to request and obtain required information at least once a year.

(C) Provide written notice of any significant change in required information

(D) MCO/PIHP/PAHP will make a good faith effort to give written notice of termination of contracted provider within 15 days after receipt of termination notice, to each enrollee who received primary care from, or was seen on regular basis by, terminated provider.

(c)_X_[Required] Content: The State, its contractor, or the MCO/PIHP/PAHP will provide the following information to all enrollees:

(i) **_X_** Benefits covered
(ii) **_X_** Cost sharing
(iii) **_X_** Individual provider information -- name, location, telephone, non-English languages, not accepting new patients (for MCO, PIHP, PAHP must include at a minimum PCPs, specialists, hospitals)
(iv) **_X_** Benefits available under state plan but not covered under contract, including conscience clause
(v) **_X_** Restrictions on freedom of choice within network
(vi) **_X_** Enrollee rights and protections
(vii) **_X_** Procedures for obtaining benefits
(viii) **_X_** Extent to which benefits may be obtained out of network (including family planning)
(ix) **_X_** Which and how after hours and emergency care are provided including

- Definition of emergency medical condition, emergency services, and post-stabilization services
- No prior authorization for emergency services
- Procedure for obtaining emergency services
- Location of emergency settings
- Right to use any hospital for emergency care

(x)__Post-stabilization rules
(xi)__Referral for specialty care

(xii)__[Optional] PAHP grievances procedures if available (if PAHP makes available, need to describe to enrollees)
(xiii)_x State fair hearing rights

- Right to hearing
- Method for obtaining hearing
- Rules governing representation at hearing

(xiv) **X** MCO/PIHP grievance, appeal, and fair hearing procedures and timeframes, including:

- Right to file grievances and appeals
- Requirements and timeframes for filing grievance or appeal
- Availability of assistance in filing process
- Toll-free number to file grievance or appeal by phone
- Continuation of benefits, including
    - Right to have benefit continued during appeal or fair hearing
    - Enrollee may have to pay for cost of continued services if decision is adverse to enrollee
- Any appeal rights State makes available to provider

(xv)_**X**_ Advance directives for psychiatric care
(xvi)_**X**_Physician incentive plan information upon request
(xvii)_**X**_Information on structure/operation of plan, upon request

IV. Enrollee Rights:

Upcoming Waiver Period -- Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PIHPs/PAHPs protect enrollee rights. The State requires:

a._**X**_ [Required] MCOs/PIHPs to have written policies with respect to enrollee rights.

b._**X**_ [Required] Ensure staff and affiliated providers take those rights into account when furnishing services to enrollees

c._**X**_ [Required] Ensure compliance with any applicable Federal and State laws that pertain to enrollee rights (such as Civil Rights Act, Age Discrimination Act, Rehabilitation Act, and Americans with Disabilities Act)

d._**X**_ [Required] The State will assure that each enrollee has the following rights:
(i)_**X**_ Receive information on their managed care plan
(ii)_**X**_ Be treated with respect, consideration of dignity and privacy
(iii)_**X**_ Receive information on treatment options
(iv)_**X**_ Participate in decisions regarding care, including right to refuse treatment
(v)_**X**_ Be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, retaliation
(vi)_**X**_ If privacy rules apply, request and receive copy of medical record and request

amendments
(vii) **_X_** Be furnished health care services in accordance with access and quality standards.

e. _X_ [Required] The State will assure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO/PIHP/PAHP or its providers treat the enrollee.

f.__ Other (please describe):

V. Monitoring Compliance with Enrollee Information and Enrollee Rights

Previous Waiver Period

a. [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PIHP/PAHP enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint, item H.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

Enrollee information is disseminated by the State in the Mental Health Enrollee Handbook. Compliance with enrollee rights regulations is monitored both by internal HRSA monitoring and certification staff and by the contracted External Quality Review Organization. Findings are addressed via corrective action plans.

Upcoming Waiver Period -- Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

a.___ The State tracks disenrollments and reasons for disenrollments or requires MCOs/PIHPs/PAHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.

b.___ The State will approve enrollee information prior to its release by the MCO/PIHP/PAHP.

c.___ The State will monitor MCO/PIHP/PAHP enrollee materials for compliance in the following manner (please describe):

d. **_X_** The State will monitor the MCO/PIHP/PAHPs compliance with the enrollee rights provisions in the following manner (please describe):

HRSA will continue to monitor using the mandatory protocols.