STATE OF WASHINGTON
HEALTH CARE AUTHORITY
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May 29, 2023

SUBJECT: Daybreak Youth Services License Suspension

On Friday, May 26, 2023, Washington State Department of Health (DOH) issued a notice for license suspension for two Daybreak Youth Services (DYS) facilities located in Spokane and Brush Prairie, Washington. DYS must cease operations and relocate patients to other facilities before Wednesday, May 31, 2023, at 12:01 a.m.

The Health Care Authority (HCA) is coordinating with managed care organizations (MCO) and behavioral health administrative services organizations (BH-ASO) to ensure the medically necessary needs of Apple Health (Medicaid) patients are being met. HCA's priority is to support and serve the patients and their families, starting with the youth in residential treatment whose needs are most critical.

HCA is in daily communication with DOH, MCOs and BH-ASOs, who are working with their networks to support the necessary transitions. The relocation plans for individual patients depend on their treatment plan and available transfer options.

Additional information about DOH's decision can be found in this press release and on the Daybreak Suspension web page.

Q&A

Q. Can Daybreak Youth Services continue to serve youth and receive Medicaid payment after license suspension?

A. Medicaid regulations require providers to have an unencumbered license to service Apple Health (Medicaid) patients. By law, Apple Health cannot pay for services in an unlicensed facility and an unlicensed facility cannot bill for services.

Q. Which Daybreak services and locations are impacted?

A. Daybreak is no longer licensed to provide behavioral health services including residential treatment services at the following locations:

Daybreak Youth Services – Brush Prairie
11910 NE 154th St.
Brush Prairie, WA 98606

Daybreak Youth Services – Spokane
628 South Cowley St.
Spokane, WA 99202

Outpatient services at other locations are not affected.

Q. How are Wraparound with Intensive Services (WISe) impacted?

A. Daybreak is not able to provide WISe services at this time because the services were certified and operated out of the Spokane Cowley Street location, which is no longer a licensed facility. (FAQ updated 6/5/23)

Q. Who can answer questions about the investigation or license suspension?

A. DOH has created a DYS Suspension web page with additional information. HCA's role is to coordinate with MCOs and BH-ASOs to ensure affected patients' medical needs are uninterrupted to greatest the extent possible.

Q. Who should parents and guardians contact if they have a youth at either of the facilities?

A. Parents and guardians who have questions about their youth in these facilities should contact the patient's Apple Health case manager, the Apple Health managed care plan's customer service line, or Apple Health Customer Service at 1-800-562-3022.

Q. Where are patients moving?

A. It is a violation of patient privacy to publicly share information about treatment or relocation details. What happens next for patients at the facilities is based on their care needs and their treatment plans. This could include, but is not limited to, discharge to an outpatient program or another inpatient program. Decisions will be made by the individuals, families or other legal custodians, and providers, assisted by MCOs and BH-ASOs, and in some cases, any other agencies that are involved.

Q. How many patients are being moved?

A. The number of Apple Health patients in the residential facility is above 20. More than 50 additional youth are receiving outpatient services through Daybreak. HCA, MCOs, and BH-ASOs are working closely with impacted clients to support transitions as needed to best meet their individual care needs.

Q: Can an Apple Health Medicaid Provider "Balance Bill" a Medicaid Client?

A. No. In general, providers must accept as payment in full the amount paid by the agency or agency-contracted Managed Care Organization (MCO) for medical assistance services furnished to clients. See WAC 182-502-160(3). A provider must not bill a client, or anyone on the client's behalf, for any services until the provider has completed all requirements in Washington Administrative Code (WAC) 182-502-0160, including the conditions of payment described in HCA rules (e.g., WAC 182-502-0100, WAC 182-502-0016, etc.), billing instructions, and the requirements of billing the agency-contracted Managed Care Organizations (MCOs). See WAC 182-502-0160(4).

A provider must fully inform the client of his or her covered options. A provider must not bill a client for:

(a) Any services for which the provider failed to satisfy the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for

billing the agency-contracted MCO in which the client is enrolled.

(b) A covered service even if the provider has not received payment from the agency or the client's MCO.

(c) `service because the required information was not received from the provider or the prescriber under WAC 182-501-0165 (7)(c)(i).

Q: Does it matter whether the client is enrolled in a Managed Care Organization vs. Fee-For-Service?

A. WAC 182-502-0160 applies to all Medicaid clients regardless of whether covered by Medicaid Fee-For-Service or a managed care plan.

Q: What are the Provider's Responsibilities when a client seeks to self-pay for a medical assistance service?

A. According to WAC 182-502-0160(2), a provider must:

(a) Verify whether the client is eligible to receive medical assistance services on the date the services are provided;

(b) Verify whether the client is enrolled with a Medicaid agency-contracted managed care organization (MCO);

(c) Know the limitations of the services within the scope of the eligible client's medical program (see WAC 182-501-0050(4)(a) and 182-501-0065);

(d) Inform the client of those limitations;

(e) Exhaust all applicable Medicaid agency or agency contracted MCO processes necessary to obtain authorization for requested service(s);

(f) Ensure that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services in accordance with this section; and

(g) Retain all documentation which demonstrates compliance with this section.

Q: When can a Provider bill a Medicaid Client, or a person on behalf of a Medicaid client for services?

A. If all requirements of WAC 182-502-0160 are met, a provider may bill a client when the client and provider sign HCA Form 13-879, Agreement to Pay for Healthcare Services, *before the service is furnished*.

Q: Are there any times when HCA Form 13-879 is not required?

A. Yes. There are a few circumstances in which HCA Form 13-879 is not required. Please see WAC 182-502-0160(6). A few examples are listed below:

(1) The client, the client's legal guardian, or the client's legal representative:

  a. Was reimbursed for the service directly by a third party (see WAC 182-501-0200); or

  b. Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third-party insurance carrier for the service.

(2) The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program. In this circumstance, the provider must:
   a. Keep documentation of the client's declaration of medical coverage. The client's declaration must be signed and dated by the client, the client's legal guardian, or the client's legal representative; and
   b. Give a copy of the document to the client and maintain the original for six years from the date of service, for agency or the agency's designee review upon request.

(3) A fee-for-service client chooses to receive nonemergency services from a provider who is not contracted with the agency or its designee after being informed by the provider that he or she is not contracted with the agency or its designee and that the services offered will not be paid by the client's health care program; and

(4) An agency contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO, i.e., a nonparticipating provider.

Q. What should I do if I receive a bill from a Medicaid provider and I did not sign HCA Form 13-879 prior to receiving services?

A. You can file a billing complaint with Medicaid by reaching out to your Medicaid Managed Care plan or to Washington State Health Care Authority Customer Service Center at 1-800-562-3022. The MCO or HCA will reach out to the contracted Medicaid provider and will assist you in resolving the billing dispute.

You can file a complaint with the Consumer Protection Division of the Washington State Attorney General. For more information, go to: https://www.atg.wa.gov/consumer-protection

You can seek free legal representation and advice from Northwest Justice Project by reaching out to their CLEAR Hotline at 1-888-201-1014. For more information, go to: https://nwjustice.org/clear-hotline (FAQ updated 6/9/23)