Health-Related Social Needs (HRSN) Services & In Lieu of Services (ILOS) Policy Guide

October 2023

All changes to be implemented on or before **January 1, 2024**

Contents

Introduction

The Washington State Health Care Authority (HCA) and Centers for Medicare & Medicaid Services (CMS) recognize that addressing health-related social needs (HRSN) is one component of promoting positive health outcomes. CMS defines[1] HRSN as "an individual's social needs—such as for housing and food security—that may exacerbate poor health and quality-of-life outcomes when they are not met."

Unmet HRSN causes higher utilization and spending in health care and contributes to adverse health outcomes. An individual's HRSN are a result of their community's underlying social determinates of health (SDOH) and the systems that shape their conditions of daily life. SDOH[2] like housing insecurity, food insecurity, and lack of reliable transportation can impact an individual's HRSN. This can negatively impact health and well-being, and result in a lower quality of life.

Washington State can improve Apple Health (Medicaid) clients' health and well-being by providing HRSN services through the Apple Health program. Apple Health includes the Children's Health Insurance Program (CHIP).

There are two ways this can occur:

1. Through in Lieu of Services (ILOS) for the managed care population, when services are allowable under federal authority and
2. Through the Medicaid Transformation Project (MTP) for MTP-approved HRSN services. MTP is Washington State's Section 1115 Medicaid demonstration waiver between HCA and CMS. It allows our state to create and continue to develop projects, activities, and services that improve Washington's health care system and can apply to the entire Apple Health delivery system, including fee-for-service (FFS) and managed care populations. Through the MTP renewal, called MTP 2.0, our state can provide or increase coverage of certain services that address HRSN.

HRSN services will be provided through a combination of delivery systems (managed care and FFS) and will establish the framework for Apple Health to address HRSN and reduce health disparities statewide.

Our state intends to implement the services listed on the HRSN services menu to address critical needs within an identified population and improve health outcomes for Apple Health clients. Operational guides for future HRSN services are under development. For updates, please visit the HCA website. The updated version of this Policy Guide will be posted when new services are available.

How to use this guide

This guide explains when an HRSN service can be offered and the process that HCA, managed care organizations (MCOs), and providers must follow. This guide lays out the requirements necessary to deliver HRSN services under the ILOS framework, which HCA, MCOs, and providers must follow. See the HRSN services menu for more information.

Who is eligible for HRSN services?

Eligibility for HRSN services depends on:

1. Legal authority and CMS' approval for our state to offer the service and
2. The delivery system that serves a client (FFS or managed care program)

Note: HRSN services authorized through the ILOS federal authority are available to clients enrolled in **managed care only**. See the HRSN services menu for more information.

[1] CMS SMD#23-001, Additional Guidance on Use of Lieu of Services and Settings in Medicaid Managed Care. https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf

[2] Holcomb, J., et al. (2022). Predicting health-related social needs in Medicaid and Medicare populations using machine learning. Scientific Reports 12, 4554. https://doi.org/10.1038/s41598- 022-08344-4

Eligibility reference table

The below table describes the population that is eligible, based on the service. Apple Health managed care includes three programs: **Integrated Managed Care (IMC), Integrated Foster Care (IFC), and Behavioral Health Services Only (BHSO)**. FFS refers to Apple Health coverage without a managed care plan.

See the HRSN services menu for more information.

Table 1: eligibility reference table

Service	IMC	IFC	BHSO	FFS
Intensive Behavioral Supportive Supervision	X	X	X	

What are ILOS?

These are services or settings that are medically appropriate, cost-effective alternatives to a state plan-covered service (identified in MCOs' contract with HCA). ILOS are optional for MCOs to offer and MCOs may not require members to use an ILOS instead of a state plan-covered service or setting. **ILOS are only available to individuals enrolled in Apple Health managed care**. ILOS are services authorized under managed care authority and can address an individual's HRSN. MCOs may use ILOS when pre-approved by HCA and identified as an ILOS in their managed care contract ("state approved ILOS"). ILOS may be immediate substitutes to a covered service, or in some cases, to prevent the need for a covered service in the future. An ILOS must be:

- A medically appropriate and cost-effective substitute for covered services/settings under the state plan;
- Optional for enrollees;
- Authorized and identified in the managed care plan contract and offered to enrollees as an option of the managed care plan; and
- Developed with consideration of utilization and actual cost of the ILOS as components of the capitation rates that represent the covered state plan services unless a federal statute or regulation explicitly requires otherwise.

Federal requirements for ILOS

On January 4, 2023, CMS released a State Medicaid Director Letter[3] outlining additional requirements for ILOS, effective no later than January 1, 2024. CMS subsequently released proposed Medicaid managed care rules that continue to support CMS's SMDL requirements; these rules are not yet final, and an effective date is not yet determined[4]. Any changes to ILOS are approved by CMS through the Medicaid managed care contract amendment review and published in this guide.

Requirements include:

- Implementation of requirements no later than January 2024;
- Defined ILOS service definition, which could be coverable under a state plan amendment (SPA) or waiver if the state chose to seek that pathway. The CMS mandate does not allow MCOs' flexible use of ILOS funding or allow real-time creation of an ILOS service to address a specific enrollee's needs;
- A target population identified, including the covered diagnoses listed;
- Encounters reporting with specific coding allowed for the service, requiring the provider be known to Medicaid and hold a Core Provider Agreement;
- Further clarification of the voluntary nature of ILOS being "tri-optional" to the state, MCO, and enrollee;
- Additional financial guardrails with thresholds for spending projected over 1.5 percent of total costs and allows CMS to deny if projected spend is over 5 percent;

[3] CMS SMD#23-001, Additional Guidance on Use of Lieu of Services and Settings in Medicaid Managed Care. https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf

[4] 88 Fed. Reg. 28092 (May 3, 2023).

- Enrollee protections and reporting, such as grievances, MCO appeals, and hearings; and
- Evaluation, monitoring, and oversight requirements.

Note: the federal managed care ILOS authority is also used to support care occurring in institutions for mental diseases (IMDs) when the average length of stay is less than 60 days. The requirements in the SMDL and proposed rules do not mandate new requirements for ILOS used to cover stays in IMDs, which are subject to existing limitations in federal law and regulations.

What is a medically appropriate service?

ILOS may be delivered when medically appropriate for the enrollee and follow the guiding principle of assuring delivery of service(s) that are "for-the-right-reason, at-the-right-time, in-the-right-place".

Per the Apple Health Integrated Managed Care (AH-IMC) contract:

> 'Medically appropriate' is a term for describing a requested service or setting for which care is intended to address the health care needs of the individual, including physical, substance use, mental health, as well as health-related social needs. The service or setting, including the level or intensity, must be appropriate to the individual's health care needs, social needs, and condition. The service or setting must be reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.

Medically appropriate services are not the same as medically necessary services, which are defined in WAC 182-500-0070. HRSN services must be medically appropriate but are not required to be medically necessary. The distinction is the definition of medically necessary includes a requirement that is not applicable for HRSN services: "There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service." HRSN are optional, offered as a substitute to a state plan service or setting.

Enrollee rights and protections

- Approved ILOS are defined by HCA in the AH-IMC contract and are voluntary for MCOs and enrollees.
- Each MCO has a grievance and appeal system in place that meets federal and contractual requirements (42 CFR part 438). Members have the right to file a grievance and request an appeal regarding the denial of a state approved ILOS that is offered by the MCO. An enrollee who disagrees with the outcome of an appeal regarding ILOS may request an administrative hearing in accordance with the rules set forth in Chapter 182-526 WAC and WAC 182-538-110.
- HCA may terminate an MCO's ILOS offering if determined to be harmful to the enrollee or is not cost-effective.
- MCOs may terminate an ILOS for the entire program once annually upon notice to HCA at the end of the calendar year. If an MCO terminates an ILOS for the entire program, they must publicize the service end date and provide at least 90 days' notice to their members and implement a plan for continuity of care for members receiving that ILOS.
- MCOs may terminate a current ILOS authorization for an enrollee only when due to member health, safety, or welfare concerns.
- If a member transfers to another MCO and the new MCO offers the same HRSN that the member was receiving from their previous MCO, then the new MCO must honor the service authorization for that member according to the Continuity of Care Section of the AH-IMC contract (section 14.1). The MCO must make a good faith effort to preserve enrollee-provider relationships or where preservation of provider relationships is not possible and reasonable, the MCO shall assist the enrollee to transition as expeditiously as the enrollee's physical and behavioral health condition requires.

Implementation timeline

The table below shows when MCOs in Washington State can launch specific HRSN services. The implementation date indicates the first date the state approves the service to be offered as an HRSN service within the Apple Health delivery system. HCA strongly encourages MCOs to:

1. Offer the HRSN services listed (also specified within the Apple Health managed care contracts),
2. Offer these services across the MCOs' contracted regional service areas, and
3. Begin offering these services on the designated implementation date.

Table 2: implementation timeline

Service	Implementation date
Intensive Behavioral Supportive Supervision	January 1, 2024

Glossary of terms

Some of the below terms and definitions are from the AH-IMC contract.

Behavioral health services only (BHSO)

According to the AH-IMC contract:

> "Behavioral Health Services Only (BHSO)" means those Enrollees who receive only behavioral health benefits through the AH-IMC Contract and the companion non-Medicaid Contract.

Continuity of care

According to the AH-IMC contract:

> "Continuity of Care" means the provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one setting as the Enrollee transitions between: facility to home; facility to facility; providers or service areas; Managed Care Contractors; and Medicaid fee-for-services (FFS) and Managed Care arrangements. Continuity of Care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include but are not limited to: from acute care settings, such as inpatient physical health or behavioral Health Care Settings or emergency departments, to home or other Health Care Settings such as outpatient settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; from one primary care practice to another; and from substance use care to primary and/or mental health care.

Health-related social needs (HRSN)

HRSN are an individual's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health (conditions in which people are born, grow, work, and age).

Health-related social needs (HRSN) services

HRSN services address an individual's unmet, adverse social conditions that contribute to poor health. These needs, including food insecurity, housing instability, unemployment, and/or lack of reliable transportation, can drive health disparities across demographic groups.

In lieu of services (ILOS)

According to the AH-IMC contract:

> "In lieu of service or setting (ILOS)" means a service or setting that is provided to an Enrollee as a substitute for Covered Services or a setting covered under the Medicaid State Plan in accordance with 42 CFR § 438.3(e)(2). An ILOS can be used as an immediate or longer-term substitute for a service or setting that is covered under the State Plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting.

Managed care organization (MCO)

According to the AH-IMC contract:

> "Managed Care Organization (MCO)" means an organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA Enrollees under HCA Managed Care programs.

Medically appropriate

According to the AH-IMC contract:

> "Medically appropriate" means a term for describing a requested service or setting for which care is intended to address the health care needs of the individual, including physical, substance use, mental health, as well as health-related social needs. The service or setting, including the level or intensity, must be appropriate to the individual's health care needs, social needs, and condition. The service or setting must be reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.

Social determinates of health (SDOH)

SDOH are the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.

HRSN services reporting instructions

Includes:

- Services provided to Apple Health-eligible individuals.

Excludes:

- All services to individuals not eligible for Apple Health.
- Non-covered services to Apple Health-eligible individuals.

General instructions for billing an HRSN service

1. HCA accepts HRSN services reported using the service and program descriptions in these instructions. The Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) codes utilized for Apple Health may not necessarily be the same codes required by other payers. HCA applies HIPAA and National Correct Coding Initiative (NCCI) principles and guidelines for the assignment of codes to the extent possible but acknowledges there may be circumstances where these instructions vary from how a code may be required to be submitted by another payer.

2. Use of standardized coding nomenclature, i.e., CPT®/HCPCS is required for reporting encounters to HCA.
3. HRSN services are reported based on services provided to the individual client and not based on staff hours. See exceptions noted in number 7c below. The intention of these instructions is to align coding practice with national coding standards and to provide comparability of HRSN services data with other medical encounters and claims for clients whose care is paid for by HCA.
4. ALL codes are reported in units. The definition of the code may specify a time segment, (for example: 15 minutes, 30 minutes, per-diem etc.) or the input from the stakeholders may have resulted in a decision to report the code in 15-minute increments.
5. The Service definition for each code provides guidance as to whether more than 1 unit can be reported for that code.
6. CPT®/HCPCS code definitions may specify how to code the units of service, as applicable. HCA applies **CMS' guidelines for reporting units of services for certain CPT® and HCPCS codes**. (See Section 20.2C). This guideline describes a "half-way" methodology for determining how to convert the number of minutes spent providing a service into units when reporting units is required for the code selected. The following guidance should be used to determine how to report the units of service for encounters:
    a. For CPT®/HCPCS codes with a fixed amount of time as a unit of service (e.g., per 15 minutes, per 20 minutes, per hour) as defined in this guide, report the first unit of service when any service is provided within 5 minutes of the defined unit of service unless otherwise specified in the current CPT® or HCPCS Manual.
    b. When the actual time spent providing the service is more than the fixed unit of time defined by the code, for example, when the actual service was 23 minutes and the code definition cites "per 15 minutes", multiple units can be reported. Follow the "half-way" methodology to determine the number of units to report. In this case, since the service was provided for at least 15 minutes + 8 minutes (half-way to 15 minutes), report 2 units, because 15 minutes = 1 reportable unit and 8 minutes is at least half of another 15 minutes = 1 more reportable unit. A total of 2 units are reportable.
7. Exceptions:
    a. When the time defined in the code definition is "per-diem;" services provided for less than a day must be coded with a non-per-diem defined code.
    b. Report multiple encounters (for different services) occurring on the same day for the same consumer separately when the encounters occur at different times. With the exceptions noted below, do not roll up multiple encounters. Each service encounter must have a progress note that meets all CMS requirements.
    c. Exception: If the same service was provided discontinuously to a consumer on a single day by the same provider, and the service was provided for less than the minimum time defined by the procedure/service code, the provider can roll-up the minutes to a single service and report the total number of units. Documentation in the client record must record these separate events and meet documentation requirements noted below. The service must be reasonably considered a single therapeutic intervention and supported by documentation.
8. Report only one encounter for an individual when more than one staff member is involved in the delivery of the service. The staff should document the service in the client's record and the provider report the encounter.
9. Staff qualifications correlate with the Provider Types listed and are included with each service description. When a service rendered is not appropriate to report at the servicing provider level, report the facility Billing Provider NPI and taxonomy as the "Provider Type," as instructed.

10. Documentation in client's records must meet, at a minimum, the general encounter reporting requirements listed below. At a minimum, the following information is required for reporting a service to a consumer and documenting that encounter in a progress note:
    a. The service must be of sufficient duration to accomplish the therapeutic intent.
    b. The record must be legible to someone other than the writer.
    c. Each printed page (front and back if two-sided) of the record must contain the consumer's name and agency record number.
    d. Entries must include all the following:
        i. Author identification, which may be a handwritten signature or unique electronic identifier.
        ii. Date of the service.
        iii. Location of the service.
        iv. Provider credentials (which must be appropriate to the service).
        v. Length of time.
        vi. Narrative description of the service provided as evidenced by sufficient documentation that can be translated to a service description title or CPT®/HCPCS code and describes therapeutic content.
        vii. Primary diagnoses for which services were provided during this encounter.
        viii. Other diagnoses for which services were provided during this encounter.
11. The service addresses an issue on the care plan, or the issue addressed is added to care plan.
    a. The service is specific to the consumer, e.g., progress note is specific to the consumer.
12. Time associated with activities used to meet criteria for the Evaluation and Management (EM) service is not included in the time used for reporting the service (i.e., time spent on history, examination and medical decision making when used for the E&M service is not treatment time). The evaluation and management (E&M) service is based on key components listed in the CPT® manual. For E&M codes 99202-99205 and 99211-99215, providers must determine the appropriate level of service based on the level of medical decision making or total time for E&M services performed on the date of the encounter per 2021 coding guidelines. For all other E&M services, providers must use either the 1995 or 1997 "Documentation guidelines for evaluation and management services" to determine the appropriate level of service. See the Medicare learning network® webpage. Once the licensed practitioner chooses the appropriate guidelines, the licensed practitioner must use the same guidelines for the entire visit. Chart notes must contain documentation that justifies the level of service billed. Documentation must:
    a. Be legible to be considered valid.
    b. Support the level of service billed.
    c. Support medical necessity for the diagnosis and service billed.
    d. Be authenticated by provider performing service with date and time.
13. A provider must follow the CPT® coding guidelines and their documentation must support the E&M level billed. While some of the text of CPT has been repeated in this guide, providers should refer to the CPT book for the complete descriptors for E&M services and instructions for selecting a level of service.
14. Time associated with ancillary or additional services is not included in the service reporting of hourly services. The ancillary or additional services must be recorded and encountered separately.

Reporting diagnosis

Providers need to submit ICD-10 diagnosis codes on all claims and encounters.
The first diagnosis (primary) represents the condition that requires the most time, the most decision-making and the most skill. Other conditions assessed or assessed and treated during the visit must also be reported. These are reported as the secondary diagnoses.

Guidelines for who should determine a diagnosis

- Licensed/credentialed professionals should determine the diagnosis for any encounter, within the scope of their licensure.
- If they are already in services, use the best applicable diagnosis in the client's record that is previously documented by their provider.

Guidance document links

This guide is available on HCA's website, which will include future revisions of the guide.

The following are also available:

- **Encounter Data Reporting Guide (EDRG)** is available online under "Regional Resources – Claims billing-encounter data."
- **HIPAA Electronic Data Interchange (EDI) website and companion guides**.
- Additional guidance on **service encounter and program reporting, coding guidelines, and data elements** for submitting to HCA is available online.

Provider enrollment, credentialing, and criteria requirements

Process for HCA provider enrollment

Apple Health providers, including those delivering HRSN services, are required to enroll with HCA as an Apple Health Provider. See HCA Provider Enrollment for more information.

Managed care credentialing requirements

To include an HRSN provider in their networks, MCOs are required to vet the qualifications of the provider or provider organization to ensure they can meet the standards and capabilities required to be an MCO-contracted provider. MCOs are required to adhere to National Committee for Quality Assurance (NCQA) credentialing standards, per Apple Health contract. For HRSN providers who do not fall within the protocols for NCQA credentialing standards, the MCO must implement policies and procedures for how they will vet the qualifications of HRSN providers. Factors MCOs must consider as part of their process include, but are not limited to:

- Ability to receive referrals from MCOs for the authorized HRSN;
- Sufficient experience to provide services like the specific HRSN they are contracted to provide within the service area;
- Ability to submit claims or encounters for HRSN using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- Review of history of fraud, waste, and/or abuse;
- Review of recent history of criminal activity, including a history of criminal activities that endanger members and/or their families; and
- History of liability claims against the provider.

Criteria for HRSN provider

The criteria to provide HRSN services to Apple Health clients varies by service. See the Services Menu for details.

Cost-effectiveness

Consistent with federal regulations under MTP and ILOS authorities, HCA determined that the state approved HRSN services meet fiscal evaluation requirements. State-approved ILOS have been determined by the state to be cost-effective substitutes for Apple Health services or settings covered in the state plan.

Requesting approval for new ILOS

MCOs must apply for and receive HCA approval in contract prior to offering any new ILOS. To request approval for a new ILOS, the following requirements must be demonstrated through the proposal submitted by the MCO. The proposed services must be shown to be:

- Medically appropriate. The submission includes research demonstrating the service as medically appropriate. The service provider, intended population, and criteria for the ILOS are clearly defined supporting how the ILOS will be offered in an equitable and nondiscriminatory manner to eligible members.
- Cost-effective. The MCO's submission demonstrates cost-effectiveness analysis, including comparison of the proposed services to the intended service(s) being substituted. The submission includes suggested claims/encounter coding. For example, the specific HCPCS or CPT® codes must be identified to support appropriate encounter coding to track the claiming and provision of ILOS.
- Substitutes for MCO-contracted, state plan services. The proposed service must be approvable as a SPA authorized through the Social Security Act, including sections 1905(a), 1915(i), or 1915(k) of the Social Security Act, or a waiver under section 1915(c) of the Social Security Act.
- Voluntary. MCOs cannot require a member to use an ILOS instead of a state plan-covered service.
- In alignment with federal ILOS requirements. ILOS may not include expenditures prohibited by CMS, such as room and board.

HCA will review the MCO's submission against ILOS requirements. If HCA approves an MCO's submitted ILOS proposal, the ILOS will be included in an on-cycle amendment of the HCA's managed care contracts as a state-approved ILOS for use by all contracted MCOs. Once the proposed service is included as a state approved ILOS, MCOs may offer the service according to the contract, as reflected in the listed implementation date in this guide.

HRSN services menu

Intensive Behavioral Supportive Supervision (IBSS)

Description/overview

Supportive supervision and oversight are direct in-person monitoring, redirection, diversion, and cueing of the participant to prevent at-risk behavior that may result in harm to the participant or others. It provides individuals with person-centered assistance to build skills and resiliency to support stabilized living and integration.

Table 3: reference table for IBSS

Eligible clients		Population		Prior authorization
IMC, IFC, BHSO managed care enrollees		Adults 18 years and older		Required
Code	**CPT®/HCPCS definition**	**Unit (UN)/minutes (MJ)**	**Modifiers**	**Provider type(s)**

S5126	Attendant care services	UN (1 = a day; 1 per encounter)	SE and Tier-based modifier below (required)	311ZA0620X - AFH 3104A0625X - ESF 310400000X - ALF; EARC; ARC

Table 4: modifier for IBSS

Tier	Hours per day	IBSS modifier (required)	Tier-based modifier
1	0.5-2	SE	None. Note: if no tier-based modifier is used this tier is assumed.
2	2.1-6	SE	TF (required)
3	6.1-10	SE	HE (required)
4	10.1-15	SE	TG (required)
5	15.1-20	SE	HK (required)
6	20.1-24	SE	HR (required)

Inclusions

- These medically appropriate services may be habilitative or rehabilitative to support individuals to remain stable in the community.

Exclusions

- These interventions are not related to the provision of personal care but can be provided concurrently.
- These interventions are not related to the provision of room and board.
- ILOS are not available for FFS clients due to the federal authority utilized; IBSS is not available to clients with only FFS coverage.

State plan service(s) that are likely to be avoided with the provision of this ILOS

Examples of state plan services to be avoided by offering this ILOS include, but are not limited to:

- Inpatient and outpatient hospital services
- Emergency hospital services
- Crisis intervention
- Crisis stabilization

Notes

These interventions are coordinated with other support services, including behavioral health or other community support services as appropriate. Supportive supervision should include integration of behavior support and/or crisis plans to help ensure community stability and an escalation process for collaborative care, including following CFR 441.710(a)(vi)(F)(1) through (8) when necessary.

Table 5: coverage criteria for IBSS

Coverage criteria	Description
Eligible Apple Health clients	• Clients enrolled in AH-IMC, AH-IFC, or BHSO managed care programs; and • Adults ages 18 years and older

Covered diagnoses	Severe cognitive impairment, such as traumatic brain injury, autism spectrum disorders, developmental delay, dementia, encephalopathy, and substance use disorder impacting cognitive functioning chronically (over 3 months)
Target population	• Individuals who are at risk for hospitalization or institutionalization and where previous institutionalization may have negatively impacted the individual's quality of life due to frequent provider movements and hospitalizations; • Individuals who have exceptional behavioral care needs requiring additional supports in the community due to being unable to remain stable outside of hospital or institutional settings without behavioral supports; and • Due to the impaired cognitive functioning paired with risky behaviors, the risk of needing inpatient care for stabilization is high thus all individuals in IMC, IFC, or BHSO managed care programs are eligible. Examples of client presentation in target population: Clients often present with co-occurring impaired cognitive functioning, intellectual/developmental disability, and a behavioral health condition. Reoccurring behaviors that present a risk to self or others, (such as elopement without safety awareness, tracheal decannulation due to behavioral outbursts, fall risk with impulsivity). Safety risk may be self-injurious or other behaviors that negatively impact the quality of life resulting in risk of involuntary detention or treatment according to the Involuntary Treatment Act (ITA), hospitalization, or institutionalization. Severe behaviors resulting in risk for ITA, hospitalization, or institutionalization such as dysregulation, reoccurring escalation, agitation, severe disruptive, aggressive, combative, or assaultive behaviors. Safety risk behaviors include but not limited to head banging, anal digging causing rectal injury, biting, tooth extraction, limb removal, eye poking, genitalia trauma.
Prior authorization	**Required** by the enrollee's assigned MCO for each IBSS service period to ensure all the following coverage criteria are met for the coverage period under review. • The coverage period is determined by the client's care needs and in accordance with contractual requirements (such as 3 months, 6 months or 12 months depending on client stability). • No longer than 12-month approvals are allowed for each authorization period.
Coverage criteria & restrictions and limitations	1. Client's diagnosis is included in ILOS covered diagnosis list addressing the care period under review. 2. Individual has clinical complexity that requires the level of supplementary or specialized services and staffing available only under the ILOS IBSS services, as evidenced by at least one or more of the following within the past year: a. Multiple assaultive incidents (two or more) related to a health condition during inpatient or long-term care that can only be prevented with a high level of staffing and/or skilled staff intervention. Self-endangering behaviors related to a health condition that would result in bodily harm if not

	prevented with a high level of staffing and/or skilled staff intervention. b. Intrusiveness (e.g., rummaging, unawareness of personal boundaries) related to a health condition that places the individual at risk of assault by others if not prevented with a high level of staffing and/or skilled staff intervention. c. Symptoms that cause distress to and escalate the individual and/or other residents to crisis if not monitored and redirected by staff. Without intervention, this could result in institutional care. d. Sexual inappropriateness related to a health condition that requires skilled staff intervention to redirect to maintain safety of the individual and other vulnerable adults. e. A history of any of the above behaviors, which are currently only prevented by additional skilled staff intervention. f. For currently hospitalized clients, subspecialties must have consulted as medically necessary to assess care needs (e.g., psychiatry). 3. Requesting provider's Plan of Care addresses all the following elements updated for the authorization period under review: a. Care specific to individual's needs; b. Staffing plan to demonstrate the amount of staffing support for ILOS requested is medically appropriate for the ILOS-covered diagnosis and behaviors; c. Proactive crisis response planning; d. Staffing readiness to support individual's behaviors and support needs while maintaining safety in the shared environment; and e. Reevaluation plan specific to individual's presentation to ensure the appropriate level of support for community stability. Proactively determined plan specifically designed to respond to individual's behavioral stability to evaluate need to adjust IBSS hours to ensure the appropriate level of support for community stability. Example(s): trial period reduction or wean from supportive supervision after one month of stability without need of caregiver intervention. Due to client's frequency in escalation pattern, evaluation to determine if adjusting hours per day warranted to support reduced crisis/de-escalation. For clients served by the Department of Social and Health Services through Developmental Disabilities Administration (DDA) or Aging and Long-Term Support Administration's (ALTSA) Home and Community Services (HCS): • The DDA or HCS case manager performs the assessment and updates the client's record in the Comprehensive Assessment Reporting Evaluation (CARE) tool to include the client's individual care needs. The ILOS care is best informed when the HCS or DDA case manager provides this information to the provider and the MCO prior to ILOS authorization submission, which supports the provider in developing the Plan of Care for the ILOS submission.

	• For approved ILOS, the MCO shall submit a copy of the Plan to Care to the client's HCS or DDA case manager.

Licensed/allowable providers

- Providers must have experience and expertise in providing these unique services in a culturally and linguistically appropriate manner.
- Qualified provider enrollment: for all Apple Health programs, providers are required to successfully complete the provider enrollment process and core provider agreements with HCA for health care services. For managed care, providers must also complete the credentialing process with each MCO. MCOs must ensure quality care is available through the provider, which may include onsite quality review as appropriate.
- Qualified providers, acting within the scope of their license to practice and who are appropriately licensed and contracted, include:
    - Licensed and allowable providers.
    - Providers operating in Washington State must be licensed as below.

Table 6: provider type and taxonomy for IBSS

Provider type	Description	Taxonomy (required)
Adult Family Home (AFH)	Licensed under Chapter 388-76 WAC	Taxonomy: 311ZA0620X
Adult Residential Care (ARC) Facility	Licensed under Chapter 18.20 RCW and Chapter 388-78A WAC as an Assisted Living Facilities with a contract to provide ARC services	Taxonomy: 310400000X
Enhanced Adult Residential Care (EARC) Facility	Licensed under Chapter 18.20 RCW and Chapter 388-78A WAC with a contract to provide EARC services	Taxonomy: 310400000X
Enhanced Services Facilities (ESF)	Licensed under Chapter 70.97 RCW and Chapter 388-107 WAC	Taxonomy: 3104A0625X
Assisted Living Facility (ALF)	Licensed under Chapter 18.20 RCW and Chapters 388-78A and 388-110 WAC	Taxonomy: 310400000X