Washington State Health Care Authority

1915(i) Community Behavioral Health Support Services Guide

Introduction

For the past several decades, Washington State has received state dollars through the Legislature to support Behavioral Health Personal Care (BHPC). BHPC is a collaboration between the Department of Social and Health Services (DSHS) and the organizations that provide behavioral health services across the state. Currently, the need for this service is assessed through Home and Community Services (HCS)/AAA and authorized and paid for by managed care organizations (MCOs) with non-Medicaid funds. Over the past several years, the number of people who need this type of support has increased. The state dollars provided no longer supported the program.

As a result, the legislature directed the Health Care Authority (HCA), in partnership with the Aging and Long-term Support Administration (ALTSA), to create a new Apple Health (Medicaid) benefit to better assist providers in supporting individuals with mental health needs in long-term care settings. In response, a 1915(i) State Plan was submitted to the Centers for Medicare & Medicaid Services (CMS). The new Community Behavioral Health Support (CBHS) services program was approved by CMS and begins on July 1, 2024.

This means that any new client who needs support for a mental health condition in long-term care residential settings will be referred to the CBHS program. Additionally, throughout the next year, Home and Community Services will stop authorizing BHPC for clients currently receiving this service. This will happen at the time the resident's CARE assessment is due for renewal. At that time, eligible clients would be referred and transitioned to CBHS.

How to use this guide

This guide is intended to supply providers and managed care organizations with relevant information about the program, criteria, forms, and resources necessary for implementation of the program.

What are Community Behavioral Health Support (CBHS) services?

Community Behavioral Health Support services are individually tailored services designed to help clients acquire, retain, restore, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community-based settings. Supportive Supervision is part of the new CBHS benefit.

What is Supportive Supervision?

Supportive Supervision is:

- A voluntary service.
- Provides staffing to providers to provide one-on-one in-person monitoring, redirection, diversion, and cueing of the client to prevent at-risk behavior that may result in harm to the client or to others.
- Provides individuals with assistance to build skills and resiliency to support stabilized living and integration.
- Supportive Supervision is coordinated as appropriate with other services such as behavior support and/or crisis plans to help ensure community stability.

These interventions are not related to the provision of personal care.

Supportive Supervision does not cover environmental modifications, such as requests for individual rooms or other material goods or services.

Who can provide CBHS services?

For all Apple Health programs, providers are required to successfully complete the provider enrollment process and have a core provider agreement.

For managed care, providers must contract with each MCO, and complete their credentialing process to serve clients enrolled in that MCO. MCOs must ensure quality care is available through the provider, which may include onsite quality reviews as appropriate.

Supportive Supervision can be provided by the following provider types when enrolled with HCA as an Apple Health provider:

1. Adult family homes (AFH)
2. Assisted living facilities (ALF)
    a. Enhanced adult residential care facility (EARC)
    b. Adult residential care facility (ARC)
3. Enhanced service facilities (ESF)

Facility Type	Taxonomy
Adult family home (AFH)	311ZA0620X
Assisted Living Facilities (ALF), including the following subcontracted under an ALF: **Enhanced Adult Residential Care Facility (EARC)** **Adult Residential Care (ARC) Facility**	310400000X
Enhanced services facilities (ESF)	3104A0625X

Providers interested in becoming a CBHS provider can learn more in the provider eligibility section below.

Client eligibility

There are two areas that individuals must meet to be eligible.

Financial

To be considered financially eligible individuals must be:

- 18+ and be Apple Health eligible. Financial eligibility is authorized for 1 year at a time.

Functional

To be considered functionally eligible, individuals must:

- Be eligible for Home and Community Services (HCS) services.
- Reside in or be discharging to a community residential setting.
- Be assessed to have a need for assistance, demonstrated by the need for hands on assistance with at least one Activities of Daily Living (ADLs) defined in WAC 388-106-0210 or Supervision with three or more qualifying ADLs.
- Meet the risk criteria.
- Have a qualifying diagnosis.

Functional eligibility may be authorized for no more than 1 year at a time.

Activities of daily living (ADL)

- Bathing
- Personal hygiene
- Body care
- Eating
- Toileting
- Dressing
- Transfers
- Bed mobility, turning, repositioning
- Walking in room, locomotion in room, locomotion outside
- Medication management

Risk criteria

1. Has behaviors caused by their behavioral health condition that require additional staffing available only under the Community Behavioral Health Support services benefit, including at least one or more of the following within the past year:

a) **Multiple assaultive incidents** related to a BH condition during inpatient or long-term care

b) **Self-endangering behaviors** that would result in bodily harm if not prevented.

c) **Intrusiveness** (e.g., rummaging, unawareness of personal boundaries) behaviors that places the individual at risk of assault by others if not prevented

d) **Chronic psychiatric symptoms that cause distress** to and escalate the individual and/or other residents to crisis if not monitored and redirected by staff.

e) **Sexual inappropriateness** that redirection to maintain safety of the individual and other vulnerable adults.

f) A history of any of the above behaviors, which are **currently only prevented by additional skilled staff intervention (BHPC).**

In addition to the above behaviors, the individual must also meet #2 and/or #3 to qualify:

2. History of being unsuccessful in community living settings, including one or more of the following:

a. History of multiple failed stays in residential settings within the past 2 years.
b. In imminent danger of losing a current community living setting due to behaviors related to behavioral health conditions.
c. Frequent caregiver turnover due to behaviors related to behavioral health condition(s) within past 2 years.

3. Past psychiatric history where significant functional improvement has not been effectively maintained due to the lack of CBHS-like services and/or supports, including one or more of the following:

a. 2 or more inpatient psychiatric hospitalizations in the last 12 months
b. An inpatient stay in a community hospital (acute or psychiatric) or free-standing evaluation and treatment facility for 30 days or more in the last 12 months, with barriers to discharge related to behavioral health conditions.
c. Discharge from a state psychiatric hospital or long-term 90/180-day inpatient psychiatric setting in the last 12 months.

Qualifying diagnoses

Supportive Supervision is for individuals who have a primary diagnosis of one or more of the diagnoses in the table below.

Having the diagnosis code is very important. The primary diagnosis represents the behavioral health condition that qualified the client to receive the approved services.

CBHS providers must submit the ICD-10 diagnosis codes on all claims and encounters.

ICD-10 Code	DIAG_DESC
F060	Psychotic disorder w hallucin due to known physiol condition
F062	Psychotic disorder w delusions due to known physiol cond
F0630	Mood disorder due to known physiological condition, unsp
F0631	Mood disorder due to known physiol cond w depressv features
F0632	Mood disord d/t physiol cond w major depressive-like epsd
F0633	Mood disorder due to known physiol cond w manic features
F0634	Mood disorder due to known physiol cond w mixed features
F064	Anxiety disorder due to known physiological condition
F070	Personality change due to known physiological condition
S062X9S	Diffuse Traumatic Brain INJ W/LOC UNS DUR SEQ
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
F28	Oth psych disorder not due to a sub or known physiol cond
F29	Unsp psychosis not due to a substance or known physiol cond
F3010	Manic episode without psychotic symptoms, unspecified

F3011	Manic episode without psychotic symptoms, mild
F3012	Manic episode without psychotic symptoms, moderate
F3013	Manic episode, severe, without psychotic symptoms
F302	Manic episode, severe with psychotic symptoms
F303	Manic episode in partial remission
F304	Manic episode in full remission
F308	Other manic episodes
F309	Manic episode, unspecified
F310	Bipolar disorder, current episode hypomanic
F3110	Bipolar disord, crnt episode manic w/o psych features, unsp
F3111	Bipolar disord, crnt episode manic w/o psych features, mild
F3112	Bipolar disord, crnt episode manic w/o psych features, mod
F3113	Bipolar disord, crnt epsd manic w/o psych features, severe
F312	Bipolar disord, crnt episode manic severe w psych features
F3130	Bipolar disord, crnt epsd depress, mild or mod severt, unsp
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disord, crnt epsd depress, sev, w/o psych features
F315	Bipolar disord, crnt epsd depress, severe, w psych features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disord, crnt epsd mixed, severe, w/o psych features
F3164	Bipolar disord, crnt episode mixed, severe, w psych features
F3170	Bipolar disord, currently in remis, most recent episode unsp
F3171	Bipolar disord, in partial remis, most recent epsd hypomanic
F3172	Bipolar disord, in full remis, most recent episode hypomanic
F3173	Bipolar disord, in partial remis, most recent episode manic
F3174	Bipolar disorder, in full remis, most recent episode manic
F3175	Bipolar disord, in partial remis, most recent epsd depress
F3176	Bipolar disorder, in full remis, most recent episode depress

F3177	Bipolar disord, in partial remis, most recent episode mixed
F3178	Bipolar disorder, in full remis, most recent episode mixed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified
F320	Major depressive disorder, single episode, mild
F321	Major depressive disorder, single episode, moderate
F322	Major depressv disord, single epsd, sev w/o psych features
F323	Major depressv disord, single epsd, severe w psych features
F324	Major depressv disorder, single episode, in partial remis
F325	Major depressive disorder, single episode, in full remission
F328	Other depressive episodes
F3281	Premenstrual dysphoric disorder
F3289	Other specified depressive episodes
F329	Major depressive disorder, single episode, unspecified
F32A	Depression, unspecified
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate
F332	Major depressv disorder, recurrent severe w/o psych features
F333	Major depressv disorder, recurrent, severe w psych symptoms
F3340	Major depressive disorder, recurrent, in remission, unsp
F3341	Major depressive disorder, recurrent, in partial remission
F3342	Major depressive disorder, recurrent, in full remission
F338	Other recurrent depressive disorders
F339	Major depressive disorder, recurrent, unspecified
F340	Cyclothymic disorder
F341	Dysthymic disorder
F348	Other persistent mood [affective] disorders
F3481	Disruptive mood dysregulation disorder
F3489	Other specified persistent mood disorders
F349	Persistent mood [affective] disorder, unspecified

F39	Unspecified mood [affective] disorder
F4000	Agoraphobia, unspecified
F4001	Agoraphobia with panic disorder
F4002	Agoraphobia without panic disorder
F4010	Social phobia, unspecified
F4011	Social phobia, generalized
F40240	Claustrophobia
F408	Other phobic anxiety disorders
F410	Panic disorder [episodic paroxysmal anxiety]
F411	Generalized anxiety disorder
F42	Obsessive-compulsive disorder
F422	Mixed obsessional thoughts and acts
F423	Hoarding disorder
F424	Excoriation (skin-picking) disorder
F428	Other obsessive-compulsive disorder
F429	Obsessive-compulsive disorder, unspecified
F4310	Post-traumatic stress disorder, unspecified
F4311	Post-traumatic stress disorder, acute
F4312	Post-traumatic stress disorder, chronic
F440	Dissociative amnesia
F441	Dissociative fugue
F442	Dissociative stupor
F444	Conversion disorder with motor symptom or deficit
F445	Conversion disorder with seizures or convulsions
F446	Conversion disorder with sensory symptom or deficit
F447	Conversion disorder with mixed symptom presentation
F4481	Dissociative identity disorder
F4489	Other dissociative and conversion disorders
F449	Dissociative and conversion disorder, unspecified
F450	Somatization disorder
F451	Undifferentiated somatoform disorder
F4520	Hypochondriacal disorder, unspecified
F4521	Hypochondriasis

F4522	Body dysmorphic disorder
F4529	Other hypochondriacal disorders
F4541	Pain disorder exclusively related to psychological factors
F4542	Pain disorder with related psychological factors
F458	Other somatoform disorders
F459	Somatoform disorder, unspecified
F481	Depersonalization-derealization syndrome
F489	Nonpsychotic mental disorder, unspecified
F603	Borderline personality disorder
F633	Trichotillomania
F6381	Intermittent explosive disorder
F6389	Other impulse disorders
F639	Impulse disorder, unspecified
F6810	Factitious disorder imposed on self, unspecified
F6811	Factit disord imposed on self, with predom psych signs/symp
F6812	Factit disord impsd on self, with predom physcl signs/symp
F6813	Factit disord impsd on self,w comb psych & physcl signs/symp
F688	Other specified disorders of adult personality and behavior
F910	Conduct disorder confined to family context
F911	Conduct disorder, childhood-onset type
F912	Conduct disorder, adolescent-onset type
F918	Other conduct disorders
F919	Conduct disorder, unspecified
F930	Separation anxiety disorder of childhood
F938	Other childhood emotional disorders
F939	Childhood emotional disorder, unspecified
F940	Selective mutism
F941	Reactive attachment disorder of childhood
F942	Disinhibited attachment disorder of childhood
F948	Other childhood disorders of social functioning
F949	Childhood disorder of social functioning, unspecified

Determining the right level of services

Once it is determined that an individual meets the eligibility criteria, the next step is to determine how much of the service will be medically appropriate for the individual to receive. A guidance document has been created to identify the right level of services that will meet the needs for each person.

HCA and the MCOs will obtain information from HCS/AAA staff through a referral process. Looking at the documentation provided and the guidance document, a prior authorization for a specific tier level will be determined.

If a member currently receiving CBHS services transfers to another MCO, then the new MCO must honor the service authorization that was in place for that member for up to 60 days. This is in accordance with the continuity of care section of the Apple Health-Integrated Managed Care 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.

Guidelines for who should determine a diagnosis

- Licensed/credentialed professionals should determine the diagnosis within the scope of their licensure.
- For a Supportive Supervision referral, use the best applicable diagnosis in the client's record that was previously documented by a provider and is on the eligible diagnosis list. If a diagnosis is not found in the list above, the client would not be eligible.

Tiering of clients

HCA leverages the information below to determine the appropriate level of care based on frequency and intensity of qualifying behaviors.

Qualifying behaviors

- A psychiatric symptom is not necessarily a qualifying behavior. To be a qualifying behavior for Supportive Supervision, the behavior must create a risk to safety and/or cause distress to and escalate the client or other residents to crisis if not monitored and redirected by staff.
- Qualifying behaviors for Supportive Supervision must be related to and driven by a primary diagnosis of mental illness, as defined found above and in WAC 182-561-0700.
- Behaviors that result in a need for additional staff or additional staff time to attend to activities of daily living (ADL) or instrumental activities of daily living (iADL) needs are not considered qualifying behaviors for the purpose of supportive supervision tiering.

- Review should consider frequency and timing of behaviors (i.e., difficulty with transitions in activities, wakefulness at night, behaviors at mealtimes, etc.)

Service level and payment for services is broken into six tiers.

Rate tier	Tiering guidance	HCPCS Code
Tier 1	At a minimum, all individuals deemed eligible for Supportive Supervision qualify for Tier 1, an average of up to 2 hours a day.	S5126
Tier 2	The individual demonstrates current, qualifying behavior(s) at a frequency that requires an average of 2.1-6 hours per day of dedicated staff and meets requirements in the tiering guidance.	S5126 Modifier TF
Tier 3	The individual demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 6.1-10 hours per day of 1:1 staffing staff and meets requirements in the tiering guidance.	S5126 Modifier HE
Tier 4	The individual demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 10.1-15 hours per day of 1:1 staffing and meets requirements in the tiering guidance.	S5126 Modifier TG
Tier 5	The individual demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 15.1-20 hours per day of 1:1 staffing and meets requirements in the tiering guidance.	S5126 Modifier HK

Tier 6	The individual demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 20.1-24 hours per day of 1:1 staffing and meets requirements in the tiering guidance.	S5126 Modifier HI

Provider enrollment, credentialing, and criteria requirements

Process for HCA provider enrollment

Apple Health providers, including those delivering CBHS services, are required to enroll with HCA as an Apple Health provider. This process is also referred to as completing a Core Provider Agreement (CPA). See HCA Provider Enrollment for more information.

The CPA governs the relationship between HCA and Apple Health providers. The CPA terms and conditions incorporate federal laws, rules and regulations, state law, HCA rules and regulations, and HCA program policies and billing instructions.

Providers of CBHS services submit CPA applications to HCA.

Once the CPA is started, you must reach out to the client's MCO to contract with them.

Managed care credentialing requirements

To include a CBHS provider in their networks, MCOs are required to verify the qualifications of the provider or provider organization to ensure they can meet the standards and capabilities required to be an MCO-contracted provider based on federal rules and their contracts with HCA. This is called credentialing. Credentialing is a method of verifying that health care professionals and facilities are certified and licensed.

This process requires multiple steps and can take up to 90 days to complete. Facility credentialing applications can vary by MCO but generally include:

- Current license(s) (must be licensed in WA state)
- Current liability insurance
- Most recent survey
- W-9 form
- CMS Ownership and Disclosure form
- Roster/list of locations.

Billing and submission

Billing depends on the program an individual is enrolled in.

Providers must bill HCA directly when clients do not have a managed care plan. These clients are eligible for services under the fee-for-service (FFS) Medicaid program. Some examples of populations that may be exempt from enrolling in a managed care plan are American Indian/Alaska Native, adoption support, and foster care alumni.

When a client is enrolled in an integrated managed care plan or a behavioral health services only plan, the provider will bill the MCOs for reimbursement of CBHS services.

Billing for adult family homes

Adult family homes (AFH) will submit the Supportive Supervision reporting spreadsheet to the client's MCO. The spreadsheet is divided by tiers.

- AFH providers must complete one row per client per day Supportive Supervision is provided.
- AFH providers will submit one spreadsheet to the MCO.
- Frequency for billing submissions can occur weekly or monthly.
- The MCO will begin to process the report for payment upon receipt.

This is a temporary process until a clearinghouse can be implemented.

Billing for other community residential settings (ALF/ESF)

ALFs and ESFs that utilize a clearinghouse will use the clearinghouse to submit claims to the MCOs. ALFs and ESFs that bill HCA, or don't currently use a clearinghouse, will submit claims via MCO portal.

What is a clearinghouse?

A clearinghouse is a trading partner securely transmitting claims (837 file) electronically from the provider to the MCO.

Benefits of a clearinghouse

- Submits multiple claims to specified payer
- Provides electronic remittance advice (ERA) for automatic updates for payments and adjustments by MCO
- Meets HIPAA compliance standards
- Stand-alone entity
- Scrubs claims for errors prior to submission to MCO to improve accuracy
- The most common electronic data information (EDI) transmissions are known as files 837, 277, 999 and 835.
- Allows providers to manage claim status in one place

How often are providers paid for clients without a managed care plan?

For clients not in a managed care plan, after claims are submitted in ProviderOne, the provider receives payment from HCA via electronic funds transfer or paper check. ProviderOne makes weekly payments, typically every Thursday. Claim submission cutoff in the payment system is Tuesday at 5 p.m. Pacific time to make payment on Thursday of the same week for a clean claim.

Clean claims submitted after cutoff will be paid the following payment cycle on the following Thursday. Clean claims are claims that have all the required data elements and do not conflict with CBHS program policies.

Claims may arrive in the payment system before 5 p.m. on Tuesday but may not process until after the cutoff time. These claims will miss the Thursday payment and will be paid the following payment cycle on the following Thursday.

Claims submitted by paper will take longer to process. Payment will be made (need to confirm with accounting).

MCOs, by federal law, are only allowed to pay clean claims.

Claims

Clean claim means a claim containing all required data elements and can be processed without obtaining additional information from the provider of the service, or from a third party. A form (see each MCO's billing guide) provide requirements for claim form submission.

Non-clean claim means a claim where not all the necessary information is provided or there are errors. For example, claims rejected for missing data elements, submitted on incorrect forms, or contain incorrect data (e.g. wrong member ID, invalid CPT/ICD code, etc.).

MCOs are not allowed to alter any information on the claim.

The spreadsheet for adult family homes will serve as a claim like submission for services rendered.

There are two reasons that an MCO or HCA would not pay a claim.

- **Rejected claim.** This is a non-clean claim. It does not get sent forward for processing of the claim due to missing or incorrect information.
- **Denied claim.** This claim has all the correct information but is denied for payment. An example of a reason for denial could be changes in the person's eligibility.

When this happens:

- For providers using the spreadsheet template to bill:
    - **MCO**. the provider will receive an email notification explaining the reason for the rejection/denial. Notification

of denial may be received via email or letter, depending on the MCO.

- **HCA**. the provider will receive a notification explaining the reason for the rejection/denial.

- For those using a clearinghouse:
    - Clearinghouses can send rejected claims reports. You may need to request these reports. The provider will need to work through these reports regularly to resolve issues and resubmit claims.

For more billing information, refer to the HCA Community Behavioral Health Support Services (CBHS) Billing Guide.

What are the documentation requirements for CBHS services?

The provider must complete the Supportive Supervision tracking and attestation form (number pending) and submit upon request. For billing purposes, providers must track services provided. These documents can be used to support changes in client tier level.

The attestation will include basic client information like name and date of birth as well as service information like date of service, hours provided, and a summary of services. Summary of services should include a description of behaviors for which intervention was needed, the intervention provided, and what occurred before the behavior began that required intervention.

The CBHS provider must maintain the client's CARE assessment.

HCA may also request the following:

- Billing spreadsheets and forms
- Supportive Supervision tracking and attestation form

Signature requirements

The provider's signature on all records and treatment notes verifies the services have been accurately and fully documented, reviewed, and authenticated. It confirms the provider has certified the medical necessity and reasonableness for the service(s) provided. For a signature to be valid, the following criteria must be met:

- Signatures are handwritten, electronic, or stamped. Stamped signatures are permitted only in the case of an author with a physical disability who can provide proof of an inability to sign due to a disability.
- Signatures must be legible.

Requests for changes

Client requests for provider change or other circumstances

The CBHS provider must coordinate with the client's HCS or AAA case manager to initiate a change in the client's circumstance. The HCS or AAA case manager will submit a change of circumstance form (#16-275) to the client's MCO or HCA for FFS for one of the following changes:

- Change in residence;
- Client/AREP/guardian request to close service;
- Long-term care closing; or
- Client passed away.

Provider requests for tier level change

The CBHS provider must coordinate with the client's HCS or AAA case manager to initiate a tier level change or notification of MCO change. The HCS or AAA case manager will submit a Supportive Supervision re-tiering request form to the client's MCO or HCS for FFS with documentation to support tier change.

Enrollee rights and responsibilities

Advanced directives

Providers must know and comply with applicable regulations (WAC and RCW) regarding advance directives and should implement advance directives as appropriate to their available services. MCOs may request provider assistance in obtaining copies of advance directives.

An advance directive gives written instructions about a patient's medical care if the patient is unable to express his or her medical wishes.

For the State of Washington there are three types of advance directives:

1. **Health care directive or living will**. Specifies an individual's wishes about end-of-life care.
2. **Durable power of attorney**. Names another person to consent to, stop, or refuse treatment if an individual is incapable of doing so.
3. **Mental health (MH) advance directive**. Allows a person with capacity to state mental health treatment preferences in a legal document that will govern during periods of incapacity.
    a. To be valid, a mental health advance directive must:
        i. Be in writing;
        ii. Include language indicating a clear intent to create a directive;
        iii. Be dated and signed by the patient, or be dated and signed in the patient's presence at his or her direction;
        iv. State whether the directive may or may not be revoked during a period of incapacity;
        v. Be witnessed in writing by at least two adult witnesses;
        vi. Conform substantially to the statutory format.

Grievance and appeal rights

A member may express dissatisfaction pertaining to quality of care, how they were treated, problems obtaining care, and billing issues.

- Refer the member to their MCO to report a grievance. Only members can file a grievance or designate someone to file on their behalf with written authorization.
- MCO will confirm receipt of the grievance within two business days of receipt.
- Grievances are resolved within 45 days and the member will be advised of the resolution.

A member or member representative may request an appeal for a denied service or authorization within 60 calendar days of the denial.

Filing a grievance or appeal contacts

MCO	Contact Number	Email
Wellpoint	(800) 600-4441	wa-grievance@wellpoint.com
Coordinated Care	(877) 644-4613	WAGrievances@Centene.com TAC_WAAppealsDept@Centene.com
Molina Healthcare	(800) 869-7165	MHWMemberServicesWeb@MolinaHealthcare.com
UnitedHealthcare Community Plan	(866) 556-8166	WACS_Appeals@UHC.com
Community Health Plan of WA	(206) 521-8830	Appealsgrievances@chpw.org

Behavioral health advocates

A behavioral health advocate is a person who is available to provide free and confidential assistance resolving concerns related to a client's behavioral health services. They can help if a client has a behavioral health grievance, appeal, or administrative hearing to resolve your concerns.

- Behavioral health advocates are independent of the MCO.
- Reach all regions at 1-800-366-3103 or email the Office of Behavioral Health Advocacy at info@obhadvocacy.org.
- Or view regional contact information.

Other federal requirements for providers

Providers that contract with MCOs have specific rules they must follow to meet federal law.

Critical incident

When a critical Incident happens, providers must report the incident. A critical incident is an event involving a member or provider with impact to health and safety. Examples include:

- Homicide or attempted homicide by an enrollee.
- The unexpected death or serious injury of an enrollee in a behavioral health facility.
- Abuse, neglect or exploitation of an enrollee.
- Violent acts allegedly committed by an enrollee.
- Unauthorized leave from facility.
- Event that is likely to attract media attention.

Critical incident occurs	Provider notifies MCO of incident using critical incident report form within one (1) business day of reporter's awareness of the incident.
Critical incident is reported	MCO enters incident into incident reporting system by close of business on the date received from the reporter.
Critical incident is closed	MCO completes investigation and follow-up and enters into the incident reporting system. HCA may request additional follow-up from the MCO.

The critical incident forms are available on each MCO's website and should be submitted to the emails listed.

MCO	Email	Link to Form
Wellpoint	qmnotification@wellpoint.com	Quality management | Wellpoint Washington, Inc.
Coordinated Care	WA_QOCCI_Reporting@Centene.com	Coordinated Care critical incident form
Molina Healthcare	MHW_Critical_Incidents@MolinaHealthcare.com	Molina frequently used forms
UnitedHealthcare Community Plan	WA_Criticalinc@UHC.com	**Critical incident report form - UnitedHealthcare Community Plan of Washington (uhcprovider.com)**
Community Health Plan of WA	Critical.Incidents@chpw.org	**CHPW_Critical_Incidents_Form_ Updated 12_13_2019**

Members can also call the number on the back of their managed care plan ID card to report any issues.

Fraud, waste, and abuse

MCOs are required by law to report any suspected fraud, waste, or abuse.

- **Fraud**. Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it or any other person; the attempt is fraud, regardless of whether it is successful. Report any misuse by reporting suspected Medicaid fraud.
- **Waste**. Includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse**. When providers or suppliers do not follow good practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not necessary.

CBHS resources

Contact the Health Care Authority with any questions at hca1915iservices@hca.wa.gov.

Use the HCA CBHS Webpage to find resources such as:

- Tiering guidance
- CBHS Billing Guide (coming 7/1/24)
- Supportive Supervision tracker and attestation form #13-0126
- Re-tiering request form #13-0125
- Fee schedule

Additional support

For additional information and support regarding the CBHS supportive supervision program, visit Community Behavioral Health Support (CBHS) services webpage or contact hca1915iservices@hca.wa.gov.