Community Behavioral Health Supports (CBHS) referral form

Washington State Health Care Authority

Instructions

Please type or print clearly and fill out form completely.

Purpose

This form is used to refer a client for CBHS Service eligibility. Clients who meet the criteria for 1915(i) and who would benefit from Community Behavioral Health Services (CBHS) are referred to the assigned managed care organization (MCO) or to the Health Care Authority (HCA) for fee-for-service (FFS) clients. If the client is found eligible for CBHS services by HCA, the MCO or HCA will authorize CBHS services at the level determined by the approver.

Good to know

This form must be submitted annually or at the time of a significant change assessment to determine ongoing eligibility for CBHS. 1915i services are approved for a 12-month period. Set a CARE tickler or reminder for at least 30 days before the end of the approval period so that another 1915i referral request can be made to the MCO or HCA to ensure continued funding.

1 To be completed by HCS or AAA Case Manager (CM)

TO:

Medicaid (FIMC/BHSO) plan assigned

Wellpoint: **wacbhs@wellpoint.com**

Community Health Plan of Washington: **bhpc@chpw.org**

Coordinated Care: **WA_Behavioral_Health_UM@coordinatedcarehealth.com**

Molina: **cbhsreferrals@molinahealthcare.com**

United Health Care: **wa_behavioralhealthreferrals@uhc.com**

Fee-for-Service (FFS): **hca1915iservices@hca.wa.gov**

Date sent to MCO (FIMC/BHSO) or HCA (FFS)

FROM:

Case Manager name | Case Manager email | Telephone

Referring organization

Home and Community Services (HCS) | Area Agency on Aging (AAA)

Type of referral

New (an initial referral or there has been a break in the 1915i authorization)

Annual renewal (a yearly request for 1915i services that aligns with CARE planned period)

Significant change (CARE planned period timeframe is changing via mid-approval period assessment)

The following documentation is included with the referral:

Service Summary and CARE Assessment | Behavior Support Plan for SBS, ECS

RE:

Client's name (as written in the CARE assessment)	Client's ProviderOne ID	WA	Date of birth (mm/dd/yyyy)
Current Residential Provider, if known	Provider email		Provider telephone

2 To be completed by referent

Complete all fields in this section and include CARE assessment and service summary.

Submit form with section 2 complete and include supporting documentation to MCO or HCA.

- **Clients NOT in an inpatient setting**: Send via secure email with the subject line: "CBHS Referral [DSHS SECURE]".
- **Clients in an inpatient setting**: Send via secure email with the subject line: "CBHS Referral-Inpatient [DSHS SECURE]".

Submit form and supporting documentation.

- **Clients in managed care**: Send the form to the MCO.
  - Wellpoint: **wacbhs@wellpoint.com**
  - Community Health Plan of Washington: **bhpc@chpw.org**
  - Coordinated Care: **WA_Behavioral_Health_UM@coordinatedcarehealth.com**
  - Molina: **cbhsreferrals@molinahealthcare.com**
  - United Health Care: **wa_behavioralhealthreferrals@uhc.com**
- **Clients in Apple Health without a managed care plan:** Send the form to **hca1915iservices@hca.wa.gov**

Functional

By checking the box, the referent confirms client meets functional criteria for LTC services.

Client is over the age of 18 years old and functionally eligible for Long-term Care (LTC) services.

Financial

Check the statement that best represents the client's LTC financial eligibility at the time of referral.

Client is financially eligible

Client is pending financial eligibility

Diagnosis

By checking the box, the referent indicates the client has a primary diagnosis of a serious mental illness. Then, select where the information confirming the mental health diagnosis was obtained from

Primary diagnosis of a serious mental illness, obtained from:

Medical record

Self-report/caregiver/ guardian report

Current BHPC recipient

Risk criteria

Check all that apply for questions 1 through 3. The comment box after each question is for the referent to provide additional details to assist MCO or HCA in determining service authorization.

Client must meet one or more criteria under question 1, and one or more criteria under question 2 or 3.

1. **Has behavioral or clinical complexity as evidenced by at least one or more of the following within the past year:**

   Assaultive history: Multiple assaultive incidents related to a behavioral 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 behavior: Related to a behavioral health condition that would result in bodily harm if not prevented with a high level of staffing and/or skilled staff intervention.

Intrusiveness: (e.g., rummaging, unawareness of personal boundaries) Related to a mental health condition that places the client at risk of assault by others if not prevented with a high level of staffing and/or skilled staff intervention.

Chronic psychiatric symptoms: That cause distress to and escalate the client and/or other residents to crisis if not monitored and redirected by staff.

Sexual inappropriateness: Related to a behavioral health condition that requires skilled staff intervention to redirect to maintain safety of the client and other vulnerable adults.

A history of any of the above behaviors, which are currently only prevented by additional skilled staff intervention.

Additional comments/clarification regarding question 1 risk criteria:

2. **History of being unsuccessful in community living settings, as evidenced by at least one or more of the following:**

Unsuccessful community setting: History of multiple failed community settings within the past 2 years.

Caregiver turnover: Frequent caregiver turnover due to behaviors related to behavioral health condition(s) within past 2 years.

Risk of loss of current setting: Without CBHS services in the community would be at imminent risk of losing long-term care setting due to behaviors.

Additional comments/clarification regarding question 2 risk criteria:

3. **Past psychiatric history, with no significant functional improvement that can be maintained without CBHS services, as evidenced by at least one or more of the following:**

2 or more inpatient psychiatric hospitalizations in the last 12 months

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 condition(s)

Discharge from a state psychiatric hospital or long term 90/180-day inpatient psychiatric setting in the last 12 months

Risk of (re)hospitalization: Without CBHS services in the community would likely be at imminent risk of requiring inpatient level of care (currently in residential setting receiving CBHS services)

Additional comments/clarification regarding question 3 risk criteria:

3 CBHS criteria review (MCO clients only)

Upon receipt, the MCO will confirm receipt with Case manager within **2 business days**. The MCO may provide additional supporting documentation with the referral form before sending to HCA for review. The MCO will return the completed form to HCA at **hca1915iservices@hca.wa.gov** within the timeframes referenced below.
Timeframe for the MCO to submit referral form to HCA:

- **Clients NOT in an inpatient setting**: 5 business days from receipt of the initial referral
- **Client in an inpatient setting**: 2 business days from receipt of the initial referral

The MCO staff reviewing the referral will complete all information in this section, and review supporting documentation and/or other tools to complete the criteria review.

MCO reviewer information

MCO staff reviewer name

Email address

Telephone

Date received

Need and risk criteria reviewed

Recommend for CBHS Service: CBHS need/risk criteria identified

Eligible ICD-10 diagnosis, as reported through claims/medical records:

Other services the MCO will coordinate, if applicable:

Do not recommend for CBHS Service: CBHS need/risk criteria not identified

Explanation on why the client does not meets need and/or risk criteria:

Other services the MCO will coordinate:

Anticipated authorization level

If the "Recommend for CBHS Service" box is marked above, indicate the tier recommended for Supportive Supervision.

Supportive Supervision

Tier 1 (0.5 - 2 hours a day)

Tier 2 (2.1 - 6 hours a day)

Tier 3 (6.1 - 10 hours a day)

Tier 4 (10.1 - 15 hours a day)

Tier 5 (15.1 - 20 hours a day)

Tier 6 (20.1 – 24 hours a day)

Date criteria review was emailed to HCA at **hca1915iservices@hca.wa.gov**:

Notes on additional supporting documentation attached:

4 CBHS eligibility (to be completed by HCA)

Upon receipt, HCA has **3 business days** to determine functional eligibility for 1915i and return to the MCO or complete the form for FFS clients. HCA will complete all information in this section and review Medicaid status to determine whether the income disregard needs to be requested.

- **Approvals** (non FFS clients): If client is eligible for CBHS (1915i) services, form is sent back to the assigned MCO.
- **Denials**: Send the form back to the referring HCS/AAA Case Manager and cc: the HCS inbox: **MCOBHOforms@dshs.wa.gov**. HCA to also send the form back to the assigned MCO.

HCA reviewer information

HCA staff reviewer name | Email address | Date received

Eligibility determination

Meets functional eligibility for CBHS (1915i) services.

Meets financial eligibility for CBHS (1915i) services:

Does NOT meet functional and/or financial eligibility for CBHS (1915i) services:

Reason justifying denial:

Date denial letter issued:

Date sent to MCO and HCS/AAA:

1915i eligibility dates from to

5 CBHS service authorization (to be completed by authorizing entity: MCO or HCA-FFS)

Upon receipt, timeframes to complete the authorization include:

- HCA will have **2 business days** to process authorization.
- MCOs will follow authorization timeframes as outlined in contract Section 11.6. MCOs will authorize within **5 business days**, per contract. The MCO will then immediately submit decision back to HCS/AAA case manager.

Once services are authorized, send completed form to the HCS/AAA Case Manager and cc: the HCS inbox: **mcobhoforms@dshs.wa.gov** and **hca1915iservices@hca.wa.gov**.

MCO/HCA staff information

MCO/HCA staff name | Email address | Telephone

Date of authorization request from provider

More on next page

Service authorized

Supportive Supervision

Tier 1 (0.5 - 2 hours a day)

Tier 2 (2.1 - 6 hours a day)

Tier 3 (6.1 - 10 hours a day)

Tier 4 (10.1 - 15 hours a day)

Tier 5 (15.1 - 20 hours a day)

Tier 6 (20.1 – 24 hours a day)

Service authorization from to

For service renewals only: Is this a service reduction? Yes No

Date *Notice Of Adverse Benefit Determination* sent to the client:

Comments:

Signature

Authorizing signature

Date sent to HCS/AAA and HCA

Where to send completed form

Once eligibility is determined and services are approved:

For HCA (fee-for-service): Send to HCS/AAA Case Manager via secure email and cc: **mcobhoforms@dshs.wa.gov**.

For MCO: Send to HCS Case Manager and cc: **mcobhoforms@dshs.wa.gov** and **hca1915iservices@hca.wa.gov**.

For HCS/AAA: Submit hard copy of form to DMS Hotmail to be included in client's electronic case record.