

CMS DRAFT FORM

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

**Requested effective date April 1, 2008**

**Washington State Integrated Community Mental Health Program  
April 1, 2008- March 31, 2010**

Submitted by:  
Washington State  
Department of Social and Health Services  
Mental Health Division  
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**US DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Center for Medicaid and State Operations**

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***PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM***

**Waiver Renewal Submittal**

**Section A. GENERAL INFORMATION**

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

**Effective Dates:** This waiver renewal is requested for a period of 2 years; effective April 1, 2008 and ending March 31, 2010.

**The waiver program is called Integrated Community Mental Health Program.**

**State Contact:** The State contact person for this waiver is Fran Collison who can be reached by telephone at (360) 902-0864, or fax at (360) 902-0809, or e-mail at [Collifk@dshs.wa.gov](mailto:Collifk@dshs.wa.gov).

**I. Statutory Authority**

- a. **Section 1915(b)(1):** The State's waiver program is authorized under Section 1915(b)(1) of the Act, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.
- b. **Other Statutory Authority:** The State is also relying upon authority provided in the following section(s) of the Act:
  - 1. \_\_\_ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.IV.b Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.
  - 2. X **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

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

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

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

1. **X Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. **This waiver program is not available throughout the State. At the time of this renewal, Pierce County has elected not to renew their contract with the State of Washington. Pierce County enrollees will continue to receive services from qualified providers via a fee for service payment system. This direct carve-out of Pierce County will remain in effect until a prepaid inpatient health plan is achieved. This is anticipated to be July 1, 2009.**

*It may be necessary however; if at any time the RSN cannot, or chooses not to, demonstrate qualifications for the State of Washington to implement a fee for service system on a time-limited basis to implement a procurement process for that geographic area. This would be done as covered in the contingency plan submitted to CMS to not disrupt care to consumers.*

2. **X Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.
3. **X Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO, PIHP or PAHP.
4. **X Section 1902(a)(4)** – To permit the State to mandate beneficiaries into a single PIHP or PAHP.
5. **X Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their CMS Regional Office to identify required submission items from this format.

**Section 438.52** Non-competitive Procurement - The MHD continues to rely on its agreement with the Centers for Medicare and Medicaid Services that the Regional Support Networks (RSN) have the first

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opportunity to contract to operate the PIHP for outpatient mental health services and community mental health inpatient services.

The Washington State Legislature passed the Mental Health Reform Act (2SSB 5400) in 1989 and created a single point of local responsibility for mental health services. This 1989 legislation created county-based RSNs to design and administer mental health delivery systems, receive available resources and to meet the unique needs of people with mental illness. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, prior to 1993 they did not have the responsibility to manage care and to control the escalating costs of the Medicaid program.

The Mental Health Division (MHD) began delivering mental health services under a 1915 (b) waiver in 1993, for outpatient mental health services and for integrated community mental health in 1997. The capitated managed mental health system gives the RSN the ability to design an integrated system of mental health care and, as necessary, subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing quality service delivery which is age and culturally competent. This established the ability to control the rate of financial growth and improved mental health service outcomes.

The first opportunity to demonstrate qualifications and enter into capitated managed mental health care contracts was provided to county-based Regional Support Networks. This opportunity was contingent upon the RSN's agreement to enter into a full-risk capitation contract at an actuarially sound rate determined by the MHD. RSNs were also required to demonstrate capacity to meet the program and fiscal requirements. The RSNs administer the Medicaid mental health care system directly, or subcontract with qualified community mental health agencies (CMHA). Such subcontracts do not relieve the RSNs of ultimate responsibility for compliance with the MHD's program and fiscal requirements. RSNs may impose additional requirements on subcontractors as needed to affect appropriate management oversight and flexibility in addressing local needs.

Pursuant to the State's Community Mental Health Services Act (RCW 71.24), the RSNs administer all community mental health services funded by the state. Under the State's Involuntary Treatment Statutes (RCW 71.05 and RCW 71.34), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Further, under other state statutes, the counties play a key role in chemical dependency treatment as well as services for people with developmental disabilities. All RSNs must meet the certification requirements of RCW 71.24 and the requirements of RCW 48.44 (the insurance code), as applicable.

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

At this time, Pierce County has chosen not to participate. The MHD is implementing a fee for service system to allow for the provision of uninterrupted services to the Medicaid enrollees of Pierce County. This is expected to be in place through 7/1/09.

The MHD ensures that whether a county-based PIHP or other entity holds the mental health managed

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care contract, that contractor is required to provide a cost effective, integrated system of mental health service delivery.

**Section 438.52** Choice – All individuals eligible for Medicaid are mandatorily enrolled in a single PIHP covering a specific catchment area. The state is requesting authority to waive 438.52, with the exception of Pierce County.

## II. Background

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

### Brief Summary

The purpose of this waiver renewal is to continue to: 1) promote age, culturally, and linguistically competent coordination of comprehensive mental health services with regionally managed care through Prepaid Inpatient Health Plans (PIHP); 2) provide community mental health rehabilitation services and community psychiatric inpatient care in a seamless manner, providing continuity of care for persons served by the public mental health system; and 3) support recovery and reintegration to the community for persons with mental illness.

### Mission Statement

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

The mission of the Mental Health Division is to administer a public mental health system that promotes recovery and resiliency as well as personal and public safety.

We are committed to taking action consistent with these values:

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

**Significant Legislation (entire section)**

The 2007 legislature passed several major bills related to the mental health system. While it is premature to predict the full impact on the mental health system, the bills promote increased accountability, coordination of care and a culture of recovery.

- **2SHB1088** - will affect delivery of services to children by increasing access to care, increased access points through the Healthy Options Insurance plan and an emphasis on early intervention and prevention, stressing the use of evidence based practices.
- **EHB 1217** - will help establish more clubhouse rehabilitation services throughout the State.
- **SHB 1456** - provides greater protection for mental health professionals who may need to conduct home visits.
- **EHB 1460** - requires that insurance carriers in Washington State provide parity between mental health services and medical surgical services.
- **ESB 6018** - further clarifies to crisis responders involuntary treatment options and detention possibilities for both the mentally ill and the co-occurring diagnosed
- **ESB 5773** - allows the sharing of drug, emergency room, and hospital information that may contain a mental health diagnosis with the client's prescribing providers for the purposes of care coordination with primary care, while protecting HIPAA rights.
- **SSB5533** - ensures that the needs of individuals with mental illness and the public safety needs of society are better served when individuals with mental illness are provided an opportunity to obtain treatment and support in the community rather than jail.

Other stakeholder involvement includes: **(updated section)**

- **The MHD Office of Consumer Partnerships (OCP)**, in the MHD, meets quarterly with consumers, families and advocates. Frequent and consistent communication assures an accurate understanding of the points of view of consumers and other family members, which is then incorporated into the workings of the public mental health system. The OCP Director is a member of the MHD Management Team. Stephanie Lane began work as the Director August 1<sup>st</sup>, 2007. Her first order of business was to change the name of the Office of Consumer Affairs to the Office of Consumer Partnership. Stephanie will be meeting with consumer groups to develop a work plan for the coming year. MHD contracts with family advocacy groups statewide for education and advocacy purposes. These groups are also very visible during the state's legislative session.
- MHD supports and meets bimonthly with SAFE Washington, a parent council, consisting of parents/caregivers of minor children who receive services through the public mental health system. Each represents a parent organization in their RSN or the Community Connector Project sponsored by the MHD. Sandra Gregoire, the Parent Advocate in the MHD will continue to meet with SAFE Washington providing input to the MHD Director through her role on the MHD's Management Team.



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- Consumers and family members comprise 51% of the state Mental Health Planning and Advisory Council (MHPAC). This council includes representatives who are advocates for children and for older adults with mental illness, RSNs, service providers and representatives of allied systems. The council meets 11 times a year and actively participates in MHD planning and evaluation activities.
- MHD, in partnership with Indian Policy Service and Supports (IPSS), has reinstated the Monthly Tribal Mental Health Workgroup. The purpose of this workgroup is to improve collaboration between the MHD and the Tribes, address policy issues and concerns and to improve tribal mental health services.
- MHD and the Division of Alcohol and Substance Abuse (DASA) staff the co-occurring disorders interagency committee (CODIAC) made up of representatives from state agencies, mental health and chemical dependency providers, and consumers from both systems. This group addresses co-occurring mental illness and substance related disorders, system and treatment issues.
- MHD meets with the Washington Community Mental Health Council (WCMHC) monthly. This provider organization represents 85% of the community mental health agencies providing services under subcontract with the RSNs. The MHD Director attends regularly, as well as the Secretary of DSHS, members of the Transformation Grant and legislative staff as requested. The MHD also receives input from the community mental health agencies that do not belong to the WCMHC but subcontract with the RSNs.

### III. General Description of the Waiver Program

- a. **Type of Delivery Systems:** The State will be entering into the following types of contracts with an MCO, PIHP, or PAHP. The definitions below are taken from federal statute. However, many “other risk” or “non-risk” programs will not fit neatly into these categories (e.g. a PIHP program for a mental health carve out is “other risk,” but just checking the relevant items under “2” will not convey that information fully).
1. \_\_\_ **Risk-Comprehensive (fully-capitated—MCOs or HIOs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:
    - (a)\_\_\_ The contractor is at-risk for inpatient hospital services and any one of the following services:
      - i. \_\_\_ Outpatient hospital services,
      - ii. \_\_\_ Rural health clinic (RHC) services,
      - iii. \_\_\_ Federally qualified health clinic (FQHC) services,
      - iv. \_\_\_ Other laboratory and X-ray services,
      - v. \_\_\_ Skilled nursing facility (NF) services,
      - vi. \_\_\_ Early periodic screening, diagnosis and treatment (EPSDT) services,

- vii. \_\_\_ Family planning services,
- viii. \_\_\_ Physician services, and
- ix. \_\_\_ Home Health services.

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

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

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

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

- i. **X** Outpatient ~~hospital~~ *community mental health rehabilitation* services,
- ii. \_\_\_ Rural health clinic (RHC) services,
- iii. \_\_\_ Federally qualified health clinic (FQHC) services,
- iv. \_\_\_ Other laboratory and X-ray services,
- v. \_\_\_ Skilled nursing facility (NF) services,
- vi. \_\_\_ Early periodic screening, diagnosis and treatment (EPSDT) services,
- vii. \_\_\_ Family planning services,
- viii. \_\_\_ Physician services
- ix. \_\_\_ Home Health services.
- x. **X** Other: \_\_\_ dental  
\_\_\_ transportation  
**X** a subset of *community mental health inpatient hospital* services (e.g. only mental health admissions)

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

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

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

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CMS):

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

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

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

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

- **Requirement for Choice:** Section 1932(a)(3) of the Act and 42 CFR 438.52 require the State to permit individuals to choose from not less than two managed care entities.
  1.  This model has a choice of managed care entities.
    - (a)  At least one MCO and PCCM (please use the combined PCCM Capitated Waiver Renewal Preprint)
    - (b)  One PCCM system with a choice of two or more Primary Care Case Managers

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(please use the PCCM Waiver Renewal preprint)

(c)\_\_\_ Two or more MCOs

(d)\_\_\_ At least one PIHP or PAHP and a combination of the above entities

2. \_\_\_ This model is an HIO.

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

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

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

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

2. X Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC) *except for those women in the family planning waiver (program S, medical code P and Z)*.

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

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

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

6. X Foster Care Children

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

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

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

i. \_\_\_ Children with special needs due to physical and/ or mental illnesses,

ii. \_\_\_ Older adults,

iii. \_\_\_ Foster care children,

iv. \_\_\_ Homeless individuals,

v. X Individuals with serious and persistent mental illness ~~and/or substance abuse, or~~

*serious emotional disorder.*

- vi. \_\_\_ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
- vii. \_\_\_ Other (please list):

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

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

The MHD wishes to continue with an amended definition in 438.2: Health Care Professional. In addition to the definition specified in 438.2, the MHD requests the definition be expanded to include Mental Health Professional and mental health specialists as described in Washington Administrative Code (WAC) 388-85-0150, or its successor under this waiver. This will allow the public mental health system to continue to have qualified staff perform authorization to mental health service, second opinion, grievance and appeal functions appropriate to their scope of practice and experience, and allow the effective use of mental health professionals

**Primary Care** definition is not applicable to mental health.

**Mental Health Care Provider (MHCP)** means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services.

**Intensity** for this waiver renewal is the same as Duration and Scope. Duration is the period of time and scope means the range of services (e.g. which state plan services an individual would receive if offered in a fee-for-service system).

**Amount** is defined as the number of sessions.

**Availability of providers** is defined as: sufficient to meet the demand.

**Adequate capacity** means that the provider can handle the volume or meet the demand.

#### **Attachment A.III.d.**

##### **Access to Care Standards – 1/1/06**

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

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

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

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

\* = *Descriptive Only*

	<b>Level One - Brief Intervention</b>	<b>Level Two - Community Support</b>
<b>Goal &amp; Period of Authorization*</b>	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment <b>OR</b> long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care <b>OR</b> may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability <b>OR</b> requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services.  The period of authorization may be up to six months of care <b>OR</b> may be up to twelve months of care as determined by medical necessity and treatment goal(s).
<b>Functional Impairment</b>  <u>Must be the result of a mental illness.</u>	<ul style="list-style-type: none"> <li>* <b>Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-</b></li> <li>* <b><u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.</u></b></li> </ul> <p><b>Domains include:</b></p> <ul style="list-style-type: none"> <li>* Health &amp; Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications</li> <li>* Cultural Factors</li> <li>* Home &amp; Family Life Safety &amp; Stability</li> <li>* Work, school, daycare, pre-school or other daily activities</li> <li>* Ability to use community resources to fulfill needs</li> </ul>	<ul style="list-style-type: none"> <li>* <b>Must demonstrate serious functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-</b></li> <li>* <b><u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.</u></b></li> </ul> <p><b>Domains include:</b></p> <ul style="list-style-type: none"> <li>* Health &amp; Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications</li> <li>* Cultural Factors</li> <li>* Home &amp; Family Life Safety &amp; Stability</li> <li>* Work, school, daycare, pre-school or other daily activities</li> <li>* Ability to use community resources to fulfill needs</li> </ul>
<b>Covered Diagnosis</b>	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)

Access to Care Standards – 1/1/06

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

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

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

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

\* = *Descriptive Only*

	<b>Level One - Brief Intervention</b>	<b>Level Two - Community Support</b>
<b>Supports &amp; Environment*</b>	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
<b>Minimum Modality Set</b>	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: <ul style="list-style-type: none"> <li>* Brief Intervention Treatment</li> <li>* Medication Management</li> <li>* Psychoeducation</li> <li>* Group Treatment</li> </ul> The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One,</u> individuals may be referred for the following treatment: <ul style="list-style-type: none"> <li>* Individual Treatment</li> <li>* Medication Monitoring</li> <li>* Peer Support</li> </ul> The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
<b>Dual Diagnosis</b>	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 1/1/06

Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

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

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

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

**\* = Descriptive Only**

	<b>Level One - Brief Intervention</b>	<b>Level Two - Community Support</b>
<b>Goal &amp; Period of Authorization*</b>	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment <b>OR</b> long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care <b>OR</b> may be up to twelve months of care when an individual is receiving long term, low intensity treatment.	Longer term treatment is necessary to achieve or maintain stability <b>OR</b> requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services.  The period of authorization may be up to six months of care <b>OR</b> may be up to twelve months of care as determined by medical necessity and treatment goal(s).
<b>Functional Impairment</b>  <b>Must be the result of an emotional disorder or a mental illness.</b>	<ul style="list-style-type: none"> <li>* <b>Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-</b></li> <li>* <b><u>Impairment is evidenced by a Children’s Global Assessment Scale (CGAS) Score of 60 or below.</u></b> (Children under 6 are exempted from CGAS.)</li> </ul> <p><b>Domains include:</b> Health &amp; Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors</p> <ul style="list-style-type: none"> <li>* Home &amp; Family Life Safety &amp; Stability</li> <li>* Work, school, daycare, pre-school or other daily activities</li> <li>* Ability to use community resources to fulfill needs</li> </ul>	<ul style="list-style-type: none"> <li>* <b>Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND-</b></li> <li>* <b><u>Impairment is evidenced by a Children’s Global Assessment Scale (CGAS) Score of 50 or below.</u></b> (Children under 6 are exempted from CGAS.)</li> </ul> <p><b>Domains include:</b> Health &amp; Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors</p> <ul style="list-style-type: none"> <li>* Home &amp; Family Life Safety &amp; Stability</li> <li>* Work, school, daycare, pre-school or other daily activities</li> <li>* Ability to use community resources to fulfill need</li> </ul>



Access to Care Standards – 1/1/06

Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

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

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

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

\* = *Descriptive Only*

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

Access to Care Standards – 1/1/06

Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

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

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

\* = *Descriptive Only*

	<b>Level One - Brief Intervention</b>	<b>Level Two - Community Support</b>
<b>Minimum Modality Set</b>	<p>Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment:</p> <ul style="list-style-type: none"> <li>* Brief Intervention Treatment</li> <li>* Medication Management</li> <li>* Psychoeducation</li> <li>* Group Treatment</li> <li>* Family Supports</li> </ul> <p>The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.</p>	<p>Access to the following modalities is based on clinical assessment, medical necessity and individual need. <u>In addition to the modalities listed in Level of Care One, individuals may be referred for the following treatment:</u></p> <ul style="list-style-type: none"> <li>* Individual Treatment</li> <li>* Medication Monitoring</li> </ul> <p>The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.</p>
<b>Dual Diagnosis</b>	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

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

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

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

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

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

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

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

**Additional Criteria for Diagnosis B**

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

- \* High Risk Behavior demonstrated during the previous ninety days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
- \* Two or more hospital admissions due to a mental health diagnosis during the previous two years
- \* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization

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\* Received public mental health treatment on an outpatient basis within the PIHP system during the previous ninety days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment).

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

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

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

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

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DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
293.82	Psychotic Disorder Due to (Indicate the General Medical Condition) With Hallucinations	A
298.9	Psychotic Disorder NOS	A

<b>MOOD DISORDERS</b>		
<b>DEPRESSIVE DISORDERS</b>		
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
<b>BIPOLAR DISORDERS</b>		
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A



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296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A
	<b>ANXIETY DISORDERS</b>	
300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	<b>SOMATOFORM DISORDERS</b>	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	<b>FACTITIOUS DISORDERS</b>	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	<b>DISSOCIATIVE DISORDERS</b>	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	<b>SEXUAL AND GENDER IDENTITY DISORDERS</b>	
	<b>EATING DISORDERS</b>	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	<b>ADJUSTMENT DISORDERS</b>	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B

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309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	<b>PERSONALITY DISORDERS</b>	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

**Additional Criteria for Diagnosis B**

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

*[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]*

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

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appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

**End of Attachment A.III.d.**

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

1.  Have Medicare coverage, except for purposes of Medicaid-only services (pure QMB, pure SLMB, expanded SLMB, qualified disables and working individuals[QDWI]);
2.  Have medical insurance other than Medicaid;
3.  are residing in a nursing facility;
4.  are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);
5.  are enrolled in another Medicaid managed care program;
6.  have an eligibility period that is less than 3 months;
7.  are in a ~~poverty level eligibility category for pregnant women~~ *program code S, medical codes P and Z in which eligibility is for pregnant women for the family planning waiver only.*
8.  are American Indian or Alaskan Native;
9.  participate in a home and community-based waiver;
10.  receive services through the State's Title XXI CHIP program;
11.  have an eligibility period that is only retroactive;
12.  are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in I. above are listed here (Please explain further in Section F. Special Populations if necessary);
  - i.  Children with special needs due to physical and/ or mental illnesses,
  - ii.  Older adults,
  - iii.  Foster care children,
  - iv.  Homeless individuals *for whom no Medicaid reimbursement is received,*
  - v.  Individuals with serious and persistent mental illness and/or substance abuse,
  - vi.  Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
  - vii.  Other (please list):

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**Residents of Pierce County**, State psychiatric hospitals, the Children Long Term Inpatient Program, persons enrolled in the PACE program, persons enrolled in the Washington Medicaid Integration Project for their mental health needs are excluded from the capitation system and paid through other means.

Persons enrolled in the Washington Medicaid Integration Project have the option to “opt-out” and continue to receive mental health services from the Regional Support Network.

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

- e. **Automated Data Processing:** Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.
- f. **Independent Assessment:** The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to CMS at least 3 months prior to the end of the waiver period.** [Please refer to SMM 2111 and CMS’s “Independent Assessment: Guidance to States” for more information]. Please check one of the following:
  - 1. \_\_\_ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to CMS as required.
  - 2. X Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State that an Independent Assessment is needed in the waiver approval letter.

## IV. Program Impact

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

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

### Previous Waiver Period

- 1. \_\_\_ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements, as well as results of the monitoring. [Reference: items A.III.a.1-7 of 1999

initial preprint; as applicable in 1995 preprint, or items A.III.a Upcoming Waiver Period of 1999 Waiver Renewal preprint].

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

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

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

4.  The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:
5.  The State permits MCOs/PIHP/PAHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
6.  The State requires MCO/PIHP/PAHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

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

- i.  The languages comprise all prevalent languages in the MCO/PIHP/PAHP service area.
  - ii.  The languages comprise all languages in the MCO/PIHP/PAHP service area spoken by approximately \_\_\_ percent or more of the population.
  - iii.  Other (please explain):
7.  The State requires MCO/PIHP/PAHP marketing materials to be translated into alternative formats for those with visual impairments.
  8. **Required Marketing Elements:** Listed below is a description of requirements that the State must meet under the waiver program (items a through g). If an item is not checked, please explain why.

Marketing requirements do not apply for the following reasons:

- ⇒ Enrollment in this waiver is mandatory and automatic for Medicaid eligibles. There is no disenrollment.
- ⇒ RSNs must serve all enrollees who meet medical necessity including access to care

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standards.

⇒ There is a single PIHP for each geographical area.

The State:

- (a)\_\_\_ Ensures that all marketing materials are prior approved by the State
- (b)\_\_\_ Ensures that marketing materials do not contain false or misleading information
- (c)\_\_\_ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of marketing materials
- (d)\_\_\_ Ensures that the MCO/PIHP/PAHP distributes marketing materials to its entire service area
- (e)\_\_\_ Ensures that the MCO/PIHP/PAHP does not offer the sale of any other type of insurance product as an enticement to enrollment.
- (f)\_\_\_ Ensures that the MCO/PIHP/PAHP does not conduct directly or indirectly, door-to-door, telephonic, or other forms of “cold-call” marketing.
- (g)\_\_\_ Ensures that the MCO/PIHP/PAHP does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

### **b. Enrollment/Disenrollment:**

#### **Previous Waiver Period**

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

*Disenrollment has been waived in our waiver modification beginning in August 2003. The state has mandatory enrollment and does not operate an alternate fee-for-service system in areas covered under the Waiver.*

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

1. \_\_\_ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns,

subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

2.      **Administration of Enrollment Process:**

- (a)      State staffs conduct the enrollment process.
- (b)      The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request the authority in 1915(b)(2) in Section A.I.b.1. (Refer to Section 2105 of the State Medicaid Manual)
  - i. Broker name: \_\_\_\_\_
  - ii. Procurement method:
    - (A).      Competitive
    - (B).      Sole source
  - iii. Please list the functions that the contractor will perform:
- (c)      State allows MCOs/PIHPs/PAHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

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

- (a)   X   Mandatory for populations in Section ~~A.III.d~~ *A.III.c*
- (b)      Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):
- (c)      Other (please describe):

4. **Enrollment:**

- (a)      The State will make counseling regarding their MCO/PIHP/PAHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.
- (b)      Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PIHPs/PAHPs and providers based on their medical needs. Please describe.
- (c)      Enrollees will notify the State/enrollment broker of their choice of plan by:
  - i.      mail

- ii. \_\_\_ phone
- iii. \_\_\_ in person at \_\_\_\_
- iv. \_\_\_ other (please describe):

- (d) **NA - mandatory enrollment** [Required] There will be an open enrollment period during which the MCO/PIHP/PAHP will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).
- (e)\_\_\_ Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.
- (f)\_\_\_ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:
- (g)\_\_\_ If a potential enrollee does not select a plan within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.
  - i. Potential enrollees will have \_\_\_ days/month(s) to choose a plan.
  - ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PIHP/PAHP that includes their current provider or to an MCO/PIHP/PAHP that is capable of serving their particular needs?
- (h)\_\_\_ The State provides guaranteed eligibility of \_\_\_ months for all MCO enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?
- (i)\_\_\_ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

5. **Disenrollment:**

- (a)\_\_\_ The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs.
  - i. \_\_\_ Enrollee submits request to State
  - ii. \_\_\_ Enrollee submits request to MCO/PIHP/PAHP. The plan may approve the request, or refer it to the State plan may not disapprove the request).
  - iii. \_\_\_ Enrollee must seek redress through MCO/PIHP/PAHP grievance procedure before determination will be made on disenrollment request
  - iv. \_\_\_ [Required] Regardless of whether plan or State makes determination,



determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- (b)  The State does not allow enrollees to disenroll from the only available PIHP/PAHP.
- (c)  The State monitors and tracks disenrollments and transfers between MCOs/PIHPs/PAHPs. Please describe the tracking and analysis:
- (d)  The State has a lock-in period of \_\_\_\_ months (up to 12 months permitted). If so, the following are required:
- i.  MCO/PIHP/PAHP enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO/PIHP/PAHP.
  - ii.  MCO/PIHP/PAHP enrollees must be notified of their ability to disenroll or change MCOs/PIHPs/PAHPs at the end of their enrollment period at least 60 days before the end of that period.
  - iii.  MCO/PIHP/PAHP enrollees who have the following good cause reasons for disenrollment are allowed to disenroll during the lock-in period:
    - A.  [Required] Enrollee moves out of plan area
    - B.  [Required] Plan does not, because of moral or religious objections, cover the service the enrollee seeks
    - C.  [Required] Enrollee needs related services; not all services available in network, and enrollee's provider determines that receiving services separately would subject enrollee to unnecessary risk
    - D.  [Required] Poor quality of care
    - E.  [Required] Lack of access to covered services
    - F.  [Required] Lack of access to providers experienced in dealing with enrollee's health care needs
    - G.  Other: (please list)
  - iv.  [Required] Ensure access to State fair hearing process for any enrollee dissatisfied with determination that there is not good cause for disenrollment.
- (e)  The State does not have a lock-in, and enrollees in MCOs/PIHPs/PAHPs are allowed to terminate or change their enrollment without cause at any time.
- (f)  [Optional] A beneficiary who is disenrolled from an MCO/PIHP/PAHP solely due to loss of eligibility for two months or less may be automatically re-enrolled with the same MCO/PIHP/PAHP.

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

apply:

- (a)\_\_\_ [Required] The MCO/PIHP/PAHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status, utilization of medical services, diminished mental capacity, and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee. Please describe the reasons for which the MCO/PIHP/PAHP can request reassignment of an enrollee:
- (b)\_\_\_ The State reviews and approves all MCO/PIHP/PAHP-initiated requests for enrollee transfers or disenrollments.
- (c)\_\_\_ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP to remove the enrollee from its membership.
- (d)\_\_\_ The enrollee remains a member of the MCO/PIHP/PAHP until another MCO/PIHP/PAHP is chosen or assigned.

**c. Entity Type Or Specific Waiver Requirements**

**Upcoming Waiver Period** -- Please describe the entity type or specific waiver requirements for the upcoming two-year period.

- 1. **X Required MCO/PIHP/PAHP Elements:** MCOs/PIHPs/PAHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR Parts 434 and 438 et seq. *Unless waived*
- 2. **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting authority under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:
  - (a) **X** The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:
    - i. **X** Although the organization of the service delivery and payment mechanism for that *mental health* service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan. *This is not different from the current system but is different from the fee-for-service system. State plan services are attached as Attachment A.IV.c.2.a.i.*
    - ii. **X** MCO/PIHP/PAHP must provide or arrange to provide for the full range of

- Medicaid services to be provided under the waiver.
- iii.  MCO/PIHP/PAHP must agree to accept as payment the reimbursement rate set by the State as payment in full.
  - iv.  Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.
  - v.  There are no restrictions that discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing services.

***Attachment A.IV.c.2.a.i***  
***State plan approved services***

1) Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

2) Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

3) Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary

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intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

4) Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

5) “Freestanding Evaluation and Treatment” Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

6) Group Treatment Services: Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same

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time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

7) High Intensity Treatment: Intensive levels of service otherwise furnished under this state plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, and neighbor). Other community agency members may include probation/parole officers\*, teacher, minister, physician, chemical dependency counselor\*, etc. Team members' work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

\*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

8) Individual Treatment Services: A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

9) Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

10) Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

11) Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

12) Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

13) Peer Support: Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by peer counselors to the consumer are noted in the consumer's Individualized Service Plan which delineates specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicate where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

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Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

14) Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes are provided by or under the supervision of a licensed psychologist. Psychological assessments shall be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

15) Rehabilitation Case Management: A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, maximize the benefits of the placement, minimize the risk of unplanned re-admission and increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

16) Special Population Evaluation: evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated as well as other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

17) Stabilization Services: Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

18) Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the enrollee as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

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Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment, and individual treatment are not billable components of this service.

**End of Attachment A.IV.c.2.a.i**

3. The State has selected/will select the MCOs/PIHPs/PAHPs that will operate under the waiver in the following manner:
  - (a) The State has used/will use a competitive procurement process. Please describe.
  - (b)\_\_\_ The State has used/will use an open cooperative procurement process in which any qualifying MCO/PIHP/PAHP may participate that complies with federal procurement requirements and 45 CFR Section 74.
  - (c) X The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

*Please see waiver request above.*

*During this current waiver period, Pierce County notified the Governor that they are no longer willing to provide oversight for mental health services effective January 1, 2008. The Mental Health Division is prepared to operate the services in Pierce County under an ASO Fee-For-Service business plan.*

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

**d. Services  
Previous Waiver Period**

1. X [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with *mental health* service provision requirements. Please include the results from those



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monitoring efforts for the previous waiver period. [Reference: items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint, items A.III.d. Upcoming Waiver Period of 9/23/99 Waiver Renewal Preprint]

PIHPs must also ensure system capacity to provide a full range of mental health services to the individual enrollee's needs in a way that provides for seamless coordination and continuity of services. These mental health services should provide for the least amount of disruption in the consumer's life and support recovery and community reintegration.

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

The 2006 EQRO report was submitted to CMSRegion X in June 2007. The report can be accessed at: <http://www1.dshs.wa.gov/Mentalhealth/publications.shtml> .

The Performance Indicator report may be found at <http://www1.dshs.wa.gov/mentalhealth>

The child and adult satisfaction surveys have been conducted. Results and comparisons of consumer surveys may be found at <http://depts.washington.edu/washinst> .

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

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

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

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

- An assessment of work history, skills, training, education, and personal career goals.
- Information about how employment will affect income and benefits the consumer is receiving because of their disability.
- Preparation skills such as resume development and interview skills.
- Involvement with consumers served in creating and revising individualized job and career development plans that include:
  - (a) Consumer strengths
  - (b) Consumer abilities
  - (c) Consumer preferences
  - (d) Consumer's desired outcomes

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- Assistance in locating employment opportunities that are consistent with the consumer's strengths, abilities, preferences, and desired outcomes.
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.
- Services are provided by or under the supervision of a mental health professional.
- Other supportive employment services that cannot legally be provided by a vocational rehabilitation program, such as extended services as defined under the federal Rehabilitation Act.

Respite Care is a service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional. Respite under this waiver is only available to those consumers who do not have this coverage under some other federal program.

Mental Health Clubhouse: A service specifically contracted by the PIHP to provide a consumer directed program to Medicaid enrollees. These services provided at a clubhouse may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must be certified by the MHD beginning in 2008. The Mental Health Clubhouse must operate at least ten hours a week outside normal business hours Monday through Friday, or anytime on Saturday or Sunday based on the needs of clubhouse members. An exception to the distance standards is granted for clubhouse services.

Services include the following:

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

2. **Emergency Services (Required).** The State must ensure enrollees in MCOs/PIHPs/PAHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson,

who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

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

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

- (b)\_\_\_ The State ensures enrollee access to emergency services by requiring the MCO/PIHP/PAHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)
- (c)\_\_\_ The State ensures enrollee access to emergency services by including in the contract with MCOs/PIHPs/PAHPs a requirement to cover and pay for the following: *Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PIHPs/PAHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.*
- i. \_\_\_ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,
- ii. \_\_\_ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,
- iii. \_\_\_ Subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- iv. \_\_\_ Continued emergency services until the enrollee can be safely discharged or transferred,
- v. \_\_\_ Post-stabilization services which are pre-authorized by the MCO/PIHP/PAHP, or were not pre-authorized, but the MCO/PIHP/PAHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PIHP/PAHP contacts the emergency room and takes responsibility for the enrollee.

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

- i.  The MCO/PIHP/PAHP may not limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms;
- ii.  The MCO/PIHP/PAHP may not refuse to cover emergency services based on the provider not notifying the enrollee's PCP or plan of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services;
- iii.  The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO/PIHP/PAHP.

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

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

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

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

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

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

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

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

v.  Other (please explain):

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

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

following services:

- (a) \_\_\_ [Required for rural exception to choice]
- The service or type of provider is not available in the plan;
  - for up to 60 days if provider is not part of the network but is the main source of care and is given opportunity to join network but declines;
  - MCO/PIHP/PAHP or provider does not, because of moral or religious objections, provide a covered service; provider determines enrollee needs related service not available in network and receiving service separately would subject enrollee to unnecessary risk.
- (b) \_\_\_ [Required if women's routine` and preventive care is a covered service] Female enrollees must have direct access to women's health specialist within the network for covered care related to women's routine and preventive care. (Please note whether self-referral is allowed only to network providers or also to non-network providers.)
- (c) X Other: (please identify)

Each PIHP has an integrated crisis system, which is accessible 24 hours/7days a week with responses from individuals, rather than recorded messages. The intent is to facilitate efficient and effective mental health crisis diversion and resolution; to resolve crises in the least restrictive manner possible, including: crisis intervention; crisis respite; investigation and detention services; and evaluation and treatment services. These services are available throughout the PIHP, including services for American Indians living on or off Indian Reservations.

Phone systems must continue to have toll free numbers to ensure access to crisis services, including people who may not have the funds to utilize a public pay phone. If these numbers are not toll free but accept collect charges it must be stated so in the public telephone directory. Services for non-English speaking and hearing impaired enrollees must also be in place.

While crisis response services from PIHPs are covered within the scope of the managed care system, enrollee access to crisis response is unrestricted, without establishing medical necessity for the first contact and without reference to the enrollee's ongoing service coverage under a particular RSN. PIHPs triage with local hospitals to reduce unnecessary utilization of emergency rooms through the working agreements with local evaluation and treatment facilities, which are a necessary qualification of PIHPs. The agreements assure that enrollees who request mental health services inappropriately from emergency rooms are directed to the crisis response system. The agreements also establish how people served in emergency rooms may be referred for Designated Mental Health Professional evaluation for possible involuntary treatment. Emergency room visits not resulting in admission are not covered by this waiver, but as part of the fee-for-service program in MAA. Inpatient services for enrollees admitted through the emergency room are covered provided the designated professional person for the consumer's county of residence has conducted a pre-admission certification and conditions of medical necessity are met.

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

PIHPs are required to report through the MHD/CIS system crisis services. Crisis service is an integral piece of the system and is monitored by MHD and PIHPs routinely. MHD calls out access to care standards with regards to transition from crisis service to routine service. For those consumers already seen by the CMHA, WAC requires access to the consumer's individual service plan 24/7. Additionally, crisis phone services must be available to Limited English Speaking people. The crisis service is also mandated to be accessible for American Indians living on the Reservation.

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

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

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

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

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

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

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

frequency of data required by the State.

The PIHPs are required to submit the data as they would for any child being served according to the requirements of the data dictionary attached as Attachment C.VI.b. There is a simple data flag if the child is referred in through an EPSDT screen. Of the 61,069 children served in the outpatient mental health system from April 1, 2005 through March 31, 2007 there were 19,948 unduplicated consumers flagged as being referred to mental health services through an EPSDT screen. This may be an under reporting of the actual numbers. This is a mandatory data field and when it is submitted unfilled or not 'Yes' or 'No', the EPSDT value is defaulted to no.

- (b)\_\_\_ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual screening rates, including behavioral components, for previous waiver period. (Please note\*: CMS requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data reported in the CMS 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.) Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.
- (c) \_\_\_ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?
- (d)\_\_\_ Immunizations are covered under this waiver, and managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.
- (e) X Mechanisms are in place to coordinate school services with those provided by the MCO/PIHP/PAHP. Please describe and clarify the aspects of school services that are coordinated including IEPs, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

The requirement for those individual community teams including the child for the development of service planning for children defined in the state's EPSDT plan also requires participation by the cross-system providers. This process includes those who know the child best, including the teacher, whenever possible to address IEP and other requirements. There is also a requirement in WAC 388-865-0425(7)(a) with regard to Individual Service Planning that, in the case of children, be integrated with the individual education plan from the education system whenever possible.

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

If a child is being seen by the mental health system or comes through the doors of the mental health system as their first access point, and is in need of other health services such as a well child check per the periodicity schedule or the child is in need of dental or substance abuse counseling they are referred to the proper provider of care. Mental Health PIHPs do not provide that type of care. There is a well established referral process between mental health and physical health that is acknowledged by both professions as making a difference in the working relationship of the two systems with regards to the holistic care of children.

## Section B. ACCESS AND CAPACITY

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residences of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

### I. Timely Access Standards

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

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

1. \_\_\_ PCPs (please describe your standard):
2. \_\_\_ Specialists (please describe your standard):
3. \_\_\_ Ancillary providers (please describe your standard):
4. \_\_\_ Pharmacies (please describe your standard):
5. \_\_\_ Hospitals (please describe your standard):
6.  Mental Health (please describe your standard):

While it is the belief that consumers should be seen in the place of their choice for community support services, the state recognizes that at times they must travel to community support services. When this occurs the following standards are in place:



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- ✓ in rural areas a 30 minute drive time,
- ✓ in large rural areas a 90 minute drive time,
- ✓ in urban areas accessible by public transportation. The total trip including transfers shall not be scheduled to exceed 90 minutes each way.

The exceptions to these standards identified in the contract are for access to clubhouse activities, if a consumer chooses to seek services from a community mental health agency that is farther than the drive time or there are hazardous road conditions, road construction, traffic congestion, public transportation shortages, ferry or bus delay etc. Travel standards do not apply: a) when the enrollee chooses to use service sites that require travel beyond the travel standards; b) **to mental health clubhouses when the population is insufficient to support additional clubhouses within the geographic area** c) to psychiatric inpatient services **including E&T**; d) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

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

8.\_\_\_\_ Dental (please describe your standard):

9.\_\_\_\_ Other providers (please describe your standard):

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

1.\_\_\_\_ PCPs (please describe your standard):

2.\_\_\_\_ Specialists (please describe your standard):

3.\_\_\_\_ Ancillary providers (please describe your standard):

4.\_\_\_\_ Pharmacies (please describe your standard):

5.\_\_\_\_ Hospitals (please describe your standard):

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

Enrollees can access medically necessary mental health services upon request that do not exceed the access standards below. A request for services is defined as a point in time when services are sought or applied for through a telephone call, walk-in, or written request for services **from an enrollee or those defined as family or receipt of a written EPSDT referral**. Urgent and Emergent medically necessary mental health services (e.g. crisis services, stabilization services) may be accessed without intake evaluations and/or other screening and assessment processes.

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The determination of eligibility for authorization to service shall be based on the Access to Care Standards. Authorization shall not take more than fourteen calendar days following initiation of an intake evaluation, unless the enrollee, CMHA, or PIHP requests an extension. An extension of up to 14 additional calendar days is possible upon request by the enrollee or the CMHA, or the PIHP justifies (to MHD upon request) a need for additional information and how the extension is in the enrollee's interest. The PIHP must have written policy and procedure to ensure consistent application of requests within the service area. The PIHP must monitor the use and pattern of extensions and apply corrective action where necessary. Urgent and emergent medically necessary mental health services (e.g. crisis mental health services, stabilization mental health services) may be accessed without full completion of intake evaluations and/or other screening and assessment processes

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

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

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

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

The following are the contract definitions:

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

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

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

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

8. \_\_\_ Dental (please describe your standard):

9. \_\_\_ Urgent care (please describe your standard):

10. \_\_\_ Other providers (please describe your standard):

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

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1. \_\_\_ PCPs (please describe your standard):
2. \_\_\_ Specialists (please describe your standard):
3. \_\_\_ Ancillary providers (please describe your standard):
4. \_\_\_ Pharmacies (please describe your standard):
5. \_\_\_ Hospitals (please describe your standard):
6. X Mental Health (please describe your standard):

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

7. \_\_\_ Substance Abuse Treatment Providers (please describe your standard):
8. \_\_\_ Dental (please describe your standard):
9. \_\_\_ Other providers (please describe your standard):

**II. Access and Availability Monitoring:** Enrollee access to care will be monitored by the State, as part of each MCO/PIHP/PAHP's Quality Assessment and Performance Improvement program, annual external quality review (EQR), and (if applicable) Independent Assessments (IA).

### Previous Waiver Period

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

The statewide EQRO report for 2006 was sent to CMS, Region X, in June 2007.

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

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

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- b.  Determination of enrollee knowledge on the use of managed care programs *through involvement with the Office of Consumer Partnerships, Washington's Health Empowerment Network, through Statewide Action For Family Empowerment of Washington, National Alliance for the Mentally Ill, and the Mental Health Planning and Advisory Council .*
- c.  Ensure that services are provided in a culturally competent manner to all enrollees, and the MCO/PIHP/PAHP participates in any State efforts to promote the delivery of services in a culturally competent manner.
- d.  Review of access to emergency or family planning services without prior authorization
- e.  Review of denials of referral requests
- f.  Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
- g.  Periodic enrollee ~~experience~~ *MHSIP* surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a sample of enrollees. ~~Corrective actions taken on deficiencies found are also planned. Individual RSNs will be compared against their own results and not statewide. They are expected to maintain or improve their results.~~
- h.  Measurement of enrollee requests for disenrollment from a MCO/PIHP/PAHP due to access issues
- i.  Tracking of ~~complaints~~/grievances concerning access issues *through the MHD established reporting process through the contract.*
- j.  Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)
- k.  Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.
- l. During monitoring, the State will look for the following indications of access problems.
  - 1.  Long waiting periods to obtain services from a PCP.
  - 2.  Denial of referral requests when enrollees believe referrals to specialists are medically necessary.
  - 3.  Enrollee confusion about how to obtain services not covered under the waiver.
  - 4.  Lack of access to services after PCP's regular office hours.
  - 5.  Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
  - 6.  Lack of access to emergency or family planning services.
  - 7.  Frequent recipient requests to change a specific PCP.

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8.\_\_\_\_ Other indications (please describe):

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

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

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

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

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

p.\_\_\_\_ Other (please explain):

### III. Capacity Standards

#### Previous Waiver Period

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

The PIHP contracts with licensed CMHAs for the provision of mental health services. The MHD is the licensor of CMHAs and also certifies inpatient beds for involuntary treatment. The number of CMHAs providing services has remained fairly consistent throughout the waiver since 1993. There have been some mergers or sales in the outpatient system but this has not reduced overall capacity. **The MHD has licensed eight new CMHAs over the course of the 2006-2008 waiver period.**

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

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

The state contracts with licensed hospitals willing to provide inpatient psychiatric care. The overall long-term impact of the loss of community psychiatric inpatient hospital beds is a national trend and continues to be difficult to predict. The MHD and the PIHPs are carefully watching capacity. Nonetheless, existing community inpatient psychiatric hospital providers are in very tenuous financial situations, often with little support from their corporate structures.

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

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

- b. NA [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate. Please describe the results of this monitoring. *Mandatory enrollment.*

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

### a. **MCO/PIHP/PAHP Capacity Standards**

1. \_\_\_ The State has set enrollment limits for the MCO/PIHP/PAHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.
2. \_\_\_ The State monitors to ensure that there are adequate open panels within the MCO/PIHP/PAHP. Please describe how often and how the monitoring takes place.

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

By contract, the PIHPs must ensure the adequate capacity to serve the entire Medicaid population in their service area that has a medically necessary need for mental health services in the public mental health system. The PIHPs are responsible for the resource and utilization management of the system. The PIHPs are required in contract to submit changes that result in reduced capacity to the MHD prior to the change. There has been a net increase in new agencies over this period. The MHD monitors grievance and satisfaction as elements of capacity.

**b. PCP Capacity Standards**

1. \_\_\_ The State has set capacity standards for PCPs within the MCO/PIHP/PAHP expressed in the following terms (In the case of a PIHP/PAHP, a PCP may be defined as a case manager or gatekeeper):
- i. \_\_\_ PCP to enrollee ratio
  - ii. \_\_\_ Maximum PCP capacity
  - iii. \_\_\_ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans
2.  The State ensures adequate geographic distribution of ~~PCPs~~ *MHCPs* within ~~MCO/PIHPs/PAHPs~~. Please explain.
- The RSNs must ensure adequate capacity to serve the Medicaid population.
3. \_\_\_ The State designates the type of providers that can serve as PCPs. Please list these provider types.

Based on the definition of PCP, mental health does not qualify.

**c. Specialist Capacity Standards**

1.  The State has set capacity standards for specialty services. Please explain.
- Mental health services are a specialty service. Services must be provided by or under the supervision of a mental health professional. WAC has additional requirements for mental health services for Children, Ethnic Minority, Geriatric and Disability Mental Health Specialists as described in 388-865-0150 and 388-865-405(5). By contract, the PIHP must comply with WAC and have the capacity and staff to meet the needs of the population.
2. \_\_\_ The State requires particular specialist types to be included in the MCO/PIHP/PAHP network. Please identify these in the chart below, modifying the chart as necessary to

reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. specialty to enrollee ratio. If specialists types are not involved in the MCO/PIHP/PAHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

#### IV. Capacity Monitoring

##### Previous Waiver Period

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

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

There are approximately 161 licensed and certified CMHAs contracting with the RSNs. Two licensed and certified CMHAs merged with larger agencies; one CMHA closed with two CMHAs expanding their service area to ensure no disruption of services to the clients of the closing agency during the 2006-2008 waiver period. This is an increase from the last waiver renewal. The number is approximated because of multiple locations of various providers. The monitoring of grievances concerning capacity issues shows that there are no significant numbers of incidents either statewide or in a particular part of the state that require intervention by MHD. The most recent MHSIP survey conducted in 2007, reflected an overall rating of access to services of 66.4%, and varied by PIHP from a low of 36.0% to a high of 83.8%. The overall rating of quality of services was 75.7%, and varied by PIHP from a low of 60% to a high of 85.3%. The overall rating of participation in treatment was 67.8%, and varied by PIHP from a high of 76.5% to a low of 58%.

##### Upcoming Waiver Period --

Please indicate which of the following activities the State employs:

- a.  Periodic comparison of the number and types of Medicaid providers CMHAs before and after the waiver.
- b.  Measurement of referral rates to specialists.
- c.  Provider-to-enrollee ratios
- d.  Periodic MCO/PIHP/PAHP reports on provider network
- e.  Measurement of enrollee requests for disenrollment from a plan due to capacity issues



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- f.  Tracking of ~~complaints~~/grievances concerning capacity issues
- g. \_\_\_ Geographic Mapping (please explain)
- i. \_\_\_ Tracking of termination rates of PCPs
- j. \_\_\_ Review of reasons for PCP termination
- k.  Consumer ~~Experience~~ *MHSIP* Survey, including persons with special needs,
- l. \_\_\_ Other (Please explain):

**V. Coordination and Continuity of Care Standards**

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

a. \_\_\_ Primary Care and Coordination

(i) \_\_\_ [Required] Implement procedures to deliver primary care to and coordinate health care service for all enrollees.

See (iv)

(ii) \_\_\_ [Required] Ensure each enrollee has an ongoing source of primary care appropriate to his or her needs, and a person or entity who is primarily responsible for coordinating the enrollee's health care services.

See (iv)

(iii) \_\_\_ [Required] Coordinate the services the MCO/PIHP/PAHP furnishes to the enrollee with services the enrollee receives from any other MCO/PIHP/PAHP.

See (iv)

(iv) \_\_\_ [Required] Ensure that in the process of coordinating care, each enrollees' privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

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

As a mental health carve out, our system does not meet the definition of Primary Care Provider. The PIHPs are required to provide continuity of care between inpatient and outpatient mental health services and are also required to refer Medicaid enrollees to their physical health care provider when they are in need of physical health care. The PIHPs are also required to work in partnership with other Medicaid managed care programs within the state when appropriate and asked.

b. \_\_\_ Additional services for enrollees with special health care needs.

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

Per CMS decision, all persons covered meet the CMS definition of a person with special health care needs. In this carve out program those persons served have a serious mental illness or a serious emotional disturbance.

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

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

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

1. X ~~Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee~~ *Developed collaboratively with the consumer and other people identified by the consumer within thirty days of starting community support services. The service plan should be in language and terminology that is easily understood by consumers and their family, and include goals that are measurable.*
2. \_\_\_ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
3. X In accord with any applicable WAC. ~~State quality assurance and utilization review standards.~~

(iv) X [Required] Direct access to *mental health professionals* ~~specialists~~. If treatment plan or regular care monitoring is needed, MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

This is a mental health carve-out waiver, therefore all services are specialty services. PIHPs are required to coordinate care with other Medicaid managed care systems and with allied social service systems upon request. Please see description of coordination of services.

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

## VI. Coordination and Continuity of Care Monitoring

### Previous Waiver Period

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

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

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

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

Effective January 1, 2007, per RCW 70.96c, providers are required to conduct the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) – a self reporting tool designed to assist in the comprehensive screening for substance abuse and mental illness.

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

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

Medication management and medication monitoring is provided through CMHAs. These services include the prescribing and/or administering and reviewing of medications and their side effects. This service is rendered face-to-face by a person licensed to perform such services. Service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy. Medication monitoring is face to face cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. This service also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service.

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

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

Additionally, MAA monitors prescription drugs in various ways:

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

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

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

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

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

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1. \_\_\_ Mental Health Providers (please describe how the State ensures coordination exists):
2. X Substance Abuse Providers (please describe how the State ensures coordination exists):
3. X Local Health Departments (please describe how the State ensures coordination exists):
4. X Dental Providers (please describe how the State ensures coordination exists):
5. X Transportation Providers (please describe how the State ensures coordination exists):
6. X HCBS (1915c) Service (please describe how the State ensures coordination exists):
7. X Developmental Disabilities (please describe how the State ensures coordination exists):
8. X Title V Providers (please describe how the State ensures coordination exists):
9. \_\_\_ Women, Infants and Children (WIC) program
10. X Indian Health Services providers
11. \_\_\_ FQHCs and RHCs not included in the program's networks
12. \_\_\_ Other (please describe):

The RSNs have working partnerships with a variety of other community services. They have the responsibility for many shared consumers. The RSNs and CMHAs are required to participate in multi-system coordination efforts whenever possible. They are required to refer consumers to alternate or additional services that the CMHA or the consumer's individual Mental Health Care Provider believes the consumer needs to complete or aid in the recovery process. However, they must use caution and care not to violate confidentiality of mental health care and the consumer's right to privacy. The MHD, as part of the umbrella agency of DSHS, also monitors coordination efforts through meetings with other divisions within the Department, through our work with the Indian Policy Advisory Committee, and stakeholder meetings with both the Office of the Superintendent of Public Instruction and the Department of Health. As described in the background section of this renewal, the MHD and the RSNs host and participate in many stakeholder groups to gather input on improvements for the system.

### **RSN contracts have the following coordination requirements:**

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

- Maintain MHD approved service protocols developed with the DSHS Children's Administration and DSHS Aging and Disability Services Administration.
- Maintain the existing working Agreement with the DSHS Juvenile Rehabilitation Administration (JRA) addressing the coordination of services for enrollees that are released from JRA facilities.

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- Maintain the relationship between the Contractor and Healthy Option plans in the service area through a Memorandum of Understanding.
- Maintain the relationship between the Contractor and the DSHS Division of Vocational Rehabilitation (DVR) office in the service area.
- Comply with published directives from MHD when the Contractor or its subcontractors are unable to resolve local disputes with other service systems (Healthy Options, other DSHS administrations as provided by MHD) regarding service or cost responsibilities.

The RSN contracts have the following requirements related to Tribal issues.

Review of assessment and treatment services against clinical practice standards. Clinical practice standards include but are not limited to Evidenced-Based Practice guidelines, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals. This review must include a review of the coordination with Tribal and Recognized American Indian Organizations (RAIO) and other consumer serving agencies.

The Contractor's liaison or designated CMHA must participate in treatment and discharge planning with the inpatient treatment team. A contracted network CMHA must be designated prior to discharge for Enrollees and their families seeking community support services.

In the event the liaison is aware that the Enrollee is a Tribal Member or receiving mental health services from a Tribal or Urban Indian Health Program and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in discharge planning and transition for the Enrollee. If the Enrollee chooses to be served only by the Tribal Mental Health Service referral to a contracted network CMHA is not required.

The Contractor must develop or attempt to develop a Tribal and Recognized American Indian Organization (RAIO) Coordination Implementation Plan with each Tribe and RAIO as listed in section 15.1.1. The Contractor must provide documentation of attempts to develop a plan if any Tribe or RAIO declines to participate. The Contractor must submit the matrix below for each Tribe or RAIO listed in Section 15.1.1 to MHD on or before March 1, 2008.

The Tribes or RAIOs listed below have service areas within the contracted Service Area of the RSN which are defined in the following documents:

- The Indian Health Services map that represents Contract Health Service Delivery areas as published in the Federal Register;
- The Bureau of Indian Affairs Service Area map; and
- The DSHS 7.01 Policy, which identifies the Recognized American Indian Organizations (RAIOs).

A Planning Checklist is available on the MHD Intranet to assist with developing the Tribal and RAIO Coordination Implementation Plan. The Contractor shall consider the planning checklist in developing the Tribal and RAIO Coordination Implementation Plan.

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As part of the Tribal and RAIO Coordination Implementation planning, the RSN must extend an invitation to those listed in section 15.1.1 to participate as members of the RSN Advisory Board. Any issues that arise from this invitation must be detailed in the plan, including a timeline to address these issues and expected outcomes. This includes any Governing Board by-laws or other local rules or regulations that would need to be changed to accommodate the Tribal representation occurring.

Subcontracts with Tribes and Recognized American Indian Organizations (RAIO).

If the Contractor chooses to enter into a Subcontract with a Tribe the Contract must include one of the following:

General Terms and Conditions that are modeled on the DSHS and Indian Nation Agreement General Terms and Conditions.

General Terms and Conditions modeled on the Intergovernmental Agreement for Social and Health Services between Tribes and The Washington State Department of Social and Health Services.

General Terms and Conditions that were developed through a process facilitated by the Mental Health Division Tribal Liaison.

General Terms and Conditions that were developed between the Tribe and the Contractor. In this case, a written statement must be provided to the Mental Health Division Tribal Liaison from each party that verifies both are in Agreement with the content in the General Terms and Conditions.

If the Contractor chooses to enter into a Subcontract with a RAIO, the Contract must include one of the following:

General Terms and Conditions that were developed through a process facilitated by the Mental Health Division Tribal Liaison.

General Terms and Conditions that were developed between the RAIO and the Contractor. In this case a written statement must be provided to the Mental Health Division Tribal Liaison from each party that verifies both are in Agreement with the content in the General Terms and Conditions.

Any Subcontracts with Tribal Mental Health Providers must exempt the Subcontractor from participation in the Telesage Outcome Assessment requirements.

Any Subcontracts with Tribes and RAIOs must be consistent with the laws and regulations that are applicable to the Tribe or RAIO. The Contractor must work with each Tribe to

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identify those areas that place legal requirements on the Tribe that do not apply and refrain from passing these requirements on to Tribes.

The Mental Health Division Tribal Liaison may be available for technical assistance in identifying what legal requirements the Contactor can be relieved of in Tribal or RAIO Subcontracts.

The Contractor shall have a policy and procedure that requires efforts to recruit and maintain Ethnic Minority Mental Health Specialists – Native American from each Tribe or RAIO listed in section 15.1.1 for use in specialists consults whenever possible.

### Section C. QUALITY OF CARE AND SERVICES

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

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

#### Previous Waiver Period

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

The 2006 EQRO report was submitted to CMS in June 2007.

- b. \_\_\_ Intermediate sanctions were imposed during the previous waiver period. Please describe.

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

- a. X [Required] The State has a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. Please indicate if the strategy has already been submitted to CMS. If not, please attach a copy (Attachment C.1.a).  
*The state has a CMS approved quality strategy in place. An update of the quality strategy was submitted in June 2007.*
- b. X [Required] The State ~~must~~ *obtained* the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.
- c. X [Required] The State must conduct periodic reviews to evaluate the effectiveness of the strategy



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and update the strategy as needed.

d. X [Required] The State must arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to the services delivered under each MCO and PIHP contract. Note: EQR for PIHPs is required beginning 8/14/03/25/04.

1. Please specify the name of the entity: *For 2005-2007, MHD contracted with APS to perform EQR activities. In August 2007 MHD, in conjunction with the Health and Recovery Services Administration (HRSA) of DSHS, began the process of conducting a RFP for a statewide EQRO process. This new contract period will be January 1, 2008 through December 31, 2010. Acumentra is the EQR vendor selected to perform these duties.*

21b. The entity type is:

(a) x A Peer Review Organization (PRO).

(b) x A private accreditation organization approved by CMS.

(c)    A PRO-like entity approved by CMS.

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

The MHD specific portion of the statewide EQRO RFP has identified mental health services issues such as

- conducting a monitoring review to determine PIHP compliance with Standards;
- annual validation of PIHP Performance Improvement Projects (PIPs) and Performance Measures (PMs); Encounter Data Validation Study for PIHPs;
- validation of the MHD Quality Strategy;
- completion of an Information System Capability Assessment (ISCA);
- conduct two activities designed to provide performance measure data, in 2008 conduct a clinical records review to assess quality of care and in 2009 conduct a study of quality management activities and report how the PIHP uses collected data, monitors results and service verification to strengthen its ongoing quality management program. The assessment will include the degree to which mental health services:
  - are driven by and incorporate enrollee and family voice;
  - are culturally and linguistically competent;
  - are age appropriate;
  - are provided in the least restrictive environment;
  - assist enrollees' progress towards recovery and resiliency;
  - and promote continuity in service and integration with other formal/informal systems and settings.

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

f.    The State monitors, on a continuous basis, MCO/PIHP adherence to the State standards, through

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the following mechanisms (check all that apply):

1. \_\_\_ Reviews and approves each MCO's/PIHP's written QAPI. Such review shall take place prior to the State's execution of the contract with the MCO/PIHP.
2. X [Required] Reviews the impact and effectiveness of each MCO's/PIHP's written QAPI at least annually.
3. X Conducts monitoring activities using (check all that apply):
  - (a) X State Medicaid agency personnel
  - (b) \_\_\_ Other State government personnel (please specify):
  - (c) X A non-State agency contractor (please specify): Acumentra Health
4. \_\_\_ Other (please specify):

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

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

## II. Access Standards

### Coverage and Authorization of Services

#### Previous Waiver Period

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

PIHPs are required to provide services comparable in scope and intensity to the state plan rehabilitation services and community inpatient services for adults and children. PIHPs must also ensure system capacity to provide a full range of mental health services to meet the individual enrollee's needs in a way that allows for seamless coordination and continuity of mental health services that create the least amount of disruption in the enrollee's life and supports recovery and reintegration to their community.

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

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grievances, and satisfaction surveys.

The 2006 EQRO report was submitted to CMS Region X in June 2007. The report can be accessed at: <http://www1.dshs.wa.gov/Mentalhealth/publications.shtml>.

The Performance Indicator report may be found at <http://www1.dshs.wa.gov/mentalhealth>

The child and adult satisfaction survey have been conducted. Results and comparisons of consumer surveys may be found at <http://depts.washington.edu/washinst>.

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

Contracts with MCOs, PIHPs, and PAHPs:

- a. X [Required] Identify, define and specify the amount, duration and scope of each service offered, differentiating those services that may be available to special needs populations only, as appropriate. Note: These services may not be furnished in an amount, duration, and scope that is less than the amount, duration, and scope for the same services under the State Plan.
- b. X [Required] Require that the MCO, PIHP, or PAHP may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;
- c. X [Required] Include a definition of "medically necessary services". This definition can be no more restrictive than that used in the State Plan. Please list that specification or definition:

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

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

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

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- e. X [Required] Require that the MCO, PIHP, and PAHP have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.
- f. X [Required] Require that the MCO, PIHP, and PAHP consult with the requesting provider when appropriate.
- g. X [Required] Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope, that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- h. X [Required] Require that, for standard authorization decisions, notice is provided as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days. The timeframe may be extended up to an additional 14 days if the enrollee or provider requests an extension or if the MCO, PIHP, and PAHP justifies a need for additional information and how the extension is in the enrollee's interest.
- i. X [Required] Require that the MCO, PIHP, or PIHP make an expedited authorization decision no later than 3 working days after receipt of the request for service. The timeframe may be extended up to 14 days if the enrollee *or the MHCP* requests an extension or if the MCO, PIHP, or PAHP justifies a need for additional information and how the extension is in the enrollee's interest. *Mental health access standards are more stringent than this requirement. They are 2 hours for emergent, 24 hours for urgent and 14 days for routine.*
- j. \_\_\_ Other (please describe):

## III. Structure and Operation Standards

### Provider Selection

#### Previous Waiver Period

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

The MHD has not received any notice from a community mental health agency with regards to selection over this waiver period. Again, the MHD licenses the CMHAs.

#### Upcoming Waiver Period

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

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

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- b.**  [Required] Each MCO, PIHP, PAHP must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment solely on the basis of the population served or condition treated.
- c.**  Each MCO, PIHP, PAHP must have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
- d.**  Each MCO, PIHP, PAHP must have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):
- 1.**  Initial credentialing
  - 2.**  Performance indicators, including those obtained through the following (check all that apply): **The PIHPs only contract with licensed Community Mental Health Centers. The following items are sent to the MHD by the PIHP and encompass their system.**
    - (a)**  The quality assessment and performance improvement program
    - (b)**  The utilization management system
    - (c)**  The grievance system
    - (d)**  Enrollee satisfaction surveys *are issued separately by MHD and not the PIHPs or the CMHAs.*
    - (e)**  Other MCO/PIHP/PAHP activities as specified by the State.
- e.**  Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State \_\_\_\_\_
- f.**  Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
- g.**  Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.
- h.**  Other (please describe): The PIHPs only contract with Licensed Community Mental Health Agencies for the provision of state plan services.

#### IV. Subcontractual Relationships and Delegation

##### Previous Waiver Period

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

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

##### Upcoming Waiver Period

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

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

- a.  Reviews and approves (check all that apply):
  - 1.  All subcontracts with individual providers or groups
  - 2.  All model subcontracts and addendum
  - 3.  All subcontracted reimbursement rates
  - 4.  Other (please describe):
- b.  [Required] Monitors to ensure that MCOs, PIHPs, and PAHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.
- c.  [Required] Requires agreements to be in writing and to specify the delegated activities.
- d.  [Required] Requires agreements to specify reporting requirements.
- e.  [Required] Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.
- f.  [Required] Ensures that MCOs, PIHPs, and PAHPs monitor the performance of the entity on an ongoing basis.
- g.  [Required] Monitors to ensure that MCOs, PIHPs, and PAHPs formally review the entity's

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performance *on an annual basis*. ~~according to a periodic schedule established by the State.~~

- h. X** [Required] Ensures that MCOs, PIHPs, and PAHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.
- i. X** [Required] Requires MCOs, PIHPs, and PAHPs to take corrective action if any deficiencies or areas for improvement are identified.
- j.** Other (please explain):

## V. Measurement and Improvement Standards

### Practice Guidelines

#### Previous Waiver Period

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

As the behavioral health field is being asked to prove it is accountable and offers a valuable service for the expended resources, a lot more work is being done to research and identify practice guidelines and evidence-based practices and their value to service recipients and the field. The EQRO monitored practice guidelines in 2005 and found it was new to the majority of the PIHPs.

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

The EQRO recommended the PIHPs delineate standards of application for the adopted practice guidelines as well as develop strategies and mechanisms to monitor fidelity of the practice guidelines and provide oversight to ensure their full utilization in clinical services.

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

- a. X** [Required] Guidelines are based on valid and reliable clinical evidence or a consensus of *mental health care professionals in the particular mental health field*.
- b. X** [Required] Guidelines consider the needs of the MCO's, PIHP's or PAHP's enrollees *with regards to mental health*.
- c. X** [Required] Guidelines are developed in consultation with contracting *mental health professionals*.

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- d. X [Required] Guidelines are reviewed and updated periodically.
- e. X [Required] Guidelines are disseminated to all affected providers and, upon request to enrollees and potential enrollees.
- f. X [Required] *When selected by the PIHP*, Guidelines are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.
- g. X Other (please explain): EBPs may be used when the practice guideline standards (above) are met.

## Quality Assessment and Performance Improvement (QAPI)

### Previous Waiver Period

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

The PIs are included in the EQRO report submitted to CMS in June 2007.

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

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

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

- a. X [Required] The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's QAPI. This review includes:

Our review occurred through the use of the three mandated EQR protocols and was submitted in June 2007.

- 1. X The MCO's and PIHP's performance *indicators* ~~on the standard measures~~ on which it is required to report.

Through the participation of the state with SAMHSA on the data infrastructure grant there will be



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

2. \_\_\_ The results of each MCO's and PIHP's performance improvement projects.
- b. \_\_\_ Please check any of the following processes and procedures that the State includes as a requirement for MCO and PIHP QAPIs

Each MCO and PIHP must have:

1.  A policy making body which oversees the QAPI
  2. \_\_\_ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.
  3.  Active participation by providers and consumers
  4.  Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.
  5. \_\_\_ Other (please describe):
- c.  [Required] Each MCO and PIHP must have in effect mechanisms to detect both underutilization and overutilization of services. Please describe these mechanisms:
- The PIHP must have documented procedures to identify at the RSN level over and under utilization and shall monitor for over-utilization and under-utilization of services and ensure that resource management and utilization management activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary mental health services to any enrollee. Care management focuses on access, referrals, oversight of care coordination, utilization review, resource management, risk management, and quality improvement. These activities must be performed by a Mental Health Professional.
- d.  [Required] Each MCO and PIHP must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. Please describe these mechanisms:

Please see our response to special health care needs above.

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

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

**Performance Improvement Projects**

- f. X [Required] Each MCO and PIHP must conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on *mental* health outcomes and enrollee satisfaction.
- g. x Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- h. X [Required] Each MCO and PIHP must report the status and results of each project to the State as requested.

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

**Non-Clinical Performance Indicator Project:**

A work group, comprised of PIHP administrators and MHD staff, has identified a statewide non-clinical Performance Improvement Project (PIP). This PIP addresses early follow-up appointments post hospital discharge. Each RSN will implement a project to improve an aspect of post discharge follow-up. The core performance measure used by all of the PIHPs will be the number of individuals who receive a follow-up appointment within 7-days post hospital discharge. PIHPs will analyze and review their own performance and identify any statewide or system barriers to early follow-up. Future projects may include quality improvement initiatives around identified statewide barriers, as well as individual PIHP initiatives.

**Clinical Performance Indicator Project:**

Each PIHP identifies a clinical PIP in their region. PIHPs have been provided training and technical assistance on PIP development. The inclusion of the statewide non-clinical PIP this year gives PIHPs further models and technical assistance for the development and maintenance of a clinical PIP.

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

- i. X [Required] Each MCO and PIHP must measure performance using objective quality indicators.
- j. X [Required] Each MCO and PIHP must implement system interventions to achieve improvement in quality.
- k. X [Required] Each MCO and PIHP must formally evaluate the effectiveness of the interventions.

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- l.**  Each MCO and PIHP must correct significant systemic problems that come to its attention through ~~internal surveillance~~ *monitoring*, complaints, or other mechanisms.
- m.**  MCOs or PIHPs are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.
- n.**  Each MCO and PIHP must select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.
- o.**  Each MCO and PIHP must select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.
- p.**  Each MCO and PIHP must provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.
- q.**  Each MCO and PIHP must establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.
- r.**  Each MCO and PIHP must use a sampling methodology that ensures that results are accurate and reflective of the MCO's or PIHP's enrolled Medicaid population.
- s.**  Each MCO and PIHP must use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.
- t.**  Each MCO and PIHP must ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).
- u.**  Other (please describe):

## VI. Mental Health Information Systems

### Previous Waiver Period

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

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

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The MHD and CMS have reached a decision on the issues of CPT/HCPC codes and our state plan service definitions. As far back as 2002, the MHD recognized that there were issues and discrepancies between the state plan definitions and allowable CPT/HCPC codes. This has led to a situation where two of our state plan definitions cannot be coded using existing CPT/HCPC coding. Those services continue to be counted as “other.”

We continue to work with SAMHSA, CMHS, and others to map CPT/HCPC onto our state plan services. Currently, under the new state agency organizational structure, the MHD is working with coding experts from the Medical Assistance section to look at identifying standard coding for all behavioral health services paid by the state.

MHD is committed to continuing to work towards making the definitions more clearly reflect the services provided and we appreciate the assistance of CMS staff in this process.

### Upcoming Waiver Period

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

The State requires that MCO and PIHP systems:

a.  [Required] Provide information on

1.  Utilization,
2.  Grievances and appeals, *not through the IS system but through other reporting*
3.  Disenrollment for reasons other than loss of Medicaid eligibility.

b.  [Required] Collect data on enrollee and provider characteristics as specified by the State. *The Data dictionary is available on request.*

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

Please see the data dictionary above

1.  [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees
2.  [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors
3.  [Required] Verifying the accuracy and timeliness of data
4.  [Required] Screening data for completeness, logic and consistency

5.  [Required] Collecting service information in standardized formats to the extent feasible and appropriate
6. \_\_\_ Other (please describe):
- d. \_\_\_ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):
1. \_\_\_ Health services (please specify frequency and provide a description of the data and/or content of the reports)
  2. \_\_\_ Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports)
  3. \_\_\_ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)
  4. \_\_\_ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)
- e. \_\_\_ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAPI.
- f.  Ensure that information and data received from providers are accurate, timely and complete.
- g.  Allow the State agency to monitor the performance of MCOs/PIHPs using systematic, ongoing collection and analysis of valid and reliable data.
- h. \_\_\_ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.
- i. \_\_\_ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs/PIHPs.
- j. \_\_\_ The State uses information collected from MCOs/PIHPs as a tool to monitor and evaluate MCOs/PIHPs (i.e. report cards). Please describe.
- k. \_\_\_ The State uses information collected from MCOs/PIHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PIHPs and/or providers). Please describe.
- l. \_\_\_ Other (please describe):

## Section D – Cost-Effectiveness

**Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section.** Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

- Appendix D1. Member Months
- Appendix D2.S Services in the Actual Waiver Cost
- Appendix D2.A Administration in the Actual Waiver Cost
- Appendix D3. Actual Waiver Cost
- Appendix D4. Adjustments in Projection
- Appendix D5. Waiver Cost Projection
- Appendix D6. RO Targets
- Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

### Part I: State Completion Section

#### A. Assurances

- a. [Required] Through the submission of this waiver, the State assures CMS:
- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
  - The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
  - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
  - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
  - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
  - The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

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- b. Name of Medicaid Financial Officer making these assurances: **Christina Winans.**
- c. Telephone Number: **360-902-0844**
- d. E-mail: **WinanCA@dshs.wa.gov**
- e. The State is choosing to report waiver expenditures based on  
 date of payment.  
 date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

**B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test**—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

- a.  The State provides additional services under 1915(b)(3) authority.
- b.  The State makes enhanced payments to contractors or providers.
- c.  The State uses a sole-source procurement process to procure State Plan services under this waiver.
- d.  Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

## C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b.**

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- a.  MCO
- b.  PIHP
- c.  PAHP
- d.  Other (please explain):

**D. PCCM portion of the waiver only: Reimbursement of PCCM Providers**

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

- a.  Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  - 1.  First Year: \$\_\_\_\_\_ per member per month fee
  - 2.  Second Year: \$\_\_\_\_\_ per member per month fee
  - 3.  Third Year: \$\_\_\_\_\_ per member per month fee
  - 4.  Fourth Year: \$\_\_\_\_\_ per member per month fee
- b.  Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c.  Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.  Other reimbursement method/amount. \$\_\_\_\_\_ Please explain the State's rationale for determining this method or amount.

**E. Appendix D1 – Member Months**

Please mark all that apply.

For Initial Waivers only:

- a.  Population in the base year data
  - 1.  Base year data is from the same population as to be included in the waiver.
  - 2.  Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b.  For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c.  [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: \_\_\_\_\_
- d.  [Required] Explain any other variance in eligible member months from BY to P2: \_\_\_\_\_
- e.  [Required] List the year(s) being used by the State as a base year: \_\_\_\_\_. If multiple years are



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- being used, please explain: \_\_\_\_\_
- f. \_\_\_\_ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period \_\_\_\_\_.
- g. \_\_\_\_ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data: \_\_\_\_\_

### For Conversion or Renewal Waivers:

- a.  [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b.  For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period. Experience is available only for the first two quarters of R2. Accordingly, the last two quarters of R2 have not been estimated..*
- c.  [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: The caseload forecasts for Medicaid eligible people are created by the Caseload Forecast Council. They are created for each eligibility group. The primary distinctions are Categorically Needy: Grant-Receiving Adults and Children, Non-Grant Pregnant Women, Non-Grant Children, SSI and SSI-Related; Medically Needy: Aged and Disabled; and State-Funded Medical Care Services. The models are generally simple time series models or entry/exit projections of a "primary" or base trend plus the addition of "steps" or interruptions to the base trend. These interruptions are generally state or federal law or program changes. The models are calculated and presented to a group of staff from the Executive and Legislative branches with the intention of reaching consensus on the results.
- d.  [Required] Explain any other variance in eligible member months from BY/R1 to P2: Pierce County RSN withdrew from the Mental Health Program, causing a significant decrease in member months in P1 and P2.
- e.  [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: R1 is FFY 2006 quarter 3 through FFY 2007 quarter 2 (4/06 – 3/07) and R2 is FFY 2007 quarter 3 through FFY 2007 quarter 4 (4/07 – 9/07).

## F. Appendix D2.S - Services in Actual Waiver Cost

### For Initial Waivers:

- a. \_\_\_\_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

### For Conversion or Renewal Waivers:

- a.  [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: No differences.
- b.  [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: Only state psychiatric services (which includes state hospitals and state only funded programs) are not included, per CMS direction. In Appendix D2.S, those services with boxes checked in Column H are included in the Waiver, are included in

the capitation payment, and are included in Appendix D3 in Column D. Those services with boxes checked in Column I are fee-for-service items not in the Mental Health Waiver that are included in Appendix D3 in Column E.

- G.** Appendix D2.A - Administration in Actual Waiver Cost  
**[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.**

For Initial Waivers:

- a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation Projected	Amount projected to be spent in Prospective Period

The allocation method for either initial or renewal waivers is explained below:

- a. \_\_\_ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. **X** The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. \_\_\_ Other (Please explain).

- H.** Appendix D3 – Actual Waiver Cost
- a. **X** The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be

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accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation Projected	Amount projected to be spent in Prospective Period

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State’s Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation Projected (PMPM Basis)	Amount projected to be spent in Prospective Period
<u>Respite, Clubhouse, and Supported Employment Services</u>	R1: \$1,824,520	R2–P1: 14.5%	P1: \$2,181,722
	R2: \$1,046,970	P1–P2: 2.6%	P2: \$2,289,543
<b>Total</b>	<b>\$2,871,490</b>		<b>\$4,471,265</b>

Note that the higher per-member-per-month projection trend from R2 to P1 is the result of Pierce County’s withdrawal from the PIHP program. Pierce County RSN’s b(3) service rate was significantly smaller than the statewide average. Also note that the amount spent in retrospective period R2 only includes the b(3) expenses from the first two quarters of R2.

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- b. \_\_\_ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:
- c. X Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. \_\_\_ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. \_\_\_ The State provides stop/loss protection (please describe):
3. X In addition to the taxing authority of the counties, the State requires that each RSN hold risk reserves for the sole purpose of ensuring solvency.
- d. \_\_\_ Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:
1. \_\_\_ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.
- i. Document the criteria for awarding the incentive payments.
- ii. Document the method for calculating incentives/bonuses, and
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.
2. \_\_\_ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)
- i. Document the criteria for awarding the incentive payments.
- ii. Document the method for calculating incentives/bonuses, and
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

**Current Initial Waiver Adjustments in the preprint**

- I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

**Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.**

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**
1. \_\_\_ [Required, if the State’s BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: \_\_\_\_\_. Please document how that trend was calculated:
  2. \_\_\_ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
    - i. \_\_\_ State historical cost increases. Please indicate the years on which the rates are based: base years\_\_\_\_\_ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
    - ii. \_\_\_ National or regional factors that are predictive of this waiver’s future costs. Please indicate the services and indicators used\_\_\_\_\_. Please indicate how this factor was determined to be predictive of this waiver’s future costs. Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
  3. \_\_\_ The State estimated the PMPM cost changes in units of service, technology and/or practice

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patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
- ii. Please document how the utilization did not duplicate separate cost increase trends.

b. \_\_\_ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
  - Reductions in State Plan Services (-)
  - Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)
1. \_\_\_ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
  2. \_\_\_ An adjustment was necessary. The adjustment(s) is(are) listed and described below:
    - i. \_\_\_ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

      - A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
      - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
      - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
      - D. \_\_\_ ***Determine adjustment for Medicare Part D dual eligibles.***
      - E. \_\_\_ Other (please describe):
    - ii. \_\_\_ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
    - iii. \_\_\_ Changes brought about by legal action (please describe):

For each change, please report the following:

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- A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe):
- iv. \_\_\_ Changes in legislation (please describe):  
For each change, please report the following:
- A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe):
- v. \_\_\_ Other (please describe):
- A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
  - B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
  - C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
  - D. \_\_\_ Other (please describe):
- c. \_\_\_ **Administrative Cost Adjustment\*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.
- 1. \_\_\_ No adjustment was necessary and no change is anticipated.
  - 2. \_\_\_ An administrative adjustment was made.
    - i. \_\_\_ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
      - A. \_\_\_ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
      - B. \_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
      - C. \_\_\_ Other (please describe):
    - ii. \_\_\_ FFS cost increases were accounted for.
      - A. \_\_\_ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

- B. \_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C. \_\_\_ Other (please describe):
- iii. \_\_\_ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
  - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years \_\_\_\_\_. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
  - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above \_\_\_\_\_.

\* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
  - 1. \_\_\_ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: \_\_\_\_\_. Please provide documentation.
  - 2. \_\_\_ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.
    - i. State Plan Service trend
      - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above \_\_\_\_\_.
- e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d**, then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.
  - 1. List the State Plan trend rate by MEG from **Section D.I.I.a.** \_\_\_\_\_
  - 2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** \_\_\_\_\_
  - 3. Explain any differences:



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f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. \_\_\_ We assure CMS that GME payments are included from base year data.
2. \_\_\_ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3. \_\_\_ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1. \_\_\_ GME adjustment was made.
  - i. \_\_\_ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
  - ii. \_\_\_ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2. \_\_\_ No adjustment was necessary and no change is anticipated.

*Method:*

1. \_\_\_ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2. \_\_\_ Determine GME adjustment based on a pending SPA.
3. \_\_\_ Determine GME adjustment based on currently approved GME SPA.
4. \_\_\_ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.

1. \_\_\_ Payments outside of the MMIS were made. Those payments include (please describe):
2. \_\_\_ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3. \_\_\_ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

*Basis and Method:*

1. \_\_\_ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. \_\_\_ State added estimated amounts of copayments for these services in FFS that were not in the

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- capitated program. Please account for this adjustment in Appendix D5.
3. \_\_\_ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
  4. \_\_\_ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. \_\_\_ No adjustment was necessary and no change is anticipated.
2. \_\_\_ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

*Method:*

1. \_\_\_ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. \_\_\_ Determine copayment adjustment based on pending SPA.
3. \_\_\_ Determine copayment adjustment based on currently approved copayment SPA.
4. \_\_\_ Other (please describe):

- i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

*Basis and method:*

1. \_\_\_ No adjustment was necessary
  2. \_\_\_ Base Year costs were cut with post-pay recoveries already deducted from the database.
  3. \_\_\_ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
  4. \_\_\_ The State made this adjustment:\*
- i. \_\_\_ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5**.
  - ii. \_\_\_ Other (please describe):

- j. **Pharmacy Rebate Factor Adjustment :** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

*Basis and Method:*

1. \_\_\_ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
2. \_\_\_ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for

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by the State in FFS *or Part D for the dual eligibles.*

3.\_\_\_\_ Other (please describe):

- k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under “Other” including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.
- 1.\_\_\_\_ We assure CMS that DSH payments are excluded from base year data.
  - 2.\_\_\_\_ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
  - 3.\_\_\_\_ Other (please describe):
- l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.
- 1.\_\_\_\_ This adjustment is not necessary as there are no voluntary populations in the waiver program.
  - 2.\_\_\_\_ This adjustment was made:
    - a. \_\_\_\_ Potential Selection bias was measured in the following manner:
    - b. \_\_\_\_ The base year costs were adjusted in the following manner:
- m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
- 1.\_\_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
  - 2.\_\_\_\_ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
  - 3.\_\_\_\_ *We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.*
  - 4.\_\_\_\_ Other (please describe):

**Special Note section:**

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the

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CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a.\_\_\_\_ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b.\_\_\_\_ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

**Special Note for initial combined waivers (Capitated and PCCM) only:**

**Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations --** Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (\*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: $\text{PMPM Waiver Cost Projection} - \text{PMPM Actual Waiver Cost} = \text{PMPM Cost-effectiveness}$

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

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1. \_\_\_ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
  2. \_\_\_ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
  3. \_\_\_ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
1. \_\_\_ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
  2. \_\_\_ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
    - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
1. \_\_\_ No adjustment was made.
  2. \_\_\_ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

## J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

**If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method, and mathematically account for the adjustment in Appendix D5.**

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.  [Required, if the State’s BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: An annual trend rate of 2.6% for FFS professional and ITA ancillary fees, 9.6% for prescription drugs, and 5% for all other FFS categories. BRS capitation is trended at 2.1% and RSN capitation costs have been determined using the contracted values for each projected period. Please document how that trend was calculated: The trends for each category of service were determined based on rates observed in similar programs.

2.  [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).

i.  State historical cost increases. Please indicate the years on which the rates are based: base years \_\_\_\_\_ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

Trend rates are applied by category of service: FFS professional and ITA ancillary fees are trended forward at an annual rate of 2.6%, prescription drugs are trended at 9.6%, and all other FFS categories are trended at 5%. BRS capitation is trended at 2.1% and RSN capitation costs have been determined using actual contracted published at the time that this waiver application is submitted.

Trend rates were based on rates observed in similar Washington State Medicaid programs. In the case of RSN capitation payments, we have relied on actual contracted rates published at the time that this waiver application is submitted.

All trends reflect changes to PMPM amounts.

ii. \_\_\_ National or regional factors that are predictive of this waiver’s future costs. Please indicate the services and indicators used:

In addition, please indicate how this factor was determined to be predictive of this waiver's future costs.

Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. \_\_\_\_ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
  - ii. Please document how the utilization did not duplicate separate cost increase trends.

b. \_\_\_\_ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

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1.  The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2.  An adjustment was necessary and is listed and described below:
  - i.  The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.  
For each change, please report the following:
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  *Determine adjustment for Medicare Part D dual eligibles.***
    - E.  Other (please describe):**
  - ii.  The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
  - iii.  The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
  - iv.  Changes brought about by legal action (please describe):  
For each change, please report the following:
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  Other (please describe):
  - v.  Changes in legislation (please describe):  
For each change, please report the following:
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  Other (please describe):
  - vi.  Other (please describe):
    - A.  The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_
    - B.  The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_
    - C.  Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_
    - D.  Other (please describe):



c. \_\_\_ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1. \_\_\_ No adjustment was necessary and no change is anticipated.

2.  An administrative adjustment was made.

i. \_\_\_ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii. \_\_\_ Cost increases were accounted for.

A. \_\_\_ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. \_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. \_\_\_ State Historical State Administrative Inflation. The actual trend rate used is: \_\_\_\_\_. Please document how that trend was calculated:

D. \_\_\_ Other (please describe):

iii.  [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. \_\_\_ Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: \_\_\_\_\_. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.): \_\_\_\_\_. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase. \_\_\_\_\_.

B.  Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above. We have applied a 3.0% trend rate to R2 administrative PMPM costs. This is somewhat below the trend for State Plan services, but is consistent with prior cost effectiveness projections.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3)

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services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.  [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is:

2.6%.

Due to lack of historical reporting for historical b(3) service costs, we are unable to calculate a b(3)-specific historical trend rate. We have applied 2.6% as a reasonable estimate of b(3) services trend. This trend rate is consistent with the trend rates for state plan outpatient services included in the waiver.

Please provide documentation.

2.  [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
  - i. State historical 1915(b)(3) trend rates
    1. Please indicate the years on which the rates are based: base years \_\_\_\_\_
    2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
  - ii. State Plan Service Trend
    1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above: 2.6% disabled and non-disabled. These trend rates are consistent with the trend rates for state plan outpatient services included in the waiver.

- e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** \_\_\_\_\_
2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.** \_\_\_\_\_
3. Explain any differences:

- f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were

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provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)\*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

*Basis and Method:*

1. \_\_\_ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
2. \_\_\_ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. \_\_\_ Other (please describe):

1. \_\_\_ No adjustment was made.

2. \_\_\_ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

### K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

### L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

### M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
  1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**: Membership projections are based on forecasts from the Caseload Forecast Council. This forecast shows the Non-Disabled MEG growing at a somewhat higher rate than the non-disabled MEG. Because the Non-Disabled MEG is less expensive on a PMPM basis, the caseload shift is contributing to the overall decrease in PMPM trend rates. For example, the annual PMPM trend rate from R2 to P1 is 5.3% Adjusted for casemix, this trend rate is 6.0% (as shown in line 46 of of D7, Column I). Hence, casemix is contributing roughly -0.7% to the overall PMPM trend rate.
  2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer

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given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J:**  
We have projected program costs on a PMPM basis, and have not attempted to distribute these trends between unit cost and utilization.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J:**

We have projected program costs on a PMPM basis, and have not attempted to distribute these trends between unit costs and utilization

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

There are several principal factors contributing to the overall PMPM trend rates in P1 and P2:

- Most FFS services are trending forward at rates that range from 2-5%, depending on the type of service.
- Prescription drug costs are assumed to be trending forward at about 9.6% per year.
- RSN contracted capitations rates increase at an effective rate of 3% from R2 to P1, and -0.4% from P1 to P2. This contributes to an overall lower trend rate from P1 to P2.

The effect of the above trend rates on the various components of the above results in a composite annual trend rate of 5.3% from R2 to P1 and about 3.0% from P1 to P2.

## Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

### Section E. FRAUD AND ABUSE

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

#### Previous Waiver Period

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

The State Auditor monitors and reported no findings of Fraud and Abuse. Staff from MHD and the RSNs attended training provided by CMS. The EQRO found no evidence of fraud and abuse in their reviews.

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

### I. State Mechanisms

- a. X The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PIHP/PAHP, by the State's claims processing system).
- b. \_\_\_ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)
- c. X The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

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

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

### II. MCO/PIHP/PAHP Fraud Provisions

- a. X [Required for MCOs/PIHPs if State payments based on data submitted by MCO/PIHP, e.g. encounter data] MCO/PIHP must certify data as follows:
- (i) data is accurate, complete, and truthful based on best knowledge, information, and belief
  - (ii) certification is made by plan CEO, CFO, or individual delegated to sign for, and reports to, plan CEO or CFO

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- (iii) certification is submitted concurrently with data
  
- b. X [Required for MCO/PIHPs] The State requires MCOs/PIHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Plan includes:
  - (i) X Written policies that articulate commitment to comply with all applicable Federal and State laws
  - (ii) X Designation of compliance officer and committee
  - (iii) X Effective training and education for compliance officer and plan employees
  - (iv) X Enforcement of standards through well-publicized disciplinary guidelines
  - (v) X Provision for internal monitoring and auditing
  - (vi) X Provision for prompt response to detected offence, and corrective action initiative related to MCO/PIHP contract
  
- c. X [Required for MCOs/PIHPs/PAHPs] The plan is prohibited from having affiliations with an individual who was, or is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation.
  
- d. X The State requires MCOs/PIHPs/PAHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.

**Section F. SPECIAL POPULATIONS**

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

**I. General Provisions for Special Populations**

**Previous Waiver Period**

- a. [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint, item F.I. Upcoming Waiver Period, 1999 Renewal Waiver Preprint].
  
- b. Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

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

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

This is a carved-out mental health program. The program is responsible for persons (with the exceptions of the excluded populations) of all ages who qualify for authorization to services through the access to care standards and meet the definition of medically necessary. The program does not discriminate based on physical disability nor does the program meet the criteria for primary care provider. Mental health services are specialty services.

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

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

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

The PIHPs have updated cross system protocols for children and older adults. The updates include the development of a cross system Individual Service Plan to identify the system responsible for meeting each identified need of the child/family. There is also an identified protocol in place to coordinate a system plan for Aging and Disability Services Administration to meet the needs of older adult consumers.

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

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

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

1. \_\_\_ Access to services (please describe):
2. \_\_\_ Quality of Care (please describe):
3. \_\_\_ Coordination of care (please describe):

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- 4. \_\_\_ Enrollee satisfaction (please describe):
- 5. \_\_\_ Other (please describe):

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

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

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

Please see the Mental Health Division website at <http://www1.dshs.wa.gov/mentalhealth> and the WIMIRT website <http://depts.washington.edu/washinst>.

## II. State Requirements for MCOs/PIHPs/PAHPs

### Previous Waiver Period

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

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

- a. \_\_\_ The State has required care coordination/case management services the MCO/PIHP/PAHP shall provide for individuals with special health care needs. Please describe by population.
- b. \_\_\_ As part of its criteria for contracting with an MCO/PIHP/PAHP, the State assesses the MCO/PIHP/PAHP's skill and experience level in accommodating people with special needs. Please describe by population.



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- c. \_\_\_ The State requires MCOs/PIHPs/PAHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population.
- d. \_\_\_ The State has provisions in contracts with MCOs/PIHPs/PAHPs that allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If not checked, please explain by population.
- e. \_\_\_ The State collects or requires MCOs/PIHPs/PAHPs to collect population-specific data for special populations. Please describe by population.
- f. \_\_\_ The State requires MCOs/PIHPs/PAHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.
1. Please note any services marked in Appendix D.2.S that are for special needs populations only by population.
  2. Please note any unique definitions of “medically necessary services” for special needs populations by population.
  3. Please note any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State’s Title V agency for any special needs children who qualify for Title V assistance?
- g. \_\_\_ The State requires MCOs/PIHPs/PAHPs to identify individuals with complex or serious medical conditions in the following ways:
1. \_\_\_ An initial and/or ongoing assessment of those conditions
  2. \_\_\_ The identification of medical procedures to address and/or monitor the conditions.
  3. \_\_\_ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
  4. \_\_\_ Other (please describe):
- h. \_\_\_ The State specifies requirements of the MCO/PIHPs/PAHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

## **Section G. APPEALS, GRIEVANCES, AND FAIR HEARINGS**

MCOs/PIHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals

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with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

Internal grievance procedures are optional for PAHPs.

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

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

**I. Definitions (MCO/PIHP):**

**Upcoming Waiver Period --**

- a.  [Required] The definition of action in the case of an MCO/PIHP means:
- ✓ Denial or limited authorization of a requested service, including the type or level of service;
  - ✓ The reduction, suspension, or termination of a previously authorized service;
  - ✓ The denial, in whole or in part, of a payment for a service;
  - ✓ The failure to provide services in a timely manner;
  - ✓ The failure to act within timeframes required by 42 CFR 438.408(b);
  - ✓ For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
- b.  Appeal means a request for a review of an action.
- c.  Grievance means an expression of dissatisfaction about any matter other than an action.
- d. Please describe any special processes that the State has for persons with special needs.

**II. Grievance Systems Requirements (MCO/PIHP):**

**Previous Waiver Period**

- a. [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken

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with respect to appeals, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint, item G.II 1999 Upcoming Waiver Renewal Preprint]. Also, please provide summary information on the types of appeals, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State’s Quality Strategy.

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

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

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

- b.** Please mark any of the following that apply:
  1. \_\_\_ A hotline was maintained which handles any type of inquiry, complaint, or problem.
  2. **X** Following this section is a list or chart of the number and types of complaints and/or (not required per BBA and CMS) grievances handled during the waiver period.

**October 2006 through March 2007**

Type	Under 21 Grievance	Under 21 Fair Hearing	Over 21 grievance	Over 21 fair hearing
Access	5		24	
Dignity and Respect	3		23	2
Quality/ Appropriateness	1		24	2
Phone calls not returned	11		11	
Service -- Intensity, Not Available, Coordination	5	2	14	1
Consumer Rights	1		16	2
Physicians & Medications	6		30	
Financial & Admin Svs	1		4	
Residential				
Housing				
Transportation				
Emergency Services	1			
Other	2		29	

April 2006 through September 2006

Type	Under 21 Grievance	Under 21 Fair Hearing	Over 21 grievance	Over 21 fair hearing
Access	8		14	1
Dignity and Respect	1		20	
Quality/ Appropriateness	3		17	
Phone calls not returned	4		5	
Service -- Intensity, Not Available, Coordination	5		16	
Consumer Rights			16	
Physicians & Medications	16		4	
Financial & Admin Svs	2		14	
Residential				
Housing				
Transportation			5	
Emergency Services			2	
Other	2		9	

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

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

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

1. X MCO/PIHPs have a system in place for enrollees that include a grievance process, an appeals process, and access to the State's fair hearing process.
2. X An MCO/PIHP enrollee can request a State fair hearing under the State's Fair Hearing process. The State permits  
 (A) \_\_ direct access without first exhausting the MCO/PIHP grievance process  
 (B) X exhaustion of MCO/PIHP grievance process before a State fair hearing can be accessed. With regard to specific mental health grievance, the state requires the consumer to exhaust grievances at the lowest level possible; first at the community mental health agency, then the PIHP level and then fair hearing with a maximum time frame for resolution of 30 days at each level.

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

DSHS rules.

3. X Enrollees are informed about their State fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.
4. X The state specifies a time frame that is no less than 20 days and does not exceed 90 days from the date of action for the enrollee to request an appeal or fair hearing. Specify the time frame 20 days
5. X [Optional] The State has time frames for resolution of grievances. Specify the time frame set by the State 90 days

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

6. X The MCO/PIHP issues a written notice of all actions. Notices meet the requirements of 42 CFR 438.404 for language, format, content, and timing.
7. X The MCO/PIHP acknowledges receipt of each appeal and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PIHPs to acknowledge complaints and grievances, please specify: *Initial acknowledgement may be by telephone, with written acknowledgement within five working days of receipt of the appeal or grievance.*
8. X The MCO/PIHP gives enrollees assistance completing forms or other assistance necessary in filing appeals or grievances (or as appeals and grievances are being resolved).
9. X The MCO/PIHP ensures individuals who make decisions were not involved in previous levels of decision making.
10. X The MCO/PIHP ensures individuals who make decisions are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease.
11. X The MCO/PIHP ensures the special requirements for appeal, i.e. on oral inquiries, reasonable opportunity to present evidence; ability to examine case file, and inclusion of parties to appeal in 42 CFR 438.406(b) are met.
12. X **Timeframes for resolution:**
  - (a) X Grievances are *investigated and* resolved within 30 days (may not exceed 90 days from date of receipt by MCO/PIHP)

- (b)  Standard appeals are resolved in 45 days (may not exceed 45 days from date of receipt by MCO/PIHP).
- (c)  Expedited appeals are resolved in 3 days (may be no more than 3 working days from date of receipt by MCO/PIHP, unless extended).
13.  Timeframes for resolution may be extended for up to 14 calendar days if it meets the requirements of 42 CFR 438.408(c).
14.  The MCO/PIHP notifies the enrollee in writing of the appeals decision and, if not favorable to the enrollee, the right to request a State fair hearing, including rights to continuation of benefits. The format and content of the notice meet the requirements of 42 CFR 438.408(d)-(e).
15.  The MCO/PIHP complies with the requirements on availability of and parties to State fair hearings in 42 CFR 438.408(f).
16.  The MCO/PIHP maintains an expedited review process for appeals when it is determined that the standard resolution timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. This includes the prohibitions on punitive actions, and action following denial of request for expedited resolution in 42 CFR 438.410.
17.  The MCO/PIHP informs the enrollee of any applicable mechanism for resolving the issue external to the MCO's/PIHP's own processes (e.g. independent state review mechanism).
18.  MCOs/PIHPs maintain a log of all appeals and grievances and their resolution.
19.  The State reviews information on each MCO/PIHP's appeals as part of the State quality strategy.
20.  The State and/or MCO/PIHP have ombuds programs to assist enrollees in the appeals, grievance, and fair hearing process.
21.  Other (please specify):

### III. PAHP Requirements

1.  [Optional] PAHPs have an internal grievance system. Please describe.
2.  [Required] PAHP enrollees have access to the State fair hearing process.

**Section H. ENROLLEE INFORMATION AND RIGHTS**

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

**I. Information – Understandable; Language; Format**

**Previous Waiver Period**

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

*The Benefit Booklet is updated on the MHD's web page as we are made aware of changes. It will be updated to reflect the changes to Pierce County in January.*

# Public Mental Health System

## **Benefits Booklet**

### For People Enrolled in Medicaid

DSHS/Mental Health Division • PO Box 45320 • Olympia WA 98504-5320

June 2007

Dear Medicaid Recipient,

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

- How to get mental health services and what to do in an emergency.
- What benefits are available under the Medicaid Mental Health Program.
- How to get information about your Medicaid Mental Health benefits.
- What your rights are.
- How you and your family members can be involved in helping us provide better services.
- Information about medical care.

#### *The Mental Health Division*

Health and Recovery Services Administration

*The information in this benefits booklet is available in Chinese and interpreter services are available upon request – Call the number below.*

*The information in this benefits booklet is available in Russian and interpreter services are available upon request – Call the number below.*

*The information in this benefits booklet is available in Laotian and interpreter services are available upon request – Call the number below.*

*The information in this benefits booklet is available in Cambodian and interpreter services are available upon request – Call the number below.*

*The information in this benefits booklet is available in Vietnamese and interpreter services are available upon request – Call the number below.*

*The information in this benefits booklet is available in Korean and interpreter services are available upon request – Call the number below.*

*The information in this benefits booklet is available in Spanish and interpreter services are available upon request – Call the number below.*

**Mental Health Division's Office of Consumer Affairs**

**Call 1-800-446-0259**



## **IMPORTANT NUMBERS**

*If there is a life-threatening emergency, please call 9-1-1.*

*If you have a mental health crisis these are the*

### **24-Hour Mental Health Crisis Line Phone Numbers by County:**

**Adams:** (collect): 509-488-5611

**Asotin:** 1-888-475-5665

**Benton-Franklin:** 1-800-783-0544  
509-783-0500

**Chelan:** 1-800-852-2923

**Clallam:** 360-374-6177  
East 360-452-7500  
West 360-374-5011

**Clark:** 1-800-626-8137

**Columbia:** 866-382-1164

**Cowlitz:** 1-800-803-8833  
360-425-6064

**Douglas:** 1-800-852-2923

**Ferry:** 1-866-268-5105

**Garfield:** 888-475-5665

**Grant:** (collect): 509-765-1717  
1-877-467-4303

**Grays Harbor:** 1-800-685-6556

**Island:** 1-800-584-3578

**Jefferson:**  
East 360-385-0321 or 1-800-659-0321

**King:** 1-866-427-4747  
206-461-3222

**Kitsap:**  
Non-Business hours: 360-374-6271  
360-479-3033 or 800-843-4793

**Kittitas:** 509-925-9861 or 509-925-4168

**Klickitat:** 509-733-5801 / 1-800-572-8122

**Lewis:** 1-800-559-6696

**Lincoln:** 1-888-380-6823

**Mason:** 1-800-627-2211

**Okanogan:** 1-866-826-6191

**Pacific:** 1-800-884-2298

**Pend Oreille:** 1-866-847-8540

**Pierce:** 1-800-576-7764

**San Juan:** 1-800-584-3578

**Skagit:** 1-800-584-3578

**Skamania:** 509-427-3850

**Snohomish:** 1-800-584-3578

**Spokane:** 1-877-678-4428

**Stevens:** 1-888-380-6823

**Thurston:** 1-800-627-2211

**Wahkiakum:** 1-800-635-5989

**Walla Walla:** 509-527-3278

**Whatcom:** 1-800-584-3578

**Whitman:** 1-866-871-6385  
**Yakima:**  
509-575-4200 or 1-800-572-8122

### **Other Resources**

#### Medical Care:

1-800-562-3022 or <http://fortress.wa.gov/dshs/maa/HealthyOptions/index.html>

#### Alcohol or Substance Abuse:

1-877-301-4557 or <http://www1.dshs.wa.gov/dasa/>

#### Aging and Disabilities Services:

1-800-422-3263 or <http://www.aasa.dshs.wa.gov>

#### Medicaid Transportation Information:

1-800-562-3022

### Who Is Eligible For Public Mental Health Services?

People who receive a Medicaid card are eligible for medically necessary mental health services at no cost to themselves.

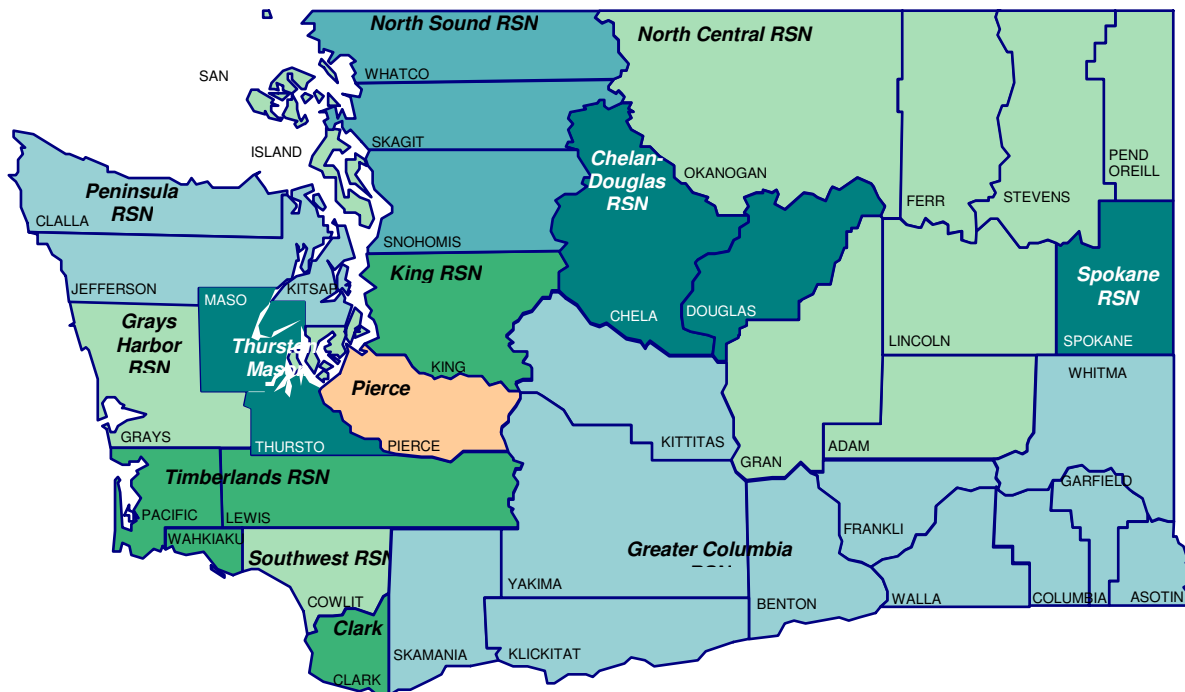
### What does Medically Necessary or Medical Necessity mean?

A Medicaid recipient must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. No other formal or informal system or support can address the individual's unmet need.

### Who Provides Services?

The Washington State public mental health system has thirteen Regional Support Networks (RSNs). Each RSN is made up of one or more counties. Medicaid recipients are automatically enrolled in a local mental health care plan managed by a RSN. RSNs coordinate mental health services offered within their service area by contracting with community mental health agencies. Except for Crisis Services, all mental health services must be authorized by the RSN in your area. You may only go to an RSN contracted agency for covered services. A list of authorized agencies begins on page 8. You may be responsible for costs if you receive mental health services through other providers. Check the list below to find out which RSN you are in.

Washington State Regional Support Networks (RSNs)



Effective January 1, 2008

<b><u>Regional Support Network</u></b>	<b><u>Counties Served</u></b>
<b>Chelan-Douglas RSN</b> .....	Chelan, Douglas
<b>Clark County RSN</b> .....	Clark
<b>Grays Harbor RSN</b> .....	Grays Harbor
<b>Greater Columbia RSN</b> .....	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Skamania, Walla Walla, Whitman, Yakima
<b>King County RSN</b> .....	King
<b>North Central WA RSN</b> .....	Adams, Grant, Okanogan, Ferry, Lincoln, Pend Oreille, Stevens
<b>North Sound RSN</b> .....	Island, San Juan, Skagit, Snohomish, Whatcom
<b>Peninsula RSN</b> .....	Clallam, Jefferson, Kitsap
<b>Southwest RSN</b> .....	Cowlitz
<b>Spokane County RSN</b> .....	Spokane
<b>Thurston-Mason RSN</b> .....	Mason, Thurston
<b>Timberlands RSN</b> .....	Lewis, Pacific, Wahkiakum

**What Services Are Available?**

Medically necessary mental health services are available to you and your family. If you need mental health services, an individual treatment plan will be developed with you. The plan will be developed according to your individual strengths and needs and it will take into consideration your age and culture. Your mental health care provider will work with you to decide which services listed below be will part of your individual treatment plan.

- Brief Intervention Treatment
  - Crisis Services
  - Day Support
  - Family Treatment
  - Evaluation and Treatment/Community
- Hospitalization
- Group Treatment Services
  - High Intensity Treatment
  - Individual Treatment Services
  - Intake Evaluation
  - Medication Management
  - Medication Monitoring
  - Mental Health Services provided in Residential
- Settings
- Peer Support
  - Psychological Assessment
  - Rehabilitation Case Management
  - Special Population Evaluation
  - Stabilization Services
  - Therapeutic Psychoeducation
  - Respite Care
  - Supported Employment
  - Mental Health Clubhouse

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

The RSN will provide information on mental health and applying for services in an easily understood way. If necessary, the information will be provided in languages other than English.

Some community mental health agencies have staff members who speak languages besides English. (There is more information on the page that lists your RSN.) If you or someone you know needs information or services in another language, your RSN must provide language assistance at not cost to you. The assistance may be provided either orally or in writing.

Your mental health care provider may also help you connect with other services such as housing, healthcare, and employment.

### **May I Choose My Mental Health Care Provider?**

You may choose a mental health care provider at the agency where you receive services. If you don't choose a mental health care provider, one will be assigned to you. You have the right to change mental health care providers during the first 30 days. You can also ask for a change once a year without a reason. If you request a second change in providers within the year you must have a reason. The agency will review your request and make a decision about whether or not you can change providers again.

### **How Can I Get Mental Health Services?**

If you think that you need mental health services, you can call or go to an authorized agency in the community where you live to schedule an appointment for an intake evaluation. The intake evaluation is used to decide what mental health services you may need. The RSN will use this to make a decision about what services to authorize for you. For more information call the toll-free or local telephone numbers listed with other RSN information, starting on page 16.

### **What If I Need To Be In a Hospital For Mental Health Care?**

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

### **What If I Get A Bill?**

You should not receive a bill for services that are covered by Medicaid. If you get a bill, contact the billing office of the agency that sent you the bill. Tell them you are covered by Medicaid and ask for an explanation of the bill. If this does not fix the problem you can contact your mental health care provider, your RSN or the Ombuds for more help.

## **What can I do if I am not satisfied with my services?**

- You can file a *Grievance* about your dissatisfaction.
- You can file an *Appeal* if you receive a written Notice of Action from your RSN.

The following information explains your rights and how to file a Grievance, Appeal or request an Administrative (“Fair”) Hearing if you are unhappy or unsatisfied with your services.

## **Who can help me with Grievances, Appeals or Fair Hearings?**

Each RSN has an Ombuds Service that can assist you with grievances, appeals, and the state fair hearing process. The Ombuds help enrollees resolve concerns about mental health services. The Ombuds Service phone numbers are listed for each RSN in this booklet. A community mental health agency can also help you contact the Ombuds.

## **How do I file a Grievance?**

Here are the steps in the grievance process:

1. To start a Grievance, contact the Community Mental Health Agency (“CMHA”) where you receive services or the RSN in your community.
2. You may request assistance with your Grievance from your RSN’s Ombuds service. Interpreter and TTY/TTD services are available to help you, if needed. You may also receive help from other individuals of your choice.
3. You may start a Grievance with a telephone call or in writing. If you choose to start with a telephone call, you must also send a letter within seven days. Please include in your letter your name, how to best contact you, the nature of your grievance, what you are requesting as a resolution for your Grievance, and your signature.
4. When a CMHA or RSN receives the Grievance, they will acknowledge the receipt of the Grievance within one working day by telephone or in person, and then follow-up with a written notice within five working days.
5. Your Grievance will first be considered by people at your CMHA who have not been previously involved with the issue of concern in your Grievance. If your Grievance is about mental health treatment issues a qualified mental health care professional will review the grievance.
6. If you started your grievance at your CMHA, the CMHA will make a decision about your Grievance within 30 calendar days from the day you started your Grievance.
7. You will receive a written statement of the decisions about your Grievance.

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8. If you are not satisfied with the decision made by the CMHA about your Grievance, you may ask for additional consideration of your Grievance from the RSN but you must do so within 5 calendar days from your receipt of your CMHA's decision.
9. Your RSN will make a decision about your Grievance within 30 calendar days from the day you started your Grievance if you filed your Grievance directly with the RSN. If you started your Grievance with your CMHA first the RSN will make a decision within 60 days from the day you started your Grievance. You may request an additional 14 calendar days for the RSN to respond if you believe it is in your best interest to request this extension. Or, in some instances, the RSN may request up to 14 additional days to make its decision if it needs additional information and the delay is in your best interest.
10. You will receive a written statement of the RSN's decision about your Grievance.
11. If you do not receive a decision about your Grievance within the timeframes outlined above, or you disagree with the decision you receive, you may file a request for a Fair Hearing.

### **When Can I Appeal?**

Whenever you get a Notice of Action from the RSN, you may file an appeal requesting that the RSN review the action. An Appeal is a request that the RSN review an Action. If an Action occurs you will get a written Notice of Action.

### **What Is An Action?**

An Action is a denial, suspension, reduction, or termination of your services as defined below:

**Denial:** The decision not to offer an intake is a denial. The decision by the RSN not to authorize Medicaid mental health services that are requested for you by a CMHA is a denial.

**A Suspension, Reduction or Termination** occurs when an RSN makes a decision to change your authorized mental health services to less than originally authorized.

### **What Kind of Decision is Not an Action?**

- Any decision other than denial, reduction, suspension or termination of services is not an "Action". Actions come only from the RSN. Examples of decisions that are not an Action include but aren't limited to:
  - A decision made by a Mental Health Professional not to request an authorization for ongoing mental health services after an intake.

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- A decision, made as part of the treatment planning process, with your mental health care provider that is within your authorized benefit.

***Decisions that are not Actions cannot be appealed but you may file a Grievance or request a second opinion from the RSN.***

## **How do I file an Appeal?**

1. To start an Appeal, contact the RSN that sent you the Notice of Action. The appeal must be requested within 20 days of receiving the Notice of Action or the intended effective date of the Action – whichever is later.

If your Appeal is regarding services you are already receiving and you wish to continue them during the Appeal you must request an Appeal within 10 days of when the RSN mailed the Notice of Action or the intended effective date of the Action – whichever is later.

2. If you need assistance with your Appeal the local mental health Ombuds service from your RSN can help you. See the page 8 of this booklet for the telephone number of the Ombuds service in your RSN. Interpreter and TTY/TTD services are available to help you, at no cost. You may also receive help from your community mental health agency or anyone else you choose.
3. You may start an appeal with a phone call or in writing. Please include your name, how to reach you, the reason for the appeal, any information you wish to submit to support your request, and sign your request.
4. You may request a faster Appeal process if you or your mental health care provider believes that a longer time for resolution would put your ability to maintain or regain maximum functioning at risk. If you require a faster Appeal process your RSN will make a decision about your Appeal within 3 working days. If the RSN takes additional time, you will be notified of the reason for the delay.
5. When the RSN receives the request for Appeal, they will send you a written notice or a telephone call acknowledging the receipt of the request for Appeal within one working day.
6. During the Appeal process, you and anyone you give permission to can look at your mental health records to help with the Appeal.
7. Your Appeal will be reviewed by someone who has the proper training and has not been previously involved with making decisions about your treatment.
8. While your Appeal is under consideration, you may request to continue your services, if:

WA 1915(b) Renewal  
Effective date: April 1, 2008  
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- The Appeal is filed within 10 days of when the RSN mailed the Notice of Action or the intended effective date of the Action – whichever is later.
- The services are covered Medicaid mental health services
- The Appeal involves the reduction, suspension, or termination of services that the community mental health agency states you need.
- The current authorization for Medicaid mental health services has not expired.

**IMPORTANT:** If the Appeal decision is not in your favor, you may have to pay for the services you received during the Appeal.

9. Unless you request a faster Appeal process, your RSN will make a decision about your Appeal within 45 days from the day you started your Appeal. Sometimes, additional time may be taken if you request it or if it is in your best interest. If the RSN takes additional time without your request, you will be notified of the reason for the delay.
10. The RSN will send you a written Appeal decision.

### **What Is A Fair Hearing?**

If you not satisfied with the outcome of your Appeal to the RSN, you may ask for additional consideration from the state Office of Administrative Hearings (OAH) within 90 days of the original date you requested an Appeal from the RSN. The OAH is not part of the Department of Social and Health Services (DSHS), the Mental Health Division (MHD) or an RSN. You may have an Ombuds represent or assist you with the hearing at no cost. You may also hire your own lawyer or anyone else to represent you, but you will have to pay for the cost. The OAH decision about your appeal must be carried out by the MHD, the RSN, and your CMHA.

Note: In some situations, an enrollee may request a Fair Hearing before filing an appeal with a RSN. This is allowed when there has been an alleged violation of state rules. Examples include the failure of a RSN to authorize services in a timely manner or to process an appeal according to the required timelines. You may call the OAH or your Ombuds if you think you qualify for a Fair Hearing.

If you want to ask the Office of Administrative Hearings to review your Appeal, send your request to:

Office of Administrative Hearings  
P.O. Box 42489, Olympia, WA 98504  
The toll-free telephone number is: 1-800-583-8271.

There are several locations of OAH around the state. Your case will be assigned to the one closest to your home. If an in-person hearing is needed, it will be held in a location close to you.

### **What are My Rights as a Person Receiving Public Mental Health Services in the community?**

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- To be treated with respect and dignity
- To have your privacy protected
- To help develop a plan of care with services to meet your needs
- To participate in decisions regarding your mental health care
- To receive services in a barrier-free location (accessible)
- To request information about names, location, phones, and languages for local agencies
- The right to receive the amount and duration of services you need
- To request information about the structure and operation of the RSN
- The right to services within 2 hours for emergent care and 24 hours for urgent care
- To be free from use of seclusion or restraints
- To receive age and culturally appropriate services
- To be provided a certified interpreter and translated material at no cost to you
- To understand available treatment options and alternatives
- To refuse any proposed treatment
- To receive care that does not discriminate against you (e.g. age, race, type of illness)
- To be free of any sexual exploitation or harassment
- To receive an explanation of all medications prescribed and possible side effects
- To make an advance directive, which states your choices and preferences for mental health care
- To receive quality services that are medically necessary
- To have a second opinion from a mental health professional
- To file a grievance with your agency or RSN
- To file a RSN appeal based on a RSN written Notice of Action
- To choose a mental health care provider or choose one for your child who is under thirteen years of age
- To change mental health care providers during the first 90 days, and sometimes more often
- To file a request for an administrative (fair) hearing,
- To request and receive copy of your medical records and ask for changes
- Be free from retaliation

You may want to ask your mental health care provider for more information about your rights. You have the right to request policies and procedures of the RSN and CMHAs as they pertain to your rights. If you receive MH care in a hospital you have additional rights.

### **What Is A Mental Health Advance Directive?**

A mental health advance directive is a written document that describes what you want to happen if you become incapacitated by mental illness and your judgment is impaired or if you are unable to communicate effectively. It tells your provider, the CMHA, the RSN and others about what treatment you want or don't want, and it can identify a person to whom you have given the authority to make decisions on your behalf.

### **How Do I Complete A Mental Health Advance Directive?**

A model "fill-in-the-blanks" form is available on the Mental Health Division web site:

<http://www1.dshs.wa.gov/mentalhealth>. Your community mental health provider or your Ombuds may also have copies of the form.

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**ACCESSING MEDICAL CARE**

**How can I access medical care that is covered by Medicaid?**

Your Medicaid ID card will have information on it that about what kind of plan you have either managed care or Fee for Service (FFS). If you are Medicaid FFS you can go to any doctor who is contracted with DSHS. Contact the doctor to see if they are a Medicaid provider before making an appointment.

To find a doctor or clinic in your area, you may call this toll-free number:

**1-800-562-3022**

If you are enrolled in managed care under Healthy Options/State Children’s Health Insurance Program (HO/SCHIP) you can call one of the plans listed directly below and request care.

If you need more help or information you can go to the Healthy Options website

<http://fortress.wa.gov/dshs/maa/HealthyOptions/index.html>

or you can call **1-800-562-3022** and speak to someone about the medical plans available in your community.

The following medical plans provide Managed Health Care to those who receive Medicaid.

Plan Name	Toll-Free Telephone Numbers
Columbia United Providers	1-800-315-7862
Community Health Plan of WA	1-800-440-1561
Group Health Cooperative	1-888-901-4636
Kaiser Foundation Health Plan	1-800-813-2000
Molina Healthcare of Washington, Inc.	1-800-869-7165
Regence BlueShield/Asuris Northwest Health	1-800-669-8791(Regence) 1-866-240-9560 (Asuris)

## **CMS draft form**

### **EPSDT RIGHTS FOR CHILDREN:**

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a health program for children with Medicaid coverage, including foster children. With EPSDT, children can get a regular checkup. If your child needs to get medical care for a problem that is found during the checkup, Medicaid will also pay for the follow-up care. Every child from birth to 21 years of age has Medicaid coverage to get regular health checkups.

### **When should children get a checkup?**

Children should receive their first exam soon after the child is eligible for Medicaid. After the first exam, Children two to six years old should get a checkup once a year. Children age seven through 20 should get a check up every other year. For children under age two, consult with your primary care provider about how often to get a check up. Medicaid will also cover a dental checkup for children twice a year.

### **What if I need transportation for medical care?**

In many cases Medicaid will pay for transportation to health related services. If you need help finding transportation call this toll-free number:

**1-800-562-3022**

### **What if my child or I need a Dentist?**

Limited dental coverage is available to Medicaid enrollees. To find a dentist, call the local dental society in your area. It will be listed in the yellow pages under "Dentist Referral" or call the number above.

## **Member Satisfaction Survey**

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

## **RSNs & Mental Health Service Providers by Region**

This information is subject to change and is updated on the MHD website on a monthly basis.  
<http://www1.dshs.wa.gov/mentalhealth/rsnmap.shtml>

## **Chelan-Douglas Regional Support Network**

Serving Chelan and Douglas Counties

636 Valley Mall Parkway, Suite 200

East Wenatchee, WA 98802-4875

Web: <http://www.cdrrsn.org>

Toll Free: 1-877-563-3678

Public Phone: 509-886-6318

Ombuds Services: 1-800-346-4529

24-Hour Crisis Line: 1-800-852-2923

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## **CMS draft form**

### *Authorized Community Mental Health Agencies*

Catholic Family & Child Services 509-662-6761  
640 South Mission, Wenatchee, WA 98801-2263  
*Alternative languages available: Spanish*

Children's Home Society 509-663-0034  
1014 Walla Walla Avenue, Wenatchee, WA 98801-1523  
*Alternative languages available: Spanish*

Columbia Valley Community Health/Behavior Health Services 1-509-662-7195 Toll Free: 888-424-6124  
701 N. Miller Street, Wenatchee WA 98801-2086

Columbia Valley Community Health/Behavior Health Services 1-509-662-4296  
504 Orondo St., Wenatchee, WA 98801

## **Clark County Regional Support Network**

Serving Clark County  
PO Box 5000  
Vancouver, WA 98666-5000  
CCRSN Web: [www.clark.wa.gov/mental-health/index.html](http://www.clark.wa.gov/mental-health/index.html)  
Toll Free: 1-800-410-1910  
Public Phone: 360-397-2130  
Ombuds Services:(360) 397-8470  
Ombuds Services Toll Free: 1-866-666-5070  
24-Hour Crisis Line: 1-800-626-8137

### *Authorized Community Mental Health Agencies*

Catholic Community Services 360-567-2211  
9300 NE Oak View Dr. #B, 2<sup>nd</sup> floor, Vancouver, WA 98662  
*Alternative languages available: French, Russian and Spanish*

Children's Center 360-699-2244  
415 W. 11th Street, Vancouver, WA 98666-0484  
*Alternative languages available: Russian and Spanish*

Children's Home Society 360-695-1325  
309 W. 12th Street, Vancouver, WA 98666-0605

Columbia River Mental Health Services 360-993-3000  
6926 E. Fourth Plain Boulevard, Vancouver, WA 98661-7254

*Alternative languages available: American Sign Language, Cambodian, Chinese, French, German, Korean, Laotian, Russian, Spanish, Tagalog, Taiwanese, Thai and Vietnamese*

Family Solutions 360-695-0115  
1104 Main Street, Suite 500, Vancouver, WA 98660-2972  
*Alternative languages available: Spanish*

Lifeline Connections 360-397-8246  
1601 E 4<sup>th</sup> Plain blvd., Vancouver WA 98668-1678

Community Services Northwest 360-397-8484

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1601 E 4th Plain Blvd, Bldg., Vancouver, WA 98668-1845  
Southwest Washington Medical Center 360-696-5300  
3400 Main Street, Vancouver, WA 98668-1600

**Grays Harbor County Regional Support Network**

Serving Grays Harbor County  
2109 Sumner Avenue, Suite 203  
Aberdeen, WA 98520-3699  
Web: [www.ghphss.org](http://www.ghphss.org)  
Toll Free: 1-800-464-7277 – County Only  
Public Phone: 360-532-8665  
Ombuds Services: 1-888-816-6546  
24-Hour Crisis Line: 1-800-685-6556

*Authorized Community Mental Health Agencies*

Behavioral Health Resources 360-482-5358  
575 E. Main Street, Suite C, Elma, WA 98541-9551

*Alternative languages available: Spanish*

Crisis Clinic 360-532-4357  
615 8th Street, Hoquim, WA 98550  
Evergreen Counseling Center 360-532-8629  
205 8th Street, Hoquiam, WA 98550-2507  
*Alternative languages available: Spanish*

**Greater Columbia Behavioral Health Regional Support Network**

Serving Asotin, Benton, Columbia, Franklin, Garfield, Kittitas,  
Klickitat, Skamania, Walla Walla, Whitman and Yakima Counties and the Yakama Nation  
101 N. Edison Street, Kennewick, WA 99336-1958

Web: <http://www.gcbh.org>  
Toll Free: 1-800-795-9296  
Public Phone: 509-735-8681  
Ombuds Services: 1-800-257-0660 or 509-783-3325  
24-Hour Crisis Lines:  
Asotin: 888-475-5665  
Benton-Franklin: 800-548-8761  
Columbia: 866-382-1164  
Garfield: 888-475-5665  
Kittitas: 509-925-9861  
Klickitat: 509-733-5801 / 1-800-572-8122  
Skamania: 509-427-9488  
Walla Walla: 509-527-3278

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Whitman: 866-871-6385

Yakima: 509-575-4200 / 1-800-572-8122

*Authorized Community Mental Health Agencies*

Benton/Franklin Counties Crisis Response Unit 509-783-0500

2635 W. Deschutes Avenue, Kennewick, WA 99336-3004

*Alternative languages available: Spanish*

Catholic Family and Child Services 509-965-7100

5301 Tieton Drive, Suite "C", Yakima, WA 98908-3478

*Alternative languages available: Spanish*

Central WA Comprehensive Mental Health (Yakima) 509-575-4084

402 S. Fourth Avenue, Yakima, WA 98907-0959

*Alternative languages available: Spanish*

Central WA Comprehensive Mental Health - Ellensburg 509-925-9861

220 W. 4th Avenue, Ellensburg, WA 98926

Central WA Comprehensive Mental Health - Goldendale

112 W. Main Street, Goldendale, WA 98620 509-773-5801

Central WA Comprehensive Mental Health - Sunnyside

1319 Saul Road S., Sunnyside, WA 98944 509-837-2089

Central WA Comprehensive Mental Health - White Salmon

251 Rhine Village Drive, White Salmon, WA 98672 509-493-3400

Garfield County Human Services 509-843-3791

856 W. Main Street, Pomeroy, WA 99347

Inland Counseling Network (Walla Walla) 509-525-0241

225 Woodland Ave, Walla Walla, WA 99362-3002

Inland Counseling Network - Dayton 509-382-2527

221 E. Washington Avenue, Dayton, WA 99328

Inland Counseling Network - Dayton 509-382-2525

213 W. Clay Street, Dayton, WA 99328

Lourdes Counseling Center 509-943-9104

1175 Carondelet Drive, Richland, WA 99352-3396

*Alternative languages available: Fijian, Hindi, Meman, Punjabi, Spanish and Urdu*

Lutheran Community Services Northwest 509-735-6446

3321 W. Kennewick Avenue, Suite 150, Kennewick, WA 99336-2959

Nueva Esperanza Community Counseling Center - La Clinica 509-545-6506

720 W. Court Street, Suite 8, Pasco, WA 99301-4178

*Alternative languages available: Spanish and Toisan*

Palouse River Counseling Center 509-334-1133

340 NE. Maple, Pullman, WA 99163

Rogers Counseling Center 509-758-3341

900 7th Street, Clarkston, WA 99403-2058

Senior Solutions 509-527-0566

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5 W. Alder, Suite#328, Walla Walla, WA 99362  
Skamania County Counseling Center 509-427-3850  
Skamania County Health Services Center  
683 SW Rock Creek Drive, Stevenson, WA 98648  
Sunderland Family Treatment Services 509-736-0704  
8514 W. Gage Boulevard, Suite#301, Kennewick, WA 99336-8120  
Walla Walla County Crisis Response Unit 509-522-4278  
310 W. Poplar, Walla Walla, WA 99362  
*Alternative languages available: Spanish*  
Yakima Valley Farmworkers Clinic Behavioral Health Services 509-453-1344  
918 E. Mead Avenue, Yakima, WA 98903-3720  
*Alternative languages available: Spanish*  
Yakima Valley Farm Workers Clinic Behavioral Health Services - Toppenish 509-865-5600 x2300  
518 West First, Building 602A, Toppenish, WA 98948

**King County Regional Support Network**

Serving King County  
821 2nd Avenue, Suite 610  
Seattle, WA 98104-1598  
NEW ADDRESS EFFECTIVE AUGUST 2007  
401 Fifth Ave, Suite 400  
Seattle, WA 98104  
Web: <http://www.metrokc.gov/dchs/mhd/mhp/guide.htm>  
Toll Free: 1-800-790-8049  
Public Phone: 206-296-5213  
Ombuds Services: 1-800-790-8049 or 206-205-5329  
24-Hour Crisis Line: 1-866-427-4747 or 206-461-3222 TDD 206-461-3219

*Authorized Community Mental Health Agencies*

Asian Counseling & Referral Services 206-695-7600  
720 8th Avenue S. Suite 200, Seattle, WA 98104-3034  
*Alternative languages available: Cambodian, Cantonese, French, H'mong, Ilocano, Japanese, Korean, Lao, Mandarin, Mien, Samoan, Tagalog, Thai, Taiwanese, Vietnamese and Visayan*  
Children's Hospital & Regional Medical Center Front Desk: 206-987-7261  
4800 Sand Point Way NE, Seattle, WA 98105-0371 Intake (New Patients Only): 206-987-2760  
*Alternative languages available: ASL*  
Community House Mental Health 206-322-2387  
431 Boylston Avenue E., Seattle, WA 98102-4903  
*Alternative languages available: Spanish*  
Community Psychiatric Clinic 206-461-3614  
4319 Stone Way N., Seattle, WA 98103-7490  
*Interpreters available for any language upon request*

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- Consejo Counseling & Referral Services 206-461-4880  
3808 S. Angeline Street, Seattle, WA 98118-1712  
*Alternative languages available: Spanish*
- Downtown Emergency Service Center 206-464-1570  
515 - 3rd Avenue, Seattle, WA 98104  
*Alternative languages available: Spanish*
- Evergreen Healthcare 206-923-6300/1-800-548-0558  
2414 SW Andover Street D-120, Seattle, WA 98106
- Harborview Mental Health Services 206-744-9611  
325 9th Avenue, BOX 359797 Seattle, WA 98104  
*Interpreters available for any language upon request*
- Highline/West Seattle Mental Health Center 206-933-7000  
2600 SW Holden Street, Seattle, WA 98126-3505  
*Alternative languages available: Interpreters for any language available o request*
- Sea-Mar Community Health Center 206-766-6976  
10001 17<sup>th</sup> Place S, Seattle WA 98168  
*Alternative languages available: Spanish*
- Seattle Children's Home 206-283-3300  
2142 10th Avenue W., Seattle, WA 98119-2899  
*Alternative languages available: ASL, Greek, Spanish and Vietnamese*
- Seattle Counseling Service for Sexual Minorities 206-323-1768  
1216 Pine Street suite 300, Seattle WA 98101
- Sound Mental Health 206-302-2200  
1600 E. Olive St., Seattle, WA 98122-2799  
Branches also available in North Seattle, Bellevue, Redmond, Renton, Kent, Auburn and Snoqualmie  
*Alternative languages available: ASL, French, Gaelic, German, Hebrew, Hindi, Japanese, Mandarin, Russian, Spanish, Tagalog and Taiwanese*
- Therapeutic Health Service, Rainier Beach 206-723-1980  
5802 Rainier Avenue S., Seattle, WA 98118-2706  
*Alternative languages available: Amharic, Cambodian, French, Japanese, Luthyia & Swahili*
- Valley Cities Counseling & Consultation 253-939-4055  
2704 "I" Street NE, Auburn, WA 98002-2498  
*Alternative languages available: Czech, French, German, Punjabi, Russian and Spanish*
- Valley Cities Counseling & Consultation – Federal Way 253-661-6634  
33301 1st Way South, Federal Way, WA 98003-6252
- Valley Cities Counseling & Consultation - Kent 253-520-9350  
325 W Gowe Street, Kent, WA 98032-5892
- YMCA Mental Health Services 206-382-5340  
2100 24<sup>th</sup> Avenue South, Suite 260, Seattle, WA 98104

## **North Central Washington Regional Support Network**

Serving Adams, Grant, Okanogan, Ferry, Lincoln, Pend Oreille and Stevens Counties.

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**CMS draft form**

119 Basin Street SW

Ephrata, WA 98823

Toll Free: 1-800-251-5350

Public Phone: 509-754-6577

Ombuds Services: 1-800-572-4459

24-Hour Crisis Lines:

Adams (collect): 509-488-5611

Grant (collect): 509-765-1717 / 1-877-467-4303

Lincoln: 1-888-380-6823

Okanogan: 509-826-6191 or 1-866-826-6191 – Okanogan County only

Pend Oreille: 1-866-847-8540

Stevens: 1-888-380-6823

Ferry: 1-866-268-5105

*Authorized Community Mental Health Agencies*

Community Counseling Services of Adams County 509-488-5611

425 East Main, Suite 600, Othello, WA 99344-1003

*Alternative languages available: Spanish*

Community Counseling Services of Adams County - Ritzville 509-659-4357

120 W. Main, Ritzville, WA 99169

Ferry County Community Services 509-775-3341

42 Klondike Road, Republic, WA 99166-9701

Grant Mental Healthcare 509-765-9239

840 East Plum Street, Moses Lake, WA 98837-0160

*Alternative languages available: Spanish*

Grant Mental Healthcare - Grand Coulee 509-633-1471

322 Fortuyn Road, Grand Coulee, WA 99133

Grant Mental Healthcare – Quincy 509-787-4466

203 South Central Avenue, Quincy, WA 98848

Okanogan Behavioral Healthcare, Inc. 509-826-6191/Toll Free 866-826-6191

1007 Koala Drive, Omak, WA 98841-3208

*Alternative languages available: Spanish*

Pend Oreille County Counseling Services 509-447-5651

105 South Garden Avenue, Newport, WA 99156

Stevens County Counseling Services 509-684-4597 866-708-4597

165 E. Hawthorne Avenue, Colville, WA 99114-2629

Davenport: 1211 Merriam, Davenport, WA 99122

509-725-3001, 888-725-3001

Chewelah: Municipal Bldg., E. Clay & 2<sup>nd</sup>, Room 201, Chewelah, WA 99109

509-935-4808

Nine Mile Falls: 6176-B, Highway 291, Suite 203, Nine Mile Falls, WA 99026

509-262-0396

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**North Sound Mental Health Administration Regional Support Network**

Serving Island, San Juan, Skagit, Snohomish and Whatcom Counties.

117 N. 1st Street, Suite 8

Mount Vernon, WA 98273-2858

Web: <http://www.nsmha.org>

Toll Free: 1-800-684-3555

Public Phone: 360-416-7013

Customer Service: Both Local and Toll Free

Ombuds Services: 1-888-336-6164

24-Hour Crisis Line: 1-800-584-3578

Regional Access System for Outpatient Services for North Sound Region

1-888-693-7200

*Authorized Community Mental Health Agencies*

Bridgeways 425- 513-8213

1220 75th Street SW, Everett, WA 98203

Catholic Community Services (Skagit County) 360-416-7546

320 Pacific Place, Mount Vernon, WA 98273

Catholic Community Services – Whatcom County (Whatcom County) 360-676-2164

1133 Railroad Avenue, Bellingham, WA 98225

Compass Health (Snohomish County) 1-800-457-9303

4526 Federal Avenue, Everett, WA 98203-8810

*Alternative languages available: American Sign Language, Arabic, Bosnian, Cambodian, Cantonese, Farsi, French, Japanese, Korean, Mandarin, Romanian, Russian, Spanish, Tagalog, and Ukrania*

Compass Health – Island County (Island County) 360-678-5555 or 360-312-4868

105 NW First St. Coupeville, WA 98239

*Alternative Languages Available: Spanish*

Compass Health – San Juan County (San Juan County) 360-378-2669

520 Spring St., Friday Harbor, WA 98250

*Alternative Languages Available: Spanish*

Compass Health – Skagit County (Skagit County) 360-419-3500

1100 South 2nd Street, Mount Vernon, WA 98273

*Alternative Languages Available: Spanish*

Lake Whatcom Residential and Treatment Center (360) 676-6000

609 A North Shore Drive, Bellingham WA 98226-4414

Sea Mar Counseling and Social Services Bellingham: 360-734-5458

4455 Cordata Pkwy, Bellingham, WA 98226-8037 Everett: 425-347-5415

*Alternative languages available: French and Spanish* Mount Vernon: 360-428-8912

Volunteers of America 425-259-3191

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2802 Broadway, Everett, WA 98201  
Whatcom Counseling & Psychiatric Clinic 360-676-2220/1-888-311-0120  
3645 E. McLeod Road, Bellingham, WA 98226-8799

**Peninsula Regional Support Network**

Serving Clallam, Jefferson and Kitsap Counties.  
614 Division Street, MS 23  
Port Orchard, WA 98366-4676  
Toll Free: 1-800-525-5637  
Public Phone: 360-337-4886  
Ombuds Services: 1-888-377-8174  
24-Hour Crisis Lines:  
Kitsap County: (360) 479-3033/ (800) 843-4793  
East Jefferson County: (360) 385-0321 / (800) 659-0321  
East Clallam County: (360) 452-4500  
West Jefferson and West Clallam County: (360) 374-5011  
(Non-Business hours): (360) 374-6271

*Authorized Community Mental Health Agencies*

Jefferson Mental Health Services 360-385-0321  
884 West Park Avenue, Port Townsend, WA 98368-0565  
Kitsap Mental Health Services 360-405-4010  
5455 Almira Drive, Bremerton, WA 98311-8331  
*Alternative languages available: Japanese, Spanish and Tagalog*  
Peninsula Community Mental Health Center 360-457-0431  
118 East 8th Street, Port Angeles, WA 98362-6129  
West End Outreach Services 360-374-5011  
530 Bogachiel Way, Forks, WA 98331-9120  
*Alternative languages available: Spanish*

**Pierce County (FFS effective January 2008)**

Serving Pierce County  
3580 Pacific Avenue  
Tacoma, WA 98418-7915  
Toll Free: 1-800-531-0508  
Public Phone: 253-798-7202  
Ombuds Services: 1-800-531-0508  
24-Hour Crisis Line: 1-800-576-7764

*Authorized Community Mental Health Agencies*

Mobile Outreach Crisis Services 253-798-2709  
Crisis Triage 253-798-4357

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3580 Pacific Avenue, Tacoma, WA 98418-7915

Crisis Intervention Teams Tacoma/Peninsula Area: 253-396-5089

Lakewood/Southwest Pierce County Area: 253-584-8933

Puyallup/East Pierce County Area: 253-445-8125

or 1-888-445-8125

Asian Counseling Services 253-697-8650

4301 South Pine Street, Suite 456, Tacoma, WA 98409

*Alternative languages available: Many Asian Languages spoken*

Catholic Community Services 253-759-9544

5410 N. 44th Street, Tacoma, WA 98407-3799

*Alternative languages available: American Sign Language, Cambodian, Chamorro, Dagaari, French, German, Korean, Nigerian, Norwegian, Romanian, Shona, Spanish, Swedish, and Tagalog*

Comprehensive Mental Health (Tacoma/Peninsula Area)

514 S. 13th Street, Tacoma, WA 98402 (Adults/Older Adults) 253-396-5000

1201 S. Proctor Street, Suite 1, Tacoma, WA 98405-2095 (Children/Families) 253-396-5800

*Alternative languages available: American Sign Language, Cantonese, Farsi, German, Hindi, Italian, Mandarin, Palauan, Punjabi, Russian, Samoan, Spanish, Swahili, Tagalog, Ukrainian and Vietnamese*

Good Samaritan Community Health Services (Puyallup/East Pierce County) 253-445-8120

325 E. Pioneer, Puyallup, WA 98372-3265

*Alternative languages available: American Sign Language, Cambodian, French, German, Korean, Mandarin, Samoan, Spanish, Taiwanese, Thai, and Vietnamese*

Greater Lakes Mental Healthcare (Lakewood/Southwest Pierce County) 253-581-7020

9330 59th Avenue SW, Lakewood, WA 98499-6600

*Alternative languages available: American Sign Language, Arabic, German, Korean, Spanish, and Tagalog*

Kwawachee Counseling Center of the Puyallup Tribal Health Authority 253-593-0247

2209 E. 32nd Street, Tacoma, WA 98404-4997

Pierce County Residential Treatment Facility

3580 Pacific Avenue Tacoma WA 98418-7915

Evaluation & Treatment 253-798-4443

Crisis Triage 253-798-4357

Detox 253-798-4430

Sea Mar Counseling and Social Services 253-396-1634

1112 S. Cushman Avenue, Tacoma, WA 98405-3631

*Alternative languages available: Spanish*

## **Southwest Regional Support Network**

Serving Cowlitz County.

1952 9th Avenue

Longview, WA 98632-4045

Web: <http://www.cowlitzcounty.org/humanservices/swrsn.htm>

Toll Free: 1-877-400-7687

Public Phone: 1-360-501-1201

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Ombuds Services: 360-414-0237  
Crisis Line: 360-425-6064  
24-Hour Crisis Line: 1-800-803-8833

*Authorized Community Mental Health Agencies*

Center for Behavioral Solutions 360-414-2280  
600 Broadway, Longview, WA 98632-3256  
*Alternative languages available: Spanish*  
Lower Columbia Mental Health Center 360-423-0203  
921 14th Avenue, Longview, WA 98632-2316  
*Alternative languages available: Filipino, German, Russian and Spanish*  
Youth and Family Link 360-423-6741  
907 Douglas, Longview WA 98632

**Spokane County Regional Support Network**

Serving Spokane County.  
312 West 8th Avenue, 3rd Floor  
Spokane, WA 99204-2506  
Web: <http://www.spokanecounty.org/mentalhealth>  
Toll Free: 1-800-273-5864  
Public Phone: 509-477-5722  
Ombuds Services: 1-866-814-3904/509-477-4666  
24-Hour Crisis Line: 1-877-678-4428

*Authorized Community Mental Health Agencies*

Catholic Charities Counseling Program 509-242-2308  
1212 West Sharp Avenue, Suite 3, Spokane WA 99201  
Children's Home Society Washington 509-747-4174  
2323 N. Discovery Place, Spokane Valley, WA 99216  
*Alternative Languages Available: Spanish*  
Family Service Spokane 509-838-4128  
7 South Howard Street, Suite 321, Spokane, WA 99201  
Hope Partners/REM Associates 509-835-3599  
1117 West First Avenue, Spokane, WA 99201  
*Alternative Languages Available: Spanish*  
Lutheran Community Services Northwest 509-747-8224  
210 West Sprague Avenue, Spokane, WA 99201  
Partners with Families and Children: Spokane 509-473-4810  
613 South Washington Street, Spokane WA 99204  
Passages Family Support Program/Volunteers of America 509-892-9241  
525 West Second Avenue, Spokane WA 99201  
Spokane County Supportive Living Program 509-477-4388

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1725 North Ash Street, Spokane, WA 99205

*Alternative languages available: Spanish*

Spokane Mental Health 509-838-4651

107 South Division Street, Spokane, WA 99202

*Alternative languages available: American Sign Language, German, Tagalog, and Spanish*

The N.A.T.I.V.E. Project 509-325-5502

1803 W. Maxwell Avenue, Spokane, WA 99201

**Thurston-Mason Regional Support Network**

Serving Mason and Thurston Counties.

Web: <http://www.co.thurston.wa.us/health/ssrsn>

412 Lilly Road NE

Olympia, WA 98507

Toll Free: 1-800-658-4105

Public Phone: 360-786-5830

TDD: 360-786-5602/1-800-658-6384/1-800-658-6384

Ombuds Services: 360-786-5585 x12982#/1-800-624-1234 x15585#

24-Hour Crisis Line: 1-800-627-2211

*Authorized Community Mental Health Agencies*

**Behavioral Health Resources**

3857 Martin Way East

Olympia WA 98506

360-704-7170 or 1-800-825-4820

*Alternative Languages Available: ASL, Cantonese, French, German, Spanish, Vietnamese*

Providence St. Peter Hospital Outpatient Services (Older Adult)

413 Lilly Rd NE

Olympia, WA 98506

360-493-7060

Evaluation & Treatment Facility

3436 Mary Elder Rd NE

Olympia, WA 98506

360-754-1338 or 1-800-270-0041

Sea Mar Community Health Center

409 Custer Way, Suite D

Tumwater, WA 98501

360-570-8258

**Timberlands Regional Support Network**

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Serving Lewis, Pacific and Wahkiakum Counties.

PO Box 217

Cathlamet, WA 98612-0217

Toll Free: 1-800-392-6298

Public Phone: 360-795-3118

Ombuds Services: 1-888-662-8776

24-Hour Crisis Lines:

Lewis County: 1-800-559-6696

Pacific County: 1-800-884-2298

Wahkiakum County: 1-800-635-5989

### *Authorized Community Mental Health Agencies*

Cascade Mental Health Care

135 W. Main, Chehalis, WA 98532-0378 360-748-6696/1-800-559-6696

2428 Reynolds Avenues, Centralia, WA 98531 360-330-9044/1-800-559-6696 (Child & Adolescent Program)

Wahkiakum County Mental Health Services 360-795-8630/1-800-635-5989

42 Elochoman Valley Road, Cathlamet, WA 98612-9602

Willapa CC Raymond Office

1107 North Pacific Hwy, Long Beach, WA 98631 360-642-3787/1-800-884-2298

300 Ocean Avenue Raymond, WA 98577-0065

360-875-9426/fax: 360-942-5312/1-800-884-2298

### **End of Attachment H.I.a.**

**Upcoming Waiver Period** -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items that apply to the State or MCO/PIHP/PAHP. Items that are required have “[Required]” in front of them. Checking a required item affirms the State’s intent to comply. If the State does not check a required item, please explain why.

**a. X** [Required] The State will ensure that materials provided to ~~potential enrollees and~~ enrollees by the State, ~~the enrollment broker,~~ and the MCO/PIHP/PAHP are in a manner and format that may be easily understandable.

The MHD makes the above information available at the first point of approval of Medicaid eligibility - the Community Service Office (CSO), including the list of relevant contact information for both the state and the RSN. Additionally, in the letter received by each Medicaid enrolled individual from DSHS there is a paragraph explaining their mental health benefit and how to access mental health services. That section reads: “Mental illness affects many of us at some time in our lives. As a part of your Medicaid

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coverage, you can get mental health services such as: case management; therapy; medication management; hospitalization or crisis services, should you need them. Look in the phone book for crisis service numbers. Other mental health services are available to you through a Regional Support Network. Ask your worker how to contact them.”

This information is again available through the Community Mental Health Agencies, the RSN offices, through the Involuntary Detention process if this is an enrollee’s first contact with the mental health system, on the Mental Health Division’s website and/or by calling the MHD’s 1-800 number.

- b. X** ~~Potential enrollee and~~ enrollee materials will be translated into the prevalent languages listed below (If the State does not require written materials be translated, please explain):

The State defines prevalent non-English languages as: (check any that apply):

1.     Spoken by significant number of potential enrollees and enrollees.

2. X The languages spoken by approximately 5% percent or more of the potential enrollee/enrollee population which is currently limited to Spanish.

3.     Other (please explain):

The Department of Social and Health Services, the single state agency, identifies and translates the benefit booklet into the following languages.

Cambodian, Chinese, Korean, Laotian, Russian, Spanish, Vietnamese

- c. X** [Required] Oral translation services are available to all ~~potential enrollees and~~ enrollees, regardless of language.

- d. X** [Required] The State will have a mechanism in place to help enrollees ~~and potential enrollees~~ understand the managed care program. Please describe.

The State has produced the required informational materials for consumers and conducts surveys of consumers and stakeholders to determine to their knowledge of managed care.

- e. X** [Required] Each MCO/PIHP will have a mechanism in place to help potential enrollees and enrollees understand the requirements and benefits of the plan. Please describe.

The State has produced the required informational materials for consumers. The PIHP is required to have more specific information with regard to authorization of services and level of care information and it must be in an easily understood format for consumers.



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f. X The State's and MCO/PIHP/PAHP information materials are available *when requested* in alternative formats that takes into consideration the special needs of those, for example, with visual impairments.

**II. Potential Enrollee Information**

Not applicable under this waiver - all Medicaid eligible are enrolled.

**Upcoming Waiver Period --** This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not checked, please explain why.

a.      **[Required] Timing.** The State or its contractor will provide the required information:

- (i) at the time the potential enrollee becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory program.
- (ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs/PIHPs/PAHPs.

b. **Content** The State and/or its enrollment broker provides the following information to potential enrollees.

- 1.      Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities
- 2.      An initial notification letter
- 3.      A form for enrollment in the waiver program and selection of a plan
- 4.      Comparative information about plans
- 5.      Information on how to obtain counseling on choice of MCOs/PIHPs
- 6.      A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);
- 7.      A health risk assessment form to identify conditions requiring immediate attention.
- 8.      **[Required]** General information about:
  - (i)      Basic features of managed care;

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- (ii) \_\_ Which populations are excluded from enrollment, subject to mandatory enrollment; or eligible for voluntary enrollment
- (iii) \_\_ MCO/PIHP/PAHP responsibilities for coordination of care

9. \_\_ [Required] Specific information about each MCO/PIHP/PAHP (a summary may be provided, but State must provide detailed information upon request):

- (i) \_\_ Benefits covered
- (ii) \_\_ Cost sharing (if any)
- (iii) \_\_ Service area
- (iv) \_\_ Names, locations, telephone numbers of, and non-English language(s) spoken by contracted providers, and identification of providers not accepting new patients (at a minimum: primary care physicians, specialists, and hospitals)
- (v) \_\_ Benefits available under state plan but not covered contract, including how and where to obtain; cost sharing; and how transportation provided. For counseling/referral service that MCO/PIHP/PAHP does not provide, State must provide information.

10. \_\_ Other items (please explain):

### III. Enrollee Information

a. The State has designated the following as responsible for providing required information to enrollees:

- (i)  the State or its contractor
- (ii) \_\_ the MCO/PIHP/PAHP

b. \_\_ [Required] **Timing.** The State, its contractor, or the MCO/PIHP/PAHP must provide the information to enrollees as follows:

- 1.  For new enrollees, all required information *will be provided at the CSO with their enrollment package* .~~within a reasonable time after the MCO/PIHP/PAHP receives notice of beneficiary's enrollment.~~
- 2.  For existing enrollees:
  - (A) ~~State must notify of disenrollment rights at least annually, and if there is a lock in, by no less than 60 days before the start of each enrollment period.~~ N/A
  - (B) Notify all enrollees of right to request and obtain required information at least once a year.
  - (C) Provide written notice of any significant change in required

information

(D) MCO/PIHP/PAHP will make a good faith effort to give written notice of termination of contracted provider within 15 days after receipt of termination notice, to each enrollee who received primary care from, or was seen on regular basis by, terminated provider.

(c) X [Required] Content: The State, ~~its contractor, or the MCO/PIHP/PAHP~~ will provide the following information to all enrollees:

- (i) X Benefits covered
- (ii) X Cost sharing
- (iii) X Individual provider information -- name, location, telephone, non-English languages, ~~not accepting new patients (for MCO, PIHP, PAHP must include at a minimum PCPs, specialists, hospitals)~~
- (iv) X Benefits available under state plan but not covered under contract, including conscience clause
- (v) X Restrictions on freedom of choice within network
- (vi) X Enrollee rights and protections
- (vii) X Procedures for obtaining *mental health* benefits
- (viii) X Extent to which benefits may be obtained out of network (~~including family planning~~)
- (ix) X Which and how after hours and ~~emergency crisis care per this waiver~~ are provided including
  - ~~• Definition of emergency medical condition, emergency services, and post-stabilization services~~
  - ~~• No prior authorization for emergency services~~
  - Procedure for obtaining *emergency crisis* services *including crisis numbers*
  - ~~• Location of emergency settings~~
  - ~~Right to use any hospital for emergency care~~
- (x)    Post-stabilization rules
- (xi)    Referral for specialty care
- (xii)    [Optional] PAHP grievances procedures if available (if PAHP makes available, need to describe to enrollees)
- (xiii) x State fair hearing rights
  - Right to hearing
  - Method for obtaining hearing
  - Rules governing representation at hearing
- (xiv) X MCO/PIHP grievance, appeal, and fair hearing procedures and timeframes, including:
  - Right to file grievances and appeals
  - Requirements and timeframes for filing grievance or appeal

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- Availability of assistance in filing process
  - Toll-free number to file grievance or appeal by phone
  - Continuation of benefits, including
    - Right to have benefit continued during appeal or fair hearing
    - Enrollee may have to pay for cost of continued services if decision is adverse to enrollee
  - Any appeal rights State makes available to provider
- (xv) X Advance directives for psychiatric care
- (xvi) X Physician incentive plan information upon request
- (xvii) X Information on structure/operation of plan, upon request

**IV. Enrollee Rights:**

**Upcoming Waiver Period --** Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PIHPs/PAHPs protect enrollee rights.

The State requires:

- a. X [Required] MCOs/PIHPs to have written policies with respect to enrollee rights.
- b. X [Required] Ensure staff and affiliated providers *and their staff* take those rights into account when furnishing *mental health* services to enrollees
- c. X [Required] Ensure compliance with any applicable Federal and State laws that pertain to enrollee rights (such as Civil Rights Act, Age Discrimination Act, Rehabilitation Act, and Americans with Disabilities Act)
- d. X [Required] The State will assure that each enrollee has the following rights:
- (i) X Receive information on their managed care plan
  - (ii) X Be treated with respect, consideration of dignity and privacy
  - (iii) X Receive information on *mental health* treatment options
  - (iv) X Participate in decisions regarding care, including right to refuse treatment
  - (v) X Be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, retaliation
  - (vi) X If privacy rules apply, request and receive copy of medical record and request amendments
  - (vii) X Be furnished *mental health* care services in accordance with access and quality standards.
- e. X [Required] The State will assure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO/PIHP/PAHP or its providers treat the enrollee.

f. \_\_ Other (please describe):

**V. Monitoring Compliance with Enrollee Information and Enrollee Rights**

**Previous Waiver Period**

a. [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PIHP/PAHP enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint, item H.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

Enrollee rights in the public mental health system are found in many statutes and regulations, both state and federal. Rights are monitored both by the EQRO and the QA&I. Findings are addressed via corrective action plans. During the 2006-2008 waiver period there were two fair hearings on rights for adults and none for youth under 21.

**Upcoming Waiver Period** -- Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

- a. \_\_ The State tracks disenrollments and reasons for disenrollments or requires MCOs/PIHPs/PAHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.
- b. \_\_ The State will approve enrollee information prior to its release by the MCO/PIHP/PAHP.
- c. \_\_ The State will monitor MCO/PIHP/PAHP enrollee materials for compliance in the following manner (please describe):
- d. X The State will monitor the MCO/PIHP/PAHPs compliance with the enrollee rights provisions in the following manner (please describe):

The MHD will continue to monitor using the mandatory protocols.

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**Section I. RESOURCE GUIDE**

Below are references that provide information related to Medicaid managed care quality assessment and improvement efforts, and rate setting and risk adjustment methodologies:

Actuarial Research Corporation, Report prepared for the Department of Health and Human Services (DHHS)/the Health Care Financing Administration (HCFA), Capitation Rate Setting in Areas with Eroded Fee-For-Service Base Final Report, 1992.

Actuarial Research Corporation, Setting an Upper Payment Limit Where the Fee for Services Base is Inadequate: Final Report, 1992.

Alpha Center, Report produced for the Robert Wood Johnson Foundation, Risk Adjustment: A Special Report, 1997.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, A Review of Rate Setting Methods of Selected State Medicaid Agencies for Prepaid Health Plans, 1991.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, Actuarially Sound Rate Setting Methodologies, 1991.

Conference Report 105-217 to accompany H.R. 2015, the Balanced Budget Act of 1997, (Section 4705 and the regulations being developed to implement these requirements).

Foundation for Accountability (FACCT), Foundation for Accountability (FACCT) Guidebook for Performance Measurement Prototype Summary, 1995.

Independent Assessment Guide Document, Health Care Financing Administration, December, 1998.

Joint Commission for Accreditation of Healthcare Organizations, National Library of Health Care Indicators, 1997.

Massachusetts Medical Society, Quality of Care: Selections from The New England Journal of Medicine, 1997.

Mathematica Policy Research, Inc, The Quality Assurance Reform Initiative (QARI) Demonstration For Medicaid Managed Care: Final Evaluation Report, 1996.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, A Guide for States: Collecting and Analyzing Medicaid Managed Care Data, 1997.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, Survey of Key Performance Indicators,

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1997.

Medicaid Management Institute of the American Public Welfare Associations, report prepared for DHHS/HCFA, Medicaid Primary Care Case Management Programs: Guide for Implementation and Quality Improvement, 1993.

Merlis, Mark for National Governor's Association (NGA), Medicaid Contracts with HMOs and Pre Paid Health Plans: A Handbook for State Managers, 1987. (\*\*Rate Setting Description still applicable)

National Academy for State Health Policy, Quality Improvement Primer For Medicaid Managed Care, 1995.

National Academy for State Health Policy, Quality Improvement Standards and Processes Used by Select Public and Private Entities to Monitor Performance of Managed Care: A Summary, 1995.

National Academy for State Health Policy, Report prepared for HCFA, Quality Improvement System for Managed Care, 1997.

National Committee for Quality Assurance (NCQA), Health Plan Employer Data and Information Set (HEDIS © Current Version).

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Final report to the President of the United States, Quality First: Better Health Care for All Americans, 1998.

U.S. DHHS/HCFA, A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, 1993.

U.S. DHHS/PHS/AHCPR, Conquest 1.1: A Computerized Needs-Oriented Quality Measurement Evaluation System, 1996.

U.S. DHHS/PHS/AHCPR, Consumer Assessment of Health Plans (CAHPS) Satisfaction Survey, 1997.

U.S. DHHS/PHS/AHCPR, Putting Research to Work in Quality Improvement and Quality Assurance: Summary Report, 1993, Publication No. 93-0034.

U.S. DHHS/PHS/AHCPR Research Activities Newsletter, Monthly publication.

U.S. DHHS/HCFA and National Committee on Quality Assurance (NCQA), Health Care Quality Improvement Studies in Managed Care Settings: Design and Assessment: A Guide for State Medicaid Agencies, 1994, Purchase Order #HCFA-92-1279.

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U.S. DHHS/HCFA/American Public Welfare Association (APWA), Monitoring Risk-Based Managed Care Plans: A Guide for State Medicaid Agencies.

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Quality Improvement Publications: “Managing Managed Care: Quality Improvement in Behavioral Health.”\*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume One, “An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies.”\*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Two, “An Evaluation of Contracts Between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders.”\*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Seven, “Technical Assistance Publication Series (TAP) 22: Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers.”\*

Websites: [www.hcfa.gov](http://www.hcfa.gov), [www.ahcpr.gov](http://www.ahcpr.gov) or outside organizations such as [www.ncqa.org](http://www.ncqa.org), [www.nashp.org](http://www.nashp.org), [www.samhsa.gov](http://www.samhsa.gov), [www.apwa.org](http://www.apwa.org).

\*document can be ordered through the National Clearinghouse on Alcohol and Drug Information (NCADI) 800/729-6686 or found on the SAMHSA Web Site at [www.samhsa.gov/mc/TAS.htm](http://www.samhsa.gov/mc/TAS.htm).